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Social Stigma and Discrimination: HIV/AIDS

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Abstract

HIV-related stigma and discrimination refers to prejudice, negative attitudes and abuse directed at people living with HIV and AIDS. In 35% of countries with available data, over 50% of people report having discriminatory attitudes towards people living with HIV. Stigma and discrimination also make people vulnerable to HIV. Those most at risk to HIV (key affected populations) continue to face stigma and discrimination based on their actual or perceived health status, race, socioeconomic status, age, sex, sexual orientation or gender identity or other grounds. In the present research paper discuss the ways of Social Stigma & Discrimination HIV/AIDS and also analysis how we can reduce social stigma & discrimination against HIV/AIDS.

Keywords: self stigma, family stigma, workplace stigma, community stigma, social stigma and health care stigma

1. Introduction

Stigma and discrimination manifests itself in many ways. Discrimination and other human rights violations may occur in health care settings, barring people from accessing health services or enjoying quality health care. Some people living with HIV and other key affected populations are shunned by family, peers and the wider community, while others face poor treatment in educational and work settings, erosion of their rights, and psychological damage. These all limit access to HIV testing, treatment and other HIV services. The People Living with HIV Stigma Index documents the experiences of people living with HIV. As of 2015, more than 70 countries were using the HIV Stigma Index, more than 1,400 people living with HIV had been trained as interviewers, and over 70,000 people with HIV have been interviewed. The fear surrounding the emerging HIV epidemic in the 1980s largely persists today. At that time, very little was known about how HIV is transmitted, which made people scared of those infected due to fear of contagion (Bell, 2003, p. 56).

This fear, coupled with many other reasons, means that lots of people falsely believe:

- HIV and AIDS are always associated with death.
- HIV is associated with behaviours that some people disapprove of (such as homosexuality, drug use, sex work or infidelity).
- HIV is only transmitted through sex, which is a taboo subject in some

cultures.

- HIV infection is the result of personal irresponsibility or moral fault (such as infidelity) that deserves to be punished.
- inaccurate information about how HIV is transmitted, which creates irrational behaviour and misperceptions of personal risk.

2. How Stigma Affects People Living with HIV

Patience E shun from Ghana, who lost her daughter to an AIDS-related illness.

HIV-related stigma and discrimination exists worldwide, although it manifests itself differently across countries, communities, religious groups and individuals. In sub-Saharan Africa, for example, heterosexual sex is the main route of infection, which means that HIV-related stigma in this region is mainly focused on infidelity and sex work.

Research by the International Centre for Research on Women (ICRW) outlines the possible consequences of HIV-related stigma as:

- loss of income and livelihood
- loss of marriage and childbearing options
- poor care within the health sector
- withdrawal of caregiving in the home
- loss of hope and feelings of worthlessness
- loss of reputation.
- HIV stigma and key affected populations

Stigma and discrimination is often directed towards key affected populations such as men who have sex with men (sometimes referred to as MSM), people who inject drugs and sex workers.

These people are increasingly marginalized, not only from society, but from the services they need to protect themselves from HIV. For example, in 2016, 60% of countries in the European Economic Area reported that health care professionals' negative and discriminatory attitudes towards men who have sex with men and people who inject drugs hampered the provision of adequate HIV prevention services for these groups (Bloom & Godwin 2017, p. 88).

More than 90% of new HIV infections in Central Asia, Europe, North America, the Middle East and North Africa in 2014 were among people from key populations and their sexual partners, who accounted for 45% of new HIV infections worldwide in 2015. Recent studies suggest that, globally, people who inject drugs are 24 times more likely to acquire HIV than the general population, sex workers are 10 times more likely and men who have sex with men are 24 times more likely. Moreover, transgender people are 49 times more likely and prisoners are five times more likely to be living with HIV than adults in the general population.

3. How Stigma Affects the HIV Response

UNAIDS and the World Health Organization (WHO) cites fear of stigma and discrimination as the main reason why people are reluctant to get tested, disclose their HIV status and take antiretroviral drugs (ARVs). One study found that participants who reported high levels of stigma were over four times more likely to report poor access to care. This contributes to the expansion of the global HIV epidemic and a higher number of AIDS-related deaths.

An unwillingness to take an HIV test means that more people are diagnosed late, when the virus may have already progressed to AIDS. This makes treatment less effective, increasing the likelihood of transmitting HIV to others, and causing early death.

