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Non-discrimination in HIV responses

1. INTRODUCTION

1. Decision 6.1 of the 24th meeting of the UNAIDS Programme Coordinating Board Requested "[…] *that the issue of non-discrimination be discussed at a Programme Coordinating Board meeting in 2010 as a substantive agenda item".*

2. HIV-related discrimination is grounded in the stigma attached to people living with HIV and marginalised communities who are most at risk of HIV, including sex workers, people who inject drugs, men who have sex with men and transgender people. (See Boxes 1 and 2). This paper summarises the currently available evidence on HIV-related discrimination and stigma and their impact on national HIV responses. It also outlines the main challenges, gaps and opportunities for effectively reducing stigma and discrimination within national HIV responses, and highlights some examples of action being taken by UNAIDS to support national, regional and global efforts to tackle HIV-related stigma and discrimination.

Box 1. What is stigma?[i]
HIV-related stigma refers to the negative beliefs, feelings and attitudes towards people living with HIV and/or associated with HIV. Thus, HIV-related stigma may affect those suspected of being infected by HIV; those who are related to someone living with HIV; or those most at risk of HIV infection, such as people who inject drugs, sex workers, men who have sex with men and transgender people.

HIV-related stigma exists worldwide and manifests itself in countries, communities, religious groups and individuals, though its basic elements are surprisingly common across cultures.[1] It is expressed in stigmatizing language and behaviour, such as ostracization and abandonment; shunning and avoiding everyday contact; verbal harassment; physical violence; verbal discrediting, blaming and gossip. Stigma often lies at the root of discriminatory actions. Stigma may also be internalized by stigmatized individuals in the form of feelings of shame, self-blame and worthlessness.

[Stigma can be reduced by empowerment of people living with HIV and other stigmatized groups, updated information and education about HIV, media campaigns, and activities that foster interaction among people living with HIV, those most at risk of infection and key audiences.]

Box 2. What is discrimination?[ii]
HIV-related discrimination refers to the unfair and unjust treatment (act or omission) of an individual based on his or her real or perceived HIV status. Though HIV-related stigma often leads to discrimination, it is important to note that even if a person *feels* stigma towards another, s/he can decide to *not to act* in a way that is unfair or discriminatory. Conversely, a person may discriminate against another without personally holding stigmatising beliefs, for example, where discrimination is mandated by law.

Discrimination in the context of HIV also includes unfair treatment of key affected

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[i] Adapted from UNAIDS, 2005. *HIV-related Stigma, Discrimination and Human Rights Violations, Case studies of successful programmes*
[ii] Adapted from UNAIDS, 2005. *HIV-related Stigma, Discrimination and Human Rights Violations, Case studies of successful programmes* and UNAIDS, 2007. *Reducing HIV Stigma and Discrimination: a critical part of national AIDS programmes, A resource for national stakeholders in the HIV response*

populations, such as sex workers, people who use drugs, men who have sex with men, transgender people, prisoners, and in some social contexts women, young people, migrants, refugees and internally displaced people.

Discrimination may occur in families, workplaces, health-care services, prisons, schools, places of worship and within social networks, or in the context of housing, insurance, social support, travel, migration and the granting of asylum and refugee settlement. Discrimination can be institutionalised through existing laws, policies and practices that negatively target people living with HIV and marginalized groups. Omission can also be a form of discrimination when, for example, the level of resources directed towards the key affected populations are not commensurate with the level of epidemic among them, or when HIV surveillance fails to track infections among these populations.

Discrimination is a human rights violation and is prohibited by international human rights law and most national constitutions.

Discrimination can be reduced through the removal of punitive laws and enactment of protective legislation, robust enforcement of protective policies, training of service providers (health care professionals, teachers, police, judiciary) on non-discrimination in the context of HIV, educating people about relevant rights and laws, promoting contact between those discriminated against and those discriminating, and providing access to legal services for affected populations.

3. In 2010, almost thirty years into the HIV epidemic, HIV-related stigma and discrimination remain highly prevalent around the globe. In the *Declaration of Commitment on HIV/AIDS (2001),* governments throughout the world made commitments to reduce stigma and discrimination against people living with HIV and groups vulnerable to HIV infection. In 2005-2006, in country and regional consultations on universal access to HIV prevention, treatment, care and support, stakeholders reported that stigma and discrimination against people living with HIV were major barriers to universal access and undermined the effectiveness of national responses to HIV. In the *Political Declaration on HIV/AIDS* (2006), in which governments committed to scaling up of programmes to achieve universal access to HIV prevention, treatment, care and support, governments again recognized the harmful effects of stigma and discrimination and made major commitments to reduce them. However, despite the recognition of the pervasiveness of stigma and discrimination and their harmful impact on HIV responses, the reduction of stigma and discrimination has not been given the political commitment, resources and programmatic effort that are required to make an impact.

4. UNAIDS, as a joint UN programme, has a mandate based on the Charter of the United Nations (1945) to promote and encourage respect for human rights and for fundamental freedoms for all. Based on this mandate, UNAIDS has an obligation to support countries to reduce HIV-related stigma and discrimination. UNAIDS also has a mandate to support governments and civil society to achieve universal access and the most effective national responses to HIV – both of which are threatened by stigma and discrimination. In the *Joint Action for Results, UNAIDS Outcome*

Framework, 2009-2011, UNAIDS set out ten priority action areas[iii] which have been selected because their realisation will contribute to the achievement of universal access and related Millennium Development Goals. Reducing stigma and discrimination is essential for achieving successful outcomes within *all* the priority areas, but among them, one – *"We can remove punitive laws, polices, practices, stigma and discrimination that block effective responses to AIDS"* – reinforces the need for UNAIDS to focus on reducing stigma and discrimination and creating an enabling legal environment in which the law protects from discrimination, law enforcement practices are human rights based, and individuals affected by HIV have access to justice.

Why do we care about HIV-related stigma and discrimination?

Stigma and discrimination harm individuals

5. Stigma and discrimination associated with HIV can be as devastating as the illness itself: abandonment by spouse and/or family, social ostracism, job and property loss, lack of access to or expulsion from school, denial of medical services, lack of care and support, and violence. In addition, internalised stigma felt by people living with HIV can, when combined with feelings of being isolated from society, lead to depression, self-imposed withdrawal and even suicide.

6. Stigma and discrimination therefore increase the personal suffering associated with HIV, affect the overall well-being and health of those affected, and may reduce their ability to remain productive, self-supporting citizens or to reach their human potential.

Harmful outcomes for public health

7. HIV-related stigma and discrimination undermine HIV prevention efforts by making people afraid to seek out information about how to reduce their risk of exposure to HIV, and to adopt safer behaviour in case this raises suspicion about their HIV status and find out whether or not they are infected. The fear of stigma and discrimination also discourages people living with HIV from disclosing their status, even to family members and sexual partners, and undermines their ability to adhere to treatment (see Box 3. below).

