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The Workplace and HIV-Related Stigma: Implications for Public Health Prevention and Control Policies and Programs in Malawi

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Abstract

HIV/AIDS is a serious global infectious and chronic condition with no cure currently available. There is significant stigma associated with being HIV/AIDS positive. This can have substantial health implications by interfering with prevention efforts and discouraging people from safe sex practices, care-seeking behaviours, and seeking a diagnosis and treatment. Because HIV mostly affects the economically productive age group between 15 and 49 years in Malawi, workplaces have been substantially affected. There is also some evidence of targeted stigmatisation of people affected with HIV and AIDS at workplaces. The socioeconomic impacts of HIV/AIDS in the workplace are well recognised. According to the Government of Malawi, the major economic cost of HIV and AIDS is the loss of human resources in both the private and public sectors. HIV/AIDS affects work productivity through increased sickness, absenteeism, and loss of staff through death and attrition. The aim of this article is to review the literature to elucidate the factors that fuel HIV-related stigma in the workplace. For effective responses to address HIV/AIDS issues, investigation of the processes that underpin HIV-related stigma and their implications for institutional policies and programs are highly recommended as key areas for future research in Malawi.

Introduction

The Human Immunodeficiency Virus (HIV) infection and the subsequent Acquired Immunodeficiency Syndrome (AIDS), hereafter referred to collectively as HIV/AIDS, remains a major public health issue accounting for substantial mortality and morbidity in Africa, including in Malawi. The prevalence of HIV in the adult population, according to Malawi Demographic Health Survey (MDHS) in 2010 was 10.6%, a slight decrease from 12% in 2004 (National Statistical Office [NSO] & ICF Macro, 2011). Since HIV/AIDS mostly affects the economically productive age group between 15 and 49 years in Malawi,

the workplace has been substantially affected. Moreover, since the most productive population is affected, the socioeconomic impact of HIV/AIDS in the workplace is considerable (Government of Malawi [GoM], 2010). In Malawi, the major economic cost of HIV/AIDS is the loss of human resources in both the private and public sectors (GoM, 2010). HIV and AIDS affect work productivity through increased sickness, absenteeism, and loss of staff through death and attrition (Yakuta, Ito, Kudo & Tsukada, 2013). This situation has prompted the Malawi government to direct that at least two per cent of Other Recurrent Transactions (ORT) funds be reserved for the public sector response to HIV.

In 2010, the National Workplace Policy was developed by the Ministry of Labour to guide the government's response (GoM, 2010). However, despite these efforts to respond to HIV, stigma and discrimination remain pervasive (Sprague, Simon & Sprague, 2011; Malawi Network of People Living with HIV [MANET+], 2013) and are perceived as potential barriers to HIV prevention (UNDP, 2010). Inevitably, stigma as a social consequence of HIV affects all areas of people's lives including in the workplace (Holzemer et al., 2007). Often, workplaces are recognised as small communities where stigma is perpetuated (Sprague et al., 2011; Madzorodze, 2012). A few studies in Malawi inform the existence of HIV-related stigma in Malawian workplaces (Holzemer, et al., 2007; MANET+, 2013). On the other hand, workplaces are also recognised as ideal social settings for HIV prevention programmes that influence behavioural change (Dickinson, 2005; Campbell & Deacon, 2006).

Stigma has profound effects, disrupting access to prevention, treatment and support services and increasing vulnerability to HIV/AIDS (Genberg et al., 2008; Nyblade et al., 2003). Additionally, HIV/AIDS stigma has social and psychological repercussions, further exacerbating the impact of HIV/AIDS (Deacon, 2005; MANET+, 2013). The fact that HIV/AIDS stigma affects the lives of people living with HIV, as well as threatens HIV prevention efforts, justifies its significance as a field of enquiry. Further, it is argued that HIV prevention cannot be successful without also addressing the associated stigma (Genberg et al., 2008). While stigma reduction is recognised as an instrumental part of an effective response to HIV/AIDS in the National Workplace Policy (GoM, 2010), there is inadequate contextual background provided for effective stigma reduction strategies. As indicated earlier, the effective prevention and control of HIV/AIDS depends upon understanding the nature and context of HIV/AIDS

stigma. The aim of this study is to review the literature on HIV/AIDS in order to elucidate the factors that fuel HIV/AIDS related stigma in the workplace and their implications for the response to HIV in Malawi.

