SOCIAL EVILS + STIGMA:
A Cumulative Study of HIV and the Moral Model of Disease in
Vietnam, Argentina & Mississippi

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This is not a project of one but rather of many who allowed me to view life through each of their own unique perspectives. To my friend in Swaziland, Africa, whom I met as a girl and who piqued my interest in the burden of disease of HIV: this project is for you. I would like to thank my family and the University of Mississippi, along with the Stamps Foundation, who supported me financially and challenged me intellectually in traveling to three different countries to pursue my interests in the field of public health. I would also like to thank the School for International Training International Honors Program, with whom I traveled to Vietnam, South Africa, and Argentina, and my professors, peers, families, and interlocutors in each country who contributed to the actualization of this thesis project.
ABSTRACT

SARAH STROUP: Social Evils + Stigma
(Under the direction of Katherine Centellas)

How can studying such diverse contexts as Vietnam, Argentina, and Mississippi—three cases from opposite corners of the world—provide remediation for the global HIV epidemic? By targeting specific populations of high-risk groups (e.g., injection drug users, females sex workers, and men who have sex with men), analysis of my ethnographic fieldwork in Vietnam, Argentina, and Mississippi, revealed a common denominator of stigma, though manifesting in varying ways, which laid the foundation for this thesis. Building from Erving Goffman’s (1993) foundational text on stigma in collaboration with Link and Phelan’s (2001) expansion thereof, I define stigma as the differentiation and exclusion from the normal based on a perceived inferior label, resulting in devaluation and unequal access to power. Furthermore, I examine, through qualitative evidence, how HIV-related stigma is implemented in the framework of the moral model of disease through micro interactions of moralized actions and identities (e.g., drug use, sex work, varying sexual identities). Focusing on the social determinants of health—social, cultural, political, and economic—through the perspectives of people living with HIV (PLHIV), family members, health care practitioners, non-governmental organization (NGO) representatives, community contacts, and Ministry of Health (MOH) employees, I studied and compared the relationship between of HIV-related stigma and morality in each country and state context. By looking at Vietnam, Argentina, and Mississippi cumulatively, this thesis seeks to illustrate the ways in which the moralization of HIV-related stigma further marginalizes and contributes to lower health outcomes of HIV-positive people.
TABLE OF ACRONYMS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Disorder</td>
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<tr>
<td>ARV</td>
<td>Antiretroviral (drug)</td>
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<td>ART</td>
<td>Antiretroviral Therapy</td>
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<td>FSW</td>
<td>Female Sex Worker</td>
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<td>HIV</td>
<td>Human Immunodeficiency Disorder</td>
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<td>IDU</td>
<td>Injection Drug User</td>
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<td>MOH</td>
<td>Ministry of Health</td>
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<td>MSM</td>
<td>Men who have Sex with Men</td>
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<td>MTCT</td>
<td>Mother-to-Child Transmission (of HIV)</td>
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<td>NGO</td>
<td>Non-governmental Organization</td>
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<td>PLHIV</td>
<td>People Living with HIV</td>
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<td>PWDs</td>
<td>People with Disabilities</td>
</tr>
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<td>UNAIDS</td>
<td>The Joint United Nations Programme on HIV/AIDS</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
# TABLE OF CONTENTS

ACKNOWLEDGEMENTS.................................................................................iii

ABSTRACT...........................................................................................................iv

TABLE OF ACRONYMS..................................................................................v

I. CHAPTER ONE: INTRODUCTION.................................................................2
   a. LITERATURE REVIEW...............................................................................7
   b. METHODOLOGY.....................................................................................17

II. CHAPTER TWO: VIETNAM CASE STUDY...............................................27

III. CHAPTER THREE: ARGENTINA CASE STUDY.....................................37

IV.  CHAPTER FOUR: MISSISSIPPI CASE STUDY.......................................48

V.  CHAPTER FIVE: CONCLUSION.................................................................58

LIST OF REFERENCES....................................................................................61
CHAPTER ONE:
INTRODUCTION

Despite nearly four decades since its original discovery, the global HIV epidemic continues to burden the international community. According to UNAIDS, 36.7 million people were living with HIV in the world in 2016 (UNAIDS, 2017). The availability of successful antiviral medications and preventative measures calls into question what else could be driving the epidemic. While most studies evaluate the HIV epidemic through quantitative measures of treatment adherence and testing (see Brent, 2016; Chambers et al, 2015), I argue that HIV-related stigma is the dominant perpetrator of the negative impacts on the health and well being of people living with HIV (PLHIV). In a 2012 report about stigma and discrimination, UNAIDS Executive Director Michel Sidibé argues “thirty years into the HIV epidemic we still have major discrimination and stigma related to HIV… [which] are undermining the HIV response across the world” (UNAIDS, 2012). Stigma associated with HIV diagnosis, thus, causes many people to avoid getting tested, adhere to treatment, or disclose their status (UNAIDS, 2012). However, stigmatization of HIV does not exist in a vacuum; contrarily, additional stigmas associated with deviations from the dominant culture – such as sexuality, drug use, and sex work – compound HIV-related stigma with those who engage in such moralized actions. I conceptualize many of the HIV-related stigmas associated with high-risk groups in Vietnam, Argentina, and Mississippi and the ways in which they
traverse to intensify the living experience of HIV under the term: intersectional stigmas. Therefore, this thesis focuses on the moralization of intersectional stigmas associated with HIV-related stigma and how they correlate to adverse health outcomes.

Four months studying public health and community in Washington D.C., Vietnam, South Africa, and Argentina in both urban and rural contexts provides the foundation for the research processes of this thesis. With an acute interest in global health and a desire to practice international medicine one day, I chose a program with an experiential learning curriculum where I would not only be able to learn about public health but also be an active participant in the communities in which I lived. With the School for International Training, I joined the International Honors Program multi-country semester abroad program in Spring 2017 entitled: Health and Community: Globalization, Culture, and Care (Spring 2). During the semester of immersive learning focused on the social determinants of health, my program was divided into four courses: Public Health; Globalization and Health; Health, Culture and Community; and Research Methods. While local faculty and staff taught the first two courses on relevant information about each respective country, a travelling professor taught the other two courses in a more fluid, comparative model as we progressed through the program. An anthropologist by profession, my travelling professor played an influential role in the development of my research theory and ethnographic-focused research. The Research Methods course that she taught centered on a comparative group project of one specific health aspect. Knowing that I wanted to do my thesis project in the field of HIV from my extensive experience in Swaziland, Africa, I chose the topic of “infectious disease” so that I
could expand my understanding of HIV and infectious diseases throughout the diverse contexts we were about to visit. Drawing off my other five teammates’ desires, I suggested to focus our topic solely on HIV for a more concentrated final research project. Therefore, my Research Methods case study group originally chose to focus on HIV and maternal and child health. However, as we moved through Washington D.C., Vietnam, South Africa, and Argentina, respectively, we narrowed our focus specifically on the manifestation of HIV-related stigma and compared our results across countries at the end of the semester. Because of this, the data in the following thesis, through analysis of specific interviews, is presented in a cumulative manner. I specifically contributed to my group dimension by researching the moral aspect of stigma because I desired to expand my own moral boundaries based on my religious beliefs in order to understand the moral guides through which different people rationalize disease.

Throughout traveling to, living in, and studying in the United States, Vietnam, South Africa, and Argentina, I learned that stigma was intrinsically tied to the identities and lived realities of PLHIV. In Vietnam and Argentina, I found that the HIV epidemic is concentrated on high-risk groups and, therefore, only affects a percentage of the countries’ populations. Conversely, in South Africa, HIV is a more generalized and normalized epidemic, in that it burdens the population as a whole, not just socially marginalized populations. Stigma still exists in South Africa to a large degree but efforts to reduce stigma are aimed at the general population and not as drastically moralized. For this reason, I chose to exclude the case of South Africa. However, as I began investigating HIV and the multifaceted affects of stigma in relation to the moral model of disease, I reflected on many parallels between the
foreign countries to which I traveled and the state from which I came – Mississippi, the state with one of the fastest growing rates of HIV/AIDS in the United States (Cooper, 2016). Driven by the similarities between the manifestations of HIV-related stigma and the moral model of disease in Vietnam and Argentina, I hypothesize that using the same framework of moralized stigma theory in Mississippi provide insightful evidence that may contribute to stigma-reducing efforts.

I am mainly interested in how HIV-related stigma contributes to marginalized populations – such as poor, ethnic minorities in Mississippi; injection drug users and sex workers in Vietnam; and transsexuals and migrants in Argentina. The main question that I will answer in my thesis is: How does the intersectionality of the moral model of disease and HIV-related stigma contribute to unfavorable health outcomes? In this thesis, I address specific ways in which stigma drives the HIV crisis, which specific intersectional stigmas contribute to the burden of disease, what successful measures have been implemented in each case, and how those measures can be applied to lessen the burden of HIV in Mississippi.

**THESIS OVERVIEW**

My thesis consists of five chapters, the culmination of which is to provide a holistic, qualitative presentation of the similarities that exist between HIV stigmas in three diverse cases through the angle of the moral model of disease. The first chapter gives a background of what led me to choose my topic and focus of study and presents my literature basis – where I define stigma and relate it specifically to the moral model of disease – and methodological approach. Once the foundation has been laid for the conceptualization of stigma in the context of the moral model of disease, Chapter Two presents my first case study – in chronological order of my
personal ethnographic experience — of Vietnam. Using the Vietnam case, I ask the question: what is the moral model and how does it apply to HIV and stigma?

Chapter Three outlines my second case study: Argentina. Furthering my research process, my Argentina data asks the question: what are the implications of moralization? Finally, the fourth chapter introduces my final case study: Mississippi. For Mississippi, I ask: how can the moral model be used to remediate the burden of HIV? I conclude a summary of my findings and the application of the moral model of disease as a functional approach to treatment and prevention of HIV-related stigma in Mississippi in the closing chapter, Chapter Five.
A. LITERATURE REVIEW

“They rumored that my grandfather sold the bell [of the Buddhist temple] to the French, thus we are disabled because of that” (Nguyen, 2017).