8. Thus, stigma and discrimination weaken the ability of individuals and communities to protect themselves from HIV and to stay healthy if HIV-positive. Stigma and discrimination act therefore as barriers to achieving universal access to HIV prevention, treatment, care and support and hinder progress towards achieving the related Millennium Development Goals.

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iii 1) We can reduce sexual transmission of HIV; 2) We can prevent mothers from dying and babies from becoming infected with HIV; 3) We can ensure that people living with HIV receive treatment; 4) We can prevent people living with HIV from dying of tuberculosis; 5) We can protect drug users from becoming infected with HIV; 6) We can protect and provide services for men who have sex with men, sex workers and transgender people; 7) We can remove punitive laws, policies, practices, stigma and discrimination that block effective responses to AIDS; 8) We can meet the HIV needs of women and girls and stop sexual and gender-based violence; 9) We can empower young people to protect themselves from HIV; 10) We can enhance social protection for people affected by HIV.

Discrimination is a human rights violation[iv]

9. Stigmatizing[v] and discriminatory actions violate the fundamental human right to freedom from discrimination. In addition, discrimination directed at people living with HIV, those believed to be HIV-infected or key affected populations, leads to the violation of other human rights, such as the rights to health, education, dignity, privacy, equality before the law, and freedom from inhuman, degrading treatment or punishment.

2. PREVALENCE OF HIV-RELATED STIGMA AND DISCRIMINATION AND EVIDENCE ON SUCCESSFUL REDUCTION APPROACHES

Prevalence of HIV-related stigma and discrimination and their impact on the HIV epidemic and response

10. Research shows that HIV-related stigma and discrimination are pervasive and have a harsh negative impact on the quality of life of people living with and affected by HIV. Stigma and discrimination have been found to act as impediments to uptake of HIV testing, and to adherence to treatment.[2] (See Box 3)

11. A sample of results from the People Living with Stigma Index[vi] show that stigma and discrimination are reportedly experienced by people living with HIV in diverse settings in all regions:
    - In Myanmar, 11 per cent of respondents reported that they were often excluded from social events, and 15 percent reported that they were often excluded from family events in the last 12 months. Although 90 percent of respondents had not been denied health care in general due to their HIV-positive status in the last 12 months, 35 percent reported that they had been denied family planning services, and 20 percent had been denied other sexual and reproductive health services.[3]
    - In the People's Republic of China, a major concern for respondents was that they might become the subjects of gossip if their status was known with 87.3 percent of female respondents and 79.4 percent of respondents overall expressing this concern. More than half of respondents worried about being insulted or threatened, and almost one quarter worried about being physically attacked. In addition, 41.7 percent of respondents reported having faced some type of HIV-related discrimination, and 12.1 percent of respondents had been refused medical care at least once since they were tested positive. Of those respondents with children, almost one tenth (9.1 percent) said that their children, who were not necessarily HIV positive themselves, had been forced to leave school because of the HIV status of their parents.[4]

[iv] The principle of non-discrimination, based on recognition of the equality of all people, is enshrined in the Universal Declaration of Human Rights and other human rights instruments. These texts prohibit discrimination based on race, colour, sex, language, religion, political or other opinion, property, birth or other status. In 1996, the UN Commission on Human Rights resolved that the term 'or other status' used in several human rights instruments 'should be interpreted to include health status, including HIV/AIDS', and that discrimination on the basis of actual or presumed HIV status is prohibited by existing human rights standards.

[v] Although the term 'stigma' is not mentioned in any of the Human Rights Instruments, concluding comments and recommendations from UN Human Rights Treaty Body recognise the link between stigma and discrimination and these bodies have called on State Parties to take measures to address stigmatisation in the context of HIV.

[vi] *The People Living with HIV Stigma Index* is an action research initiative to measure stigma, by and for people living with HIV. It has been developed through a partnership between the Global Network of People Living with HIV (GNP+), the International Community of Women living with HIV (ICW), the International Planned Parenthood Federation (IPPF), and UNAIDS.

- Although 87 percent of the respondents in Rwanda reported that they had never been denied health services, a large percentage (88 percent) of respondents reported being denied family planning services because of their HIV positive status in the last 12 months. HIV-positive status was also a major reason reported for denial or refusal of access to accommodation, work, and educational services.[5]
- In the United Kingdom, 46 percent of respondents reported that their rights may have been violated in the last 12 months. Twenty-two percent of participants reported being physically harassed, and 40 percent reported being verbally harassed, with 54 percent of respondents saying that the harassment was at least partly due to their HIV status. Seventeen percent reported that they had been denied health services in the last 12 months.[6]

12. Stigmatising attitudes and discrimination do not apply to all people living with HIV equally, and HIV stigma intersects with other pre-existing stigmas.[vii] Research has shown that already marginalised groups tend to experience the most severe forms of stigma and are also more likely to experience discrimination than others when diagnosed with HIV, including refusal of services[7] [8]. One study, for example, found that there was significantly less sympathy for people living with HIV who use drugs, somewhat more for people described as homosexual and the most sympathy for children and heterosexual women living with HIV[9]. Similarly, verbal and physical abuse can be especially severe for already marginalized people. One study in Dakar, Senegal found that 40 percent of men who have sex with men had experienced verbal abuse, and 13 percent had experienced physical abuse by the police[10].

13. HIV-related stigma and discrimination also affect men and women differently. Women and girls in many countries face discrimination that makes them more vulnerable to HIV. Due to harmful gender norms regarding social expectations, stereotypes, roles, status and power, many women and girls worldwide lack the social power to control key aspects of their lives, including sexual and reproductive decision-making. Women and girls are often discriminated against in public and in private spheres, such as in the context of employment, education, property ownership, marriage and community. As a result of this structural discrimination, women in many countries are at a disadvantage when it comes to negotiating sexual encounters and accessing HIV prevention information and commodities.

14. Stigma and discrimination are also experienced differently by men and women living with HIV. Although evidence is partly inconsistent, several studies indicate that women experience HIV-related stigma and discrimination more than men, are more likely to experience the harshest and most damaging forms, and have fewer resources for coping with it[11] [12] [13] [14] [15] [16]. For example, in Tanzania, a significantly higher number of women than men living with HIV reported experiencing stigma and discrimination in the past year (63.1% vs. 49.6%). Women were also more likely to report violence, loss of property and abandonment by partner or family because of their HIV status[17]. Gender based violence related to HIV status also affects HIV prevention and service provision: women report increased violence for requesting condom use, accessing voluntary testing and counselling, refusing sex within or outside marriage, or for testing HIV positive.[18] In addition, women living with HIV are

[vii] This intersecting of several stigmas, such as those relating to HIV, drug, use, sex work or homosexuality have often been called ‘layered stigma’ in literature.

more likely to experience discrimination in the context of their reproductive health choices. They are often counselled to avoid pregnancy and sometimes forcibly sterilized or forced to terminate pregnancy violating their rights to have control over and to decide freely and responsibly on matters related to their reproductive health. Discrimination against marginalized women can take particularly violent forms, for instance, a study of street-based sex workers in Bangladesh found 60 percent reported being raped by police or other men in uniform in the previous year[19].

