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COMBINING INTERGROUP PERSPECTIVES AND EXPERIENCES OF HIV/AIDS-RELATED STIGMA AND DISCRIMINATION IN FIJI: A MIXED METHODS STUDY

by

Shazna M. Buksh

A thesis submitted in fulfilment of the requirements for the degree of Master of Arts (Psychology)

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Discipline of Psychology
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May, 2014
DECLARATION

Statement by Author
I, Shazna M. Buksh, declare that this thesis is my own work and that, to the best of my knowledge, it contains no material previously published, or substantially overlapping with material submitted for award of any other degree at any institution, except where due acknowledgement is made in the text.

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Statement by Supervisor
The research in this thesis was performed under my supervision and to my knowledge is the sole work of Ms. Shazna Buksh.

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DEDICATION

This work is dedicated to my family for their unequivocal support in my personal goals. My parents, Mohammed and Shamshad Hilal for instilling the value of education and the confidence to pursue my dreams. My husband Zaheer for his patience and understanding. To my sister Naaz for listening to me talk incessantly about my work and my brother Muhsin for his understanding. And finally, to my daughter Naeemah, for her love and for understanding that this is important for me. She was patient when my attention and time were divided. I cannot thank you all enough.
This thesis would not have been possible without the support and patience of some truly amazing individuals in my life, only some of whom it is possible to mention here.

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ABSTRACT

Addressing HIV/AIDS-related stigma and discrimination is a mainstream approach adopted by the Government of Fiji in HIV prevention, treatment, and care. The current exponential growth in HIV cases in Fiji warrants an examination of this approach. This study adopts an ecosocial research orientation within a sequential mixed methods research design to present ingroup experiences and outgroup perceptions of HIV and people living with HIV/AIDS (PLWHA). The primary goal for this study was to identify the social forces and inequalities that cause HIV/AIDS-related stigma in Fiji and its impact on the psychosocial reactions of PLWHA and the attitudes of post-secondary students.

Two separate studies were conducted in stages. In Stage 1 - Qualitative Exploration of Dominant Experiences of PLWHA, semi-structured interviews were conducted with 11 HIV positive (six females and five males), heterosexual participants. Use of Interpretative Phenomenological Analysis permitted detailed exploration of the participants’ personal experiences and perceptions as well as adopting a questioning hermeneutics stance. The qualitative data then informed the research questions and measures for Stage 2 - Survey of Attitudes of Post-Secondary Students (N = 300).

Results from both stages indicated that the epidemiology of HIV/AIDS in Fiji is affected by social forces and inequalities such as gender-based inequality and violence; ethnic variations in psychosocial reaction to stigma; fear of contagion and disease, and sexual stigma associated with the pandemic. These societal mechanisms impact the (1) perception of HIV/AIDS, modes of transmission of HIV/AIDS, and of PLWHA, (2) focus of social policies, and (3) determine the success of stigma interventions. Results also indicated that stigmatising attitudes are complex interrelated constructs and interventions need to concurrently address stigma driven by fear of contagion and disease, and stigma driven by conceptions of immorality, shame, and blame. Finally, while data from the two stages indicated greater prevalence of supportive behaviour and attitudes towards PLWHA, Stage 2 survey data indicated that HIV/AIDS-related stigma has an impact on willingness to provide support for HIV positive close family members amongst post-secondary students. Future research would benefit from continuing to investigate the impact of
stigma on perceptions of HIV/AIDS and PLWHA with other samples from the general public.
ABBREVIATIONS, ACRONYMS AND
SPECIAL TERMS USED

AIDS – Acquired Immune Deficiency Syndrome
ANNOVA – Analysis of Variance
ART – Antiretroviral Therapy
CDC – Centres for Disease Control
FBOs – Faith Based Organisations
FCDC – Fiji Centre for Communicable Diseases Control
FLE – Family Life Education
FJN+ - Fiji Network for People Living with HIV/AIDS
FS – Fear Driven Stigma Score
GRID – Gay-related Immune Deficiency
HIV – Human Immunodeficiency Virus
HIV- – HIV negative
HIV+ – HIV positive
Indian – Fiji national(s) of Indian descent
ICRW – International Centre for Research on Women
IPA – Interpretative Phenomenological Analysis
iTaukei – Individual(s) indigenous to Fiji
JUNP – Joint United Nations Programme
KHIV – Knowledge on modes of transmission of HIV/AIDS Score
MTCT – Mother-to-child transmission of HIV during pregnancy, labour, delivery, and breastfeeding.
MOH – Government of Fiji - Ministry of Health
MRA – Standard Multiple Regression Analysis

NGOs – Non Governmental Organisations

PLWHA – People or Person Living With HIV/AIDS

PIAF – Pacific Islands AIDS Foundation

PASW – Predictive Analytics Software

SARS – Severe Acute Respiratory Syndrome

Seronegative – Having a negative result in a blood test for the presence of HIV.

Seropositive – Having a positive result in a blood test for the presence of HIV.

Serostatus – Term used to refer to the presence or absence of HIV in the blood serum.

STI – Sexually Transmitted Infections

SPSS – Statistical Package for the Social Sciences

SS – Anticipated Secondary Stigma Score

SUP – Support for a hypothetical HIV+ Family Member Score

UNAIDS – United Nations Joint Programme on AIDS

UNGASS – United Nations General Assembly Special Session

VCT – Voluntary Counselling and Testing

VS – Value Driven Stigma Score

WHO – World Health Organisation
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CHAPTER 1
INTRODUCTION

Fiji has a low prevalence of HIV/AIDS (<0.1%). However, unlike the global HIV trend which has stabilised in recent years, HIV is a growing problem in Fiji with figures increasing by approximately 44% in the last five years only (Fiji Centre for Communicable Diseases Control [FCDC], 2011; “Worldwide HIV & AIDS Statistics”, n.d). The primary strategy adopted by the governments of the South Pacific, including Fiji, to curb the proliferation of the pandemic into our societies includes replication of initiatives being used globally. Addressing HIV/AIDS-related stigma and discrimination is a mainstream approach adopted by the Government of Fiji in HIV prevention, treatment, and care and is implemented through the HIV/AIDS Decree (‘Fiji National Plan on HIV and STIs, 2012 – 2015’, 2011).

However, the public perception, response to the pandemic, and response to these interventions have not been analysed. The current exponential growth in HIV cases warrants an examination of Fiji’s approach to HIV control and prevention to determine its relevance and comprehensiveness.

Fiji’s focus on stigma and discrimination is supported by a strong literature base with compelling arguments and evidence. In 2011 United Nations launched the Stigma Fuels HIV campaign: Yet another campaign that reinforces the widely held view that HIV/AIDS-related stigma is one of the greatest obstacles to HIV/AIDS control and prevention (‘Stigma Fuels HIV Campaign – Final Report’, 2012). Stigma and discrimination discourage governments from acknowledging the devastating effects of the pandemic hence taking timely action and it deters individuals from seeking testing and participating in education and prevention activities (Herek, 1999; United Nations Joint Programme on AIDS [UNAIDS], 2007). The fear of discrimination prevents those who know they are infected from disclosing their diagnoses, taking action to protect others, and seeking treatment and care for themselves (Cao, Sullivan, Xu, & Wu, 2006; Chesney & Smith, 1999). This lack of disclosure places both the HIV positive (HIV+) person and potential caregivers (e.g. romantic partner) at risk. Inability to seek treatment and care can also lead to faster disease progression as well as mental health problems such as anxiety, loneliness, depressive symptoms, and having attempted or seriously
considered suicide (Gallego, Gordillo, & Catalan, 2000; UNAIDS, 2007; Whetten, Reif, Whetten, & Murphy-McMillan, 2008). Chesney and Smith (1999) associate these psychological distresses created by HIV/AIDS-related stigma and discrimination with impeded coping and adjustment of people living with HIV/AIDS (PLWH). One of the most significant negative effects of HIV/AIDS-related stigma is the associated sexual stereotypes of PLWA it generates (Herek & Capitanio, 1999). Association of the disease with only certain groups of people (e.g. commercial sex workers, homosexuals, and promiscuous people) generates a false sense of immunity from the disease and handicaps the adoption of practices that prevent sexually transmitted infections (STIs) (Herek, Widaman & Capitanio, 2005).

Qualitative studies conducted in Fiji on HIV/AIDS-related stigma and discrimination with predominantly female, iTaukei HIV+ participants have yielded fairly consistent results. Specifically, these women reported HIV/AIDS-related discrimination from health-care providers, neighbourhood communities, family members, churches, and employers (The Pacific Islands AIDS foundation ([PIAF], 2009; 2011). Gender inequality and poverty were associated with increased risk of infection and exacerbated HIV/AIDS-related stigma. Family members, church groups and non-governmental organisations (NGOs) were identified as important support networks that assist in coping with HIV and associated issues (PIAF, 2009).

In combination, these studies have covered some very important HIV/AIDS-related issues; however several key issues remain unexplored and will be addressed in the present study. Firstly, studies investigating HIV/AIDS-related stigma have selectively focused on identifying forms of stigma and discrimination through qualitative research (e.g. PIAF 2009). This limited focus involves a significant amount of subjectivity and ignores a very important variable in the HIV/AIDS stigma debate; support for PLWA. Fiji has made considerable efforts to address HIV/AIDS-related stigma and discrimination such as extending HIV-oriented activities to under-served groups and rural communities through a partnership between the government and at least 41 community organisations including NGO’s and faith based organisations (FBOs) (Government of Fiji, Ministry of Health [MOH], 2010). Specialised reproductive health clinics (Hub Centres) have been established in the Central (Suva), Western (Lautoka) and Northern (Labasa) divisions. These centres offer voluntary testing and counselling (VCT) and out-
patient care for PLWHA including providing government funded Antiretroviral Therapy (ART). Moreover the Government of Fiji increased its budget allocation for HIV by approximately five million USD in 2009 and is in the process of piloting reproductive health curriculum in secondary schools in Fiji (MOH, 2010). A bidirectional exploratory approach which documents dominant experiences (positive and negative) of PLWHA will indicate if these initiatives are effective.

Secondly, even though sexual stigma and fear of contagion and disease appear to be closely associated with HIV/AIDS-related stigma (Cao et al., 2006; Herek et al., 2005; Parker, Aggleton, & Horizons, 2002), there has not been any empirical assessment of whether these factors might influence HIV/AIDS-related stigma in Fiji by PIAF (2009). Studies also need to extend beyond basic description of forms of discrimination offered in the PIAF studies (e.g. PIAF 2009, 2011) to thoroughly exploring social forces and inequalities that cause HIV/AIDS-related stigma and discrimination with a sample that has representation from both sexes and other ethnic groups. Greater attention should also be given to the psychosocial impact of stigma on emotional responses and coping strategies of PLWHA. These types of investigations would provide interesting extensions to the HIV/AIDS-related stigma research.

Finally, the bulk of the literature on HIV/AIDS-related stigma has either concentrated on PLWHA or the general population. Very few studies have presented the perspectives of the two. Stigma can be fuelled by power differences between an outgroup (PLWHA) and an ingroup (the general population) (Link & Phelan, 2001). Hence HIV/AIDS-related stigma can be better understood and suitable stigma interventions can be formulated when the perspectives and behaviour of both groups are considered. There is a significant amount of qualitative and simple descriptive data on HIV risk behaviour in Fiji. FCDC data indicates an exponential growth in other sexually transmitted infections (STIs) suggesting high prevalence of behaviours that increase risk of HIV transmission. Between 2006 and 2009 STIs like syphilis and gonorrhoea have increased in the overall population by 53%; the incidence amongst teenagers (15 – 19 years old) has increased by a staggering 359% (FCDC, 2011). Fiji also has the highest rates of Chlamydia in the Pacific with one in four women visiting antenatal clinics being diagnosed with the STI (Rina, 2010). Studies conducted in Fiji indicate low and inconsistent use of condoms and barriers
to condom negotiation amongst commercial sex workers (McMillan & Worth, 2010), men who have sex with men (Bavinton et al., 2011), STI clinic attendees, tertiary students, seafarers and uniformed services (MOH, 2010). Low knowledge on modes of transmission of HIV, high rates of multiple and casual partners, low perceived risk of HIV transmission, and early onset of sexual behaviour have also been recorded through qualitative investigations in Fiji (e.g. Hammar et al., 2011). These studies make useful contribution to understanding behaviour behind the exponential increase in STIs such as HIV in Fiji. However, given Fiji’s focus on HIV-stigma interventions as a primary means of controlling HIV infections, studies with representative samples that measure public knowledge on HIV transmission and attitudes (supportive and stigmatising) towards PLWHA need to be conducted and potential relationships between these variables need to be investigated.

This thesis uniquely contributes to literature on HIV/AIDS-related stigma. Previous researchers (e.g. Castro & Farmer, 2005; Link & Phelan, 2001; Parker et al., 2002) have argued that to improve our understanding of HIV/AIDS-related stigma, a series of variables need to be considered including (1) dominant experiences [positive and negative] of PLWHA, (2) the social forces and inequalities that cause and exacerbate HIV/AIDS-related stigma such as pre-existing stigma and discrimination associated with sex, gender, ethnicity, poverty, and fear of contagion and disease, (3) the psychosocial impact of stigma on PLWHA, and (4) public knowledge on HIV transmission and perceptions of PLWHA. This thesis has responded to all of these recommendations and has addressed gaps in local literature on HIV/AIDS-related stigma. The overarching research question for this study is: *What social forces cause HIV/AIDS-related stigma in Fiji and how do they influence the psychosocial reactions of HIV+ participants and the attitudes (stigmatising and supportive) of post-secondary students towards PLWHA?*

Culture shapes practices such as sexual behaviour and attitudes towards HIV/AIDS, PLWHA, VCT, and HIV/AIDS-related interventions, therefore HIV-prevention initiatives need to be culturally and personally sensitive (Parker, 2001; Scrimshaw, Carballo, Ramos, & Blair, 1991). The results of this research will be pivotal in gaining an understanding of the issue of stigma and discrimination in local contexts and bridging gaps between the responses that are being adopted and the actual problem. It will also create awareness on the impact that stigma and discrimination
have, not only on PLWHA, but also on the general public in terms of gaining awareness of the pandemic and preventing its spread. Awareness programmes may then be contextualised which target the misconceptions that Fiji’s society has about HIV/AIDS and PLWHA.

### 1.1 Overview of Research Design and Rationale

To address the overarching research question, this study uses an exploratory mixed methods design. Two separate studies were conducted in stages. The first study was labeled *Stage 1 – Qualitative Exploration of Dominant Experiences of PLWHA*. Semi-structured interviews were conducted with HIV+ participants to explore the social forces and inequalities that cause HIV/AIDS-related stigma in Fiji and identify the resultant psychosocial reactions of PLWHA. A qualitative research strategy was desirable by this stage for two reasons. Firstly, although there is a rich literature base on social forces that cause stigmatising attitudes from other parts of the world, HIV/AIDS-related studies conducted in Fiji have not thoroughly explored the manifestation of these social forces and inequalities in our societies and their relationship with HIV/AIDS-related stigma. Secondly, since HIV/AIDS is considered as a highly stigmatised disease and a sensitive research area as it documents very personal experiences of respondents, subject participation can be expected to be low and will require non-probability sampling techniques. A qualitative research strategy therefore, takes into consideration the limited local research and issues of participant recruitment, while providing in-depth information on the topic.

Five themes were identified from Stage 1 interviewee reports and the data was examined to identify variables that can be effectively measured in the quantitative component. Consequently five variables, which existed across several of these themes, were included in *Stage 2 – Survey of Attitudes of Post-secondary Students*. Patterns observed in the qualitative data set also informed research questions and hypotheses for Stage 2. Finally, statements for the Likert scales used in Stage 2 survey questionnaire were derived from Stage 1 interviewee reports. Stage 2 was geared towards providing a quantitative dimension to the narratives of HIV+ participants from Stage 1. Survey data collected in Stage 2 assisted in interpreting
and verifying qualitative findings by providing an assessment of whether the presentation and distribution of HIV/AIDS-related stigma and support amongst post-secondary students was similar to what was reported by Stage 1 participants. More specifically Stage 2 (1) measured the dominant attitudes (stigma and support) towards PLWHA with a sample of 300 post-secondary students and (2) determined the relationships between social forces and inequalities that cause HIV/AIDS-related stigma and supportive attitudes towards PLWHA. Figure 1.1 outlines the procedures and outcomes for the two stages of this mixed methods sequential exploratory design.

Figure 1.1. The sequential exploratory design adopted in this study.
1.1.1 Thesis Overview

The structure of this thesis is guided by characteristics of the research method used; A sequential exploratory mixed methods design (Creswell, 2009). The underlying principle of this research design dictates that firstly, due to the exploratory nature of the study, no predictions (specific research questions and hypotheses) of the quantitative component are developed until qualitative data has been analysed. Secondly, as the qualitative component dominates the study outcomes, research questions and hypotheses and the development of research materials for the quantitative component are to be grounded and substantiated by the findings of the qualitative component. To remain truthful to this research design, the thesis presents the method and results of Stage 1, the qualitative component first (Chapter 3), followed by the method and results of Stage 2, the quantitative component (Chapter 4). The results from both stages are then combined and discussed in Chapter 5. Adopting this approach in the structure of this thesis also ensures that presentation of qualitative results are not biased towards themes expected to be pursued in the quantitative component. It also creates greater transparency on the rationale behind selection of variables, formulation of research questions, generation of hypotheses, and the construction of research materials for the quantitative component. Due to an extensive literature base on HIV/AIDS-related stigma, Chapter 2 reviews literature on frameworks for defining and studying HIV/AIDS-related stigma and concludes with research questions derived from the literature.
CHAPTER 2
LITERATURE REVIEW – CONCEPTUALISING HIV/AIDS-RELATED STIGMA AND DISCRIMINATION

The HIV/AIDS-pandemic has had extensive global impact in a relatively short time. It has sparked considerable interest among a wide array of groups and organizations such as governments, advocates of vulnerable groups, FBOs, funding agencies, the media, scientists, healthcare professionals and researchers (Fee & Krieger, 1993; WHO [World Health Organisation], 2013). Each interest group has argued its own interpretation of which aspect of this multifaceted phenomenon should be relevant and important. This has resulted in a plethora of approaches and frameworks to study and address issues related to the pandemic. To achieve a logical discussion on HIV/AIDS-related stigma and discrimination a careful examination of these approaches and frameworks need to be conducted. This chapter starts with the identification of a relevant framework for defining stigma which then forms the foundation for discussions for the remainder of the chapter. Power inequalities and their relationship with HIV/AIDS-related stigma are explored, followed by a discussion on manifestations of stigma at five societal levels namely policy and legal, institutional, community, family, and individual. The final section of this chapter reviews literature on theoretical approaches to studying HIV/AIDS-related stigma and discrimination and identifies stigma indicators that will be used in this mixed methods study. Research questions for Stage 1 are also presented at the end of this chapter.

2.1 Conceptualising Stigma

In his landmark book, *Stigma: Notes on the Management of Spoiled Identity*, Goffman (1963, p. 3) described stigma as “an attribute that is deeply discrediting within a particular social interaction”. His description of stigma focused on the attitude of a dominant group (ingroup) towards individuals who possess attributes that fail to meet societal standards and expectations (outgroup). An individual with the undesirable attribute is then “reduced in our minds from a whole and usual person to a tainted, discounted one” (Goffman, 1963, p. 3).
Goffman’s work has been fundamental in creating a framework for research on the stigma construct and continues to provide the theoretical underpinnings for much of the literature on stigma, including in the discipline of social psychology (e.g. Crocker & Major, 1989; Dovidio, Hewstone, Glick & Esses, 2010; Major & O’Brien, 2005). At the individual level, this socio-cognitive approach is especially useful in understanding stigma as an outcome of categorisation followed by stereotyping. However, as others have pointed out, studies that adopt Goffman’s definition underestimate the role of social structural forces as the source of this differentiation (Mahajan et al., 2008; Scambler, 2009). This has been a shortcoming of much of the research in social psychology, most of which have adopted Goffman’s definition of stigma (Fiske, 1998 as cited in Link and Phelan 2001). Structural forces such as inequalities on the basis of gender, ethnicity, class, fear of contagion, and sexuality have been widely identified as social forces that not only create HIV/AIDS-related stigma but also maintain and exacerbate stigmatising attitudes (e.g. by Castro & Farmer, 2005; Parker et al., 2001; Parker & Aggleton, 2003). A combination of the two perspectives of stigma (individual and structural) is offered by Link and Phelan’s (2001) conceptualisation of stigma which explains their relationship (also see Figure 2.1).

Figure 2.1. Framework for defining HIV/AIDS-related stigma adopted in this study.
Drawing from Goffman’s description of stigma, Link and Phelan (2001) stress that stigmatisation is largely the product of supremacy of one group over another and can be a consequence of loss of status. They define stigma as the combination of four core components including labelling, stereotyping, separation, and status loss and discrimination. The first three create a distinction between the ingroup and the outgroup, eventually culminating into the fourth or last step of status loss and discrimination. According to this view, societal mechanisms such as pre-existing conceptions of stigma cause power differences between the ingroup and the outgroup and play a vital role in the creation and maintenance of stigma and discrimination, making it a “persistent predicament” at multiple levels throughout the society (Link & Phelan, 2001, p. 379). Therefore, discrimination is an extension of stigma, embodying negative actions resulting from stigmatisation such as the unjust treatment of an individual based on his or her real or perceived HIV status (Goffman, 1963; Link & Phelan, 2001; UNAIDS, 2007).

Stigma can take two forms (1) *anticipated stigma*, that is imagined fear of discrimination due to an undesirable attribute, for example being HIV+ and (2) *actual stigma*, that is an experience of discrimination due to an undesirable attribute: Studies note the debilitating impact of both types of stigma (e.g. Courtenay-Quirk, Wolitski, Parsons, & Gomez, 2006, p. 56; Wong & Wong, 2006, p. 97). In keeping with these descriptions of stigma, this study adopts the definition proposed by UNAIDS (2007, p. 9) which defines HIV/AIDS-related stigma and discrimination as a “process of devaluation” of PLWHA or individuals associated with HIV/AIDS and recognises that this ‘process’ is driven by social inequalities. This study also recognises the differences between actual and anticipated stigma at the individual level.

### 2.2 Social Forces that Create, Shape and Maintain Stigma

Link and Phelan’s (2001) conceptualisation of stigma is underpinned by power differences caused by social inequalities. This focus has been shared by several researchers and theorists of HIV/AIDS-related stigma. For example drawing from the work of Parker et al. (2002), Castro and Farmer (2005) propose “structural violence” as a conceptual framework for understanding the reasons behind
HIV/AIDS-related stigma. They define the term as the “large-scale social forces” that mould a society, for instance, racism, sexism, poverty, and other social inequalities that are rooted in historical and economic processes (Castro & Farmer, 2005, p. 54). These forces also shape the distribution and outcome of HIV/AIDS. Racism, sexism, and poverty exacerbate one another, especially where political violence and social inequalities are added to the equation. Together, these social forces and inequalities determine not only a risk of HIV infection but also a risk of HIV/AIDS-related stigma (Castro & Farmer, 2005; Parker et al., 2002). Sub-sections 2.2.1 – 2.2.5 further explore the relationships between HIV/AIDS-related stigma and pre-existing stigma associated with sex, gender, ethnicity, poverty, and fear of contagion and disease.

2.2.1 Sexual Stigma

Stigma and discrimination associated with HIV/AIDS is “most closely related to sexual stigma” (Parker et al., 2002, p. 2). The knowledge that the disease is mostly sexually transmitted and initially infected individuals associated with deviant sexual practices such as homosexuality has resulted in much value-laden reaction (Valdiserri, 2002). For instance, without sufficient knowledge about the modes of transmission, in 1981 Curran, (representing Centres for Disease Control [CDC] in Atlanta) claimed that there was no evidence to suggest that the virus could spread to heterosexual communities and women (New York Times, as cited in, Kanabus & Fredriksson, 2009). Likewise, initial names suggested for the pandemic (e.g. gay-related immune deficiency [GRID] and gay cancer) also reflected this conviction that AIDS was a disease for homosexuals only (Altman, 1982 as cited in Kanabus & Fredriksson, 2009; The Washington Blade, 1982 as cited in Kanabus & Fredriksson, 2009).

HIV/AIDS related stigma and discrimination have also “appropriated and reinforced pre-existing sexual stigma associated with STI, homosexuality, promiscuity and prostitution” (Parker et al., 2002, p. 2). For example, a survey conducted between 1996-1997 indicated that in the United States most heterosexuals associate homosexuality and bisexuality with AIDS (Herke & Capitanio, 1999). Nearly a decade later, another American study noted that homosexual and bisexual HIV+ young adults experienced more HIV/AIDS-related stigma than their heterosexual counterparts (Swendeman, Rotheram-Borus, Comulada, Weiss, & Ramos, 2006).
Media in the United States have been blamed for fuelling the sexual stigmatisation of HIV/AIDS. For example media reports focus on moral issues pertaining to disclosure of homosexual behaviours to female partners and blame bisexual men for spreading infection among heterosexual women. Labelling this suggestion as “a fallacy at best” Malebranche cautions that instead of using “moral judgements against homosexuality or bisexuality as the crux of the analysis” focus should be on behaviour that places one at risk namely low usage of condoms. According to Malebranche, this discrepancy in focus impedes public health strategies for fighting the pandemic (as cited in Anonymous, 2008, p. 92).

Stigma associated with homosexuality and criminalisation of homosexuality have been cited as reasons for the re-emergence of the HIV epidemic amongst men who have sex with men in the United States (Jaffe, Valdiserri, & De Cock, 2007) and in Shanghai, China (Liu & Choi, 2006). Drawing similar conclusions Manji, Peña, and Dubrow (2007) insist that interventions against homosexuality-related stigma are crucial to combat an imminent HIV epidemic in Nicaragua among adolescent men who have sex with men. Gostin, Surfis, and Lazzacini (1999 as cited in Johnstone, 2008, p. 42) explain that “negative social attitudes and social hostility towards gay men have been a key contributor” in creating a subculture of multiple sexual partners and that "through the social force of stigma, homosexuality was constructed as shameful, but shame coupled with overt oppression to ensure that gay sexual behaviour was secret and furtive" thus increasing risk of HIV infection.

Being part of a minority group with poor socioeconomic background, places individuals with sexual practices that are not consistent with the dominant norms of the community at greater risk. For example, inability to negotiate condom use was reported by commercial sex workers due to fear of loss of income and because it implied disclosure of HIV+ status to clients. Similar reasons were quoted by men who have sex with men as the cause for their inability to practice safe sex with partners due to negative reactions of partners who linked this caution to HIV+ status (Sri Krishnan et al., 2007). Perhaps one of the most appalling cases HIV/AIDS-related discrimination has been recorded in HIV+ “Kothi” (Indian men with a feminine gender expression who have sex with men) who engage in commercial sex work in India. Common forms of stigma reported by this group include verbal and
physical harassment; blackmail and extortion; and sexual intimidation, assault and rape resulting in an inability to negotiate condom use, hence increasing chances of HIV infection (Chakrapani, Newman, Shunmugam, McLuckie, & Melwin, 2007).

Furthermore, the continued focus on high risk groups such as homosexuals, commercial sex workers and people with multiple partners in intervention programmes and by the media has further fuelled the sexual stigmatisation of PLWHA. Parker et al. (2002) explain that “HIV/AIDS is associated with marginalised behaviour [such as that of commercial sex workers, homosexuals, promiscuous people] and PLWHA are stigmatised because they are assumed to be from these groups, [likewise] already marginalised groups are further marginalised because they are assumed to have HIV/AIDS” (p. 4).

2.2.2 Gender-based Stigma
Gender inequality has two profound consequences for women; firstly, intimate partner violence increases chances of HIV infection and secondly, HIV+ women tend to endure greater levels of HIV/AIDS-related stigma than HIV+ men (Dunkle et al., 2004; Paxton et al., 2005). Gender-based violence and inequity has seen a shift from infection trends of conventional high risk groups (e.g. men who travel for work, men who have sex with men and female commercial sex workers) to married women. In one study, Sri Krishan et al., (2007) found that single partner heterosexual sex with their husbands accounted for the increase in infection amongst married Indian women in South India. The study highlighted that married HIV+ women in India have been infected by their husbands, attributing this vulnerability to their inability to negotiate condom use because they find this “difficult and embarrassing”. The study quotes a HIV+, married female participant saying, “I used to feel shy even to say the word condom” … “I cried when they [counsellors] taught me to use a condom” (Sri Krishnan et al., 2007, p. 340). There is some evidence that women felt powerless to negotiate when to have sex and whether to use condom and even if some married women were able to negotiate condom usage, accessing condoms was highly dependent on whether her husband buys it or not. Initiating condom usage was also linked to insinuation of adultery, sex work, or frequenting commercial sex workers, making the negotiation process even more difficult for women (Amuyunzu-Nyamongo, Okeng’O, Wagura, & Mwenzwa, 2007). In Pacific
Island countries, women’s vulnerability to the pandemic is increased as many Pacific cultures also link women’s chastity to submissive sexual acts such as not initiating and discussing condom use with sexual partners (McMillan, 2008; PIAF, 2011).

Problems with condom negotiation have also been recorded amongst African-American and South African women. For example, a survey of 125 African-American women from Fulton County, Georgia indicated that 42% of the women had been coerced into having sex through threats of abuse and the use of physical abuse (Kalichman, Williams, Cherry, Belcher, & Nachimson, 2009). Studies also indicate that American women in abusive relationships are more likely to have poor partner communication (Crosby et al., 2002), to have used marijuana, crack, and cocaine and abused alcohol (Kalichman et al., 2009; Wingood, DiClemente, & Raj, 2000). These women are also more likely to perceive condom negotiation as a potentially violent situation (Campbell et al., 2002; Kalichman et al., 2009), and to experience abuse (verbal, emotional, and physical) whilst negotiating condom use (Wingood & DiClemente, 1997) and hence are less likely to use condoms (Campbell et al., 2002; Wingood & DiClemente, 1997).

Moreover, a South African study which included a random sample of women ($N = 1306$) drawn from three provinces indicated that condom negotiation was positively associated with participants’ education, having multiple partners, and absence of domestic violence. The study also identified negative associations between poor partner relationship and (1) condom negotiation and (2) discussions of HIV (Jewkes, Levin, & Penn-Kekana, 2003). Another South African (longitudinal) study of 1099 HIV-women at baseline, who were tested for over two years of follow-up, indicated that power inequity in a relationship and intimate partner violence increases the risk of HIV infection (Jewkes, Dunkle, Nduna, & Shai, 2010). The reason for the observed higher infection rates amongst abused women can be twofold; firstly, abusive male partners are associated with coercing risky sexual practices that place women at additional risk of HIV (Dunkle et al., 2004) and secondly abusive men engage in significantly higher levels of HIV risk behaviour (Dunkle et al., 2006).

Upon contracting HIV/AIDS, existing discrimination against women is amplified (Aggleton et al., 2002). In highly sexist communities, disclosure of HIV infection is
more likely to provoke stigma and threat of domestic violence as compared to communities where women enjoy gender equity (Castro & Farmer, 2005, p. 54). For example in the United States many of the infected women are of African American or Hispanic American descent: These women are labelled as drug users, prostitutes or vectors of the disease and are stigmatised for their gender, sexuality, minority status, and serostatus (Bunting, 1996; Lawless, Kippax, & Crawford, 1996). Within family and communal settings, Asian women are significantly more likely to experience HIV/AIDS-related discrimination than men, including ridicule, harassment, physical assault, and being forced to change their place of residence (Paxton et al., 2005). The researchers argue that these findings have serious implications, especially due to the increasing trend in many countries to test all pregnant women in order to prevent mother-to-child transmission (MTCT). Early detection and treatment can greatly minimise MTCT and as such these initiatives cannot be completely disregarded. However, HIV+ women can become targets of increased stigma and discrimination in communities where there is lack of adherence to patient confidentiality policies and there is high violence against women. This potential consequence should be taken into consideration by governments and policy makers implementing these testing initiatives.

All of the HIV/AIDS-related studies undertaken by the International Centre for Research on Women (ICRW) revealed that “women tend to endure more HIV/AIDS-related stigma than men”. This is due to the society’s expectation of women to “uphold moral traditions” and their HIV status is indicative that they are failing to perform this responsibility. While men are expected to be more “reckless and adventuresome”, women are expected to be “sexually faithful, chaste and morally upstanding” (ICRW, 2006, p. 6). ICRW-led studies also documented that the term “disgrace” is more commonly used for women than for men in relation to HIV+ status (ICRW, 2006). Like Paxton et al. (2005), they report physical assault, abandonment by family and spouse, violent threats and properties being taken away as some of the forms of discrimination more commonly experienced by women than their men counterparts (ICRW, 2006, p. 6).

Women are also faced with increased risk of HIV/AIDS-related secondary stigma due to their traditional role as caregivers and are potentially more susceptible to anticipated stigma which can lead to self-exclusion from seeking information,
treatment and care (Malcolm et al., 1998; PIAF 2009). This causes poor mental health (Courtenay-Quirk et al., 2006) and poor quality of life (Thomas et al., 2005). The role of women as primary caregivers of PLWHA and the associated secondary stigma that they are subjected to has been documented in Africa (Ogunmefun et al., 2010), Uganda (Ssengonzi, 2009), China (Lin, McElmurry, & Christiansen, 2007), India (Bharat, 1999), America (Hackl, Somlai, Kelly, & Kalichman, 1997) and Pacific Island countries (PIAF, 2009, 2011).

### 2.2.3 Ethnicity and Stigma

Racial and ethnicity stigma also interact with stigma related to the pandemic. In societies where racism is rampant, it is expected that people of colour and minority ethnic groups with AIDS will be more stigmatised than in societies which are more accommodating of other races (Castro & Farmer, 2005). A study exploring this relationship between ethnicity and HIV/AIDS-related stigma amongst HIV+ Caribbean people in the United Kingdom (UK) found that compared to UK-born respondents, Caribbean-born respondents experienced higher levels of stigma related to the pandemic (Anderson et al., 2008). Self-reports of the latter group included greater incidences of more severe enacted stigma, including violence and discrimination in employment. Williams (2003) in his analysis of the impact of racism and socio-economic status on health, notes that the racial gap in mortality of African Americans and their white counterparts is widening, with disease rates being more “pervasive and persistent” amongst the former group. While he attributes this largely to differences in socio-economic status, he nonetheless observes that inequality in health status also exists between racial groups of the same socio-economic status. Williams proposes that this is due to the debilitating effects of racism in securing socio-economic opportunities and mobility, hence he labels racism as an “added burden for non-dominant populations” which impedes their chances of adequate health opportunities (Williams, 2003, p. 173).