INTRODUCTION

The primary and secondary sources that contribute to my theory of HIV-related stigma center around two fundamental concepts: stigma and the moral model. In the following literature review, I begin by conceptualizing the existing theory of the moral model of disability, explaining why a disability happens to someone. Using that perspective, I operationalize the moral model of disability to encompass the moral model of disease, specifically relating to HIV. I then explain how moral judgments toward negative actions related to HIV lead to stigma. Starting from Erving Goffman’s definition, and expanding it through the use of additional sources on public health and HIV, I define stigma through a negative moral perspective. Thus, the concepts of the moral model and stigma become influential throughout the cumulative research process of this thesis.

THE MORAL MODEL OF DISABILITY

In my public health class at the Hanoi Medical University in Vietnam, my professor outlined three models for which to explain disability – the medical model, social model, and moral model. The medical model focuses on rehabilitation and adaptation of disability with a biomedical approach (Nguyen, 2017). Using a human rights approach, the social model focuses on equality and dignity for people with disabilities (PWDs) (Nguyen, 2017). Finally, the moral model uses an ethical approach, focusing on religious and moral origins of disability. Each model of disability contributes to the overall understanding and outcomes of disability in
society. While the United States tends to focus more on the medical and social models of disability, the moral model, the main model in Vietnam, provides a unique perspective based on negative moral attribution.

The moral model of disability is largely influenced by Buddhist and Confucian philosophies that “place physicality of the individual body within a larger moral universe of interpersonal connections, responsibilities, and dependencies, tying individuals into a dense sociomoral network of moral belonging,” (Gammeltoft, 2014: 145). Through the moral model of disability, society may blame a person’s disability on either religious and spiritual origin or character weakness (Nguyen, 2017). Religious and spiritual origin blames a disability on punishment from god, evil spirits, witchcraft, or bad karma and reincarnation (Nguyen, 2017). Similarly, character weakness, which includes corruptness or immorality, also explains why an individual is disabled (Nguyen, 2017).

Presented through the moral model, disability results from negatively nuanced behaviors. As opposed to a moral model referring to positive moral guidelines by which to approach health, the moral model of disability rests upon culturally grounded deleterious actions that harm health. Even the terminology referring to PWDs in Vietnam is deeply intertwined with the influence of counter-morality (Gammeltoft, 2014: 144). The terms express a double meaning, acknowledging influence from both the biological and moral universes. For example, the word tật implies both “physical defect” and “moral fault” (Gammeltoft, 2014: 144). By demoralization through the use of linguistic identification, “PWDs are perceived as inherently incapable of significant participation in social and economic mainstream” (Nguyen, 2017). Because of this, PWDs become targets of social isolation and
ridicule (Nguyen, 2017).

**THE MORAL MODEL OF DISEASE**

Expanding from the existing moral model of disability, I operationalize the moral model to apply to disease. The moral perspective expands the Vietnamese concept grounded in Buddhist and Confucian philosophies to a general understanding of disease based on cultural values of right and wrong. Focusing on culturally wrong actions, the model attains a negative connotation. Thus, the moral model of disability that blames the presence of a disability on culturally deviant behaviors may also be used to explain why an individual contracts HIV under the moral model of disease. The association of HIV with social evils such as IDU, FSW, or MSM, follows the context of character weakness by blaming HIV infection on corruptness and immorality of an individual. Though biomedical science explains the technical pathways in how HIV is transmitted, one still blames why it happens on participation in culturally adverse behavior. For example, a healthcare worker in Mississippi may blame a young, African-American homosexual’s new HIV diagnosis on his sexuality, stating that he deserved to get HIV for being gay. Focusing on moral deviation, through the moral model of disease, a person consequentially contracts HIV because he is immoral. Inherently different from mainstream society, PLHIV, like PWDs, become targets of marginalization and scorn. Therefore, prejudice against the negative behaviors that lead to HIV provides the foundation for stigma.

**CONCEPTUALIZATION OF STIGMA**

In order to understand how stigma emerges through the moral model of disease, I must first operationalize the concept of stigma, expand it to the application
of public health and HIV, and then assert it into the moral framework. I begin
analysis of stigma with Erving Goffman’s book *Stigma: Notes on the Management of
Spoiled Identity*. The principle resource in literature exploring stigma, Goffman coined
the stigma concept in 1986. Drawing from personal experiences with people
suffering from mental illness, physical deformities or socially deviant behaviors,
Goffman analyzed what it felt like to be marginalized from society and, thus, built
his concept of stigma. Goffman’s explanation of stigma forms the foundation of the
concept in my work. He describes stigma as such:

“While a stranger is present before us, evidence can arise of his possessing an
attribute that makes him different from others in the category of persons available
for him to be, and of a less desirable kind – in the extreme, a person who is quite
thoroughly bad, or dangerous, or weak. He is thus reduced in our minds from a
whole and usual person to a tainted, discounted one. Such an attribute is *stigma*”
(Goffman, 1986:11-12).

Stigma, though not as physically evident as a disease or disability itself, plays a
prominent role in devaluing an individual due to an aspect of her wellbeing.

Goffman’s idea of stigma centers on the identification of an “attribute” that
differentiates a person in a negative manner. For example, homosexuality in
Mississippi becomes a negative “attribute” because it differentiates an individual
from the majority heterosexual population.

Additional sources have expanded upon Goffman’s original work using
concepts of variation from the norm, negative attribution, and devaluation. Stigma,
thus, originates from “a characteristic of persons that is *contrary* to a norm of a social
unity” (Stafford & Scott, 1986: 80). From the example above, homosexuality is
*contrary* to the social norm of heterosexuality. Stafford and Scott’s definition of the
“norm” as a “shared belief that a person *ought to* behave in a certain way at a certain
time” suggests that the opposite behavior is *wrong* (81). Continuing with the example
of sexual identity, homosexuality then becomes wrong because it is different from the norm. As an “attribute and a stereotype” stigma produces a “mark,” linking an individual to undesirable characteristics, producing a negative connotation in regards to acceptable behavior (Goffman, 1963: 4; Jones et al, 1984). Therefore, not only is homosexuality wrong, but also it negatively “marks” an individual. Furthermore, “stigmatized individuals posses (or are believed to possess) some attribute, or characteristic, that conveys a social identity that is devalued in a particular social context” (Crocker et al, 1998:505). Thus, the individual who outwardly identifies as homosexual becomes less than his heterosexual counterparts.

Building from the conceptualization of stigma above, I define stigma as: the differentiation and exclusion of an attribute or attributes, which results in devaluation and unequal access to power. As an “attribute that is deeply discrediting,” stigma becomes a kind of thing, a culturally constructed negative in which society not only rejects the attribute but the entire associated individual (Goffman, 1963: 3). In this way, the “undesirable difference” that an individual possess leads to a “spoiled identity” (Goffman, 1963: 3). The “mark” dangerously impedes on an individual’s self-identity, becoming who the person is rather than a culturally imposed negative feature that the person has. For example, a patient has cancer, but at the same time, a person is homosexual. The mark of homosexuality threatens to marginalize the entire individual for just one aspect of his identity. For this reason, I use the term “people living with HIV” in order to express sensitivity and mitigate some of the negativity associated with HIV.

**HIV-RELATED STIGMA**

With HIV-related stigma, the HIV “mark” is essentially invisible due to the
nature of the virus, however, associated attributions, such as homosexuality and racial minority, negatively “mark” and devalue an individual. As multiple negative identities create a compounding stigmatizing effect, the progression of stigma definitions listed above highlight the intersectionality of stigma. Synthesizing the progression of the conceptualization of stigma from Goffman to Crocker et al, Link and Phelan identified five-interrelated components of stigma, adding that they must converge under the exercise of power (Link & Phelan, 2001: 367). First, like above, people must distinguish and label differences. Second, the dominant culture links the label to undesirable characteristics, which culminate into the third characterization of an “us versus them” mentality. In the penultimate category, the labeled persons lose status and face discrimination that leads to unequal outcomes. The first four components follow the progression of the definitions given previously, but Link and Phelan insist that the components of stigma will not converge unless an imbalance of power exists – the fifth component of stigma. Thus, stigma exists when labeling, stereotyping, separation, status loss and discrimination co-occur under the exercise of power (Link & Phelan, 2001: 367). The co-occurrence of stigma perpetuates HIV stigma, as multiple HIV-related negative actions cumulate and further marginalize PLHIV.

Like the definition of co-occurrence implies, HIV-related stigma does not occur in isolation. HIV-related stigma results not only from HIV itself but also from negative behaviors associated with its infection. It is impossible to isolate one stigmatizing variable related to HIV – such as sexual identity – and attain accurate results without the influence of other variables intrinsic to an individual – such as race or sexual behavior. Rather, a “host of stigmatizing circumstances” influences
each outcome (Link & Phelan, 2001: 382). The mutual intersection of stigma with other forms of marginalization creates “interlocking matrices of oppression” (Crenshaw, 2002: 207-13). Therefore, high-risk behaviors become “interlocked” with HIV stigma. Because of this, efforts to reduce stigma must be multifaceted and multilevel to combat the multitude of stereotypes – such as labels of PLHIV, FSW, or MSM – in the “matrices” of HIV oppression.

**THE DICHOTOMY OF HIV-RELATED STIGMA**

In order to better understand how HIV-related stigma is manifested on an individual level, public health definitions divide stigma into two categories: **perceived** stigma and **enacted** stigma (see Brown et al, 2001; Chamber et al, 2015). The different ways in which individuals experience stigma become important in the intersectional matrix of HIV-related stigma. First, enacted stigma applies to the real experience of stigmatization (Brent, 2016: 234). Enacted stigma occurs when a person suffers real consequences of stigmatization, such as the loss of a job due to HIV status (234). Second, perceived stigma refers to the fear of being stigmatized (Brent, 2016: 234). Occurring before any actual stigma occurs, I use the concept of perceived stigma to analyze how PLHIV manage their fear of stigmatization through avoidance in testing and treatment. Identifying both categories of stigma helps the research process.

Further analyzed in the following chapters, the mere fear of being stigmatized compounds already existing stigmas experienced by individuals. Already marginalized from society, one who fears being “outed” may further ostracize him. For example, physical segregation of walls and gates in HIV wards in medical facilities exhibits enacted stigma. The stigmatization of the enacted stigma is further compounded with perceived stigma, as PLHIV fear being marginalized if a family
member reads their prescription label, patient records, or medical books.

