

Full Length Research Paper

Curtailing the stigma associated with HIV/AIDS through mandatory testing: A management perspective

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HIV/AIDS continues to ravish society and yet legislators and health care practitioners overlook the impact the disease has on a social level. Advocating for mandatory HIV/AIDS testing as a means of curtailing stigma is a necessity. This paper proposes that mandatory HIV/AIDS testing be considered as a means of curtailing the spread of stigma. The paper discusses the causes of stigma, the ways in which stigma is spread and a solution as to how stigma can be abated through mandatory HIV/AIDS testing.

Key words: Stigmatisation, discrimination, mandatory HIV/AIDS testing.

INTRODUCTION

'Stigma remains the single most important barrier to public action. It is the main reason too many people are afraid to see a doctor to determine whether they have the disease, or to seek treatment if so. It helps make Acquired Immune Deficiency Syndrome (AIDS) the silent killer, because people fear the social disgrace of speaking about it, or taking easily available precautions. Stigma is a chief reason the AIDS epidemic continues to devastate societies around the world' (Ban Ki-moon, 2008). AIDS-related stigma refers to prejudice, negative attitudes, abuse and maltreatment directed at people living with Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS). The consequences of stigma are wide-ranging: being shunned by family, peers and the wider community, poor treatment in healthcare and education settings, an erosion of rights, psychological damage and a negative effect on the success of HIV testing and treatment (Averting HIV/AIDS (Avert), 2011:1).

In recent year, stigma has fuelled the transmission of HIV/AIDS, greatly increasing the negative impact associated with the epidemic. HIV-related stigma continue to be manifest in every country and region of the world, creating major barriers to preventing further infection,

alleviating impact and providing adequate care, support and treatment.

The stigma associated with HIV has silenced open discussion, both of its causes and of appropriate responses. Visibility and openness about HIV/AIDS are prerequisites for the successful mobilization of government, communities and individuals to respond to the epidemic (Joint United Nations Programme on HIV/AIDS (UNAIDS), 2005:4). Subdual or suppression of stigma encourages denial that there is a social problem that requires an urgent response. This deliberate suppression causes people living with HIV/AIDS to be seen as the means to the epidemic, rather than as a possible solution to kerbing and managing the spread of the epidemic.

Stigmatization associated with AIDS is underpinned by many factors, including lack of understanding of the illness, misconceptions about how HIV is transmitted, lack of access to treatment, irresponsible media reporting on the epidemic, the incurability of AIDS and prejudice and fears relating to a number of socially sensitive issues including sexuality, disease and death and drug use (UNAIDS, 2005:4).

Stigma can lead to discrimination and other violations of human rights which affect the well-being of people living with HIV in fundamental ways. In countries all over the world, there are well-documented cases of people living with HIV/AIDS being denied the right to health-care, work, education, and freedom of movement, among

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others (Human Rights Watch, 2003:1; Busza, 1999).

It may be argued that emphasis on curtailing the spread of stigma at the present stage of the epidemic may be a periphery concern and that all effort should be invested in finding a cure and creating a vaccine. The need to curtail the spread of stigmatisation is a concern as urgent as formulating a vaccine. Delay in either process would continue to result in the loss of lives. The author postulates the curtailing of the spread of HIV/AIDS through mandatory HIV/AIDS testing. The paper reflects on mandatory HIV/AIDS as a means of curtailing stigmatisation and uplifting the treatment and awareness of individuals both positive and negative. It also suggests a possible method to coming to the aid of these individuals that often cannot speak out for fear of being identified as HIV positive or recognised as a sympathiser. It is proposed in this treatise that mandatory HIV/AIDS testing could be a possible method of curtailing the spread of pandemic.

Problem statement

The rising trend in stigma related abuse surpasses the destructive nature of the HIV/AIDS disease. While HIV/AIDS is a virus that resides in the body of the person, stigma is a virus that resides in the mind of individuals. HIV/AIDS seethes on a compromised immune system stigma; rages on ignorance and fear- a trait that can be difficult to medicate. Unlike most other diseases stigma which is a social disease cannot be eradicated by the administration of a serum. Society that perpetuates this social disease needs to accept individuals, unlike themselves and share in their experience. Therefore, by implementing mandatory HIV testing each individual would be expected to undergo testing irrespective of their status. The stigma and the fear of being tested or labelled as HIV positive would be eliminated.