Methodology

A systematic search of published and unpublished electronic literature on HIV/AIDS stigma was conducted in PubMed, Scopus, Google Scholar and ELDIS. Further, the Google search engine was consulted to incorporate any 'grey' literature. The following search terms were used: 'HIV,' 'AIDS' and 'HIV/AIDS' combined with 'stigma' 'discrimination,' as well as 'HIV/AIDS-related stigma'. These were further combined at various times with 'workplace,' 'sub-Saharan Africa' and 'Malawi'. Through snowballing, reference lists were also cross-examined for inclusion.

The search was limited to full text articles and documents published between 2002 and 2013 in the English language. Articles providing a conceptual background for stigma were also consulted to enrich the review. Studies not focusing on HIV/AIDS stigma and those looking at special population groups such as antenatal mothers and gay communities were excluded. Identified articles were carefully scrutinised based on their relevance to aims of the study. Finally, a total of 39 articles were critically analysed. Since this was a narrative review, a thematic approach was employed in the analysis where similarities, differences and patterns were identified and appraised according to themes. The review was also further analysed to incorporate socio-psychological (Goffman, 1963) and sociological frameworks (Link & Phelan, 2001) of understanding stigma, as well as the authors' knowledge of the subject matter.

Results

Despite extensive research being conducted in non-workplace settings, a thorough search of published literature confirmed earlier findings by Deacon (2005) of a paucity of empirical evidence on HIV/AIDS stigma in workplace settings, especially in Malawi. It is also recognised that HIV/AIDS stigma can manifest differently in different settings as it is socially constructed, and this may pose a limitation to its study (Deacon, 2005). Following the content analysis, this review has been structured around the following major themes: the conceptualisation of stigma, including HIV/AIDS stigma; HIV/AIDS stigma in Malawi; the response to HIV/AIDS stigma; the determinants

of HIV/AIDS stigma; and the implications of HIV/AIDS stigma for HIV/AIDS prevention.

The conceptualisation of stigma

Stigma is a broad and multidimensional concept beset with conflicting theories (Greef et al., 2008). The complexity and paradoxes in the conceptualisation of stigma perhaps explain our poor understanding of and ineffective strategies in addressing it (Genberg et al., 2008; Parker & Aggleton, 2003). Goffman (1963) defined stigma as “an attribute that is deeply discrediting” and further suggested that a stigmatised person is reduced “from a whole and usual person to a tainted, discounted one” (p. 3). Goffman’s definition further articulates that physical features, individual behavioural characteristics and social status prompt stigmatisation. This has important consequences for an individual’s self-concept. This socio-psychological conceptualisation of stigma excludes issues of power, inequality and exclusion (Campbell & Deacon, 2006). The work of Link and Phelan (2001) marked a major shift in the conceptualisation of stigma; and they cite dominant cultural beliefs as possible drivers of stigmatisation. While Goffman’s definition focused on the individual, Link and Phelan conceptualised stigma as a social process rooted in power structures. Likewise, Parker and Aggleton (2003) assert that stigma encompasses processes that underpin social inequality, emanating from broader power relations, and that HIV/AIDS stigma reinforces pre-existing forms of social inequalities. Similarly, Castro & Farmer (2005) offer a structural perspective of HIV/AIDS stigma where social, economic and political arrangements shape HIV/AIDS stigma.

The literature consistently indicates that HIV/AIDS stigma is a societal rather than an individual issue (Nyblade et al., 2003) “grounded in social inequalities” (Castro & Farmer, 2005, p. 53) and power relations emanating from the broader social processes (Johnson, 2012; Niehaus, 2007; Parker & Aggleton, 2003). Evidently, since the effects of HIV stigma at the individual level spill over to communities, institutions and the broader society, the focus when conceptualising stigma should also be moved from an individual focus to its broader social aspects. Airhihenbuwa et al. (2009) argue that “we cannot fully understand personal behaviours unless we understand the structures and systems that influence these behaviours” (p. 416). Therefore, it would appear that addressing stigma requires a broad approach that confronts the socio-structural factors fuelling HIV/AIDS-related stigma.

HIV/AIDS stigma in Malawi

Although HIV/AIDS stigma is recognised to be universal, its particular manifestation is context specific (Parker & Aggleton, 2003). The Government of Malawi reported in 2012 that HIV/AIDS stigma is still prevalent despite increased HIV/AIDS awareness (GoM, 2012) and the availability of free antiretroviral therapy (ART) (Berendes & Rimal, 2011). While the 2010 MDHS reported increased HIV/AIDS awareness, only about 68% of adult populations knew their HIV/AIDS status (NSO & ICF Macro, 2011), which is lower than expected rate. Studies indicate that fear of stigma partly explains the relatively low uptake of HIV/AIDS testing in Malawi (Berendes & Rimal, 2011; GoM, 2012).

