Stigma, Discrimination, and Social Exclusion

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Abstract

Stigma is an important part of the social determinants of health that performs a crucial aspect in the distribution of health status and life chances for many individuals through the manufacturing of inequalities and inequities. The consequence of stigma is that the stigmatized are systematically excluded from life chances and opportunities such as education, housing, employment, and health and social care. Clearly, stigma is inextricably linked with social exclusion. Stigma is used by people to interpret specific traits of others as "unworthy" and thus "discreditable"; and this results in the stigmatized person becoming "tainted" or "discounted." Individually, the effects of stigma and social exclusion can be profound and destructive. They can result in isolation, low self-esteem, depression, self-harm, poor academic achievement and social relationships,

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poor physical and mental health, and suicide. The best strategy to fight against social stigma is social inclusion. It is hoped that we will see more reduction of stigma which will result in the improvement of the social inclusion of many people in the world. This will lead to better health and well-being for all people, reduction of inequalities through devoid of discrimination, vulnerability, and marginalization, and more equitable health at the global level. This chapter will bring readers through several important issues relevant to deviance, difference, and stigma. The chapter will first introduce the concepts of stigma and discrimination. It then discusses the impact of stigma and discrimination on the health and well-being of those who are stigmatized. It also outlines the impact of stigma and discrimination on those who experience mental health and those living with HIV/AIDS. Lastly, the chapter discusses strategies to combat stigma in society.

Keywords

Stigma · Discrimination · Deviance · Differences · Labeling theory · Social exclusion · Mental illness · HIV/AIDS · Destigmatization

1 Introduction

> Stigmatization is a complex process of social control in which labeling, stereotyping and negative attitudes towards a person, based on a condition or behavior often lead to status loss, rejection or discrimination (Rivera-Segarra et al. 2019, p. 2).

Stigma is an important part of social determinants of health that performs a crucial aspect in the distribution of health status and life chances for many individuals through the manufacturing of inequalities and inequities (Link and Hatzenbuehler 2016). The consequence of stigma is that the stigmatized are systematically excluded from life chances and opportunities such as education, housing, employment, and health and social care (Link and Phelan 2001; Phelan et al. 2008; Felner et al. 2018). Clearly, stigma is inextricably linked with social exclusion.

The word stigma is derived from Ancient Greece, meaning "mark." Marks were impressed on slaves as a way to identify their position in the social structure and which suggested that they were of lesser value or to be socially excluded (Goffman 1963; Link and Stuart 2016). Stigma creates "difference" and sanctions and sustains social inequalities in society (Mumin et al. 2018). It is an underlying origin of health inequalities because it adds to "the unequal distribution of resources and power through multiple pathways" (Clair et al. 2016, p. 223). Often, the stigma will result in discrimination against individuals who are stigmatized. Although stigma are socially constructed concepts, they have a negative impact on the life and well-being of individuals and groups who are so labeled (Link and Stuart 2016). As such, stigma and discrimination form an important component of the social exclusion of people in society (Berry and Greenwood 2018).

Stigma can occur at different levels: the individual, interpersonal, and/or structural level (Cook et al. 2014). There are interconnections between individuals, society, and greater societal structures that influence each other within and between

levels. Additionally, there appears to be an intersecting stigma that occurs when individuals are "marked" with multiple stigmas. For instance, when an individual who belongs to an ethnic minority group, have low socioeconomic status, is a member of LGBTI community, and is living with mental illness, he or she will carry multiple stigmas basing on his or her ethnicity, social, gender, and health statuses (Stangl et al. 2019). Stigma is a universal phenomenon, with similar features across cultures (Brakel et al. 2019; Stangl et al. 2019). However, how they manifest and are experienced are locally specific and influenced by the cultural context within individuals reside (Yang et al. 2007; Koschorke et al. 2017; Rivera-Segarra et al. 2019).

This chapter will bring readers through several important issues relevant to deviance, difference, and stigma. The chapter will first introduce the concepts of stigma and discrimination. It then discusses the impact of stigma and discrimination on the health and well-being of those who are stigmatized. It also outlines the impact of stigma and discrimination on those who experience mental health and those living with HIV/AIDS. Lastly, the chapter discusses strategies to combat stigma in society.