Research question

The following research questions will be considered:

- i. What is stigma in relation to HIV/AIDS?
- ii. How does stigma relate to HIV?
- iii. What are the various forms of stigma?
- iv. How does stigma encourage the spread of HIV/AIDS?
- v. How can mandatory HIV/AIDS testing curtail the spread of stigma?

The aim and objectives of the paper

The paper aims:

- i. To unpack what is understood by the term stigma in

relation to HIV/AIDS?

- ii. To clarify the various form of stigma experienced by HIV positive individuals.
- iii. To understand how HIV/AIDS encourages the spread of stigma.
- iv. To determine how mandatory HIV/AIDS testing would curtail the spread on HIV/AIDS.

METHODOLOGY

The paper is a meta-analysis, which relied on secondary sources of information. It is a qualitative study that is based on conceptual analysis. It considers mandatory HIV/AIDS testing from an "emic" perspective (author's viewpoint). The analysis has included a comparative review of literature relating to HIV/AIDS, stigma, Human Rights and mandatory testing. Curtailing the spread of stigma through mandatory HIV/AIDS testing has been discussed by examining literature that discusses stigma, and the impact sustained by individuals infected by HIV/AIDS. Literature was further probed to investigate the option of mandatory HIV/AIDS as a means of curtailing the spread of stigma.

THEORETICAL FRAMEWORK

Global consensus on the importance of tackling AIDS-related stigma was highlighted by the Declaration of Commitment adopted by the United Nations General Assembly Special Session on HIV/AIDS in June 2001. The Declaration states that confronting stigma is a prerequisite for effective prevention and care, and reaffirms that discrimination on the grounds of one's HIV status is a violation of human rights (UNAIDS, 2001). The labelling of other human beings diminishes their humanity and permits them to be treated in a less than human way (Madru, 2003:42).

Gender-based violence, stigmatization, and discrimination are examples of violation of the human rights of people living with HIV/AIDS and this, according to Parker and Aggleton, (2003) has been recognized increasingly as a central problem that impedes the fight against HIV/AIDS. Responses to HIV/AIDS can be placed on a scale of prevention, care and treatment, and the negative effects of stigma can be seen on each of these aspects of the response. Individuals should be able to seek and receive as the acronym suggests voluntary and confidential counselling and testing to identify their HIV status without fear of stigmatisation. Those who test HIV-negative are expected to receive prevention counselling so as to enable the individual to remain negative. Those individuals who test HIV-positive should receive available treatment and care, and prevention counselling. This very precise process encourages awareness, a practice that protect others from infection and individuals from reinfection. Ideally, people living with HIV/AIDS should be able to live openly and experience compassion and support within their communities similar to their uninfected counterparts. Their open example personalizes

the risk and experience to others, thereby aiding prevention, care and treatment efforts (UNAIDS, 2005:4).

A society that stigmatises cultivates an attitude that poses barriers at all stages of the preventative cycle by virtue of being, by definition, non-supportive and discriminative. The consequences related to HIV stigma have stagnate prevention and awareness efforts by making people afraid to find out whether or not they are infected or to seek information and counselling on how to reduce their risk of exposure to HIV. The constant fear of being suspected or identified as HIV positive and the need to avoid suspicion often result in not accessing life extending treatment (Madru, 2003:39). The overwhelming burden of stigma undermines the ability of individuals and communities to protect themselves. The fear of stigma also discourages people living with HIV from disclosing their HIV infection, even to family members and sexual partners. Non-disclosure of HIV-infection within families often leads to lack of forward planning, leaving orphans and other bereaved dependents economically deprived once the bread winner dies and often marginalized, if their association with AIDS becomes known. The secrecy that surrounds HIV infection and results from fear of stigma causes people to imagine that they are not themselves at risk of HIV infection.

The stigma associated with HIV/AIDS also suggests that people living with HIV/AIDS are much less likely to receive care and support. Even those not actually infected but associated with the infected, such as spouses, children and caregivers suffer stigma. This stigma needlessly increase the personal suffering associated with the disease. The personal suffering associated with stigma has been described by some writers as 'internalized' stigma. This process of self-loathing or stigmatisation may also prevent people living with HIV from seeking treatment, care and support and exercising other rights, such as working, attending school etc. Such personal suffering can have a powerful psychological influence over how people with HIV see themselves and adjust to their status, making them vulnerable to blame, depression and self-imposed isolation.