Additionally, lack of education of about HIV and associated identities in medical school leads to healthcare discrimination. PLHIV also fear oppression at the hospital, oftentimes causing them to avoid hospital and taking medication. In taking care of one’s own health and wellbeing, PLHIV engage in management strategies in order to lessen the negative affects of perceived and enacted stigma (Chambers et al, 2015: 8). First, PLHIV manage both perceived and enacted stigma through health care utilization such as turning to informal care, commuting to larger or more distant facilities, postponing disclosure to healthcare professionals, avoiding HIV-related clinics or organizations, and refusing treatment entirely (Chambers et al, 2015: 8). PLHIV also manage both forms of stigma through adherence (Chambers et al, 2015: 8). Because adherence to medication could inadvertently disclose HIV status, perceived stigma profoundly impacts optimal adherence to antiretroviral (ARV) treatments. Unfortunately, stigma avoidance versus medication adherence leads to “competing priorities,” where a patient may permanently compromise his or her health for temporary exemption from enacted stigma (Ware et al, 2006: 905).

Throughout my research process, many interlocutors referred to felt or enacted stigma as influential to accessing healthcare benefits or treatment regimens. Though not in specific terminology of “perceived” or “enacted” stigma, the marginalized groups that I studied overwhelmingly avoided situations in which they feared stigmatization or being “outed” or faced some degree of loss once disclosing their status. I will detail evidence for both facets of stigma later in my case study chapters.

STIGMA + THE MORAL MODEL OF DISEASE

By breaking stigma into smaller categories and addressing the specific
sources, it becomes possible to create focused efforts to begin reducing HIV-related stigma. A UNAIDS report aimed at reducing stigma gives a three part explanation for the perpetuation of negative views toward PLHIV (UNAIDS, 2012). Blaming society’s negative attribution on “ignorance about the harm of stigma, continuing irrational fears of infection and moral judgment” the UNAIDS identifies a moral explanation for the continuation of HIV-related stigma (UNAIDS, 2012). Evaluating thousands of articles on the topics of HIV and stigma in order to explain stigma in the context of health care, Chambers et al also identified an influential moral component (Chambers et al, 2015). Judgmental perceptions based on social beliefs of infection and transmission exist inside and outside the healthcare sphere (Chambers et al, 2015:6).

By focusing on ways in which “judgementalism” persists, I contextualize HIV-related stigma under the moral model of disease (Chambers et al, 2015: 7). For my thesis research, social moralization of HIV infection occurs when health care providers or societies in general blame patients for their infections due to denigrated lifestyles. I argue that interconnections between HIV-related stigma with other forms of social ostracism in the cases of Vietnam, Argentina, and Mississippi most clearly synthesize under the moralization theory. Under the moral management framework, health outcomes are viewed through the perspective of the dominating moral compass in a society. As I have exhibited throughout the operationalization of the definition of stigma, dominant forces use moral attributions to devalue social groups that deviate from dominant social values. Dominant social groups enforce moral attributions to constructions of society – such as sexuality, drug use, and sex work – and any deviation from the dominant culture results in demoralization and blame. In
addition, those with HIV who participate in “socially deviant” activities consequently attach HIV-related stigma to those actions (Madru, 2003: 39-48).
B. METHODOLOGY

Due to the nature and sensitivity of the topic of HIV, I have elected to take a qualitative approach focused on ethnographic exploration to compare and contrast the effects of stigma and moralization in the contexts of Vietnam, Argentina, and Mississippi. With the three cases of Vietnam, Argentina, and Mississippi, this thesis is a comparative study that utilizes the most-different systems design. A most-different systems approach compares very different cases that share the same dependent variable (Mechstroth, 1975). While each case may at first appear drastically different from the others, they all tie together under my elected dependent variable: HIV-related stigma. I have chosen to focus only on the cases of Vietnam and Argentina, and not include South Africa, because of their similarities of association of HIV with high-risk populations. The data collected is a compilation of primary and secondary sources as well as immersive fieldwork from living and studying in each country context. The majority of data comes from my semester abroad studying public health and community in the United States, Vietnam, South Africa and Argentina. For this thesis, I reviewed my jottings in my field journal from interviews and site visits in Vietnam and Argentina. Unfortunately, due my purse getting stolen mid-semester in South Africa, I lost my physical copy of my field journal that contained all of my notes from class as well as from each excursion. I fortunately saved pictures from relevant site visits that I needed for class assignments, so I use my pictures and class presentations to fill in missing details from my interviews in Vietnam. I also accessed my class Dropbox to retrieve articles and class PowerPoints from the semester in order to use them as sources. At the end of each country section, my case study group and I presented our findings from...
interviews and relevant class lectures and compared them in a final presentation at the end of the semester in Argentina.

I found through my exploratory fieldwork that Vietnam and Argentina faced similar burdens of disease as my current home state of Mississippi. First of all, the populations affected by HIV are focused and already stigmatized populations. In Vietnam, the high-risk groups of association include injection drug users and prostitutes. The epidemic does not quite affect the population at large. Though I have had difficulty finding exact data for the percentage of the population that is HIV-positive, due to misinterpreted data and corruption of the Ministry of Health while reporting such figures, my personal experiences interviewing locals and people living with HIV revealed that the disease is strongly looked down upon and correlated with other immoral acts – such as doing drugs and having multiple sexual partners, either legally or out of wedlock. Religion, and more generally morality, also played a strong role in the attitudes toward HIV and the high-risk causes. Vietnam is strongly influenced by the moral model of disease, in which moral actions have serious physical consequences on one’s health. Moving to Argentina, I noticed a similar trend, though not as obviously linked to the moral model and karma but with a predominantly Catholic influence. Like Vietnam, the percentage of persons affected with HIV is generally small compared to the population at large. However, certain populations are affected more than others, and typically populations that are already outcast from the general society. Thus, the moral model of disease framework applies to the Argentina case, as HIV is associated with immoral acts and associations – such as the transgender female population and men who have sex with men. Due to the presence of HIV-related stigma being negatively associated with
already marginalized populations, the cases of Vietnam and Argentina are similar to Mississippi because of the burden of HIV falling mainly on minority groups of gay and black men and the presence of intersectional stigmas of social deviations – race, sexuality – combining to produce a greater HIV-related stigma. Furthermore, my experiences in Vietnam and Argentina reminded me of similar associations in Mississippi, so I continued the same methods of research based on the moral model of disease in my current home state.

As part of the curriculum for my Research Methods course, my case study group, consisting of five other females and myself, explored HIV and stigma in further detail in each respective country, applying the methodological concepts and tools covered in the course. At the beginning of the semester, my group set out to study mother-to-child (MTC) transmission of HIV; however, after our primary interviews and site visits in Washington, D.C. and Hanoi, Vietnam, with little access to MTCT-specific HIV organizations and the prevalence of discussion around stigma as a main obstacle to HIV treatment, that original research question transformed into wondering how stigma was manifested in each country. Personal experience and participant observation have greatly influenced the direction of this thesis. In each country, I lived with a host family, which allowed me to intimately participate in the lived experience of the locals. Through personal experience, I became to the best of my ability, though I did not phenotypically fit in very well, part of the society in which I lived. Additionally, I was also able to participate in the life of my intellectual peer group and the broader societies in which I lived through participant observation. For example, I sat in the homes, and sometimes on the beds, of the interlocutors I interviewed, sat in on city meetings in the rural towns we
visited, and constantly directly observed the world around me and my place in it.

For this reason, I predominantly utilized an ethnographic method for collecting qualitative data. This approach recognizes my position as interviewer, observer and participant in my research. By living in the communities with local families in both Vietnam and Argentina, I developed a more holistic understanding of how stigma is manifested in various parts of life in both cases. Kleinman and Benson’s definition below of ethnography in the medical field, specifically, shares the importance of understanding a person holistically, as I tried to do with the people whom I interviewed:

Ethnography emphasizes engagement with others and with the practices that people undertake in their local worlds. It also emphasizes the ambivalence that many people feel as a result of being between worlds… ethnography eschews the technical mastery that the term “competency” suggests. Anthropologists and clinicians share a common belief – i.e., the primacy of experience. The clinician, as an anthropologist of sorts, can empathize with the lived experience of the patient’s illness, and try to understand the illness as the patient understands, feels, perceives, and responds to it (2006: 1674).

Similar to classic definitions of stigma, this quote relies on the observer, the outsider and oftentimes the dominant to report the lived experience of another. In the context of stigma, an illness is considered socially inferior and deviant from its dominant, and more powerful counterpart of wellness. Putting stigma into the context of medicine, or vice versa, this insight from Kleinman and Benson necessitates the observer, as an anthropologist or clinician, to remove as many possible pre-dispositions toward a particular situation or person in order to minimize intersectional stigma.

My ethnographic research consists of semi-formal field research, informal and semi-formal interviews, and direct and participant observations. With limited internet or library access, my field research mainly consisted of taking detailed notes
and pictures from sites and collecting pamphlets or other physical materials when provided. The photographs below show an excerpt from my field

Notes from my field journal used at each interview. Excerpt from IDU Peer Group Meeting, 2/27/17

notes in Vietnamese from a visit with an HIV/AIDS peer group named “White Sand.” Speaking with the group, which chose its name on the foundations that “white sand, if it stands alone, has not meaning; but together we are important,” I learned how important ethnographic fieldwork is in the research process of learning the lived experience of HIV. Additionally, an informal meeting, where I sat around in a circle dispersed with PLHIV and my group members, provided an intimate environment where the members felt comfortable sharing personal experiences and stories.

The formality of interviews like the group meeting with White Sand depended on the
activity. Some interviews were planned and prepared in advance, with thought-provoking questions specific to the interlocutor, while other class activities required organic conversation with little structure. The country coordinators in Vietnam and Argentina organized specific case study days, where my group would meet with an individual or organization that was an HIV expert for an interview. In each country, my case study group interviewed people in both urban and rural settings about cultural-specific issues surrounding HIV in order to get a sense of how stigma was manifested in each case. As part of my program, we lived and studied in an urban setting for three to four weeks and then moved to a rural setting for about a week. This allowed us to compare the large government hospitals and HIV clinics in the city of Hanoi to provincial health clinics and community health worker programs in the rural towns.