2 Stigma and Discrimination

In his classic work, Irving Goffman (1963, p. 3) theorizes that stigma is a "devaluation" process that links with stereotyping and prejudice. It is used by individuals to interpret specific traits of others as "unworthy" and thus "discreditable"; and this results in the person stigmatized becoming "tainted" or "discounted" (Thomas 2006, p. 3175). Those who are stigmatized, or "marked" will then be "disqualified from full social acceptance" (Goffman (1963, preface). Following Goffman's theory of stigma as an attribute, the term "mark" was coined to mean stigma which would eventually lead to the definition of the person as being "flawed" or "spoiled" (Yang et al. 2007, p. 1525). Based on a social position that dictates that some individuals are "tainted" and "less than," stigma is a mark that separates people from one another (Goode 2016; Major et al. 2018).

The foundation of stigma lies in "deviance" and "differences." These deviances and differences can be in physical appearance, gender, sexuality, personality, age, illness, disability, and specific behavior which evoke discontent, abhorrence, panic, or sympathy from others (Goode 2016). According to Link and Phelan (2001), the main element of the stigmatizing strategies is to create the "us and them" principle; what Powell and Menendian (2016) refer to as the "Othering" concept. Its aim is to lay a foundation that could separate individuals who are perceived as "good and in favour" from those who are "bad and out of favour" within a given social norm. Once this principle is initiated, stigmatization and social exclusion are permitted. This process is then established and confirmed by the prejudiced position which accentuates the difference; that is the "us and them" or "Self and Other" (Udah and Singh 2019). Often, this leads to discrimination against the discrediting persons (Krupchanka and Thornicroft 2016; Malik and Dixit 2017; Mumin et al. 2018; Udah and Singh 2019).

Stigma is "a multidimensional construct" (Link and Phelan 2001). Goffman (1963) suggests that there are three kinds of stigmatizing conditions. The first is "tribal identities" which include such identities as gender, race, religion, and nationality. Second is the "blemishes of individual character" and these may include having a mental illness, having a history of addiction or incarceration, and living with HIV/AIDS. Third is "abominations of the body" which include such bodily conditions as deformities and physical disabilities (LeBel 2008; Mumin et al. 2018). Basing on Goffman's stigmatizing conditions, many individuals would be stigmatized due to their social and health statuses in many societies. However, Falk (2001) proposes two types of stigmatizing states which are based on the "cause" of stigma. First, "existential stigma" occurs when an individual does not create stigma or has very little control over it. These include being old, his/her race and ethnicity, and having mental illness. Second, "achieved stigma" which happens when an individual has acquired a stigma due to his/her action and behavior and/or because he/she has personally cultivated it. These may include such actions as becoming a refugee, immigrant, prisoner, or homeless, and living with HIV/AIDS (LeBel 2008).

Stigma theorists have focused more on the position of social norms in the process of constructing stigma (Stuber et al. 2008). Goffman (1963), for instance, contends that because deviations from social rules are inescapable, stigmatization is a common characteristic of any society. Stigmatization is a characteristic of all sociocultural groups. It is employed to elicit conformity with the social standings of society so that law and order can be enforced. Based on this perspective, stigmatization is the result of deviating from social rules which attempt to make the deviant individual conform (Goffman 1963; Mumin et al. 2018). It is also used to illustrate to other group members the behaviors which are not condoned, and the effects that will be felt by those who engage in such actions. However, it can only be used in these ways to enforce conformity around voluntary behaviors, for example, illicit drug consumption and cigarette smoking (Stuber et al. 2008). Stigma has also now been defined by scholars in terms of a person's social identity, and the essence of unique social contexts has been more emphasized. The central feature of social stigma suggests that stigmatized persons have, or are believed to have, some characteristics which are associated with a disvalued social identity in a particular social situation (Major et al. 2018).