HIV/AIDS-related stigma has also been documented within minority ethnic groups and leads to further reduction in an already small support network. Körner (2007) conducted a study on HIV+ immigrants from Asia, South America, and Southern Europe living in Sydney and found that cultural factors play a significant role in self-disclosure of serostatus. The study revealed that for all participants, disclosure
of serostatus, either voluntary or involuntary, could potentially cause or lead to actual disruption within their family systems and with their ethnic communities. For instance, heterosexual men upon disclosure experienced stigma and avoidance from family and ethnic community and interdependence with these groups were disrupted. Moreover, the fear of such reactions motivated non-disclosure amongst heterosexual female participants, who were anxious to conceal their seropositive status from everyone except the medical staff involved in their treatment. The findings of Körner’s (2007) study also emphasise the need for adopting an ecological perspective of health which considers decision making in the context of familial and ethnic group relations.

In Fiji, greater caution must be exercised in discussing HIV/AIDS. Using terminology suggested by Link and Phelan (2001), labels such as (1) the relatively higher prevalence of STIs amongst iTaukei, (2) the consistent media coverage highlighting statements such as “Fijians [iTaukei] top the list” of STI infections (e.g. Elbourne, 2011; Silaitoga, 2008; ‘Stop, HIV lover told’, 2008; Vunileba, 2008;) and, (3) only iTaukei PLWHA going public with their serostatus and participating in contact based intervention programmes (“Why all iTaukei at HIV meet”, 2011), readily facilitate ethnic stereotypes which associates HIV/AIDS with the iTaukei population. Such labels may also facilitate a false sense of immunity amongst other races in Fiji.

2.2.4 Poverty and Stigma
Mosley (2004) posed an intriguing question in his paper titled ‘Does HIV or poverty cause AIDS? Biomedical and epidemiological perspectives’. He proposes that the biomedical and epidemiological perspectives assume different approaches to the diagnosis of the pandemic and hence the manner in which it should be addressed (see also 2.4). From an epidemiological perspective, he argued that poverty is a major causative factor in the African AIDS epidemic and it should not be disregarded in the face of the biomedical cause, HIV. Therefore, to be effective all HIV/AIDS-related interventions should transcend boundaries of biomedicine and incorporate poverty as a legitimate and significant causal factor (Mosley, 2004). Similarly Parker et al. (2002) posit that poverty increases vulnerability of an individual to infection and HIV in turn exacerbates poverty. For example, poverty
causes increased migration in search of work which in turn encourages unsafe sexual practices such as having casual partners and unprotected sex, ultimately increasing the risk of infection (Smith, 2002).

Williams (2003) also emphasised the impact of poverty on health stating that “socio-economic status predicts variation in health within minority and white populations and accounts for much of the racial differences in health” (p. 176). He observed that while life expectancies of European Americans are higher than African Americans, a considerable amount of variation exists within each racial group. African Americans in the highest income group live 7.4 years longer than those from the lowest income group. A difference of 6.6 years was found amongst European Americans, suggesting socio-economic status was a major contributor to differences in life expectancies of the two ethnic groups (Williams, 2003). In the Pacific two impacts of poverty have been documented; firstly poverty affects the ability of family members to continue financially supporting HIV+ relatives and secondly, the physical effects of HIV also intensify poverty by making it difficult to get employed or maintain employment and secure adequate housing and food (PIAF, 2009).

2.2.5 Fear of Contagion and Disease
Valdiserri (2002, p. 341) in an introduction to a special issue of American Journal of Public Health writes “stigma is not new to public health, nor is it new to HIV/AIDS”, quoting stigma associated with epidemics of leprosy and cholera that have been documented in history. However, it is through the analysis of the reactions to the more recent episodes of severe acute respiratory syndrome (SARS) that one can gauge the inherent nature of human beings to fear contagion of diseases. Person et al, (2004) suggest that outbreaks of infectious diseases can be associated with significant amount of fear when (1) the disease is new, (2) there is a general lack of understanding about the cause and transmission and (3) it causes a significant number of deaths. Their study recorded the effects of fear and stigmatisation on delay in seeking treatment, remaining undetected and hence exposing others to the virus as well as the stigmatisation of Asian-American communities in the United States during the 2003 SARS epidemic.

Unfortunately, HIV/AIDS meets all of the three criteria proposed by Person et al. (2004). The ICRW’s four-country study on HIV/AIDS-related stigma demonstrates
how lack of proper understanding has created a fear that is deeply rooted across the four cultures studied (Ogden & Nyblade, 2004). In 2001, ICRW launched its study in three sub-Saharan African countries namely, Ethiopia, Tanzania and Zambia and later included Vietnam. Across all four sites, fear and poor knowledge were found to be the common denominators fuelling HIV/AIDS-related stigma. Ogden and Nyblade (2004) note “fundamental similarities in all aspects of fear and knowledge and their relationship to stigma are striking” (p. 15). Across all four countries a preoccupation of fear of casual transmission through everyday activities caused avoidance or isolation of PLWHA. The findings of the study demonstrate that the most common fear involving modes of casual transmission include “peripheral contact with blood (e.g. left on nail clippers or hair cutting scissors or through mosquitoes) and other non-sexual body fluids (saliva, sweat)” (Ogden & Nyblade, 2004, p. 16). Moreover, while participants from all four countries were able to easily “recite” the three correct modes of transmission (sex, blood, MCTC), a general “lack of confidence about how HIV is not transmitted” was identified (Ogden & Nyblade, 2004, p. 17). Herek, Capitanio, and Widaman, (2002) also demonstrated that approximately 50% of individuals express discomfort in drinking from a sterilized glass and sharing public toilets used by PLWHA. Fear of contagion has also been cited as the reason behind discriminatory attitudes such as unwillingness of participants to share public bath houses, food, cooking and eating utensils, benches, and even shaking hands or talking to PLWHA (Cao et. al., 2006; Letamo, 2003). The ICRW attributes this fixation on casual transmission to three factors; (1) HIV/AIDS-related messages which lack in-depth information on HIV, over-emphasise modes of transmission, and portray HIV as an incurable deadly virus, (2) a history of usage of fear-appeals in prevention and control interventions coupled with sensationalised media reporting, and (3) the “relative newness of the epidemic” resulting in the evolving nature of knowledge about its transmission and treatment, causing people to doubt the reliability of the information provided (ICRW, 2006, p. 20).

2.3 Societal Manifestations of HIV/AIDS-related Stigma

Parker et al. (2002) in their analysis of main literature documenting the incidence of HIV/AIDS-related stigma, also acknowledged the social nature of the pandemic and
identified five main levels namely, policy and legal, institutional, community, family, and individual where prevalence of HIV/AIDS-related stigma was especially high. These five levels have also been adopted in this study for purposes of identifying common societal manifestations of HIV/AIDS-related stigma.

### 2.3.1 Policy and Legal

The laws and policies adopted by governments can have a significant effect on counteracting or reinforcing HIV/AIDS-related stigma. In political and legal contexts, HIV/AIDS-related stigma is commonly manifested in the forms of laws, policies and administrative procedures such as requiring compulsory screening and notification of HIV/AIDS cases, prohibition of PLWHA from certain occupation and medical examinations prior to travel (Parker et al., 2002). While some of these laws and policies are not inherently discriminatory, they can potentially fuel HIV/AIDS-related stigma especially if doctor-patient confidentiality laws are not present or not enforced. For example, a Fiji national was deported from Cook Islands after testing positive for HIV during a routine test for renewal of work permit. This information was also leaked to the public by medical personnel and led to the brutal assault of two other Fijians living in Cook Islands during the incident (Wise, 2011).

While developing countries like Cook Islands are still in the process of drafting laws to prevent such cases, according to *Global report on the AIDS epidemic, 2008*, 67% of countries had some form of law in place for protection of PLWHA from stigma. However, the report did not comment on the extent to which these laws were reinforced by governments (HIV/AIDS, Joint United Nations Programme [JUNP], 2009). In 2010, a promising 91% of the national governments reported addressing HIV/AIDS-related stigma as part of their national HIV strategy. A review of HIV/AIDS national planning documents from 56 countries indicated poor chances of implementation of these national plans as more than 50% of the sample did not budget for stigma-reduction programmes (UNAIDS, 2010). HIV reports also indicate that 63% of countries have some form of legislation that impedes “access to HIV prevention, treatment, care and support among population at risk” (UNAIDS, 2008, p. 92). This is usually manifested through criminalisation of homosexual behaviour and commercial sex work, making it difficult for these groups to be
specifically targeted especially in terms of their access to treatment and/or intervention programmes (UNAIDS, 2010). Likewise adoption of legislation that criminalises transmission of HIV can potentially create an image of PLWHA as inherently criminal. JUNP (2009) suggests that wilful HIV transmission can easily be accommodated in existing public health policies for other infectious diseases, hence negating the need for special policies which reinforce existing stigma against PLWHA. Other examples of discriminatory legislations include applications for special visiting visas for PLWHA and cancellation and rejection of work permits and residency visas based on seropositive status. In 2010, countries like United States of America and China lifted HIV-related restrictions on travel, however 51% of countries continue to restrict the entry, stay and residence of PLWHA (UNAIDS, 2010). Mapping of the manifestation of HIV/AIDS-related stigma at the policy and legal levels was not pursued in this study as Fiji has made substantive efforts to safeguard the rights of PLWHA and others associated with the pandemic by the gazetting of the National Code of Practice for HIV/AIDS in the Workplace in 2007 and the HIV/AIDS Decree in 2011 (‘Fiji National Plan on HIV and STIs, 2012 – 2015’, 2011).

2.3.2 Institutional
Stigma and discrimination at an institutional level is well documented and includes a cross-section of people in a variety of settings including children in schools, employees, users of medical services, and adherents of religious groups. Children with HIV/AIDS or associated with the pandemic through infected family members have been stigmatised or discriminated in educational settings (Parker et al., 2002). Children of PLWHA and AIDS-orphaned children and adolescents experience high levels of HIV/AIDS-related stigma and are subjected to ridicule and isolation by their peers and are neglected by teachers (Cluver, Gardner, & Operario, 2007; Gilborn, 2002). The ICRW-led four-country study indicated presence of HIV/AIDS-related stigma across all four sites whereby teachers supported the notion of separating children of PLWHA to “protect other students” (Ogden & Nyblade, 2004, p. 26).

In relation to employment, discriminatory practices such as denial or termination of employment (Anderson et al., 2008) and having medical assistance schemes like
insurance policies that don’t cover PLWHA in employment settings is common (Parker et al., 2002). Ogden and Nyblade (2004) posit that in all the four countries (Ethiopia, Tanzania, Zambia and Vietnam) “one of the most profound consequences of stigma was the impact it had on their [PLWHA] ability to earn a living”. Forms of discrimination documented by the study include dismissal from employment upon disclosure of serostatus, loss of customers and business for symptomatic PLWHA especially those involved in the food industry and domestic workers (Ogden & Nyblade, 2004, p. 30). Enforcement of employment rights of PLWHA may address some of these discriminatory practices in employment settings: A study on HIV+ bisexual men in America revealed that participants who had informed their employers of their serostatus reported positive outcomes (Simoni, Mason, & Marks, 1997).

Within the medical sector, HIV/AIDS-related stigma and discrimination have been recorded by several studies across the world. Findings of a study of 764 HIV+ people in four countries (India, 302; Indonesia, 42; Thailand, 338; and the Philippines, 82) revealed that the major area of discrimination in each country was within the health sector. Moreover, in all countries, a majority of people did not receive pre-test counselling before being tested for HIV. A considerable number of respondents were also refused treatment after being diagnosed with HIV and experienced delayed treatment and breaches of confidentiality by health workers (Paxton et al., 2005). ICRW-led four-country study indicated that PLWHA commonly experienced enacted stigma in medical sector in the form of differential treatment. Examples of HIV/AIDS-related stigma documented by the studies included excessive and unwarranted precautions by healthcare professionals including use of separate medical tools for PLWHA, avoiding treating HIV+ patients, denial of health services, and isolation of HIV+ patients (Ogden & Nyblade, 2004). HIV+ pregnant women in Kenya have also reported breaches of confidentiality, lack of pre-test and post-test counselling, and discriminatory attitudes of nurses and midwives (Turan, Miller, Bukusi, Sande, & Cohen, 2008). Wong and Wong’s (2006) study on older PLWHA in Hong Kong documented breaches of confidentiality, demanding disclosure of serostatus, using excessive precaution, and difficulties in accessing dental care and treatment.
Religious institutions play a major role in reinforcing HIV/AIDS-related stigma: PLWHA are commonly labelled as sinners and their ailment is seen as punishment for their behaviour (Parker et al., 2002). Allen (2000) explains that punishment theories of causation of illness reinforce the belief that the illness is caused because of an offense committed by the sick, reinforcing existing stigma against the sick. Hence communities and religious groups that identify with the punishment theory tend to support isolating or purging “the “impure”—people whose illness or imagined “sinfulness” would contaminate the whole—while reassuring that their own virtue and social status will protect the righteous from harm” (Rankin, Brennan, Schell, & Rankin, 2005, p. 703).

Similar value-driven rationale for enacted stigma has been cited by several studies. Referring to PLWHA, a religious leader in Zambia is quoted as saying, “Those patients are promiscuous . . . careless with themselves. God is punishing them for disobedience . . . the diseases are not traditional in nature and those affected are examples of what God can do to those who disobey His commandments” (ICRW, 2006, p. 4). A Ugandan study that aimed to explore perceptions of key decision-makers on the roles of FBOs in HIV/AIDS work, revealed that FBOs were perceived to promote HIV/AIDS-related stigma (Otolok-Tanga, Atuyambe, Murphey, Ringheim, & Woldehanna, 2007). This was attributed to a lack of knowledge, moralistic perspectives condemning infection, and fear of discussing sensitive issues such as sexuality and death. Reports of key informants also revealed that the language used by FBOs not only reinforced HIV/AIDS-related stigma but also contributed to internalisation of stigma. Religious leaders were sighted as saying in relation to HIV+ status “you have been cursed by God, you are a sinner, you have been misbehaving” (Otolok-Tanga et al., 2007, p. 57). However, the same study also sighted FBOs attempts to address HIV/AIDS-related stigma and provide support and care for PLWHA and their families, suggesting a positive change in attitudes of FBOs towards PLWHA (Otolok-Tanga et al., 2007). Other studies have also documented the crucial role of FBOs in challenging the stigmatising attitudes and discriminatory practices in non-Western countries by assisting in HIV prevention efforts, providing care and support to PLWHA and creating social spaces for challenging stigma (e.g. Campbell, Skovdal, & Gibbs, 2010; Morisky, 2006; Trinitapoli, 2006).
2.3.3 Community

HIV/AIDS-related stigma at the community level has been studied quite extensively in certain parts of the world including America (e.g. Bunting, 1996; Herek, 1999; Herek et al., 2002; Herek & Capitiano, 1999; Swendeman et al., 2006), Asia (e.g. Cao et al., 2006; Chakrapani et al., 2007; Paxton et al., 2005; Sri Krishnan et al., 2007), and Africa (e.g. Gilborn, 2002; Letamo, 2003; Ogden & Nyblade, 2004). Of these studies the ICRW-led four-country study offers a comprehensive record of some common communal expressions of HIV/AIDS-related stigma. The study recorded avoidance (e.g. in public transports, places of worship and eating); social isolation and exclusion of PLWHA from major family and community functions; and loss of status, roles and responsibilities in the family system and the community (Ogden & Nyblade, 2004). The authors also note alterations of traditional practices such as eating with hands and sharing a common platter in the presence of PLWHA. Changes in relationships between PLWHA and their friends and neighbours were also noted with the latter groups cutting off all dealings with HIV+ persons. Another rather unique form of discrimination documented in the studies in African countries included “voyeurism” whereby symptomatic PLWHA were visited by friends and community members so that they could report back to the community how the illness was progressing (Ogden & Nyblade, 2004, p. 28).

While avoidance, social isolation and exclusion of PLWHA by fellow community members has been largely attributed to irrational beliefs about transmission of HIV (Cao et al., 2006; Ogden & Nyblade, 2004), Parker et al. (2002) suggest that the reaction of the community is also dependent on whether it ascribes to collectivist or individualistic views. In collectivist societies the individual is blamed for bringing shame to the family and community and punished accordingly whereas individualist cultures perceive infection as irresponsibility on the part of the individual. However, the results of the ICRW-led study on the four predominantly ‘collectivistic’ societies, namely Ethiopia, Tanzania, Zambia and Vietnam, contradicts these claims as PLWHA were blamed both for bringing shame to the family as well as for being “careless with themselves” (ICRW, 2006, p. 4). In Fiji, while community-based HIV/AIDS-related discrimination such as gossiping, social and physical isolation has been documented, the study did not identify cultural perceptions of HIV infection which fuel these forms of discrimination (PIAF, 2011).
2.3.4 Family

Increased constraints in provision of healthcare in developing countries result in family members taking greater responsibility in providing care and support required by PLWHA. ICRW-led studies in the four countries revealed that despite the stigma surrounding HIV/AIDS, majority of PLWHA included in the study received “loving care in the context of their families” with close family members, especially women, adopting the role of the primary caregivers (Ogden & Nyblade, 2004, p. 31). Similar accommodating attitudes of family members were noted in Botswana where a majority (89%) of the respondents reported willingness to take care of a HIV+ family member (Letamo, 2003). Palattiyil and Chakrabarti (2008) acknowledged the additional physical and financial challenges faced by caregivers in developing countries and compared coping strategies adopted by family caregivers in India and Scotland. Caregivers from Scotland used a variety of coping strategies including problem-focused coping, positive reappraisal, seeking social support, and detachment. Their counterparts in India scored lower in these measures and higher on self-blame. Results also indicated that access to medical and support services, socioeconomic status, and HIV/AIDS-related stigma and discrimination have an impact on forms of coping strategies adopted by family members of PLWHA (Palattiyil & Chakrabarti, 2008).

While families are expected to be the main source of support, negative family responses are also common. The ICRW-led study also documented “burn-out often experienced by caregivers” especially in cases of symptomatic patients where additional care is required (Ogden & Nyblade, 2004, p. 31). Stojanovski, Stojanovic, and Prvulovic (2007) posit that caregiver burnout is caused by the psychological impact of caring for PLWHA and its accompanying stressors including fear of contagion, excessive grief and bereavement, high intensity of care required, being under-skilled and under-resourced, maintaining secrecy of serostatus in order to avoid stigmatisation, ethical dilemmas, and secondary stigma. Struggling under such additional burdens some caregivers were seen to either renounce their role completely or slowly diminish care, for instance, family members would stop buying medicine and leave HIV+ family members “to die slowly” (Ogden & Nyblade, 2004, p. 31). Other examples of HIV/AIDS-related discrimination recorded by the study included physical isolation of HIV+ family members through...
separating shared articles like clothes and utensils and having separate sleeping quarters as well as social isolation through exclusion during family events like weddings and diminishing roles, responsibilities and decision making capacities. Also recorded were more extreme manifestations of physical isolation including abandonment, divorce and separation from children to “protect” them from getting infected (Ogden & Nyblade, 2004, p. 27). Rejection and abandonment by family members of PLWHA, although less common, was also reported by Cao et al. (2006), Paxton et al. (2005) and PIAF (2011). Familial expressions of HIV/AIDS-related stigma have been attributed both to fear of contagion and disease and to value-driven when families prefer to shun HIV+ members to protect their “reputation” (Cao et al., 2006; Ogden & Nyblade, 2004, p. 28). In Fiji, cultural differences in family support have been reported by the chairperson of Fiji Network for People Living with HIV/AIDS (FJN+) who said that, “Fijians [iTaukei] are way ahead in accepting their people diagnosed with HIV”, attributing this to cultural differences that foster strong family support systems amongst iTaukei (“Why all iTaukei at HIV meet”, 2011). She also hypothesised that other ethnic groups in Fiji prevented HIV+ family members from joining FJN+ and participating in HIV-oriented programmes due to fear of stigmatisation.

2.3.5 Individual

Ogden and Nyblade (2004) argue that one of the “most profound consequences” of HIV/AIDS-related stigma is internalisation of stigma, whereby PLWHA “impose stigmatising beliefs and actions on themselves” (p. 32). HIV/AIDS stigma is manifested in various forms and at different levels within the society and a PLWHA is faced with the added burden of having to deal with the negative reactions. A study which examined 268 HIV+ men and women in the United States revealed that the majority of the sample experienced internalised stigma related to their HIV status (Lee, Kochman, & Sikkema, 2002). This is partially due to the fact that PLWHA ascribe to the same values and norms as their stigmatisers and hence have a similar perception of the pandemic. However, internalised stigma is largely attributed to the continuous and widespread mistreatment of PLWHA (Ogden & Nyblade, 2004).

Common expressions of internalised stigma identified by the ICRW-led four-country study included loss of hope in regaining social, economic and health conditions; deterioration of mental health including low self-esteem, depression and
suicidality; and believing self as having no prospects in life (ICRW, 2006). Cao et al. (2006) also note that internalisation of HIV/AIDS-related stigma led to self-imposed isolation amongst HIV+ Chinese villagers. Their study quoted a 43-year-old HIV+ woman as saying, “Usually, I disliked talking with others, because I always thought I am an AIDS patient and AIDS is horrible” (p. 523). PLWHA have a tendency to feel guilt and shame as a result of their infection and may be expected to feel ashamed as well which leads to the internalisation of the stigma (Cao et al., 2006). Internalised stigma is worst during the early stages of knowledge of infection and may persist throughout life. PLWHA go through stages of initial shock, despair, shame and grief to eventual acceptance of their ailment. Internalised HIV/AIDS-related stigma can handicap an individual’s ability to reach the stage of acceptance, cause mental health illness and increase susceptibility to engage in risky behaviour (Babayan, Arakelyan, Hovhannisyan, & Arzakanyan, 2007; Ogden & Nyblade, 2004).

While all terminal, chronic illness impact mental health of patients, PLWHA are more susceptible to mental health problems due to the stigma surrounding the pandemic (Babayan et al., 2004). Studies on life-time mental health issues amongst PLWHA demonstrate fairly consistent manifestations of mental health illnesses (e.g. Babayan et al., 2004; Gallego et al., 2000; Whetten et al., 2008). Depression has been classified as the most common form of mental disorder amongst PLWHA with up to 61% possessing depressive symptoms. Likewise anxiety disorders (up to 29.5%) and suicide ideation or attempts have also been commonly recorded amongst PLWHA (Babayan et al., 2004; Gallego et al., 2000; Whetten et al., 2008). For example, a study by Courtenay-Quirk et al. (2006) revealed that HIV+ men who have sex with men revealed positive associations between stigma (anticipated and actual) and mental health including increased levels of anxiety, loneliness, depressive symptoms and having attempted or seriously considered suicide. Gallego et al. (2000) conducted a systematic review of literature which allowed comparison of incidences of mental disorders between PLWHA and the general population in the United States. Incidence of mental disorders amongst PLWHA is significantly higher than the general population (15.4-30%) and 30-50% of PLWHA will have at least one psychiatric disorder in their lifetime. Lifetime incidence of depressive disorders among PLWHA (30-61%) is also higher than the general population (4-
However, Gallego et al. (2000) could not quantitatively establish prevalence of emotional reactions to diagnosis, suicidality, substance abuse and risky behaviour amongst PLWHA due to a lack of studies in this area.

Greater incidence of mental health illness amongst PLWHA can be attributed to adoption of unconstructive coping strategies. Approach coping strategies such as *cognitive approach* (e.g. logically analysing the situation and positive reappraisal) and *behaviour approach* (e.g. seeking assistance and taking action to resolve the situation) mediate the impact of stressors on health (Zeidner & Endler, 1996, p. 28). On the other hand, avoidance coping strategies such as *cognitive avoidance* (e.g. denial and withdrawal) and *behavioural avoidance* (e.g. seeking alternative rewards through substance abuse and imprudent emotional discharge) predicts psychological distress and physical harm (Zeidner & Endler, 1996, p. 29). A study on HIV+ men who have sex with men in America revealed that participants predominantly used avoidant coping strategies such as avoiding developing close relationships with HIV- men and completely avoiding relationships with other men who have sex with men due to fear of rejection (Courtenay-Quirk et al., 2006). The study indicated that such avoidant coping strategies were reinforced by negative experiences and predicted non-disclosure of serostatus. Likewise, Wong and Wong’s (2006) study of HIV/AIDS-related stigma in healthcare settings in Hong Kong revealed that HIV+ participants used a variety of avoidant coping strategies including non-disclosure of serostatus to medical practitioners such as private doctors and seeking treatment and care from HIV/AIDS-specialists only. The study also identified that some participants preferred attending out-patient clinics so as not to attract attention of fellow patients and other members of the public to their HIV+ status. Similarly, predominantly cognitive avoidance coping strategies were recorded among HIV+ women in India (Joseph & Bhatti, 2005). Using unconstructive coping mechanisms not only increase susceptibility to mental illness but also directly impact disease progression and HIV infection rates.

Studies indicate positive associations between mental health illnesses (depression and anxiety disorders) and poor adherence to medication regime and HIV/AIDS-risk behaviours (Gallego et al., 2000; Sabin et al., 2008; Whetten et al., 2008). A lowered self-esteem due to internalisation of HIV/AIDS-related stigma may lead to
risky behaviour such as multiple sexual encounters in an attempt to seek self-validation and result in alcohol or drug abuse which in turn impairs judgement and interferes with a person's ability to negotiate and practice safer sex (Valdiserri, 2002). Unconstructive behavioural reactions (risky behaviour) and poor mental health can be attributed to a strong desire to be part of the ingroup followed by rejection (Sirin & Fine, 2008).

Branscombe, Schmitt, and Harvey (1999) propose a rejection-identification model to explain the negative impact on well-being due to rejection by the ingroup (e.g. HIV-individuals). The model describes an approach coping strategy: identification with the outgroup (e.g. HIV support networks) which can mediate the negative consequences on mental health of minority groups. The model has been supported by research with ethnic and religious minority groups (Ramos, Cassidy, Reicher, & Haslam, 2011; Sirin & Fine, 2008) and PLWHA (Molero, Fuster, Jetten, & Moriano, 2011). Identification with the ingroup is characterised by poor mental health such as depressive and anxiety disorders amongst members of the outgroup (Molero et al., 2011; Ramos et al., 2011; Sirin & Fine, 2008). Conversely, association with fellow members of the outgroup appear to mitigate the negative effects of stigma on mental health resulting in positive self identities and higher sense of self-worth amongst minority groups such as PLWHA (Branscombe et al., 1999; Molero et al., 2011; Ramos et al., 2011; Sirin & Fine, 2008).

2.4 An Ecosocial Framework for Studying HIV/AIDS-related Stigma

Frameworks proposed to study and address issues related to the pandemic have been influenced by the historical accretion of experience with the disease. Fee and Krieger (1993) emphasise that “AIDS is, in essence a social disease” (p. 1482). In their analysis of the various paradigms that have been used for addressing the pandemic, Fee and Krieger argued that neither the Individualism paradigm which focused only on those that there were perceived to be at risk nor the Biomedical paradigm that conceptualised AIDS as a chronic disease to be clinically managed had been successful in managing the pandemic. Instead they proposed another paradigm that describes AIDS as a “collective chronic infectious disease and a persistent pandemic”, where the term “collective” denotes the social nature of the
pandemic (1993, p. 1482). Adopting this definition encompasses four distinct characteristics of the pandemic

i. The pandemic is deeply rooted in the political and cultural tenets of society and is inseparable from them.

ii. Illness is prolonged.

iii. HIV can be transmitted from one person to another.

iv. It has had global impact for a long period of time.

Following a similar methodological orientation, Poundstone, Strathdee, and Celentano (2004, p. 22) proposed adopting a social epidemiological perspective to understanding the incidence, distribution and control of HIV/AIDS as social factors are “fundamental causes of disease”. Studies adopting a social epidemiological perspective “examine how persons become exposed to risk or protective factors and under what social conditions individual risk factors are related to disease” (Poundstone et al., 2004, p. 22). Three main theories of social epidemiology have been identified namely, the psychosocial theory, the social production of disease theory, and the ecosocial theory. While all three theories attempt to explain the role of social inequalities in the distribution of disease, they differ mainly in their respective emphasis on the role of the different social and biological conditions and their impact on health (Krieger, 2001, p. 669). The ecosocial theory overcomes the methodological gaps of the psychosocial theory and the social production of disease theory by combining their research foci and methodologies. It also allows adoption of a methodological framework which reflects Link and Phelan’s (2001) definition of stigma.

The ecosocial theory is ideal for this study as it provides a holistic perspective by encompassing both the psychosocial reactions to social interactions and the pre-existing social and economic inequalities that cause health disparities and maps their impact on health consequences. In the context of research on HIV/AIDS-related stigma, an ecosocial approach will (1) explain the epidemiology of HIV/AIDS as a biological expression of social relations and inequities; (2) clarify how societal mechanisms can change our perception of HIV, how it is transmitted, and people affected by HIV (including PLWHA); and (3) identify the psychosocial impact of social interaction (including stigma, discrimination, and support) on PLWHA.
2.4.1 Stigma Indicators
Yet another barrier to studying HIV/AIDS-related stigma is the lack of understanding on stigma indicators or types of stigma. The ICRW-led four-country study found that unlike conventional assumptions about HIV/AIDS-related stigma being primarily culturally determined, “key causes of stigma, its impact and consequences have many more similarities than differences across contexts” (ICRW, 2006, p. 1). Consequently, a set of common causes and manifestations of stigma were identified through these studies including, fear-driven stigma and value-driven stigma. These two manifestations of HIV/AIDS-related stigma were tested and validated through a 10 month study in Tanzania encompassing three populations including health-care providers, PLWHA and the general community and provide an effective means of categorising stigma (ICRW, 2006). They have also been adopted as two of the three types of HIV/AIDS-related stigma included in this study.

2.4.1 Fear-driven Stigma
HIV/AIDS is a progressive, incurable and life-threatening disease that people are afraid of contracting. Fear-driven stigma is essentially a fear of casual transmission of HIV/AIDS and refusal to have contact with PLWHA because of this fear (Tanzania stigma-indicators field test group, 2005). Guni (2005) drawing from Herek’s (1999) research identified a similar category of stigma: “Instrumental HIV/AIDS-related stigma” defined as “the reflection of fear and apprehension likely to be associated with any deadly and transmissible illness” (Guni, 2005, p. 7).

Fear-driven stigma is fuelled by pre-existing stigma associated with fear of contagion and disease such as a fear of the degenerative nature of HIV/AIDS which ultimately leads to an “unpleasant and unsightly death” (Cao et al., 2006, p. 519; Herek, 1999). In many cases, fears associated with the pandemic are based on irrational beliefs on casual transmission of HIV and have formed the basis of many studies which have looked at attitudes towards PLWHA and knowledge on modes of transmission of HIV (Cao et al., 2006; Herek et al., 2002; Letamo, 2003; Valdiserri, 2002). Bishop, Alva, Cantu, and Rittiman (2006) used an experimental design to test the relationship between discrimination and fear of transmission and found that willingness to interact with PLWHA was strongly correlated to perceived contagiousness of HIV/AIDS. These studies indicate that generally people with poor
knowledge on modes of transmission of HIV/AIDS are more likely to hold negative attitudes towards PLWHA.

2.4.2 Value-driven stigma
Much of the stigma associated with HIV/AIDS arises from shame and blame which appears to be more strongly associated with the way the disease was acquired rather than the disease itself (Cao et al., 2006 p. 519). Value-driven stigma, defined as the “moral dimension of stigma that justifies stigma through judgement, shame and blame”, is fuelled by pre-existing stigma associated with sex, gender, ethnicity, and poverty (Tanzania stigma-indicators field test group, 2005, p. 3). HIV/AIDS is usually associated with deviant behaviour and especially morally unsanctioned behaviour such as promiscuity, sex work, homosexuality, and drug abuse. The disease is seen as the responsibility of the individual and that PLWHA are deserving of their affliction (Alonzo & Reynolds, 1995; Valdiserri, 2002). Concurrently, results of a national public opinion survey conducted in United States revealed that nearly one in four respondents agreed that people who contracted AIDS through sex or drug use deserve being infected (Herek et al., 2002). Negative attitudes for individuals who had contracted HIV/AIDS through homosexual behaviour and support for mandatory testing of high-risk groups were also reported (Herek et al., 2002). In yet another study, participants admitted to feelings of disgust towards PLWHA (Herek & Capitanio, 1999). Similarly, ICRW-led studies reveal that HIV infection is commonly perceived as a result of personal choice. Respondents felt that “one chooses to engage in bad or risky behaviours and therefore it is their fault that he or she becomes infected.” More than 50% of the respondents felt that PLWHA should be ashamed of themselves and 65% felt that it was a punishment from God for bad behaviour (ICRW, 2006, p. 4). A study among 333 market vendors in southern China, where sexual transmission is the principal route, approximately 77% of participants thought that PLWHA would be blamed by others for their disease (Hu et al., 2005).

2.4.3 Secondary Stigma
Although a combination of both fear-driven stigma and value-driven stigma, secondary stigma deserves special mention due to its debilitating effects on individuals and communities associated with the pandemic and its potential to act as barrier to supporting PLWHA. Cree, Kay, Tisdal, and Wallace (2004) describe HIV
as a highly stigmatised disease experienced by PLWHA and their families. Secondary stigma is the extension of stigma to individuals associated with PLWHA, including but not limited to family members, friends, community members and caregivers (Ogden & Nyblade, 2005). This category of stigma has also been acknowledged by Goffman, (1963) and later adopted by Snyder, Omoto, and Crain (1999) and Guni (2005). “Courtesy HIV/AIDS-related stigma”, as they termed it, entails “the stigmatisation of people connected to the issue of HIV/AIDS” and PLWHA (Guni, 2005, p. 7).

Several studies have explored this extension of stigma to all those associated with the pandemic for instance, Snyder et al. (1999) explored secondary stigma amongst HIV/AIDS volunteers and discussed how stigmatisation acts as a barrier to HIV/AIDS volunteerism. Their research revealed that stigma may influence the willingness of health care workers, volunteers and non-volunteers to work with PLWHA or may make their work more difficult as HIV/AIDS volunteerism was considered more stigmatising compared to other forms of volunteerism. Another study which explored the forms of secondary stigma experienced by elderly caregivers in South Africa revealed that these women were subjected to isolation and separation from family and community members, gossiping, blaming and jeering (Ogunmefun, Gilbert, & Schatz, 2008). Secondary stigma experienced by family members was also cited as one of the barriers to adherence to ART among Chinese HIV-infected patients (Sabin et al., 2008). Study undertaken by Cao et al. (2006) revealed that stigma was extended towards entire villages in rural China where prevalence of HIV/AIDS was high. Likewise ICRW-led studies documented secondary stigma across all four countries with attribution of blame to family members for poor child rearing practices being the most common reason cited for stigmatisation. Forms of secondary stigma experienced by family members included gossiping, social isolation and ostracism, and loss of income, employment and housing (Ogden & Nyblade, 2005).

