

Bringing Marginalized Population Intonational Stream.

Dr. Khalid Iraqi

Dean Faculty of Management Sciences, University of Karachi, Karachi, Pakistan

Abstract: *Marginalized people have little control over their lives which makes them handicap in delving contribution to society. They are prevented from participating in local life, which in turn leads to further isolation. It has a tremendous impact on development of human life, as well as on society at large. In this paper, we have systematically reviewed the scientific literature on marginalization, its nature, types of marginalization, marginalized groups and then we have focused on one marginalized group who suffer from HIV/AIDS related stigma. We have highlighted promising strategies to address stigma related issues. We have focused on the following key challenges: defining and reducing HIV/AIDS related stigma as well as assessing the impact of stigma on the effectiveness of HIV prevention and treatment programs. Based on the literature and personal observation we have concluded by offering a set of recommendations that may represent important next steps that how can we bring this marginalized group into national stream through communication.*

I. Introduction

The term 'marginalization' describes the overt actions or tendencies of human societies, where people who they perceive to objectionable or without useful function are excluded, i.e., marginalized. The people who are marginalized are outside the existing systems of protection and integration. This limits their opportunities and means for survival. The term has been defined in the different ways:

Merriam-Webster's online dictionary defines the term, marginalize, is "to consign to an insignificant, or powerless position within a society or group". Laitin describes that marginality is demeaning for economic growth, human dignity and for physical security. Marginalized people face irrevocable discrimination by members of dominant society. These definitions are mentioned in different contexts, and show that marginalization is a slippery and multilayered concept. To further clarify the meaning and concept we will discuss certain features of marginalization.

Sometimes, whole societies can be marginalized at national and global levels, while classes and communities can be marginalized from the dominant social order within the local level. In some other contexts, the same community can be marginalized in certain country (Jews in Germany or Russia) whereas they are not marginalized in another country (Jews in the U.S.A.).

Marginalization also increases or decreases at certain stages of life cycle. For example, the marginalized status of children and youth may decrease as they get older; the marginalized status of adults may increase as they become older; the marginalized status of single mother may change as their children grow up. Individuals or groups might enjoy high social status at some point of time, but as social change takes place, they may lose this status and become marginalized.

Thus, marginalization is a complex as well as shifting phenomenon linked to social status. The purpose of this paper is to describe marginalization and to propose a new conceptual framework to help inform thinking about the processes of stigma & discrimination, about the way these processes relate to HIV/AIDS, and about potential interventions to address stigma & discrimination and minimize their impact through communication. To do this, the paper: i. describes the nature and types of marginalization. ii. Defines marginalized groups. iii. Analyzes the sources of Stigma & Discrimination and, its consequences. iv. Proposes an agenda for bringing this marginalized group into national stream through communication.

Nature of Marginalization

Marginalization is a multidimensional, multi causal, historical phenomenon. There are no general laws to understand and comprehend the complex nature of marginalization. The analytical tools that can be used in most cases include class, in relation to specific social, cultural, economic and political conditions, as well as ideological systems, social awareness, and human action. The nature of marginalization varies in different settings for example, the marginalization of women in India is not the same as Iraq, though they broadly share some features. The religious, ideological system, political economy of a country, and the overall social system have an impact on the marginalization of specific groups or an individual.

Types of marginalization

To be marginalized is to be distanced from power and resources that enable self determination in economic, political and social settings. Though there are various types of marginalization, we identify some broad types, such as social, economic, and political marginalization. Those who are socially marginalized are deprived from social opportunities. They are stigmatized and often receive negative public attitude which creates social isolation. Economic marginalization relates to economic structure which directly or indirectly affects people's well being and health where as political marginalization doesn't allow people to participate in decision making.

Marginalized groups

In this section we will discussed about the most vulnerable marginalized groups in almost every society. i. Marginalization is one of the manifestations of gender inequality or gender identity. In every culture and country women are always marginalized relative to men. Eunuchs are also marginalized. ii. People with certain disabilities (mentally or physically handicap) / diseases (HIV/AIDS, Leprosy and TB) suffer from biased assumptions which left them in a severe state of impoverishment for centuries. iii. Ethnic and religious minorities are also marginalized in terms of social status, education, employment, wealth and political power.