Stigmatising practices exist in communities and families, religious circles, workplaces, healthcare settings, and enacted policies (Chirwa et al., 2010 cited in GoM, 2012); Holzemer et al., 2007; MANET+, 2003; MIAA, 2006; Uys et. al., 2006). However, research conducted by the Malawi Interfaith AIDS Association (MIAA) in 2006 highlighted that overt cases of stigmatisation were uncommon. Nonetheless, this does not mean that subtle manifestations of stigma are any less damaging. Evidence of stigmatisation exists. For example, it has been reported that 48.4% of people living with HIV/AIDS (PLWHA) experience negative verbal comments, while 35.1% experience harassment and threats and 16.6% physical assault (Chirwa et al., 2010, cited in GoM, 2012). This is consistent with more recent evidence (MANET+, 2013), but perceived stigma has been found to be more prevalent than actual stigmatisation (Rimal & Creel, 2008). Perceived stigma or felt stigma is linked to feelings of shame, guilt and fear of being stigmatised (Neuman & Obemeyer, 2013). Therefore, perceived stigma should also be given adequate attention since it may pose an even greater barrier to HIV/AIDS prevention, treatment and support (Deacon, 2005). However, in a multi-country comparative study, Malawi registered lower levels of internalised stigma (9.6%) compared to other countries, while interpersonal stigma (43%) was relatively higher (Neuman & Obermeyer, 2013). These authors hypothesised that internalised stigma is reportedly lower due to the high prevalence of HIV/AIDS in the country (Neuman & Obermeyer, 2013). This is contrary to Stigma Index Study which indicated higher levels of internalised stigma (MANET+, 2013).

Lay conceptualisations of HIV/AIDS through language also indicates evidence of HIV/AIDS stigma. Language used in describing PLWHA such as ‘clothes-hangers’ and ‘*kaliondeonde*’ (thin person), clearly

illustrate evidence of HIV/AIDS stigma in Malawi (Uys et al., 2005). HIV/AIDS media messages also sometimes reinforce HIV/AIDS stigma and discrimination (Malawi Voice, 2012). The public conceptualisation and discourse of illness is influenced by social circumstances and is hence critical in shaping HIV/AIDS stigma.

Stigma in the workplace

Evidence exists of the presence of HIV/AIDS stigma in Malawian workplaces (Holzemer et al., 2007), including stigmatisation of people living with HIV/AIDS by fellow employees which has frequently been observed in healthcare settings (Uys et al, 2009). At the policy level, stigmatisation is often established in laws, procedures and organisational ethos (MANET+, 2013; Parker, Aggleton, Attawell, Pulerwits & Brown, 2002; Sprague et al., 2011). This manifests itself in breaches of confidentiality by employers and HIV/AIDS programme officers, forced HIV/AIDS status disclosure, gossiping and ridicule, social isolation, denied educational opportunities and job termination (Dickinson, 2005, Sprague et al., 2011). However, job termination is said to be infrequent where the prevalence of HIV/AIDS is high (Sprague et al., 2011). Despite stigmatisation being pervasive in the workplace, workplaces are also recognised as avenues of social networks with the potential to deconstruct stigma (Campbell & Deacon, 2006). While few studies have been conducted on HIV/AIDS stigma in workplaces in Malawi, the informal operation of stigma might be prevalent even where HIV/AIDS workplace policies are institutionalised.

HIV/AIDS stigma response in Malawi

Since 1985, when the first AIDS case was identified in Malawi, considerable effort has gone into HIV/AIDS responses including prevention and treatment. However, the national HIV/AIDS policy was first developed in 2003. In 2004, the Malawi Government directed that at least two per cent of ORT be reserved for HIV programmes in the public sector. Since then, tremendous progress in responding to HIV/AIDS has been made with evolving prevention strategies.