For example, in the United Kingdom (UK), many people who are diagnosed with HIV are diagnosed at a late stage of infection, defined as a CD4 count under 350 within three months of diagnosis. Although late diagnosis of HIV has declined in the UK in the last decade, from 56% in 2005 to 39% in 2015, this figure remains unacceptably high. In South Africa, stigma stopped many young women involved in a trial on HIV prevention from using vaginal gels and pills that would help them stay HIV free. Many reported being afraid that using these products would lead them to being mistakenly identified as having HIV, and so the fear of the isolation and discrimination that being identified as living with HIV would bring led them to adapt behaviors that put them more at risk of acquiring the virus. In 2015, WHO released new treatment guidelines that reflect the need to address stigma and discrimination as a barrier to accessing HIV treatment (IIPM, 2016, p. 119).

4. Forms of HIV Stigma and Discrimination

HIV and AIDS-related stigma can lead to discrimination, for example, when people living with HIV are prohibited from travelling, using healthcare facilities or seeking employment.

4.1 Self-Stigma/Internalized Stigma

Self-stigma, or internalized stigma, has an equally damaging effect on the mental wellbeing of people living with HIV or from key affected populations. This fear of discrimination breaks down confidence to seek help and medical care. Self-stigma and fear of a negative community reaction can hinder efforts to address the HIV epidemic by continuing the wall of silence and shame surrounding the virus. Negative self-judgement resulting in shame, worthlessness and blame represents an important but neglected aspect of living with HIV. Self-stigma affected a person's ability to live positively, limits meaningful self agency, quality of life, adherence to treatment and access to health services (Cehat, 2001, p. 92).

4.2 Governmental Stigma

A country's discriminatory laws, rules and policies regarding HIV can alienate and exclude people living with HIV, reinforcing the stigma surrounding HIV and AIDS.

In 2014, 64% of countries reporting to UNAIDS had some form of legislation in place to protect people living with HIV from discrimination. While, conversely, 72 countries have HIV-specific laws that prosecute people living with HIV for a range of offences. Criminalization of key affected populations remains widespread with 60% of countries reporting laws, regulations or policies that present obstacles to providing effective HIV prevention, treatment, care and support. As of 2016, 73 countries criminalized same sex activity, and injecting drugs use is widely criminalized, leading to high incarceration levels among people who use drugs. More than 100 countries criminalize sex work or aspects of sex work. Even in countries where sex work is at least partially legal the law rarely protects sex workers and many are at risk of discrimination, abuse and violence from both state and non-state actors such as law enforcement, partners, family members and their clients. For example, some 15,000 sex workers in China were detained in so-called custody and education centres in 2013 (Paradhan, 2017, p. 119).

4.3 Restrictions on Entry, Travel and Stay

As of September 2015, 35 countries have laws that restrict the entry, stay and residence of people living with HIV. In 2015, Lithuania became the most recent country to remove such restrictions. As of 2015, 17 countries will deport individuals once their HIV positive status is discovered, five have a complete entry ban on people living with HIV and four require a person to be able to prove they are HIV negative before being granted entry. Deportation of people living with HIV has potentially life-threatening consequences if they have been taking HIV treatment and are deported to a country that has limited treatment provision. Alternatively, people living with HIV may face deportation to a country where they would be subject to even further discrimination — a practice that could contravene international human rights law.

4.4 Healthcare Stigma

Healthcare professionals can medically assist someone infected or affected by HIV, and also provide life-saving information on how to prevent it. However, HIV-related discrimination in healthcare remains an issue and is particularly prevalent in some countries. It can take many forms, including mandatory HIV testing without consent or appropriate counseling. Health providers may minimize contact with, or care of, patients living with HIV, delay or deny treatment, demand additional payment for services and isolate people living with HIV from other patients.

For women living with HIV, denial of sexual and reproductive health and rights services can be devastating. For example, 37.7% of women living with HIV surveyed in 2012 in a six-country study in the Asia–Pacific region reported being subjected to involuntary sterilization. Healthcare workers may violate a patient's privacy and confidentiality, including disclosure of a person's HIV status to family members or hospital employees without authorization. Studies by WHO in India, Indonesia, the Philippines and Thailand found that 34% of respondents reported breaches of confidentiality by health workers. People from key affected populations may face additional discrimination in healthcare settings. Discriminatory attitudes held by health providers may also lead them to make judgments about a person's HIV status, behavior, sexual orientation or gender identity, leading individuals to be treated without respect or dignity. These views are often fuelled by ignorance about HIV transmission routes among healthcare professionals. A study of health providers in urban health facilities in India found 55-80% of providers displayed a willingness to prohibit women living with HIV from having children, endorsed mandatory testing for female sex workers (94-97%) and stated that people who acquired HIV through sex or drugs "got what they deserved" (50-83%) (Dixit, 2013).