Discrimination against these groups takes place in terms of physical, psychological, emotional and cultural abuse. All these factors affect their physical and psychological well being and their quality of life.

As we discussed above that there are many marginalized groups but in this paper we will discussed about HIV/AIDS related marginalized group and stigma and discrimination which is associated with this disease and how it can be resolved.

HIV/AIDS related stigma and discrimination

HIV-related stigma and discrimination have been acknowledged as an hindrance to mitigating the HIV epidemic since its early days, yet programming and activities to reduce stigma and discrimination have been given much less attention than other aspects of the epidemic. Fortunately, in recent years there has been an increase in the literature on HIV stigma as the issue has gained visibility and greater conceptual clarity and as means to measure stigma have been refined. Despite international efforts to tackle HIV/AIDS since then, stigma and discrimination remain among the most poorly understood aspects of the epidemic. Peter Piot, executive director of UNAIDS In 2000, identified stigma as a "continuing challenge" that prevents rigorous action at community, national, and global levels.

Analyzing Stigma and discrimination

The sociologist Erving Goffman (1963) defined stigma as a "significantly discrediting" attribute possessed by a person with an "undesired difference". Stigma is a powerful means of social control applied by marginalizing, excluding and exercising power over individuals who display certain traits. It is a common response to perceived threat when escape from, or the destruction of, this threat is impossible. While the societal rejection of certain social groups (e.g. "homosexuals", injecting drug users, sex workers and migrants) may predate HIV/AIDS, the disease has, in many cases, reinforced this stigmatization. McGrath (1992) stated that "by attributing blame to specific individuals and groups, society can absolve itself from the responsibility of caring for and looking after such populations". To analyze stigma and discrimination it is essential to understand its sources.

Sources of HIV/AIDS stigma and discrimination

De Bruyn has identified five factors as contributing to HIV/AIDS-related stigma:

The fact that HIV/AIDS is a life-threatening disease; the fact that people are afraid of contracting HIV; the disease's association with behaviors (such as sex between men and injecting drug use) that are already stigmatized in many societies; the fact that people living with HIV/AIDS are often thought of as being responsible for having contracted the disease; religious or moral beliefs that lead some people to conclude that having HIV/AIDS is the result of a moral fault (such as promiscuity or "deviant" sex) that deserves punishment.

From early in the AIDS epidemic, a series of powerful metaphors was mobilized which serve to reinforce and legitimate stigmatization. These include HIV/AIDS as death (e.g. through imagery such as the Grim Reaper); HIV/AIDS as punishment (e.g. for immoral behavior); HIV/AIDS as a crime (e.g. in relation to innocent and guilty victims); HIV/AIDS as war (e.g. in relation to a virus which needs to be fought); HIV/AIDS as horror (in which infected people are demonized and feared); and HIV/AIDS as "otherness" (in which the disease is an affliction of those set apart). (Omangi, 1997) has found, "it is widespread belief that HIV/AIDS is shameful", these metaphors constitute a series of "ready-made" but highly inaccurate explanations that provide a powerful basis for both stigmatizing and discriminatory responses. These stereotypes also enable some people to deny that they personally are likely to be infected or affected.

People living with HIV/AIDS are seen as ignominious in many societies. Where the infection is associated with minority groups and behaviors (for example, homosexuality), HIV/AIDS may be linked to “perversion” and those infected punished (Mejia, 1988). (Kegeles et al., 1989) are of that “ in individualistic societies, HIV/AIDS may be seen as the result of personal irresponsibility”. In some circumstances, HIV/AIDS is considered as a reason for bringing shame upon the family and community (Panos, 1990; Warwick et al., 1998). The manner in which people respond to HIV/AIDS therefore varies with the ideas and resources that society makes available to them. (Warwick et al., 1998) have come with the view, “While negative responses to HIV/AIDS are by no means inevitable, they not infrequently feed upon and reinforce dominant ideologies of good and bad with respect to sex and illness, and proper and improper behaviors”.