15. HIV-related stigma and discrimination also affect children and young people in specific ways. In some settings, orphaned or abandoned children of HIV-positive mothers are placed in specialised orphanages for HIV-positive children, segregated from the outside world. In addition, some day care centres and educational institutions may refuse to accept a child who is HIV positive or whose parents are HIV-positive.[20] Across a range of settings, young people may be stigmatised and discriminated against for being sexually active before marriage or for engaging in forms of sexuality which are considered "against the norm" by their communities, such as homosexual practices. Young people may also be discriminated against in terms of access to age-appropriate information on sex, sexuality and sexually transmitted infections (STIs), including HIV, as well as condoms, other forms of contraceptives and STI services.[21] In many countries, parental consent is required for young people to access information on HIV, treatment, care and support services. In addition, young people living with HIV often face breaches of confidentiality when accessing these services.[22]

Box 3. Prevalence of HIV-related stigma and discrimination and their impact on universal access to HIV prevention, treatment, care and support

Prevalence of stigma and discrimination

- The experience of stigma was universal in a study in Brazil.[23]
- In a study of pregnant women in Vietnam, nearly all had experienced stigma.[24]
- A large household study in Kenya found that 75% of HIV-positive respondents had experienced "enacted stigma" (i.e. discrimination - differential treatment because of their HIV-status).[25]
- A multi-country study in Lesotho, Malawi, South Africa, Swaziland and Tanzania documented extensive verbal and physical abuse and neglect in health services, reported by both patients and nurses.[26]

Impact of stigma on HIV prevention and testing

- In Botswana, a survey of patients receiving antiretroviral therapy found 40% delayed getting tested for HIV, mostly due to stigma.[27]
- In a survey of injecting drug users in Indonesia, 40% said stigmatization was why people who use drugs avoided HIV testing.[28]
- A study in Vietnam found that fear of stigma and discrimination were dominant reasons for the 60% of pregnant women who refused HIV tests.[29]

Impact of stigma on disclosure of HIV status

- A study among Tanzanian people living with HIV found that only half of respondents had disclosed their status to intimate partners. Among those who disclosed, the average time from knowing their status to disclosure was 2.5 years for men and 4 years for women.[30] Stigma contributed to delayed disclosure.

Impact of stigma and discrimination on HIV care and treatment

- In a survey of more than 1,000 healthcare professionals working directly with HIV patients in four Nigerian states, 43% observed others refusing a patient with HIV hospital admission.[31]
- In Jamaica, researchers found that more than two-thirds of newly diagnosed AIDS cases in 2002 tested late in the progression of their illness, a phenomenon linked to stigma and homophobia. The remaining third were reported as deaths, indicating patients failed to seek care and support as their disease progressed.[32]
- In the United States, patients who feared stigma were 3.3. times more likely *not* to adhere to their ART regimen.[33]
- A study in Peru demonstrated that stigma decreased and adherence to treatment improved with intensive investment in daily adherence support.
- Evidence from Kenya suggests that quality of care by family members is improved when stigma is low. Those who expressed less stigmatizing attitudes provided better care and had better insight into the needs of children under their care.

Evidence base on programmes to reduce stigma and discrimination

16. In the last decade, considerable progress has been made in identifying the causes, manifestations and consequences of stigma and discrimination and in increasing the evidence of effective approaches to reduce them. Research suggests that the underlying drivers of stigma and discrimination are consistent across different contexts and epidemics and include:
    - lack of awareness of stigma and discrimination and their harmful consequences;
    - fear of HIV infection through casual contact; and
    - social judgement linking people living with HIV to behaviours considered improper or immoral.[34]

    These drivers can be effectively addressed through dealing with fears and misconceptions about HIV; participatory education which involves activities that encourage dialogue, interaction and critical thinking on “taboos”, including gender inequalities, violence, sexuality, and injecting drug use; “contact strategies”, which involve direct or indirect interaction between people living with HIV or key affected populations and key audiences to dispel myths about people affected by HIV; mobilizing community and religious leaders and celebrities to foster respect and compassion for people living with HIV and to encourage greater openness around sexuality; through strengthening networks of people living with HIV to take the lead in addressing stigma; and raising awareness through the media, including “edutainment”.[35]

17. Programme activities using the media and mass communications have been evaluated in a number of countries. One Ghanaian programme that used religious leaders to convey compassionate messages showed that stigmatizing attitudes declined, sometimes dramatically, both over time and with exposure to the campaign[36]. Exposure to edutainment programs, such as serial dramas aired on TV or radio, was correlated with more accepting attitudes in Botswana and Kyrgyzstan,

although no significant relationship was found with a similar programme in Malawi[37 38 39 40].

18. Several community-based interventions with multiple activities, including awareness-raising, sensitisation and community participation and interaction, demonstrated significant changes in stigma at the community level in Tanzania, Thailand, Vietnam and Zambia[41 42 43 44]. Studies in Vietnam and Tanzania suggest that opportunities for sustained dialogue about values and beliefs is important for reducing social judgement- driven stigma and tackling other drivers of stigma.

19. Evidence also exists of the positive impact of interventions to reduce stigmatising attitudes and discriminatory care practices among health care providers in several settings, including China, Ghana, India, Tanzania and Vietnam[45 46 47 48]. Additional documented effective stigma and discrimination programmes include a micro-credit programme in Thailand that partners HIV-positive and negative loan recipients[49] and a workplace intervention in South Africa[50].

20. Evidence is also starting to emerge on the cost-effectiveness of stigma and discrimination reduction. A new model on the impact of stigma on the prevention of mother to child transmission (PMTCT) estimates that up to 55 percent of cases of mother to child transmission in settings where PMTCT services are readily available may be caused by stigma and discrimination. Even where PMTCT services are not as strong, 28 percent of mother to child transmission may be due to stigma. The most effective stigma and discrimination programmes could potentially result in significantly more mothers using HIV services and adhering to treatment, potentially reducing mother to child transmission by as much as one-third is settings where stigma is prevalent.[51] Effective stigma and discrimination reduction could therefore have a major impact on the HIV epidemic in this epidemic context.

21. Despite the recent progress in increasing the evidence base of effective stigma and discrimination reduction programmes, gaps in evidence still remain. The published evaluations do not represent the whole breath of programmes that should be used to tackle stigma and discrimination at multiple levels. Relatively little is known, for example, about effective programme approaches to address intersecting or layered stigma and discrimination. Approaches that seek to empower people living with HIV and key affected populations and to educate them about their rights have also rarely been the subject of published evaluations.

22. What is clear from the current evidence is that programmes that are effective are the ones that address deep-seated drivers of stigma and discrimination, have been supported at least for 3 to 5 years, are tailored to the context, involve people living with HIV and key affected populations in the design, implementation and monitoring, and employ multiple strategies to achieve change[52]. Given the pervasiveness of stigma and discrimination, a large scale response needs to intervene at different levels, including with families, communities and institutions, such as health care, education, employment, the media, judiciary and at the level of policies, laws, and legislation over a sustained period of time.[53]

3. CHALLENGES TO EFFECTIVE HIV RESPONSES

Punitive laws and law enforcement

23. Legal protection against HIV-related discrimination is an essential prerequisite for an effective national HIV response. The lack of protective legislation and/or its enforcement and the existence of punitive laws and punitive law enforcement can feed stigma and discrimination and hinder access to HIV services for people living with HIV, men who have sex with men, transgender people, sex workers and people who use drugs.

