Stigma and HIV Testing Decisions: A Qualitative Analysis

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Abstract

The current emphasis on HIV testing as an AIDS prevention strategy assumes that, since the benefits of testing can be easily understood, many people will seek to know their HIV status. This paper argues that, beyond the benefits of knowing one's serostatus, a critical factor in deciding whether or not to test, has more to do with the fear of the consequences of a positive HIV test result than the health benefits of taking the test. Based on analysis of focus group discussions with students from the University of Swaziland's three campuses, this paper explores the fears associated with HIV testing and examines why many young people do not test despite knowing the benefits of testing. The paper considers the social context of HIV-related stigma and argues that, beyond simply sensitising individuals and groups on the merits of knowing one's HIV status, the issue of stigma associated with being HIV positive needs to be comprehensively addressed in all AIDS prevention activities.

Introduction

Studies conducted in both developed and developing countries have documented the critical role played by testing in preventing the spread of HIV. Some of these studies have shown a decrease in unprotected sexual intercourse with both steady and casual partners, and an increase in consistent condom usage following a voluntary counselling and testing (VCT) intervention programme (van Dyk and van Dyk, 2003). Voluntary counselling and testing efficacy studies have also demonstrated that VCT is successful in helping people reduce risk behaviours (UNAIDS, 2002; Hutchinson and Mahlalela, 2006). Moreover, VCT for HIV is a necessary precursor to developing effective treatment, care and support services including programmes to reduce mother-to-child transmission, preventive therapy for tuberculosis, or the administration of antiretroviral therapies (Pronyk *et al.*, 2002; Godfrey-Faussett, 2002; Galvan *et al.*, 2004; Grusky *et al.*, 2005; Rennie and Behets, 2006). The importance of HIV testing is underscored by the fact that appropriate care for people infected with HIV and

AIDS cannot begin without the diagnosis of HIV infection (Valdiserri, 2002).[5] Therefore, increasing targeted testing is a crucial prevention strategy that also facilitates linkage to early HIV treatment (Vargo *et al*., 2004).

This paper examines the role of HIV-related stigma as an impediment to HIV testing. The analysis argues that beyond the benefits of testing, other factors mediate the decision to test and to a large extent, such factors ultimately determine whether individuals test or decline to test. In this regard, the motivation to go for testing is influenced by interplay between varieties of factors, including HIV-related stigma. As Weiss and Ramakrishna (2006) have argued, an important aspect of stigma that merits being studied is the magnitude and nature of its contribution to, *inter alia,* delay in appropriate help-seeking, and treatment dropout. There is a dearth of literature that specifically examines the barriers to HIV testing (Awad *et al*., 2004). Awad *et al* further argue that available studies have not been replicated with other populations such as student samples. Importantly, as Fako (2006) notes with regard to studies conducted in sub-Saharan Africa, people's willingness to test among different sectors of the population remains largely unexplored and not adequately documented.

Literature Review

The concept of stigma

The term stigma dates back to ancient Greece (Herek, 2002; Varas-Díaz and Toro-Alfonso, 2003; Cusack *et al.,*2003). Citing Crawford (1996), Varas-Díaz and Toro Alfonso (2003) state that the concept of stigma was used to describe persons with bodily marks or tattoos which evidenced their involvement in a bad deed and were, therefore, to be avoided. Varas-Diaz and Toro-Alfonso surmise that all the definitions of the concept share the idea that stigma is a negative evaluation of a particular difference that may be identified in a person. The diverse definitions of the concept are a result of the fact that the term has been applied in an enormous array of circumstances (Link and Phelan, 2001). Link and Phelan, therefore, state that "it is wise to continue to allow variation in definition so long as investigators are clear as to what is meant by stigma when the term is used" (Link and Phelan 2001:365).