Sexuality

HIV/AIDS-related S&D are most closely related to sexual stigma. This is because HIV is mainly sexually transmitted and in most areas of the world, the epidemic initially affected populations whose sexual practices or identities are different from the “norm.” HIV/AIDS-related S&D has now appropriated and reinforced pre-existing sexual stigma related with sexually transferable diseases, promiscuity, homosexuality prostitution, and sexual “deviance” (Gagnon and Simon 1973; Plummer 1975; Weeks 1981). The belief that homosexuals are to blame for the epidemic or that homosexuals are the only group at risk of HIV is still common. Promiscuous sexual behavior by women is also commonly believed to be responsible for the heterosexual epidemic, regardless of the epidemiological reality. (Parker and Galvão 1996) maintained that “ In Brazil, for example, where surveillance data have shown high rates of HIV infection among monogamous married women, HIV-positive women are still widely perceived to be sexually promiscuous”.

Gender

HIV/AIDS-related S&D are also linked to gender-related stigma. Aggleton and Warwick (1999) observed that, “The impact of HIV/AIDS-related S&D on women reinforces pre-existing economic, educational, cultural, and social disadvantages and unequal access to information and services”. In settings where heterosexual transmission is significant, the spread of HIV infection has been associated with female sexual behavior that is not consistent with gender norms. For example, prostitution is widely perceived as non-normative female behavior, and female sex workers are often identified as “vectors” of infection who put at risk their clients and their clients’ sexual partners. Equally, in many settings, men are blamed for heterosexual transmission, because of assumptions about male sexual behavior, such as men’s preference or need for multiple sexual partners.

Race, ethnicity and class

Racial and ethnic stigma & discrimination also interact with HIV/AIDS related stigma & discrimination, and the epidemic has been characterized both by racist assumptions about “African sexuality” and by perceptions in the developing world of the West’s “immoral behavior.” Racial and ethnic S&D contribute to the marginalization of minority population groups, increasing their vulnerability to HIV/AIDS, which in turn exacerbates stigmatization and discrimination. New forms of social exclusion associated with these global changes have reinforced pre-existing social inequalities and stigmatization of the poor, homeless, landless, and jobless. As a result, poverty increases vulnerability to HIV/AIDS, and HIV/AIDS exacerbates poverty (Parker, Easton, and Klein 2000). HIV/AIDS-related S&D interacts with pre-existing S&D associated with economic marginalization. In some contexts, the epidemic has been characterized by assumptions about the rich, and HIV/AIDS has been associated with affluent lifestyles.

Thus, we can infer that, stigmatization is a process that involves identifying differences between groups of people, and using these differences to determine which groups fit into structures of power. Stigma and discrimination are used or can be used to produce and reproduce social inequality. Stigmatization, therefore, not only helps to create difference in society but also plays a key role in transforming difference based on sexuality, gender, race, ethnicity or class in to social inequality.

Fear of contagion and disease

HIV/AIDS is a life-threatening illness that people are afraid of contracting. (UNAIDS 2000; Malcolm et al. 1998; Daniel and Parker 1993) have found the following:

The various metaphors associated with AIDS have also contributed to the perception of HIV/AIDS as a disease that affects “others,” especially those who are already stigmatized because of their sexual behavior, gender, race, or socioeconomic status, and have enabled some people to deny that they personally could be at risk or affected.

HIV/AIDS-related S&D is, therefore, the result of interaction between diverse pre-existing sources of S&D and fear of contagion and disease. The pre-existing sources, such as those related to gender, sexuality, and

class, often overlap and reinforce one another. This interaction has contributed to the deep-rooted nature of HIV/AIDS-related S&D, limiting our ability to develop effective responses. It has also created a vicious circle of S&D which works in two ways. (i) HIV/AIDS is associated with marginalized behaviors, and people living with HIV/AIDS (PLHA) are stigmatized because they are assumed to be from marginalized groups. (ii) Already marginalized groups are further marginalized because they are assumed to have HIV/AIDS.

Thus, stigmatization is a process that involves identifying differences between groups of people based on sexuality, gender, race, ethnicity or class in to social inequality. Now we will examine consequences of stigma and discrimination.

Consequences of stigma and discrimination

Individual

Daniel and Parker (1993) noticed that “in contexts where HIV/AIDS is highly stigmatized, fear of HIV/AIDS-related S&D may cause individuals to isolate themselves to the extent that they no longer feel part of civil society and are unable to gain access the services and support they need “. This has been called internalized stigma. In some cases, premature death through suicide is commonplace. A fear of negative and hostile reaction from other is lingering threat for individuals who are already marginalized, reflecting the interaction between HIV/AIDS-related and pre-existing sources of Stigma & discrimination.