24. In 2008, two thirds (67%) of countries reported having laws that prohibit discrimination against people living with HIV. However, the degree to which these laws are enforced or to which people have access to them is not known. Nongovernmental informants indicate, for example, that HIV-related legal services are available in less than half of countries (47%). Moreover, one third of countries (33%) do *not* report having protective laws. Non-discrimination laws that specify protections for vulnerable sub-populations are even less common – 39% of countries report protections for men who have sex with men, 33% report protection for sex workers and 27% for people who use drugs. [54] In addition, punitive laws that feed stigma and discrimination are widespread: 84 countries report having laws and regulations that present obstacles for vulnerable sub-populations[viii] to access HIV prevention, treatment and care[55]; 49 countries have HIV specific laws that criminalise HIV transmission or exposure[56] [57]; 86 countries have laws that prohibit sexual intercourse between people of the same sex, with seven providing the death penalty for it[58]; 110 countries criminalise some aspect of sex work[59]; 51 countries have HIV-related travel restrictions[60]; and numerous countries criminalise harm reduction measures in the context of drug use[61].

25. Negative law enforcement practices, including illegal police activity such as harassment and violence against key affected populations, further fuel HIV-related stigma and discrimination. It also appears that countries have not systematically implemented mechanisms to report, document and address cases of discrimination against people living with HIV or key affected populations. Only 53 percent of countries reported having such mechanisms in 2008[62].

26. Punitive laws and law enforcement appear to be behind government failure to recognize and address the needs of stigmatized and/or criminalized populations in terms of promoting sufficient access to HIV services for these groups. Conversely, a supportive legal environment enables governments to better respond to HIV – for example, the reach of HIV prevention programmes for key affected populations is generally better in countries with non-discrimination laws in place than in countries without such laws[63].

[viii] 40 percent of countries report having laws that interfere with their ability to provide services for injecting drug users, 32 percent and 45 percent report laws that hinder the access of men who have sex with men and sex workers respectively to HIV services.

Inadequate responses to HIV-related stigma and discrimination in institutional settings

Health care settings

27. Much HIV-related discrimination is experienced in health care facilities.[64] Although effective programmes to reduce stigma and discrimination in health care settings are being implemented in diverse settings, most of these efforts remain very small in scale and *ad hoc* in nature. A recent survey of key informants among the UN, civil society and donors identified the reduction of stigma and discrimination in health services as a top priority and pointed to the evidence-base, tested tools and materials required to expand stigma and discrimination reduction in these settings. Optimally, this would involve a move away from isolated training sessions to integrating stigma and discrimination reduction into the pre- and in-service training of health care professionals.[65]

Workplaces

28. Employment settings remain a major source of HIV-related discrimination and include mandatory testing, dismissal on the basis of HIV status, refusal of promotion or health insurance benefits, and harassment. Some 41 countries have included HIV in their Decent Work Country Programmes.[66] However, much more needs to be done to ensure that HIV in the workplace policies and programmes are rolled out at a necessary scale and that people living with HIV have access to redress mechanisms in cases of discrimination in the workplace.

Schools

29. HIV-related stigma and discrimination in schools take the form of teasing, bullying, isolation or rejection of students by other students, or refusal of enrolment, denial of access to activities, breach of confidentiality or a failure to protect students from harassment by teachers and school authorities. Stigmatising attitudes of teachers may also have an impact on whether or not they deliver sexuality education and positive prevention messages. Teachers living with HIV may also experience stigma and discrimination in the workplace and in their communities. The education sector's response to HIV-related discrimination is currently under-researched and reported. HIV-related stigma and discrimination is also insufficiently addressed in education sector toolkits and teacher training manuals, and in school teaching materials.[67]

Prisons

30. The forms of HIV-related discrimination in prison settings include mandatory testing, segregation of HIV-positive individuals, exclusion from collective activities and a failure to provide access to the same levels of HIV prevention, treatment and care as available in the community. Although a limited number of countries have implemented programmes such as peer education, condom distribution, opioid substitution therapy and needle exchange in prisons, these programmes are not generally implemented at a scale to impact upon the HIV epidemic. Moreover, the refusal by most countries to provide clean needles, condoms, opioid substitution therapy and access to antiretroviral treatment and to prevent sexual violence in prisons continue to hamper HIV prevention efforts in these settings in most countries.

Inadequate programming to reduce stigma and discrimination

31. The importance of addressing stigma and discrimination in national HIV responses is now nearly universally recognised. National governments in nearly all countries (98%) report addressing stigma and discrimination as part of their national HIV strategy[68]. Most of these efforts include the use of various strategies including the media, community education and celebrities speaking out about HIV. Seventy five percent of countries also report the existence of programmes designed to educate and raise awareness among people living with HIV of their human rights[69]. However, the quality, scale and coverage of these programmes have not been measured or evaluated.

32. It is also not clear whether national HIV responses address stigma and discrimination in a comprehensive manner. Stigma and discrimination are most effectively reduced through a package of mutually-reinforcing programmes which address stigma and discrimination at the level of laws, institutions and communities and include (a) "know your rights/laws" campaigns; (b) HIV-related legal services; (c) law reform efforts; (d) training of health care workers on non-discrimination, confidentiality, informed consent and duty to treat; (e) programmes to train and sensitise law enforcement agents, lawyers and judges; (f) programmes to reduce stigmatising attitudes; and (g) programmes to promote the rights of women in the context of HIV. However, a recent analysis of national AIDS planning and strategy documents showed that, although many countries include some of these programmes in their National Strategic Plans and Global Fund applications such programmes are seldom taken through the full planning process – from strategy to activities, costing, budgeting, monitoring and evaluation.[ix] Thus, it is doubtful that they reach the implementation phase. Moreover, a recent analysis of Global Fund Round 6 and 7 proposals found that some 50 per cent of programmes to reduce stigma and discrimination and increase access to justice which are included in proposals are not explicitly included in grant agreements, indicating that whilst such programmes are to a certain degree recognised at the planning level, they are significantly less likely to be implemented and monitored within Global Fund-supported programmes.[70]

33. In addition, countries rarely include a full package of such programmes in their national HIV responses. For example, none of the 59 proposals included in the study of Global Fund Round 6 and 7 Global Fund-supported HIV programmes referred to above included the full package of programmes.[71]

34. It is important to note that there are many promising small scale programmes being implemented at community level, often with an active involvement of people living with HIV and key populations. The implementers of these programmes possess a wealth of expertise and know-how on stigma and discrimination reduction. However, there is an urgent need to increase the capacity of these community actors to evaluate these interventions and to support their expansion through funding,

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[ix] The review, carried out by UNAIDS and International HIV/AIDS Alliance in 2009, analysed the inclusion of the following six programmes in National Strategic and Operational Plans in 56 countries and Global Fund Round 6 and 7 proposals in 36 countries: 1) Programmes to reduce HIV-related stigma and discrimination; 2) HIV-related legal services for people living with HIV and key populations at risk; 3) Training of key services providers (e.g. health care workers, judiciary and police) on non-discrimination, informed consent and confidentiality; 4) Legal audit and law reform programmes; 5) "Know your rights/laws" campaigns; and 6) Programmes to reduce violence against women and girls. For more information, please contact Susan Timberlake, Senior Human Rights and Law Advisor, UNAIDS timberlakes@unaids.org.

technical support and inclusion in National Strategic Plans and major national funding applications.