In his sociological text on stigma, Goffman (1963) explored further the concept of stigma which he defined as spoiled identity, discrediting, and blaming by others. Accordingly, stigma describes the shared meanings or schemas through which a person's inferiority or danger to others is explained, and it labels a person unusual, bad, or morally suspect (Poindexter, 2005). It is an enduring condition, status, or attribute that is negatively valued by a

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[5] Rosenberg (2003: 275) argues that persons who test late in the course of HIV infection are not able to benefit fully from antiretroviral therapy and prophylaxis to prevent opportunistic infections and, thus, are more likely to progress to AIDS.

society and whose possession consequently discredits and disadvantages an individual (Herek, 2002). Some scholars have argued that stigma often plays the role of "master-status trait" because it is assumed to be central to the identity of the individual and becomes the individual's perceived defining feature (see Cusack *et al.,* 2003). With reference to AIDS, Sontag (1991) notes that the epidemic has emerged as a disease whose charge of stigmatisation, and whose capacity to create spoiled identity is far greater than that of other diseases.[6] Most pointedly, the fact that those who believe that HIV can be spread through casual social contact are more likely to fear contact with those who have HIV and AIDS is worrying and feeds stigma (Dias *et al.,* 2006).

Drawing on Goffman's (1963) definition of stigma, Herek and Capitanio (1998) define AIDS-related stigma as prejudice, discounting, discrediting, and discrimination directed at people perceived to have AIDS or HIV, their loved ones and associates, and the groups and communities with which they are affiliated. The terms AIDS-related stigma, AIDS stigma, HIV-related stigma, and HIV/AIDS stigma are often used interchangeably in the literature. HIV-related stigma covers all stigmas directed at persons perceived to be infected with HIV, regardless of whether they are actually infected and whether they manifest symptoms of AIDS or AIDS-related complex (Herek and Glunt, 1988). HIV-related stigma is expressed in a variety of ways including support for stigmatizing AIDS policies (quarantine, publicly identifying people living with HIV and AIDS), support for mandatory testing, attributions of responsibility and blame to PLWHA, and discomfort with and avoidance of people living with HIV and AIDS (PLWHA) (see Herek *et al*., 2002). The centrality of stigma in any society faced with the daunting challenge of the AIDS epidemic is aptly summed up by Barnett and Whiteside (2002: 66):

> Stigmatisation is itself an important part of the history of any particular epidemic. It is a social process: a feature of social relations, reflecting the tension, conflict, silence, subterfuge and hypocrisy found in every human society and culture. While illness and death are the public facets of an epidemic disease like HIV/AIDS, these others are its private facets.

Thus, according to Herek and Glunt (1991), public attitudes surrounding AIDS are shaped by the complex characteristics of the epidemic: first, that AIDS is a transmissible and, to date, lethal disease; and, second, those personal reactions to it inevitably are influenced by concerns about individuals' well-being and that of their loved ones.

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[6] Cited in Rohleder and Gibson (2006:26).

HIV testing

Myers *et al.* (2003) provide a cogent background to HIV testing. They argue that views of HIV testing and counselling, in particular within public health discourse, have varied over time. They note that initially, with limited treatment options, the test was seen predominantly as a means of identifying potential transmitters of the infection. Thus, given the debates surrounding the functions of the test, many individuals were discouraged from seeking the test. In the late 1990s, because of the promise of new and effective treatment options and the potential of early detection of HIV, the HIV test became more normative. With this, the role of the test as an educational tool has continued to evolve.

In their study of psychosocial barriers to HIV voluntary counselling and testing, van Dyk and van Dyk (2003) point out that earlier studies focused on the fear of lack of confidentiality. In addition, there was concern about the possibility of prejudiced behaviour by health care personnel who are aware of the patient's serostatus. Citing the case of rural south west Uganda, van Dyk and van Dyk note that there were widespread rumours of medical staff that intentionally killed HIV-positive patients to stem the spread of infection.

Godfrey-Faussett *et al.* (2002) point out that, although VCT has long been an established part of HIV programmes, the vast majority of people in developing countries living with HIV infection do not know that they are infected for a number of reasons. These include the high cost of VCT services, the stigma of identification as HIV-positive, and the widespread perception that HIV testing offers little to the individual who tests positive. In a study of voluntary counselling and testing services in Eastern Cape, South Africa, Hutchinson and Mahlalela (2006:449) found out that the probability of being tested was generally tied to age and education, as well as to psychosocial indicators such as absence of stigma and knowing someone with HIV and AIDS.