The Malawi Government has instituted national legal and policy frameworks that protect employees from HIV/AIDS discrimination (GoM, 2010), including coordination structures for public and private sector responses (GoM, 2012). The National HIV/AIDS Workplace Policy provides a framework for the implementation of HIV/AIDS programmes in workplaces and explicitly reinforces the need to reduce stigma and discrimination, and mitigate the impact of HIV/AIDS in the

workplace (GoM, 2010). Most workplaces have adopted and implemented the National HIV/AIDS Workplace Policy. Non-discrimination, reasonable accommodation for infected staff, confidentiality, voluntary disclosure of HIV/AIDS status and education are some of the major commitments emphasised in the policy. However, a strong foundation incorporating evidence-based sociocultural aspects of HIV stigma and discrimination is lacking in the policy formulation. Despite policies highlighting the importance of tackling stigma and discrimination, a gap seems to exist between the intent and outcome due to inadequate exploration of the underlying issues. For instance, the public sector reporting system does not adequately capture issues relating to stigma. Thus, knowing the extent of HIV/AIDS stigma at workplace is paramount in order to develop appropriate strategies to address them. Meanwhile, there is no comprehensive HIV/AIDS legislation that explicitly explains the rights and obligations of infected and uninfected Malawians (GoM, 2012). Moreover, the degree to which legislation is accessed, monitored and enforced is debatable. The existence of a policy or law alone cannot adequately tackle HIV/AIDS stigma.

Factors influencing HIV/AIDS stigma

Undeniably, HIV/AIDS is a highly stigmatised illness, which can be explained by myriad of factors operating at different levels of social interaction. The deep-rooted understanding of HIV/AIDS as incurable, contagious and deadly instigate stigma (Nyblade et al., 2003) Coupled by inadequate knowledge, sexual norms, beliefs and inability to identifying stigmatising behaviours, this exaggerated sense of fear may be attributed to inadequate knowledge of prevention and treatment measures currently available. Again, the negative public discourse around HIV/AIDS may increase fear in individuals. Niehaus (2007) has argued that death, as opposed to negative connotations associated with sexual promiscuity, is the main source of HIV/AIDS stigma. This argument implies that the availability of treatment may reduce HIV/AIDS-related fears, as supported by findings in Haiti (Castro & Farmer, 2005). However, as argued by Johnson (2012) this discounts other sociocultural factors that may create such fears, since, besides fear of contagion, HIV/AIDS can be a threat to moral positions and beliefs.

Sociocultural factors

HIV/AIDS stigma is complex, taking place within the social structure that shapes everyday actions and circumstances. The

sociocultural sphere is important in understanding stigma in sub-Saharan African settings. According to Weiner (1995), the social construction of illness and its psychological representation explain stigmatisation. Indeed, social meanings shape how people experience illness and respond to the affected (Conrad, 2009). Socio-culturally, HIV/AIDS is conceived of as an illness resulting from unacceptable sexual behaviour and lack of social responsibility (Nyblade et al., 2003). These lay narratives of HIV/AIDS transmission propel HIV/AIDS stigma. According to sociocultural theory, society upholds particular norms to maintain order (Yang et al., 2007). Therefore, the dominant HIV/AIDS discourse results in an individual being labelled as deviant and shameful. For instance, the connection of HIV/AIDS to a particular negatively ascribed social group such as prostitutes heightens stigma (Deacon, 2005). Certainly, in a setting where cultural and moral values are deep-rooted, having HIV/AIDS is perceived as a violation of shared values and norms. As asserted by Low et al. (2006) cultural meanings and prejudices become attached to infected people, who become stigmatised as being wicked, dirty and not deserving of care” (p. 2001). In such instances, the stigmatised person may have a diminished self-identity and lose social support. Moreover, Wilkinson and Marmot (2003) have argued that psychosocial stressors also negatively affect health outcomes.

The stigmatisation resulting from such labelling includes social isolation, verbal abuse and discrimination (MANET+, 2013). Parker and Aggleton (2003) explicitly explain how powerful social structures create the categories of people based on the ideas that those who live with the disease are both different due to their HIV infection and less than those who are uninfected leading to stigmatisation and social exclusion. Furthermore, Deacon (2005) used the ‘blaming’ model to elucidate the social processes involved in stigmatisation rooted in existing symbolic systems which grant power and control in some groups in the society. The power that communities have is also reflected in health decisions made by individuals. For instance, condoms are culturally unacceptable and linked to immorality and prostitution and are therefore highly stigmatised in Malawi (Mgbako, Fenrich & Higgins, 2008).