This may be exacerbated in cases where individuals are members of particular groups that are already isolated and stigmatized such as injecting drug users, men who have sex with men, and sex workers or migrants. In settings where medical care is available, stigma may increase the difficulty of adhering to treatment regimens. These patterns of non-disclosure and difficulty in seeking treatment, care and support themselves feed stigma, reinforcing the cycle. This is because stereotypes and fear are perpetuated when communities often only recognize people living with HIV when they are in the debilitating and symptomatic final stages of AIDS, and denial and silence reinforce the stigmatization of these already-vulnerable individuals.

'Stigma devalues and discredits people generating

shame and insecurity. Stigma is harmful both in itself, since it can lead to feelings of shame, guilt and isolation of people living with HIV, and because it promotes people to act in ways that directly harm others and deny the access to services and entitlements such as unjust treatment is tantamount to a violation of human rights' (Marumo, 2006).

19 December, 2008 commemorated the anniversary of the death of Gugu Dlamini and the unveiling of her tombstone that bears the prominent red ribbon. Gugu Dlamini was stoned to death when neighbours discovered she was HIV positive (Sayagues, 2008). Gugu died as a result of stigma like many other South Africans. Gugu was abused, beaten and stigmatised by her community because of her status and vulnerability.

The surmounting number of incidences against HIV positive individuals goes unnoticed. Calling for mandatory testing would place Gugu's neighbours in her position. Each would have to be tested in order to decide whether he/she is positive or negative. The rationale for the study is if the entire South African population is asked to be mandatorily tested, every wife, husband, and neighbour would be compelled to deal with the stigma until it no longer exists.

Knowledge of one's status would contribute to South Africa's management of the epidemic, as more individuals take responsibility for their actions. Self-imposed prevention measures would insure that fewer people are infected by individuals ignorant of their status. Data has indicated that the knowledge of one's HIV status reduces the risk of sexual HIV transmission by 68% (Harvey, 2006). Mandatory testing would compel every man, woman and child to be tested whilst test results remain confidential. No individual would be excluded allowing very little room for stigma.

Proposing mandatory testing would be beneficial in getting society involved in their personal health and the health of fellow South Africans. The benefits derived from such testing would help reduce the spread of stigma by placing every individual in a similar position of accountability and exposure.

In order to identify potential solutions to HIV-related stigma, it is necessary to understand what is meant by these concepts, to describe how they are manifested, and to analyse the relationships between them.

Stigma

Stigma has been described as a dynamic process of devaluation that 'significantly discredits' an individual in the eyes of others. The qualities to which stigma adheres can be quite arbitrary for example, skin colour, manner of speaking, or sexual preference. Within particular cultures or settings, certain attributes are seized upon and defined by others as discreditable or unworthy (Wood, n.d: 5). Goffman (1963) defines stigmas as an undesirable or

discrediting attribute that an individual possesses, thus reducing that individual's status in the eyes of society. Goffman (1963) further explains that stigma can result from a particular characteristic, such as a physical deformity, or it can stem from negative attitudes toward the behaviour of a group, such as homosexuals or commercial sex workers.

HIV-related stigma as stated by Parker and Aggleton, (2003) is multi-layered, tending to build upon and reinforce negative connotations through the association of HIV/AIDS with already-marginalized behaviours, such as sex work, drug use, and homosexual and transgender sexual practice. It also highlights fears of other vulnerable groups, such as prisoners, migrants and elderly. Individuals living with HIV are often believed to deserve their HIV-positive status as a result of having done something 'wrong'.