Stigma is a process which is grounded within the "construction of social identity" (Yang et al. 2007, p. 1527). Stigma eventuates through what Goffman (1963, p. 32) refers to as a "moral career." It is a process when a stigmatized individual initially makes sense of his or her social position in society and later acquires a set idea of what it would be like to have a specific stigma. The person will then pass from a "normal" to "discreditable" status. And through social interaction, he or she will eventually obtain a "discredited" status and "damaged identity" (Curra 2014; Finzen 2017). In Goffman's term, when an individual's new identity is "assumed through interaction (i.e., "re-identifying") with socially constructed categories," the stigma will occur (Yang et al. 2007, p. 1527). A good example is the case of mental illness. A person with mental illness (a non-visible stigma) passes

from "normal" status to "discredible" one. His or her "discredited" status is gained when he/she discloses the mental illness condition to others.

Stigma also occurs through the process of "labeling" (Curra 2014; Goode 2016). People are stigmatized when they are "labelled, set apart, and linked to undesirable characteristics" which result in the loss of their status and discrimination (Link and Phelan 2001, p. 369; Huebner et al. 2019, p. 716). For example, when an individual living with mental illness is given a deviant label, it will eventually lead the person to change his or her self perception and social opportunity (Yang et al. 2007; Link and Stuart 2016). Individuals learn about the stereotypes of mental illness through the process of socialization and daily reinforcement. Due to its highly discrediting status, once the stereotype is fully formed, the person's "patient" role will emanate as a "master status" (Markowitz 2005). Consistent reactions from others, particularly the application of social exclusion, will prevent the person from reclaiming his or her former ("normal") social functions (Yang et al. 2007; Goode 2016; Link and Stuart 2016). Similarly, individuals with criminal history experience stigma and discrimination in the community and when seeking employment, housing, and social services when "the 'felon' label becomes their master status" (Huebner et al. 2019, p. 716).

3 Stigma, Discrimination, Health, and Well-Being

Health and illness conditions which tend to produce stigma are those which are connected with negative characteristics, have uncertain or unknown causes and limited treatment, and produce intense reactions such as fear and disgust (LeBel 2008). Historically, leprosy and tuberculosis were met with revulsion and later on one witnessed the same emotional responses toward cancer, mental illness, HIV/AIDS, and, more recently, obesity and overweight (LeBel 2008; Liamputtong 2013a, b; Malik and Dixit 2017; Gaebel et al. 2017; Pont et al. 2017). Currently, one still see numerous health-related issues that have attracted stigma, for example, abortion, infertility, being overweight, obesity, bottle-feeding practices, and cigarette smoking. Those who belong to stigmatized, such as poor people, homeless people, gay, lesbians, and transgender individuals, refugees, indigenous people, and ethnic minority groups, are also likely to have to deal with the negative repercussions of stigma-related social and health issues (Ritterbusch et al. 2018; Liamputtong and Kitisriworapan 2019).

The effect of stigma on the stigmatized individuals can differ in its magnitude and manifestation (Link and Phelan 2001; Link and Stuart 2016; Major et al. 2018). Often, stigma generates negative credibilities; these are termed stereotypes. It then gives legitimacy to the negative credibilities; this is referred to as prejudice. This prejudice then leads to a wish to shun individuals who possess stigmatized statuses. This is called discrimination (Link and Phelan 2001; Krupchanka and Thornicroft 2016; Major et al. 2018). Any form of discrimination and prejudice may lead to social exclusion as it functions to disconnect stigmatized persons from society and prohibits them from societal benefits, such as access to services

like education, housing, social support, and health care (LeBel 2008; Krupchanka and Thornicroft 2016; Major et al. 2018).

Individually, the effects of stigma and social exclusion can be profound and destructive. They can result in isolation, low self-esteem, depression, self-harm, poor academic achievement and social relationships, poor physical and mental health, and suicide (Yang et al. 2007; Krupchanka and Thornicroft 2016; Ferlatte et al. 2017; Major et al. 2018). For stigmatized individuals with major health problems, stigma can also "intensify the sense that life is uncertain, dangerous, and hazardous" (Yang et al. 2007, p. 1528). Therefore, it is clear that stigma and discrimination have a negative impact on the quality of life of stimatized persons (Major et al. 2018). Discrimination has dire consequences for the stigmatized person who is in a vulnerable position because of a power differential due to his/her cultural alliances (such as marginalized ethnic groups), socioeconomic status (e.g., living with poverty and have little social capital), sexual identity (such as members of LGBIQ groups), or experiencing stigmatized health issuses (such as mental illness, leprosy, obesity, and HIV/AIDS) (Paul 2018).