2.5 Summary
HIV/AIDS-related stigma is a complex phenomenon to study: breaking this multifaceted construct into definite and clear components allows better understanding of the construct. The literature suggests that stigma is a consequence
of status loss and is caused by power differences between the ingroup and the outgroup. These power differences are attributed to pre-existing social inequalities such as stigmatisation of sexuality, gender, ethnicity, socio-economic status, and fear of contagion and disease which play a crucial role in creating and maintaining HIV/AIDS-related stigma and in determining the epidemiology of HIV/AIDS. Adopting an ecosocial approach as the methodological framework to study HIV/AIDS-related stigma in Fiji will allow the identification of social inequalities that drive stigma and the mapping of psychosocial reactions to social interactions at three societal levels (institutional, community and family). Three types of HIV/AIDS-related stigma, categorised on the basis of their causes and manifestations, are identified namely, fear-driven, value-driven and secondary stigma and form the basis of analyses for this study.

2.6 Research Questions - Stage 1 – Qualitative Exploration of Dominant Experiences of PLWHA

Several issues of interest were identified through review of literature, consequently Stage 1 of the study attempts to answer the following research questions

1. How do PLWHA in Fiji describe their experiences with institutions, neighbourhood communities and family members?
2. What common causes of HIV/AIDS-related stigma are identified by PLWHA?
3. What emotional changes do PLWHA identify since diagnosis?
4. What forms of coping strategies do PLWHA use in relation to stressors associated with being HIV+?
CHAPTER 3
STAGE 1 – QUALITATIVE EXPLORATION OF DOMINANT EXPERIENCES OF PLWHA

3.1 Methodology and Methods

3.1.1 Rationale for Methodology
Data collection, preparation, and analysis for Stage 1 - Qualitative Exploration of the Dominant Experiences of PLWHA are informed by Interpretative Phenomenological Analysis (IPA). This branch of phenomenology recognises the impossibility of (a) gaining a direct access into the world views of the interviewee and (b) suspending all existing suppositions and biases in order to attain a “state of pre-reflective consciousness” (Willig, 2001, p. 52). Instead, it proposes that research analysis is the product of three core components; interviewee’s experiences, interpretations of the interviewer, and the nature of interactions between the interviewee and the interviewer. In this regard IPA is both phenomenological (allows detailed exploration of the participant’s personal experiences and perceptions) and interpretative (implicates the researchers own experiences and conceptions in understanding the phenomena) (Eatough & Smith, 2009; Smith & Osborn, 2008). IPA is optimal for this study for three reasons

1. IPA will capture detailed interviewee accounts on their experiences of being HIV+, their reactions (behavioural and emotional) to HIV/AIDS-related stigma and discrimination, and their perception of what causes stigmatising attitudes.

2. IPA allows adoption of two interpretative stances: ‘empathetic hermeneutics’ and ‘questioning hermeneutics’ (Smith & Osborn, 2008, p. 53). This characteristic of IPA is especially useful in interpreting interviewee descriptions of stigma to identify whether it is an actual experience (actual stigma) or an expectation (anticipated stigma). While both types of stigma may feel real to the participant and may be equally debilitating, differentiating between the two accounts will assist in identifying societal manifestations of stigma in Fiji. Furthermore, it will also assist in clarifying whether participants’ reports of reactions of named others towards them are
directly caused by their seropositive status or through a combination of pre-existing stigma. This approach to differentiation of stigma and analysis has not been used in Fiji for example by PIAF (2009, 2011) where the focus was on mainly describing dominant themes that arose from qualitative interviews.

3. IPA is similar to cognitive psychology in that it recognises the relationship between interviewees’ narrative, their thinking, and their emotional reactions. However, it also assumes that this “chain of connection” is complicated and interviewees may struggle to express their thoughts and emotions and recognises the need for the researcher to interpret interviewees’ emotional states from their narratives (Smith & Osborn, 2008, p. 54). The interpretation of emotional states and their effects form an integral part of research questions three and four (see also 2.6).

4. The experience of stigma is both personal and relational and is interpreted and constructed through social interactions with a variety of individuals and groups. IPA being an idiographic approach allows the establishment of interconnections between predominant themes within and across cases (Willig, 2001). Hence using IPA allows discussion of HIV/AIDS-related stigma in relation to experiences of the entire group as well as those of individual interviewees.

3.1.2. Participants

3.1.2.1 Recruitment

The participants for this stage had been clinically diagnosed to be HIV+ (N=11) and were recruited through Hub Centres where they were receiving specialised outpatient care. Medical Officers serving at the two Hub Centres were provided with copies of the *Stage 1 - Participant Information Sheet and Consent Form* (Appendix A) and were briefed on the research objectives, research method, steps undertaken to maintain confidentiality and; rights to participation, withdrawal and compensation. The Participant Information Sheet was discussed with all HIV+ patients attending the clinic and once an individual agreed to participate, the researcher was contacted by the Medical Officer. Informed consent was obtained by the researcher and witnessed by the Medical Officer. Interviewees were assigned pseudonyms to
protect identities. Table 3.1 provides the summary of individual profiles of the 11 interviewees.

3.1.2.2 Research Sites

PLWHA were recruited from the Lautoka and Suva Hub Centres, the two specialised reproductive health clinics in Viti Levu. Amongst other services including pre and post-test counselling, testing and treatment of sexually transmitted infections, the two centres provide outpatient care for PLWHA.

Table 3.1

<table>
<thead>
<tr>
<th>Gender &amp; Ethnicity</th>
<th>Pseudonym</th>
<th>Age (yrs)</th>
<th>Religious Affiliation</th>
<th>Highest Level of Education</th>
<th>Occupation</th>
<th>Marital Status</th>
<th>Number of Children</th>
<th>Housing Status</th>
<th>Date of Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Lena</td>
<td>29</td>
<td>Christian</td>
<td>Form 6</td>
<td>Domestic duties</td>
<td>Widowed</td>
<td>3 (Eldest is HIV+)</td>
<td>Living with brother</td>
<td>Oct., 2003</td>
</tr>
<tr>
<td></td>
<td>Luisa</td>
<td>35</td>
<td>Christian</td>
<td>Form 4</td>
<td>Former Waitress (Unemployed)</td>
<td>Married</td>
<td>None</td>
<td>Living with husband</td>
<td>Sept., 2008</td>
</tr>
<tr>
<td></td>
<td>Clare</td>
<td>34</td>
<td>Christian</td>
<td>Diploma in Counselling</td>
<td>Professional Counsellor (NGO)</td>
<td>Married</td>
<td>None</td>
<td>Living with Husband and mother</td>
<td>Sept., 2004</td>
</tr>
<tr>
<td></td>
<td>Unaisi</td>
<td>29</td>
<td>Christian</td>
<td>Form 3</td>
<td>Former Commercial Sex Worker</td>
<td>Never Married</td>
<td>None</td>
<td>Living with sisters family</td>
<td>2006</td>
</tr>
<tr>
<td>Indian Female</td>
<td>Vinita</td>
<td>31</td>
<td>Hindu</td>
<td>Form 6</td>
<td>Domestic duties</td>
<td>Separated</td>
<td>1</td>
<td>Living with mother</td>
<td>June/July 2006</td>
</tr>
<tr>
<td>iTaukei Male</td>
<td>Samuel</td>
<td>38</td>
<td>Christian</td>
<td>Diploma in Biblical counselling</td>
<td>Trainer and Counsellor (NGO)</td>
<td>Married</td>
<td>1</td>
<td>Living with wife and son</td>
<td>Jan, 2007</td>
</tr>
<tr>
<td></td>
<td>L.N.K</td>
<td>31</td>
<td>Christian</td>
<td>Certificate in Carpentry</td>
<td>Trainer (NGO) &amp; takes private carpentry jobs</td>
<td>Cohabiting</td>
<td>1</td>
<td>Living with partner and daughter</td>
<td>2002</td>
</tr>
<tr>
<td></td>
<td>Tevita</td>
<td>43</td>
<td>Christian</td>
<td>Class 3</td>
<td>Farmer</td>
<td>Married</td>
<td>4</td>
<td>Living with wife</td>
<td>2004</td>
</tr>
<tr>
<td></td>
<td>Mosese</td>
<td>35</td>
<td>Christian</td>
<td>Class 3</td>
<td>Prisoner</td>
<td>Divorced</td>
<td>1</td>
<td>Prison</td>
<td>1998</td>
</tr>
<tr>
<td>Indian Male</td>
<td>Narayan</td>
<td>41</td>
<td>Hindu</td>
<td>Class 3</td>
<td>Carrier Driver</td>
<td>Married</td>
<td>4</td>
<td>Living with wife and children</td>
<td>July, 2008</td>
</tr>
</tbody>
</table>

3.1.2.3 Age, Ethnic Background and Religious Affiliation

The sample consisted of 11 individuals with an age range of 29-43 years. However, males (mean age 37.6) were generally older than females (mean age 31.3). Five of the participants were iTaukei females, four iTaukei males and one Indian male and
one Indian female. All nine iTaukei claimed Christian affiliation and the two Indian participants identified themselves as Hindus.

3.1.2.4 Occupation
Of the eleven participants, six (two females and four males) at the time of the interview were in paid employment. Clare, L.N.K and Samuel had left their previous jobs to join HIV/AIDS-related non-governmental organisations (NGOs) as counsellors and/or trainers. L.N.K also took contracts for building houses and preferred this to his “desk job” at the NGO. Bulao at the time of the interview was a secondary school teacher and Tevita managed his own farm after being imprisoned several times for drug peddling. He also volunteered at a HIV-related NGO. Narayan worked as a carrier driver. Three of the female participants were supported by their families, two of whom had left their previous occupations; Unaisi was formerly a commercial sex worker and Luisa was a waitress since diagnosis. Mosese at the time of the study was serving a sentence.

3.1.2.5 Marital Status
Bulao and Unaisi had never married, however Bulao was cohabiting with her partner until he passed away from HIV-related infections. L.N.K was cohabiting with his current partner after being widowed in 2006 and Lena was recently widowed. Spouses of both participants passed away from HIV-related infections. Luisa, Narayan, Samuel, Clare and Tevita at the time of the interview were married and the spouses of the latter two are HIV+. Vinita at the time of the study was separated from her HIV+ husband and Mosese was divorced.

3.1.2.6 Housing Status
All participants were living with their family members and no major changes had occurred in their housing status since diagnosis. However, Vinita had moved in with her mother after being separated from her husband a month prior to being interviewed. Unaisi moved in with her sister’s family after having problems with her mother.

3.1.2.7 Diagnosis
At the time of the study, Mosese had known about his infection for 11 years and was diagnosed with HIV at the age of 24. L.N.K was also diagnosed at the age of 24 and had known of his status for the past seven years. He had lost a son and wife to the
pandemic. Bulao and Lena’s diagnosis was confirmed in 2003 after waiting for the window period (period of several weeks in which newly infected person has not produced enough HIV antibodies which can be detected via a blood test), they were 24 and 23 respectively. Clare was 30 and Tevita was 39 when they were diagnosed five years prior to being interviewed.

Unaisi and Vinita learnt of their diagnosis in 2006, they were 26 and 27 respectively and Samuel was 36 when he confirmed his diagnosis in 2007. He had been ill for some time and requested for a HIV test which came back positive. Although Luisa and Narayan were diagnosed in 2008 they had also been sick for a long period of time; three and four years respectively, suggesting that they may have been infected as early as 2004. The modal age when diagnosed was 24 years and range for period of knowledge of diagnosis was 10 years (1-11 years).

3.1.3 Materials

3.1.3.1 Interview Guide

The semi-structured interview guide contained principally open-ended questions and prompts presented in Appendix C. These questions and prompts were used simply as guides to provide some direction in the interview. Language was carefully vetted so that terms like ‘stigma’ and ‘discrimination’ were not used to avoid leading participants. Instead, interviewees were asked to describe their dominant experiences and share their perceptions on the issues being discussed. Permission was sought to record interviews in a digital recorder (see also Appendix B). The five sections in the interview guide were included to elicit information for the four research questions.

3.1.3.2.1 Section 1 – Participant Profile

The first section was designed to obtain some basic information on the interviewees such as their age, religious affiliation, housing arrangement, marital status and if they had children and date of diagnosis.

3.1.3.2.2 Section 2 – Perceptions of HIV/AIDS

Poor HIV/AIDS knowledge has been linked with higher stigmatisation of PLWHA, hence the main focus of this section was to determine interviewees’ pre-diagnosis and post-diagnosis perceptions of HIV and PLWHA (Cao et al., 2006; ICRW, 2006).
3.1.3.2.3 **Section 3 – Serostatus disclosure**
Studies indicate that past experiences and pre-conceived notions regarding attitudes towards PLWHA might affect decisions regarding disclosure of serostatus (Ogden & Nyblade, 2005). Under this section interviewees were asked to share their views and experiences of telling someone that they are HIV+. Interviewees were also prompted to identify individuals or groups who were aware of their serostatuses and describe the circumstances under which their serostatuses became known to others.

3.1.3.2.4 **Section 4 – Reasons and sources of HIV-related stigma and discrimination and coping strategies adopted.**
HIV/AIDS-related stigma has been recorded at various levels in the society including close family members, members of the community, healthcare providers, employers, and by religious groups (Cao et al., 2006; Ogden & Nyblade, 2005; Parker et al., 2002; Paxton et al., 2005; Wong & Wong, 2006). The purpose of this section was to map the interpersonal relationships between the interviewee and members of his/her social and community groups and how the interviewee copes with negative experiences. For each group, the interviewee was asked to describe common reactions or perceived reactions (if their serostatus was not known by members of the group) and their perceived reasons for these reactions. Interviewees were also subtly prompted to differentiate between ‘anticipated stigma’ and ‘actual stigma’: Questions were based on perceptions and then participants were requested to describe an incident. To ascertain if the described reaction was related to the interviewees’ seropositive status or through a combination of pre-existing stigma, interviewees were asked if they had been treated like this before their diagnosis. Interviewees were also asked to describe how they handled negative reactions of the groups.

3.1.3.2.4 **Section 5 – Psychosocial reactions to diagnosis**
Self-esteem is closely related to how people feel about themselves (Brown & Marshall, 2001). Most social psychological theories suggest that internalised stigma leads to a low self-esteem as self-worth is determined from the social evaluation by the group that one identifies with (Dovidio et al., 2010) This section mapped changes in self-esteem, if any, since diagnosis and identified what emotions participants attached to with different ratings of self-esteem. Consistent with an exploratory stance encouraged by IPA, interviewees were provided with a simple definition of self-esteem as, ‘Self-esteem is how people think or evaluate
themselves’. Interviewees were then prompted to rate how they viewed themselves on a scale of 1-10 (with 10 being the highest positive rating) before diagnosis, directly after diagnosis and at the time of interview. For each instance, interviewees were prompted to identify the reasons behind their personal rating and were subtly prompted to also focus on emotions they would attach to each rating. Section 5 also sought information on whether the personal self-esteem ratings had in any way impacted upon the participants’ willingness to take part in treatment, counselling and HIV-oriented support programmes.

3.1.4 Procedure

3.1.4.1 Ethical Approval
Written proposals for the research were submitted to the Research and Postgraduate Committee, School of Social Sciences, Faculty of Arts & Law, University of the South Pacific and then to the National Health Research Committee – Ministry of Health, Fiji Islands (Appendix A) for their scrutiny and ethical approval. This was received prior to commencement of the study.

3.1.4.2 Setting
Individual interviews were conducted by the researcher in a private room at the Hub Centre premises as it was easily accessible and provided a comfortable and non-threatening environment that the respondents were accustomed to.

3.1.4.3 The Semi-structured Interview
An in-depth interview has been described as a purposeful conversation between a skilled interviewer and the interviewee with the primary aim of eliciting rich, comprehensive information which captures the meaning of the experience or issue from the latter’s perspective (Bryman, 2008). This method of data collection recognises the interviewee as the expert on the issues being studied and has been strongly recommended for studies governed by the IPA methodology (e.g. by Eatough & Smith, 2009; Smith & Osborn, 2008)

All interviews were conducted in English and lasted from 50 minutes to 1 hour and 45 minutes. Interviews were semi-structured and followed an interview guide, however the interview was not constrained by this guide. Rather, interviews were free-flowing and interactive: The sequence of interview questions was dictated by considerations of conversational flow, interviewees were encouraged to explore
topics of their interest and were probed on ‘new issues’ that emanated from the conversion. For instance as the interview progressed, some interviewees felt the urge to talk about things that they held of importance. Unaisi was angry about certain aspects of the NGO that she was affiliated to and while this theme was not included in the original interview guide, it became evident that in order to achieve co-operation in the process, this issue needed to be acknowledged and explored first. Using this technique permitted comprehensive and thorough exploration of the interviewee’s attitudes, feelings, behaviour and experiences in relation to his/her serostatus.

Most of the interviewees were eased into the interview using questions on their basic demographics which were used to set the mood and pace for the interview. Self disclosure by the researcher on issues such as age, religious affiliation, marital status and number of children were used to make a connection with the interviewee and create an environment of trust, honesty and disclosure. All apparently contradictory statements were resolved through further probing. Interviews were recorded in a digital recorder and were transcribed within two days of the interview by the researcher. In instances where the interviewee continued speaking after the interview had formally ended and the recorder had been turned off, with the permission of the interviewee, hand-written notes were taken and included as a separate section in the transcription.

Preliminary analysis of data was conducted after every interview and data collection and analysis were treated as iterative processes. This informed the relative emphasis on the different components of the interview guide as well as issues that would require greater probing in consecutive interviews. All interviews were completed and all questions posed were answered. The session was closed with a verbal debriefing with the participants. Participants who were identified as requiring counselling services were given the names and contact of pre-arranged qualified counsellors in their geographical areas. Upon completion of interviews, participants were thanked for their participation and given $15.00 as compensation for their time, effort and costs incurred for travelling to the interview venue.
3.1.5 Data Analysis
Data analysis for Stage 1 was carried out in accordance with the guidelines prescribed under IPA. This approach to analysis has been especially desirable for qualitative data analysis in psychological research due to its versatility to a variety of topics and its ability to investigate both the “diversity and variability of the human experience” (Willig, 2001, p. 53). It has also been widely used in health research (Biggerstaff & Thompson, 2008; Eatough & Smith, 2009; Smith & Osborn, 2008). In data analysis, IPA encourages constant engagement with the transcript so as to enable an interpretation of the transcript that not only reflects interviewees’ perceptions, emotions, and behaviour but also the researcher’s personal insights, knowledge and experiences. Therefore, in reporting results, the themes identified are the researcher’s interpretations of interviewee narratives on the basis of literature reviewed for this study. These ‘personal interpretations’ are then substantiated by interviewee quotes to ensure that the results reflect the ‘dual interpretation’ encouraged by IPA.

All eleven transcripts were read five to nine times and upon each reading notes about main quotes, preliminary interpretations, apparent associations, questions and contradictions were made on the right hand margin of the transcript. Themes identified by the researcher for the five sections in the interview guide were noted on the right hand margin and colour coded to depict clusters of inter-related themes. The main themes for the first interviewee were then noted in a summary table which comprised of the theme and relevant quote(s) from the transcript. Subsequent transcripts were then analysed according to the dominant themes recorded for the first interviewee. Where additional themes became apparent, these were recorded and the previous transcript(s) was/were re-analysed to see whether these “new” themes were merely different manifestations of old themes or they in reality added new meanings or concepts in understanding the experience of being infected with HIV in Fiji. Finally, the main themes with their constituent themes were then arranged and re-arranged until a coherent narrative account was produced. This process was undertaken till all master themes were identified and themes that were not supported well by the data were dropped.
3.2 Results
Analysis of the interview transcripts revealed five predominant themes. The patterns identified in each theme draw from various combinations of sections identified in the interview guide (Appendix C). The five themes and their subsections sometimes overlap therefore, to avoid creating a false sense of distinctness amongst a rather complex data set with interrelated motifs, the reader is directed to data recorded in another section of results.

3.2.1 Theme One – Dominant Experiences of Interviewees Concerning Their Serostatus
Interviewees reported variety of experiences related to their seropositive statuses at different levels within their communities including accommodative, supportive, stigmatising and discriminatory. While interviewees described both actual experiences and anticipated experiences of HIV/AIDS-related stigma and discrimination (refer to 2.1 for definitions) for the purposes of documenting their dominant experiences only actual experiences are recorded in this section of results. The following subsections also include a tabulated summary of dominant experiences, wherein ‘positive reactions’ and ‘negative reactions’ refer to the researcher’s distinction of an experience, based on its perceived impact on the interviewee.

3.2.1.1 Healthcare Settings
Interviewees attended clinics at the Hub Centre and the general hospitals when they needed more specialised care, in-patient care or when they were “very sick.” In some cases, interviewees also visited private General Practitioners.

3.2.1.1.1 Doctors
Interviewees reported very positive experiences with doctors who handled them; these are summarised in Table 3.2.
Table 3.2

*Summary of dominant experiences with doctors at main hospitals (N=11).*

<table>
<thead>
<tr>
<th>Positive Reactions</th>
<th>Negative Reactions</th>
<th>Dominant Patterns</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Good pre &amp; post-test counselling.</td>
<td>• Testing without consent.</td>
<td>• 90% of the interviewees felt that they were treated very well by doctors who attended to them.</td>
</tr>
<tr>
<td>• Maintained confidentiality.</td>
<td>• Breaches of confidentiality.</td>
<td>• 90% of the interviewees also expressed satisfaction with how doctors had handled pre and post-test counselling.</td>
</tr>
<tr>
<td>• Source of emotional support.</td>
<td>• Uncompassionate demeanour.</td>
<td></td>
</tr>
<tr>
<td>• Professional in handling PLWHA.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The following reports explicate some of the positive experiences with doctors recorded in Table 3.2

**Clare:** ... I found him [Doctor] very compassionate and understanding. [] I give them an earful of my experience ... I share with Doctor XXX. (Depending on doctors for emotional support).

**Lena:** The doctors that I have come into contact with are really really nice. Some of them don’t even use gloves when they treat my sores and stuff. It’s those kinda small things that really touches me ..., make me feel good. Like I’m not some kind of untouchable. Like you are not so different after all. (Describing accommodative attitudes of her doctors)

**Vinita:** And the doctors came and they asked him [husband] if he had told me. And then they told me, they drew the curtains and then they explained it to me. They were nice and they advise me to take test. (Review of pre-test counselling).

**L.N.K:** There were two doctors and they were speaking and using all these Fijian terms to explain us. They were speaking very slowly, very comforting and calmly. (Review of post-test counselling).

Negative reactions recorded in Table 3.2 are derived from reports of Luisa who had been sick for three years prior to her diagnosis

**Researcher:** Did they ask you if they can take your blood for a HIV test?

**Luisa:** No, they don’t tell me for HIV, they just told me we have to take your blood.

**Researcher:** How did your doctor tell you that the results are positive?

**Luisa:** You know I thought only the doctor knows, but I don’t know everyone beside the doctors knows. In the morning when the doctor came to me eh..., he just say like you and me [casually as conversation] that you have. Like you know plenty people there ..., doctors, nurses,
students [interns] and the doctor can’t come beside me ..., you know come and touch me and tell me slowly …, no he just stand there at the end of my bed and tell me straight, “You having HIV, it’s positive”. I feel sorry about me, I was crying that day, he saw me the doctor saw me …, the way he told me, it’s not right. But he didn’t come ..., just look away.

Moreover, while Lena describes her own experience with her doctors as “good” and “supportive”, she also reported breaches of confidentiality by a doctor regarding her husband’s serostatus.

3.2.1.1.2 Nurses

Interviewees reported mixed experiences with nurses at main hospitals, with 70% reporting breaches of confidentiality of patients’ serostatus, lack of compassion, neglect, and derogatory behaviour of nurses. Conversely, nurses at the Hub Centres were described as “more professional” and “nicer.” Table 3.3 summarises these reactions.

Table 3.3

Summary of dominant experiences with nurses at main hospitals (N=11).

<table>
<thead>
<tr>
<th>Positive Reactions</th>
<th>Negative Reactions</th>
<th>Dominant Patterns</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nice and professional in their conduct.</td>
<td>Breach of patient confidentiality.</td>
<td>70% reported negative reactions.</td>
</tr>
<tr>
<td>Maintained confidentiality.</td>
<td>Nurses gossiping amongst themselves.</td>
<td>The most common form of discrimination reported was breach of confidentiality of patient serostatus (reported by 63%) which led to further discrimination of interviewees by others.</td>
</tr>
<tr>
<td></td>
<td>Lack of compassion.</td>
<td>Higher rates of mistreatment reported when patients were symptomatic.</td>
</tr>
<tr>
<td></td>
<td>Professional neglect.</td>
<td>Mistreatment appeared to be unrelated to seropositive status and stemmed from general lack of professional conduct.</td>
</tr>
<tr>
<td></td>
<td>Derogatory attitudes and maltreatment of symptomatic patients.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The following interviewee reports illustrate the various forms of breaches of confidentiality recorded in Table 3.3

**Luisa**: Nurses were talking to each other..., there was a bench just outside my room and they were all talking and looking at me. One Indian nurse said “Is it that one?” and I knew they were talking about me. (Nurses gossiping amongst themselves).

**Luisa**: [],because even the patient [sic] and the people looking after the patient, [caregivers] they all know I have HIV from the nurses. (Nurses disclosing serostatus to other patients and their relatives/caregivers)
L.N.K: Nurses yes, for her [deceased wife] some of the nurses were related to her and when my parents went they told them. And it went from A to B [information spread in the family]. (Disclosing serostatus to family members).

Unaisi: [and the place it was stapled, she took it out and she read it, and this one told the nurse form XXX [from Unaisi’s village] who knew me and that’s when the story spread in my village. (Nurse accessing medical records without approval and disclosing serostatus to other nurses and members of the community).

Lack of compassion and derogatory attitudes of nurses at main hospitals recorded in Table 3.3 is illustrated by the following report of Luisa, a symptomatic patient

Luisa: They are not doing their job to [sic] me …, like I was in the hospital two weeks, the time I was having food, the first day I forgot to take my cup and plate. And I ask one nurse, just to do me a favor, just to borrow a cup. And what they gave me was a ..., um ..., um ..., a margarine container, two margarine containers for eating and one and one for drinking my tea [crying]. And she told me you can’t use any plates.

Researcher: Did you ask her why not?

Luisa: No, I know why she said it, because of what I got [HIV].

Interviewee accounts also suggested that attitudes of nurses were especially negative towards symptomatic patients. These are demonstrated by the following accounts

L.N.K: When it comes to HIV people, we can see when someone reaches Stage three of HIV. This is the stage when people lose weight …, it’s a nasty thing people look like alien and that’s the time their [nurses] attitude changes …, um …, they [nurses] won’t come near. They will stand at a distance …, they won’t spend much time …, because they think she’s [wife] going to die …, there’s no more hope. They don’t want to waste their time there. From the [sic] there the mentality begins to build negative. (Attitudes of nurses towards his wife became negative when she became very sick).

Mosese: You can tell by their face what they think about me. They can’t even do their job to me [sic] …, some nurses eh, they give me my tablet just like that [motions- sliding across the table]. They won’t look at me, talk to me. They don’t even change my sheet ... , um ..., my pillow sheet [pillow cover]. I was very sick. But just for first month eh, after that I get better, and then they set [thumbs up sign] (Attitudes of nurses at the main hospital became more positive after his health picked up).

On the other hand, interviewees like Lena, who had never been seriously sick, did not report being discriminated by nurses even though she had a fair amount of contact with nurses as a caregiver for her HIV+ son and deceased aunt.

Lena: They were very nice as well. They were really good to me. All these people [other PLWHA at a workshop] were saying that they have
negative experiences with nurses and I’m thinking why didn’t I go through that? I’m thinking they went through a whole bunch of different nurses. (Reported having very positive experiences with nurses at the main hospitals)

From the reports of the interviewees of this study, it was inconclusive whether the negative reactions were a result of HIV/AIDS-related stigmatisation or stemmed from a lack of professional conduct of some nurses; comparison of reports of symptomatic and asymptomatic interviewees tends to suggest an inclination towards unprofessional conduct of nurses. The most common form of HIV/AIDS-related discrimination was breach of confidentiality: without patients’ consent, nurses shared his or her serostatus with individuals outside the patient care team.

3.2.1.1.3. Differences between services at Hub Centre and Main Hospitals

With the exception of Lena who feels at ease with both groups of healthcare staff, the remaining interviewees (n=10) reported that they had better relationships with doctors and nurses at the Hub Centre compared to doctors and nurses at the main hospitals, the details of which are summarised in Table 3.4.

Table 3.4

<table>
<thead>
<tr>
<th>Positive Reactions</th>
<th>Negative Reactions</th>
<th>Dominant Patterns</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Provided emotional support and counselling.</td>
<td>• None reported.</td>
<td>• 90% of interviewees report better relationships with staff of Hub centre over staff of main hospital.</td>
</tr>
<tr>
<td>• Maintained confidentiality.</td>
<td></td>
<td>• 90% preferred attending clinics at Hub centre over main hospital because:</td>
</tr>
<tr>
<td>• Responsive to patients needs.</td>
<td></td>
<td>1. They felt more comfortable in talking to doctors who already had shown some degree of acceptance of their seropositive status.</td>
</tr>
<tr>
<td>• Lobbying on behalf interviewees with staff at the main hospitals for better treatment</td>
<td></td>
<td>2. When attending checkups at the main hospital, they were constantly worried about others finding their status and the negative reactions of healthcare workers.</td>
</tr>
<tr>
<td>• Creating HIV/AIDS awareness to alleviate stigmatisation of patients.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The following account demonstrates reasons for interviewees’ preference of attending clinics at Hub Centre as opposed to the main hospital recorded in Table 3.4

**L.N.K**: CWM is for the public and this centre is very specific. I don’t find the comfort in CWM that I find here. We feel more confident coming here, at CWM I’m going there, I’m sitting there and I don’t know if those doctors there know if I am HIV+ and I don’t know how
they will react. When I go there I am constantly thinking what if people find out about me. Here [Hub Centre] I am more relaxed.

Positive reactions of doctors and nurses at the Hub Centres are summarised in Table 3.4 can be evidenced by the following reports:

**Unaisi:** No, I have always liked coming here. I always want [sic] come even if it’s not my appointment coz they talk to me counsel me and its nice talking to the nurses. I love to be check up [sic] every time. They are very friendly. (Emotional support).

**Luisa:** I called XXX staff nurse at Hub centre and XXX came and talk to her [nurse from main hospital who had given Luisa margarine containers to eat from instead of plates] that she don’t have to do that to me.

**Researcher:** Did their behaviour change after XXX spoke to the nurses?

**Luisa:** Yes

**Researcher:** How?

**Luisa:** Things I want, they give it to me.

**Mosese:** I come and complain to Dr. XXX [Doctor from Hub Centre] that they [prisoners and prison officers] doing this and Dr. XXX form a team they come and do the counselling and after that their [prison officers and prisoners] behaviour changed. Now we eat together, we sit together and they understand about me and they understand about the disease.

### 3.2.1.4 Additional precautions for HIV+ patients

Interviewees reported two main forms of additional precautions used by their healthcare providers; use of double gloves and placement in a separate room/area. Differences in how interviewees appraised these situations became apparent. Some interviewees saw usage of double gloves as a “universal and acceptable precaution” from infection of HIV and reported incidences where they encouraged healthcare providers to use gloves while handling open wounds for example Clare reports

**Clare:** There was an incident where the doctor who attended to me …, because this doctor did not know that I was HIV+, I had to tell the person …, [] he was attending to me without gloves on. So I just told him that I am HIV+ …, and I think you should put your gloves on.

Some interviewees also reported that they preferred being placed in a separate room

**Samuel:** Because I was in the isolation ward …, which was good, it was the right place for me because I had diarrhoea and all that so I needed a separate toilet. So a special room was good for me, so I didn’t see that as a negative thing …,
However, interviewees especially those who are secretive about their seropositive status found placement in a separate room or area as counterproductive and saw it as a form of HIV/AIDS-related discrimination

**Vinita:** Other family members said, because he [husband] was put in a separate room, we know what kind of people are admitted in that separate room nah. When visitors would come to see him, they would see him in *that* room. If you have any other kind of disease, you will be in normal room not separate like that.

### 3.2.1.2 Prisons Department

Three of the interviewees were associated with the Prisons Department including Tevita (ex-convict), Mosese (inmate) and Lena (husband passed away in prison). Table 3.5 summarises the main experiences reported by Mosese and Lena.

Table 3.5

*Summary of dominant experiences with the prisons department (n=2).*

<table>
<thead>
<tr>
<th>Positive Reactions</th>
<th>Negative Reactions</th>
<th>Dominant Patterns</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Accommodative.</td>
<td>• Breaches of confidentiality regarding serostatus.</td>
<td>• Reactions became positive post awareness of modes of transmission of HIV/AIDS.</td>
</tr>
<tr>
<td>• Physical support (Act as caregivers upon hospitalisation).</td>
<td>• Verbal abuse.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Physical isolation.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Social ostracism.</td>
<td></td>
</tr>
</tbody>
</table>

Forms of HIV/AIDS-related discrimination recorded in Table 3.5 are demonstrated by the following reports

**Lena:** And the police officer went back and told his [husbands] sister who went to visit him and his friends in the cell. They actually called her and told her. (Police officers disclosing serostatus to family and friends without consent).

**Mosese:** One year and five months in prison, I escape [from] in prison eh. When I escape in prison, they [prison officers] release the statement that if someone see me they catch me because I have this disease eh. And they [people from his village] got it from the radio that I have this disease. (Public disclosure without consent).

**Mosese:** I am sleeping separate from other inmates. And when I am sleeping time the officer come and check and me, and tell “Hey put your mosquito net down because the mosquito come and bite you and HIV gonna spread”. (Physical isolation and verbal abuse).
Mosese: I can’t go outside, only do office work. I live in a separate room ..., only me there. [ ] ..., we use separate spoon and separate plates. I’m not allowed in the kitchen. (Physical isolation and social ostracism).