The interviews were done in groups with four to five students, an interpreter, and an interlocutor and lasted approximately thirty to forty-five minutes. Led by the students with semi-structured, pre-formed interview questions based on the interlocutor’s background, the interview questions were open-ended and flexible to the direction and discretion of the interviewee. Because of the somewhat short time in each country and availability of interlocutors, we used a snowball sampling method. While a snowball method does not allow for a totally randomized study, it still provides a satisfactory representation of the population. Though we understood that our interlocutors would not in any way represent the entire countries’ views on their stance of stigma in regards to HIV, we worked with the program directors to speak with a variety of representatives from all sectors working with HIV – including NGOs, physicians, government staff, and HIV-positive persons.
For best efficiency, my group delineated tasks for each interview; we split up so half would take notes and the other half would actively ask questions, switching roles each time. As an active participant in my case study group, I designed two to three interview questions for each formal interview, took detailed notes from half of the interviews as well as asked question and led one-fifth of the interviews. Focusing on the topic of morality, I specifically asked how people thought about PLHIV, where PLHIV lived in regards to the general society, and what problems they faced in their day-to-day lives. In Argentina, I played a more active role in asking questions, jotting notes, and interpreting since I am more efficient in Spanish. I was able to help the case study coordinator and interlocutors with variable words and phrases in describing stigma and exclusion, as well as pick up on the specific words and phrases that the interlocutors used themselves. By noting the actual words of the interviewee instead of the interpreted version, which sometimes altered from the original statement, my notes and understanding of HIV in Argentina was more thorough and authentic.

The interviews included representatives from various non-governmental organizations (NGOs), the Vietnam and Argentine Ministries of Health (MOH), physicians and residents at both private and public hospitals, professors, host families, locals, and persons living with HIV. In Vietnam, most interviews were conducted with the aid of an interpreter, who would often translate our questions to Vietnamese and then to the local dialect with the help of another interpreter, who would then relay the response back to English. I took care to ask clear, explicit questions, often in multiple ways and using various descriptive alternative words for stigma – such as exclusion, discrimination, or shame – in order to get accurate and
appropriate responses. In Argentina, most interviews were conducted in English, with the help of our Spanish-speaking case study coordinator to translate if clarification was needed. As I said, I played a crucial role in Argentina because, unlike in Vietnam, I spoke the native language. This allowed a greater variety of interviews, as I could for example, speak to the cleaning staff at our rural stay and ask for clarification from healthcare workers at the city clinics. Not only did I note the responses, but also I paid close attention to non-verbal cues, such as body language and tone of voice, in order to “hear” what the interviewee was really saying.

To compliment the interviews and attempt to fill in some of the gaps left from our somewhat small sample size of interviewees – ranging from five to seven interviews per country – my ethnographic approach also includes direct and participant observations, site visits, and guest lectures. I observed both private and public hospitals as well as community clinics and rural hospitals in both Vietnam and Argentina. In each setting, I noted if I saw condom bins, HIV publications, and sexual education materials, among other visual observations. Since my study abroad program focused on experiential learning, we often visited museums, indigenous communities, or low-income neighborhoods in order to gain a better understanding of the lived experience and health obstacles our neighbors faced. Detailed field notes from those excursions, like the shantytown in Argentina and neighborhood walk in Vietnam with my host family, helped provide data about hospital prevalence and resident perceptions of HIV in their communities. Finally, guest lecturers about topics in HIV/AIDS, Health and Gender, and Immigration Health provided additional data to compliment my interviews.

Methodology for collecting data in Mississippi is similar but differs slightly.
due to the less structured nature of conducting ethnographic research independently of my program. I still took a qualitative approach, but data more equally relies on the contribution of primary and secondary sources to compliment fieldwork. All data from interviews and observations are covered under IRB approval to interview and report data from interactions with individuals who work in the field of HIV in the state of Mississippi, mainly in Oxford and the Jackson Metropolitan Area. In the same sense, I am an active participant in the context of Mississippi and have even more empathy and understanding due to the longer period of time I have spent in the state. However, because of my comfort with the context, I must be aware of my personal biases or apathy in certain circumstances. In a way, I must reevaluate my positionality as if I were a newcomer to this context. My approach in the case of Mississippi consists of an interview with a physician in Oxford, Mississippi, as well as clinic observations and continuous field notes, as I did in the other two cases. The qualitative approach will be useful in focusing on the lived experience of stigma.

The combination of qualitative and quantitative data with a most-different systems research design ultimately provides a holistic representation of how stigma appears in the varying contexts of Vietnam, Argentina, and Mississippi. My Research Methods professor, a French anthropologist, emphasized how the ethnographic experience fosters an awareness that ambiguity will always persist in ethnographic research. Because of this innate ambiguity, the interviewer and interviewee will never be on the same page. However, the process of ethnography is built upon a mutual cooperation to reveal the truth of the research. I admit that my research will never perfectly represent the people whom I studied. However, I am confident that the research presented in the following thesis represents the lives and experiences of the
dozens of people with whom I built relationships. Using a quote from Durant, my professor explained the mutual agreement that the information we collect, though biased toward our own perceptions, reflect the truth at the bottom line:

“Intersubjectivity means the condition whereby I maintain the assumption that the world as it presents itself to me is the same world as it presents itself to you, not because you can read my mind but because I assume that if you were in my place you would see it the way I see it.” (Duranti, 2010)

The accumulation of my interviews, site visits and observations relies on the understanding that the truth of individuals is mutually represented through my research. Due to limited time in each context, I was not able to build personal relationships like in typical ethnographic fashion. But I used the time and resources I had to provide a thorough representation of HIV-related stigma in the three cases.

I had to be most careful when approaching my main topic of stigma. The term “stigma,” however, has a stigma in and of itself. Because of this, related terms, like exclusion and discrimination, are used for clarity for both the interlocutors and for the research. By living alongside many of the interviewees and gaining my own understanding of what stigma looks likes during my day-to-day activities, I realized the importance to remove all of my previous perspectives and open my eyes to the lived realities of those around me. Like Evans-Pritchard states, people’s rationalities for beliefs and occurrences are vastly different; and using their lens of rationality is utterly important in helping to understand the choices they make and their lived realities as we put their ideals into the overall context of our greater theory (Evans-Pritchard, 19).
CHAPTER TWO: 
VIETNAM CASE STUDY

INTRODUCTION

My study abroad program began in Vietnam, and so began the process of researching what HIV looked like through the perspective of a post-colonial, Communist, deeply religious country. Originally, our research question sought to determine the relationship between maternal and child health and HIV in the countries to which we were planning to travel: Vietnam, South Africa, and Argentina. However, the Vietnam context did not lend itself easily to ethnographic research of mother-to-child transmission of HIV because that specific population only constitutes a very small percentage of the burden of HIV in the country, and with only one month in the country, I did not have ample time to track down people involved in such a small portion. Also, the HIV epidemic and resulting government propaganda centers on high-risk populations. After interviews in rural villages, meeting with members from support groups for sex workers, injection drug users, and mother and children with HIV, guest lecturers, and discussions and readings from class, the theme of stigma stuck out. Stigma, whether the word was explicitly spoken or not, was a common thread throughout my ethnographic process in Hanoi and the northeast countryside. Due to government propaganda and a stratified healthcare system, most of the interlocutors referred to stigma by name (Inter-Parliamentary Union, 2015: 1).
Thus, the process of our research began a sort of metamorphosis in Vietnam that continues throughout this thesis project. The organic development of the original research question that eventually turned into this thesis project began with a single interview in a Thai village in the northeastern corner of Vietnam. Following a lavish welcome from the Village Headsman, who greeted us with hot tea and an impressive recount of the public healthcare initiatives set in place in his community, my team of three other female students, our research methods professor, a local translator and myself continued to an elderly woman’s stilt house. After opening with small talk and many questions of why we were so old and not yet married – Vietnamese custom, we learned from trial and error, to participate in casual conversation when meeting someone – we asked about the presence of infectious disease in the village. Immediate whisper ensued. Gossip, we realized, is a universal language. Though the Village Headsman assured us that HIV did not exist in his village, this gentle, innocent elderly woman apparently knew otherwise. The woman at the rest stop, she began, was gossiped to be HIV-positive. While her husband was away for work, which was often, she was rumored to have many affairs. Because of these immoral acts, she apparently had contracted HIV. In fact, the public health representative, who would regularly drive up and down the dirt roads on his motorbike with a loudspeaker to make community and health announcements, used to shame this woman and other people who were engaging in unacceptable behaviors. The relationship between morality and disease and the obvious association of shame and secret-keeping led to the further exploration of the influence of the moral model of disease on HIV stigma.

Empirical evidence of the presence and extent of HIV in Vietnam seemed
impossible because of the Communist regime due to limited access to official files and reports. Within a few days in the country, I realized that public information is difficult to attain and even harder to verify. For example, each guest lecturer for my public health classes shared conflicting statistics from the previous. Our public health professor attributed this falsification of statistics to what he termed “performance syndrome” – basically, a pressure from the government to appear better than one really is. Under a Communist Regime that boasts universal healthcare, the government and, therefore, representatives thereof would want to portray it as providing adequate social services. Thus, statistics shared by guest lecturers and at site visits were often not correct at all, and, therefore, not referenced in this study at all. I use reliable international sources to fill in quantitative data.

According to UNAIDS, PLHIV constitute 0.4% of the population, and the epidemic remains concentrated among populations of IDU, MSM, FSW, and people who live in urban cities and the mountainous provinces (UNAIDS VN). The majority of this study focuses on qualitative data from ethnographic experiences, especially in the case of Vietnam. Studying personal conceptions of stigma, qualitative data from people in the field about their own lived experiences of how HIV burdens the population is superior to quantitative data about HIV in general or statistical data about stigma. Stigma is difficult to quantify in general, and even after that, varying definitions of stigma complicate analysis.