Family

The family is the main source of care and support for PLHA in most developing countries. However, negative family responses are common. “Infected individuals often experience S&D in the home, and women are often more likely to be badly treated than men or children “(Bharat and Aggleton 1999). Women, suffering from HIV/AIDS, are faced with the negative community and family responses including blame, rejection, and loss of children and home. (Panos 1990; Misra 1999; Mpundu 1999; Mujeeb 1999) have found, “since HIV/AIDS-related S&D reinforce and interact with pre-existing S&D, families may reject PLHA not only because of their HIV status but also because HIV/AIDS is associated with promiscuity, homosexuality, and drug use”. HIV/AIDS-related S&D in families and communities is commonly manifested in the form of blame, scapegoating, and punishment. Communities often shun or gossip about those perceived to have HIV or AIDS. It has turned into form of violence in some extreme cases; for example, some reports have come into sight about the physical assault on the men who are supposed to be gay.

Society

Kegeles et al. (1989) are of the view that cultural systems of the societies place greater emphasis on individuals : hence HIV/AIDS is taken as a result of self irresponsibility, so the individuals are charged for prone to infection . On the contrary, societies where cultural systems place greater weight on collectivism, HIV/AIDS is regarded as reason for ignominy on the family and community (Panos 1990; Warwick et al. 1998). The type of cultural system will therefore define the ways in which communities respond to HIV/AIDS and the ways in which S&D are manifested.

Bringing this marginalized population into national stream through communication

Isolated and marginalized groups face particular constraints with regard to access to information and communication, and thus have limited participation and voice in the public sphere and in decision-making processes affecting their lives. They belong to the culture of silence. They are on the wrong side of the digital divide, unable to participate in the Information Society and thus risk further marginalization, politically, socially and economically.

Communication as process

The Challenge for Change Program’s work with the Fogo Islanders in the 1960s has often been seen as a turning point in the development of participatory communication processes. The Fogo Process was one of the first examples of filmmaking and video as a process to obtain social change in a disadvantaged community. It included a series of working practices that have influenced many participatory communication programs throughout the world and that are still very valid. Key ingredients included: (i) Communication as a process for empowerment, for conflict resolution, and to negotiate with decision makers to modify policy. (ii) Communication technology and media only as tools to facilitate the process. (iii) Programms planned and produced with and by the marginalized themselves, about their social problems, and not just produced by outsiders. (iv)The professional quality of the product becomes secondary to content and process. (v) The importance of interpersonal communication and the role of a facilitator, a community worker or a social animator. (vi) Community input into the editing of the material, and dialogue with decision makers.

“The Fogo Process provides evidence of how local communities who have been marginalized by

economic and political structures can become empowered through communication to transform conditions of uneven development". (Crocker, 2003).

Fogo is one of the best example which can be utilized with HIV/AIDS people and through which we can help this marginalized population to get out of trouble and play a productive role in society.

II. Conclusion

Marginalization is a complex phenomenon which is link to social status. Marginalized people are largely deprived of social opportunities. There are several marginalized groups and people living with HIV/AIDS also one of them. HIV/AIDS related stigma and discrimination is considered a major barrier to effective responses to the HIV epidemic. Yet, there is little or no consensus among policy makers and intervention program implementers about how to define measure and diminish this phenomenon. This paper argues that we need a new way of understanding about stigma related intervention programs and through communication we can bring marginalized population into national stream.

For marginalized communities, increased community empowerment through access to information, improved networking and opportunities for women, access to medical information for isolated communities and new employment opportunities are only a few of the examples that have bolstered the belief that these technologies have a key role to play in the development of these communities. While the work described in this paper doesn't claim to offer the last word on the above mentioned matters, it does highlight a series of practical steps that can be taken in programming, policy and research.