Mosese, who reported the greatest degree of HIV/AIDS-related discrimination within the prison system, explains that attitudes towards him have become more accommodative and supportive post HIV/AIDS awareness training conducted by doctors at the Hub Centre and a consequent greater awareness of modes of transmission of HIV amongst prison officers and inmates. This also paved the way for Mosese to talk to prison officers and inmates himself and address the misconceptions about HIV/AIDS, gaining their acceptance in the process.

Mosese: Now everything is normal. Before no. They got counselling they understand. Where I come from and where they are. There’s no separation, I talk to them and counsel them, tell [sic] about HIV. I am allowed to serve food to inmates. (Attitudes of prison officers and inmates becoming more positive).

Mosese: They bring me here for my checkups every month. [] When I am sick one officer, stay [sic] with me in the hospital. I ask the officer to change the sheets... um ... the pillow sheets [pillow cover]. And he helps me when the nurse [sic] don’t want to. (Prison officers taking on a more supportive role).

3.2.1.3 Religion
This sub-section focuses on dominant experiences with religious groups. Religious leaders played an important role in the interpretation and application of religious doctrines. Consequently, interviewees reported that religious leaders played several roles: advocating, reinforcing, rationalising and counteracting HIV/AIDS-related stigma and discrimination and providing support for PLWHA. All Christian interviewees (n = 9) suggested that HIV+ people are viewed as “sinners” in their religion and the infection is seen as a form of punishment. When questioned about the view of their religious group towards PLWHA interviewees reported

Clare: [] as sinners. You must have done something against your religion.

Bulao: I think to them it’s just a punishment..., like you get sick..., you just being punished by God ..., Interviewees were further questioned if this view was reflected in the actions of their religious leaders towards them and Table 3.6 contains a summary of their dominant experiences with their religious leaders. On the other hand, Indian participants
(Hindu) were unsure about the stance of Hinduism on PLWHA and appeared to be more concerned about the reactions of community members. Both Indian participants reported that their community members will associate HIV with immorality and especially promiscuity.

Table 3.6

*Summary of dominant experiences with religious leaders (N=11).*

<table>
<thead>
<tr>
<th>Positive Reactions</th>
<th>Negative Reactions</th>
<th>Dominant Patterns</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Counteracting HIV/AIDS-related stigma</td>
<td>• Advocating stigmatisation of PLWHA</td>
<td>• 80% reported having at least one positive experience with religious leaders.</td>
</tr>
<tr>
<td>• Source of emotional support</td>
<td>• Advocating social ostracism of PLWHA</td>
<td>• 30% reported negative reactions.</td>
</tr>
<tr>
<td>• Positive reappraisal of infection</td>
<td>• Promoting isolation of PLWHA through discouraging association with HIV+ member.</td>
<td>• Christian leaders are becoming increasingly accepting and supportive of PLWHA.</td>
</tr>
<tr>
<td>• Physical support</td>
<td>• Reinforcing stigmatisation of PLWHA.</td>
<td>• In discriminating PLWHA, church leaders reportedly attempt to increase their popularity amongst their congregations.</td>
</tr>
</tbody>
</table>

80% reported having at least one positive experience with religious leaders. 30% reported negative reactions. Christian leaders are becoming increasingly accepting and supportive of PLWHA. In discriminating PLWHA, church leaders reportedly attempt to increase their popularity amongst their congregations. Hindu interviewees (n=2) were unsure regarding the stance of Hinduism on HIV/AIDS and were more worried about the attitudes of members of their family and community who they believed would associate HIV infection with immorality.

The following quotes explicate the reactions of religious leaders recorded in Table 3.6

**L.N.K:** You know I was in NACA meeting in 2006 and there was this Methodist pastor there and right at the meeting he said in front of everyone ‘Why don’t we send HIV+ people to an island?’ (Advocating physical isolation of PLWHA).

**Samuel:** [] there was a church elder …, who said that it will be good for you guys to release the names of infected people, so that we can know them. [] He then said his second motion is that if we could put out the names and their photos, put it out in the Post Office. (Advocating stigmatisation of PLWHA)

**Clare:** When I was diagnosed, every other denomination came and visited me in my home …, but Methodist [her former church] people never turned up …, I realised that it must have been the church and the leaders also …, discriminating positive people …, It shows in the way that they reacted. (Promoting social ostracism of PLWHA through discouraging association of HIV+ member)

**L.N.K:** The church people who did all this damage, spread the story about me, my wife …[,] They [Church leaders] look at us like we are sinners, we are dirty people …, we don’t deserve love the love of God
because of our sins we got infected. (Rationalising HIV/AIDS-related stigmatisation as a punishment for sinners).

**Samuel:** When I went to the church I told them that I am positive, I told it straight to the men and I said I wanted to speak to the congregation. [] And they said for me to speak to the parents first and then they asked me to hold a special session for the youths. (Counteracting HIV/AIDS-related stigma through facilitating HIV awareness sessions for members of their congregation).

**Bulao:** To me I feel comfortable going to that church because the Church pastor himself is very comfortable and like understanding and like he always encourage me eh and basing it on Bible eh ..., like encourage me ..., He helps me move forward ..., like cope eh. (Church pastors being accommodative, supportive and a source of emotional support [positive reappraisal]).

**Unaisi:** And those people from the mission they were there for me, they were there for me, they were so protective. I mean I owe [sic] life to them like they always follow me, make sure I don’t do anything wrong. Like in the beginning I [sic] when I found out what I have, I tried to kill myself. I tried to jump out of the window. And after that these people like they look [sic] they always keep a watch on me, say kind words like, like they were very very supportive ya and that was what saved my life. (Church leaders and members as a source of emotional support and taking care post-diagnosis).

**Vinita:** I don’t know what they will think about it. There’s nothing in our religion about it. But Indian people if they know they will talk about how I got it, like my character or about my husband what kind of man is he. [] I don’t think the pundits [Religious leader] know about HIV and even if they do they won’t be able to talk about it to us. In our religion we don’t talk about things like this. (Unsure about the reaction of her religious leader and was more concerned with the attitudes of members of their family and community).

L.N.K, Samuel and Clare who reported negative attitudes of their Church pastors, recorded in Table 5.5, suggested that in labelling PLWHA as “sinners”, Church pastors were misinterpreting biblical scriptures to meet their own needs and increase their popularity amongst their congregations as evidenced by the following report:

**L.N.K:** It’s the way they [church leaders] interpret the Gospel. They interpret the bible to suit them. They aim to draw the audience to them rather than to God. [] The pastors they use the church as an umbrella, they use the word of God like an umbrella to suit them to satisfy them and they are not interpreting the scriptures in the way it’s supposed to be.

However, L.N.K. also reports that the village church pastor has recently approached him to undertake some construction work for the church and feels his gaining acceptance by him.
3.2.1.4 HIV/AIDS-related NGOs

Apart from Bulao, Vinita and Narayan, all the other interviewees reported having some contact with HIV/AIDS-related NGOs, either as employees or members of support networks or through attending workshops organised for PLWHA and their partners; a summary of their dominant experiences is presented in Table 3.7.

Table 3.7

<table>
<thead>
<tr>
<th>Positive Reactions</th>
<th>Negative Reactions</th>
<th>Dominant Patterns</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Emotional support through providing counselling services</td>
<td>• Exploitation of public disclosure of serostatus in bids to attract funders.</td>
<td>• 64% of interviewees report very positive experiences.</td>
</tr>
<tr>
<td>• Positive reappraisal.</td>
<td>• Threatening members against joining other NGOs.</td>
<td>• Negative attitudes closely tied to securing and maintaining funding.</td>
</tr>
<tr>
<td>• Financial support.</td>
<td>• Encouraging financial dependency.</td>
<td></td>
</tr>
<tr>
<td>• Providing housing for PLWHA who have been rejected by family members.</td>
<td>• Involving members in unpaid activities for extended periods of time.</td>
<td></td>
</tr>
<tr>
<td>• Conducting HIV/AIDS awareness workshops.</td>
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</tbody>
</table>

Reasons cited for not joining HIV/AIDS-related NGOs especially support groups included (a) fear of serostatus becoming public knowledge if seen associating with other PLWHA, (b) associations would confirm existing speculations about their seropositive status and (c) remaining unconvinced as to the usefulness of these groups. These reasons are illustrated by the following reports:

**Bulao:** I haven’t joined any of those organisations …, just because I don’t want people at my work knowing about my status. (Bulao was afraid she would lose her job if her employers became aware of her serostatus).

**Lena:** I don’t want to join them for the fear that people will put two and two together and then say I’m positive. I’d be okay working for them, that way if someone sees me there I can explain why, but right now, no. Plus I don’t see a point of these things unless they are able to assist in me getting a job.

**Narayan:** I don’t understand, and I don’t see a point in sitting around and wasting time. It’s not going to put food on my table.

Interviewees who had attended workshops organised by the NGOs gave very positive feedback on them. For example, Luisa reported that attending one such
workshop inspired her to re-look at the way she used to view being infected with HIV and felt empowered to take charge of her life.

**Luisa:** It was a very good workshop. It gives me plenty know [sic] about this sickness. Because people say you have HIV, I can’t do anything …, no we can still move we can survive. No, I thought when I got the sickness, I can’t go back to work. I can’t do anything, when I attended the workshop, I know I can do anything, I can go in front. I will try working again (Positive reappraisal).

Similarly, interviewees who are currently working in HIV/AIDS-related NGOs attribute their present vigour to continue living as HIV+ persons and create awareness about HIV to the counselling interventions by HIV/AIDS support groups

**Clare:** So I decided to look at positively…, it takes a lot of strength for me to be able to do that … but the counsellors played an important role.[] Helped me to look at HIV in a positive light and not as a punishment.

**L.N.K:** Yes because in the beginning, I was trying to hide myself and not go out I didn’t want to know anything. I felt sorry for myself, very down and this counselling and the support network from FJN+ really helped me. It was the counselling that helped me come out of it.

However, some of the interviewees who were or currently are members of support networks for HIV+ people shared their grievances as well. Forms of HIV/AIDS-related discrimination by HIV/AIDS-related NGOs reportedly stemmed from attempts of NGOs to secure and maintain funding as evidenced by the following report of L.N.K.

**L.N.K:** HIV is now like a business now. [] It’s all about the funds now. Everything deals with money, everything we do we need money for all projects. They [HIV/AIDS-related NGOs] use these positive people for funding and once they get the funding they use it how they want.

**Samuel:** NGOs are cashing in on the positive people. Quote me on this.

Interviewee reports indicate three primary ways in which HIV/AIDS-related NGOs have mistreated its members. Firstly, NGOs have been used as platforms for public disclosure of serostatus. The account of Tevita, regarding his wife who has gone public about her status reveals that she may have been pressured to do so in the past.

**Tevita:** 2005 I told her, just show your face to the public that you have this. Just show yourself, never mind what they say.

**Researcher:** Why?

**Tevita:** So that people know she got this. Because XXX and XXX [fellow members of the NGO] go public and say to her go also [sic] .
And I told her too. Just show your face. (Tevita used to blame his wife for infecting him – see also 3.2.1.7.1)

L.N.K. explains that NGOs encourage public disclosure of members to attract funders

**L.N.K:** They [PLWHA] are being used ..., to come public of their positive status, so that the people [NGOs] can get money.

Secondly, interviewees also accused NGOs of attempting to create a sense of financial dependency to ensure continued membership. This was reportedly done in three ways; (a) failing to empower unemployed members to be financially independent through continued financial support, (b) continually engaging members into unpaid activities of the organisation requiring travelling, which have little relevance to the member, (c) preventing members from seeking training assistance from other organisations as is evidenced by the following reports:

**Samuel:** But the thing that I don’t like about the organisation is that it is creating a feeling to people outside that they need to pity us [PLWHA]. In that we we, [sic] please feed us. Give us money rather than as motivating positive people to go out there to sweat for their food. ..., And that is missing. The members are given the feeling that you have to come to us so that we can give you your food, so that we can give you this, without us you won’t be anything, they don’t empower them. They train them to do screen printing, so on one hand they train them but on the other hand a dependency is created by the leaders. (NGOs fostering continued dependency).

**Unaisi:** I came back in 20XX, from [workshop] and when I came back I didn’t know what I was doing there ..., actually what I am doing there. I don’t understand a thing they [facilitators of workshop] say. Like I have been here for three years and I ask them [other members] and some say eight and seven like that and damn I can’t be like that I need to go and do something, I told them I don’t wanna be eight years here and borrowing and dying slowly ..., (NGOs involve members in unpaid NGO-related activities that have little relevance to the member hence further increasing financial dependency).

**Unaisi:** Like I wanted to do some XXX [subject area] course or something so that I can get a job cause [sic] I need to work and they at XXX [NGO] don’t want to fund me so I go to XXX [another NGO] to ask for them to sponsor and this people [members of the NGO Unaisi is with] find out and they say that they terminate [sic] me if I do. [] I need to to take care of myself. I have been telling them that I am tired for them [of them], I need to be able to support myself and they just do their works and those things like looking for funding and all like [sic] ignore and I am getting very tired of this. (NGOs discouraging affiliation of members with other NGOs).
Thirdly, the above reports of Unaisi also suggest that NGOs strongly discourage members from seeking help from other NGOs through use of threats of termination of membership. With a comparatively small number of diagnosed PLWHA in Fiji and eight HIV/AIDS-related NGOs operating at the time of this study, reports of interviewees indicate that a competition seems to exist amongst HIV/AIDS-related NGOs at two levels; (a) securing membership which maybe symbolic of the NGOs success and (b) securing funding. The following reports of L.N.K. and Samuel depict this tension amongst NGOs and some of its effects on the members

Samuel: There are so many NGOs and there is limited funding so definitely there is a …, a competition between them for funds.

L.N.K: I think they are losing track of why we started this support group. [] They use these positive people for funding and once they get the funding they use it how they want. It now more of a money issue …, people in the organisation …, people who see the opportunity and they make use of it.

3.2.1.5 Neighbourhood Community

Of the 11 interviewees, the seropositive statuses of 6 are known to members of their neighbourhood communities namely, Clare, L.N.K., Mosese, Samuel, Tevita and Unaisi. The dominant experiences of these interviewees are recorded in Table 3.8.

Table 3.8

<table>
<thead>
<tr>
<th>Positive Reactions</th>
<th>Negative Reactions</th>
<th>Dominant Patterns</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acceptance and respect.</td>
<td>Gossiping.</td>
<td>50% of interviewees report very positive experiences.</td>
</tr>
<tr>
<td>Accommodative.</td>
<td>Verbal abuse.</td>
<td>50% report negative experiences in the past.</td>
</tr>
<tr>
<td></td>
<td>Avoidance.</td>
<td>Stigmatisation and discrimination more common in collective settings such as rural village settings.</td>
</tr>
<tr>
<td></td>
<td>Secondary stigmatisation of family members.</td>
<td>Communities are becoming increasingly accommodative of HIV+ members of community.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Changing attitudes are attributed to:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1. Intervention by individuals with a high social standing and religious leaders making way for a personal appeal by interviewee.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Increase in knowledge on modes of transmission of HIV.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Lacking physical symptoms of being HIV+.</td>
</tr>
</tbody>
</table>
The following reports of Samuel and Clare who are known widely as being HIV+
indicate positive reactions of their communities, recorded in Table 3.8

Samuel: Community members no, I think the most positive reactions
that I have got have been from the community.

Clare: [] no such negative reactions …, what they have for me is
probably respect for the person that I have become …,

Tevita and L.N.K. share that they have not directly experienced any HIV/AIDS-
related discrimination by community members, attributing this partially to the fact
that they do not live in a village setting

Tevita: But we not staying in a village, just our farm so that is okay.

However, both are aware of the negative attitudes of members of their communities
through the actions of their close friends. L.N.K describes this as cautious
association whereby his friends only spend time with him in the absence of other
community members

L.N.K: Before they [friends] are very close to me, now they are still
close but from a distance. They worry about their image from [sic] other
people. They will sit with me at the right time and in the right place
when they are not seen by anyone else.

L.N.K. who also has more interaction with members of his community as a
carpenter explains that the dominant reactions of the members of his community is
that of confusion and awe. He explains that community members are generally
amazed by the fact that contrary to their expectations, he continues to lead a healthy
and productive life even though he has been known to be living with HIV for the
past 11 years. Furthermore, he attributes the changing attitudes of community
members from stigmatising to accommodating to his continuing good health

L.N.K: When they see me building, they give me strange looks and they
stand afar and they talk like it’s a big thing. But one of the things
changing the perception of my community members is my building
houses in the area. People don’t expect HIV+ [people] to be able to do
anything …, you know be sick …, but I don’t look sick …, [chuckles] so
that is a major reason. Some of them are starting to doubt that I am
positive [chuckles].

Unaisi on the other hand, who used to reside in a village with her mother, describes
the greatest degree of HIV-related stigma. Forms of stigma reported by her include,
gossiping, verbal abuse and avoidance as evidenced by the following report
**Unaisi:** They don’t wanna talk to me or come close to my house, ya they used to point fingers and they’d say words, they’d be gossiping but like I [sic] hear here, like loud.[\*] And when I go home they don’t want to come and share our toilet and bathroom, they don’t wanna [sic] closer to our compound and even at home, they don’t want to come inside, normally they would come over for tea and stuffs but when I am there, they won’t and um they won’t borrow things from my mum you know stuff like that.

However, Unaisi also reports that attitudes towards her have become more positive since her elder brother addressed her community asking them not to treat her badly (see also 3.2.1.6) which gave her an opportunity to address members of the community herself and to create awareness about modes of transmission of HIV

**Unaisi:** And I have went [sic] there sometime and I educated them about this and they ask a lot of questions and things so I answer like they can’t get it if we share toilets and things and it has been good. They are all good now. I talk to them, they listen and we communicate. They have started coming over and it’s good now.

Similarly, Samuel describes how he used disclosure of serostatus to dissipate anger and fear directed towards PLWHA while facilitating a HIV/AIDS-related workshop in a village community

**Samuel:** [...] and one of the village elders stood up demanding that the government release the names of all PLWHA in Fiji. And he said “My second motion is to put the pictures of all HIV people in the post office so we can know them and avoid them”. And I asked him “Do you want see the face of HIV? Do you really want to see the face of HIV? I was angry. And he said “Yes!” And I said “You looking at it, I’m HIV+.” And after that everything went silent and calm. [laughs] He calmed down and the workshop went really well. They were open to what we were saying. And after the workshop he came shook my hand and said “Sorry”.

**3.2.1.6 Family**

With the exception of Lena, close family members of all the other interviewees are aware of their seropositive status. Lena quotes fear of discrimination as her main reason for non-disclosure of serostatus

**Lena:** I have been thinking of telling my family, but I know my family, they are very judgemental most of them. [...] My family members have very negative attitudes towards HIV+ people.

Of the remaining interviewees, 80% report very positive attitudes of their family members and a summary of dominant experiences are recorded in Table 3.9.
Table 3.9

Summary of dominant reactions of family members (n=10).

<table>
<thead>
<tr>
<th>Positive Reactions</th>
<th>Negative Reactions</th>
<th>Dominant Patterns</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Emotional support (driving force).</td>
<td>• Considering with disdain and contempt.</td>
<td>• 80% of interviewees report very positive reactions of family members.</td>
</tr>
<tr>
<td>• Financial support.</td>
<td>• Gossiping.</td>
<td>• The greatest levels of HIV-related stigma perpetuated by family members.</td>
</tr>
<tr>
<td>• Physical support (caregivers).</td>
<td>• Damaging property.</td>
<td>• Families living in rural and communal settings and those that became victims of</td>
</tr>
<tr>
<td></td>
<td>• Stealing.</td>
<td>secondary stigma were more prone to perpetuate stigmatisation and discriminate their</td>
</tr>
<tr>
<td></td>
<td>• Rejection.</td>
<td>HIV+ relative.</td>
</tr>
<tr>
<td></td>
<td>• Secondary stigmatisation of members of household.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Rejection.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Physical isolation.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Social ostracism.</td>
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</tr>
</tbody>
</table>

Family members reportedly adopted several roles including providing emotional, financial and physical support to their seropositive relatives

**Bulao:** I told them, first their response was..., they were supporting me..., eh. They were giving their encouragement ..., my uncle and auntie and the kids. [ ] They all just said positive things to me and they all encourage me. (Emotional support and positive reappraisal).

**Vinita:** My sister, her husband and my mother ..., they do everything for me and my daughter. Like all our expenses ..., now we live with my mother and she takes good care of me ..., tells me not to worry too much. (Family members provide financial and emotional support).

**Mosese:** Every time they and visit me. They support me, [sic] lot of support. They buy the fruits they bring me fruits because I am sick. (Family members continue to be supportive, unaffected by his conviction and seropositive status).

**Clare:** I was very sick and could not take care of myself ..., she looks after me ..., takes care of me. [ ] But I know it was her strength that helped me come out as well ..., if she was weak in the way she looked at me and the way she responded to me when I was sick... I won’t have been able to make it... Maybe it is her motherly love... that strength that kept me going. (Family members [mother] as caregivers and a source of emotional support).

However, compared to all the other levels, the greatest levels of HIV/AIDS-related discrimination were also perpetuated by family members of two interviewees namely L.N.K. and Luisa. Both interviewees live in a collective rural setting; Luisa in a village and L.N.K. on a piece of land he co-owns with his relatives including mother, uncles and brothers and their families. Forms of HIV/AIDS-related
discrimination reported by the two interviewees included being considered with
disdain and contempt, gossiping, damaging property, theft, rejection, physical
isolation, social ostracism and secondary stigmatisation of nuclear family members
(see also 3.2.4)

**L.N.K:** They [family members] look down upon me … People treat us
[him and his child] like a dirt or something. (Considered with disdain).

**L.N.K:** … they gossip between them. [] There was a guy who came
along and he was sitting at home and he brought some grog and we were
having a party [grog drinking session] at my place. He was staying with
my mother but he came to see me. They [family members] told the
husband and wife about me but the husband doesn’t [sic] care and came
to see me. (Family members gossiping and encouraging isolation).

**L.N.K:** They steal my tools and my house has been broken into. And
when I go to the farm things are gone from there. (Family members
damaging property and stealing).

**L.N.K:** If they have a get together, my daughter and I am never invited.
(Social ostracism by family members).

**Unaisi:** And the negative thing is that that [sic] wrote a warning letter,
they [Family members] did a case on me they wrote a letter of complaint
[sic] they took me to a police station. So she [Mother] told the police
she don’t [sic] want me to stay with her. My family don’t want to talk to
me, they just shut me out. (Rejection and physical isolation).

Unaisi explains that actions of her mother stemmed from secondary stigma that she
was being subjected to by members their community. However, since her elder
brother who has a high social standing in her village has spoken to them, asking
them to treat her nicely, family members have become more accepting of her.
Similarly, L.N.K. reports that the attitudes of his family members are also becoming
more positive as he is increasingly gaining acceptance in his community.

**L.N.K:** The same people who didn’t want to know us are beginning to
come back to us. People who did all this damage, spread the story about
me, my wife …, and they were my relatives, my mother, my brothers …,
when they see this [current partner moving in with him and village
pastor giving him a contract for building houses] …, it didn’t agree with
what they wanted to see [ostracized from family] …, Before they used to
look at us down but now when my wife came in they [sic] at us up [have
started treating them better].

### 3.2.1.7 Partner

Dynamics of HIV/AIDS-related stigma revealed an interesting pattern as attitudes of
and towards partners were reported by interviewees. Ten of the eleven interviewees
identified a main partner. While partners of Bulao and Lena have passed away,
Vinita at the time of interview was separated from her husband and Mosese is divorced, reaction of and towards the partners of these interviewees are also recorded in this section. Reports revealed that attitudes were closely associated to which partner was infected or was identified as the source of infection and the coping strategies generally employed by interviewees. A summary of dominant experiences with partners is presented in Table 3.10, followed by further analysis of patterns included in the table in sub-sections 3.2.1.7.1 – 3.2.1.7.3

Table 3.10

Summary of dominant experiences with partners (n=10).

<table>
<thead>
<tr>
<th>Positive Reactions</th>
<th>Negative Reactions</th>
<th>Dominant Patterns</th>
</tr>
</thead>
</table>
| ● Emotional Support.  
● Eventual Acceptance.  
● Physical support (caregivers). | ● Blame.  
● Rejection. | ● Reactions associated with who was seen as the source of infection.  
● Diagnosis causes some disruption in relationships but generally leads to acceptance of HIV+ partner (80%).  
● 30% of interviewees report positive changes in relationships since diagnosis. |

3.2.1.7.1 Spouse as the source of infection

Bulao, Clare, Lena, Tevita and Vinita report that they were infected by their spouses. Reports of these interviewees reveal that either their partners were infected before marriage, or had high-risk behaviours such as multiple partners (some of whom were known to be infected) and history of substance abuse, or unlike their partners, the interviewee had to wait for the window period before he/she could be given a conclusive diagnosis. All of these interviewees blame their spouses for their infection, but how they reacted towards them varied greatly and appeared to be linked to individual coping styles (see also 3.2.5.2 for discussion on coping styles). Clare and Tevita responded with high levels of anger; Clare by going public with her seropositive status, citing her husband as the source of her infection and Tevita by physically assaulting his partner.

**Clare:** I didn’t tell him that I was becoming public…., I did it out of spite as well because I was angry.

**Tevita:** I was angry. Very angry. I just punch [sic] her.
However, both interviewees report that they have forgiven their spouses and are moving on with their marital lives:

**Clare:** [...] and 18 months was all that took me to accept him..., forgive him.

Bulao and Vinita while being upset with the nonchalant attitudes of their partners eventually forgave and accepted them as well. Upon diagnosis, partners of the two women successfully convinced them that there was no point in worrying over what had happened and that they needed to move on. Both women’s partners also made promises about things changing for the better and that they will be supported. However, both interviewees reported that after some time their partners went back to their abusive habits, which the women continued to tolerate. The same cycle of violence was reported by both women prior to diagnosis: they had abusive relationships with their partners and were continually subjected to domestic violence but did little to address these problems. Being infected did not appear to cause any major changes in their relationship.

**Bulao:** In fact he [partner] was tested first and he told me about it …, like he was just casual about it eh …, like him knowing that his got the virus and me joining him..., so he was quite like…, umm casual with it eh. [...] He said that for me not to worry and all that and we are going to be together even though we’ll be sick …, and that he will [sic] there to support me and take care of me.

**Vinita:** In the beginning he was sorry, he cried but when he got discharged and we were better, he started just like before. He still fights with me. Always thought he is my husband na ... He will improve someday. He beats me up [].

Conversely, Lena who also reports an abusive pre-diagnosis relationship used the diagnosis to negotiate a better relationship with her husband. She describes herself as being “blinded by love” for her deceased husband and used the diagnosis to convince her husband to stop having extramarital affairs through threatening him that he’ll be “jailed for it”. Consequently, she describes feelings of relief and happiness upon diagnosis.

**Lena:** For me personally I thought what the heck? Now his all mine …, shit I was too much in love. I was that much in love. [...] What really appealed to me was that we were in this together and it just made us closer, it really cemented our relationship. I was happy, because now he wasn’t going with other women.
3.2.1.7.2 Source of infection unknown
Luisa was unable to identify how she got infected. She got married in 2003 and was diagnosed in late 2008 with HIV. Throughout her interview, she maintained that she was unsure how she got infected. She had been sick for the past three years and was eventually diagnosed with HIV. Reactions of her husband who had not been tested at the time of the interview are extremely supportive and she described him as her driving force

Luisa: When I was sick…, nobody [sic] beside me, that’s the time I couldn’t walk, even I can’t walk to the toilet or bathroom, nobody beside me, only my husband …, he look [sic] after me. With my husband, I feel …, happy and strong. I can go [survive]…,

3.2.1.7.3 HIV- Spouse
Four of the interviewees (Mosese, Samuel, Narayan and L.N.K.) shared that their partners had been tested and were seronegative. The main feelings shared by these interviewees were that of guilt and regret. Partners of Samuel and Narayan reportedly blamed them for disruption of their family lives.

Samuel: Her moving back with me makes me feel regretful that I am positive, it just give [sic] me the lesson you know …, that we can say to other people, you might have differences between you two …, marital problems like that …. but don’t …, don’t go outside [extra-marital sexual relations] …, because later on you may decide to get back together but there are things like HIV …. that …. you won’t be able to have sexual relations like you used to have before.

Narayan: At time [sic] she gets very upset. Because of me and my behaviour she has to go through a lot. We have three sons and she will have to look after all four of us. We have arguments and she lashes out at me at times, blaming me for this mess.

Mosese’s ex-wife demanded a divorce, which he attributed to him being imprisoned and infected

Mosese: She told Dr. XXX that she don't [sic] want me anymore. She want [sic] a divorce.
Researcher: Why do you think she asked for a divorce?
Mosese: Reason together [sic], because I am in prison, I have HIV.

On the other hand, married lives of Samuel and Narayan have improved since diagnosis and they have gained acceptance of their wives. Wives of both
interviewees are their primary caregivers. Samuel, who had been separated for three years before diagnosis, reunited with his wife after diagnosis and is taking concrete steps to make his married life work

**Samuel:** HIV catalysed our getting back together because we had to think about our son…, it was all about our son.

Narayan who described himself as a husband who used to regularly cheat on his wife and spent a lot of time drinking with his friends, shared that he had abandoned these habits and now tries to concentrate more on ensuring the financial security of his family

**Narayan:** So I have stopped hanging out with my friends and drinking, going with other woman [sic]. I just go to work and back home. I want to focus on the important things in life. I have three sons that I need to look after.

Finally, two years after the death of his wife and being ostracised by his family for the past eleven years, much to his surprise L.N.K. has found love and acceptance of his current partner.

**L.N.K.:** The way she shows her love …, I am very happy …, [] I can’t believe this, I still can’t understand how she can accept me. [] I am still surprised. I still can’t explain it.

From the reports of the interviewees of this study it is evident that the attitudes towards and of their partners were dependent upon who was ‘blamed’ as the source of infection. Interviewee reports also indicate that while a positive diagnosis caused some disturbance in the relationship between interviewees and their partners, they generally achieved a stage of acceptance. Likewise, Vinita has lived separately from her husband due to marital problems before diagnosis and after diagnosis and she cites pre-existing marital problems rather than HIV as the cause for this separation. However, while Mosese’s divorce has other compounding influences such as his increased jail term, he cites his HIV status as one of the reasons for his wife requesting for a divorce.

3.2.1.8. **Summary**
This theme summarised the dominant experiences of interviewees with seven key groups namely, healthcare professionals, prisons officers, religious leaders,
HIV/AIDS-related NGOs, neighbourhood communities, family members, and partners. Three dominant trends are identified; (1) with the exception of nurses working at main hospitals, greater levels of positive experiences were reported by participants with the other six groups, (2) reactions to PLWHA are becoming increasingly accommodative and supportive overall, (3) HIV/AIDS-related stigma and discrimination can be alleviated via intervention by religious leaders, individuals with a high social status, and authority figures combined with a personal appeal by PLWHA.

3.2.2 Theme Two – Sexual Stigma: A Dominant Social Force That Creates and Maintains HIV/AIDS-related Stigma in Fiji

3.2.2.1 Perceptions on modes of transmission of HIV
The level of knowledge on modes of transmission of HIV/AIDS varied greatly amongst interviewees. Unaisi, when informed of her seropositive status, was unmoved and proceeded to enquire how she could be treated for it, suggesting that she had no knowledge about HIV/AIDS. Some interviewees saw it as a contagious disease spread by casual contact. When questioned on knowledge of modes of transmission of HIV/AIDS before diagnosis interviewees explained

Luisa: If you touch ..., you get AIDS. [I] I think sometimes it will come to me by the crowd of people, I am working in one place lots of people…., I don’t know where I’m gonna touch someone and get AIDS.

Lena: ..., sharing toilets, utensils even standing beside a positive person.

Mosese: ... mosquito bite, the plate ... [I] By touching the skin, the shaving gear, sweating, like that they think they can get [HIV].

Even a year after diagnosis and having undergone post diagnosis counselling, Narayan remains unconvinced that HIV/AIDS is not transmitted through saliva as is apparent through his statement

Narayan: At home I don’t give anything that I have tasted to my sons or wife. The doctor has said you can’t get it that way, but you never know. I am afraid I might give it to my family.
However, majority of interviewees (including Lena) were aware that HIV/AIDS was sexually transmitted. Samuel, formerly a HIV/AIDS peer educator and Clare shared that they were aware of all the modes of transmission of HIV/AIDS

Clare: …, I was very aware of HIV; I had knowledge …, information, everything. From the reports of interviewees of this study, no relationship was seen between levels of knowledge and consequent adoption of preventative practices. This is apparent in the following explanation provided by Samuel regarding why he did not use a condom to protect himself

Samuel: Information was enough but it’s just the behaviour …, it did not change my behaviour.

3.2.2.2 Sexual stigma
Interviewee reports indicated that knowledge that HIV/AIDS was sexually transmitted was associated with sexual stigmatisation of PLWHA. HIV/AIDS was most closely linked with sexual stigma and was perceived by interviewees as a disease for sex workers, promiscuous individuals and homosexuals. These stereotypes can be respectively identified from the following accounts of interviewees regarding their understanding of how a person can get HIV/AIDS

Clare: Only women who stand on the streets, like prostitutes get HIV.

Bulao: People who are sexually active eh ..., have many partners ...eh.

L.N.K: Just the gay and lesbian people.

Association of the pandemic with sex workers, promiscuous individuals and homosexuals created a false sense of personal immunity to HIV/AIDS. Furthermore, ascribing to value-driven stigma that only individuals with such deviant sexual practices were infected with HIV/AIDS, interviewees were adamant that their personal values, cultural and religious beliefs and practices will protect them from infection. These attitudes can be identified from the following accounts

Clare: …, I never expected to get HIV, [laughs] it was a shock …,

Researcher: Why not?

Clare: Because of my background. [ ] I was brought up in a very strictly religious family. (Associated HIV/AIDS with prostitution).

Bulao: Didn’t think I would get it. I never expected to get it. [ ] I had a boyfriend in XXXX [Educational institution] and after that I was with him [partner]. (Associated HIV with promiscuous behaviour).
L.N.K: It was a non-issue …, it didn’t really [occur to me] that this could happen to me. [] I didn’t really care about all this [HIV/AIDS-related information], I thought it was my custom and religion that would protect me …, I believed that my ancestral spirit would protect me against all bad things like AIDS. (Associated HIV/AIDS with homosexuality).

The attribution of HIV/AIDS to certain groups of people also affected interviewees’ attitudes towards HIV/AIDS awareness initiatives and adopting of preventative sexual practices for those who were at risk. For example in regards to her reactions towards HIV/AIDS awareness programme organised in her school Lena explained

Lena: I couldn’t be bothered [chuckles]. I was sitting at the back, pretending to listen but thinking about something else. [] It was an incurable disease but I didn’t have to worry about it because only people like prostitutes got it.