Inadequate funding and technical support

Funding

35. Despite the recognition of the importance of stigma and discrimination reduction, commitment to appropriate levels of funding for such programmes is still lacking. The need for greater evidence of the link between stigma and discrimination and health outcomes and of effective programme approaches are often quoted by donors as reasons for the inadequate funding support. However, these excuses ring hollow. First of all, the harmful impact of stigma and discrimination on the uptake of and adherence to HIV services is well documented (see above in Chapter 2). Secondly, the elimination of stigma and discrimination is a public good in and of itself. No individual should suffer from HIV-related stigma and discrimination, or any other form of human rights violation. As for the evidence of effective programmatic approaches, the evidence base is sufficiently robust to support expanded and institutionalised programmes to reduce stigma and discrimination within national HIV responses.

36. Another reason often quoted for the lack of funding for a scaled-up response to stigma and discrimination is that local solutions are difficult, or even impossible to scale up. However, scaling up of community-based stigma and discrimination is possible. It simply requires facilitating knowledge transfer between communities and replicating successful models in several settings. This could be achieved with relatively modest amounts of funding.[72]

37. There is also a need to increase cooperation and collaboration between private and public funders to better work together to address funding gaps for stigma and discrimination reduction. More flexibility and a longer term commitment are required on the part of donors in order to support the scale-up of stigma and discrimination strategies. Critically, funding for operational research and evaluations should be integrated as an essential part of these scale-up efforts. There is also a need for increased funding to increase capacity of community groups to conduct research and to increase their expertise on stigma reduction so that they can act as sources of support to others.

Technical support

38. The poor understanding of how to comprehensively address stigma and discrimination in national responses is underpinned by a lack of readily available technical assistance on human rights, law, stigma and discrimination in the context of HIV. Technical support is required for developing comprehensive strategies that address stigma and discrimination at the legal, institutional and community levels and use a variety of programmes to simultaneously reduce stigma and discrimination and increase access to justice as part of HIV responses. Support is also required in terms of basic planning, costing, budgeting, monitoring and evaluating such programmes and on resource mobilisation. However, it appears that major technical support providers are currently not used as a source of expertise on human rights, law and stigma and discrimination. For example, a survey of UNAIDS Country Offices in 2008 showed that only 3 percent of technical support on human rights and law sourced by UN Country Teams to assist national counterparts was obtained from UNAIDS Technical Support Facilities.

Inadequate involvement of people living with HIV and key populations

39. Networks of people living with HIV and other stigmatised groups are key actors in effective stigma and discrimination reduction efforts. These networks provide vital community support and are well placed to understand the legal and social challenges faced by communities. However, experience has shown that addressing self-stigma (the internalization of society's negative attitudes) is often a pre-condition for the participation of these populations in stigma and discrimination reduction activities.[73] In addition, empowerment of people living with HIV and key affected populations in terms of knowledge of their rights and access to justice is important for them to be able to take the lead in reduction of stigma and discrimination. Strengthening the capacity of networks and providing access to social, legal and peer support is therefore critical. This support and capacity strengthening has so far not been systematically provided

40. The increased emphasis on community systems strengthening, including through support from the Global Fund to Fight AIDS, Tuberculosis and Malaria presents an opportunity increase the capacity of people living with HIV and key populations to address stigma and discrimination in their communities. The People Living with HIV Stigma Index (see Box 4 below) is another good example of community action whereby people living with HIV take the lead in measuring stigma and discrimination and advocate for change.

Inadequate measurement of stigma and discrimination

41. Commitment to expand stigma and discrimination programmes must be matched with an increased emphasis on measuring changes in the level of stigma and discrimination over time. Without such measurement, progress in stigma and discrimination efforts will be difficult to track. However, according to UNGASS Country Progress Reports of 2008, only 33 percent of countries used performance indicators or benchmarks for the reduction of stigma and discrimination. In addition, the indicators that are currently used at the global level, such as those included in the *Demographic and Health Surveys* (DHS) to measure accepting attitudes towards people living with HIV and those in the National Composite Policy Index to measure the legal and policy environment do not capture all the causes and

Box 4. The People Living with HIV Stigma Index

The *People Living with HIV Stigma Index* is an innovative way to measure HIV-related stigma and discrimination. It is not only a measurement tool but also a tool for change, as it is used by, and for, people living with HIV. The implementation of the Index is led by national networks of people living with HIV. The process of rolling it out empowers the individuals and communities most affected by the epidemic by enabling them to quantify the stigma and discrimination experienced in their communities and by giving them the data required for advocacy.

To live up to its potential both as a measurement tool and an empowerment tool, the rollout of the Stigma Index at country level must be properly resourced. Funding should include capacity and partnership- building for networks of people living with HIV. Local and national research institutions should also be engaged in the process. Most importantly, the Index findings should inform the “know your epidemic and response” analysis, as well as national planning and programming.

manifestations of stigma and are inconsistent with the new indicator standards set by the UNAIDS Monitoring and Evaluation Reference Group (MERG).

42. Although much progress has been made in the last few years to develop measures and measurement tools by which to measure stigma and discrimination, most of these use different questions to measure the same areas of stigma and discrimination, and there is still little standardisation in this area. There is also a need to translate measures used for research purposes into indicators that can inform programming and policy decisions and track progress over time.

43. Ideally, a core set of stigma and discrimination indicators should become part of the monitoring of the national and global progress in responding to the epidemic. This is critical in terms of accountability for the commitments made in the *Declaration of Commitment on HIV/AIDS (2001)* and the *Political Declaration on HIV/AIDS (2006)*. Indicators for global level reporting should therefore urgently be developed.

44. Although it is important to measure stigma and discrimination in terms of accountability, it is also critical in terms of being able to tailor responses to the local context, to strategically use resources and to improve programmes over time. It is therefore also important to develop standardised programme level indicators on stigma and discrimination and to incorporate these in national HIV monitoring and evaluation frameworks and in the M&E frameworks of major donors such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, PEPFAR and the World Bank.

