FACT SHEET

RURAL CENTER for AIDS/STD PREVENTION

A Joint Project of
INDIANA UNIVERSITY, PURDUE UNIVERSITY, AND UNIVERSITY OF COLORADO

Stigma as a Barrier to HIV Prevention in the Rural Deep South

Stigma has been associated with HIV/AIDS since the early 1980s when the U.S. public became aware of a new, fatal sexually-transmitted disease afflicting gay men and other risk groups. The characterization of gay men as vectors of this new disease was a rallying point for HIV prevention in the gay community during the 1980s,[1] but also provided a framework for representing the "AIDS sufferer" in terms of social deviance.[2] This stigma construct has been a potent barrier to HIV/STI prevention,[3,4] especially in the rural South where conformity to social conservatism is highly valued,[5] and where issues of race, gender, and social class have complicated care-seeking for all sexually transmitted infections.[6,7,8] The stigma context of the Deep South may be fueling the HIV/STI epidemics in the region, since these epidemics are more severe in the Southeast than in any other region of the United States.[9]

How Should HIV-Related Stigma be Defined?

HIV-positive persons became stigmatized as the result of widespread negative attitudes about people who engage in same-sex activity, injection drug use, or sexual promiscuity.[10] As noted by Aggleton (2002),[11] HIV-related stigmatization is a process that also reinforces existing social inequalities based on race, gender, ethnicity, and sexual orientation. Aggleton's definition of HIV-related stigma distinguishes between the act of stereotyping (e.g., labeling gay men as "disease bearers"), and the act of discrimination (e.g., violence towards HIV-positive persons). There is also a difference between "enacted stigma" which concerns discrimination, prejudice, or blame for violating sexual norms, and "felt stigma" which involves the shame and guilt of being infected.[12] Fear of being blamed for violating sexual norms (i.e., heterosexual monogamy) can lead to non-disclosure to sexual partners if someone is infected. These distinctions play out in culturally-specific ways in what Kleinman (1999) describes as "the geography of blame."[13] In the rural Deep South, this moral geography involves notions of sin and sexuality, such as HIV/AIDS being God's punishment for sexual deviance.

HIV/AIDS Is More Stigmatized in the Deep South

Social conservatism is more pronounced in the South compared to the rest of the nation. The measures of social conservatism in Table 1 offer a context for understanding stigma as a barrier to HIV prevention in Southern states.

Table 1: Social Conservatism and Stigma Measures for the South Compared to All U.S. States

	South	United States
Political Conservatism		
% Negative views on homosexuality	55	50
% Punitive attitudes towards crime	67	62
% Racial prejudice	56	48
% Political conservatism	42	35
Religious Conservatism		
% church attendance	49	38
% youth in church weekly	43	35
% religious conservative	21	19
% pro life	10	8

Sources: (1) Political: USA Today/Gallup Poll 2003[14]; Chiricos, Welch & Gertz (2004)[15]; (2) Religious: Laumann et al. (1994).[5]

STI-Related Stigma Promotes Feelings of Betrayal or Revenge

STI-related stigma manifests in negative attitudes or actions toward infected persons.[3] In the Deep South, STI-related stigma has had a demonstrable effect on people's willingness to be treated for sexually-transmitted infections, including HIV/AIDS. In a recent telephone survey in Alabama, over 50 percent of the respondents said they would delay seeking medical care for STIs because of stigma, and one third would not seek treatment at all (Figure 1). Rural residents, especially if they were African-American and church-going, were even more likely than others to say that they would avoid screening or treatment for STIs because of stigma.When it came to disclosing the names of sexual partners to health providers (a legal requirement for some infections), almost half of the respondents feared what this disclosure would do to their relationship, and almost one third said they would refuse because of embarrassment (Figure2). Almost all of the respondents said they would feel angry, betrayed, and embarrassed if they were infected with a STI. Some respondents would seek revenge against someone who infected them. This revenge typically takes the form of outing infecting partners to family and associates, which can be particularly damaging in small rural communities where people know one another and where stigma can be long-lasting.[16]

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Figure 1: Stigma and Treatment