Clare who not only relied on what she had been taught in school about HIV/AIDS but also did her personal research on the topic explained

Clare: ..., well it won’t happen to me ..., so even though I take in the knowledge, I knew for sure that I won’t be HIV+ …, I didn’t take it seriously.

The sense of personal immunity to HIV/AIDS was so strong amongst interviewees that even when interviewees had knowledge of modes of transmission and practices that prevent infection, and their partners exhibited behaviour placing them at risk, they themselves never felt at risk of infection thus did not take any precautionary measures. For example, even though Lena was aware that her husband was sleeping with other women she continued having unprotected sex with her husband and was convinced that she would never contract HIV

Lena: My husband and I weren’t using condoms. [] And I never ever thought I’ll get it ..., ever. There was something in my head, that I couldn’t ever get HIV even though my husband was with other women. It’s strange, it’s this feeling, no you won’t get, no you won’t get it. I was convinced I won’t get it, till I got it.

HIV/AIDS was seen as a disease for ‘other’ immoral people and not for self or partner. For example, Vinita explains why she did not use condoms with her husband who she knew was sexually active before marriage

Vinita: I thought that kind of sickness you won’t get it – we are married and we are not like them [promiscuous]. My husband was like that
[promiscuous] before but not anymore. He used to sleep with European women. [I] can’t get it because I’m not that kind of person.

3.2.2.3 Use of Condoms
Use of condoms was also associated with sexual stigma and was seen as more appropriate for individuals that the interviewee thought were at risk of infection. The following accounts depict this

Lena: I would tell him to use condoms when he is with other women ...

Vinita: Because we don’t need to use it, especially if we are faithful.

Researcher: Did you use condoms?
Mosese: Sęqa! No way!
Researcher: Why not?
Mosese: Because I don’t have a disease!

Hence, suggestions regarding use of condoms were viewed with negative connotations such as lack of trust in the partner, having an STI and being promiscuous. For example, Samuel explains

Samuel: You may have been thinking about it [negotiating use of condoms] …, but you may think that if you request for a condom, the other person may think you are sick or dirty you know …, or that you think he or she is dirty … [I] It’s about how much you can trust me or this is how much I trust you …, the feeling eh …, the emotion takes over …, yap the feeling takes over.

Not using condoms was also seen as a gesture of acceptance, unconditional love and intimacy for partners who were aware of the interviewee’s seropositive status.

L.N.K: I told her about condom but she refused. [...] I still cannot believe why she accepted my situation [Being HIV+]. She told me that we all will die one day so [shrugs his shoulders] …, it’s taking me time to understand this and [sic] answer.

Other barriers to use of condoms included reduction of sexual pleasure and lack of accessibility: The former was cited as one of the main reasons for interviewees or their partners not willing to use condoms, even after diagnosis. For example

L.N.K: …, and she has never felt that pleasure. I’m a married man and I know how to make love, she told me that. With me she wants the whole thing.

Luisa: Because me I don’t want to use condoms …, I don’t like it.
Researcher: Why not?
Luisa: It’s not good for me … not the same feeling …,
Researcher: What about your husband?
Luisa: No he [husband] doesn’t like it, the feeling about using condoms, it’s not natural.

L.N.K: One problem is that where people stay they may not get it.

While both male and female interviewees shared facing difficulties in negotiating usage of condoms with their partners, women were coerced into having unprotected sex through use of both implicit and explicit threats. For example, when questioned on why interviewees continued having unprotected sex even after diagnosis they explained

Lena: I tried to ask him, but he didn’t want to so I let go. I wasn’t ready to jeopardise our relationship because of that.

Bulao: Because mostly he was forcing me to …, he also threats [sic] me…, you know when I wanted to …, like always refuse him [having unprotected sex] …, he would say …, always threat me saying that …, his gonna go public and tell everyone about our status.

From the reports of the interviewees of this study it appeared that sexual stigmatisation of HIV/AIDS was associated with sexual stigmatisation of condoms.

3.2.2.4 The Moral Rationalisation of HIV/AIDS-related Sexual Stigma
Reports of interviewees suggests that HIV/AIDS was generally viewed as a disease for sinners or immoral people who engaged in religiously and culturally unsanctioned behaviours such as prostitution, having multiple partners and homosexuality (see also 3.2.1.3. and 3.2.2.1.). Interviewees reported that they or their partners were seen by their stigmatisers as being responsible for getting infected and were expected to feel guilty for being infected

L.N.K: They try to make me feel guilty …, feel bad that I have HIV.

Interviewees who were infected by their partners also ascribed to this belief and generally blamed their partners for infection while sharing that they were the victims of the immoral actions of their partners (see also 3.2.1.7.1.)

Vinita: I get very angry and upset, because he is the reason I got it. I was always good but he had many girlfriends and he was like that [promiscuous].

Value-driven stigma dominated interviewee reports and included forms of punishments perceived to be fitting of PLWHA such as being perceived as deserving
of infection, “dirty”, undeserving of love, and feelings of hatred for being infected as evidenced by the following reports

**Unaisi**: Like bad words, like swears, like she ..., serves her right that she got infected, she never listen to her mother and she too much fancy like that you know. And like she always hang around boys that’s why she’s got it (Value-driven stigmatisation by community members).

**Tevita**: And they say, “see you left the other one [ex-wife], and get this one [wife]. You do all these wrong things and that’s why you get it. Before you got a wife and you going around with other women. See this time, see what you have got”. (Value-driven stigmatisation by family members).

**Mosese**: I hated people with HIV. The USP student who got it, I hated her. Only street people got HIV. (Value-driven stigmatisation of other PLWHA).

Moreover, as L.N.K. explains, PLWHA are viewed as “satanic angels …, they are impure and ungodly” and hence as sinners they don’t “deserve love, the love of God”; instead PLWHA are expected to be punished by God for their immorality or sinfulness. This notion of punishment was also reflected in physical descriptions of PLWHA provided by interviewees while relating their understanding of HIV+ people before diagnosis. Physical descriptions offered included “the body is going skinny”, “hair is falling”, “skin dry and covered with sores”, “look like an alien” and “it’s an ugly thing”.

As a result, interviewees shared that when they continued to look healthy, be active and continued to gain acceptance of others, their stigmatisers started to (a) doubt that they were HIV+ and (b) started to reassess their own actions and attitudes towards PLWHA gravitating towards being more accommodative

**L.N.K**: The same people who didn’t want to know us are beginning to come back to us. People who did all this damage, spread the story about me, my wife ..., and they were my relatives, my mother, my brothers …, when they see this [current partner moving in with him and village pastor giving him a contract for building houses] …, it didn’t agree with what they wanted to see [ostracized from family] …. Before they used to look at us down but now when my wife came in they [sic] at us up [have started treating them better].

Furthermore, interviewees also associated lack of physical symptoms and increasing acceptance by others, members with a high social standing and especially church leaders as a catalyst for gaining the eventual acceptance of their stigmatisers.
Tevita: Because what he say is very powerful ..., the power of God. And everybody listen [sic]. And when he accepted me and support me, they [members of community] don’t say anything.

Therefore, it is evident from the reports of interviewees that while they are generally viewed as “sinners” by their religion and the infection was seen as a punishment hence they were discriminated, the lack of physical symptoms and increasing acceptance by especially church leaders alleviated value-driven stigma.

### 3.2.3 Theme Three – Role of Fear in the Development and Maintenance of HIV/AIDS-related Stigma

Lack of accurate knowledge on modes of transmission of HIV reportedly resulted in fear-driven stigma and discrimination of interviewees whereby individuals who came into contact with them feared getting infected. Interviewee reports revealed that before diagnosis they unanimously considered HIV/AIDS as an incurable, life threatening disease that they were afraid of contracting.

**L.N.K:** ..., it’s death, has no cure and people who were infected would die.

**Luisa:** I don’t know where I’m gonna touch someone and get AIDS. I’m [I was] so afraid.

This perception of HIV as an incurable, deadly disease was also reflected in the actions of other people around interviewees as is apparent from the reports of Mosese who shared that when he told his parents that he was HIV+ they went back to the village and started fundraising for his funeral, expecting him to die shortly afterwards

**Mosese:** And they went back to the village and they start [sic] to collect money.

**Researcher:** Why?

**Mosese:** Because they think I have this kinda disease and that I’m gonna past away [sic] soon aye. All [sic] my family were upset and they knew the story about HIV, if someone have HIV, it will be soon they will past away [sic] . So they were doing a fundraising for my funeral.

Reports of interviewees also indicate that HIV/AIDS was considered by some as a highly contagious disease spread through casual contact. Apart from sexual contact, other forms through which HIV/AIDS was perceived to be transmitted included touching, contact with sweat and saliva, peripheral contact with blood such as on shaving blades and mosquito bites (see also 3.2.2.1). Consequently, when others
knew the serostatuses of interviewees, especially in the absence of sound knowledge of modes of transmission of HIV, interviewees were subjected to fear-driven stigma. Reports of interviewees suggest that some community and family members avoided contact with them due to the fear that they may get infected

**Samuel:** One of my sister’s told another sister that I have HIV and this sister was living with me at that time but is right from the village. This created fear. When I came home, everything was gone …, she had packed everything, taken all her things she and left …, she thought she had AIDS just by living with me. (Fear-driven stigmatisation by family members).

**Unaisi:** They don’t want to use what we using. There’s three houses that we are staying together, like they use our water and toilets and at times they ask for stuffs but when they heard about what I have, they stopped. [] I think they think they can get it also if they do. They just afraid of getting it. (Fear-driven stigmatisation by fellow villagers).

**L.N.K:** They [family members] told the husband and wife about me but the husband doesn’t care and came to see me. And then he asked for my shaving gear and I gave him my shaving gear. When he was about to shave one of my brothers called him “Hey just come, come.” When he came back my shaving gear is gone and he has a new shaving gear. (Family members perpetuating Fear-driven stigma by others).

However, interviewees also shared that increase in awareness of modes of transmission of HIV coupled with a personal attempt to engage with their stigmatisers resulted in reduction in Fear-driven stigma (Also see 3.2.1.2 Prisons Department and 3.2.1.5 Neighbourhood Community).

**Unaisi:** And I have went [sic] there sometime and I educated them about this and they ask a lot of questions and things so I answer like they can’t get it if we share toilets and things and it has been good. They are all good now. I talk to them, they listen and we communicate. They have started coming over and it’s good now.

From the reports of interviewees of this study it is evident that inaccurate beliefs about casual transmission of HIV resulted in avoidance of PLWHA by family and community members due to the fear of being infected. Furthermore, it was also apparent from the accounts of the interviewees of this study that increase in knowledge about modes of transmission of HIV and engaging in dialogue with stigmatisers assisted in addressing fear-driven stigmatisation of participants.
3.2.4 Theme Four – Extension of HIV/AIDS-related Stigma to HIV-Family Members

Two interviewees reported that HIV/AIDS-related stigma was extended to HIV-family members when people became aware of their serostatuses. Forms of secondary stigma reported included social ostracism of family members, verbal abuse and physical isolation as evidenced by the following reports

**L.N.K:** My family members are very scared of the child [daughter] …, they don’t allow her to play with their children. [] When my daughter tries to play with their kids they don’t let them play with her “Hey what you doing playing with her, don’t you know they are HIV [sic] people”. If ever my daughter runs inside their house following their kids, they tell her, “Go and stay in your house.”

**Uanisi:** [] everybody is telling her [mother] we don’t wanna come home cause [sic] your daughter is like, she’s sick. And my mum said “What are you people talking about?” And my mum came home. And they not even smiling to [sic] her when she smile or say anything like talk to her. Like they stay far away from her.

Secondary stigma and or fear of secondary stigmatisation also reportedly resulted in further stigmatisation of interviewees through abandonment and cautious association by members of family and close friends

**L.N.K:** Because of the older generation in the village, they have the power to say that and it’s the gossip thing that flies around, they [close friends] will be called names and people will talk bad about them (see also 3.2.1.5 and 3.2.1.6).

Similarly, fear of secondary stigmatisation of her daughter is one of the main reasons cited by Vinita for her being extremely secretive about her seropositive status

**Vinita:** I’m just very worried about my daughter. Her life can be spoilt because of me. A boy can stay in the house, but the girl goes away. If people know that I have HIV, who will marry her? I just worry about her all the time.

From the reports of interviewees of this study, secondary stigma or fear of secondary stigmatisation discouraged serostatus disclosure and was a contributor to lack of support and HIV/AIDS-related stigmatisation by family members and close friends.

3.2.5 Theme Five – Psychosocial Impact of HIV/AIDS-related Stigma and Discrimination on the Interviewees

This theme presents the impact of interviewees’ perceptions and experiences recorded in Themes 1-4 on their emotional and behavioural responses (i.e.
psychosocial reactions). A HIV+ diagnosis reportedly had manifold implications on the psychological wellbeing and behavioural responses of interviewees based on three commonly reported pre-diagnosis assumptions of HIV/AIDS held by interviewees; (a) “an incurable disease”, (b) “death sentence” (c) getting infected is a “big shame”. Reports indicated that before diagnosis interviewees held both fear-driven (see also, 3.2.3) and value-driven (e.g. sexual stigma – see also 3.2.2.2) stigmatising attitudes regarding HIV/AIDS and PLWHA and hence upon diagnosis expected negative reactions, as evidenced by the following report

**Lena:** But I know what’s in their heart. They would be treating that person differently because, I know I would do the same.

While negative reactions to interviewees’ seropositive statuses reinforced this expectation, positive reactions were viewed either with scepticism or when convinced about sincerity, with appreciation and gratitude. For instance, Bulao related that when she eventually shared her serostatus with her family members (five years after diagnosis) and received positive reactions, she was sceptical regarding the genuineness of these reactions

**Bulao:** Like if they know about me I may be fired from school because they don’t trust me eh... especially with children eh... you know very much worried about people’s reaction to [sic] me eh. I know they [family members] may be supportive, but I am not sure whether they are [sic] genuinely care…,

In relation to their experiences, interviewees indicated that in comparison with other PLWHA, they felt they had more positive experiences. While this positive reappraisal appeared to be an important coping strategy, it also indicated that the interviewees expected higher degrees of discrimination or from a broader spectrum of individuals. These can be evidenced by the following reports

**L.N.K:** No unlike other positive people I have been very lucky. (In comparison with other interviewees reported greatest levels of discrimination by family members – see also 3.2.1.6).

**Clare:** I have been so fortunate in that way, unlike other people I have never been discriminated in any way or stigmatised. (Reported discrimination by church members)

Consequently, all of the interviewees reported some degree of internalised stigma whereby they imposed stigmatising attitudes upon themselves. Both anticipated and
actual stigma were seen to influence the internalisation of stigma and consequent emotional and behavioural reactions of interviewees, therefore unlike the previous themes, the impact of anticipated stigma has also been recorded under this theme. Sub-sections 3.2.5.1 – 3.2.5.2 map (1) the changes in internalised stigma through identifying changes in self-esteem and accompanying emotional changes reported by interviewees, (2) the coping strategies adopted (3) the impact of internalised stigma on mental health and, (4) the impact of fear of stigmatisation on health seeking behaviour.

3.2.5.1 Emotional Responses
Low self-esteem was characterised by negative emotional states which signalled internalised stigma: This was reported to be greatest during the early stages of knowledge of infection and would gradually decrease as the interviewee learnt to accept the diagnosis. Upon diagnosis, interviewees went through various emotional stages which were preceded in all the cases by shock. Even interviewees like Samuel who had requested a test himself and was expecting a HIV+ diagnosis relates that he was also in a state of shock when he was informed about his serostatus. L.N.K provides an interesting description of this feeling

L.N.K: It’s like a big bomb just blasted and everything’s finished ... gone just like that. [clicks fingers] [...] just numb.

Right after diagnosis, all interviewees reported a low self-esteem with personal self-esteem ratings ranging from 0-2 (see also 3.1.3.2.4 for self-esteem ratings) and expressed self-stigmatising emotions including self-blame, guilt, shame, self-pity, feelings of worthlessness and hopelessness and disappointment for not meeting personal goals. At the time of the interview, interviewees like Clare, Samuel, and L.N.K had developed a stage of acceptance accompanied by a resolve for a better future. These interviewees also reported high self-e steems which ranged from 7-10. All of these emotions are evident in the following reports:

Bulao: I blame myself for getting the disease..., I was ignorant and I didn’t listen to my parents..., I never obeyed them..., And that’s why I blame myself [tearful] and I had to get the disease from my partner..., [...] ...and one thing I decided to do at that time was not to..., not to tell anyone about it..., just to keep it to myself..., just allow myself to suffer..., I mean what I did was let [sic] myself suffer..., (Blamed herself for going against the wishes of her parents who did not approve of her partner, hence felt she deserved to be infected, resulting in self-imposed punishment.)
Narayan: Because of me and my behaviour she [wife] has to go through a lot. It makes me feel bad ..., I feel guilty for what I have done and how I got this thing. (Feelings of guilt for getting infected and disrupting family life).

Vinita: I was always good [abstained from sexual or romantic relationships] and then when I got married I was never happy. I just feel bad for myself. (Self-pity).

Clare: I couldn’t see happiness in anything and life was just meaningless ..., everything that I see was hopeless and things that I used to treasure so much, it’s nothing ..., nothing at all ..., (Feelings of hopelessness and worthlessness).

Luisa: [] I was worried about it ...., Because I am a big girl, I should look after myself and my family and I am having [sic] the diagnosis, can’t do anything. (Feelings of worthlessness due to inability to meet familial responsibilities).

Narayan: I don’t want to tell anyone else because they ..., I find it very shameful, because of the kind of disease this is, I have brought shame to the family. (Feels family members will be ashamed of him and hence feels ashamed as well).

Clare: This is not what I was supposed to be ..., a HIV+ person. (Disappointed with self).

L.N.K: I began to accept myself as a HIV+ person. It’s like I am a HIV+ person, that’s a fact, I can’t run away from it. ... I have to .... I have to get on with it. (Eventual acceptance).

Interviewee reports indicated that this emotional journey from shock to acceptance was accompanied by changes in self-esteem and influenced by (a) the types of coping strategies adopted (avoidant or approach) by interviewees, (b) social support provided, (c) differentiation especially between partners of who was perceived to be “guilty” and who was perceived as the “victim” of infection. Section 3.2.5.2 discusses the emotional stages in regards to these three variables.

3.2.5.2 Coping Strategies Adopted
This section presents the researcher’s interpretation and categorisation of the emotional and behavioural responses to stressors associated with being HIV+ on the basis of the classification of coping strategies proposed by Zeidner and Endler (1996; see also 2.3.5). Both avoidant and approach coping strategies were adopted by interviewees of this study: neither being a dominant strategy, however, some interviewees utilised a combination of both. Several observations were made regarding the coping strategies utilised by interviewees

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1. Avoidant coping strategies were accompanied by low self-esteem and low acceptance of diagnosis, whereas approach coping strategies with comparatively healthier self-esteem, resolve for a better future and generally catalysed acceptance of diagnosis.

2. Coping strategies adopted by interviewees to stressors related to their diagnosis were similar to those adopted before diagnosis.

3. Counselling interventions allowed interviewees to develop more constructive coping strategies and a general movement from avoidant to approach strategies was observed amongst these interviewees.

To explicate these three patterns, sub-sections 3.2.5.2.1 – 3.2.5.2.3 discuss participant experiences based on three categories of coping strategies identified in Table 3.11.

Table 3.11

**Categorisation of Interviewees Emotional and Behavioural Responses to Stressors Associated with being HIV+ on the Basis of Implied Coping Strategies (N = 11).**

<table>
<thead>
<tr>
<th>Sub-section (Group Label)</th>
<th>Interviewees</th>
<th>Dominant Coping Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.2.5.2.1. (Group 1)</td>
<td><em>Lena, Vinita and Narayan</em></td>
<td>Used predominantly avoidant coping strategies.</td>
</tr>
<tr>
<td>3.2.5.2.2. (Group 2)</td>
<td>L.N.K., Samuel, Luisa, Tevita</td>
<td>Used predominantly approach coping strategies.</td>
</tr>
<tr>
<td>3.2.5.2.3. (Group 3)</td>
<td>Clare*, Unaisi*, Bulao, &amp; Mosese</td>
<td>Switched* or appeared to be switching from predominantly avoidance to approach coping strategies.</td>
</tr>
</tbody>
</table>

### 3.2.5.2.1 Avoidant coping strategies

Three interviewees (Lena, Vinita and Narayan) were seen to utilise predominantly cognitive and behavioural avoidance coping strategies. Lena was the only interviewee who reported using of cognitive avoidance strategy to cope with her diagnosis.

**Lena:** For me this disease is mental. I don’t think much about it. Even if I start thinking, shit I’m gonna die or something like that, that’s the time I start to get really sick.
Interviewees who largely adopted avoidant coping strategy more often employed behavioural avoidance. Forms of behavioural avoidance strategies used by interviewees included emotional discharge (common amongst interviewees who felt that they were victims of infection by their partners) and behavioural avoidance through seeking alternative rewards, usually entailing “getting drunk” or physical avoidance such as removing self from the scene.

**Lena:** Well when I am down I do go out partying and try getting drunk. That’s why I don’t think about it. I don’t dwell on the fact that I have HIV. I don’t let it get to me. I just do things that I would normally do, just be happy go lucky. Just be myself. I keep telling myself that I have to focus on my kids now. (Using drinking and partying to cope with stress of being infected with a life-threatening disease).

**Narayan:** I just keep quiet and stay in the room. When it’s really bad I start drinking to forget my troubles. (Removing himself from the scene and using alcohol to cope with family problems).

**Vinita:** I say harsh words to him and I go to my mum’s place when it gets too much. (Emotional discharge and physical avoidance – blames husband for infection).

While Lena maintains that she doesn’t “think about it”, reports of Vinita and Narayan indicate that they continue to have self-stigmatising feelings, especially shame, self-pity, hopelessness for a better future and have external locus of control, hoping someone else or something else will change their situation. All three interviewees also report low acceptance of their diagnosis and went through longer periods of denial than interviewees from Group 2. Vinita relates that it took her nearly three years to accept that she was really HIV+. Similarly, Narayan was unconvinced of his diagnosis, doubted the credibility of his doctors and refused to take his medication when initially diagnosed.

**Narayan:** When the doctors told me I didn’t believe them and I didn’t take the tablets that they gave me. I thought they were lying and they didn’t know anything.

Some other common characteristics shared by this group of interviewees include

1. Preoccupation with an inevitable death. (Lena maintains she tries her best not to think about it).

**Vinita:** People help me but I still think about me, how I will die? When I will die? Will I see my child grow up? Ever since I have been diagnosed I have been thinking about death. I worry a lot about it.
2. Being extremely secretive about serostatus. Apart from healthcare workers these interviewees have shared their serostatus with only a selected few people.

   **Vinita:** First of all, we shouldn’t be telling anyone. If one person finds out, another will find out and it will just spread from there.

3. Unwilling to join HIV/AIDS-related support groups citing fear of serostatus becoming known to others as their main reason (see also 3.2.1.4).

4. Apprehensive about visiting Hub Centres due to the fear of serostatus becoming public knowledge but maintained that they were regular with their medical check-up because they were aware of the implications of it on their health.

   **Vinita:** Well this is my only hope to stay healthy. I have to nah. But when this clinic was in the first place we can enter from the side and no-one will be able to see who’s inside the fence. But here it’s just the [sic] opposite to the road and it’s so busy, everyone can see who comes here. People will say, oh this is a clinic, what kind of people go there. Because it’s written there in big letters. So I worry about it, but can’t do anything nah? [] I don’t want to get sick so I look after myself; I take my medicine on time.

5. Low self-esteem. Lena rates her self-esteem as 8 out of 10 but shares that when she starts thinking about her serostatus, “I would rate myself as 2. I’d be really really down. So that would really bring me down, I’d probably die early”.

6. Lack of emotional support, inability to share true feelings and feelings of loneliness.

7. Usage of avoidance coping strategies before diagnosis. For example, Narayan used to “go out drinking with friends” when he and his wife used to have a fight before diagnosis. In seven years of marriage, this is the fourth time Vinita has left her husband and moved in with her mother due to marital problems. Likewise, Lena, fully aware of her deceased husband’s extra-marital affairs maintains that she trusted him and had a good relationship.

Finally, Lena strongly believes that using avoidant coping strategy is serving her very well, however, she also reports that she feels very lonely and has anger issues and finds it difficult to cope with her children.
3.2.5.2.2. Approach Coping Strategies

Group 2 interviewees reported using principally approach coping strategies. The most common form of approach coping strategy utilised by interviewees included cognitive approach (positive reappraisal) and behavioural approach whereby interviewees shared their serostatus with individuals or groups (especially family members and HIV/AIDS-related NGOs) in order to gain physical, emotional, and/or financial support (see also 3.2.1).

**L.N.K**: [not just thinking of it [HIV/AIDS] as a death sentence …, life goes on. I …, I began to accept myself as a HIV+ person. It’s like I feel positive about being HIV+! Stop worrying about tomorrow and live life every day. (Positive reappraisal).]

**Luisa**: I joining one[HIV support group] in Lautoka, like Saturdays we come and talk.  
**Researcher**: Does it help?  
**Luisa**: It helps me a lot, by sharing what this disease and how I am feeling and my husband here so he knows as well. (Seeking emotional support through joining support network).

Some interviewees also used the problem solving approach which was more commonly employed to alleviate HIV/AIDS-related stigmatisation. Interviewees being discriminated from this group either sought support from authorities to increase knowledge and to lobby on their behalf to ensure better treatment or tried to educate their stigmatisers about HIV/AIDS, especially regarding modes of transmission (see also 3.2.1.2).

**Tevita**: The first time I tell, I tell my friend. One good friend and they [sic] said, “Hey you better kill yourself because that thing gonna spread”. Because sometime we smoke thing together and they don’t want to take it. And I told them. “Hey it can’t spread like this. This thing not gonna pass through the cigarette, spoon, plate like that thing, only if I have sex, that thing gonna spread [sic].” So they are okay now. (Alleviating stigmatisation through creating awareness regarding modes of transmission.)

Some other commonalities shared by interviewees of Group 2 included

1. Higher degree of acceptance of seropositive status and determination to continue living a productive life.  
   **Samuel**: Because now I am accepting my status and I am seeing the positive response from people and in that I see there is more, I do more to help sensitising people, helping others makes me feel really good about myself. I am very positive I can continue living with the support I
have and also with the positive mentality that I have ..., positive like ..., this this ..., there’s more to HIV ..., more in life than just HIV.

2. Absence of internalised stigma when interviewed.
   
   Tevita: I have accepted that I am positive. I understand what this is now and I am trying to do better for myself. Before I was pushing drugs, going to prison, but now I am a better man.

3. Internal locus of control and higher degree of self-reliance.
   
   Tevita: I do farming, do some exercise like that. Eat green. You know try to keep healthy. I take care of myself. Now after I get this, I know that you have only one life, don’t waste. I am trying to change my life, be a better man now. And I know I can change, have a better life.

4. Healthier self-esteeems. Reports of interviewees of this study indicate that renouncing self-stigmatising attitudes and a healthy self-esteem resulted in them taking better care of themselves.
   
   Samuel: Yes, because myself esteem is high I am doing other things to keep myself healthy. I undergoing a detox program now and I am looking at my diet. With a good mentality of myself, I am striving for this. Taking my antiretroviral drugs and doing other stuff to keep myself healthy.

5. Membership of support networks and/or HIV-related NGOs, attributing their high sense of self-worth and renouncing self-stigmatising views to the support provided.
   
   Samuel: The NGO I work for works in this area of HIV and they are very supportive. When I am HIV+, I think everything is finished when all this reaction I feel I can keep going. I feel good and confident. And that’s all people like me need …, some sort of encouragement to keep going forward.

6. Strong social support systems usually comprising of family members.
   
   Luisa: My husband ..., he is beside me …, my closest …, we are like this [gestures – puts forefinger and middle finger together]. With my husband, I feel ..., happy and strong. I can go …, my sisters, my uncles [sic] also support is there.

3.2.5.2.3 Changes in coping strategies.

Some interviewees from Group 3 were seen to have switched from avoidance to approach coping strategies. This section of results attempts to map changes in internalised stigma, self-esteem, and mental health with changes in coping strategies due to counselling intervention. Clare’s case is especially relevant as apart from counselling intervention and a subsequent change in coping strategies, no other changes in her physical or social environment had occurred. For instance, she did
not report any changes in her relationship with her family members since diagnosis, instead she reported being “well accepted and received” by family and community members. Forms of internalised stigma reported by Clare included self-blame, self-pity, disappointment with herself and feelings of worthlessness. Consequently, Clare reports a very low self-esteem after diagnosis

**Clare:** My self-esteem right after diagnosis went straight to zero because…, I lost a lot of things that I used to be proud of; my looks, my job [laughs] and everything went down the drain because of HIV… [] I couldn’t even look at myself in the mirror. …, and I was scared of what I’ll see and I knew that if I would look at myself in the mirror I won’t be able to live with myself.

Clare also reported using primarily avoidant coping strategies, especially emotional discharge and physical avoidance. She reported feeling “very angry” with her husband who she blamed for “knowingly infecting” her.

**Clare:** For eighteen months [Post diagnosis] I haven’t been [sic] talking to him anyway …, we are [sic] living together but we [sic] just not talking. I am not wasting [sic] my energy on talking to him because of the anger that I had…,

**Clare:** I came public about my status because I didn’t tell him that I was becoming public. …, I did it out of spite as well because I was angry….,

During these 18 months, Clare attempted three times to commit suicide and was clinically diagnosed to be depressed and had to seek counselling services. She attributed her current acceptance of being HIV+, a healthy self-esteem and determination to continue living a productive life to this counselling intervention

**Clare:** Immediately after diagnosis I became very depressed ..., and in the eighteen months that I had the counselling I attempted three times to take my life [] and having gone through the 18 months [of counselling] and then I realised that the decision to get married to the man that I am married and who’s responsible of infecting was my own [] like I took responsibility of my own decisions and actions that made it easier for me to be able to [accept]…, then I decided that I will not let HIV to take me down….., I decided to stand up and say realistically this is what I have, what can I do differently to make my life worth living?

Clare also reports adopting approach coping strategies since this counselling intervention including positive reappraisal and problem solving approach

**Clare:** ..., that I still have a purpose and that I am looking at the bigger picture, my life doesn’t end with HIV.

**Clare:** If I see something is not working, not functioning as it should , I’ll make sure that I’ll seat people down and straighten things out.[] I go
and do awareness training with these nurses at the hospital. ..., Just to take away the fear that they may have. ..., To enable them to look at HIV people in the way that they supposed to be doing.

In summary from the reports of the interviewees of this study it was evident that (1) approach coping strategies catalysed acceptance, resulted in healthier self-estees, facilitated better support networks and increased sense of productivity; and (2) counselling interventions played a substantial role in the adoption of healthier coping mechanisms.

### 3.3 Research Questions for Stage 2 - Survey of Attitudes of Post-secondary Students

The qualitative data set was carefully examined to identify variables that can be effectively measured using a sample of post-secondary students in *Stage 2 – Survey of Attitudes of Post-secondary Students*. Qualitative data indicated the prevalence of three types of HIV/AIDS-related stigma within the sample namely, (1) stigma that is driven by sexual stigma and the discrimination of PLHWA is rationalised on the basis of religious and cultural beliefs and practices i.e. value-driven stigma [Theme Two], (2) stigma that is driven by fear of contracting HIV/AIDS and the discrimination of PLWHA is motivated by the fear of infection i.e. fear-driven stigma [Theme Three] and (3) stigma that is extended to family members of PLWHA i.e. secondary stigma [Theme Four]. These three forms of stigma are also consistent with the stigma indicators identified in 2.4.1. Another important variable identified in Theme One and Theme Five was familial support which played an important role in mediating the impact of stigma. Finally, knowledge on modes of transmission of HIV/AIDS was a variable that was prevalent across all five themes.

Research questions for Stage 2 were framed using these five variables and (1) measured patterns and inter-variable relationships observed in the qualitative data set and (2) explored demographic (gender and ethnic) differences. The five hypotheses were also formulated on the basis of dominant findings from Stage 1. Research questions and relevant hypotheses tested through Stage 2 participants were

1. What is the level of accurate knowledge of participants regarding modes of transmission of HIV/AIDS?
2. What relationship exists between knowledge on modes of transmission of HIV/AIDS and (a) fear-driven stigma, (b) value-driven stigma, (c) anticipated secondary stigma and, (d) support for a hypothetical HIV+ family member?
   - **H$_1$**: Knowledge on modes of transmission is negatively correlated with fear-driven, value-driven, and anticipated secondary stigma.
   - **H$_2$**: Knowledge on modes of transmission is positively correlated with willingness to support a hypothetical HIV+ family member.

3. What significant ethnic and gender differences exist, if any in (a) knowledge on modes of transmission of HIV/AIDS, (b) fear-driven stigma, (c) value-driven stigma, (d) anticipated secondary stigma, and (e) support for a hypothetical HIV+ family member?

4. What relationships and differences exist between support for a hypothetical HIV+ family member and HIV/AIDS-related stigma?
   - **H$_3$**: Support for HIV+ family member is negatively correlated with fear-driven, value-driven and, anticipated secondary stigma.
   - **H$_4$**: Value-driven stigma scores will be higher than fear-driven stigma and anticipated secondary stigma scores.
   - **H$_5$**: Support for HIV+ family member scores will be higher than fear-driven stigma, value-driven stigma and, anticipated secondary stigma scores.

5. How much of variance in support for a hypothetical HIV+ family member can be predicted by HIV/AIDS-related stigma?
CHAPTER 4
STAGE 2 - SURVEY OF ATTITUDES OF POST-SECONDARY STUDENTS

This chapter includes a description of the method and results for the quantitative component of this mixed methods study; Stage 2 – Survey of Attitudes of Post-secondary Students. Research questions, hypotheses, measures (and their indicators) and participant selection criteria used in Stage 2 were developed on the basis of interview data from Stage 1.

4.1 Method

4.1.1 Approval Process
In addition to approval from the Research and Postgraduate Committee – School of Social Sciences and the National Health Research Committee (Appendix A), approval for Stage 2 was also obtained from the heads of the institutions incorporated in the study.

4.1.2 Participants
Survey participants were ‘post-secondary students’ studying at tertiary institutions in Fiji. The following sub-sections describe the demographic eligibility criteria for participants and sampling procedures.