The impact of stigma on the health and well-being of the stigmatized individuals and groups is huge (Pausé 2017; Major et al. 2018). The fact that stigma has a damaging effect on individuals' health has led public health officials and advocates to notice the powerfully negative results of stigmatization for public health. In the area of HIV/AIDS, for example, it is now clear that the stigmatization of certain groups such as commercial sex workers, injecting drug users and gay men would only make them more susceptible to HIV infection and push them out of reach of those who attempt to help them to modify the behaviors that put them and others at risk (Stuber et al. 2008; Ferlatte et al. 2017).

Being labeled can also have intrinsic ramifications if the negative experiences are internalized, which can lead to lower self-esteem, self-efficacy, and self-blame (Link and Phelan 2001; Watermeyer and Swartz 2016). Weight stigmatization and discrimination are the social results of obesity. Stigma relating to a weight that embodies negative stereotypes about people with "non-normative bodies" has been perceived as a "truly globalized" and "emotionally damaging" reality of many obese people (Monaghan 2017, p. 182). Weight stigma can be seen as the societal devaluation of an individual because he/she has obesity or overweight. Often, this results in stereotypes that persons with obesity are "lazy, unmotivated, or lacking in willpower and discipline." These stereotypes exhibit in many ways such as teasing, bullying, and weight-based victimization leading to social rejection, discrimination, and unfair treatment. Experiences of weight stigma impact the quality of life of individuals, particularly young people (Pont et al. 2017; Monaghan 2017; Flint 2019). Stigma can also be a key driver of social exclusion for stigmatized persons. Common stereotypes of homeless individuals as disorganized, lazy, unemployable, drug users, mentally ill, and likely to be dangerous, are a critical feature of "othering" leading to social exclusion. Clearly, the division of "us" and "them" adds to social distancing and exclusion (Bullock and Garland 2017) (Fig. 1).

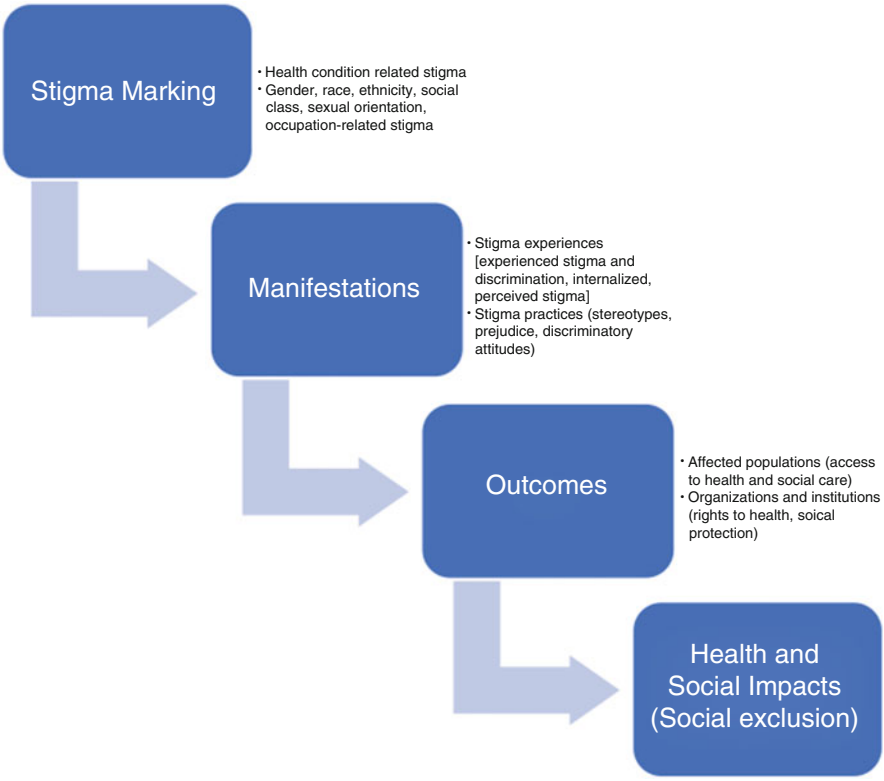

Fig. 1 Stigma and discrimination model. (Adapted from Stangl et al. 2019, p. 3)