How stigma does relates to HIV

The fear of contamination combined with negative connotations associated with individuals who are infected have led to high levels of stigma surrounding HIV and AIDS. Factors that are known to contribute to HIV/AIDS-related stigma includes:

- i. HIV/AIDS is a fatal disease, without a known cure and therefore people react to it with caution and ignorance.
- ii. HIV infection is negatively associated with behaviour (such as homosexuality and promiscuity) and social standing (such as poverty and race) that are already stigmatised in many societies.
- iii. Most people become infected with HIV through sex, which often raises moral debate around HIV/AIDS and the association with homosexuality, drug addiction, prostitution or promiscuity.
- iv. The lack of awareness combined inaccurate information about how HIV is transmitted creates misperceptions as to the risk associated with the disease.
- v. HIV infection is often thought to be the result of personal irresponsibility and negligence.
- vi. Religious or moral beliefs lead some people to believe that being infected with HIV is the result deserving of punishment that warrants cleansing or purification.
- vii. The effects of AIDS on individuals' physical appearance (lesions, rapid weight loss and change in pigmentation) can result in forced disclosure and discrimination based on appearance.

The fact that HIV/AIDS is a relatively new disease, also contributes to the stigma attached to it. The fear surrounding the emerging epidemic in the 1980s is still fresh in many people's minds. At that time very little was known about the risk of HIV transmission, which made people, scared of those infected due to fear of contagion (Avert, 2011:1).

Media can to a certain extent be held responsible for the spread of HIV-related stigma. One can view examples of alarming 1980s public health advertisements from the UK and Australia associating AIDS with death. The lack of concern and awareness as to individuals' rights at the very early stage of the disease has contributed to a culture of acceptable abuse and stigmatisation. The powerful images that were used reinforced and legitimised stigmatisation. HIV/AIDS was seen as punishment apocalyptic in nature (Avert, 2011:1).

Forms of stigma

Stigma is most often expressed in language. Since the beginning of the epidemic, the powerful metaphors associating HIV with death, guilt and punishment, crime, horror and alienation have compounded and legitimated stigmatization (UNAIDS, 2005:7). Language being the easiest form of expression is often swift carrying with it very little evidentiary proof unlike physical violence.

Stigma takes many other forms example self-hatred, felt-stigma and enacted stigma. Self-stigma as explained by Smart (2009:124) include the feelings of self-hatred, shame, blame etc. Self-stigma refers to the process whereby people living with HIV impose feelings of difference, inferiority and unworthiness on themselves. The manifestations of self-stigma include: dejection, self-doubt, guilt and inferiority. The individual may experience moments of low self-esteem and loss of confidence social withdrawal and isolation. Self-exclusion from services and opportunities, and refusing help that is offered, hatred towards siblings and family members that are uninfected (Smart, 2009:124). Self-stigma is often worse when an individual is first diagnosed with no or limited emotional support at the time of diagnosis, feelings of self-hate and blame are exacerbated for seeming to be negligent.

Felt-stigma can be blatant or subtle, but it is always value-laden and compromises the human rights of those affected. Felt-stigma is characterised by pointing out or labelling differences, shunning, isolation, rejection and overt abuse (Hope, 2009:73).

The effects of enacted stigma are wide-ranging and may include actions taken by the person concerned in response to the stigma, and actions taken against the person concerned, which are discriminatory (Smart, 2009:126). Felt and enacted stigma can take many forms including; physical and social isolation from family, friends and community, gossip, name-calling, insults and loss of rights and decision-making power. Enacted stigma bears consequences for the individual that is labelled as HIV positive; the loss of employment, stigma based on appearance, dropping out of school, violence, loss of perceived 'manhood' or 'womanhood' (Smart, 2009:126).

Stigma is deeply rooted, functioning within the values of everyday life. Although images associated with AIDS

vary, they are associated in a particular way so as to ensure that HIV/AIDS-related stigma is embedded, reinforcing social inequalities. These inequalities particularly include those linked to gender, race and culture, and sexuality. Thus, for example, men and women are often not dealt with in the same way when infected or believed to be infected by HIV: a woman is more likely to be blamed even when the source of her infection is her husband, and infected women may be less likely to be accepted by their communities (Jackson, 2002:88).

'This process is linked to long-standing gender inequalities supported by ideas about masculinity and femininity that have historically resulted in women being blamed for the transmission of sexually transmitted infections of all kinds, and have guilt imputed to them out of assumed promiscuity' (USAID/Synergy, 2004:20). Similarly, the attribution of blame to homosexual and transgendered people builds on long-standing stigmatization related to assumptions about their lifestyles and sexual practices. Racial and ethnic stereotyping also underpins AIDS-related stigma.