4.1.2.1 Key Demographics
Post-secondary students from four specialist study areas namely; Trade and Commerce, Medicine and Nursing, Teacher Training, and Policing were incorporated into the study. Religion and ethnic criteria were also included because results of Stage 1 indicated that religion and ethnicity influence value-driven stigma.

Participants belonged to the two main ethnic groups in Fiji; iTaukei and Indian and all iTaukei participants identified themselves as Christians and 98% of Indian participants identified themselves as Hindus: 2% did not respond. The mean age of participants of the study was 20.68 and the age range was 11 years (18 – 29). Demographic characteristics of the participants are summarised in Table 4.1.
Table 4.1

Summary of basic demographics of participants (N=300).

<table>
<thead>
<tr>
<th>Gender (n)</th>
<th>Ethnicity (n)</th>
<th>Religious Affiliation (%)</th>
<th>Age</th>
<th>Educational Background</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Female (150)</strong></td>
<td>iTaukei (90)</td>
<td>Christian (100%)</td>
<td>MEAN – 20.93 years S.D – 2.67</td>
<td>Trade &amp; Commerce 30</td>
</tr>
<tr>
<td></td>
<td>Indo-Fijian (60)</td>
<td>Hinduism (98%)</td>
<td>MEAN - 20.07 years S.D 2.17</td>
<td>Medicine &amp; Nursing 28</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Police Officers (New Recruits) 12</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Teacher Training 20</td>
</tr>
<tr>
<td><strong>Male (150)</strong></td>
<td>iTaukei (90)</td>
<td>Christian (100%)</td>
<td>MEAN - 20.99 years S.D – 2.32</td>
<td>Trade &amp; Commerce 30</td>
</tr>
<tr>
<td></td>
<td>Indo-Fijian (60)</td>
<td>Hinduism (98%)</td>
<td>MEAN – 20.47 years S.D – 2.1</td>
<td>Medicine &amp; Nursing 19</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Medicine &amp; Nursing 19</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Police Officers (New Recruits) 0</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Teacher Training 22</td>
</tr>
<tr>
<td>TOTAL 300</td>
<td>TOTAL 300</td>
<td></td>
<td></td>
<td>TOTAL 300</td>
</tr>
</tbody>
</table>

A balance of educational background was difficult due to gender and ethnic differences in enrolment in some programmes: for example lower enrolment of males in nursing programmes and low numbers of Indian Police Officers (New Recruits) joining the Fiji Police Force. Of the participants sampled, 39% (117) reported that they were sexually active, 60% (181) reported that they did not have sexual intercourse in the past 10 years and 1% (2) did not respond. Amongst sexually active participants 79% (91) reported they were single and 22% (26) reported that they were married.

4.1.2.2 Sampling and Recruitment

Samples were drawn from 12 sites around the Western and Central Divisions of Viti Levu. The sampling procedure used a combination of stratified and cluster sampling techniques using three main strata: (1) ethnicity (iTaukei and Indian participants) as the primary strata, (2) gender as the secondary strata, and (3) area of study as the tertiary strata. Clusters of the four main areas of study (Trade and Commerce, Medicine and Nursing, Police Officers (New Recruits), and Teacher Training) were identified and samples were drawn from these clusters. For example, three main clusters of teacher training programmes were identified and samples were drawn
from all three clusters: In each cluster, effort was made to attain the appropriate balance of ethnicity and gender.

A ‘facilitator’ allocated by each institution assisted in the recruitment of participants and witnessed informed consent being obtained. Prospective participants were approached during class times or after meal times on their campuses and in the case of Police Officers (New Recruits) at the police stations that they were undertaking their practicum. Religious and ethnic eligibility criteria were highlighted and the Stage 2 - Participant Information Sheet (Appendix D) was discussed with prospective participants. Participants were given a chance to raise any questions regarding the study before consent forms were signed.

Three hundred and forty eight post-secondary students consented to take part in the survey. Four percent (12) of the participants were not included in the data file because substantial data was missing (i.e. 50% of the variables were missing) or key demographics (e.g. gender, ethnicity and area of study) were not entered. The remaining questionnaires were randomly selected to generate a subsample of 300 post-secondary students which (1) reflected the ethnic division ratio of 3:2 (iTaukei: Indian) in Fiji and (2) and was gender balanced (‘2007 Census of Population and Housing’, 2006).

4.1.3 Survey Questionnaire
A draft version of the questionnaire was piloted with 18 post-secondary students and modified as a consequence of the feedback received. For example, one of the areas that participants of the pilot phase commented on was the language used, including rewriting promiscuous as “people who sleep around” or “people who have many partners”. The final version of the Survey Questionnaire is presented in Appendix E.

4.1.3.1 Measures
The survey questionnaire consisted of five scales; corresponding questions and the method for computing the scores for the scales are presented in Appendix F. With the exception of the scale measuring knowledge on modes of transmission of HIV/AIDS, all other scales were 4-point Likert scales. Response options for these scales were “1= Strongly Disagree”, “2 = Disagree”, “3= Agree” and “4= Strongly Agree”.

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4.1.3.1.1 **Knowledge on modes of transmission of HIV/AIDS Score (KHIV)**

Fourteen statements measured KHIV, of which only four statements were correct (transmission through blood transfusion, breastfeeding, unprotected sex with an infected partner and injections). These statements were derived from the universally accepted main modes of transmission of HIV/AIDS (“Transmission of HIV,” 2006). The remaining 10 statements focused on perceptions of casual transmission. Response options were “1 = yes” and “2 = no” and a high score (maximum of 2) represented high level of KHIV (see also Appendices E and F).

4.1.3.1.2 **Fear Driven Stigma Score (FS)**

Seven statements pertaining to avoiding PLWHA due to fear of casual transmission of HIV/AIDS measured the FS. The statements were formulated to reflect Stage 1 interviewee accounts of fear-driven stigma and had two components; the form of avoidance and the reason for avoidance. For example item 28 was drawn from Samuel’s account on how a village elder had requested the release of the identities of all PLWHA in Fiji so that they can be avoided (see also 3.2.1.5.). Cronbach’s alpha for items for the scale was 0.83 and a high score represented high levels of FS (see also Appendices E and F).

4.1.3.1.3 **Value Driven Stigma Score (VS)**

Seven statements relating to value judgements and sexual stigmatisation of PLWHA and three stereotypical groups associated with HIV/AIDS (e.g. promiscuous people, homosexuals and commercial sex workers) measured VS. Items measuring VS reflected Stage 1 interviewee accounts on how PLWHA are labelled as “sinners” who deserve getting infected. Item 25 was included to reflect Bulao’s fear that she may be terminated as teacher if the parents and guardians of her students came to know that she is HIV+ (see also 3.2.5). Cronbach’s alpha for items for VS was 0.84 and a high score represented high levels of VS (see also Appendices E and F).

4.1.3.1.5 **Anticipated Secondary Stigma Score (SS)**

Five statements describing instances of secondary stigma were used to measure SS. The statements reflected interviewee accounts on the forms of discrimination that were extended to their family members. For example item 31 was drawn from Unaisi’s account on how members of her village avoided contact with her mother as well (see also 3.2.4.). Cronbach’s alpha for the scale was 0.73 and a high score represented high levels of anticipated SS (see also Appendices E and F).
4.1.3.1.6  Support for a hypothetical HIV+ Family Member Score (SUP)

Seven statements pertaining to the level of support rendered to a HIV+ close family member measured the SUP. The statements reflected interviewee descriptions of forms of support provided by family members. For example item 39 reflects Unaisi’s report on how her brother intervened to address the discrimination she was suffering from her community members (see also 3.2.1.6). Cronbach’s alpha for this scale was 0.84 and a high score represented high levels of SUP (see also Appendices E and F).

4.1.4  Procedure

The self-completion questionnaires were administered in groups of up to 30 participants at a time. Participants were instructed to answer questions in the order given and were especially instructed (1) not to miss question(s) with the intention of going back to answer the question(s) and (2) not to change responses of a question once they had finalised their answer for a question. This was done to ensure that the first response of the participant towards PLWHA was recorded and that responses for statements measuring VS and FS were not modified after the participant was given the hypothetical situation whereby he/she was instructed to imagine that he/she had a HIV+ close family member. Adopting this approach allowed testing of Hypothesis 5, which is based on the premise that regardless of general views towards HIV/AIDS or PLWHA, participants will demonstrate high levels of support for HIV+ family member: Results of Stage 1 indicated that an empathetic understanding of PLWHA alleviated HIV/AIDS-related stigma and discrimination.

Participants spent 10 -15 minutes answering the questionnaire and once filled questionnaire were collected, voluntary debriefing sessions were conducted which was attended by all participants. The four universally accepted main modes of transmission of HIV/AIDS and some myths regarding HIV/AIDS were discussed. Participants were also encouraged to raise additional questions regarding HIV/AIDS which were addressed before closing the session and thanking the participants for their time.

4.1.5  Data Analysis

Predictive Analytics Software (PASW) by SPSS was used for data analysis. All effect sizes were interpreted using Cohen’s (1988) conventions. Partial eta-squared (partial $\eta^2$) was used as a measure for effect size for factorial between groups.
analysis of variance (ANOVA). While its use has been described as problematic as it incurs a positive bias by over-estimating effect sizes, partial $\eta^2$ for all ANOVA results reported are weak (partial $\eta^2 \leq .009$), therefore negating the conversion to the more preferred omega-squared (Allen & Bennet, 2010). Table 4.2 identifies the research questions and their corresponding statistical analyses and sub-sections of results.

Table 4.2

**Overview of Research Questions and their Corresponding Analyses and Sub-sections of Results.**

<table>
<thead>
<tr>
<th>Research Question Number</th>
<th>Analyses and Screening Tests</th>
<th>Sub-section of Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What is the level of accurate knowledge of participants regarding modes of transmission of HIV/AIDS?</td>
<td>• Descriptive analyses and Bar Chart</td>
<td>4.2.1 Knowledge on Modes of Transmission of HIV</td>
</tr>
</tbody>
</table>
| 2. What relationship exists between knowledge on modes of transmission of HIV/AIDS and (a) fear-driven stigma, (b) value-driven stigma, (c) anticipated secondary stigma and, (d) support for a hypothetical HIV+ family member? | • Spearman’s Rho  
- Assumptions of normality were not met for KHIV and SUP. | |
| 3. What significant ethnic and gender differences exist in (a) knowledge on modes of transmission of HIV/AIDS, (b) fear-driven stigma, (c) value-driven stigma, (d) anticipated secondary stigma, and (e) support for a hypothetical HIV+ family member? | • Mann-Whitney U test for KHIV, SUP, and SS  
- KHIV and SUP were positively skewed and variances of SS were not equal.  
- Factorial between groups ANOVA for VS and FS  
- Tests for normality and homogeneity of variances indicated minor violations for normality; ANOVA is robust against these violations (Allen & Bennet, 2010). | 4.2.2 Differences by Ethnicity and Gender |
| 4. What relationships and differences exist between support for a hypothetical HIV+ family member and HIV/AIDS-related stigma? | • Spearman’s Rho for FS, VS, SS and SUP  
- Partial correlation was used to further assess these relationships after controlling for the effects of KHIV.  
- Freidman two way ANOVA to compare the three stigma scores FS, VS, and SS  
- Follow-up pair wise comparisons using Wilcoxon Signed Rank Test and Bonferroni adjusted $\alpha$ of 0.017  
- Freidman two way ANOVA to compare SUP and the three stigma scores (FS, VS, and SS)  
- Follow-up pair wise analyses using Wilcoxon Signed Rank Test (Bonferroni adjusted $\alpha$ of 0.0125)  
- Descriptive Analysis – Box Plots | 4.2.3 Inter-variable Correlations and Comparisons |

*table continues*
Research Question Number | Analyses and Screening Tests | Sub-section of Results
--- | --- | ---
5. How much of variance in support for a hypothetical HIV+ close family member can be predicted by HIV/AIDS-related stigma? | • Standard multiple regression analysis (MRA) - Stem-and-leaf plots and box plots were used to test for normality and univariate outliers; two extreme scores for FS were detected and were deleted from data file. Assumptions of normality, linearity and homoscedasticity of residuals were met. | 4.2.4 Multiple Regression Analysis

4.2 Results

4.2.1 Knowledge on Modes of Transmission of HIV
Descriptive analyses revealed that participants were well informed on the modes of transmission of HIV ($M=1.87$, $S.D=0.13$, mode = 1.93), with scores ranging from 1.29 – 2.00. Furthermore, 91% of the participants had $\geq 86\%$ correct responses. Percentages of “yes” and “no” responses for the 14 items of this scale were graphed to identify areas with greatest misconceptions regarding transmission of HIV and correlations with the other four variables were explored.

4.2.1.1 Percentage Responses for KHIV
Figure 4.1 provides the response rate for the 14 statements describing modes of transmission of HIV.

![Figure 4.1. Perceived Modes of Transmission of HIV/AIDS (N=300). The three most common misconceptions regarding modes of transmission of HIV in the sample were saliva (36%), kissing (30%), and mosquito bites (21%). Other misconceptions included possible...](image-url)
peripheral contact with blood on nail clippers and hair cutting scissors (13%), sweat (13%), and cigarettes (10%). Participants (30%) did not identify breastfeeding as a mode of transmission of HIV.

### 4.2.1.2 Correlations

Correlations between KHIV and FS, VS, SS and SUP were computed: Table 4.3 summarises these correlations.

<table>
<thead>
<tr>
<th>Variable</th>
<th>n</th>
<th>( r_s )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Value Driven Stigma Score (VS)</td>
<td>189</td>
<td>-0.22*</td>
</tr>
<tr>
<td>Fear Driven Stigma Score (FS)</td>
<td>219</td>
<td>-0.30*</td>
</tr>
<tr>
<td>Anticipated Secondary Stigma Score (SS)</td>
<td>203</td>
<td>0.05</td>
</tr>
<tr>
<td>Support for Hypothetical HIV+ Family Member Score (SUP)</td>
<td>222</td>
<td>0.23*</td>
</tr>
</tbody>
</table>

Note: KHIV = Knowledge on modes of transmission of HIV/AIDS Score
* \( p < 0.001 \), one-tailed

Spearman’s rho \( (r_s) \) indicates that there is a stronger negative correlation between KHIV and FS \( [r_s(219) = -0.30] \) as opposed to VS \( [r_s(189) = -0.22] \) (Cohen, 1988). Furthermore, KHIV shows a weak positive correlation with SUP \( (r_s(222) = 0.23) \). The hypothesis was not supported for the predicted negative correlation between SS and KHIV.

### 4.2.2 Differences by Ethnicity and Gender

Ethnic and gender differences were explored using parametric and non-parametric tests after screening for normality and homogeneity of variances and results for the five variables have been divided according to the type of statistical test used.

#### 4.2.2.1 KHIV, SS and SUP.

Statistically significant gender and ethnic differences in KHIV, SS and SUP were calculated using Mann-Whitney \( U \) test; the results of the test are displayed in Table 4.4.
Table 4.4

Mann-Whitney U tests by Gender and Ethnicity of Participants.

<table>
<thead>
<tr>
<th>Variables</th>
<th>Mean Rank (n)</th>
<th>U</th>
<th>z</th>
<th>r</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KHIV</td>
<td>147.07 (149)</td>
<td>150.94 (148)</td>
<td>10738.5</td>
<td>-0.3</td>
</tr>
<tr>
<td>SS</td>
<td>111.67 (106)</td>
<td>93.71 (99)</td>
<td>4327.5*</td>
<td>-2.18</td>
</tr>
<tr>
<td>SUP</td>
<td>123.33 (112)</td>
<td>101.67 (112)</td>
<td>5059.5*</td>
<td>-2.51</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KHIV</td>
<td>160.66 (119)</td>
<td>141.21 (178)</td>
<td>9204*</td>
<td>-1.96</td>
</tr>
<tr>
<td>SS</td>
<td>116.85 (86)</td>
<td>92.99 (119)</td>
<td>3925.5*</td>
<td>-2.85</td>
</tr>
<tr>
<td>SUP</td>
<td>117.11 (85)</td>
<td>109.68 (139)</td>
<td>5516</td>
<td>-0.83</td>
</tr>
</tbody>
</table>

Note: KHIV= Knowledge on modes of transmission of HIV/AIDS Score, SUP=Support for Hypothetical HIV+ Family Member Score, and SS=Anticipated Secondary Stigma Score. z has been corrected for ties * p < 0.05

Females (Mean Rank =123.33) had significantly higher SUP as opposed to males (Mean Rank =101.67). There was also a statistically significant difference in SS between males (Mean Rank = 93.71) and females (Mean Rank = 111.67) i.e. female participants reported higher expectancies of being stigmatised if they had a HIV+ close family member. Statistically significant differences also exist in KHIV and SS for the two ethnic groups. Indian participants had higher levels of KHIV (Mean Rank = 160.66) as well as higher expectancies of being subjected to secondary stigma (Mean Rank = 116.85). These significant gender and ethnic differences are small sized effects (Cohen, 1988). There were no statistically significant differences in (1) ethnicity for SUP and (2) gender for KHIV.

4.2.2.2 VS and FS

A 2 (gender – male, female) x 2 (ethnicity – iTaukei, Indo-Fijian) factorial between groups ANOVA was used to compare average VS and FS. The ANOVA revealed that a statistically significant main effect existed only for ethnicity in the levels of VS, $F (1, 186) = 17.19, p < .001$, partial $\eta^2 = 0.09$; a medium sized effect. There was no significant main effect for sex in the levels of VS $F (1, 186) = .141, p = .708$, partial $\eta^2 = .001$ and no interaction between sex and ethnicity for VS, $F (1, 186) = .06, p = .806$, partial $\eta^2 = .000$.  

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Similarly, there was no significant main effect of ethnicity, \( F (1, 215) = 1.5, p = .223 \), partial \( \eta^2 = .007 \) or sex, \( F (1, 215) = 3.84, p = .051 \), partial \( \eta^2 = .018 \) in FS. There was also no interaction between sex and ethnicity for FS, \( F (1, 215) = .745, p = .386 \), partial \( \eta^2 = .003 \). Mean scores for each group are given in Table 4.5.

Table 4.5

Mean scores for Value Driven Stigma Score (VS) and Fear Driven Stigma Score (FS).

<table>
<thead>
<tr>
<th></th>
<th>Value Driven Stigma Score (VS)</th>
<th>Fear Driven Stigma Score (FS)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Female</td>
<td>Male</td>
</tr>
<tr>
<td>Indian</td>
<td>1.81</td>
<td>1.82</td>
</tr>
<tr>
<td>iTaukei</td>
<td>2.23</td>
<td>2.29</td>
</tr>
<tr>
<td>Marginal means (sex)</td>
<td>2.02</td>
<td>2.06</td>
</tr>
</tbody>
</table>

4.3 Inter-variable Correlations and Comparisons

4.3.1 Correlations

Inter-variable bivariate and partial correlations of FS, VS, SS, and SUP are given in Table 4.6.
Table 4.6  
*Correlations between Stigma and Support scores.*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Spearman’s rho</th>
<th>Partial Correlation*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>rs</td>
</tr>
<tr>
<td>Fear-driven Stigma (FS)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support for Hypothetical HIV+ Family Member Score (SUP)</td>
<td>219</td>
<td>-.52*</td>
</tr>
<tr>
<td>Value Driven Stigma Score (VS)</td>
<td>169</td>
<td>.68*</td>
</tr>
<tr>
<td>Anticipated Secondary Stigma Score (SS)</td>
<td>166</td>
<td>.01</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Value Driven Stigma Score (VS)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support for Hypothetical HIV+ Family Member Score (SUP)</td>
<td>156</td>
<td>-.38*</td>
</tr>
<tr>
<td>Anticipated Secondary Stigma Score (SS)</td>
<td>154</td>
<td>.02</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anticipated Secondary Stigma Score (SS)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support for Hypothetical HIV+ Family Member Score (SUP)</td>
<td>199</td>
<td>-.02</td>
</tr>
</tbody>
</table>

* Note: *Variables have been partialled for Knowledge on modes of transmission of HIV
  
  *p < 0.001 one-tailed

Spearman’s rho ($r_s$) indicated a strong negative correlation between FS and SUP ($r_s(219) = -.52$). A partial correlation used to further assess this relationship after controlling for the effects of KHIV also showed a significant, albeit moderate negative correlation that is after partialling out KHIV, FS accounted for 20% of variability in SUP. An even stronger positive relationship was seen between FS and VS ($r_s(169) = .68$) and even after partialling out KHIV, VS accounted for 48% of variability in FS. However, correlations were not statistically significant for the FS and SS.

A moderate negative correlation was found between VS and SUP, $r_s(156) = -.38$. A partial correlation was used to assess the relationship between these two variables after controlling for KHIV also showed a significant negative correlation, $r_s(156) = -.31$, $p < .001$, one-tailed i.e. after partialling out KHIV, VS predicted 10% of variability of SUP. However, Spearman’s rho was not significant for the
relationships between SS and (1) VS $r_s(154) = .02, p = .383$, one-tailed and (2) SUP $r_s(199) = -.02, p = .42$, one-tailed.

### 4.3.2 Comparisons of the Stigma Scores

A Friedman two way ANOVA indicated that there were statistically significant differences between the three stigma variables; FS, VS, and SS, $\chi^2_F = 41.88$ (corrected for ties), $df = 2$, $N – Ties = 138$, $p < .001$. Follow-up pair wise comparisons using Wilcoxon Signed Rank Test and Bonferroni adjusted $\alpha$ of 0.017 indicated that the VS ($Mean \text{ Rank} = 2.34$) were significantly higher than FS ($Mean \text{ Rank} = 1.59$), $T = 1247.5$, $z = -7.69$ (corrected for ties), $N – Ties = 140$, $p < .001$, one-tailed, $r = -0.65$. This can be considered a large sized effect according to Cohen’s (1988) conventions. VS was rated higher than FS by 82% of the participants.

Similarly, VS was rated higher by 59% of the participants in comparison with SS ($Mean \text{ Rank} = 2.07$). The differences were statistically significant, $T = 4112$, $z = -2.8$ (corrected for ties), $N – Ties = 149$, $p = .0025$ one-tailed, $r = -0.23$; a small sized effect by Cohen’s (1988) conventions.

Finally, while FS were rated higher by 60% of the participants in comparison with their SS; there were very small differences in their mean ranks (0.48). Nonetheless, the differences were statistically significant $T = 5040$, $z = -2.39$ (corrected for ties), $N – Ties = 160$, $p = .0085$ one-tailed, $r = -0.19$; a small sized effect by Cohen’s (1988) conventions.

### 4.3.3 Comparisons of Stigma and Support Scores

A Friedman two way ANOVA with follow-up pair wise analyses using Wilcoxon Signed Rank Test (Bonferroni adjusted $\alpha$ of 0.0125) were also conducted to compare SUP and the three stigma scores (FS, VS, and SS).

The Friedman two way ANOVA indicated that there were statistically significant differences between the four variables, $\chi^2_F = 202.24$ (corrected for ties), $df = 3$, $N – Ties = 120$, $p = .001$ with SUP having the highest mean rank of 3.85 in comparison with VS ($Mean \text{ Rank} = 2.41$), SS ($Mean \text{ Rank} = 2.08$) and, FS ($Mean \text{ Rank} = 1.65$).

SUP was rated higher than VS by 90% of the participants. A Wilcoxon Signed Rank Test indicated that the differences were statistically significant, $T = 427.5$, $z =$
-9.9 (corrected for ties), \( N - \text{Ties} = 151, p = .0005 \) one-tailed, \( r = -0.8 \). Likewise, SUP was rated higher than FS by 96% of the participants and the differences in scores were also statistically significant, \( T = 88.5, z = -11.35 \) (corrected for ties), \( N - \text{Ties} = 175, p = .0005 \) one-tailed, \( r = -0.86 \).

Finally, SUP was rated higher than SS by 99% of the participants. Differences between the two scores were also statistically significant, \( T = 5, z = -11.31 \) (corrected for ties), \( N - \text{Ties} = 170, p = .0005 \) one-tailed, \( r = -0.87 \). These differences between SUP and the three types of stigma scores can be characterised as very large effect sizes according to Cohen’s (1988) conventions. Figure 4.2 shows box plots for the stigma and support scores.

![Box Plots comparing stigma and support scores. SUP was positively skewed and the lowest SUP value was higher than the mediums of VS, FS, and SS. The upper quartile of FS was slightly higher than the mediums of VS and SS.](image)

**Figure 4.2.** Box Plots comparing stigma and support scores. SUP was positively skewed and the lowest SUP value was higher than the mediums of VS, FS, and SS. The upper quartile of FS was slightly higher than the mediums of VS and SS.

### 4.4 Multiple Regression Analysis

To estimate the proportion of variance in SUP that can be accounted for by VS, FS, and SS, a standard multiple regression analysis (MRA) was performed. In combination, VS, FS, and SS accounted for a statistically significant 24% of the variability in SUP, \( R^2 = .24 \), adjusted \( R^2 = .21 \), \( F = (3, 114) = 11.58, p < .001 \), \( f^2 = 0.3 \); an approximately large sized effect according to Cohen’s (1988) conventions. The unstandardised (\( B \)) and standardised (\( \beta \)) regression coefficients, and squared semi-partial correlations (\( sr^2 \)) for each predictor in a regression model predicting
SUP are reported in Table 4.7. FS has the greatest impact on SUP after controlling for the effects of VS and SS.

Table 4.7

*Summary of Multiple Regression Analysis for Stigma Variables Predicting Variances in Support for Hypothetical HIV+ Family Member Score (SUP).*

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>[95% CI]</th>
<th>β</th>
<th>s²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Value Driven Stigma Score (VS)</td>
<td>-0.014</td>
<td>[-0.17, 0.142]</td>
<td>-0.019</td>
<td>0.0003</td>
</tr>
<tr>
<td>Fear Driven Stigma Score (FS)</td>
<td>-0.485</td>
<td>[-0.697, -0.274]</td>
<td>-0.473</td>
<td>0.15</td>
</tr>
<tr>
<td>Anticipated Secondary Stigma Score (SS)</td>
<td>0.044</td>
<td>[-0.144, 0.233]</td>
<td>0.038</td>
<td>0.002</td>
</tr>
</tbody>
</table>

Note. n = 116. CI = confidence interval, *p < 0.001

4.5 **Hypotheses Testing**

Results for Stage 2 presented in this chapter answer research questions and test the hypotheses generated from the stigma and support narratives of HIV+ participants. Table 4.8 identifies the hypotheses that were supported and rejected by this data.

Table 4.8

*Summary of Effect Sizes and Statistical Significance Levels for Hypotheses Generated.*

<table>
<thead>
<tr>
<th>Hypothesis</th>
<th>Supported (Effect Size, Statistical Significance)</th>
<th>Not Supported (Effect Size, Statistical Significance)</th>
</tr>
</thead>
<tbody>
<tr>
<td>H₁: Knowledge on modes of transmission of HIV/AIDS is negatively correlated with fear-driven stigma, value-driven stigma, and anticipated secondary stigma.</td>
<td>KHV is negatively correlated with FS (r = -0.3, p &lt; 0.001) and VS (r = -0.22, p &lt; 0.001).</td>
<td>KHV is negatively correlated with SS (r = -0.05, p = 0.45).</td>
</tr>
<tr>
<td>H₂: Knowledge on modes of transmission of HIV/AIDS is positively correlated with willingness to provide support for a hypothetical HIV+ family member.</td>
<td>KHV is positively correlated with willingness to SUP (r = 0.23, p &lt; 0.001).</td>
<td></td>
</tr>
<tr>
<td>H₃: Support for a hypothetical HIV+ family member is negatively correlated with fear-driven stigma, value-driven stigma and, anticipated secondary stigma.</td>
<td>SUP is negatively correlated with FS (r = -0.52, p &lt; 0.001) and VS (r = -0.38, p &lt; 0.001)</td>
<td>SUP is negatively correlated with SS (r = -0.02, p = 0.42 )</td>
</tr>
<tr>
<td>H₄: Value-driven stigma scores will be higher than fear-driven stigma and anticipated secondary stigma scores.</td>
<td>VS are higher than FS (r = -0.065, p &lt; 0.001, one-tailed) and SS (r = -0.23, p = 0.0025).</td>
<td></td>
</tr>
<tr>
<td>H₅: Support for a hypothetical HIV+ family member scores will be higher than fear-driven stigma, value-driven stigma and, anticipated secondary stigma scores.</td>
<td>SUP are higher than FS (r = -0.8, p &lt; 0.0005), VS (r = -0.86, p = 0.0005) and, SS = (r = -0.87, p = 0.0005)</td>
<td></td>
</tr>
</tbody>
</table>

Note: p values reported are one-tailed.
CHAPTER 5
DISCUSSION OF STAGE 1 AND STAGE 2 FINDINGS

The primary objective for this study was to explore the social forces and inequalities that cause HIV/AIDS-related stigma in Fiji and identify its impact on psychosocial reactions of PLWHA and the attitudes of post-secondary students. This chapter summarises the main findings of this mixed methods study in relation to this objective. The focus in this chapter is on collective conclusions: Data from Stage 1 (PLWHA) and Stage 2 (HIV- post-secondary students) are discussed together under each sub-section to provide a balanced picture of the perspectives and experiences associated with HIV. This chapter is organised into four sections. First, research findings are summarised on social forces and inequalities. The second section examines implications of findings for individuals and organisations which play key roles in addressing HIV/AIDS-related stigma and discrimination and providing support for individuals associated with HIV/AIDS. The final section identifies the strengths and limitations for this study and the chapter concludes with identification of the overarching conclusions for both stages.

5.1 Social Structural Forces that Create and Maintain HIV/AIDS-related Stigma in Fiji

Reflecting an ecosocial research orientation, this section discusses (1) the social forces that create and maintain HIV/AIDS-related stigma in Fiji, (2) their impact on PLWHA and post-secondary students, and (3) the implications of findings on HIV/AIDS-related stigma intervention programmes.

5.1.1 Gender

Two prominent effects of gender were recorded in this study. Firstly, Stage 1 interview data revealed that women in abusive relationships faced greater problems in negotiating the use of male condoms and were coerced into having unprotected sex through use of both implicit threats (e.g. possibility of terminating relationship due to pleasure reduction) and explicit threats (e.g. threats of revealing serostatus to others post diagnosis) hence increasing their susceptibility to infection (see also 3.2.2.3). This finding is consistent with a number of studies on the relationship
between intimate partner violence and condom use and negotiation (Campbell et al., 2002; Crosby et al., 2002; Dunkle et al., 2004; Jewkes, et al., 2010; Kalichman et al., 2009; Wingood et al., 2000).

The second impact of gender demonstrated in this study is associated with the traditional role of women as caregivers. This gendered role and its negative consequence was reflected in the survey data where female post-secondary students were more willing than their male counterparts to provide support for a hypothetical HIV+ family member and had higher expectations of experiencing secondary stigma if they had a HIV+ close family member (also see Table 4.4). While the effect sizes for these differences were small ($r < 0.2$), samples drawn from other segments of Fijian societies for example rural communities where gendered role perceptions may be stronger may have larger effect sizes. This role of women as primary caregivers of PLWHA, the associated secondary stigma that they are subjected to, and the psychosocial impact of stigma is well supported by other studies (e.g. Bharat, 1999; Lin et al., 2007; Malcolm et al., 1998; Ogunmefun et al., 2010; Thomas et al., 2005; Ssengonzi, 2009).

The results of this study indicate that gender-based violence and inequalities are determinants of HIV risk amongst women (see also 3.2.2.3). Moreover, these two structural gendered power inequities and role ideologies place women at greater risk of secondary stigmatisation and anticipated stigma. According to the 2009 HIV statistics, Fiji is falling in with the global trend of increasing numbers of female infections (FCDC, 2011). Hence, the structural role of gender in creating and maintaining HIV/AIDS-related stigma needs to be considered when designing HIV/AIDS-related interventions in Fiji. HIV intervention strategies should address domestic violence issues (with both men and women), counsel women on STI prevention such as use of female condoms, foster the development of better condom negotiation skills and adoption of healthy coping strategies amongst women.

5.1.2 Ethnicity
Influence of ethnicity was also investigated. Results showed cultural differences in perception of the impact of HIV, rather than stigma fuelled by ethnic inequalities as documented by Anderson et al. (2008) and Williams (2003). Stage 2 survey data indicated that iTaukei participants attributed greater shame and blame to PLWHA
(i.e. higher value-driven stigma; also see 4.2.2.2) and had lower expectations of being stigmatised if they had a HIV+ close family member (i.e. lower anticipated secondary stigma; also see Table 4.4) in comparison with Indian participants.

This difference also indicated that a HIV infection was perceived as having wider implications on the entire family by Indian participants in comparison with iTaukei participants. Hence Indian post-secondary students affixed greater negative consequences on the family members of PLWHA. While the effect sizes for these findings are medium to weak and may require further research with other segments of the Fijian population, reports of HIV+ interviewees also show ethnic variation and provide an insight into the reasons for these differences.

All iTaukei interviewees \((n = 9)\) from Stage 1 reported that Christians generally view PLWHA as “sinners” and the infection as “punishment from God” whereas the two Indian participants were unconcerned about the stance of Hinduism on HIV and PLWHA (see also 3.2.1.3). Instead they were very worried about the views of members of their community and how this will impact upon their nuclear family members and especially the future of their children. The difference amongst the two ethnic groups on what was perceived as the ‘source’ of punishment (God or members of the community) may be one reason for the difference in anticipated secondary stigma scores in Stage 2: Christian participants may see punishment for the ‘sinner’ only but in the case of Indian participants, the community may extend responsibility for the deviant act to the family members of PLWHA. As a result, Indian interviewees managed their ‘public image’ by concealing their serostatuses and apart from healthcare personnel only a select few close family members (up to three persons) were aware of their seropositive statuses. Additionally, three debilitating strategies used by Indians to conceal their sero-positive status have been documented. Firstly, the concern of their serostatus becoming known to others outside their family networks prevented Indian participants from seeking assistance from service providers such as HIV/AIDS-related NGOs. Secondly, Indian participants also interpreted normal medical procedures such as being placed in a separate room when extremely sick as acts of discrimination as it was counterproductive to their attempts to conceal their serostatus, causing additional emotional distress. Finally, this secretive nature is also reflected in the non-participation of Indians in other published studies on HIV/AIDS (e.g. Hammar et al.,
2011; PIAF, 2009) in Fiji even though Indians comprise 12% of overall HIV infections (FCDC, 2011). This means that the experiences and needs of Indian participants go undocumented.