4. UNAIDS RESPONSE TO HIV-RELATED STIGMA AND DISCRIMINATION

Joint Action for Results, UNAIDS Outcome Framework Priority Area 6

45. Under the *Joint Action for Results, UNAIDS Outcome Framework, 2009-2011* Priority Area 6, UNAIDS will work towards the elimination of punitive laws, policies and practices that fuel stigma and discrimination. UNAIDS has set the following three targets for the Priority Area 6 in which it will support countries to:
    - Eliminate HIV-related restrictions on entry, stay and residence in at least 50% of countries which currently have such restrictions.[x]
    - Eliminate inappropriate criminalization of HIV transmission and other behaviours and practices, such as male to male sex and sex work in 20 countries.
    - 30% year on year increase programmes to reduce stigma and discrimination and increase access to justice for people living with HIV and other key populations in 20 countries.

46. To achieve these targets, UNAIDS has developed an Operational Plan for 2010-2011. The UNAIDS response focuses on expanding the evidence base and increasing political engagement; strengthening policy coherence within the Joint Programme; engaging stakeholders to invest in programmes to reduce stigma and discrimination and increase access to justice; strengthening technical support for addressing punitive laws, practices, stigma and discrimination; strengthening support to civil society; and developing relevant indicators to measure progress in this area.

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[x] *UNAIDS role with regard to law is to: (1) support countries to reform law and law enforcement where they block effective AIDS responses and (2) support countries to live up to their commitments concerning law, human rights and HIV in the Declaration of Commitment on HIV/AIDS (2001) and the Political Declaration on HIV/AIDS (2006).*

Supporting law reform efforts

47. In order to assist countries to remove punitive laws which block effective HIV responses and enact protective legislation, UNAIDS supports law reform efforts at national and regional levels. For example, the UNAIDS Secretariat has provided official comments to draft law in some twelve countries in 2010. In West and Central Africa, the engagement of UNAIDS Secretariat and UNDP with key stakeholders has helped create a momentum for the amendment of coercive provisions adopted in some countries of the region. For instance, in November 2009, Guinea amended its HIV Law of 2005 to remove any restriction to access to HIV-related services to children and to ensure access to HIV-related prevention, treatment and care for members of key affected populations, including men who have sex with men. UNAIDS Secretariat and UNDP are supporting law reform processes in Benin, Burundi, Cote d'Ivoire, Gambia, Lesotho, Liberia, Rwanda, Senegal, Sierra Leone and Togo. In East Africa, UNAIDS Secretariat and UNDP are currently supporting the development of a protective regional Bill on HIV which would protect against HIV-related stigma and discrimination.

48. In the Asia Pacific region, UNDP and UNAIDS Secretariat have supported reviews of HIV-related laws, contributing to the development of more enabling legal environments for people living with HIV and key populations in Fiji, the Maldives, Thailand and Viet Nam. Similar rights-based law reform processes were also supported in Ukraine and Macedonia.

Supporting the elimination of HIV-related entry, stay and residence restrictions

49. Some have called HIV-related restriction on entry, stay and residence, "proxy indicators" of stigma and discrimination. UNAIDS Executive Director Michel Sidibé has called for 2010 to be the "Year of Equal Freedom of Movement for All", and UNAIDS is intensifying its support to countries towards the elimination of restrictions on entry, stay and residence due to HIV status. As of April 2010, it appears that 51 countries, territories and areas continue to impose some form of HIV-related restriction. Some 22 countries are known to deport non-nationals living with HIV on the basis of their HIV status. In 2009, UNAIDS provided official public comments in support of proposed reform in the United States of America to remove HIV-related entry, stay and residence restrictions, as well as mandatory HIV screening in the context of health assessments. UNAIDS, together with the UN Secretary-General, issued a statement in January 2010 which applauded the United States of America for lifting their restrictions. In other countries where restrictions still exist, UNAIDS staff are continuing to raise the issue with key officials, parliamentarians, civil society, the private sector and UN system counterparts, and convening those who can work together for change. Supporting the elimination of entry, stay and residence restrictions follows up the recommendations of the *International Task Team on HIV-related Travel Restrictions*, convened by UNAIDS in 2008, and subsequent decisions of the UNAIDS Programme Coordinating Board, the Board of the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the UN Human Rights Council.

Promoting a package of programmes to reduce stigma and discrimination and increase access to justice

50. Key programmes to reduce HIV-related stigma and discrimination and to increase access to justice should be seen as integral and essential to every national HIV response, and fundamental to the successful achievement of the goals and activities articulated in HIV strategies, plans and funding proposals.

51. UNAIDS promotes the inclusion of a package of the following key programmes to reduce stigma and discrimination and increase access to justice in all national responses to HIV (their scope and coverage to be tailored to the nature of the epidemic):
    - Stigma and discrimination reduction programmes that seek to reduce HIV-related stigma and discrimination by addressing their causes, e.g. ignorance, fear, myths, social judgement and lack of interaction with people living with HIV, through a variety of approaches.
    - Legal services for people living with HIV and members of affected and/or marginalised groups, including legal advice and representation in litigation; legal information and referral; alternative forms of dispute resolution; assistance with informal or traditional legal systems.
    - Programmes to reform and monitor laws relating to HIV, including HIV-related legal audits; advocacy for legal reform; law reform and/or improvement of law enforcement and access to justice.
    - Legal literacy programmes that empower those affected by HIV to know their rights and laws in the context of the epidemic and draw them down into concrete demands in terms of access to services, non-discrimination on the basis of HIV and other social status, etc.
    - Human rights training for health care workers that focuses on informed consent, confidentiality, non-discrimination and duty to treat.
    - Training and sensitization of law enforcement agents, judges and lawyers on HIV and the human rights of people living with HIV and key populations, particularly in terms of supporting access to services, non-discrimination, non-violence, and freedom from harassment and arbitrary arrest and detention.
    - Programmes to promote the rights of women in the context of HIV, including programmes that address the intersection between violence against women/girls and HIV; programmes to transform harmful and inequitable gender norms that increase vulnerability to infection and impact for men, women and young people; and programmes to ensure the equal rights of women and girls in the context of marriage and family law and access to economic and employment opportunities.

52. UNAIDS has been promoting the entire package of programmes, as well working on a range of initiatives aimed at expanding specific programmes within this package. In relation to HIV-related legal services, UNAIDS Secretariat and UNDP have collaborated with the UNAIDS Secretariat and the International Development Law Organization (IDLO) to develop and roll out the *Toolkit: Scaling Up HIV-Related Legal Services*. UNDP has also supported IDLO missions to Burkina Faso and Nepal to establish/scale up of HIV-related legal services in those countries, with missions to Botswana, Cameroon, Democratic Republic of Congo, Ethiopia, Ghana, Swaziland, Uganda, Sri Lanka and Guatemala planned.

53. UNDP has also been working with Governments in Kyrgyzstan, India and Viet Nam, and with civil society groups in Kenya, to promote access to justice through the provision of legal aid to people living with HIV and other key populations.

54. UNDP has also been working to scale up 'know your rights and laws' campaigns. Cards entitled "Know Your Universal Human Rights" have been widely disseminated in Arabic, English, French, Spanish and Russian. In Viet Nam, the card content was adapted to educate affected populations about their rights and responsibilities under the new HIV Law. In 2010, UNDP is supporting eight pilot 'One UN' countries to implement "know your rights" campaigns focusing on women and girls and other key populations in the context of HIV.