A number of conceptual frameworks have been used to guide studies examining how individuals and groups confront issues of health and illness. One of these frameworks is the health belief model (HBM). Developed in the early 1950s, the HBM is one of the most widely used conceptual frameworks for understanding health behaviour, and it has been used with great success to promote preventive and screening behaviour (Werner, 2003). This model focuses on the barriers in the explanation of health related behaviours (Awad *et al.*, 2004). The HBM consists of six main components including perceived susceptibility (belief concerning the likelihood of getting a condition); perceived severity (belief regarding the seriousness of the condition); perceived benefits (beliefs about the effectiveness of an action to reduce or eliminate the condition); perceived barriers (tangible and psychological costs associated with an advised action); cues to action (environmental prompts that activate a person's willingness to take action); and, self-efficacy (confidence in ability to take action). According to Awad *et al.*, the model posits that for individuals to change a behaviour they must first feel threatened by their current behaviour and believe that change would bring about a valued result at minimal cost. Zak-Place and Stern (2004) maintain that the Health Belief Model (HBM) continues to be suggested in identifying preventive behaviours. Their study operationalizes preventive STD and HIV behaviours as three dependent variables: intention to use condoms and intention to obtain STD and HIV testing.

In order to adequately explore the concept of HIV-related stigma and its impact on HIV testing, this paper will focus on some of the components of the HBM within an interpretivist framework that views stigma as an outcome of definitional and meaning-making social processes. The analysis will therefore use the social constructionist framework, and it will attempt to elucidate how the “self” is continuously shaped through the prevailing social discourses and construction of meanings in relation to HIV-related stigma. This is essential because the wider social context in which people with HIV live and the way they are represented are important determinants of stigmatising actions. This context also provides a framework within which negative images are internalised or fought against to maintain an assured HIV-positive identity (Chapman, 2000). This approach emphasises that stigma is relationship- and context-specific; it does not reside in the person but in a social context (Major and O’Brien, 2005). Accordingly, as Lichtenstein *et al.* (2005) have argued, stigma is both produced and reified through social interaction and through social processes that construct “in” and “out” groups.

HIV and AIDS in Swaziland

Although the first AIDS case was reported in Swaziland in 1987, it took the government over ten years to declare the epidemic a “national crisis” and proceed to work out strategies to combat the scourge. There was, therefore, no sector preparedness within the government. This stance by the government has been attributed to a false sense of security that the Ministry of Health and Social Welfare was taking care of the issue (Key et al., 1999). Besides, HIV/AIDS was initially not recognized as a severe problem in Swaziland (Buseh et al., 2002). The declaration of AIDS as a “national crisis” in 1999 by King Mswati III signalled the official definition of the pandemic as a social problem in the sense that, since the King occupies an important position in the world view of the Swazis, he is an essential actor in the problem legitimation process (Zamberia, 2004).

Since the declaration of AIDS as a crisis, the national response has included the formation of a Cabinet Committee on HIV/AIDS, and the multi-sectoral Crisis Management and Technical Committee (CMTC) on HIV/AIDS. The two bodies are meant to support and accelerate the on-going efforts of the Ministry of Health and Social Welfare through the Swaziland National AIDS/STDs Programme and to ensure a significant reduction of the epidemic through a multi-sectoral response (UNDP, 2001). The CMTC comprises government representatives, NGOs, the private sector, churches, youth, women, the media, traditional healers, chiefs, and the donor community. Furthermore, the government's commitment to combating the pandemic saw the establishment of the National Emergency Council on HIV and AIDS (NERCHA) in 2001 (Zamberia, 2004).

Notwithstanding the intensification of these efforts, little has been accomplished with respect to countering the problem of HIV-related stigma that is greatly contributing to the escalation of HIV infections in the country. This being the case, society still continues to view PLWHA in a way that sets them apart from other members of society. For instance, Prince Tfohlongwane, chairing the Swazi National Council (SNC), commented in favour of segregating people with HIV and AIDS: "One should not keep rotten potatoes in the same bag with good ones because they will all get spoilt in the end" (SANASO, 2001: 6, cited in Jackson 2002: 347). Addressing the senate, Prince Khuzulwandle advocated branding people with HIV in the armpit so that potential sexual partners could easily tell their status (Jackson, 2002: 347). Bayer and Stuber (2006) point out that, when people view the issue of AIDS in this manner, what comes to the fore is the question of whether there are occasions when the mobilisation of stigma may effectively reduce the prevalence of behaviours linked to disease and death. In this regard, according to these scholars, some believe that anything that might work has to be considered, even heavy handed moral opprobrium. This paper examines the extent of these stigmatising beliefs and attitudes, and their effects on HIV testing decisions among students at the University of Swaziland.