These findings shed greater light on the claims made by the chairperson of FJN+ regarding the family members of HIV+ individuals of “other” ethnic backgrounds (not iTaukei). Evidence from Stage 1 of this study contradicts this stance; reports of Vinita and Narayan indicate that their family members (nuclear and extended) have been their primary sources of physical (as caregivers), financial, and emotional support since diagnosis. Stage 2 survey data also indicates that there were no statistically significant ethnic differences in support for hypothetical HIV+ family member score.

Results of both stages point to a different explanation for the secrecy surrounding sero-statuses of Indian participants: Within the context of HIV/AIDS-related stigma, the concern of “face” or public image (Ting-Toomey, 1996) had a greater impact on Indian participants (as opposed to having sinned in the eyes of God). This is evident from reports of Vinita who stressed several times in her interview that “If Indian people know about it [HIV infection], they will talk about how I got it, like my character”. The concept of face has been widely studied in Asian countries (e.g. Lau & Wong, 2006; Rao, Angell, Lam, & Corrigan, 2008; Yang & Kleinman, 2008) and explain the findings of this study. According to Yang and Kleinman (2008, p. 398) public image or face associates an individual’s or groups’ social status with upholding the moral obligations set by the collective group: Stigmatised individuals fail to uphold the set moral obligations resulting in “social death”. In this context, stigma and discrimination extend beyond the individual to encompass groups (e.g. family members of PLWHA) that are expected to play a role in the moral development of the individual (Yang et al., 2007). For example, employers of two Asian countries, China and Hong Kong associate ‘loss of face’ with HIV infection and cite this as a reason for employment discrimination. According to the employers, association with PLWHA will have a negative impact on the company’s public image (Rao et al., 2008).

The negative impact on help-seeking behaviour recorded with the two Indian interviewees has also been documented by other studies. For example, ‘loss of face’
was cited as a major deterrent to seeking help for symptoms of postnatal depression by Hong Kong Chinese women: Participants with high concern for preserving public image were 1.36 times less likely to seek help (Lau & Wong, 2006). The implication of “face” on help seeking behaviour of PLWHA has not been studied before and more research in this area is needed to clarify its impact on the behaviour of PLWHA.

The studies cited and the results of this study lend credibility to this alternative explanation of ‘losing face’ being a factor in the reluctance to seeking help outside family networks amongst Indian participants. Consequently, Indian HIV+ individuals and their family members may experience higher levels of anticipated stigma and are at greater risk of missing out on other forms of support outside their family systems due to the perceived lower tolerance of STI within their communities. These two issues need to be considered whilst formulating approaches to address stigma and discrimination in the Indian population. These findings also imply that faith-based organisations can play a crucial role in reduction of HIV/AIDS-related stigma within the iTaukei population; this role is further discussed in 5.1.4.

5.1.3 Fear of Contagion and Disease
The impact of fear of contagion and disease on discriminatory attitudes and reactions towards PLWHA was recorded in both stages of this study. Reports of Stage 1 HIV+ interviewees indicated that HIV/AIDS was considered a life-threatening disease that they were afraid of contracting. Furthermore, these interviewees described experiences of fear-driven stigma whereby people avoided contact with them and their family members to prevent infection. This ‘fear’ of infection was usually rooted in irrational beliefs regarding casual transmission of HIV including via touching, saliva, peripheral contact with blood and sweat of the HIV+ person. The fear-driven stigma scale that was developed using the reports of HIV+ interviewees of Stage 1, when tested with post-secondary students had a high internal reliability. Stage 2 survey data indicated a strong negative correlation between fear-driven stigma and support for hypothetical HIV+ family member, indicating that fear of contagion and disease had a negative impact on willingness to provide support to HIV+ family members (also see Table 4.6). The implication of this finding is further discussed in 5.2.2.
Survey data also indicated that correlations between knowledge on modes of transmission of HIV/AIDS and fear-driven stigma and value-driven stigma were moderate to weak among post-secondary students and that the correlation between knowledge on modes of transmission of HIV/AIDS and anticipated secondary stigma were not statistically significant (see also Table 4.6). Therefore, interventions which focus on increasing knowledge on modes of transmission of HIV may only be somewhat successful in alleviating fear-driven stigma and may not adequately address other forms of HIV/AIDS-related stigma. This approach is especially problematic given that survey results indicate that the prevalence of fear-driven stigma within this sample was much lower than value-driven stigma ($r = -0.65$).

Nonetheless, creating awareness on modes of transmission and more recently modes in which HIV cannot be transmitted has been the primary form of intervention adopted by the Ministry of Health with aims to curb the spread of HIV and to alleviate HIV/AIDS-related stigma and discrimination. Similar information-focused initiatives have also been used by HIV/AIDS-related NGOs and international organisations operating in Fiji. Data from both stages of this study showed that increasing knowledge on modes of transmission can have some success in alleviating HIV/AIDS-related stigma. However, this relationship is far more complex than initially perceived and propagated locally and internationally such as in countries like America (e.g. Herek et al., 2005), United Arab Emirates (Brass et al., 2009), South Africa (e.g. Chao, Gow, Akintola, & Pauly, 2010), China (e.g. Sullivan et al., 2009), Ethiopia, Tanzania, Zambia, and Vietnam (Ogden & Nyblade, 2004).

An explanation for this moderate to weak relationship can be gleaned from the narratives of Mosese and Unaisi who explain that it was not only the increase in awareness on modes of transmission but also an attempt to personally engage with their stigmatisers after intervention by an authoritative figure that paved way for the diminishing of ‘fear’ related to HIV and the eventual acceptance by their stigmatisers. Another explanation can be gleaned from reports of L.N.K, who attributes the changing attitudes of his community members from stigmatising to accommodating to his continued good health due to ART. He also acknowledges the role of church leaders in facilitating the increasingly accommodative attitudes of his
community members. These three observations also guide the intervention approach discussed in 5.1.5.

5.1.4 Sexual Stigma
Sexual stigma was by far the most prominent form of stigma recorded in Stage 1 of this study whereby PLWHA were associated with ‘deviant’ sexual practices such as having multiple sexual partners, sex work and homosexuality (see also 3.2.2.4). Interviewee reports indicated that value-driven stigma is used to justify HIV/AIDS-related sexual stigma whereby PLWHA were characterised as “sinners” to be punished hence, warranting acts of discrimination.

Link and Phelan’s (2001) four-part conceptualisation of stigma explains the nexus between sexual stigma and value-driven stigma and the underlying power structure, observed in Stage 1 of this study. Two ‘labels’ of relevance to this section that HIV+ interviewees associated with HIV prior to diagnosis include; (1) HIV is an STI and (2) promiscuous people, sex workers and homosexuals are at high risk of contracting HIV. Therefore, while initial approaches to curbing HIV infection by targeting high risk groups may have had some merits in discouraging some of the risky behaviour, it is evident from the reports of interviewees of Stage 1 that this message has been distorted and has fuelled sexual stigmatisation of HIV/AIDS.

The transformation of these two labels associated with HIV/AIDS into the negative stereotype whereby participants categorised all PLWHA as promiscuous, sex workers and homosexuals was rather “automatic” (Link & Phelan, 2001, p. 369) and is well supported by the dominant beliefs (cultural and religious) identified in Stage 1 (see also 3.2.1.3 and 3.2.2.2). The sexual stigmatisation of PLWHA facilitated the differentiation between ingroup (HIV- individuals) and the outgroup (PLWHA). Link and Phelan (2001, p. 370) propose that in extreme cases, the stigmatised individual is thought to be so different from the ingroup that they are no longer perceived as humans: This level of demarcation is apparent in the descriptions of PLWHA by Stage 1 participants prior to diagnosis as “alien”, “ugly thing” with skinny body, hair falling out and dry skin covered in sores. Finally, this clear distinction between the ingroup and outgroup became the rationale for devaluing the statuses of PLWHA and discriminatory practices. Stage 1 participants shared that as
‘sinners’, they were expected to feel guilty about being infected, were socially ostracised and were subjected to other forms of discrimination.

The source of power inequity that the entire system, from separation to discrimination of PLWHA feeds from, is drawn from the religious (Christian iTaukei) and cultural (Hindu Indian) tenets of society that tie negative sexual stereotypes to immorality. For example, according to iTaukei (Christian) participants, HIV was seen as a form of punishment from God for immoral behaviour therefore PLWHA were to be hated and excluded. Hence sexual stigma (association of PLWHA with deviant sexual practices) fuels, substantiates and maintains value-driven stigmatisation of PLWHA which in turn is deeply rooted in the religious and cultural ideals of morality.

Stage 1 data also indicates that religious and cultural institutions play dual roles in (1) encouraging and facilitating stigmatisation and discrimination of PLWHA and those associated with them and (2) counteracting HIV/AIDS-related stigma. These two roles have also been documented by other studies (Campbell et al., 2010; ICRW, 2006; Otolok-Tanga et al., 2007; Morisky, 2006; Rankin et al., 2005; Trinitapoli, 2006). Stage 1 data indicates that in playing these two very conflicting roles, FBOs are potentially one of the most influential structural actors and as such they can make an enormous impact on the success of any HIV stigma intervention efforts.

This crucial role of FBOs is being recognised by Pacific Island countries including Fiji and several initiatives have been mobilised (e.g. Pacific Conference of Churches organised meetings and fundraising initiatives) which sees the participation of churches in stigma reduction efforts (Baghw an, 2010). However, it is important that such initiatives incorporate other religious and cultural bodies and receive consistent support from other structural actors for example government departments, NGOs, and international organisations. Interview data also reinforces findings of studies which indicate that sexual stigmatisation of HIV/AIDS also (1) acts as a barrier to seeking information that may alleviate stigmatising attitudes, (2) distorts messages regarding the use of condoms (McMillan, 2008), (3) creates a false sense of personal immunity to HIV (e.g. Hammar, 2011; Smith, 2003) and, (4) inhibits adoption of STI-preventative practices and obtaining of timely health services such as VCT (e.g.
Chesney & Smith 1999; Fortenberry et al., 2002; Kalichman & Simbayi, 2003; Lieber et al., 2005).

These variables need to be quantitatively measured to determine their external validity to the Fijian population. Nonetheless, these findings highlight the importance of adopting a holistic approach to reproductive health education rather than focusing primarily on HIV/AIDS-prevention. Sexual stigma, as documented in this study, has wider implications on reproductive health education in Fiji, especially in relation to STI prevention and warrants further research to fully understand this construct.

Stage 2 survey data also mirrored the stronghold of value-driven stigma reported by interviewees. The value-driven stigma scale developed through the interview findings had a high internal reliability. Statistically significant differences were recorded in value-driven stigma, fear-driven stigma, and anticipated secondary stigma (see also 4.3.2). Furthermore value-driven stigma scores were rated higher than fear-driven stigma scores by 82% of the participants and the differences can be characterised as a strong sized effect. Value-driven stigma was also rated higher than anticipated secondary stigma scores by 59% of the participants. However, although value-driven stigma scores were higher than other stigma scores, they had only a moderate impact on willingness to provide support to a hypothetical family member. These findings indicate that inducing empathy (by getting survey participants to visualise a close family member as being HIV+) can mitigate the impact of value-driven stigma (see also 4.1.4).

These findings also raise important implications for intervention methods for alleviating HIV/AIDS-related stigma used in Fiji and raise serious reservations regarding the primary use of information-focused strategies. This is not to say that information focused intervention approaches are not useful, rather that on their own, they are insufficient and to some extent represent a misdirected focus.

5.1.5 HIV Stigma Alleviation Efforts: Combining Information-Focused and Contact-Based Initiatives

Data from Stages 1 and 2 indicate that HIV/AIDS-related stigma is a multifaceted, complex concept requiring a combination of intervention approaches to address the different facets of stigma. Variables that impact fear-driven and value-driven stigma
were established through interviews and further tested through inter-variable comparisons and correlations of survey data (see also Table 4.6). In particular, survey data indicated (1) that stronger correlations exist between fear-driven stigma and knowledge on modes of transmission of HIV and (2) that inducing empathy can mitigate the impact of value-driven stigma.

The combined approach to stigma intervention and alleviation proposed in this section is based on the strong positive correlation between value-driven stigma and fear-driven stigma observed in the survey: Even after partialling out knowledge on modes of transmission of HIV, value-driven stigma accounted for 48% of variability in fear-driven stigma (see also Table 4.6). This finding provides the numerical evidence for the association between stigma driven by fear of contagion and disease and stigma driven by conceptions of immorality, shame and blame. It also indicates that HIV/AIDS-related stigma reduction efforts need to simultaneously target both types of stigma. Therefore, this section proposes a HIV/AIDS-related stigma intervention and alleviation method that combines information-focused strategies (increase knowledge on transmission routes and nature of the virus; control and prevention of HIV/AIDS; and target misconceptions about PLWHA) and contact-based strategies (involve inducing empathy for PLWHA through contact).

Furthermore, Stage 1 interviewee reports indicate that apart from knowledge on modes of transmission of HIV, other confounding variables that serve as barriers to alleviating HIV/AIDS-related stigma include (1) social status of the stigmatised individual within the society, (2), an inability to empathise with PLWHA by community members (3) lack of support from authoritative figures and, (4) the terminal nature of the disease. These four confounding variables are in line with Allport’s (1954) intergroup contact theory which sees increased inter-group communication as a means of reducing discrimination under four specified conditions namely, equal status, common goals, inter-group co-operation and support of authorities, law or custom (as cited in Pettigrew, 1998, pp 66 – 67). The application of Allport’s (1954) framework of stigma reduction using a combination of information-focused and contact-based strategies is discussed and substantiated using Stage 1 interview findings in the next paragraph.
Three predominant negative stereotypes (driven by fear and/or values) associated with HIV/AIDS and HIV+ participants were identified through interviews namely, (1) PLWHA are either promiscuous, or prostitutes or homosexuals, (2) HIV is an infectious, incurable and terminal disease and, (3) PLWHA suffer a painful death soon after diagnosis (see also 3.2.1.5 and 3.2.1.6). As a result participants like L.N.K., Unaisi and Mosese who lived in communal or group settings were avoided and socially ostracised and hence lost their statuses within their social groups. It was the intervention by a well-respected authority figure (e.g. village leader, religious leader, medical doctor) on behalf of the HIV+ participant and the lack of physical symptoms that assisted in regaining some of the ‘lost status’. This uplifting of status paved way for HIV+ participants to engage personally with their stigmatisers for the common goal of creating and gaining a better understanding of HIV/AIDS, respectively. In this process, participants dispelled inaccurate beliefs regarding HIV transmission and clarified modes in which HIV can be transmitted. The contact between the two groups under the changed circumstances (elevated status) increased empathetic attitudes amongst stigmatisers, somewhat alleviating HIV/AIDS-related stigma and discrimination in the process. The importance of ‘equality of status’ also explains why participants like Clare and Samuel, who had a relatively high social standing due to their professional backgrounds (business woman and NGO worker, respectively) had very positive experiences with members of their communities (see also 3.2.1.5).

While information-focused strategies have been widely used in Fiji, very few initiatives properly use contact-based strategies. Stigma alleviation strategies that focus on increasing contact with PLWHA have been the focus of several studies and have mounted support for the inter-group contact theory (Pettigrew, 1998). For example, Batson et al. (1997), using an experimental design measured the impact of inducing empathetic attitudes towards a HIV+ person on attitudes towards PLWHA in general, found that inducing empathy led to more positive views towards PLWHA. Schiff et al. (2003) also found strong relationships between contact with PLWHA and attitudes towards PLWHA amongst African American youths.

Herek and Capitantio’s (1997) study examined the relationship between HIV/AIDS-related stigma and two variables (1) direct contact with PLWHA and (2) vicarious contact with PLWHA through the media and showed support for the theory. Direct
contact was associated with reduced support for coercive AIDS policies and less blame for and avoidance of PLWHA. Vicarious contact was also associated with reduction in stigmatising attitudes and was found to be especially influential on participants with highly stigmatising attitudes, however, it did not cause reduction in support for coercive AIDS policies and less blame to specific groups for spreading the virus. A more recent study also showed mixed results of stigma reduction through vicarious contact with PLWHA with some success in stigma reduction. The researchers measured the impact of a Malawian radio programme, which featured personal stories of PLWHA on stigmatising attitudes of participants drawn from 30 villages (N = 300) (Creel, Rimal, Mkandawire, Böse, & Brown, 2011). Results indicated that the programme was effective in the reduction of fear of casual contact amongst participants, however had mixed results for value-driven attitudes such as shame and blame within subgroups; participants who knew someone with HIV reported feeling lower levels of shame compared to those participants who did not. Furthermore, no major changes were seen in attribution of blame to PLWHA through exposure to the programme however, participants reported significantly lower levels of blame when exposure to the programme was followed by discussion on the contents.

The literature cited and the narratives of interviewees of this study support Allport’s inter-group contact theory (1954, as cited in Pettigrew, 1998) and lend credibility to interventions such as the AIDS Ambassadors Outreach Programme, developed by the PIAF. This programme uses contact with PLWHA (direct and vicariously through media) for reduction of HIV/AIDS-related stigma at the individual level and if executed properly can be very promising in alleviating HIV/AIDS-related stigma and discrimination in Fiji. The programme also trains PLWHA to engage with the community in information-focused strategies by clarifying misconceptions regarding HIV. Such initiatives use a combination of information-focused and contact-based strategies: By giving a ‘face’ to HIV they assist in creating empathetic understanding of PLWHA within the general population and dispelling fear and myths associated with HIV. They can also be very useful in challenging the sense of personal immunity that the HIV+ participants of Stage 1 shared they held prior to diagnosis and the strong belief that equates HIV with certain death and incapacitation.
These findings also emphasise the necessity of the four favourable conditions which have implications on the outcome of inter-group contact and raise issues and considerations regarding the proper planning of how, when and where this inter-group contact should occur: premature interventions driven by assumptions of casual associations between increased contact and stigma reduction (as indicated in studies by Creel et al., 2011; Herek & Capitanio, 1997) may not be as successful and can have damaging repercussions, especially for the outgroup (Stein, 2003). Results of this study indicate that the success of this contact between the ingroup (community or group members) and outgroup (HIV+ participants) for alleviating stigma is dependent on meeting the four governing conditions. Therefore, contact-based initiatives will only be successful provided regaining of status of the stigmatised individual precedes the ‘contact’. Interview findings indicate that support from religious leaders (especially for iTaukei Christians), community leaders (e.g. village elders) and other authority figures (e.g. doctors) can assist in elevation of the statuses of stigmatised PLWHA.

Additional methods that may prove to be useful in regaining lost statuses of PLWHA were also found. According to interviewees, the lack of physical symptoms of HIV and continued productivity (attributed to use of ART), caused their stigmatisers to reassess their actions and attitudes towards PLWHA gravitating towards becoming more accommodative. ART may also cause people to reassess labels such as ‘certain death’ and incapacitation that is associated with HIV/AIDS. Furthermore, challenging the sense of personal immunity that HIV/AIDS-related sexual stigma generates within the ingroup may also prevent them from devaluing the statuses of PLWHA (Ben-Zur, Breznitz, Wardi, & Berzon, 2000; Hammar et al., 2011; Smith, 2003). Therefore focus from ‘high risk groups’ needs to be shifted to behaviour that places one at risk of contracting HIV i.e. HIV/AIDS messages should emphasise that anyone who engages in unprotected sex is at risk of contracting HIV regardless of their sexual preferences and behaviour.

The proposed approach to HIV stigma alleviation and intervention uses the intergroup contact theory to combine contact-based and information-focused approaches. In doing so, it acknowledges that stigma and discrimination are consequences of status loss and identifies four conditions that can assist in regaining the ‘lost statuses’ of PLWHA. Furthermore, this approach to stigma alleviation and
intervention targets both fear-driven stigma and value-driven stigma and hence will have a greater success in addressing HIV/AIDS-related stigma and discrimination in Fiji as opposed to the approaches currently being used. Differentiating types of stigma based on what drives them was methodologically useful for identifying appropriate intervention methods, as demonstrated in this study. However, it is evident that stigmatising attitudes are complex and interrelated constructs requiring a combination of approaches, involving multiple actors at different levels within a society.

5.2 Implications of Findings for Institutions and Individuals Associated with HIV/AIDS and PLWHA

Results of both stages of research point to a single dominant finding: Contrary to popular belief and media sensationalisation of HIV/AIDS-related stigma and discrimination, PLWHA receive and can expect greater levels of support in comparison to HIV/AIDS-related stigma and discrimination in Fiji. Stage 1 interviews mapped dominant experiences of interviewees with healthcare professionals, prison officers, religious leaders, HIV/AIDS-related NGOs, neighbourhood communities, family members and partners of PLWHA. Results indicated that with the exception of nurses working at main hospitals, greater levels of positive experiences were reported by participants with the other six groups and that reactions to PLWHA are becoming increasingly accommodative and supportive. The negative experiences with nurses at the main hospital (predominant of which was disclosure of serostatus to others without patients’ consent) appeared to be more closely linked to a lack of understanding and adherence to the professional code of conduct of nurses, rather than HIV/AIDS-related discrimination.

Stage 2 survey results provided the numerical evidence for the ‘greater levels of support’ recorded in Stage 1: support for hypothetical HIV+ family member scores were rated higher than (1) value-driven stigma by 90% of participants, (2) fear-driven stigma by 96% of the participants and, (3) anticipated secondary stigma by 99% of the participants (see also 4.3.3). The differences in stigma and support had strong effect sizes. The following sub-sections discuss the implications of these findings on five groups (not previously covered in this chapter) which are central to
addressing HIV/AIDS-related stigma and discrimination and form crucial support networks for PLWH.

5.2.1 Role of Education: Policy Makers and Curriculum Developers

The scale created through narratives of HIV+ participants of Stage 1, indicated that although post-secondary students had generally high scores on knowledge on transmission of HIV, similar inaccurate beliefs regarding modes of transmission persisted amongst participants of both stages. Contact with saliva (36%), deep kissing (30%), and mosquito bites (21%) were the most common inaccurate beliefs held by post-secondary students. Further, survey results indicated that 30% of participants did not identify breast milk as a form of transmission of HIV (see also Figure 4.1). These inaccurate beliefs about HIV transmission need to be targeted by HIV intervention messages in Fiji.

At least three explanations appear relevant. Firstly, initial intervention approaches have focused on modes of transmission of HIV through ‘bodily fluids’ such as blood, semen and vaginal fluids without clarification on ways in which HIV cannot be transmitted and why it cannot be transmitted through these routes. Ogden and Nyblade (2004) associate an overemphasis on modes of transmission of HIV and the lack of focus on modes in which HIV cannot be transmitted as one of the factors that drives irrational fear of casual transmission. Consequently, it is suggested that intervention messages need to highlight that (1) HIV is not an airborne, mosquito borne, water borne or food borne disease and (2) the generally fragile nature of the virus means it cannot survive for long outside the human body; hence HIV cannot be spread via ordinary, superficial social contact (“Transmission of HIV”, 2006).

A second factor might be a lack of teacher training in the area of reproductive health. Up until 2008, the most common and in most cases the only formal source of HIV/AIDS-related information for post-secondary students in Fiji was the Health Science curriculum taught in classes 7 and 8 (Forms 1 and 2 of junior secondary school) which takes a very ‘scientific approach’ to what is essentially a socially construed pandemic. With cultural taboos on discussion of reproductive health topics especially with young children coupled with the lack of teacher training on dissemination of such information, there is a real issue of distortion of HIV/AIDS-related information. A third factor can be gleaned by the findings of a pre-
intervention study for the Family Life Education (FLE) curriculum currently being piloted by Fiji’s Ministry of Education (Seru-Puamau & Roberts, 2008). According to this survey, up to 72% of Form 3 students in Fiji, first hear about sex from their peers. Therefore myths can be widely propagated within this population if inaccurate HIV/AIDS-related information is held by peers.

Since 2009, it appears that the two needs of (a) adequate training of teachers and (b) providing accurate information to students are being addressed by Fiji’s Ministry of Education through the development of the FLE curriculum and instructional training for teachers from participating pilot schools (“Family Life Education Pilot Teacher Training Workshop”, 2008). An analysis of the Training Manual for the FLE programme also indicates that the content and design adopts the much needed holistic approach (encompassing both the scientific and social dimensions) to addressing reproductive health issues amongst secondary school students in Fiji and it addresses misconceptions on transmission of HIV more effectively in comparison with the Health Science curriculum. The findings of this survey underscores a need to formalise and implement educational programmes, such as the FLE curriculum which effectively address reproductive health issues at all three levels (policy, institutional and individual) in all schools in Fiji.

5.2.2 Role of Family Members and Partners as Caregivers
Stage 1 interviews indicated that HIV/AIDS-related stigma has a dramatic impact on the life experiences of PLWHA, their partners, and family members. Family members and partners (infected and uninfected) fall targets of HIV/AIDS-related stigma and as documented in the cases of Unaisi and L.N.K, this can have an impact on the willingness of family members to take care of PLWHA (see also 3.2.1.6). These findings are consistent with other studies which have documented the secondary stigmatisation of partners and family members of PLWHA and its negative impact on willingness to support HIV+ family members (e.g. Alonzo & Reynolds, 1995; Cao et al., 2005; Ogden & Nyblade, 2006; Paxton et al., 2005; Powell-Cope & Brown, 1992). Interview results also indicate that constraints of healthcare and support systems in Fiji and cultural influences on serostatus disclosure (especially with Indian participants) results in family members shouldering greater responsibilities of providing physical, emotional and financial support for their HIV+ family members. Coupled with potential secondary
stigmatisation, this makes caregivers of PLWHA especially vulnerable to burnout, consequently, HIV/AIDS-related support mechanisms such as counselling services need to be extended to this group.

Survey data indicated that, in combination value-driven stigma, fear-driven stigma, and anticipated secondary stigma predicted 24% of variances in support for a hypothetical HIV+ family member, with fear-driven stigma being the strongest predictor of support (see also 4.4). This finding highlights the importance of involving potential caregivers in post-diagnosis counselling in order to clarify misconceptions regarding modes of transmission of HIV which has a moderate relationship with fear-driven stigma.

Powell-Cope and Brown (1992) suggest that because family members of PLWHA share the burden of stigma and discrimination associated with HIV/AIDS they may also share similar passion for social activism against stigma and discrimination. Therefore, family members of PLWHA can be formidable forces in stigma alleviation efforts: it may be worthwhile to explore this avenue locally, especially in contact-based intervention programmes discussed in 5.1.5. Finally, the scope of this study was limited to measuring stigma as a possible barrier to support. Further research needs to be conducted with family members of PLWHA to ascertain other variables (e.g. financial obligations, possible physical and psychological impact of caring for PLWHA etc.) that may have an impact on willingness to support HIV+ family members.

5.2.3 Role of HIV/AIDS-related NGOs
The crucial role of HIV/AIDS-related NGOs in providing support for PLWHA was documented in Stage 1 of this study. Moreover, the comparatively lower levels of stigma and higher levels of support for PLWHA documented in the survey may be a result of intervention efforts of these NGOs. Consistent with the rejection-identification model (Branscombe et al., 1999), association with HIV/AIDS-related NGOs had very positive influences on the coping strategies adopted and mental well-being of participants. For example, Clare attributed her membership to one NGO and the counselling services that they provided as the primary reason behind her healthy self-esteem and confidence to continue living as a HIV+ person. The study also documented the poor coping strategies adopted by participants (Lena,
Vinita and Narayan) who were not willing to engage with such groups further reinforcing and reaffirming the positive influence of such memberships (see also 3.2.5.2.1).

Some negative experiences with HIV/AIDS-related NGOs were also recorded in this study and appeared to stem from efforts of NGOs to secure and maintain funding. In response to an ‘epidemic’ that on records has directly impacted only 420 individuals over 32 years (Gopal, 2012), a total of 41 government departments, NGOs, international organisations and, FBOs that have answered the call to address the various aspects of the epidemic. This response is unprecedented and outnumbers organisations setup to address other prominent social problems (e.g. domestic violence or child abuse) and health problems (e.g. non-communicable diseases) that affect much larger proportions of the Fijian population. The mushrooming of HIV/AIDS-related NGOs, partially driven by the aid money available, has created immense competition for grant money and appears to have resulted in unethical practices identified by this study. These include a struggle to retain membership by discouraging membership with other HIV service providers, creating financial dependency amongst members and impelling public disclosure of serostatus for contact-based intervention efforts which may demonstrate proof of the NGOs success (see also 3.2.1.4).

Findings of the study do not dispute the central role of NGOs in stigma intervention efforts and as service providers of PLWHA in Fiji. However, they also highlight the need for proper policies that oversee the establishment and functioning of HIV/AIDS-related NGOs. The struggle for continued funding has caused some NGOs to be counter-productive: It is imperative that establishment and registration of NGOs are scrutinised by government and other funding agencies to avoid the detrimental effects of the emanating financial competition.

5.2.4 Role of Healthcare Officials
Stage 1 results indicated that participants generally had very positive experiences with healthcare officials. HIV/AIDS-specialist Hub centre officials were perceived as more accepting as opposed to non-specialist medical officials and played a variety of roles such as providing emotional support and counselling, lobbying on behalf of
patients and, creating HIV/AIDS-related awareness. However, 70% of participants reported at least one negative experience with non-specialist nurses at main hospitals. These included breaches of confidentiality (which in some cases led to further discrimination of the interviewee) and mistreatment of symptomatic patients, indicating lack of training on ethical conduct and adherence to patient confidentiality protocols. These findings are consistent with other studies that cite disclosure of serostatus as the most common form of discrimination within the healthcare system (e.g. Andrewin & Chien, 2008; Wong & Wong, 2006).

With clear differences in interviewee experiences with specialist and non-specialist healthcare officials recorded in this study, it is important that practitioners specialising in HIV/AIDS-care adopt a more formal role in the training and sensitising of non-specialist practitioners in managing disclosure of sero-status and use of unreasonable ‘precautions’ during treatment. Studies indicate that formal HIV/AIDS training of healthcare officials is associated with less stigmatisation such as attitudes towards imposed measures, value-driven stigma, and testing without consent and will be useful in addressing the stigma and discrimination issues within the healthcare system in Fiji (Andrewin & Chien, 2008; Wong & Wong, 2006).

Another approach that appears useful in addressing HIV/AIDS-related stigma and discrimination is the discouragement of discrimination of PLWHA by healthcare institutions. A survey of healthcare providers in China indicated perceived levels of support from their medical institutions for protection of PLWHA against discriminatory practices by healthcare personnel was an important predictor of discrimination intent (Lin et al., 2007). Therefore, interventions within the health sector need to incorporate both institutional and individual levels. In Fiji, efforts are being undertaken by the government whereby initial HIV awareness training was offered to a group of medical staff however, such initiatives need to be undertaken at much larger scales to adequately address issues such as HIV/AIDS-related stigma and discrimination within the health care system (MOH, 2010). Moreover, institutional protocols that discourage stigma and discrimination of PLWHA need to be developed and existing ones need to be reinforced in healthcare systems in Fiji in order to counteract the problem of HIV/AIDS-related stigma.

Finally, healthcare officials in Fiji play a major role in the pre-diagnosis and post-diagnosis counselling of PLWHA. It is important that they understand and
adequately respond to the psychosocial responses that follow a positive diagnosis and are able to refer HIV+ patients to individuals and organisations that can provide the necessary emotional support and training. This issue is further discussed in 5.2.5.

5.2.5 Role of Counselling Service Providers

Being diagnosed with a terminal, chronic illness that is stigmatised has serious implications on the mental health of PLWHA. The most debilitating psychosocial consequence of HIV/AIDS-related stigma found in this study was the internalisation of stigma. Stage 1 interviewees \( (N = 11) \) reported that when diagnosed with HIV, they imposed stigmatising attitudes upon themselves. Interview data also indicates that internalised stigma was caused by (1) the fear of an impending death, (2) actual experiences of discrimination, and (3) anticipated stigma due to stigmatising attitudes towards PLWHA held by interviewees prior to diagnosis.

Internalised stigma placed added emotional strain on participants and triggered self-stigmatising feelings such as self-blame, guilt, shame, self-pity, feelings of worthlessness and hopelessness and disappointment for not meeting personal goals, culminating into a low self-esteem. In most cases \( (n = 9) \), internalised stigma was not permanent and two factors mediated the psychosocial impact of internalised stigma including use of approach coping strategies and strong social support systems consisting of partners, family members, HIV/AIDS-related NGOs, FBOs and healthcare officials. Case analysis of interviewees, whereby participants were grouped according to the type of coping strategy adopted (approach or avoidant), indicated that approach coping strategies catalysed acceptance of diagnosis which resulted in healthier self-esteem, facilitated development of better and wider support networks and increased sense of personal productivity (see also 3.2.5.2.2). On the other hand, avoidant coping strategies were accompanied by low self-esteem, feelings of loneliness, low acceptance of diagnosis, and depression (see also 3.2.5.2.1). The behavioural avoidant coping strategies documented in this study included non-disclosure of sero-status and engaging in risky behaviour such as self-harm through social exclusion, alcohol abuse and suicide attempts. An apprehension of visiting healthcare facilities was also documented in this study but it did not appear to have a major implication on access to healthcare with this group of participants. However, as participants were recruited through visits to Hub Centres, this theme needs to be further explored by recruiting participants through other
avenues (e.g. NGOs and public advertisements) to identify variations within this theme.

The negative psychosocial impact of internalised stigma on PLWHA recorded in this study is well supported by other studies (e.g. Gallego et al., 2000; Sabin et al., 2008; Whetten et al., 2008). The findings of this study also contribute to an expanding body of literature which have documented the negative impacts of use of avoidant coping strategies to stressors associated with HIV/AIDS-related stigma on HIV/AIDS prevention and care (e.g. Courtenay-Quirk et al., 2006; Joseph & Bhatti, 2005; Wong & Wong, 2006). Case analysis indicates that counselling interventions played a substantial role in the development and adoption of healthier coping mechanisms (also see 3.2.5.2.3). This makes counselling service providers crucial to the training of PLWHA on adopting healthier coping mechanisms in response to the stressors of suffering from terminal, chronic illness and associated stigma. Unfortunately, very few qualified counselling service-providers are available in Fiji and it is important that the Fijian government invests in developing this area of HIV-service providers as they are crucial to both HIV prevention and treatment initiatives. Although, beyond the scope of this study, future research will also benefit from exploring what counselling practices and therapies are most useful in alleviating the impact of internalised stigma.

5.3 Strengths and Limitations

This thesis adopted an ecosocial research orientation within a sequential mixed methods research strategy. Methodologically it has capitalised on the strengths of constructionist and positivistic worldviews in creating a somewhat balanced report on HIV/AIDS-related stigma: Findings from the two stages were used to explain relationships and contextualise observations making the discussion more robust and rich. This thesis has also made two unique contributions to the existing literature on HIV/AIDS-related stigma and discrimination; firstly, it integrated ingroup experiences and outgroup perceptions of stigma. Secondly, it moved beyond the precincts of most social psychological literature on stigma which focus purely on individual level variables (e.g. the psychosocial impact of HIV/AIDS-related stigma) to encompass identification of social forces such as the pre-existing inequalities that drive stigma in Fiji. Adopting this ecosocial approach also
permitted identification of possible reforms at policy, institutional and individual levels. However, the study is in no way exhaustive and a number of limitations with this study can be noted.