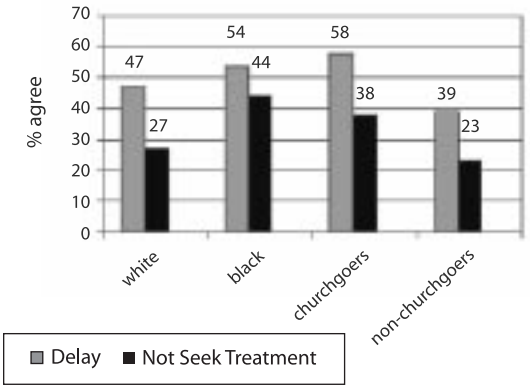
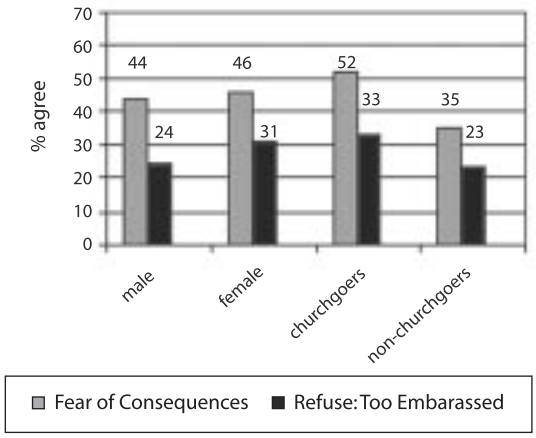


Figure 2: Stigma and Partner Naming



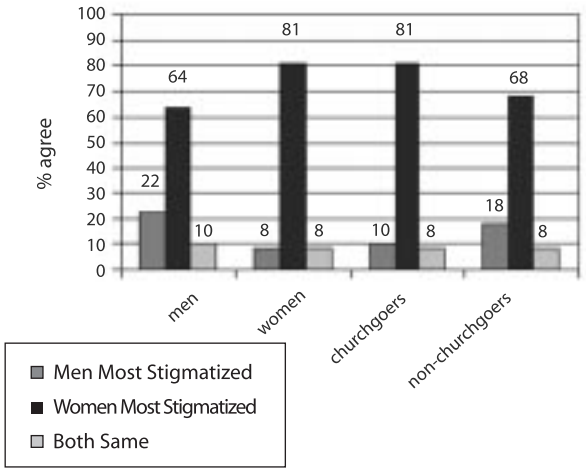
Source: Lichtenstein, Hook and Sharma (2005).[17]

Homophobia is Especially Harmful in Rural Areas

Men in the rural Deep South fear being labeled as homosexual. This fear is more pronounced for African-Americans, especially in rural communities where homophobia intersects with religiosity and with cultural constructions of a dominant heterosexual masculinity.[18] Bisexually-active men may deny risky behavior or expect women partners to take responsibility for health checks, including for HIV/AIDS. Bisexually-active men fear being outed in rural communities for another reason – they may be shot and killed.[19] Rural men are sometimes so fearful of being outed that they are publicly homophobic and join in harassing or outing other men.[19] The impact of this stigma for HIV prevention in rural communities often leads bisexually-active men to engage in "sneaky sex" with other men, and to be difficult to reach for safer sex messages.[19] The internet has enhanced the ability of rural, non-identified gay men to avoid being stigmatized in their communities and to seek sexual partners without being detected.[20] However, this trend is not associated with men's greater willingness to use condoms for safer sex, but with desire to "hook up" in ways that avoid local scrutiny.

Rural HIV-positive men are unlikely to disclose their diagnosis to women partners.[21] HIV-positive African-American men, in particular, are fearful that disclosure might result in being labeled homosexual or in being charged with a crime.[21,22] This climate of non-disclosure increases the HIV risk of rural African-American women whose access to male partners is limited by geography and by the pooling of infection in small or bounded populations. [5] A recent study of women and HIV/AIDS in Alabama's Black Belt found that non-disclosing men in rural areas had infected a number of local women, including women who were related to each other.[21] Despite these outbreaks, blame is placed on allegedly "dirty" or "promiscuous" women in relation to heterosexual HIV transmission, and cultural silences over same-sex activity make it almost impossible to counter the blame.[23] This type of gender stigma (see Figure 3) not only deflects attention from same-sex activity as a likely mode of HIV transmission for African-American men in the Deep South, but prevents African-American women from knowing why they are being infected at a higher rate than other women.

Figure 3: Gender Blame for Being Infected with STIs in the Deep South



Source: Lichtenstein, Hook and Sharma, 2005.[17]

STI-Related Stigma is a Heavy Burden for African-Americans

African-Americans have higher STI/HIV rates than other ethnicities in the United States.[9,24] This disparity has been reported to occur on a historical basis, with white physicians in the Deep South commonly labeling African-Americans as "syphilis soaked" up until the mid 20th century. [25, 26] Several barriers to HIV prevention have occurred as a result of this racist history. The first is African-Americans' deep distrust of the "white" health system.[25] The second is the widespread belief among African-Americans that official statistics on HIV/AIDS are biased against them.[27] The third is African-American men's perceptions that they are being unfairly pursued by the authorities for disease surveillance purposes. [22] The fourth is that African-Americans who live in impoverished

rural areas lack equitable access to all forms of health care, including for STI/HIV. This barrier particularly occurs in racially segregated areas of the Deep South known as the Black Belt.