These experiences may leave people living with HIV and people from key affected populations too afraid to seek out healthcare services, or be prevented from accessing them — for instance, if a nurse refuses to treat a sex worker after finding out about their occupation. It also prevents many people from key affected populations being honest with healthcare workers if they're a sex worker, have same-sex relations, or inject drugs, meaning they are less likely to get services that could help them.

4.5 Employment Stigma

In the workplace, people living with HIV may suffer stigma from their co-workers and employers, such as social isolation and ridicule, or experience discriminatory practices, such as termination or refusal of employment. Evidence from the People Living with HIV Stigma Index suggests that, in many countries, HIV-related stigma and discrimination are as frequently or more frequently a cause of unemployment or a denial of work opportunity as ill health. By reducing stigma in the workplace (via HIV and AIDS education, offering HIV testing, and contributing towards the cost of ARVs) employees are less likely to take days off work, and be more productive in their jobs. This ensures people living with HIV are able to continue working (Kelly, 2013, p. 47).

4.6 Community and Household Level Stigma

Community-level stigma and discrimination towards people living with HIV can force people to leave their home and change their daily activities. In many contexts, women and girls often fear stigma and rejection from their families, not only because they stand to lose their social place of belonging, but also because they could lose their shelter, their children, and their ability to survive. The isolation that social rejection brings can lead to low self-esteem, depression, and even thoughts or acts of suicide.

The International Center for Research on Women (ICRW) reports that in Bangladesh more than half of women living with HIV have experienced stigma from a friend or neighbor and one in five feel suicidal. In the Dominican Republic, six out of ten women living with HIV fear being the subject of gossip, while in Ethiopia, more than half of all women living with HIV report having low self-esteem. A survey of married HIV-positive women (15–29 years) in India found 88% of respondents experienced stigma and discrimination from their family and community. Women with older husbands and from households with lower economic status were significantly more likely to experience stigma and discrimination from their husbands' family as well as from friends and neighbors. Stigma and discrimination can also take particular forms within community groups such as key affected populations. For example, studies have shown that within some lesbian, gay, bisexual, transgender and intersex (LGBTI) communities there is segregation between HIV-positive and HIV-negative people, where people associate predominately with those of the same status.

4.6.1 As part of This Work

A virtual community of practice, Equal Health for All, has been created to facilitate the sharing of communication, collaboration and experiences in implementing the action plan. Over the year, its membership grew to more than 160 members from more than 70 organizations. In Malawi, the National Association of People Living with and Affected by AIDS, in partnership with Aritel Malawi and UNAIDS, is using an SMS-based reporting system to provide real-time monitoring of experiences of stigma and discrimination faced by people living with HIV in the healthcare sector. In Argentina, 21 service centres friendly to LGBTI people aim to increase the accessibility and acceptability of health services for key affected populations. Healthcare professionals have been trained on the specific healthcare needs of LGBTI people as well as on non-discrimination, accessible opening hours, and the active involvement of LGBTI people in the design and functioning of services. In 2016, Kenya reaffirmed its commitment to end HIV-related stigma and discrimination by embarking on a national 'Kick out HIV stigma' campaign. This aims to leverage the power of football to mobilize young people to end HIV stigma and link them to stigma-free HIV testing, treatment and care (Mahal, 2013, p. 68).

4.7 Stigma and Discrimination Towards PLHIV at the Workplace

At the workplace, PLHIV experience enacted stigma and discrimination. Enacted stigma occurs when work colleagues display negative attitudes towards PLHIV, while discrimination is experienced when PLHIV are sent away from work, or denied opportunities for career growth at the workplace.

4.7.1 Enacted Stigma at the Workplace

Enacted stigma at the workplace is also experienced when workmates talk negatively of PLHIV, tending to demonize him/her by considering them to be immoral. Workmates sometimes openly refuse to associate with PLHIV. In some instances, the affected PLHIV are not able to withstand the situation, and opt to voluntarily leave their jobs.