References

- [1]. AFAO (Australian Federation of AIDS Organizations). 1997. "Human rights: from policy to practice," National AIDS Bulletin 11(5):28-29.
- [2]. Aggleton, P. and I. Warwick. 1999. Household and Community Responses to HIV and AIDS in Developing Countries: Findings from Multi-site Studies: Geneva, UNAIDS.
- [3]. Bharat, S. and P. Aggleton. 1999. "Facing the challenge: Household responses to AIDS in India," AIDS Care 11:33-46.
- [4]. Byrne, L. 1992. "Health risks of Rio's street children," British Medical Journal 304:1459-50.
- [5]. Crocker, S. 2003. The Fogo Process: Participatory Communication in a Globalizing World in Shirley White (ed) Participatory Video: Images that Transform and Empower. Sage Publications, New Delhi, Thousand Oaks, London.
- [6]. Daniel, H. and R. Parker. 1993. Sexuality, Politics and AIDS in Brazil. London: Falmer Press.
- [7]. De Bruyn, T. (1999) HIV/AIDS and discrimination 2. Stigma and discrimination: definitions and concepts. Ottawa, Canadian HIV/AIDS Legal Network and the Canadian AIDS Society.
- [8]. Goffman, E. (1963) Stigma: notes on the management of a spoiled identity. New York, Simon and Schuster.
- [9]. Gilmore, N. and M.A. Somerville. 1994. "Stigmatisation, scapegoating and discrimination in sexually transmitted diseases, overcoming 'them' and 'us'," Social Science and Medicine 39:1339- 1358.
- [10]. Kanbur, Ravi. (2007), Conceptualizing Economic Marginalization, (Key-notes for the Living at the Margins Conference Cape Town, March 26, 2007), www.people.cornell.edu/pages.
- [11]. Kegeles, S.M., Coates, T.J., Christopher, T.A. & Lazarus, J.L. (1989) Perceptions of AIDS, the continuing saga of AIDS-related stigma, AIDS, 3 (suppl.1):S253-S258.
- [12]. Malcolm, A. et al. 1998. "HIV and AIDS-related stigmatization and discrimination: its form and contexts," Critical Public Health 8(4):347-370.
- [13]. McGrath, J.W. (1992) the biological impact of social responses to the AIDS epidemic, Medical Anthropology, 15:63-79.
- [14]. Mejia, M. (1988) SIDA, historias extraordinarias de siglo XX. In: Gavan Diaz, F., ed. El SIDA en México, los efectos sociales. Mexico City, Mexico, Universidad Autónoma Metropolitana.
- [15]. Misra, S. 1999. "Social discrimination and rejection in Cambodia," posting to SEA-AIDS, Tue, 29 Jun 1999.
- [16]. Murshed, Marlsoob (ed.) (2002), Globalization, Marginalization, and Development, London, New York: Routledge.
- [17]. Mpundu, M. 1999. "Ignorance, denial, fear and violence: stigmatisation and discrimination in African communities-Zambia," posting to SEA-AIDS.
- [18]. Mujeeb, S. 1999. "Human right violations of PLWA/HIV by their family members,"_posting to SEA-AIDS, Tue, 06 Jul 1999.
- [19]. Omangi, H.G. (1997) Stigmatization and discrimination in the context of HIV and AIDS in Kenya, Newsletter of African Network on Ethics, Law and HIV, 3:4-5.
- [20]. PANOS. 1990. The 3rd Epidemic: Repercussions of the Fear of AIDS. London: Panos Institute.
- [21]. Parker, R.G. and J. Galvão (ed.). 1996. Quebrando o Silêncio: Mulheres e AIDS no Brasil. Rio de Janeiro: Editora Relume-Dumará.
- [22]. Parker R.G., D. Easton, and C. Klein. 2000. "Structural barriers and facilitators in HIV prevention: a review of international research," AIDS 14(Suppl. 1):S22-S32.
- [23]. Peterson, C. 1990. "Prostitutes and public health services co-operate on AIDS prevention in Brazil," Hygiene 9:29-31.
- [24]. Plummer, K. 1975. Sexual Stigma: An Interactionist Approach. London: Routledge and Kegan Paul.
- [25]. UNAIDS. 2000. "HIV and AIDS-related stigmatization, discrimination and denial: forms, contexts and determinants," research studies from Uganda and India (prepared for UNAIDS by Peter Aggleton). Geneva, UNAIDS.
- [26]. Warwick, I. et al. 1998. "Household and community responses to AIDS in developing countries," Critical Public Health 8(4):291-310.
- [27]. Weeks, J. 1981. Sex, Politics and Society: The Regulation of Sexuality since 1800. New York: Longman.