Methodology

This paper is based on data from focus group discussions (FGDs) conducted with students from the University of Swaziland (UNISWA). This was part of a larger study on social-structural factors that influence behaviour in relation to HIV and AIDS at UNISWA. Focus group discussions (FGDs) were conducted with groups of 6-12 students. Recruitment of participants in the FGDs was done using purposive sampling. However, researchers ensured that the groups consisted of a representative mix of the larger student population, and a fair representation of both male and female students. Five focus group discussions were conducted: three at the Kwaluseni campus, one at the Luyengo campus, and one at the Mbabane campus. One of the FGDs was conducted with some members of the UNISWA Peer Counsellors and Educators. An interview guide was used in conducting the discussions which covered the following, among other issues: AIDS-related knowledge, attitudes, beliefs and practices among students; HIV and AIDS awareness; AIDS stigma; voluntary counselling and testing (VCT), as well as attitudes towards HIV-positive people.

All participants in this study were informed about the nature of the group discussion and gave informed consent to their participation. The FGDs were tape-recorded and, then, transcribed and analysed thematically. The material presented in this analysis was selected to highlight key issues pertaining to the social context of stigma and its impact on individuals and groups with regard to HIV testing. Verbatim quotes are employed where appropriate to enable the reader to gain some insights into the material upon which the concluding observations are made.

Findings and Discussion

Although several themes emerged from the analysis of the focus group data, the discussion presented here focuses, in the main, on stigma related issues, specifically the influence of stigma on HIV testing decisions, in particular, and health-seeking behaviour, in general, among students at UNISWA. Where appropriate, issues not directly related to these themes, but which serve to illuminate the central concerns of the analysis will be highlighted.

Health-seeking behaviour among UNISWA students was explored with regard to voluntary counselling and testing (VCT), and other issues pertaining to individual health and well-being. Data from the FGDs demonstrate that health-seeking behaviour is influenced by a variety of factors. Key among these include the institutional arrangements and the kind of social setting within which individuals are located. With respect to institutional arrangements, the organisation and location of services were found to be critical in determining whether or not students went for health-related services. Although locational and organisational factors were found to be important, the general societal view of those who go for certain health services (people often stigmatised in society) influence how individuals generally respond to these services. More specifically, given that AIDS has been, to some extent, associated with immorality, those infected or thought to be infected have been stigmatised in society.

The stigma associated with PLWHA has a direct bearing on those who do not know their HIV status and, to a large extent, influences how they respond to AIDS prevention and control messages that advocate the importance of knowing one's HIV status. In this respect, stigma leads to reluctance to go for HIV testing on the part of those who do not know their HIV status. Besides, even those who are HIV positive, according to some of the FGD participants, may be unable to access the necessary care and treatment due to the fear engendered by their stigmatised status in society. For this reason, the fear of HIV-related stigma has contributed greatly to people not seeking care or testing to know their HIV status. Importantly, receiving an HIV-positive diagnosis puts into the foreground the stigma of HIV and AIDS (Rohleder and Gibson, 2006). Referring to a hypothetical case of a positive HIV test result and the possibility of enacted stigma, a participant said,

> If we lived in a non-discriminating environment it would be a minor problem for life doesn't end as soon as you become infected. But considering the discrimination around us, it would be a very big problem to deal with especially if you don't get support from your family or relatives. (Male participant, Faculty of Social Science & Humanities FGD)

Under such circumstances, "ignorance is bliss" (Hutchinson et al., 2004:109). These findings are consistent with evidence from the literature that shows that the stigma associated with HIV and AIDS has threatened the physical and psychological well-being of people who are perceived to be infected with HIV and impaired the society's ability to provide treatment to people with AIDS and to prevent further transmission of HIV (Herek and Capitanio, 1993). Flowers et al. (2003) state that although the HIV test could be understood as a means to resolving uncertainty about one's HIV status, for some people, it was avoided because of the potential impact and fear of a positive diagnosis in terms of the psychosocial management of a positive diagnosis (and identity) in everyday life.