One grounding fact about HIV in Vietnam is important to keep in mind: HIV is not a widespread epidemic and is most often associated with what the Vietnamese would associate with promiscuity. The population does not outwardly discuss or acknowledge the issue due to the connection with immorality, but more
importantly, with the implementation of The National Strategy on HIV/AIDS Prevention and Control in Viet Nam till 2010 with a Vision to 2020, the government has officially associate HIV to specific interrelated activities – specifically injection drug use and female sex work (Ministry of Health, 2009). By law, HIV is associated with acts that are considered promiscuous and against the conservative religious beliefs carried by a large portion of the country’s population.

In order to study effects of HIV stigma on persons with HIV and the general population, I used an ethnographic approach. By asking open-ended questions in semi-structured interviews, this approach allowed for the interlocutor to help mold the research project and ultimate research question, as referenced above. Ultimately, the case study of Vietnam seeks to ask the question: what is the moral model and how does it apply to HIV?

**METHODS**

Included in my ethnographic process was a series of interviews and meetings with support groups as well as site visits to Provincial Hospitals and rural clinics. The interviews important for the outcome of my thesis research were conducted in the two indigenous H’Mong and Thai villages in a northern mountain province of Vietnam mainly with women of childbearing age. Additional group interactions with female sex worker and injection drug user support groups helped to get a holistic understanding of the personal experience of living with HIV. We also visited an HIV clinic and maternal ward in Hanoi, where women with HIV were physically separated from the other pregnant mothers. Guest lectures, class discussions, and infectious disease assigned readings helped fill in the gaps for more, yet limited, quantitative data.
Most research consisted of semi-structured interviews in a group setting. Due to limited time in the Thai and H’Mong villages – only a day spent in each – the number of interviews as well as scope of the topic was restricted. The language barrier presented a unique challenge, in which the interviews were often translated from English to Vietnamese and then to a local dialect and back to English through the cycle. From the first interview in the Thai village, we quickly learned the importance of using words other than stigma – such as discrimination, exclusion, or asking where the people who have HIV live in relation to the interlocutor or how people in the village treat him or her. Since stigma kept coming up in both interactions with local Vietnamese people and personal conversations with our case study group, we began to focus future research on the effects of stigma. I, deeply religious personally, took an acute interest in the moral model and directed my questions at negative moral principles guiding stigmatization.

**CASE STUDY ANALYSIS**

The interviews, though small in number, proved to be influential in the development of this thesis. Conversations from interviews in two rural villages provide the foundation for the Vietnamese case study. The first village, the Thai village – already referenced in the introduction of the chapter, consisted of two semi-formal interviews and a post-observed important informal interaction. After a two-hour walk uphill to reach our destination among rice paddies and stilt homes, my group began an exercise to walk around to people’s homes and ask if we could speak to them. The head of the village graciously awaited us and invited us into his home. He spoke of how the community is about a thirty-minute motorbike ride from the nearest hospital. When we brought up the topic of HIV, after much hesitation, he
quickly gave a seemingly recited response that they, the people of his village, do not stigmatize. This quick response showed the influence of government propaganda against stigmatization in word – not quite in action. He claimed, then, that his village did not have anyone with HIV, however, the village nearby had almost twenty HIV-positive people. When using the actual term of stigma, the Village Headsman denied any existence of its impacts or associations with persons living with HIV. However, by stating that many people nearby do have HIV, he exemplified Link and Phelan’s aspect of the creation of power structure through an “us versus them” mentality that links “labels of undesirable attributes” to the other (Link & Phelan, 2001: 370). This was a breakthrough in our ethnographic research, as we realized that his words against stigmatization did not match his actions. By saying that those people have HIV, he was belittling the neighboring village, making them inferior and less of people than his own – thus, by definition, perpetuating HIV-related stigma.

The village headsman’s story starkly juxtaposed the story of an elderly lady whom we visited next, who claimed the shop owner had HIV. Just about a quarter mile apart, the stories of the two differed greatly. To get to the home of the elderly woman’s stilt home, I had to physically pass the rumored storeowner with HIV. In fact, my group and I stopped at her little shop to eat lunch. While there, we smiled at each other, talked a little with the help of our interpreter, and reveled at her hospitality – giving us cold Coca Cola’s from her refrigerator and napkins to eat the food we brought. All smiles, this woman graciously welcomed us into her store. Little did we know, though, that mere steps away, we would learn that she had been marked by the neighbors because of promiscuous acts with men. In hindsight, I realized that she had about two or three
men in her shop with her, and she probably loved the company since she was ostracized from her own village. The Thai village experience revealed the intricacy of stigma – while some increase its marginalization through gossip and blame, others perpetrate it even further by denying its existence.

A hand-drawn map of the Thai village I drew, showing the physical layout of the three visits

In addition to interviews, site visits to hospitals and other healthcare facilities illustrate the affects of HIV-related stigma. Though I do not recall the name of the facility, I visited an HIV clinic in the city with my class. At the clinic, we had a short lecture from the director of the clinic and a tour of the facilities. During the informal lecture and question and answer portion of our site visit, the director explained the general demographics of the population that attended the clinic. Most of the patients came from rural areas or opposite sides of town, she explained, so that their family members or community would not discover their status. The patients’ utilization of health care for fear of disclosure or stigmatization exhibits the
framework of HIV-related stigma in the context of the dichotomy of perceived and enacted stigma. Like Chambers et al states, one way in which PLHIV manage stigma through health care utilization is by “commuting to care outside of their community” (2015: 8).

Additionally, the majority of the population that attended the clinic also came for weekly allowances of methadone in addition to antiretroviral treatment (ART), as they were recovering injection drug users. Another contributing factor to HIV-related stigma is the presence of intersectional stigma and the “connection between moral attributions and the devaluations of social groups disproportionately impacted by HIV” (Chambers et al, 2015: 11). The presence of a pharmacy that dispensed only methadone, a drug used in Vietnam to help rehabilitate drug addicts, at the HIV clinic connotes not only the power in intersectional stigmas but also morality. Though also practical, the government was helping to perpetuate the moralization of stigma by ascribing HIV-related stigma, a negative attribute, to those who participate in injection drug use, another deviation from the dominant culture (Chambers et al, 2015: 11). Furthermore, in a study conducted in Vietnam, Maher et al reported that some people living with HIV internalize the social moralization attributed to drug use (2007). The Maher et al study introduces a phrase that I often heard during my study in Vietnam. Participants in the study articulated the phrase, social evil, often associated to high-risk behaviors in Vietnam, in reference to themselves as social evils (Maher et al, 2007). The label of oneself as so morally demonizing as evil proves just how strong the negative moralization of disease plays into the experience of HIV-related stigma in Vietnam.

Following the informal lecture and question and answer segment of the visit,
the director of the clinic led my group of about eight American students on a tour of the two-story duplex-like clinic. Being such an intrusive and obvious group, I felt as though we were a physical embodiment of a confidentiality violation (Chambers et al, 2015: 6). As we toured the facility, a physical barrier of a fence separated the HIV clinic side from the other side that housed a pediatric clinic. I could see through the fence, though, to the patients waiting on the other side, and remembered wondering how the patients on my side of the fence felt to not only be exposed but also so segregated at the same time. As UNAIDS and Chambers et al describe a negative affect of HIV stigma in terms of institutional discrimination, the barrier served to further differentiate the population of those living with HIV from the general population (see: UNAIDS, 2012; Chambers et al, 2015). Another study from Vietnam that focused on HIV/AIDS stigma in regards to women, a twenty-two year old postpartum woman revealed how segregation within health care settings functions as a means to stigmatize people with HIV:

“You know, at [the] hospital, when we come, everybody knows who we are. Infected people want as few people to know about their situation as possible. With other diseases like hepatitis, the patients may die sooner but aren’t as discriminated. This disease is repellent. Therefore at [the] hospital, there is a room reserved for the patients of this [HIV/AIDS] disease. Anyone coming there is infected. When we’re waiting outside the room, we will be identified as infected. That room is for this disease. You go elsewhere for other disease or for consultation. That room is for this disease.”
(Brickley, 2007: 107)

CONCLUSION

Whether a physical reminder of HIV-related stigma in an HIV clinic or the words that weren’t said in an interview with a village leader, the amalgamation of HIV-related stigma with other “social evils” confirms the implementation of stigma in the negative moral model of disease in the Vietnamese case. The moral model
adds a complex dimension that manifests as stigma in action but not always in word. Yes, people with HIV are viewed differently and outcast in many circumstances. However, this is because they are a representation of immorality in a family or group—not solely due to a diagnosis of a disease. Thus, negative social moralization is deeply internalized, and the blame on the individual for his or her infection evades the labeler from personal responsibility of stigmatization.
CHAPTER 3: ARGENTINA CASE STUDY

INTRODUCTION

Following my in-depth study of the application of the moral model of disease in Vietnam in regards to HIV and stigma, and the itinerary of my study abroad program, I began my study of HIV in Argentina next. Though traveling from one big city – Hanoi – to another – Buenos Aires – the only thing in common between the two cities seemed to be the traffic. More familiar in a sense of European architecture and the hustle and bustle of cars versus motorbikes, the HIV environment was not what I had expected. At first, via lecture topics, guest lectures, site visits to community health clinics, and meetings with my case study coordinator, HIV appeared widespread, contrary to Vietnam’s 0.4% prevalence (UNAIDS Vietnam, 2018). However, under closer inspection, I realized that my mostly false sense of HIV as a ubiquitous epidemic was not completely untrue because Buenos Aires, nor was it true. Where I lived served as a magnet for the growing population of migrant transsexual women seeking refuge from condemnation from their families and communities. In fact, as I learned in my Public Health class, thirty-four percent of transsexuals in Argentina are living with HIV. In Argentina, like Vietnam, HIV impacts high-risk, marginalized populations – in Argentina’s case: transsexual women, men who have sex with men, and rural women. The contexts of HIV stigma in Vietnam and Argentina were not so different after all. Though Argentina
boasts a progressive stance regarding the lesbian, gay, bisexual, and transsexual (LGBT\textsuperscript{a}) population, devaluing attributions still linger. Just like in Vietnam, HIV-positive persons are likened to actions of immorality and shame, such as the gay and trans population. I use the Argentinian case to expand on the implications of negative moralization of HIV-related stigma.