The first of these relates to the participant demographics and sample sizes of the two stages. Participants of Stage 1 were those who regularly attended clinics and findings are not representative of PLWHA who are not regular attendees. Future investigators could continue to explore and identify variations within the themes by recruiting participants through other avenues (e.g. NGOs and public advertisements). An important insight from this study is that ethnicity has implications on perceptions of serostatus disclosure and it would have been ideal to explore the impact of ‘face’ further with Indian participants. However, recruiting Indian HIV+ participants has been difficult in this study. Furthermore, although socio-economic inequalities were found to increase risk of HIV infection and exacerbate HIV/AIDS-related stigma in Fiji by PIAF (2009), no evidence for this was found in this study. Stage 1 participants were either employed or were financially supported by family members and NGOs. A variation in this theme may also be determined through purposive recruitment of participants from low socio-economic backgrounds.

Similarly Stage 2 participants belonged to an ‘elite’ group of post-secondary students and are not reflective of the Fijian population. Further research needs to be conducted with a wider cross-section of the Fijian population to determine wider reliability of Stage 2 questionnaire; the stigma and support scales may require further refinement to increase reliability to other populations. Items on the value-driven stigma scale may require rewording to increase applicability to other ethnic groups so that punishment is not attributed to God only. For example rewording item 26 (Appendix E) to ‘Getting infected from HIV/AIDS is a punishment for immoral behaviour’. Issues of statistical power were also of concern in Stage 2 and may have stemmed from missing data; the reduced sample size may have contributed to the high $p$ values of correlations (e.g. for support for hypothetical HIV+ family member and secondary stigma scores) and gender and ethnic differences. However, integration of qualitative with quantitative data has ameliorated some of the impacts of the low power.
Combining information-focused and contact-based initiatives in stigma alleviation efforts need practice and familiarisation. The assumption that the proposed technique can function seamlessly, or that it should not require further validation and fine-tuning if its use becomes mainstream, is naive. Finally, results of Stage 2 indicate that HIV/AIDS-related stigma has an impact on willingness to provide support for HIV+ close family members amongst post-secondary students. Future research would benefit from continuing to tease out the impact of stigma on supportive attitudes towards all PLWHA with other samples.

5.4 Conclusion

The impact of HIV/AIDS has tremendous and wide reaching consequences. The responses are not limited to the physical alone: The psychosocial impact on PLWHA is considerable and should be an integral consideration in providing these individuals and their families with an effective and comprehensive package of care. Stigma reduction is unquestionably a crucial component of all of this. Adopting an ecosocial approach in this thesis has permitted the identification of the social causes of HIV/AIDS-related stigma and an understanding of its psychosocial impact, enabling development of intervention approaches that considers ingroup and outgroup dynamics within the Fijian contexts.

The epidemiology of HIV/AIDS in Fiji appears to be affected by social forces and inequalities relating to gender, ethnicity, fear of contagion and disease and sexual stigma associated with the pandemic. These societal mechanisms impact the perception of HIV/AIDS, modes of transmission of HIV/AIDS and of individuals associated with HIV/AIDS; focus of social policies; and determine success of stigma interventions. Therefore to be effective, HIV/AIDS-related stigma intervention approaches need to simultaneously address institutional policies and practices; and individual attitudes and behaviour.

The findings of this study provide strong support for the following stigma intervention and alleviation methods; firstly, there needs to a shift in the focus of STI awareness programmes. Reproductive health education programmes need to be incorporated into the formal curriculum and should encompass both the scientific and social dimensions to addressing reproductive health issues: The FLE curriculum is a formidable option as it represents this holistic approach to reproductive health
education. The delivery of this curriculum needs to be reinforced by training of teachers implementing it in order to make substantive impact on individual attitudes. Secondly, gender-based social inequalities and violence perpetuate women’s vulnerability to HIV/AIDS and addressing domestic violence issues are central to managing the increasing number of female infections in Fiji. Acknowledging ethnic differences in psychosocial reactions to HIV/AIDS-related stigma is also important to the development of prevention, treatment and support initiatives that are inclusive of all ethnicities in Fiji’s multi-cultural society. Finally, stigmatising attitudes are complex interrelated constructs and interventions need to concurrently address stigma driven by fear of contagion and disease; and stigma driven by conceptions of immorality, shame and blame. A combination of contact-based and information-focused approaches underpinned by considerations of equality of status, shared goals in HIV/AIDS control and prevention, co-operation between ingroup and outgroup and support by community leaders and policy makers will have greater success in addressing HIV/AIDS-related stigma and discrimination in Fiji.

Perhaps, one of the greater contributions of this thesis, especially from the perspective of PLWHA, was charting levels of support for PLWHA against HIV/AIDS-related stigma and discrimination. Both interview and survey data indicate that PLWHA can expect greater levels of support as opposed to stigma and discrimination. This empirical finding can form a crucial component of post-diagnosis counselling. Social support networks consisting of religious and cultural leaders, family members and partners, HIV/AIDS-related NGOs, healthcare officials, and counselling service providers are central to the management of dysfunctional psychosocial reactions that follow HIV diagnosis. These social structural actors also play important roles in mediating the impact of stigma and assisting in stigma alleviation efforts. In particular, counselling support that fosters adoption of approach coping mechanisms assist in the development of strong support networks, healthier self-esteem and an increase in sense of personal productivity, all of which are crucial to the management of infection and the control and prevention of HIV/AIDS.
REFERENCES


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doi:10.1300/J010v39n01_04

doi:10.1136/sti.79.6.442

doi:10.1089/jwh.1998.7.371


doi:10.1080/13691050600975462

doi:10.1093/ije/30.4.668

doi:10.1016/j.ijnurstu.2006.08.002


APPENDIX A
LETTERS FOR APPROVAL OF RESEARCH

National Health Research Committee

Phone • (679) 3221424 /3221481          Dr. Shareen Ali, Secretariat
                                        • (679) 3318227
                                        Ministry of Health
                                        P.O. Box 2223, Govt. Bldgs.
                                        Suva, Fiji Islands
                                        Email • shareen.ali@health.gov.fj

13th March, 2009

Division of Psychology,
School of Social Sciences,
Faculty of Arts and Law,
University of the South Pacific,
Suva
Fiji.

Dear Shazna Buksh,

Thank you for your application for review to the National Health Research Committee

Title of Research: Perceptions of Young Adults and Experiences of People Living with HIV/AIDS

FNRERC Reference Number: 2009 - 001

I am pleased to advise you that the NHRC has granted approval for your above-mentioned study with the following amendment:

1. Participant Information Sheet to include assurance on data storage and security.

Please note that the following conditions apply to your approval. Failure to abide by these conditions may result in suspension or discontinuation of approval and /or disciplinary action.

(a) Duration of Approval – approval is till October 2009. However if the study cannot be completed in the timeframe given, researcher has to seek for extension by submitting a progress report.
(b) **Variation to Project**: Any subsequent variations or modifications you might wish to make to your project must be notified formally to the Chair, NHRC for further considerations and approval. If the Chair considers that the proposed changes are significant, you may be required to submit a new application for approval of the revised project.

(c) **Incidence or adverse affects**: Researchers must report immediately to the Chair of the NHRC anything which might affect the ethical acceptance of the protocol including adverse effects on subjects or unforeseen events that might affect continued ethical acceptability of the project. Failure to do so may result in suspension or cancellation of approval.

(d) **Monitoring**: Projects are subject to monitoring at any time by the NHRC.

(e) **Final Report**: You must submit a final report at the conclusion of the project by completing the Final Report Form.

Please quote the FNRERC reference number and the name of the project in any future correspondence. If you have any further queries on these matters or require additional information, please do not hesitate to contact the secretariat on telephone: (679) 3221424 or email:

shareen.ali@health.gov.fj.

Yours Sincerely,

--------------------------

Ms Laite Cavu

Chair, NHRC
To Whom it May Concern

Re Ms Shazna Buksh

Ms Buksh is a graduate assistant in the Division of Psychology in the School of Social Sciences at this University. She is engaged in a research project dealing with the incidence and experience of HIV/AIDS in Fiji.

Her proposal has been submitted to me for approval, and this has been given. Her proposal meets the Ethics guidelines established by the Research and Postgraduate Studies Committee of the School of Social Sciences.

Professor Ian Campbell
Chair
Research and Postgraduate Studies Committee
School of Social Sciences.
Hello! My name is Shazna Buksh and I am conducting a study designed to explore the experiences of people living with HIV/AIDS in Fiji. I wish to invite you to participate in this study which is being undertaken with the approval of School of Social Sciences, University of the South Pacific and National Health Research Committee, Ministry of Health and follows the “Code of Research Ethics” for psychology in accordance to the guidelines set by the British Psychological Society.

This means that if you decide to participate in this study all possible steps have been undertaken when designing the study to safeguard your rights, protect your identity and ensure that you will not be exposed to any additional risks because of your participation. Your participation in the study is entirely voluntary. Please read the information given below and ask questions if you cannot understand anything, before deciding whether or not to take part in the study.

**Purpose of Study**

There are two aims of this study:

1. To describe the personal experiences of people living with HIV/AIDS (PLWHA) in Fiji.
2. To identify some of the psychological and behavioral responses of PLWHA to attitudes of the community such as family members, friends, medical workers, religious leaders e.t.c. towards them.

**Importance of the Study**

Information derived from this study will create awareness about the needs of PLWHA in Fiji, especially the forms of support that PLWHA need. Therefore, it is extremely important that you answer all questions honestly and to the best of your ability. Your contribution will be much appreciated.

**Method**

After reading the consent form, and giving your written consent to take part in the study, you will be asked to participate in an interview of approximately 1 hr – 1 hr 30 minutes in length.
The interview will include questions regarding the following:

- General knowledge of HIV/AIDS.
- Family reactions and community attitudes towards HIV.
- Reasons for such reactions and attitudes.
- The effect of these attitudes on you.
- Ways in which you cope with community attitudes.
- Willingness to participate in treatment and/or counselling services.
- Your opinions about disclosure of serostatus.

The interview will be recorded with your consent. There are no “right” answers; I’m only interested in your views on the above issues.

**Privacy and Confidentiality**

I respect your privacy and will undertake the following measures to protect your identity:

1. You are not required to reveal your true name, address or to sign the consent form.
2. Details which can potentially identify you will not be shared with anyone.
3. The only person who will have access to the recordings and your responses is me (and the translator, should you request for one).
4. The actual recording will only be used so that I will be able to correctly write down all your responses, which is difficult to do while conducting an interview.
5. **Storage and security of data** – all audio recordings used during your interview will be destroyed once the data has been transcribed (written down) and analyzed, after which you will be referred to by your pseudonym (fake name). Only your pseudonyms will be used in reporting results.
6. Individuals from the greater Suva area and Western Division are participating in the study, making it difficult to track individual participants like you.
7. The interview will take place in a private room and your responses will not be discussed with any other individual, including those who have assisted in recruiting you.

**Your Rights to Participation and Withdrawal**

- Your participation in this survey is entirely **VOLUNTARY**, which means you can choose whether or not you want to participate in the study. Your choice will not affect your relationship with the organisation that has assisted in recruiting you or other services including medical care that you are entitled to.

- If you give consent to participate, you can choose to stop answering questions when you want to and/or refuse to answer any questions that you don’t want to answer.
Participant Compensation

Upon completion of the interview, you are entitled to $15.00 in compensation for any expenses that you would have incurred for travelling to the agreed venue.

Consent to Participate in Research

I have read and I understand the information provided above. I have been given the opportunity to ask any questions that I may have and all of the questions have been answered to my satisfaction.

1. By writing the phrase “consent granted” in the space provided below, I give my consent to participate in the research that the attached Participant Information Sheet describes.

_______________________________________                                                   ________(Date)

2. By writing the phrase “consent granted” in the space provided below, I give my consent to have my interview session recorded in a digital voice recorder:

_______________________________________                                                   ________(Date)

Witnessed by: ___________________________________(name of medical officer)

_______________________________(signature)                                                  _________(Date)

Witnessed by: ___________________________________(name of researcher)

_______________________________(signature)                                                    ________(Date)

If you have any additional questions regarding the research, please contact me on:  
Email: shazna_buksh@yahoo.com
APPENDIX C
STAGE 1 – INTERVIEW GUIDE

Note: To be administered after the participant has read the Research Information Sheet, has agreed to participate, and signed the Consent Form and any other individual present has left.

Experiences of People Living With HIV/AIDS

Before we start I wish to mention a few things:

1. Some of the questions which I will ask may trigger some strong feelings in you. Be assured that this is normal.
2. Please take your time to respond thoughtfully and truthfully to the questions.
3. Feel free to ask for clarifications if you do not understand any of my questions.
4. Remember there are no “right” or “wrong” answers; I am interested in your experiences and your views, whatever they might be.
5. And be assured that your anonymity will be carefully protected therefore, it is important that you respond thoughtfully and honestly.

The first part is designed to provide some basic demographic information.

[Section 1 - Participant Demographics]

<table>
<thead>
<tr>
<th>Question</th>
<th>Responses/Notes</th>
<th>Code</th>
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<tbody>
<tr>
<td>Gender (observed) Sex (observed)</td>
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<tr>
<td>When is your birthday?</td>
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<tr>
<td>What is your ethnic affiliation?</td>
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<tr>
<td>What, if any is your religious affiliation?</td>
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<td></td>
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<tr>
<td>What is your current marital status?</td>
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<tr>
<td>Do you have any children?</td>
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<tr>
<td>What is the highest level of education you have achieved?</td>
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</tbody>
</table>
When were you diagnosed with HIV/AIDS?  

<table>
<thead>
<tr>
<th>Question</th>
<th>Responses/Notes</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Where and with whom were you living just before being diagnosed with HIV?</td>
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<td></td>
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<tr>
<td>Has this changed since diagnosis?</td>
<td></td>
<td></td>
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<tr>
<td>What was your occupation before being diagnosed?</td>
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<td></td>
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<tr>
<td>What is your current occupation?</td>
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</tr>
</tbody>
</table>

[Section 2 - Perceptions of HIV/AIDS.]

SAY I will now ask you some questions about your understanding of HIV/AIDS.

<table>
<thead>
<tr>
<th>Question</th>
<th>Responses/Notes</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core Question</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. What was your understanding of HIV/AIDS before you were diagnosed?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prompts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>– What was your understanding of how a person can get HIV/AIDS?</td>
<td></td>
<td></td>
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<tr>
<td>– Did you think that there was any particular thing/factor that would place a person at greater risk of getting HIV?</td>
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</tr>
<tr>
<td>Core Question</td>
<td></td>
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</tr>
<tr>
<td>2. From whom and where did you get this information on HIV/AIDS and other STI’s?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prompts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>– What were your initial reactions to this information?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>– What about your understanding of HIV right now?</td>
<td></td>
<td></td>
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</tbody>
</table>
### [Section 3 - Serostatus Disclosure]

**SAY** — I would now like to change the focus of our discussion to your experiences and views of telling someone that you are HIV+ / have AIDS.

<table>
<thead>
<tr>
<th>Question</th>
<th>Responses/Notes</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What are some issues you consider when/if you tell someone?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Can you describe some experiences of when you told someone that you are HIV+?</td>
<td></td>
<td></td>
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<tr>
<td>3. How many individuals/what groups of people do you think know about you having HIV/AIDS?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Apart from you telling these individuals what do you think were some other ways in which they came to know about it?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### [Section 4 - Reasons and sources of HIV/AIDS-related Stigma and Discrimination & Coping Strategies]

**SAY** - The next set of questions relate to the reactions of your families, friends and the general society to you having HIV/AIDS and how you cope with these attitudes and/or behaviour.
## Part A – Caregiver(s)

<table>
<thead>
<tr>
<th>Questions</th>
<th>Responses/Notes</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Core Question</strong>&lt;br&gt;1. Let’s start with your primary caregiver. Who takes care of you when you are sick?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Core Question</strong>&lt;br&gt;2. How would you describe his/her/their experiences as your caregiver?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Prompts</strong>&lt;br&gt;– What are the reactions of close family members or people from your community towards him/her/them?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Part B – Familial and societal reactions and coping strategies

**SAY** - Now let’s concentrate on some other individuals in your life like family and friends and their reactions towards you having HIV/AIDS? I will ask you the same/similar questions about the following individuals in your life.

**DO – ASK THE APPLICABLE CORE QUESTIONS & PROMPTS FROM THE TABLE. OMIT THE COLUMN THAT IS NOT APPLICABLE.**

<table>
<thead>
<tr>
<th>Question</th>
<th>Responses/Notes</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Core Question 1</strong>&lt;br&gt;Aware of serostatus&lt;br&gt;Will you share with me the reactions of your partner to you having HIV/AIDS?</td>
<td><strong>Core Question 1</strong>&lt;br&gt;Unaware of serostatus&lt;br&gt;How do you think your partner will react to you having HIV/AIDS?</td>
<td></td>
</tr>
<tr>
<td><strong>Prompts</strong>&lt;br&gt;What are some of the reasons for this/these reaction(s)?</td>
<td><strong>Prompts</strong>&lt;br&gt;Why do you think he/she/they would react in this manner?</td>
<td></td>
</tr>
<tr>
<td>How does this make you feel?</td>
<td>How does the thought that he/she/they could react in this manner make you feel?</td>
<td></td>
</tr>
<tr>
<td>How do you cope with negative reactions?</td>
<td>Did you experience similar reactions before you were diagnosed?</td>
<td>Did you experience similar reactions for any other reason before you were diagnosed?</td>
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<tr>
<td>------------------------------------------</td>
<td>---------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
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<tr>
<td>Did you experience similar reactions before you were diagnosed?</td>
<td>Core Question 2</td>
<td>Core Question 2</td>
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<tr>
<td><strong>Core Question 2</strong></td>
<td><strong>Core Question 2</strong></td>
<td><strong>Core Question 2</strong></td>
</tr>
<tr>
<td><strong>Aware of serostatus</strong></td>
<td><strong>Aware of serostatus</strong></td>
<td><strong>Unaware of serostatus</strong></td>
</tr>
<tr>
<td>What about close family members? How do they react?</td>
<td>How do you think your close family members will react?</td>
<td>How do you think you friends would react to your serostatus?</td>
</tr>
<tr>
<td><strong>Prompts</strong></td>
<td><strong>Prompts</strong></td>
<td><strong>Prompts</strong></td>
</tr>
<tr>
<td>Why do you think they react in this manner?</td>
<td>Why do you think he/she/they would react in this manner?</td>
<td>Why do you think he/she/they would react in this manner?</td>
</tr>
<tr>
<td>How does this make you feel?</td>
<td>How does the thought that he/she/they could react in this manner make you feel?</td>
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<tr>
<td>How do you cope with negative reactions?</td>
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<td></td>
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<tr>
<td>Did you experience similar reactions before you were diagnosed?</td>
<td></td>
<td>Have you experienced similar reactions for any other reason before you were diagnosed?</td>
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<table>
<thead>
<tr>
<th>Core Question 3</th>
<th>Core Question 3</th>
<th>Core Question 3</th>
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<tr>
<td><strong>Core Question 3</strong></td>
<td><strong>Core Question 3</strong></td>
<td><strong>Core Question 3</strong></td>
</tr>
<tr>
<td><strong>Aware of serostatus</strong></td>
<td><strong>Aware of serostatus</strong></td>
<td><strong>Unaware of serostatus</strong></td>
</tr>
<tr>
<td>And what are the common reactions of your friends to your serostatus?</td>
<td>How do you think you friends would react to your serostatus?</td>
<td></td>
</tr>
<tr>
<td><strong>Prompts</strong></td>
<td><strong>Prompts</strong></td>
<td><strong>Prompts</strong></td>
</tr>
<tr>
<td>Why do you think they react in this manner?</td>
<td>Why do you think he/she/they would react in this manner?</td>
<td></td>
</tr>
</tbody>
</table>
**SAY – The next set of questions focus around your experiences of when you were initially tested and diagnosed with HIV/AIDS.**

<table>
<thead>
<tr>
<th>Core Questions</th>
<th>Responses/Notes</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Will you please describe to me how you were approached to take the test for HIV?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
2. After results came positive, how was this relayed to you?

3. Is there anything you wish was done differently?

SAY – I will now like to change the focus of our discussion to your experiences with healthcare providers since diagnosis

<table>
<thead>
<tr>
<th>Questions</th>
<th>Responses/Notes</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core Question</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Can you describe some common reactions of healthcare providers such as doctors who have been involved in your treatment?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prompts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>– Have you experienced any difference in the way in which you are treated at general hospitals like Colonial War Memorial Hospital/Lautoka Hospital and the reproductive health clinics that you attend?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>– Apart from your seropositive status, can you suggest some other reasons why they/he/she may treat you like this?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Core Question</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. What about reactions of nurses towards you?</td>
<td></td>
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</tr>
<tr>
<td>Prompts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>– Have they/ has he/she ever disclosed to others that you are positive without your permission?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
How will you describe the way in which your medical records are stored and handled?

Have you experienced any difference in the way in which you are treated at general hospitals like Colonial War Memorial Hospital/Lautoka Hospital and the reproductive health clinics that you attend?

Apart from your seropositive status, can you suggest some other reasons why they/he/she may treat you like this?

SAY – Earlier you mentioned that you are _______________ (QUOTE FROM DEMOGRAPHICS NOTED EARLIER – RELIGIOUS AFFILIATION)

<table>
<thead>
<tr>
<th>Question</th>
<th>Responses/Notes</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core Question</td>
<td>How do you think your religion views HIV/AIDS and a person living with HIV/AIDS?</td>
<td></td>
</tr>
<tr>
<td>Prompts</td>
<td>Do you think this view of your religion is reflected by your religious leader(s)?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>What effect does this view have on you?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>How do you cope with negative reactions?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Were you ever treated like this before you were diagnosed with HIV/AIDS?</td>
<td></td>
</tr>
</tbody>
</table>
[DO – ASK THE FOLLOWING QUESTIONS IF THE PARTICIPANT WAS EMPLOYED/IS CURRENTLY EMPLOYED.]

SAY – Earlier you shared with me that you are/were employed as a ____________________
(QUOTE FROM DEMOGRAPHICS NOTED EARLIER - OCCUPATION)

<table>
<thead>
<tr>
<th>Question</th>
<th>Responses/Notes</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Core Question</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Can you describe an experience of your current/previous employer towards your seropositive status?</td>
<td></td>
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<tr>
<td><strong>Prompts</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>– Why do you think they react/will react in this manner?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>– How do you cope/do you think you will cope with negative reactions?</td>
<td></td>
<td></td>
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<tr>
<td>– Have he/she/they ever treated you like this before your diagnosis?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Core Question</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How do you think your colleague(s) would react/would have reacted if they knew that you were HIV positive/have AIDS?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Prompts</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>– Why do you think they react/will react in this manner?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>– How do you cope/do you think you will cope with negative reactions?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>– Have he/she/they ever treated you like this before your diagnosis?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Core Question</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amongst the reactions that you have described today, which ones have you experienced the greatest difficulty in coping with?</td>
<td></td>
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</tr>
<tr>
<td>Whose reactions to your seropositive status would matter to you the most?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**[Section 5 - Psychosocial Reactions to Diagnosis ]**

**SAY** - The next set of questions that I will ask focus on your self-esteem. Self-esteem is how people think or evaluate themselves as. It is like a rating that you give yourself.

<table>
<thead>
<tr>
<th>Core Questions</th>
<th>Responses/Notes</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Now on a scale of 1 – 10, with 10 being really high self esteem</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Core Question**

1. How would you best describe your self-esteem before you were diagnosed with HIV/AIDS?

**Prompts**

- Why did you give yourself this rating?
- Can you describe some of the emotions or feelings you attached to yourself?

**Core Question**

2. How would you best describe your self-esteem after you were diagnosed with HIV/AIDS?

**Prompts**

- Why did you give yourself this rating?
- Can you describe some of the emotions or feelings you attached to yourself?

**Core Question**

3. How would you best describe your self-esteem right now?

**Prompts**

- Why did you give yourself this rating?
Can you describe some of the emotions or feelings you attached to yourself?

Core Question

4. What effects if any, do the reactions that we have discussed today towards you have on how you feel about yourself?

5. How has your self-esteem affected your behavior in terms of taking care of yourself or seeking help?

[Conclusion]

<table>
<thead>
<tr>
<th>Core Question</th>
<th>Responses/Notes</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>You have shared a lot of your emotions and experiences with me today. Taking all these into consideration how well equipped do you think you are to deal with issues arising from your serostatus?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>This is all I have prepared for this interview. Is there anything else you would like to add?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SAY - Once again thank you for your time and participation in this study. I really appreciate your openness and honesty during our discussion. If you need to explore any of these issues further, I can provide you with a list of services that you can seek and individuals you can contact. I will also leave a copy of this list with the person who has assisted in recruiting you.

[DO – PROVIDE CONTACTS]

I will be giving you a fake name for this interview, is there anything that you particularly want to be called?

[DO – NOTE THE PREFERED NAME]

SAY - Goodbye. Have a nice day!
Stage 2 – Survey of Public Perception

You are requested to participate in a study by Shazna Buksh, Master of Arts Student, Division of Psychology, at the University of the South Pacific. Your participation in the study is entirely voluntary. Please read the information given below and ask questions if you cannot understand anything, before deciding whether or not to take part in the study.

Purpose of Study

The main aims of the study include:

1. To identify the attitudes within young adults towards People Living With HIV/AIDS (PLWHA) and to identify some of the contributing factors for shaping these attitudes of young adults towards PLWHA.
2. To identify some of the psychological and behavioural responses to attitudes towards PLWHA within young adults.

Importance of the Study

Information derived from this study will help make people making policies aware of the needs of young adults like you in Fiji, especially regarding the forms of support that young adults need in safeguarding themselves from contracting HIV/AIDS. It is extremely important to me that you answer all questions honestly and to the best of your ability. Your contribution will be much appreciated.

Method

After reading the consent form, and giving your written consent to participate in the study, you will be asked to answer a questionnaire which will require 30 – 40 minutes of your time. The questionnaire will include questions regarding the following characteristics:

a. Knowledge about transmission of HIV/AIDS.

b. *Attitudes towards people living with HIV/AIDS.

*There are no “right” answers, the researcher is only interested in your views on the above issues.
Privacy and Confidentiality

The researcher respects your privacy and will undertake the following measures to protect your identity:

1. You are not required to write your name on the questionnaire or to sign the consent form.
2. The only person who will have access to the questionnaire is the researcher and therefore even if your peers or supervisors see you in this room, there is no way they can find out what your answers were.
3. There are a number of tertiary and vocational institutions who are participating in this survey, making it impossible to track individual participants like you.
4. After you submit the filled out questionnaire, the questionnaire will be given an Identification (ID) number, after this point the ID number assigned will be used for analysing of results.

Your Rights to Participation and Withdrawal

- Your participation in this survey is entirely VOLUNTARY, which means you can choose whether or not you want to participate in the survey. Your choice will not affect your relationship with the institution that you are enrolled into or other services that you are entitled to.

- If you give consent to participate, you can choose to stop answering questions when you want to and refuse to answer any questions that you don’t want to answer.

Consent

I have read and understand the information provided above. I have been given the chance to ask any questions that I may have and all of the questions have been answered to my satisfaction. By signing below, I give my consent to participate in the research that this Consent Form describes.

_____________________________________                                           _________(Date)

If you have any additional questions regarding the research, please do not hesitate to contact me on:

Email: shazna_buksh@yahoo.com                                           Ph: (679) 3232100
APPENDIX E
STAGE 2 - SURVEY QUESTIONNAIRE

Thank you for agreeing to participate in this study. Before you start I wish to mention a few things:

6. Please take your time to respond thoughtfully and truthfully to the questions.
7. Feel free to ask for clarifications if you do not understand any of the questions.
8. Remember there are no “right” or “wrong” answers; I am interested in your experiences and your views, whatever they might be.
9. And be assured that your anonymity will be carefully protected therefore, it is important that you respond thoughtfully and honestly.

Please sign below if you wish to proceed with the survey.

<table>
<thead>
<tr>
<th>Consent</th>
</tr>
</thead>
<tbody>
<tr>
<td>I agree to complete the questionnaire and do so in a completely <em>voluntary</em> manner. I understand that my responses will be kept confidential</td>
</tr>
<tr>
<td>Signature _____________________                                            Date: _____________</td>
</tr>
</tbody>
</table>

Please place a tick in the columns on the right or write in the space provided to indicate your response.

1. SEX            2. AGE: __________

    Female [ ] Male [ ]

3. Ethnic Affiliation:

    Ethnic Fijian [ ] Indo-Fijian [ ]

4. Religious Affiliation (*PLEASE SPECIFY denomination in the column on the right.*)

    Christian [ ]
    Hindu [ ]
    Muslim [ ]

5. What is the program of study you are currently enrolled in?

    Trade & Commerce [ ]
    Medicine & Nursing [ ]
    Police Officers (New Recruits) [ ]
    Teacher Training [ ]

6. Marital Status:

    Single [ ]
    Married [ ]
    Living Together [ ]
    Widowed [ ]
    Divorced [ ]
    Separated [ ]
In your opinion what are some of the ways a person can get infected with HIV? Please respond by ticking the answers on the right column that you think are **ways in which a person can get infected with HIV**.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>French kissing or deep kissing a HIV positive person.</td>
</tr>
<tr>
<td>2</td>
<td>Sharing toilets with a HIV positive person.</td>
</tr>
<tr>
<td>3</td>
<td>Touching a HIV positive person.</td>
</tr>
<tr>
<td>4</td>
<td>Sleeping in the same room as a HIV positive person.</td>
</tr>
<tr>
<td>5</td>
<td>Not using condoms during sexual intercourse with a HIV positive person.</td>
</tr>
<tr>
<td>6</td>
<td>Sharing cigarettes with HIV positive person.</td>
</tr>
<tr>
<td>7</td>
<td>Breastfeeding (HIV positive mother to child).</td>
</tr>
<tr>
<td>8</td>
<td>Mosquito bites.</td>
</tr>
<tr>
<td>9</td>
<td>Sharing nail clippers or hair cutting scissors.</td>
</tr>
<tr>
<td>10</td>
<td>Contact with sweat of a HIV positive person.</td>
</tr>
<tr>
<td>11</td>
<td>Transfusion of contaminated blood.</td>
</tr>
<tr>
<td>12</td>
<td>Sharing needles with a HIV positive person.</td>
</tr>
<tr>
<td>13</td>
<td>Sharing clothes with a HIV positive person.</td>
</tr>
<tr>
<td>14</td>
<td>Contact with the saliva of a HIV positive person.</td>
</tr>
</tbody>
</table>
The table below describes some attitudes towards people living with HIV/AIDS (PLWHA). Please indicate by writing the appropriate number in the column on the right, how much you agree or disagree with the following statements. Given below are the options I want you to use.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

15. Only people who don’t follow religious teachings get HIV/AIDS.
16. I don’t want to share cooking and eating utensils with PLWHA because I can get HIV.
17. I will not share food with PLWHA because I can get infected.
19. I don’t want to share toilets with PLWHA because I can get HIV.
21. I will not shake hands or hug PLWHA because I can get infected.
22. Only women who sleep around and have many partners get HIV.
23. PLWHA should be ashamed of themselves.
24. I don’t want to be around PLWHA because I can get infected from mosquito bites.
25. PLWHA should not be allowed to work with children because you can’t trust them.
26. Getting infected from HIV/AIDS is a punishment from God for immoral behaviour.
27. PLWHA should be kept in a separate area/room because the infection can spread to others around them.
28. The Government should release the names of all PLWHA so that we can avoid them.
Please indicate by writing the *appropriate number* in the column on the right, how much you agree or disagree with the following statements. Given below are the options I want you to use.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

**IF** one of your close family members (e.g. parent, sibling, spouse e.t.c.) was HIV positive or had AIDS which of the following will apply to you?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>29</td>
<td>I will cut off all ties with him/her.</td>
</tr>
<tr>
<td>30</td>
<td>If I have the means and ability I will support him/her financially (money-wise).</td>
</tr>
<tr>
<td>31</td>
<td>People from my community will avoid contact with me.</td>
</tr>
<tr>
<td>32</td>
<td>I will ensure that he/she has access to all treatments offered.</td>
</tr>
<tr>
<td>33</td>
<td>People from my community will treat me badly because I am related to him/her.</td>
</tr>
<tr>
<td>34</td>
<td>I will accompany him/her to his/her health checkups.</td>
</tr>
<tr>
<td>35</td>
<td>I will be blamed for him/her getting infected.</td>
</tr>
<tr>
<td>36</td>
<td>I will take care of him/her when he/she gets sick.</td>
</tr>
<tr>
<td>37</td>
<td>I will avoid contact with him/her to prevent getting infected.</td>
</tr>
<tr>
<td>38</td>
<td>People from my community will look down upon my family.</td>
</tr>
<tr>
<td>39</td>
<td>I will stand up for him/her if people treat him/her badly.</td>
</tr>
<tr>
<td>40</td>
<td>People from my community will gossip about my family.</td>
</tr>
</tbody>
</table>
APPENDIX F
COMPUTING SCORES FOR STAGE 2 QUESTIONNAIRE

Items for Scoring Scales in Questionnaire.

<table>
<thead>
<tr>
<th>Scale</th>
<th>Items on Questionnaire</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge on modes of transmission of HIV/AIDS Score</td>
<td>1, 2, 3, 4, 5*, 6, 7*, 8, 9, 10, 11*, 12, 13, 14</td>
</tr>
<tr>
<td>Value-Driven Stigma Score</td>
<td>15, 18, 20, 22, 23, 25, 26</td>
</tr>
<tr>
<td>Fear-driven Stigma Score</td>
<td>16, 17, 19, 21, 24, 27, 28</td>
</tr>
<tr>
<td>Anticipated Secondary Stigma Score</td>
<td>31, 33, 35, 38, 40</td>
</tr>
<tr>
<td>Support for a hypothetical HIV+ Family member Score</td>
<td>29*, 30, 32, 34, 36, 37*, 39</td>
</tr>
</tbody>
</table>

*Note: *Items are reverse coded.

Calculation

All reverse coded items are to be re-computed before computing scores for the scales.

For each scale, add participant’s scores for all items and then divide by the number of items on the scale.