4 Stigma, Discrimination, and Mental Illness

Individuals experiencing mental illness are particularly vulnerable to stigma, discrimination leading to social exclusion. Stigma and discrimination resulting in social exclusion have immense impacts on individuals with mental illness. Stigma and discrimination can lead to poor self-esteem, and disrupt help-seeking attempts and access to health care of people with mental illness. This results in the constraint of their recovery (Hall et al. 2019). Stigma often portrays individuals with mental illness as "dangerous, unpredictable and unintelligent." These beliefs are produced through "discriminatory and exclusionary behaviour" (Hall et al. 2019, p. 2). In all covers of the world, people living with mental illness are ostracized, blocked from employment, and denied sexual, reproductive, and legal rights to vote (Hall et al. 2019).

Although stigma toward mental illnesses is a worldwide phenomenon, the manifestation and implication of stigma are often "culturally specific" (Koschorke et al.

2017; Krupchanka et al. 2018). For instance, stigma is a powerful element in Asian cultures. Not only it reflects badly upon the mentally ill, but it also reduces the marriage value for a person as well as the value of his/her family (Tran 2018).

Among Asians, religion has a strong connection with mental illness. Wynaden et al. (2005), in their research with Asian Americans, point out that Buddhism and Taoism have a great influence on the health beliefs of community members. Buddhists believe in reincarnation and the philosophy of karma. Karma, the law of cause and consequence, emphasizes that there is a consequence for every action. Positive/good actions result in positive/good reactions and negative actions/bad results in negative/bad reactions in the present life and a later reincarnation. For parents who have a child with a mental illness would be seen as being punished for their bad deeds in their past lives. Other beliefs about the cause of mental illness are that the person is possessed by the evil spirit (Wynaden et al. 2005, p. 91). Tran (2018) found that traditional beliefs of mental illness among Asians are also linked to the concept of bad blood and this bad blood is transmitted through the mother, not the father: ". . . it was some bad blood in your family that caused it [mental illness]. Sometimes if the child has this problem [mental illness] then it must be the mother's fault, not the father. The mother brought all this to the family" (p. 83).

Mental illness is "a silent epidemic" in most parts of Africa (Kimotho 2018, p. 21). In their recent study in Botswana, Becker and colleagues (2019, p. 1574) suggest that mental illness was commonly referred to as "*bahaphegile*," suggesting deviance and difference which results in discrimination. Local people see mental illness as chronic and incurable. It is portrayed locally as happening "when the trees blossom." Predominantly, local people believe that mental illness is caused by witchcraft; one can befall victim of witchcraft by social transgression or jealousy of other's social success. People with mental illness, particularly schizophrenia, are widely stereotyped as dangerous, unpredictability, cognitively impaired, and not trustworthy (Zäske et al. 2019). These cultural beliefs and stereotypes perpetuate stigma and discrimination among people experiencing mental illness (Koschorke et al. 2017; Kimotho 2018; see also Goffman 1963; Link and Stuart 2016; Gaebel et al. 2017; Zäske et al. 2019).

Any form of discrimination and prejudice may lead to social exclusion as it functions to disconnect stigmatized persons from society and prohibits them from societal benefits, such as access to services like education, housing, social support, and health care (Yang et al. 2007; Gaebel et al. 2017; Krupchanka and Thornicroft 2016; Major et al. 2018; Zäske et al. 2019). Individually, the effects of stigma and social exclusion can be destructive. They can result in isolation, low self-esteem, depression, self-harm, poor academic achievement and social relationships, poor physical and mental health, and suicide (Ferlatte et al. 2017; Gaebel et al. 2017; Link and Stuart 2016; Krupchanka and Thornicroft 2016; Major et al. 2018; Liamputtong and Kitisriworapan 2019; Ngubane et al. 2019). Importantly, cultural stigma toward mental illness has resulted in the underutilization of mental health care in many groups (Kimotho 2018; Ngubane et al. 2019). Individuals living with mental illnesses may feel shame, stigmatized, and hide their problems for fear of being labeled. Some may prolong or never seek help (Tran 2018; Ngubane et al. 2019; Zäske et al. 2019).