By passing multiple progressive laws about gender identity, Argentina is moving in the right direction in mitigating sexually-related stigmas associated with HIV. In general, the right to universal healthcare in Argentina benefits the reduction of the overall burden of HIV by providing free ARVs and testing. Ley 26.791, known as the anti-femicide law, prevents hate crimes based on sexual orientation, gender identity and gender expression (Ministerio de Justicia y Derechos Humanos). In 2012, Argentina passed The Gender Identity Law, which allows transgender or transsexual persons to legally change their gender both on legal documentation and physically with the help of free hormone treatment and gender reassignment surgery provided by the country’s universal healthcare system (Schmall, 2012). A series of progressive laws in relation to the LGBT community help to reduce intersectional stigma through the normalization of varying sexual identifications, thus reducing HIV-related stigmatization. HIV-advocacy groups hope these progressive laws will allow for greater acceptance of the marginalized population into society, thus helping to reduce additional stigmas that affect people living with HIV.

In Argentina, HIV is a focused epidemic – mainly affecting the LGBT population, specifically transsexual women, and a growing population of rural

\footnote{I limit the designation of the LGBT community in Argentina to just the four letters presented, as opposed to the LGBTQIA version used in the United States, because that is what was used in the literature and lectures in Argentina.}
females. With approximately 120,000 people living with HIV in 2016, PLHIV in Argentina constitute just under 0.3% of the population (UNAIDS Argentina, 2018). While a leader in South America for its treatment of HIV, a poignant question remains for Argentina in regards to their plight against HIV: why, in spite of universal access to healthcare and focused marketing to high-risk populations, do populations of PLHIV continue to rise? Simply, what are the implications of negatively associated moral connotations toward stigma on the burden of HIV? I argue that it is because of how the negative moralization of disease facilitates stigma against already socially marginalized populations.

METHODS

Most of the data from the Argentina case study involve ethnographic research. In order to best understand how HIV-related stigma is manifested in the framework of the moral model of disease in Argentina, I had to focus on experiential learning through interviews and observation. Aligning with this approach, my methodology consisted of semi-structured interviews, clinic observations, site visits, field-note taking. We visited medical facilities – clinics, hospitals – as well as non-governmental organizations and the Ministry of Health. Additionally, the country coordinator in Argentina chose case study coordinators for each group to help lead interviews and research, so we were already at an advantage over Vietnam because we now had an HIV expert who coordinated a holistic list of interviews and site visits as well as provided endless information for her personal experience. For one of our first assignments in the country, I traveled by public transportation to a government clinic in a predominantly Colombian migrant community in Buenos Aires with a group of six classmates and my Globalization and Health professor.
Additionally, during a case study interview with an infectious disease specialist from Hospital Juan Fernández, the leading hospital in the country for HIV care, I toured the infectious disease ward and spoke to infectious disease residents at varying levels of their residencies about their experiences of stigma and opinions.

The semi-structured interviews included a representative from the Ministry of Health, various non-governmental organizations, an infectious disease specialist and residents, locals, and a person living with HIV. We conducted most of the interviews in English, with the help of our case study coordinator to translate when needed. Between our travels from Vietnam to Argentina, one of my case study group members had to return home, so my group consisted of four females, including myself. This enabled an even rotation of roles as note-taker versus interviewer and allowed the opportunity for all to ask questions if desired. I continued with asking questions directed at the moral blame origination of stigma in order to contribute to my group’s overall project of finding how stigma was manifested in Argentina. Due to the influential introduction of the case study coordinator in Argentina, the interviews became more formal, structured, and impactful. My case study coordinator, Cecilia, not only facilitated interviews with a representative group of individuals working in the realm of HIV, but she was an expert herself and served as a key source for holes in our research and helping to construct questions that would lead to robust discussion. The interviews became more formal and structured in that we created a more structured outline for the interview, in which I contributed intellectually through question asking and theme connecting. Because Cecilia met with us when we first arrived and chose interlocutors specific to our research question of identifying the ways in which
stigma perpetuates HIV in Argentina, each interview provided a valuable contribution to our transformative research project. Finally, since Argentina was the last country, I became more confident in asking more direct questions about HIV and stigma, and my group functioned well together as we all contributed to build upon our theoretical framework. My research question became more focused, and we improved our mastery of delegation of interview tasks and question preparation. For example, each group member prepared two to three questions for each interview. Additionally, we focused on the ethical aspect of reciprocity and mutuality. Feeling intrusive at first, I learned how to show my gratitude toward the interlocutors in a way to not be the only one benefitting from the interview. Acute awareness of our positions in the interviews – as mostly white, cis, and heterosexual females – helped us to learn to speak about and to people of a marginalized group to which we did not belong.

**CASE STUDY ANALYSIS**

The interviews were non-random, however, I believe they consist of a holistic compilation of interlocutors. My first interlocutor addressed many aspects of HIV-related stigma in Argentina, as he worked for the Ministry of Health Department of HIV/AIDS, directed a youth-run organization of adolescents living with HIV, and spoke of his personal experience of living with HIV. Tomás spoke of his personal experience with internalized shame and guilt, of coming out to his family both as homosexual and HIV-positive, and of the purposes and experiences of the youth-led organization he runs – Red Argentina de Jóvenes y Adolescentes Positivos (RAJAP). Using his personal story as an anecdote, Tomás emphasized the impact of intersectional stigma on the wellbeing of PLHIV, though he used the term
“secondary stigma” to refer to compounding social identities that contribute to a greater burden of HIV-related stigma. To begin, Tomás expressed his own living experience with HIV. In his early twenties, he told us that just months after coming out to his family, he found out he had HIV. He remembered being terrified of losing his home, friends, and family, so he kept his diagnosis a secret for a little while. Through his own experience, Tomás emphasized the influence of stigma internalization. When he was first infected, Tomás admitted that he fell into a deep depression, feeling as though he had become the socially constructed, terrible label that was now associated with him. He began to blame himself for getting HIV, thinking that he had done it to himself for having sexual intercourse with another man and not wearing protection. The judgment that he feared from those around him was also coming from within, he explained. He felt as though he almost deserved the “life sentence” because he engaged in immoral actions. Applying the concepts I have explained, Tomás, at first, faced perceived stigma, which kept him from getting proper care and treatment.

However, Tomás finally came to terms with his diagnosis and decided to help his peers through the challenges he faced. Therefore, Tomás joined a youth-run group for adolescents living with HIV – RAJAP. Through RAJAP, Tomás spoke of the importance of having an outlet to talk about age-specific issues related to HIV. Age, though not as obvious as sexuality, he said, contributed to the burden of HIV-related stigma. As a teenager when he contracted HIV, Tomás said that he faced great stigmatization from adults who claimed he “should have known better.” In addition, adults would scorn youth living with HIV because they believed teenagers should not be having sexual intercourse. His age also placed him at a disadvantage.
for treating his illness. Though medications are free, he needed an adult to see a
doctor and get medication. In this way, his own age became a stigmatizing obstacle.

A barrier to receiving proper treatment, RAJAP helped the adolescents
address their position in society and provided ways in which the youth could get
contraception and proper medications. RAJAP allowed Tomás to manage both
enacted stigma, as he disclosed his status to the group and became an advocate for
PLHIV, and predicted stigma, as he presented examples of discussing age-related
issues such as navigating sexual partners and negative moral connotations from
elders. His definition of “secondary stigmas” exemplifies Link and Phelan’s
assertion that stigma is never isolated (Link & Phelan, 2001). Using his position as a
homosexual youth living with HIV, Tomás proudly told of his work in the Ministry
of Health to lessen the burden of HIV. He said he used his identities that much of
society considered negative and sinful to elevate his platform, through RAJAP and
the MOH. The culmination of the impacts of “secondary stigma” and constant fear
of stigmatization influenced Tomás’ self identity and wellbeing, however, he is now a
healthy HIV advocate who does not let any number of negative labels define who he
is.

Advancing the conceptualization of HIV-related stigma from the interview
with Tomás to a more acute understanding of HIV and stigma in a health care
environment, I visited Hospital Fernández and Doctora (Dra.) Rolón. At Hospital
Fernández, the first and leading hospital for HIV/AIDS treatment in Argentina, we
spoke formally with Dra. Rolón, an infectious disease specialist, and then informally
with her residents. As I followed Dra. Rolón through the narrow hallways of the
infectious disease wing at Hospital Fernández, she spoke of the origins of the
hospital and her dismay at the country’s ability to manage increasing rates of HIV. When asked about the demographics of her patients, the doctor asserted that she treated a large number of LGBT individuals. After leading us to the break room to converse with about a half dozen infectious disease residents, a second year resident added to Dra. Rolón’s sentiment, claiming that many LGBT individuals prefer to be seen by the infectious disease physicians, even if the patients do not have an infectious disease, because the doctors treat the patients with more value and respect. This exemplifies the operationalization of the fear management theory, as the residents and Dra. Rolón and her residents admitted that many other doctors in their own hospital discriminated against sexual identity and were ill equipped to treat transsexual patients, especially transsexual patients living with HIV. The doctors blamed a lack of social science education on varying sexual orientation in medical school for their peers’ inabilitys of and judgment toward differing sexual orientations.

Finally, Cecilia and her coworker at Fundación Huésped presented one of their projects on the Northern Bolivia-Argentina border that serves a primarily indigenous population. Addressing the migrant, indigenous populations of the northern Argentinian border, Cecilia explained the border is home to one of the most concentrated populations of people living with HIV in the country. Fundación Huésped runs a program that addresses vertical-transmission of HIV – otherwise known as MTCT. While geographic difficulties at the border physically hinder health care services, Cecilia stated that multiple compounding variables exist that further marginalize the population and limit treatment for HIV. Differences in language and ethnicity of the population contribute to stigmatization; however,
Cecilia identified religious conservatism of healthcare providers as the largest barrier to effective education and care in order to effectively reduce HIV. To illustrate her point, Cecilia shared a story about a young girl who went to the clinic on the border seeking to acquire contraceptives. Instead of giving the teenage girl oral contraceptive and condoms, as was her legal duty due the application of universal health care, the physician lectured the teenage girl about the importance of abstinence for someone “her age” and refused to give her contraceptives. In this case, the doctor at the border positioned herself as a social judge, condemning the girl based on negative moralization of sexual activity (Chambers et al, 2015: 7).