The epidemic has been characterized, by individuals' interpretation of 'African polygamy'. These so called insights are often based on negative opinions surrounding polygamy which is often based on the western world's concept of 'immoral behaviour'.

Through these associations, stigma has become linked to power and domination creating and reinforcing inequality. Victims of stigma are made to feel inferior and devalued whilst placing the oppressor in a dominant and repressive role. The association of HIV with already-stigmatized groups and practices intensifies these pre-existing inequalities, reinforcing the production and reproduction of inequitable power relations. Pre-existing stigma compounds HIV-related stigma, not simply because already-stigmatized groups are further stigmatized through association with HIV, but also because individuals living with HIV may be assumed to belong to marginalized groups (ICASO, 2007:16).

People HIV-related stigmatization, is a process by which people living with HIV are discredited. It may affect both those infected or suspected of being infected by HIV and those affected by AIDS by association, such as orphans or the children and families of people living with HIV (ICASO, 2007:15).

Means through which stigma encourage the spread of HIV/AIDS

Stigma enables people to believe they are not at risk for HIV. People who express stigmatising attitudes about HIV often have retained misinformation about the transmission of HIV. A recent survey conducted by MacPherson (2011:3) in urban Blantyre, Malawi, found that anticipated stigma was common. Of the 216

participants, 193 (89%) indicated a stigmatizing attitude or anticipated stigma in response to at least one question. Nearly one-quarter (47/216, 22% - question 11) feared verbal abuse should they be diagnosed HIV-positive and 14% (29/216 – question 13) thought they would be side-lined by friends. A high proportion (62.0%) of participants totally agreed that pregnant women should be prevented from having babies (MacPherson, 2011:3).

How does stigma encourage the spread of HIV/AIDS? The scorn shown by individuals fuels the spread of the infection because it keeps HIV positive people from finding out or revealing their status, getting treatment, or protecting their partners. Campbell (2005) identified six causes of stigma which perpetuate the spread of HIV, namely Fear, HIV/AIDS information, the fact that HIV/AIDS is linked to sex, Poverty, lack of open discussion and lack of HIV/AIDS services.

Fear of the possibility of acquiring the disease due to the overwhelming presence of the disease or guilt arising out of one's own poor sexual practices generates fear towards the disease. This fear is transposed to those who remind them of the danger. The hatred or associations towards the disease becomes a hatred for the person who has the disease. The victim of such stigma often denies that they have HIV/AIDS. The need to fit into society, perpetuated by denialism, forces individuals not to access medical treatment for fear of being identified with the disease. Lack of treatment, fear of disclosure, harbours the disease spreading infection.

HIV/AIDS information or rather the lack thereof allows society to remain ignorant and fearful of the disease. Knowledge and awareness as to how HIV is and is not transmitted, the difference between HIV and AIDS, how long people with HIV or AIDS can expect to live, the fact that people living with HIV/AIDS can be productive members of society and how to support and care for someone with HIV or AIDS is vital (Campbell, 2005:21).

The fact that HIV/AIDS is transmitted by or linked to sex, results in a substantial cause of stigma. Many societies perceive sex and sexual relations as immoral and therefore taboo. HIV/AIDS is recognised as a shameful disease for its association with sex. The desire to have sex and the lack of open discussion forces individuals to have sex in secrecy exposing them to the disease and sexual abuse.

The lack of open discussion amongst parents and youth results in loss of sharing vital life experiences. It is usually too late when parents are forced to share their experiences often at the death bed of an HIV infected child or at the delivery or abandonment of a grandchild. Poverty should not be seen as reason not to discuss sexuality or adulthood.

Poverty fuels the spread of HIV/AIDS and, communities and individuals that are burdened to care for HIV infected loved ones are stigmatised for caring for a loved one that has been infected. The need for treatment drives these households into poverty. This type of poverty unlike

unemployment is seen as deserving, deserving for indulging in immoral sexual behaviour. Patriarchal communities often choose not to assist victims of the disease for the need to uphold their own moral values are perceived as critical (Campbell, 2005:35). The lack of HIV services further prohibits access to treatment and awareness.