5 Stigma, Discrimination, and HIV/AIDS

From the onset of the epidemic, HIV/AIDS has been seen not only as a medical condition but also as a stigmatized state (Letteney and LaPorte 2004). HIV/AIDS was first recognized in 1981 and since then it has provoked forceful reactions from others (Scambler 2003). HIV/AIDS uniquely combined "sex, drugs, death, and contagion" (Scambler 2003, p. 199). This unique combination made HIV/AIDS a powerfully stigmatizing disease. It is also prevalent among those who are already members of stigmatized groups, initially gay men, and later injecting drug users (Parker and Aggleton 2003). Globally, in countries where HIV/AIDS is predominantly heterosexually transmitted, stigmatization and discrimination are also pervasive. Those who are from marginalized groups such as poor people, women, mothers, sex workers and injecting drug users heavily bear the brunt of the impact of HIV/AIDS (Liamputtong 2013a, b; Ferlatte et al. 2017; Malik and Dixit 2017; Le et al. 2018). Some have suggested that the stigmatization and discrimination of these people have violated the human rights of human beings.

Despite the fact that society now has a better understanding of the causes and impacts of HIV/AIDS, the burden of prejudice continues to exist (Liamputtong et al. 2009; Vlassoff and Ali 2011; Liamputtong 2013a, b). Research continues to reveal the ways in which society neglects the need for health care for those living with HIV/AIDS (Deng et al. 2007; Anderson et al. 2010). Stigma may be manifested in actions such as gossip, verbal abuse, and distancing from individuals living with HIV/AIDS. It ranges from subtle actions to "extreme degradation, rejection, and abandonment" (Thomas 2006, p. 3175). Often, ignorance, a lack of accurate information about HIV and AIDS, and misunderstanding about HIV transmission are the common sources of HIV/AIDS stigma (Zhou 2007; Vlassoff and Ali 2011).

HIV/AIDS has particular traits that initiate a high level of stigma (Parker and Aggleton 2003). As stigma is socially constructed and is attributable to cultural, social, historical, and situational factors, stigmatized individuals are subject to "feelings of shame and guilt." As discussed earlier, a major consequence of stigmatization is discrimination and it occurs when an individual "is treated unfairly and unjustly" due to the perception that the individual is deviant from others (Deng et al. 2007, p. 1561). As such, the HIV/AIDS stigma is perceived as "an individual's deviance from socially accepted standards of normality" and these can include such deviance as "immorality," "promiscuity," "perversion," "contagiousness,' and "death." Hence, people living with HIV/AIDS (PLWHA) are socially constructed as the "other" who is "disgracefully different from and threatening to the general public" (Zhou 2007, p. 2856). Often, individuals living with HIV experience "intersectional stigmas"; the convergence of multiple stigmatized identities resulting from intersecting prejudices that are linked to affiliations (gender, ethnic identity, or sexual orientation) or societal views about particular behaviors or characters (poverty, sex work, incarceration, or substance use) (Andersson et al. 2019; Turan et al. 2019).

Stigma is multi-dimensional. There are three broad types of HIV/AIDS-related stigma. First is self-stigma which occurs through "self-blame and self-deprecation" of those living with HIV/AIDS. Second is perceived stigma which is related to the fear of

individuals, that if they disclose their HIV positive status, they may be stigmatized. Third is enacted stigma, which occurs when individuals are actually discriminated against because of their HIV status – actual or perceived (Thomas 2006, p. 3175).

6 Managing Stigma and Social Inclusion

The best strategy to fight against social stigma is social inclusion. There have been several means that attempt to reduce stigma around the globe. In this section, some salient means that can promote social inclusion and reducing social stigma are discussed.

At a societal level, there is a need for more organized and structural attempts that include both policy and legal action to entirely reshape public perceptions and reactions toward stigmatized people (LeBel 2008). The results of these attempts may produce a long-term effect on anti-stigma efforts. It has been suggested that through contact with the stigmatized persons and educational campaigns, the stigmatizing attitudes of the public could be improved. It has been shown that when the general public has a direct interaction with individuals from stigmatized groups, the attitudes of the public toward the stigmatized have improved (Brown et al. 2003). This is what Clair et al. (2016) refer to as the "destigmatization" strategy. Similarly, involving stigmatized individuals as speakers in educational sessions to educate the general public is effective in promoting positive perceptions and responses of the target audiences as these individuals can provide more accurate information and debunk many misconceptions about them (see Corrigan et al. 2002; Couture and Penn 2003; Clair et al. 2016).

