A Community "Hub" Network Intervention for HIV Stigma Reduction: A Case Study

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We describe the implementation of a community "hub" network intervention to reduce HIV stigma in the Tlokwe Municipality, North West Province, South Africa. A holistic case study design was used, focusing on community members with no differentiation by HIV status. Participants were recruited through accessibility sampling. Data analyses used open coding and document analysis. Findings showed that the HIV stigma-reduction community hub network intervention successfully activated mobilizers to initiate change; lessened the stigma experience for people living with HIV; and addressed HIV stigma in a whole community using a combination of strategies including individual and interpersonal levels, social networks, and the public. Further research is recommended to replicate and enhance the intervention. In particular, the hub network system should be extended, the intervention period should be longer, there should be a stronger support system for mobilizers, and the multiple strategy approach should be continued on individual and social levels.

(Journal of the Association of Nurses in AIDS Care, 27, *166-179*) (*Copyright © 2016 Association of Nurses in AIDS Care*)

Key words: *community, HIV stigma reduction, hub network intervention, South Africa*

The serious manner in which HIV stigma and discrimination affect the global response to HIV is well known (Turan & Nyblade, 2013); HIV stigma and discrimination have an impact across the board as a significant barrier to HIV reduction activities such as prevention, care, and treatment. The International HIV/AIDS Alliance and the Global Network of People Living with HIV (2011) issued a call for the integration of HIV stigma-reduction activities into all HIV programs, which underlines the importance of deepening the response to HIV on all levels, as the stigma attached to HIV leaves nobody untouched.

In the quest to understand stigma and its devastating effects, various models and frameworks have been proposed through the years. Alonzo and Reynolds (1995) pioneered an analysis of HIV stigma in terms of a trajectory spanning the course of the disease tied to the stigmatizing responses of society. Over time, researchers have postulated that inequalities in power (social, political, and economic), structural violence (racism and sexism amongst others), and preexisting stigmas (against marginalized groups) result in labeling, stereotyping, status loss, and discrimination, and that these are the factors on which stigma is founded (Mahajan et al., 2008; Weiss, Ramakrishna, & Somma, 2006).

The model of HIV stigma as conceptualized by Holzemer and colleagues (2007) formed the theoretical framework for the research for our study. The model refers to both context and process. The context of HIV stigma is created by the environment (including cultural, economic, political, legal, and

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JOURNAL OF THE ASSOCIATION OF NURSES IN AIDS CARE, Vol. 27, No. 2, March/April 2016, 166-179
http://dx.doi.org/10.1016/j.jana.2015.10.007

policy environments), the health care system (including hospitals, clinics, home-based care, and health service delivery settings), and agents (such as people living with HIV [PLWH], families, colleagues, and communities). The process of HIV stigma as conceptualized by Holzemer and colleagues (2007) showed the interconnectedness of elements in the context that play a role in stigmatization. These elements are triggers, stigmatizing behaviors, types of stigma, and outcomes. Triggers, namely HIV disease itself, diagnosis, disclosure, and the suspicion of having the disease, lead to a person's own negative perceptions about the self and to stigmatizing behaviors by other people, including blame, insults, avoidance, and accusations. These in turn give rise to certain types of stigma (received, internal, and associated) and finally to certain stigma outcomes, such as poorer health and decreased quality of life, among others.

The same group of researchers conducted intensive research on HIV stigma within the African setting during a 5-year period (Holzemer et al., 2007). They aimed to understand HIV stigma in Africa, formulating the conceptual model for HIV stigma (as described above) and developed and validated two stigma scales for the African context for PLWH and nurses (Holzemer et al., 2007). This was followed by a health care settings-based HIV-related stigma-reduction intervention (Uys et al., 2009). Greeff, as a researcher in this team, continued the research by conducting a transdisciplinary, comprehensive community-based HIV stigma-reduction and wellness-enhancement intervention that involved PLWH as well as people living close to them (PLC), be it a partner, child, family member, friend, community member, or spiritual leader. French, Greeff, Watson, and Doak (2015) found that the comprehensive nature of the intervention facilitated relationships in all groups and enhanced knowledge about stigma. PLWH felt less stigmatized and more willing to disclose, and PLC became aware of their stigmatizing behaviors and were empowered to lead stigma reduction in their communities.

In a study with a population of ethno-racial and sexual minorities, it was found that HIV-related stigma threatened and disrupted accepted social connections and affected social structures in the studied community (Galindo, 2013). Human beings are part of shared social spaces carrying the burdens of care and being part of getting things done together for the community to address illness and stigma. Social interactions take place at the individual level, but individuals do not come to social interaction without affect, values, and motivations; individuals exist in structured political, cultural, and social contexts with defined social norms. Thus, social interactions take place in a structured context, where the norms of that society create ideas of difference (Pulerwitz, Michaelis, Weiss, Brown, & Mahendra, 2010).

There is a growing interest in addressing the social drivers of HIV, using core social change communication principles of participation, which are mutual understanding, equal voices, local ownership, sustainability, collective learning, and multiple accountabilities. In other words, the focus shifts to social change (Byrne & Vincent, 2011). Community Health Psychology, the body of theory and practice that focuses on the processes of collective action through which communities identify the impacts of oppressive social relations on their well-being and engage in social struggles to create more health-enabling social environments, introduces a new way of conceptualizing community health action, which is called *trusting the process*, which brings possibilities of an open-ended, antihierarchical, and inclusive mode of community action (Cornish, Montenegro, Van Reisen, Zaka, & Sevitt, 2014). Community Health Psychology is grounded in respect for communities, believing (a) that they carry their own wisdom and that the foundation for human sociality, organization, and creativity lie in everyday human relationships and practices in communities; and (b) that community mobilization changes residents from clients to change agents (Hadjez-Berrios, 2014).

If the perspective on how change in human behavior occurs is, in itself, changing, a new look should be taken at interventions to reduce HIV-related stigma and the elements necessary for its success. A systematic review of 48 interventions to reduce HIV-related stigma and discrimination from 2002 to 2013, presenting 14 different target populations in 28 countries, revealed advances in the stigma-reduction field during the last decade (Stangl, Lloyd, Brady, Holland, & Baral, 2013). It became clear that multi-tiered factors needed