Since HIV/AIDS stigma is rooted in power structures, the socially disadvantaged may experience greater stigmatisation (Parker & Aggleton, 2003). In Malawi, women are often socially disadvantaged (Lindgren, Rankin & Rankin, 2005). In a recent HIV Stigma Index study, low empowerment of women was cited as one of the barriers to effective HIV prevention (MANET+, 2013). Although it may be argued

that the improved economic status of women offers greater negotiating power over preventive health behaviours, in settings where counteracting cultural norms prevail such a hypothesis might be found wanting.

Goffman (1963) articulates that stigma is extended to affiliates of the stigmatised person, such as family members, friends and health providers. Hence, in African settings, where societies are close-knit, stigma may be extended to other members (Parker & Aggleton, 2003). The incidence of associative stigma was reported among health workers and caregivers in Malawi (Holzemer et al., 2007). Clearly, drawing on socio-structural theory, understanding stigma requires critically examining its socioeconomic and cultural background (Williams, 2003). Furthermore, community engagement is critical in addressing socio-structural problems which prompt stigmatisation.

Religious beliefs also contribute to HIV/AIDS stigma in most African countries, including Malawi. Evidence demonstrates that HIV/AIDS stigma and discrimination is profound within faith communities in Malawi (GoM, 2012; MANET+, 2013). HIV/AIDS is purported to result from immorality and punishment for sin in religious circles (MIAA, 2003; Nyblade et al., 2003). Not surprisingly, PLWHA in the church may be stigmatised during the performance of religious rites. For instance, certain religious groups enforce mandatory premarital HIV/AIDS testing before officiating marriage (MIAA, 2006). While this might reduce the spread of HIV, it is also an infringement of human rights. Sometimes congregation members are strongly opposed to access to prevention measures such as condoms (GoM, 2012), in part because it is believed that promoting condom use may facilitate immorality (Rankin Lindgren, Rankin, & Ng'oma, 2005). These deep-rooted religious beliefs regarding sexual behaviour can perpetuate stigma and prevent the uptake of certain prevention services.

Religious leaders are accorded much respect in Malawi and exhibit a lot of power and influence. Religious groups sometimes act in opposition to existing national prevention efforts. Nonetheless, given the power that religious leaders have over their members, they are in a position to contribute positively to prevention efforts. However, the fact that most leadership positions in religious institutions are held by men means that addressing HIV/AIDS issues affecting women can be challenging. In sociological terms, religious institutions may present a structural barrier to HIV/AIDS prevention; yet, they can also provide opportunities for behavioural change and social support (Nyblade et al., 2003). Prevention efforts should therefore work with dominant social

structures in order to be effective. Currently, faith-based organisations are regarded as a necessary part of the solution in Malawi's official HIV/AIDS response (GoM, 2012).

Gender and HIV/AIDS stigma in Malawi

Men and women experience stigma differently (MANET+, 2013). Women may face greater stigmatisation as they are often a marginalised group in the society (Lindgren et al., 2005). Evidence indicates that women are more vulnerable to stigmatisation than men, as they are often blamed for promiscuity (Airhihenbuwa et al., 2009; Niehaus, 2007). Subsequently, women suffer greater verbal abuse, social isolation and domestic violence (Mgbako et al., 2008). For example, in Malawi female sex workers are highly stigmatised and often harassed by law enforcers (Mgbako et al., 2008). According to the Malawi Stigma Index, women face more physical abuse (MANET+, 2013). While Neuman and Obermeyer (2013) found no gender difference in terms of internalised stigma, a study in South Africa by contrast found internalised stigma higher in men than women. Traditional gender roles and norms, wherein women are expected to be more accepting than men, might explain these differences.

The stigmatisation of women is attributed to the belief that women can control their sexual desires better than men (Nyblade et al., 2003). Culturally, women play an important role in upholding moral traditions; thus having HIV is an indication of moral breakdown. Contrary to western countries, where blame is often placed on gay communities (Deacon, 2008), women bear greater blame in African societies. For instance, in both Malawi and South Africa, sexually transmitted diseases are labelled 'woman's disease' (Beck, 2004; Rankin et al., 2005). For their part, women regard themselves as victims of their husbands' promiscuity (Nyblade et al., 2003). However, men's promiscuity is often more tolerated than women's promiscuity in African societies (Duffy, 2005; MANET+, 2013). Undeniably, Malawi being a patriarchal society, gender inequality becomes one of the social contexts in which stigma is created and permitted (Deacon, 2005). Hence, women face a double stigma of gender and HIV/AIDS (Mgbako et al., 2008).