Promoting community level responses to stigma and discrimination

55. The World Bank and partners supported twenty-six community-level implementers of stigma and discrimination reduction programmes from Afghanistan, Bangladesh, Bhutan, India, Nepal, Pakistan and Sri Lanka through the *Tackling HIV and AIDS Stigma and Discrimination, the South Asia Region Development Marketplace*[xi] *(SARDM*) over an 18 month period in 2008-2009. The total grant support was US$1.04 million with an average grant size of US$40,000. Grants focused on innovative interventions by groups most affected by HIV-related stigma, including sex workers, people who use drugs and men who have sex with men. The SARDM experience demonstrates that community organizations can achieve a great deal for relatively little investment and provide a strong foundation on which to build stigma reduction efforts in the South Asia region and elsewhere.[74] As part of this work, the World Bank also provided a good model for the provision of technical support on monitoring and evaluation for community groups.

56. UNDP has also supported programmes to strengthen the leadership and participation of community groups, including women's groups, in legislative and political processes in the Gambia, Cameroon, Lesotho and Uganda. Community empowerment has also been supported though activities such as the establishment of representative organizations of people living with HIV, sex worker organizations and virtual communities for affected populations in China, Indonesia, Iran and Thailand. These initiatives have enabled marginalised populations to voice their needs, empowered them to claim their right to be free of stigma and to non-discriminatory access to HIV prevention, treatment, care and support, and strengthened their capacity to participate in decision-making at community level and above.

57. In the Arab States region UNDP has been working on a comprehensive programme to engage religious leaders to address HIV-related stigma and discrimination against people living with HIV and vulnerable groups. Studies conducted in Morocco, where religious leaders were trained nationwide, show that a compassionate religious message significantly contributed to reducing HIV-related stigma. In Swaziland, church leaders were capacitated with support from UNDP on HIV advocacy and conflict resolution. In Viet Nam, UNDP has supported HIV capacity building within the Communist Party and elected bodies. Results of such activities include increased

[xi] The South Asia Development Marketplace partnership is sponsored by the World Bank Group, the Government of Norway, SIDA, UNAIDS, UNICEF and UNDP.

engagement in advocacy activities including the promotion of non-discrimination in the HIV response by community leaders.

Reducing discrimination against women and girls in the context of HIV

58. Under the *UNAIDS Action Framework: Addressing Women, Girls, Gender Equality and HIV,* UNAIDS Secretariat and Cosponsors have been leading on a multitude of activities to reduce discrimination against women in the context of HIV. These include baseline gender surveys; legal assistance to empower women to access HIV services and address customary laws that render women vulnerable to infection; development of gender-responsive HIV strategies and laws; sensitization of the police on HIV and violence against women, especially in the context of sex work; and work with various stakeholders, such as lawyers, judges, community leaders and policy makers, to promote women's property and inheritance rights. (For more information, please see paper under the agenda item on *Gender sensitivity in AIDS responses)*

Supporting the reduction of HIV-related stigma and discrimination in institutional settings

Health care settings

59. UNAIDS Secretariat, ILO, UNDP and WHO, together with civil society partners[xii] are developing a standardised curriculum on stigma and discrimination for health workers. This effort is an important step towards providing guidance on the scale-up of stigma and discrimination programmes through systematising and disseminating training curriculum standards.

60. In the United Arab Emirates, UNDP has supported stigma reduction training for healthcare professionals in order to reduce stigma and discrimination against people living with HIV and populations most at risk.

Promoting non-discrimination in the workplace

61. In 2001 governments, employers and workers agreed on the ground-breaking Code of Practice on HIV/AIDS and the World of Work. The Code of Practice has been translated into 58 languages, and ILO, together with other partners, continues to provide technical assistance to ILO constituencies in the form of legislative and policy advice and training and capacity building for a range of target groups in order to translate the Code into practice. For example, a new training course on "HIV/AIDS and the World of Work" took place at the ILO International Training Centre in Turin in September 2009, and a series of workshops for judges on non-discrimination and HIV were carried out in West Africa. In 2005, UNESCO joined ILO to develop education sector workplace policies to complement the Code of Practice. This initiative has been implemented at regional level in the Caribbean and Southern Africa, each resulting in: (1) a workplace policy on HIV and AIDS for the education sector adapted and specific to each region; (2) implementation guidelines; and (3) action plans/strategy outlines for each country participating in the development of the regional policy. Following the regional policy formulation for Southern Africa,

[xii] Engender Health, International Center for Research on Women (ICRW), International Planned Parenthood Federation (IPPF), Global Network of People Living with HIV (GNP+) and International HIV/AIDS Alliance

workplace policies for the education sector were operationalised at the school level in Zambia and Mozambique (September 2007 to May 2008).

62. The Code of Practice will now be complemented by a Recommendation on HIV/AIDS and the World of Work, expected to be adopted in June 2010. Recommendations provide guidance for States and for employers' and workers' organizations, among others, and form a basis for ILO monitoring and assistance measures. The Governing Body may require periodic reports from member States on the measures they are taking to implement Recommendations.

63. In Namibia and Eritrea, UNDP and partners have supported the creation of enabling working environment, where employees are free from stigma and discrimination and can access HIV-related services, through activities such as workplace policy development and strengthening workers' unions to respond to issues relating to HIV and discrimination.

Schools

64. UNESCO is supporting countries to adopt a comprehensive education sector HIV response that addresses stigma and discrimination among other things. A critical element of UNESCO's support to the education sector response and a cultural approach is enabling individuals and communities to understand the forms that stigma and discrimination can take and to empower them with the knowledge and know-how to prevent it.

Prisons

65. UNODC is supporting countries to ensure that HIV prevention, treatment and care services available to prisoners are equivalent to those available to the general population. UNODC assists countries in providing HIV prevention information, education and commodities to prisoners, wardens and other prison staff as well as treatment and care services to HIV-positive prisoners. UNODC also encourages countries to address legal issues such as the development of alternatives to imprisonment and structural issues such as overcrowding in prisons as part of efforts to ensure that persons deprived of their liberty are not discriminated against in their access to HIV prevention, treatment, care and support.

Keeping the UN house in order through the work of UN Plus

66. UN Plus, the advocacy group of UN Staff living with HIV, has significantly increased the visibility of people living with HIV in the UN system and given voice and support to UN staff living with HIV. UN Plus has also partnered with UN Cares, the UN workplace programme on HIV, to ensure that all staff know the facts about HIV prevention, treatment, care and support and are aware of the UN Codes of Conduct that require equal treatment and respect for all staff, regardless of their health status. In addition, UNAIDS Secretariat and Cosponsors have been developing an in-reach training programme for UN staff addressing stigma around people living with HIV, men who have sex with men, transgender people, people who use drugs, prisoners and sex workers.