4.7.2 Discriminatory Practices Towards PLHIV at Workplace

In the discussions, PLHIV reported that they were faced with threats of imminent loss of employment, due to a positive HIV status. Employers were skeptical about the ability of PLHIV to continue work. Employers also wanted to avoid the costs associated with employing a PLHIV, such as medical costs and costs associated with absenteeism. Workplaces fail to support and provide care for their employees when they become ill with HIV/AIDS. Supervisors block the promotion of staff who are HIV positive. In some cases, PLHIV are reassigned to lower positions within the organizations. Some PLHIV reported they had lost their jobs due their HIV status (Basu & Vans 2016, p. 73).

4.8 Stigma and Discrimination Experienced in the Home by PLHIV

Although the home is supposed to provide a loving and caring environment, PLHIV experience stigma and discrimination in their homes. Results show a belief among some PLHIV that HIV/AIDS stigma and discrimination at the household level is gender-based. Female PLHIV are more stigmatized than men. PLHIV reported that when men test positive, they expect to receive a lot of support and care from their spouses. On the other hand, when the women test positive, the men are not willing to support them.

"In some communities when a married woman has tested positive, they are not given support. However, when the husband tests positive, they expect maximum support from their wives." (Female PLHIV)

Lack of spousal support was cited as a major form of HIV stigma and discrimination by female PLHIV. Discussions show that some men failed to support their spouses and instead abandoned them. This increases stigma and leads to discrimination among the affected persons.

4.8.1 Enacted Stigma Against PLHIV in the Home Setting

One of the ways through which PLHIV experience stigma is when family members and friends begin to treat them as if they were already dead. This practice is manifested when family members scramble for and distribute the property of bedridden PLHIV, even before the latter pass away. PLHIV also reported that some family members were scared about the burden of care associated with long illnesses and preferred that the PLHIV died quickly, as a way of saving resources that would otherwise be spent on caring for the sick. "In some families, once they get to know that your HIV positive their prayer is that you 'die quickly'. They try their level best to stress you so that you can pass away in a very short period of time to take your possessions. This happened to my colleague. All of his property was taken because he was bedridden. However when he unexpectedly recovered, very serious family wrangles took place." (Male PLHIV) (Busza, 2014, p. 136).

"There are some families which are so bad. When they hear that you are HIV positive they tend to really look at you as if you are not living." (Female PLHIV)

The lack of caring professionals in Uganda means family members have to take-up the care-giving roles when a close relative becomes bed-ridden due to AIDS. Many family members lack the knowledge and skills to provide quality care and nursing services for PLHIV. Caretakers are stressed and overwhelmed by the caring responsibility.

Caretakers stigmatize PLHIV when providing care. For example, there are cases where PLHIV are denied food and/or are not cleaned when they defecate. Soiled clothes are not washed; they are kept until the PLHIV gets better and gains enough strength to wash their own clothes. This kind of treatment does not happen when people are sick with other ailments such as malaria.

Because of the stigma and discrimination that accompanies HIV and AIDS, families need to handle the information that a member is HIV positive with care. In some cases, however, the news that a family member has HIV is not handled sensitively and in confidence. All members within a family are told about the positive status of an individual, and yet they may not have skills or ability to treat such information confidentially. In some cases, family members, including children will tell other people about the HIV status of the affected individual.

4.8.2 Self Stigma Faced by PLHIV in the Home Setting

Families caring for people with AIDS make attempt to adopt infection control practices in order to minimize illness within their households. Infection control within the families comprises of separating utensils and other facilities used by the PLHIV from those used by the rest of the household members. This practice is viewed by the PLHIV as discriminatory and stigmatizing. PLHIV who are already experiencing felt stigma tend to translate family level infection control practices as unfair, which results into self-stigma. This illustrates the need to sensitize PLHIV and their carers that the virus cannot be transmitted through sharing utensils and implements for washing or eating (Chandra, 2015, p. 145).