The lack of HIV services or the shortage results in patients being sent home often to care givers who in turn are afraid of infection. The combined effect of: fear, poverty, lack of information and innate stigma result in the patient not receiving the best of treatment. Ignorance in handling the patient results in the infection of caregivers or loved ones who are unable to identify signs of infection.

How does stigma affect the management of HIV/AIDS?

The question may arise as to how does stigma affect the management of HIV/AIDS. One may argue that HIV/AIDS related stigma is a concept that refers to prejudice, directed at persons perceived to have AIDS or HIV and that the impact of stigma should drive the management of the disease rather than perpetuate the disease. Regrettably it is not the case stigma effects prevention.

Effects of stigma on prevention

The effects of stigma on prevention are perpetuated by the six forms of stigma as described by Campbell (2005). The weight of these six forms deludes individuals in not accessing treatment and support required for the management of the disease. These six forms include the lack of AIDS care, social support and empathy.

AIDS care

HIV/AIDS prevention is hampered by stigma in numerous ways. The stigma associated with carrying or being in possession of HIV/AIDS drugs prevent HIV infected individual from commencing treatment (Okechukwu, 2009:65). Stigma may limit or prevent the stigmatized individual's access to care. Access to care according to Okechukwu (2009:65) is affected by stigma in one of three ways, namely barrier to care for HIV positive individuals, reluctance of health care providers to treat individuals with HIV and stigmatization of provider of ancillary or support services to PLWHA.

The findings made by Kinsler in 2007 confirm Okechukwu (2009) suggestion that the low access to care are of a particular importance because lack of access or delayed access to care may result in clinical presentation at more advanced stages of HIV disease thus preventing adequate management of the disease.

Kinsler (2007:584) recommends that interventions are needed to reduce perceived stigma in the health care setting. Educational programs and modelling of non-stigmatising behaviour can teach health care providers to provide unbiased care.

Social support

The manner in which HIV-positive people successfully manage HIV stigma are influenced by the extent of social support and social resources that they have available in their lives. Social support within the domain of health refers to support systems that provide assistance and encouragement to individuals with physical or emotional disabilities in order that they may better cope. Informal social support is usually provided by friends, relatives, or peers while formal assistance is provided by church groups, professional caregivers or health care practitioners (Breskin, 2007).

Social resources are the social support that one recognises as being available in one's life. Perceived social support refers to the beliefs one has about the relationships in one's life (Galvan, 2008:423-426). Several benefits have been found to be associated with perceived social support. Individuals with high levels of perceived social support describe themselves in more positive and less negative terms compared to others (Pierce et al., 1996: 434-451). These positive self-evaluations in turn promote the development of more effective coping skills that can prove effective when confronted with life changing situations. An added benefit of social support according to Galvan (2008:423-426) is that it may allow individuals to deal more effectively with life stressors because they may believe that others will be there to help them if necessary. This sense that others are available to provide assistance can result in enhancing one's ability to cope with life challenges.

These behaviour patterns are consistent with social support theory that hypothesizes that social support serves to protect individuals against the negative effects of stressors by leading them to interpret stressful occasions less negatively (Lazarus and Folkman, 1984). This theo-retical perspective focuses on an individual's perception of the availability of support for a stressful situation. When working from such a theoretical framework, the lack of or the sudden loss of social support in the context of an HIV positive individual can be devastating resulting in withdrawal, depression and the will to live (Hoffman, 1996; Peltzer and Shikwane, 2011). The management of HIV/AIDS is strongly hampered by the impact of stigma, often manifesting itself through poor social practices.

Managing HIV stigma

HIV-positive people are forced to deal with the stigmatizing aspects of living with HIV through a number

of ways. Stigma management refers to the different strategies that can be used in addressing HIV-related stigma and have been described as ranging from reactive strategies to proactive strategies (Galvan, 2008:423-426). Reactive strategies are those that involve avoiding or lessening the effects of the stigma, such as concealment and selective disclosure. Proactive strategies, such as mandatory HIV/AIDS testing, are those that actually confront stigma.

Mandatory HIV/AIDS testing

This paper suggests the implementation of mandatory HIV/AIDS testing as a means of curtailing stigma. Given the high prevalence rates of HIV in many low-resource settings in Africa (UNICEF, 2011:1) an argument in favour of mandatory testing is sound. Opponents of mandatory testing have defined mandatory HIV/AIDS testing based on laws limiting the rights of individuals to bodily integrity. Suggesting that failure to comply with this testing could then have legal implications. Those who argue for mandatory testing generally do so in the interests of the 'public's health' (Austin-Evelyn, 2011:1).