Efforts to provide reproductive health services and promote safe sex behaviour have been hampered by the society's view of sex, and its association with HIV and AIDS. Campbell et al. (2005) argue that the link made by many between sex, sin, and immorality is another factor that supports stigmatisation of HIV and AIDS. One of the participants expressed the negative overtones associated with sex by many religious faiths as follows:

> Most religions, especially Christianity, present sex as a sinful and dirty act. Yet in my comprehension of the Bible, it is an act of love for fulfilling needs of marriage mates, and this produces the most cherished gifts – babies. (Female participant, Faculty of Agriculture FGD)

When the church approaches the issue of sexual prohibitions in this manner, the rules about sexual conduct tend to carry the force of taboo, or shame, rather than that of moral reasoning.[7] Herek and Capitanio (1998) assert that whereas an individual may understand AIDS as a test of his or her capacity for compassion and caring for other human beings, another may believe that AIDS poses a moral imperative to reject conduct that he or she regards as sinful, and this contributes to negative attitudes towards people with AIDS. Because of this association between sex, immorality, and AIDS, some students at UNISWA are unwilling to go for reproductive health services, and

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[7] Many of the participants explained that this has been the major reason for the failure of parents to openly discuss issues related to AIDS and sex with their children within the family context.

are thus not in a position to practice safe sex. As Seckinelgin (2004) notes, most AIDS campaigns carry implicit moral judgment about sex and the patient that exacerbates the stigma problem and, as a result, people refrain from attending clinics or getting condoms. The participants in nearly all the FGDs noted that there is an underlying fear among students who are in steady relationships that practising safe sex by using condoms could be interpreted to mean that one is either HIV positive (or suspects that he/she is HIV positive), or that he/she has been unfaithful. This underscores the belief by some that people contract HIV only through sexually promiscuous behaviour. It is this belief that serves to sustain the link between sex and HIV, and further negatively affects efforts to promote HIV testing and make reproductive health services accessible to those who need them.[8] As one participant put it,

> With the issue of stigmatisation, I think whoever is diagnosed HIV positive is stigmatised. I think such people will feel it's the end of the world for them. They will have it in their minds that everybody is seeing me as that person who has been sleeping around, and of course most people think that the only way you get AIDS is through sex, though there are other ways. (Male participant, Faculty of Agriculture FGD)

This view regarding people who are HIV-positive, and the stigma attached to being HIV positive, inhibit the likelihood of students testing for HIV. This negatively affects HIV and AIDS prevention and control initiatives since HIV testing as been viewed as one of the key means by which the spread of the epidemic can be curbed (Pronyk et al., 2002; Godfrey-Faussett et al., 2002).

This fear of stigma has contributed to the underutilization of the voluntary counselling and testing services provided by the university. Participants pointed out that, at the Mbabane Campus -- which houses the Faculty of Health Sciences, and the only campus with a VCT facility -- students hardly go for counselling and testing at the facility. This is explained by the fact that many students believe that being seen going to a VCT facility automatically implies that either you are HIV positive, or that you suspect that you could be positive. A participant stated,

> It is normal for people to assume that if you want to have a test, you actually had engaged in sexual intercourse prior to the test. Actually you may find that the reason you want to

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[8] This exacerbates the mismatch between need and access to health care services. Scholars have noted that problem of access to health care has become more acute with the rise of AIDS cases in the developing countries (see, for instance, Barnett and Blaikie, 1992).

> test may be that you have been taking care of an HIV-positive person, and may be that person died. You are like, there might be a chance that I might be positive even though I never engaged in sex. (Female participant, Faculty of Health Sciences FGD)

Moreover, being seen seeking VCT services could be interpreted to mean that one is promiscuous and, thus, likely to be HIV positive.[9] In this case, the possibility of being subjected to HIV-related stigma through such subtle acts as avoidance is high. Therefore, as Herek (2002) states, being the target of stigma inflicts pain, isolation, and hardship on many people with HIV, while the desire to avoid it deters some from being tested for HIV, seeking treatment, or practising risk reduction.

Despite being aware of the benefits of knowing one's HIV status, many students are afraid of testing, and in cases where a student has been known to have died of AIDS, knowledge of such deaths serves to reinforce the stigmatisation of PLWHA. In one case recounted by one of the participant's regarding one student's HIV positive status, the reaction of some students following her demise highlighted the power of the notion of stigma within the student community. The participant explained this case as follows:

> Last academic year, there was a student, some of you may not know this, she was doing BASS IV[10] and she was HIV positive. It was not clear what caused her death, but I was listening to the views of people talking about this. And it was like, this person was, I don't know, was having something scary that has never been seen before. I think it all boils down to the stigma that is attached to being HIV positive. (Female participant, Faculty of Social Science & Humanities FGD)