Apparently, sociocultural norms and expectations emanating from existing power structures (Lindgren et al., 2005) and the social, economic and cultural disadvantage of women (GoM, 2012) explain the increased vulnerability of women to stigma. This may as well constrain their ability to exercise autonomy. Thus, it can be assumed that in workplace settings, women may be stigmatised more by employers and

fellow employees than men. Conversely, working women may face reduced stigma due to increased socioeconomic status and autonomy. However, it is well known that due to socio-cultural structures in the society, even working women do not have equal decision-making power with their spouses (Lindgren et al., 2005). Overall, pre-existing forms of marginalisation such as gender and economic inequality must also be considered in stigma-reduction strategies.

HIV/AIDS language and discourse

HIV/AIDS dominates public discourse in Malawi, especially in the media. The language and discourse surrounding HIV/AIDS shape and exacerbate stigma. As discussed earlier, the local oral discourse relates HIV/AIDS to immorality and a deviation from social norms and places blame on certain groups of people. For instance, HIV is known as the '*matenda a boma*' meaning 'government disease'. This name reflects the belief that AIDS is a deliberate ploy by the government to control the population. Sometimes 'government disease' refers to the increased efforts by the government to address the pandemic.

The manner in which the media portrays HIV/AIDS messages, it has been argued, has social ramifications by creating public fear and misinterpretation of infection (Mykhalovisky & Rosengarten, 2009). For instance, Johnson (2012) points out that the language used to describe the spread of HIV/AIDS by the government, NGOs and the media, such as through 'illicit sex' further escalates the stigmatisation of HIV/AIDS. Blame also features highly in media discourse around HIV/AIDS. As reported by Malawi Voice (2012), HIV media messages sometimes reinforce HIV/AIDS stigma and discrimination. Media is therefore a powerful force in both shaping and reducing stigma. In this latter regard, the radio has been an important avenue of healthy behaviour promotion and HIV/AIDS stigma reduction in Malawi (Rimal & Creel, 2008).

Level of HIV/AIDS knowledge and HIV/AIDS stigma

The heightened sense of risk and fear of contagion may also be attributed to inadequate understanding of HIV/AIDS. Logically then, increased HIV/AIDS knowledge should reduce levels of stigma. Berendes and Rimal (2008) have demonstrated that sound HIV/AIDS knowledge is associated with low HIV/AIDS stigma. However, evidence indicates that comprehensive HIV/AIDS knowledge is relatively low in Malawi (GoM, 2012). According to NSO and ICF Macro (2011), comprehensive knowledge was estimated at 41% and

44.5% for women and men aged 15 to 49 years respectively. It may be implied that despite increased HIV/AIDS awareness, some people still have misconceptions about modes of contagion.

Lack of recognition of stigmatising behaviour, its consequences and the denial of its existence is another important challenge underpinning stigma reduction (Mbgako et al., 2009). Individuals are unlikely to admit having stigmatising attitudes. Arguably, understanding stigma and the relationship of HIV/AIDS to supposedly risky behaviours might contribute to reduction in HIV/AIDS-related fears and misconceptions. Importantly, behaviour is complex and requires understanding of the broader issues that influence stigmatisation.

Policies and Programmes

Workplace policies and programmes may inadvertently reinforce stigma (Parker et al., 2002). Studies from Uganda cited the redeployment of PLWHA and the creation of special provisions for PLWHA as discriminatory and stigmatising (Hadjipateras, Abwola, & Akullu, 2013). Similarly, having a separate on-site voluntary counselling and testing (VCT) clinic was perceived as being discriminatory and stigmatising at one Malawian workplace (Soko, Umar, Noniwa, & Lakudzala, 2012). Other studies have suggested the incorporation of HIV/AIDS testing and counselling services within existing health promotion programmes as a way to reduce stigma (Arimoto, Ito, Kudo, & Tsukada, 2013). Certain inadequate HIV-prevention resources and capacity may also instigate and exacerbate HIV/AIDS stigma (Genberg et al., 2009). For instance, individualised interventions such as ‘abstinence’ and ‘condom use’ emphasise individual responsibility and thus insinuate blame (MIAA, 2006). In situations where individuals perceive they may be judged, the uptake of prevention services may be compromised. (Frohrich & Potvin 2010, p.379).