Attitudes towards African Americans as disease-ridden were the ideological basis of the Tuskegee Syphilis Study conducted from 1932-1972.[25] In this study, approximately 400 syphilitic African-American men in rural Alabama were enrolled without being treated for the disease, with 100 men dying of syphilis-related complications. This public health scandal not only invoked a deep distrust of the medical profession among African-Americans,[28] but led to widespread fears of HIV/AIDS being deliberately introduced to reduce the size of the black population.[25] Such fears have been further fueled in recent years by public health warnings of an AIDS crisis in the African-American community. In the wake of such warnings, African-Americans in the rural Deep South often invoke the specter of a biased public health system, and are sometimes convinced that AIDS is a U.S. government plot to kill Blacks.[27] This distrust particularly involves men who are suspicious of the motives of public health workers and who are reluctant parties to partner notification for STIs and testing for HIV/AIDS.[22,27]

Moral Geography is a Stumbling Block to HIV Prevention Efforts

Religiosity is highly valued in the Deep South, especially in rural areas. A major stumbling block for HIV prevention, however, is that several church leaders have stated publicly that HIV-positive persons deserve their fate[29], and some state and local politicians have refused to fund HIV prevention and life-saving medications for infected persons on the basis of their "ungodly lifestyle."[30] There have been numerous reports of church-based responses to HIV/AIDS being absent, inadequate, or condemning (see Fullilove and Fullilove 1999 and Morales and Fullilove 1992 for a discussion of these responses in the Black church).[31,32]

Frequency of church attendance was positively associated with stigma in Lichtenstein, Hook and Sharma's (2005) telephone survey.[17] The results of the survey indicated that the most frequent churchgoers, especially in rural areas, were more likely than other respondents to be judgmental, and would be more likely to delay or avoid being treated for STIs. This moral geography also affects HIV prevention when high school students receive abstinence-only sex education and when at-risk persons are denied publicly-funded HIV prevention.[30] The moral geography is further implicated when needle-exchange programs are prohibited, and when condom use is denigrated as a safer sex method.[6]

STI Clinics Can Be Stigmatizing: Enter at Your Own Risk

STI clinics are often avoided because of stigma. Visibility at STI clinics in rural counties may be of such concern that clients travel to other counties for checkups or treatment, or they avoid seeking treatment altogether. A qualitative study found that residents of public housing that was adjacent to a county STI clinic engaged in "patient spotting" and gossiped about their sightings to neighbors. [16] Non-clients have been reported to take snapshots of clients at rural STI clinics with their camera phones. Visibility is particularly damaging at Health Departments with separate STI clinics or with client sign-up sheets that are visible to the public. In order to avoid this type of stigma, symptomatic persons are sometimes likely to share medications or use herbal remedies, to douche, or to buy non-prescription medicines to treat STIs.[16] None of these informal methods will cure infection, and disease complications or transmission to sexual partners can occur if medical treatment is not sought in a timely manner.[33]

Being the recipient of free public health care is also stigmatizing. "Free care" for STIs was part of an expanded public health policy in the New Deal of the 1930s, when public health clinics were established in low-income, urban neighborhoods and in county Health Departments.[34] An unintended consequence of this policy in the Deep South is that rural whites have been reluctant to seek treatment at what they consider to be "Black" clinics.[16] Clinic employees often mirror the moral attitudes of the community and have been known to discriminate against clients deemed promiscuous or immoral. One multi-site study of Health Department clinics in Alabama, Mississippi, South Carolina and Tennessee found that the staff treated African-American clients (the large majority) badly, and concluded that they have not learned the lessons of the Tuskegee Syphilis Study.[6] Another study found that clients felt so stigmatized that they feared they would not receive adequate treatment.[35] Other stigmatizing factors in relation to STI clinics in small communities include staff and clients knowing one another, and clients believing that employees divulge confidential personal information to friends and neighbors.[8]

Summary

The topic of HIV prevention in the rural Deep South is so stigmatized that some state and local legislators have refused to fund HIV prevention efforts, many church and other leaders refuse to acknowledge the impact of the epidemic on their communities, and schools are prevented from teaching safer sex methods. As a result, STI services are hampered by pejorative labeling and by lack of funding. Progress towards HIV prevention in the Deep South has stalled, even as the epidemic is having a significant effect on rural communities. The outlook for HIV prevention in the rural Deep South is discouraging. Race, gender, and social inequalities are significant barriers to HIV prevention, and the moral politics of the region are likely to stymie efforts to protect rural residents from HIV/AIDS in the foreseeable future.

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