As a result of the stigma attached to HIV and AIDS, and the association of sex with AIDS, students are deterred from going for HIV testing and also from freely seeking sexual and reproductive health services. The FGDs revealed that since many students have not tested for the virus, some who suspect that they are HIV positive, but fail to seek proper VCT due to the fear of stigma attached to being HIV positive, resort to using available local products touted

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[9] In his discussion of the stigma of seeing a psychiatrist, Bar-Levav (1976) asserts that a mere consultation with a psychiatrist casts serious doubt on the sanity of a person and may disqualify him from holding public office. In a similar manner, society can contribute to the stigmatization of people seeking VCT.

[10] BASS IV (Bachelor of Arts in Social Science Year IV).

by local herbalists as effective treatment for HIV and AIDS. Thus, despite the availability of antiretroviral provided by government and non-state agencies, a large number of people may not benefit from antiretroviral therapy since they are unwilling or afraid to get tested for the virus. This, undoubtedly, strikes at the core of the AIDS prevention and control objectives pursued by the state and non-governmental agencies.

Evidence from the FGDs demonstrates that stigma greatly influences the character of interpersonal relations and partnership formation at UNISWA. HIV-related stigma has fostered a social environment within which individuals are afraid to be associated with PLWHA or those they suspect could be infected with HIV. Thus, there is a tendency to socially exclude PLWHA or other persons thought to be HIV positive. This is a form of instrumental AIDS stigma tied to the apprehension likely to be associated with any transmissible and deadly disease (Herek, 2002). Due to the fact that many of the interpersonal relationships at UNISWA, according to the FGD participants, are based on mutual trust, any suspicion on the part of any of the parties involved in a relationship that his or her partner could be HIV positive could signal the dissolution of the relationship. Once this foundation is shaken by suspicions arising from HIV and AIDS related issues, the relationships are ultimately likely to crumble. As one participant stated,

> In the process, after you have tested and you are positive, you lose your friends and some people whom you value, those you think are the best thing to have happened in your life. You tend to lose those people. And where does this put you as an individual who is HIV positive? You are all alone. It goes back to the issue of trauma and you get sick even more. (Female participant, Faculty of Social Science & Humanities FGD).

These words demonstrate the extent of the impact of stigma on interpersonal relationships on campus. As participants from the Faculty of Health Sciences pointed out, even when people have been informed about how HIV is transmitted, and the fact that they cannot get infected through casual contact, in practice they tend to avoid people living with AIDS and even severe links with friends they suspect could be HIV positive. Under such circumstances, it is difficult for sexual partners to openly discuss issues related to sex and AIDS, or broach the topic of HIV testing.

Conclusion

This paper has shown that HIV-related stigma negatively affects efforts to stave off the spread of HIV and AIDS through voluntary counselling and testing. The fear engendered by stigma has given rise to a situation whereby, as Seckinelgin (2004) argues, awareness and subsequent stigmatisation are leading to a hidden epidemic. Therefore, for AIDS prevention and control activities to succeed, stigma reduction must be made a central component of these programmes. Campbell *et al.* (2005:808) highlight three anti-stigma strategies from the existing HIV and AIDS literature: (1) information based awareness programmes designed to reduce ignorance about people with AIDS; (2) institution of legal safeguards making discrimination against people with AIDS a punishable offence; and (3) participation of local community efforts in anti-stigma efforts. Thus, to minimise stigma and foster an environment conducive to effective AIDS prevention and control initiatives, there is need to introduce strategies that directly address the underlying conditions that perpetuate the stigmatisation of people living with HIV and AIDS.

The foregoing analysis has highlighted the centrality of the social context with regard to HIV testing decisions. It has been demonstrated that the meaning and context of HIV diagnosis is an essential element in framing testing decisions. For this reason, it is not so much the changing medical aspects of HIV that shape HIV testing decisions, but the meaning and social consequences of HIV diagnoses (Flowers *et al.,* 2003). This implies that influencing and changing the character of the social context is a prerequisite for the success of AIDS control and prevention initiatives involving HIV testing. As Link and Phelan (2001) argue, in the absence of fundamental changes, interventions targeted at only one mechanism at a time will ultimately fail, because their effectiveness will be undermined by contextual factors that are left untouched by such narrowly conceived interventions

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