Austin-Evelyn (2011:1) postulates that mandatory testing would promote the 'public good' by identifying new infections and beginning treatment, which has been proven to be a form of prevention in itself. Mass testing programmes have the potential to increase early detection and deter infection, thereby promoting safe sexual behaviour. Supporters of mandatory testing advocate that it is a justifiable infringement of an individual's right to bodily integrity and privacy as the benefits to society outweigh the individual cost.

Other opinions in favour of mandatory HIV/AIDS testing include that of Dr. Gilles van Cutsem from Médecines sans Frontières (MSF), who argues that mandatory testing for HIV and the initiation of treatment (commonly known as the test-and-treat strategy) are critical to reverse the current trend of increasing HIV infections (Odendal, 2011:1). Dr Janet Giddy, former HIV programmes manager at McCord Hospital concurs with Dr. Cutsem that HIV testing, with the use of pre and post-test counselling, should be carried out as it is for other diseases, such as malaria. She argued that HIV testing should be offered at every visit of a person to a health facility with the option of refusing instead of the current approach that requires people to come forward on their own accord if they wish to be tested (Odendal, 2011:1).

Odendal (2011:1) quotes Pholokgolo Ramothwala, an HIV activist and journalist who was initially opposed to mandatory testing for HIV but changed his view after witnessing the unnecessary deaths of many people around him who did not know their HIV status. He argued that mandatory testing was the only way to prevent this. Ramothwala, who has openly lived with HIV for the past 13 years, said: "As people living with HIV, we need to be

able to assist in stopping the spread of HIV but to do that we need to know our status." He said mandatory HIV testing could be likened to laws about wearing safety belts in cars, which limits human rights but protect people. "Why is it that we wait for people to be so sick with HIV that their bodies cannot recover, even if they start HIV treatment?"

Van Cutsem et al. (2011:1) speak of mandatory HIV/AIDS testing as means of stopping the spread of HIV/AIDS. Thus, mandatory HIV/AIDS testing in addition to curtailing the spread of HIV/AIDS would also curtail the spread of stigma.

Means of curtailing the spread of HIV/AIDS through mandatory HIV/AIDS

It may be argued that curtailing the spread of HIV/AIDS and stigma are unrelated. Literature suggests differently, and confirms that stigma perpetuates the spread of HIV/AIDS. By proposing mandatory testing the spread of HIV/AIDS and stigma would be curbed.

With society being asked to undergo an HIV/AIDS test, more individuals would become aware of their status and with such awareness, taking an HIV/AIDS test would be seen as common practice. The six causes of stigma as described by Campbell (2005:21) would gradually cease to occur.

Fear of being stigmatised or identified as HIV positive will no longer exist as testing would be mandatory. Laws enforcing non-disclosure should continue to be enforced with laws remaining in place mandatory tested individuals would not need to fear disclosure of their status, as for all intended purposes every individual within this context is either HIV positive or negative. The room for the spread of stigma would not be necessary as every individual will have the same status, that of 'tested'.

HIV/AIDS information would be easier to disseminate, and individuals would have the opportunity to access pre and post counselling by virtue of being tested. Joint United Nations Programme on HIV/AIDS (UNAIDS) / World Health Organisation (WHO) recommend that such testing be conducted only when accompanied by counselling for both HIV-positive and HIV-negative individuals and referral to medical and psychosocial services for those who receive a positive test result (UNAIDS, 2004:3).

These sessions would allow for discussion and information sharing, on both awareness and management of the disease. With awareness and management being discussed, the individual does not need to reveal his status of being either previously or newly tested for HIV/AIDS.

The fact that HIV/AIDS is linked to sex has many interpretations. This could imply that an individual has many sexual partners and is therefore stigmatised, or the

person wants to conceal his or her sexual activities and does not want to be tested for fear of being found out by a parent or guardian. These concerns would no longer threaten an individual of being stigmatised ones sexual habits or affiliations would no longer be the concern of the person that stigmatises as he or she will not be able to separate the sexually active from the non-sexually active. Reason to stigmatise based on sexual practices would be futile.