Additionally, protest and advocacy can work effectively as a strategy to reduce stigma (LeBel 2008). Collective tactics such as "social activism" have proved to be valuable (see Gaebel et al. 2017; Rodier 2017; Daftary et al. 2018). Thus far, these collective responses have been witnessed from several stigmatized groups including gays/lesbians/transgender persons, individuals with physical disabilities, people living with mental illness, and other stigmatized groups, which have been successful in changing official policies and laws. It is argued that this strategy is the most powerful and long-lasting means for the reduction and eradication of prejudice and discrimination for many stigmatized groups.

The motive and ability to resist or deny the label of deviance among stigmatized groups is an interesting aspect of stigma-related reduction and eradication. In Foucault's term (1981), these people would employ "reverse discourse" as a way to resist the label of deviance and hence avoid being stigmatized. This discourse allows individuals and groups to "present a positive affirmation of their identity and perspectives rather than a deviance designation" (Roach Anleu 2006, p. 422). Collectively, the stigmatized groups can generate a strategy that can be used to reject the standard social values and norms (Liamputtong et al. 2009; Major et al. 2018). In the HIV/AIDS area, there have been many strategies that individuals and groups have used to combat and abolish stigma. Gay men have adopted such symbols as the pink triangle, which is a symbol that the Nazis used in the Holocaust to mark out homosexuals before slaughtering them, to counteract their

stigmatization. Two UK voluntary organizations, "Gay Men Fighting AIDS" and "ACT UP" (AIDS Coalition to Unleash Power) are good examples of political activation which make use of power as a response to combat stigma.

6.1 Destigmatization of Stigma

Destigmatization is the process by which the cultural constructions of stigmatized individuals/groups are changed which will lead to the improvement of the worth and status of these people. It has significant ramifications for their health and well-being (Clair et al. 2016). According to Clair et al. (2016, p. 229), the change of cultural constructions of individuals/groups may help to decrease societal-level stigma in the long run. This is referred to as the "social process of destigmatization."

The cultural constructions of stigmatized groups involve the redefinition of the stigmatized group. This results in the improvement of attitudes and beliefs among the stigmatizers. This change allows more positive interactions between stigmatized and non-stigmatized groups, and, in turn, reduce devaluation and discrimination. It is the process that constructs the stigmatized individuals as blameless, and who are "just like us" instead of the "us" and "them" position. This process can occur both in informal interaction and in institutions that regulate opportunities and resources such as medical settings where stigma can link to differential health care (Clair et al. 2016).

Clair et al. (2016) propose a sociological framework that can be used to understand how new cultural constructions that draw equivalences and remove blame shape public and structural stigma over time. This framework can be applied to any other stigmatized areas and groups. They posit that there are three social conditions linked with the reduction of public and structural stigma (Fig. 2):

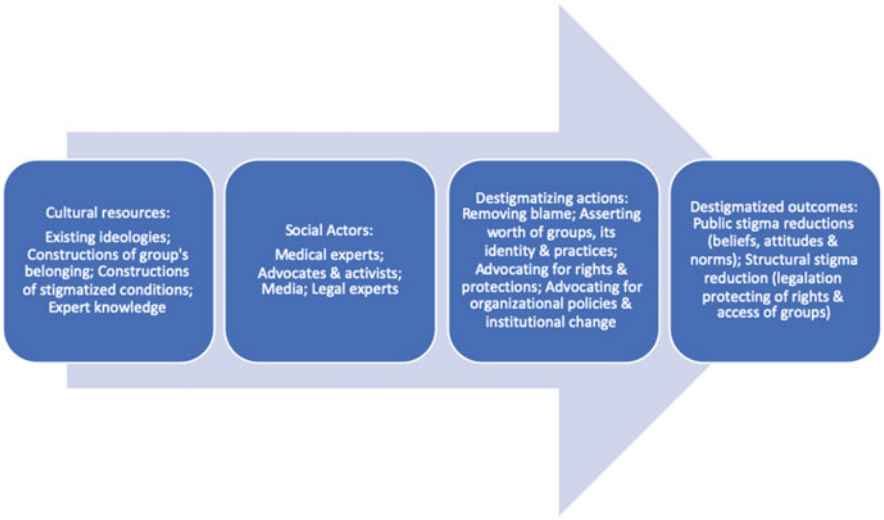

Fig. 2 Destigmatizing process (adopted from Clair et al. 2016, p. 230)