Sometimes family members and communities stigmatize PLHIV unintentionally as they try to help them. Out of concern, some family members offer to assist PLHIV, even where the latter feel they do not need help. Offering help, where it is not needed, makes the PLHIV feel worthless. This help comes at a time when PLHIV want to prove their independence and self reliance, and as such assistance may not be welcome. People living with HIV/AIDS at times experience stigma and discrimination when they are recipients of acts of kindness and compassion. When caretakers and others offer to help PLHIV, this makes the latter feel inadequate and stigmatized. Caretakers unintentionally stigmatize PLHIV when they pamper and treat them as individuals with exceptional needs and who require assistance with every detail of their lives. PLHIV want to prove that they are persons of worth who are capable of making valuable contribution to society. In this regard, offers of help may signal to the PLHIV that they are no longer capable of doing anything valuable (Richhard, 2016, p. 39).

4.8.3 Discrimination Against PLHIV in the Home Setting

One of the reported common practices within families is the exclusion of a PLHIV in family discussions and decision-making processes. PLHIV are denied the opportunity to participate in family level decision-making. People living with HIV/AIDS feel discriminated against when they are not given an opportunity to participate in activities on the basis of their HIV status. They begin to feel that they are not of any use to their families. In some cases, families are hesitant about spending money on medical and non-medical needs of PLHIV, because of fear they may not recuperate completely. Children infected with HIV/AIDS are often denied the opportunity to attain education. Education is seen as an investment and families are not willing to invest in the education of children, whose chances of surviving up to adulthood are in the balance. Information from the PLHIV indicated that although ARVs have become more available and accessible, compared to the past, there is insufficient public knowledge regarding the benefits of ARVs. The views that children with HIV/AIDS will die continue to persist (ILO, 2015, p. 68).

4.9 Stigma and Discrimination Faced by PLHIV at Community Level

At the community level, there are practices that tend to lead to enacted stigma among PLHIV. Some PLHIV have experienced situations where the communities in which they live fail to see HIV/AIDS as the problem, but instead focus on those who are HIV positive as the problem. This often results in labelling and treating those with HIV as a category. Community members fail to recognize PLHIV are individuals, with inherent dignity, feelings and rights.

4.9.1 Self Stigma Faced by PLHIV at Community Level

Acts of kindness that stigmatize PLHIV are not limited to personal care activities but extend to the community. Some communities are sensitive to the unique needs of PLHIV and make public display of care, which the PLHIV may find stigmatizing. In some cases, PLHIV are given first priority to eat food at public functions in recognition of their nutritional needs. HIV/AIDS stigma affects even those PLHIV who have openly disclosed their status. While it is commonly believed that being open about one's

HIV status is a key milestone in addressing stigma, experience shows that stigma is prevalent even among those PLHIV who are open about their HIV status. PLHIV who have come out in the open about their positive status are selective about whom and where to disclose their status. Group discussions revealed that some PLHIV who have come out with their positive status, avoid being openly associated with groups that provide support to people living with HIV/AIDS (NACO Report, 2015, p. 96).

4.10 Stigma and Discrimination Faced by PLHIV at Health Facilities

Health workers discriminate against PLHIV in health facilities. They treat PLHIV differently from other patients. Some health workers are rude towards the PLHIV and lack respect for PLHIV. This affects the quality of care that PLHIV receive.

5. Barriers to Overcoming Stigma and Discrimination

PLHIV identified several barriers to overcoming stigma and discrimination, including low response to HIV counseling and testing (HCT), fear, weak policy environment and lack of accurate information.

5.1 Fear of Loss of Social Status

Uncertainty about the response of significant others is also a barrier to overcoming stigma and discrimination. PLHIV have a frontline position in the fight against stigma and discrimination. The PLHIV are however faced with fear over the reactions of others, when they find out their HIV status. Fear of rejection and uncertainty of future social relations after disclosure means that some PLHIV do not disclose and are not able to lead the crusade against stigma and discrimination.

5.2 Inadequate Legislative and Policy Environment

PLHIV identified the lack of laws and policies to protect PLHIV against stigma and discrimination as a major barrier. The weak legal environment means that people who stigmatize and discriminate against others are not held responsible. The lack of HIV related laws that address stigma by asserting social norms of respect and equality for PLHIV, their families, and those at risk of contracting HIV are a major barrier to addressing stigma and discrimination. The laws that guarantee the rights of PLHIV to education, employment, confidentiality, information, and treatment are either weak or not adequately enforced (Pradhan 2006: P.61).