Poverty would no longer be an agent for the spread of HIV/AIDS Government would be given adequate notice based on accurate prevalence statistics derived from mandatory testing sites. Government would be given the opportunity to better plan and equip local medical facilities with necessary support. Eliminating poverty may be difficult. However, accessing treatment at a municipal will be one burden less.

The lack of open discussion would be a concern of the past. The frustration of sitting in the queue waiting ones turn to be tested would open discussion for the need to be tested or not. Pre and post counselling would encourage discussion, which would previously not have existed, had the opportunity to be tested not arisen.

Lack of HIV/AIDS services, the sixth causes of stigma according to Campbell (2005:21) would lie in the hands of Government. With quantifiable statistics at hand, Government would be forced to provide services as the needs arise. The question that may follow is that given the fact that mandatory HIV/AIDS testing may curtail the spread of HIV, is it ethical?

Ethical concerns

Mandatory HIV/AIDS testing is not a new practice and has been undertaken in many countries around the world. In Canada for instance since 2002 has required HIV testing of all persons aged 15 years and above who request Canadian permanent residency (such as immigrant and refugee persons) and temporary residence (such as migrant workers, students, and long-term visitors from designated countries). HIV screening, which takes place during the immigration medical examination carried out in sanctioned Canadian and foreign medical offices, is a mandatory component of Canada's immigration process. Until recently, little has been documented about the empirical functioning and consequences of the mandatory policy on persons tested and on health systems because the policy has not been systematically followed or reviewed since its introduction more than eight years ago (Bisaillon, 2010:1).

In the United States of America if you join the US military or the Foreign Service, you are tested not just on entry, but periodically. Immigrants to this country are tested for HIV and inmates in the federal prison system and in many state systems are often tested for HIV (Oluwafemi, 2011:47).

In a desk review undertaken by the International Labour Organisation (ILO) in 2009, eight South-East Asian countries (Cambodia, Indonesia, Malaysia, Myanmar, the Philippines, Singapore, Thailand and Vietnam) were pointed out that despite the existence of national laws and policies protecting workers against HIV-based discrimination and mandatory HIV testing in these countries, those that are mainly countries of origin permit and facilitate pre-departure health examinations of migrant workers, and these include an HIV test where required by the receiving country (ILO, 2009:7).

The UNAIDS (2004:3) recognises that many countries require HIV testing for immigration purposes on a mandatory basis and that some countries conduct mandatory testing for pre-recruitment and periodic medical assessment of military personnel for the purposes of establishing fitness.

From an ILO and International Organisation of Migration (IOM) perspective, however, any HIV testing related to entry and stay should be done voluntarily, on the basis of informed consent. Adequate pre-test and post-test counselling should be carried out, and confidentiality strictly protected (ILO, 2009:7).

There are various examples of mandatory testing that are uncontested and subsequently deemed acceptable. If one donates blood, for instance the donated blood is tested for HIV infection; pre-natal HIV testing is mandatory and is undertaken without resistance. Insurance companies require an HIV test, when assessing premium rates, the insuree agrees to undergo the test prior to entering into insurance agreement. When obtaining a visa for entering into certain countries like the United States of America and Canada, Embassies inquire into the status of the applicant or in the case of Canada request an HIV test.

The question that follows is; why is mandatory testing ethical for the promotion of one's self-interest but not ethical for another? Taking the ethical stance may appear heroic when advocating Human Right violations, yet individuals that advocate against mandatory testing agree to undergo mandatory testing for their own benefits whether going on vacation, seeking new employment or choosing to have a healthy baby. Activist advocating against mandatory HIV testing need to acknowledge, that the benefits of mandatory HIV testing outweigh the debate.

Conclusion

The choice in advocating against HIV test lies in the hands of the individuals that either stigmatise or advocate against stigmatisation. Individuals need to see beyond the soap box and look into the eyes of the infected. HIV/AIDS ravishes the body and mind, while stigma ravishes your home and personal space. To allow individuals to continue to live life prejudiced by a disease

that does not let up and a society that enjoys reeling in the prejudice, is a Human Rights violation. Advocates against mandatory testing, need to advocate for the betterment of life and not for ethical stance.

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