HIV/AIDS stigma and implications for HIV/AIDS prevention

Stigma presents social and structural barriers to effective HIV/AIDS prevention and treatment. At the individual level, stigma affects people’s choices with regard to seeking health services such as testing, prevention, treatment and support (Conrad, 2009; Nyblade et al., 2003). In the workplace, HIV/AIDS stigma prevents the disclosure of HIV/AIDS status, the adoption of preventive behaviours, the uptake of voluntary counselling and testing services, and social support services (Sprague et al., 2011; Arimoto et al., 2013). The fear of stigma and

anticipated loss of social relationships in the workplace often explain the inadequate use of VCT and non-disclosure of HIV/AIDS status (Arimoto et al., 2013). Non-disclosure of HIV/AIDS status may also be a way of maintaining moral status and a coping strategy against enacted stigma (Nyblade et al., 2003).

Internalised stigma leads to psychological distress and low self-esteem which may ultimately affect social interactions (Deacon, 2005). Low self-esteem may also interfere with the adoption of healthy behaviours. Stigma is therefore regarded as a social determinant of health since it affects health-seeking behaviour, including mental health (Dean & Fenton, 2010; Wilkinson & Marmot, 2003). Thus, even in the presence of workplace programmes, internalised stigma might inhibit access to the benefits of social support networks. It is known that social support and networks are critical in supporting and promoting health behaviours (Neuman & Obemeyer, 2013, Wilkinson & Marmot, 2003). Further, the presence of social support influences health outcomes (Wilkinson & Marmot, 2003).

It is believed that HIV/AIDS disclosure (Mazorodze, 2012) and increased access to Anti-Retroviral Therapy (ART) contribute to HIV/AIDS stigma reduction (Castro & Farmer (2005). On the other hand, the same authors have claimed that stigma impedes ART provision and the uptake, especially in poor countries.

Despite the benefits of HIV/AIDS status disclosure, (MANET+, 2003) there are also anticipated negative effects. Arguably, disclosure may negatively affect social relationships in the workplace and limit educational and financial opportunities for PLWHA (Greef et al., 2008). The use of care and support services by PLWHA may lead to the public identification of individuals' HIV status, inadvertently influencing social stigma and may lead to delays in seeking healthcare services (Nyblade et al., 2003). Without disclosure of status, access to treatment, care and support services is hampered. While increased accessibility to ART is believed to lead to reductions in HIV/AIDS stigma as demonstrated by studies in Tanzania and Zimbabwe (Roura et al., 2008), the material discussed in this review suggests that the biomedical model alone cannot address a social issue such as stigma. For example, in Tanzania, there was an unexpected emergence of ART stigma (Roura et al., 2008). In Malawi, individuals on ART are labelled as “rechargeable batteries” (MIAA, 2006, p. 31). In this sense, despite ART having transformed HIV/AIDS from a terminal illness to a chronic illness, stigma remains a stumbling block in the HIV/AIDS response.

Undoubtedly, for effective HIV/AIDS workplace programmes, the context of HIV/AIDS stigma should be thoroughly explored.

Conclusion

Despite a proactive response to HIV/AIDS in Malawi, stigma remains a stumbling block (GoM, 2012) and addressing HIV/AIDS effectively remains elusive. As such HIV/AIDS stigma may remain a major barrier to HIV prevention and control in workplaces in Malawi. For an effective HIV/AIDS response in workplaces, the processes that underpin HIV/AIDS stigma and the implications of institutional policies for HIV/AIDS stigma should be explored. Although the review has revealed that workplace policies include stigma-reduction interventions, in practice these are not effective. However, it is plausible to argue that, the current HIV stigma index will act as an advocacy tool to proactively address stigma and discrimination issues in the HIV/AIDS response in the workplace in Malawi.

Additionally, we believe that this review has highlighted the need for continuous exploration of HIV/AIDS stigma in all spheres of human life. Since stigma is subtle and less readily defined, efforts should be made to contextualise HIV/AIDS stigma in workplace strategic planning. There should also be increased efforts in building capacity in effective counselling and investigating guidelines on confidentiality in workplace programmes. Equally important, social inequalities that perpetuate HIV-related stigma should be addressed.

Because of existence of the paucity of empirical research into Malawian workplaces, dealing with HIV/AIDS stigma and discrimination requires theory and evidence-informed HIV programmes that are context specific (Sprague et al., 2011). Thus, drawing on socio-cultural perspective within sociological theory (Williams, 2003), HIV/AIDS stigma should be understood within the context of larger political, economic and cultural factors.

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