While prevailing moral contradictions toward sexuality, as exemplified in physician discrimination toward sexual minorities at Hospital Fernández and the Bolivian-Argentinian border, Argentina passed legislature in 2006 that mandates comprehensive sexual education at every school in the country. The Educación Sexual Integral program includes suggested curricula and workshops aimed at educating children with age-appropriate content in primary, secondary, and tertiary levels of education about sexuality, legal rights, and safe-sex practices (Ministerio de Educación, 2006). A specific amendment to the law, Ley Nacional de Sida 23.798/9128, mandates that the prevention of AIDS is to be incorporated into the program themes taught at all levels of education (Ministerio de Educación, 2006: 85). The lesson plans include common stereotypes and prejudices toward HIV, as well as common misconceptions of infection. By doing so, a game as simple as categorizing phrases that are true about HIV and excluding ones that are not help to combat HIV-related stigma through the operationalization of the fear management aspect of stigma.
CONCLUSION

In conclusion, the marginalization of ethnic, sexual, and youth minorities from the dominant society in Argentina create stigma that is further compounded by these groups’ associations with HIV. Though not as obvious as the assertion of the moral model of disease in Vietnam, societal moralization of HIV infection exists in Argentina. For example, Tomás’ original internalization of stigma through personal blame of sexuality and sexual actions exemplify how HIV-related stigma is implemented through a general moral framework. Furthermore, lack of trust toward healthcare practitioners at Hospital Fernández due to overt judgment based on labels of sexuality contextualize the morality of HIV-related stigma in the health care environments. Finally, Fundación Huésped’s project on the Bolivian-Argentinian border in which a doctor’s social judgment against sexual activity demonstrated how the power of the dominant can inadvertently lead to debilitating health outcomes for
a population in addition to exclusion from society, such as the perpetuation of the spread of HIV through the refusal of contraceptives based on moral claims. In the case of Argentina, the moralization of HIV and its modes of transmission further marginalize the populations of transsexual women, rural women, and youth, which are already devalued in society.
CHAPTER 4:
MISSISSIPPI CASE STUDY

INTRODUCTION

“Fifty-seven-year-old white male with abdominal pain,” blurted Dr. Smith, one of the physician hospitalists at Baptist Hospital Oxford, on our way to round on her patients. “What does that sound like?” I pondered the various causes of this man’s pain as we walked to the patient’s room. When we arrived at the patient’s room, Dr. Smith explained to me, as well as the patient, that he had a colon infection and would need to stay in the hospital for a few more days as well as continue taking a strong antibiotic with a particularly high dosage for about two weeks, rather than the normal seven-to-ten day recommended dose. Either this patient has a very serious infection, I thought, or there is something else going on here. The patient, Dr. Smith explained as she charted afterwards, required a particularly intense treatment plan because he had a progressing case of HIV. Wow, I remember thinking. Similar to the village headsman in the Thai village in Vietnam who blamed the nearby village for having HIV, I found myself thinking that yes, HIV did exist in the United States, just not here. That patient experience not only opened my eyes to the HIV epidemic that was right in front of me, but it also revealed the intricacies of health care, and the myriad of compounding factors that contribute to a person’s overall health. I distinctly remember being shocked when Dr. Smith told me about her patient’s diagnosis, and it caused me to become more aware of the HIV epidemic in
Mississippi. Through this thesis project, I aim to bring light to the growing number of HIV cases right in our own backyard.

The United States Deep South has some of the highest rates of HIV infections in the world, with Mississippi in the lead. According to Dr. Leonardo Mena, an infectious disease specialized physician reports that Mississippi as a whole has the ninth highest infection rate of HIV in America (Bellino, 2017). Furthermore, Jackson, Mississippi, which is nearly 80% African-American, has the country’s highest rate of new HIV diagnoses amongst African American gay and bisexual men (Cooper, 2016). In fact, four out of every ten African American gay or bisexual man in Jackson are living with HIV (Villarosa, 2017). In this chapter, I will underline the socio-economic, racial, and cultural factors that affect the increasing rate of HIV/AIDS infections in Mississippi as well as how moralizing influences about racial, gender, and socio-economic drive the epidemic. I argue that the marginalized identities in the case of Mississippi – race and gender identity – have deeply moralized attributions that integrate HIV-related stigma under the framework of the moral model of disease.

METHODS

Unfortunately, many attempts to coordinate meetings with leaders in the fight against HIV in Mississippi fell through; however, quantitative data presented by the state as well as a recent rise in publications increasing awareness to the crisis in Mississippi allow me to present my final case as a prominent and purposeful case, even if it looks a little different than my two previous chapters which focused on personal ethnographic experience. Instead of multiple personal interviews coupled with field visits and observation, I more heavily rely on articles, such as the New York
*Times* article entitled “America’s Hidden H.I.V. Epidemic” for my qualitative analysis (Villarosa, 2017). Pointing to the instable balance with the burden of HIV falling mainly on the African American gay and bisexual male population, articles like the *Times* one present personal stories and challenge the status quo in many Southern states that tend to be overly conservative and religious.

Two laws recently passed in Mississippi also provide the basis for a moral argument in the state. Right now, Mississippi does not offer a holistic sexual education program, only offering abstinence-based programs to be taught in regards to sex and sexuality (Siebold, 2014). When the state passed a law requiring all school districts to educate their students about sex, it at first seems a success. However, most schools teach that sex is a sin and refuse to offer any education about condom use and STDs (Siebold, 2014). Furthermore, with the passing of House Bill 1523, “Mississippi sex-ed classes teach kids that homosexuality is illegal” (Sakuma, 2014). In the name of religious freedom, Mississippi legally allows discrimination against homosexuals on the basis of “religious liberty” (Campbell, 2017). Mississippi educators are required to teach their students in line with the state bill that identifies “unnatural intercourse” as “the detestable and abominable crime against nature committed with mankind or with a beast” (Sakuma, 2014). While teachers may opt out of the anti-homosexual section, they may not contradict the state’s teachings.

Not teaching proper sexual education in classrooms and preaching that being gay is a sin, Mississippi government is perpetuating judgments and further marginalizing gay people and sexually active youth on moral grounds.

**QUALITATIVE ANALYSIS**

While lack of quality healthcare burdens Mississippi as a whole, people living
with HIV face a greater challenge as they need constant medications and doctors visits. This causes many people in Mississippi with HIV to not be able to receive proper treatment (Carmon). Jermerous Butler from Jackson, Mississippi, recalls the “over ten times” complications from AIDS have hospitalized him, since his diagnosis a decade ago. He cites both lack of a support system and access to medical care as the cause of severe ill health and “deep depression that repeatedly threatened by life” (Murguia & Sandell, 2016). The US Health and Services Administration (HRSA) requires each state that receives HIV/AIDS funding to report an estimate of “unmet need” for HIV care. This data comes from the percentage of people who have tested positive for HIV and are aware of their status but have not received basic healthcare services for HIV. The findings of the report were astounding. Roughly fifty percent of HIV positive people in Mississippi have not received any care or support for their disease (Rights and Risk, 15). Shockingly, the percentage of people in Mississippi who do not receive HIV services is equivalent to developing countries that have been hit harder by the HIV/AIDS epidemic, such as Ethiopia and Rwanda (Carmon).

Lack of access to affective healthcare through the means of antivirals and other medications for people living with HIV may also be intentional on the part of the person living with HIV in order to avoid both perceived and enacted HIV-related stigma. Donna, a homeless Mississippian living with HIV, described how her unstable housing situation affected her health outcome. She was so afraid of her relatives finding out her diagnosis and evicting her that she explains, “First I tore the labels off [my medicines], then I ended up throwing them away. I was scared [my family] would kick me out if they found them,” (Rights at Risk, 19). Donna had to
choose between a stable home and treating her HIV, a decision a person should never have to make. Her socioeconomic condition and fear of being ostracized from her family caused her to compromise a very basic human right: health. Donna’s case exemplifies the extreme in which a person living with HIV manages perceived stigma, or fear of the possibility stigma, by refusing treatment altogether (Chambers et al, 2015: 7). Compounded with socioeconomic status, this case also operationalizes the definition in which a person living with HIV manages stigma through adherence, or lack thereof (Chamber et al, 2015: 7). The fear of being excluded from society, or in Donna’s case, being physically removed from ones current home often results in “competing priorities” of adherence versus stigma.

Along with inaccessibility to health care due its rural characteristic and lack of health insurance, there is also a shortage of health care providers in Mississippi. Over forty percent of Mississippi is “medically disenfranchised, (Rights and Risk, 21). This means that forty percent of the population has little to no access to a primary care physician. The scarcity of health care providers is even more critical for HIV positive people in Mississippi because there are not even thirty infectious disease specialists in the entire state, with most of the centralized in Jackson (Right and Risk, 21). I witnessed this disparity during my shadowing experience with Dr. Smith. After disclosing the information about her HIV-positive patient, I proceeded to ask Dr. Smith questions about the prevalence of HIV patients and specialists in the area. To my surprise, she informed me that Baptist Memorial Hospital in Oxford does not have an infectious disease specialist, but that she believed that they were in the process of hiring one soon. While I realized this was not a shock after putting the size of Oxford and Mississippi’s meager health care system into
perspective, I pictured the situation of the patient whom we had seen earlier.

Though Dr. Smith treated her patient with equality and respect, the stigmatization of HIV in Mississippi among physicians and their willingness to treat HIV-positive people is unfortunately prevalent.

In an interview with Human Rights Watch, an HIV care manager at Crossroad Clinic in Greensville, MS, expressed her difficulty in finding a physician for her client in need of gynecological services and other patients by saying, “I called 20 gynecologists and all of them said flat-out no when I told them she was HIV-positive. I have also been turned down by podiatrists. A lot of stigma is coming from the doctors themselves,” (Right and Risk, 22). Unfortunately, the lack of knowledge and openness about HIV is preventing patients from access to physicians, due to the irrational fear of infection (UNAIDS, 2012). Some may choose not to disclose their status at all, for fear of judgment or association with demoralizing behavior. “I didn’t tell them that I was HIV positive,” states Cedric Sturdevant when he first sought treatment for the first time following his diagnosis with HIV. “They never checked, either,” (Ford, 2012). Mississippi’s predominantly rural population and shortage of health facilities make the human experience of having HIV much more difficult than the virus itself as the exacerbation of stigmatizing actions by medical professionals, then, directly contributes to negative differentiation of people living with HIV.