5.3 Ignorance and Lack of Sufficient Knowledge

PLHIV identified the lack of adequate knowledge about HIV and AIDS as one of the barriers against addressing HIV stigma and discrimination. Many people are not aware of the distinction between HIV and AIDS. As a result, individuals think people who are HIV positive are sick, and on the verge of death. This means that PLHIV continue to be treated as if they are dying soon. Stigmatizing labels like the “living dead” continue to be relevant to most people when referring to PLHIV. PLHIV also believe there is insufficient knowledge on HIV transmission.

6. Conclusion

All governments have recognized that stigma, discrimination and violations of other human rights are major barriers to effective national responses to HIV. Consequently, they have committed to protect the human rights of people living with HIV, as well as the rights of women, children, and members of vulnerable and key populations in the context of HIV. This not only reduces the personal suffering that can be associated with HIV, but also helps to create social and legal environments that encourage people to take up and use HIV services. Such efforts are essential to achieve universal access to HIV prevention, treatment, care and support, and to halt and reverse the epidemic — other government commitments. For these reasons, UNAIDS has recognized “advancing human rights and gender equality” as one of three strategic pillars in the response to HIV.

7. Suggestion and Recommendations for Reduce Social Stigma and Discrimination Related to HIV/AIDS

7.1 Stigma and Discrimination Reduction

Programmes aimed at reducing stigma and discrimination against people living with HIV or people at risk of HIV infection should address the actionable causes of stigma and discrimination and empower people living with and vulnerable to HIV. Research has shown that the actionable causes are: (a) ignorance about the harm of stigma, (b) continuing irrational fears of infection, and (c) moral judgement. Programmes to address these causes can involve a variety of approaches, including:

(1) Community interaction and focus group discussions involving people living with HIV

and members of populations vulnerable to HIV infection;

(2) Use of media, including advertising campaigns, entertainment designed to educate as well as to amuse ("edutainment"), and integration of non-stigmatizing messages into TV and radio shows;

(3) Engagement with religious and community leaders, and celebrities;

(4) Inclusion of non-discrimination as part of institutional and workplace policies in employment and educational settings;

(5) Measurement of HIV-related stigma through the People Living with HIV Stigma Index7, including in health care settings and communities; and

(6) Peer mobilization and support developed for and by people living with HIV aimed at promoting health, well-being and human rights

7.2 HIV-Related Legal Services

HIV-related legal services can facilitate access to justice and redress in cases of HIV-related discrimination or other legal matters. These might include: estate planning; breaches of privacy and confidentiality; illegal action by the police; discrimination in employment, education, housing or social services; and denial of property and inheritance rights. Specifically, these services may include:

- Legal information and referrals;
- Legal advice and representation;
- Alternative/community forms of dispute resolution;
- Engaging religious or traditional leaders and traditional legal systems (e.g., village courts) with a view to resolving disputes and changing harmful traditional norms; and
- Strategic litigation.

7.3 Monitoring and Reforming Laws, Regulations and Policies Relating to HIV

Laws, regulations and policies relating to HIV can negatively or positively impact a national HIV epidemic, as well as the lives and human rights of those living with and affected by HIV. It is thus essential to monitor and reform laws, regulations and policies so they support, and not hinder, access to HIV and health services. Examples of programmes to monitor and reform laws, regulations and policies in the context of HIV include:

- Review of laws and law enforcement practices to see whether they impact the response to HIV positively or negatively;
- Assessment of access to justice for people living with or vulnerable to HIV;
- Advocacy and lobbying for law reform;
- Engagement of Parliamentarians and Ministers of Justice, Interior, Corrections, Finance, Industry, Labour, Women's Affairs, Education, Immigration, Housing, Defence, Health and Trade, religious and traditional leaders, among others; and
- Promotion of the enactment and implementation of laws, regulations and guidelines that prohibit discrimination and support access to HIV prevention, treatment, care and support.

7.4 Legal Literacy ("Know Your Rights")

Legal literacy programmes teach those living with or affected by HIV about human rights and the national and local laws relevant to HIV. This knowledge enables them to organize around these rights and laws and to advocate for concrete needs within the context of HIV. Thus, these programmes focus on both legal and rights knowledge and on strategies regarding how to use this knowledge to improve health and justice. The programmes may also provide information on different legal or human rights fora in which one can advocate or seek redress, such as patients' rights groups, ombudsmen offices and national human rights institutions. Legal literacy programmes can form part of other HIV services (e.g., health care provision, prevention outreach, peer education, support groups, in prisons) or can be stand-alone programmes involving such activities as:

- Awareness-raising campaigns that provide information about rights and laws related to HIV through media (e.g., TV, radio, print, Internet);
- Community mobilization and education;
- Peer outreach; and
- Telephone hotlines.