Fig. 3 The U=U slogan

> First, the public must come to see new cultural constructions as credible. The credibility of constructions often relies on the degree to which expert knowledge supporting such constructions is perceived to be conclusive. Increasingly conclusive medical knowledge demystified stereotypes about PLHAs, especially that only gays get AIDS… The credibility of destigmatizing constructions is affected by the status and visibility of social actors who disseminate them… Second, even when new constructions are credible, their destigmatizing potential depends on their interaction with preexisting understandings and ideologies… Third, destigmatization is more likely when non-stigmatized individuals find their own fate linked to the stigmatized group. When AIDS became understood as viral, not bound to a 'homosexual lifestyle', the general public could see HIV/AIDS as relevant to their own lives (pp. 228–229).

6.2 The Undetectable=Untransmissable (U=U) Slogan/Campaign

There has been an interesting campaign to reduce the stigma of individuals living with HIV that deserves great attention. In early 2016, the Undetectable=Untransmissable (U=U) slogan was launched by the Prevention Access Campaign to promote the finding which has scientifically revealed that individuals who are infected with HIV but virally suppressed cannot sexually transmit the virus to others. Since the launch, the campaign has rapidly captured strength and has been recommended by more than 400 organizations from 60 different nations. U=U is a simple but immensely crucial campaign that is based on a solid foundation of scientific evidence. It helps people to base their knowledge on science, not stigma. In the Editorial of the Lancet (2017), it states that the campaign is successful in influencing public opinion, allowing more people with HIV as well as their families and friends to realize that they "can live long, healthy lives, have children, and never have to worry about passing on their infection to others." The campaign helps to "promote the undeniable benefits of treatment, which will encourage more and more people with HIV to seek treatment, bringing the HIV community one step closer to the achievement of the UNAIDS' 90-90-90 target by 2020 and to complete elimination of the entirely unfair and outdated stigma still faced by many people living with HIV today" (p. e475) (Fig. 3).

7 Conclusion and Future Directions

> To decreasing stigma and promoting social inclusion in its place. It will require a devoted, concentrated effort, but we know from past successes that by working together we can achieve a great thing. (Carter et al. 2013, p. 773)

Since the publication of sociologist Erving Goffman's seminal work on stigma in 1963, one has witnessed the expansion of research on stigma across many disciplines such as social science, public health, and medicine. There has been a more in-depth understanding about how stigma functions and resulting harm in the context of different identities and diseases (Stangl et al. 2019). Stigma is based on the idea that some individuals are different and this often leads to discrimination. Although stigma is socially constructed, it can impact on the lives of many individuals and groups, particularly those who are already vulnerable to ill health such as individuals with mental health concerns or living with HIV/AIDS. In order to eradicate stigma, Scambler (2003) contends that there should no longer be any sanction to "mark" some individuals as deviant and stigmatized and then treat them as "outsiders." Instead of treating difference as a basis for discrimination and rejection, it should be credited as "a source of celebration." The authors entirely agree with this position. This is reflected in the destigmatization of realities that are discussed in this chapter.

As primary deliverers of health care, health care professionals are in the best position to embark on local and global discourse which can influence the creation of new policies and practices that would make the experiences of stigmatized individuals and groups more positive. This will inevitably enhance their health and well-being and make the lives of many marginalized and vulnerable people in the globe better in many ways.

In the near future, it is hoped to see more reduction of stigma which will result in the improvement of the social inclusion of many people in the world. This will lead to better health and well-being for all people, reduction of inequalities through devoid of discrimination, vulnerability, and marginalization, and more equitable health at the global level (UNAIDS 2019; Andersson et al. 2019).

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