The stigmatization of HIV is the most influential non-biomedical factor that negatively affects people living with HIV in Mississippi. PLHIV as well as the people who work to advocate for them identified the negative attitudes toward them as the primary barriers to “prevention, care and treatment in Mississippi,” (Right and
Risk, 22). Jordon, a college-aged African American man lives just ninety miles east of Jackson. Barely skin and bones from very progressed HIV due to prolonged avoidance of testing and treatment, Jordon reports how he let his health deteriorate to a deathly state because of hateful feelings he felt, blaming himself for his condition. Now trying to recover, Jordan explains that his mother or grandmother take him to Jackson to receive better medical care because of HIV specialists, but also adds it is to “avoid the small-town gaze at the local facilities” (Villarosa, 2017). “Everybody knows everybody here,” Jordan explains his reasoning for commuting to care outside his community. “At the hospital, they know my mom and my brother and my grandmother. I would rather be around people who don’t know me” (Villarosa, 2017). By utilizing a healthcare facility outside of his town, Jordan is therefore managing predictive stigma by and avoiding disclosure.

Marginalization due to stigmatization causes HIV-positive people to sacrifice their health, like in the case of Donna who threw away her HIV medication because she was so terribly afraid that her family would kick her out of the only shelter she had. The HIV/AIDS Plan prepared by the Department of Health identifies the affect of stigmatization on health by stating, “Many Mississippians fear being thought to have or known to have HIV far more than they fear the disease itself. Such over-arching fear prevents effective behavioral interventions from being received and practiced, limits the number of citizens seeking HIV testing, and decreases the likelihood of remaining in care after diagnosis,” (Right and Risk, 23). HIV-related stigma amplifies stigma in regards to racial minority. African Americans are much more likely to contract HIV, and it is largely due to the racial hierarchy in Mississippi. In fact, even though about 37.5% of the Mississippi population is African American,
78% of newly diagnosed HIV infections are African Americans (“Mississippi: HIV/AIDS”). Not only are African Americans more susceptible to HIV, but also they are ten times more likely to die from AIDS (“Mississippi HIV Statistics”). Stigmatizing actions attack race as a means of outcasting, which results in less attention and less resources addressing the population that needs them the most.

Homophobic discrimination plays a role in HIV-related stigma in Mississippi. Homophobia can be dangerous to one’s health as it creates this blocked-off society, making homosexuals afraid to get proper medical treatment and testing. Moreover, homosexuality stigmas are a primary factor in avoidance of testing and care among men who have sex with men, the group that has the highest infection rate (MSM) (Lampton, 360). “Men who have sex with men are an extremely hard to reach population,” Juanita Davis of the Department of Health stated. “There is so much stigma that they do not want to come forward,” (Right and Risk, 40-41). The homophobic stigmas are only serving to drive the HIV epidemic. John Hines, an African American State Representative of the 50th District and a strong advocate for the HIV community, points out the backwards thinking of many of Mississippi’s leaders (Right and Risk, 42). Hines, a politician himself, is a strong advocate for the HIV community and claims that homophobia is a key barrier to the improvement of state support for HIV/AIDS positive people. He states, “Legislators in Mississippi don’t see it as a public health crisis; they see it as a punishment for an unhealthy lifestyle,” (Right and Risk, 42). The mindset of the people of Mississippi needs to change in order for the health outcomes for gay and lesbian individuals to improve. The public health problem is clearly part of a larger political context. So long as the Mississippi government continues promoting discriminatory policies, creating harsh
environments for the LGBT community, the health of the “hard to reach population” of men to have sex with men will be significantly and negatively affected. Moreover, the marginalized population that constitutes the greatest percentage of HIV infects relies on the intersectionality both racial and gender differentiation.

“HIV stigma,” however, is a misnomer. The stigma lies behind historical, social, and religious prejudice and discrimination against vulnerable groups, in which social moralization of people with HIV further marginalizes already devalued populations of society based on the rationality of blame, as I contextualized in my original definition of stigma. Such marginalized groups in Mississippi include African Americans and homosexuals, and the amalgamation of the two. Tonic article entitled “What It’s Like to Be Back, Gay, and HIV-Positive in the South” exemplifies the intersectionality of confounding marginalized identities on overall lived experience of a person with HIV (MURGIA & SANDELL, 2016). Through a portrait series, individuals living with HIV use their voice to increase awareness of HIV in Mississippi (Murguia & Sandell, 2016). Alexis Santi, a twenty-four year old trans women with HIV says she ignored her illness until she ended up collapsing after a performance. In addition to being black and living with HIV, Alexis also faces a greater risk of discrimination due to her gender identity (Murgui & Sandell, 2016). In the first photo of the photo series, Rovoskie “Ro” Mays, a twenty-year old male living with HIV, poses in front of the Mississippi State Capitol Building to make a statement about House Bill 1523 (Murgui & Sandell, 2016). The Religious Freedom Act that Governor Phil Bryant signed in April of 2016 embodies the way in which deviations from heterosexuality are deeply immortalized under a conservative,
Christian framework in Mississippi. Completely opposite to the progressive gender laws that I discussed in the Argentina case, House Bill 1523 allows for anyone to decline services to LGBTQ people based on their religious beliefs (Dreher, 2016). The list of services that may be declined based on religious objection includes medical care and counseling (Dreher, 2016). Due to the enactment of this bill, this law gives the dominant group in Mississippi, typically white, heterosexuals, even more power over which to discriminate and devalue an already marginalized and suffering population in our society.

**CONCLUSION**

Socio-economic, racial, and cultural factors combine to create a high-risk environment for people with HIV in Mississippi, making it difficult to avoid infection and access life-saving medical care. Additionally, limited access to medical treatment and specialized healthcare professionals contribute to feelings of inferiority of people with HIV, thus adding to their stigmatization. While additional stigmas combine to augment HIV-related stigma, such as low socioeconomic status or age, the moral model of disease facilitates stigma against the minority population of black gay and bisexual men, further marginalizing those populations and leading to lower health outcomes.
CHAPTER 5:
CONCLUSION

This thesis presents the importance of examining qualitative evidence that strongly shapes health outcomes. The synthesis of qualitative evidence from three case studies – Vietnam, Argentina, and Mississippi – illustrate the significance of stigma on health outcomes of people living with HIV. As the exclusion and devaluation of an individual based upon a socially constructed label, stigma contributes to adverse health outcomes in a multifaceted manner.

With the case study of Vietnam, I focused my research question and found how the moral model of disease leads to moral condemnation, leading to stigma. First of all, I found that one specific stigma could not be isolated. In this way, the intersection of multiple stigmas combine to further complicate the lived experience of persons with HIV. Additionally, dividing of stigma into two categories helps to understand how people act in response to fear of stigmatization (predicted stigma) or in response to stigmatization (enacted stigma). People living with HIV use strategies to manage both predicted and enacted stigma through utilizing health care or adhering or not to treatment. Synthesis of my findings identified predicted stigma to be more influential on the health and wellbeing people with HIV. People for whom stigma affects try to avoid disclosure of their undesirable attribute due to fear of negative consequences. However, avoiding stigma leads to detrimental health consequences. While avoiding stigma may temporarily save face or reduce burdens
of the intersections of other stigmas, the benefits are short-lived. As I showed in examples throughout my thesis, avoiding stigma has deleterious effects on the health outcomes of people living with HIV. Though a Buddhist and Confucian perspective, the moral model may, then, be applied to the larger realm of stigma. It looks at why people differentiate certain “marks,” and how moral codes establish stigma on the basis of “good” and “bad.”

Furthermore, the Argentina case study presents how HIV-related stigma is manifested and reveals the implications. Categorized as a moral judgment, stigma may be better mitigated with focused efforts. Strategies used by either institutional practices or personal perceptions may be discriminatory or stigmatizing toward people with HIV. The moral aspect of stigma enforces dominant social values – such as constructions of sexuality, drug use, and sex work – through moral attributions. By positioning themselves as social judges, health care practitioners and individuals explain the existence of HIV infection by blaming it on corrupted behaviors. I conceptualized and operationalized moral model of disease to encompass the social moralization of HIV stigma. Therefore, the negative moralization that the moral model of disease extends rationalizes the diagnosis of HIV through attribution of a bad behavior to participation in an immoral act. Implemented in framework of the moral model of disease, stigma exists as discrimination toward individuals who participate in socially moralized activity, resulting in marginalization and devaluation, and as a result, adverse health outcomes.

The accumulation of the three cases presented in this thesis demonstrates the intersections of marginalized minority populations and HIV-related stigma in the
context of the moral model of disease. Injection drug use, female sex work, and men who have sex with men compromise high-risk groups in Vietnam, often labeled social evils in the country context. In Vietnam, I identified what the moral model is and operationalized it to the case of HIV and related stigmas. Transsexual women and indigenous, rural women in the case of Argentina constitute the high-risk group that society ostracizes. With examples from Tomás’s story and Hospital Fernández, I looked at the implications of moralization in Argentina. Finally, following the theme of gender identity, Mississippi society marginalizes gay and bisexual black men on the basis of negative gender identity and race. Applying the moral model of HIV-related stigma to Mississippi, I showed how negative moral condemnation prevents PLHIV in Mississippi to access basic healthcare and essential treatment – to the extent of negative government intervention advancing the condemnation of the LGBT community on religious moral grounds. In conclusion, HIV-related stigma in Vietnam, Argentina and Mississippi, thus coalesce into the framework of the moral model of disease as each dominant culture condemns the high-risk actions associated with the disease – sexual identity, drug use, sex work, and race – on moral grounds.
LIST OF REFERENCES


Inter-Parliamentary Union. 2015. HIV and AIDS in Viet Nam – facing the challenges.