7.5 Sensitization of Law-Makers and Law Enforcement Agents

These programmes seek to inform and sensitize those who make the laws (parliamentarians) and those who enforce them (Ministers of Interior and Justice, police, prosecutors, judges, lawyers, traditional and religious leaders) about the important role of the law in the response to HIV, e.g., to protect those affected by HIV against discrimination and violence and to support access to HIV prevention, treatment, care and support. Sensitization programmes aim to help ensure that individuals living with and vulnerable to HIV can access HIV services and lead full and dignified lives, free from discrimination, violence, extortion, harassment and arbitrary arrest and detention. Such programmes may include:

1) Sensitization of police regarding HIV and how it is and is not transmitted; the importance of reaching out to and accessing populations at risk; the importance of appropriately addressing domestic and sexual violence cases in the context of HIV; and the negative consequences of illegal police activity on justice and on the HIV response;
2) Facilitated discussions and negotiations among HIV service providers, those who access services and police to address law enforcement practices that impede HIV prevention, treatment, care and support efforts;
3) Information and sensitization sessions for Parliamentarians, personnel of Ministries of Justice and Interior, judges, prosecutors, lawyers, and traditional and religious leaders on the legal, health and human rights aspects of HIV and on relevant national laws and the implications for enforcement, investigations and court proceedings; Training for prison personnel regarding the prevention, health care needs and human rights of detainees living with or at risk of HIV infection; and
4) HIV in the Workplace programmes for law makers and enforcers.

7.6 Training for Health Care Providers on Human Rights and Medical Ethics Related to HIV

Human rights and ethics training for health care providers focus on two objectives. The first is to ensure that health care providers know about their own human rights to health (HIV prevention and treatment, universal precautions, compensation for work-related infection) and to non-discrimination in the context of HIV. The second is to reduce stigmatizing attitudes in health care settings and to provide health care providers with the skills and tools necessary to ensure patients' rights to informed consent, confidentiality, treatment and non-discrimination. Human rights and ethics training should be conducted with:

(1) Individual health care providers to raise awareness of their own human rights in the context of HIV, and the negative impact that stigma, breaches of confidentiality and neglect of informed consent in health care settings have on patients' lives, as well as to address fears and misconceptions about HIV transmission and to promote understanding, compassion and professionalism;

(2) Health care administrators to ensure that health care institutions provide the information, supplies and equipment necessary to make sure health care workers have access to HIV prevention (including the universal precautions needed for prevention of occupational transmission of HIV) and treatment and are protected against discrimination; and

(3) Health care regulators to ensure enactment and implementation of policies that protect the safety and health of patients and health care workers, and prevent discrimination against people living with and vulnerable to HIV.

7.7 Reducing Discrimination Against Women in the Context of HIV

These programmes address gender inequality and gender-based violence as both causes and consequences of HIV infection. This includes programmes that address women's and girls' inequality in sexual and reproductive decision-making; gender barriers to health services; discrimination in inheritance, property-holding, marriage, divorce and custody; sexual and other violence; lack of equal access to educational and economic opportunity; and lack of support to care-givers in HIV-affected households. Such programmes should be complemented by programmes targeting men and boys which address harmful gender norms that make women and girls, as well as men and boys, vulnerable to HIV infection. These programmes can include:

1) Strengthening the legal and policy environment to ensure that laws protect women and girls from gender inequality and violence;
2) Efforts to reform domestic relations and domestic violence laws and law

enforcement where these fail to sufficiently protect women or create barriers to HIV prevention, treatment, care and support;

3) Efforts to reform property, inheritance and custody laws to ensure equal rights for women, children and caregivers affected by HIV;
4) Age-appropriate sexuality and life-skills education programmes that also seek to reduce gender inequality and gender-based violence;
5) Programmes to reduce harmful gender norms and traditional practices that put women, girls, men and boys at risk of HIV infection, including capacity development of civil society groups working for women's rights and gender equality;
6) Programmes to increase access to education and economic empowerment opportunities for women living with or vulnerable to HIV infection; and
7) Integrated health services with a well functioning referral system, including post rape care and post exposure prophylaxis (PEP).

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