Increasing the involvement of human rights and legal actors in HIV responses in order to tackle stigma and discrimination

Fostering the leadership role of judges in the HIV response

67. Members of the judiciary can play an important role in challenging stigma and discriminatory laws, policies and practices against people living with HIV and members of key populations inside the court and the community. However, for the judiciary to play such a role, it requires a proper understanding of the key medical, epidemiological and legal facts and issues related to HIV. In fostering such understanding, UNAIDS Secretariat and UNDP held, in December 2009 in Johannesburg, South Africa, a Meeting of Eminent African Jurists on HIV and the Law which brought together over 30 high ranking judges from 15 African countries. The meeting provided an opportunity for members of the judiciary to share experiences on HIV-related legal and human rights issues and to hear the lived experiences of people living with HIV and key affected populations. The meeting led to the adoption of a "Statement of Principles on HIV, Law and the Judiciary in sub-Saharan Africa" which calls on members of the judiciary to address HIV-related stigma and discrimination. UNAIDS is following up this meeting to reinforce and expand positive judicial engagement in the response in Sub-Saharan Africa.

68. At country level, UNDP has supported awareness raising and leadership capacity building projects for judges, law enforcement and lawyers in countries as diverse as Libya, Guinea, Rwanda, Ukraine and Panama.

Engaging National Human Rights Institutions in the HIV response

69. UNAIDS Secretariat and UNDP, together with OHCHR and the Danish Institute for Human Rights organised a series of regional HIV workshops for NHRIs during the course of 2009 and 2010 (East and Southern Africa, West and Central Africa, Latin America and Asia Pacific). These workshops were part of the efforts to operationalise the UNAIDS/OHCHR (2007) *Handbook on HIV and Human Rights for National Human Rights Institutions* and were intended to encourage these institutions to become active partners in promoting rights-based responses to HIV. The workshops allowed the participating NHRIs to gain a better understanding of HIV-related human rights, share lessons learnt, develop action plans on HIV, establish links with key populations and initiate regional collaboration on HIV-related human rights. Action plans drafted at the meetings are providing a means of developing stronger partnerships and greater involvement in national HIV responses.

Engaging Parliamentarians in the HIV response

70. UNAIDS, together with UNDP and the Inter-Parliamentarian Union (IPU) produced a *Handbook for Parliamentarians, Taking Action against HIV and AIDS* (2007) which provides guidance on the leadership, budgetary and legislative roles of parliamentarians in the response. UNAIDS works with the IPU Advisory Committee on AIDS and supports IPU's HIV-related initiatives with Parliamentarians.

Global Commission on HIV and Law

71. On behalf of the UNAIDS Programme, UNDP has established a Global Commission on HIV and Law. The Commission will run to the end of 2011 and will aim to develop actionable and evidence-informed policy guidance on human rights for people living with HIV and key affected populations and stimulate regional and country dialogues on the removal of punitive laws which are blocking effective responses to HIV

Measuring stigma and discrimination

72. UNAIDS is partnering with the Global Network of People Living with HIV (GNP+), International Community of Women living with HIV (ICW) and International Planned Parenthood Federation (IPPF) to support the efforts of national networks of people living with HIV to measure stigma and discrimination experienced by people living with HIV through the rollout of the People Living with HIV Stigma Index. (See Box 4.) The Stigma Index has now been fully rolled out in China, Dominican Republic, Myanmar, Rwanda, Thailand and the United Kingdom. The data-processing and analysis phase is currently going on in Bangladesh, El Salvador and Paraguay. The Index is in various stages of planning and implementation also in Argentina, Cambodia, Cameroon, Colombia, Estonia, Ethiopia, Fiji, India, Kenya, Malaysia, Mexico, Mozambique, Nigeria, Pakistan, Papua New Guinea, Philippines, Poland, Russia, South Africa, Tanzania, Ukraine and Zambia.

73. UNAIDS is working together with GNP+, IPPF and the International Center for Research on Women (ICRW) on a process to review current stigma and discrimination indicators and develop new indicators to be approved by the UNAIDS Monitoring and Evaluation Reference Group (MERG) for tracking stigma and discrimination at the programmatic, national and global levels.

74. UNDP has been supporting work in a number of countries to increase understanding of stigma and discrimination at the country level and to use this understanding to shape policy and programming. For example, efforts in India included a study to better understand stigma in health care settings, in the general population and amongst key populations. The results of the study were presented at the meeting of the South Asia Regional Forum in March 2010. Factsheets and tools for policy-makers and programme managers are now being developed based on the key findings from the study.

5. CONCLUSIONS AND RECOMMENDATIONS

75. Over the last decade, great strides have been made in terms of commitments and efforts to reduce HIV-related stigma and discrimination. The foundation for an expanded and effective response to HIV-related stigma and discrimination is now in place: (a) knowledge of the causes, manifestations and consequences of stigma and discrimination; (b) knowledge and tools on how to measure and reduce them; (c) stigma reduction training materials and information, education and communication materials; (d) networks of people living with HIV and other stigmatised groups responding to stigma and discrimination in various ways and claiming their rights; (e) practitioners implementing promising small scale projects to reduce stigma and discrimination; and (f) an agenda for legal reform to establish better protection from discrimination and to remove punitive laws, policies and practices.

76. However, despite this progress in addressing stigma and discrimination, much more needs to be done. This points to a number of strategic opportunities which have the potential of making HIV responses more effective and advancing universal access and the Millennium Development Goals:

77. **Sufficiently resource a package of comprehensive programmes to reduce stigma and discrimination and increase access to justice:** Despite the widespread global agreement of the importance of addressing HIV-related stigma and discrimination, strategic, coordinated and comprehensive programmes for stigma and discrimination reduction at the country level are still missing. What is needed now is a major shift of resources to scale up stigma and discrimination programmes to a level to have a significant impact.

78. Programmes should (a) address the attitudes of the general population and empower people living with HIV and key affected populations; (b) ensure that non-discrimination becomes an integral part of training for health care workers, teachers, police and the judiciary; and (c) ensure that workplaces have sufficient policies and programmes against HIV-related discrimination. These efforts should not remain *ad hoc* but should be fully taken on by National Strategic Plans and major funding applications and become an integral element of national HIV responses. For this to happen, there is a need for donors and technical support providers to better collaborate in order to address the gaps in funding and know-how for effective reduction of stigma and discrimination.

79. **Create an "enabling legal environment" in terms of protective law, law enforcement and increased access to justice for people living with HIV and affected populations:** Laws can protect people living with and at risk of HIV from discrimination, violence, vilification and lack of due process. However, where law related to HIV or to those at high risk of HIV is punitive, the law and its enforcement can become a major barrier to access and uptake of HIV prevention, treatment, care and support. There is a need for countries to enact non-discrimination laws and to ensure that these laws are applied to HIV, that they are enforced, and that people living with HIV and other key populations have access to the justice system and legal support and/or an administrative redress system. Though these are big challenges, their achievement will have benefits beyond HIV.

80. **Greater attention to gender differences in addressing stigma and discrimination:** Men and women experience HIV-related stigma and discrimination differently. In addition, women in many contexts face discrimination that makes them vulnerable to HIV and impacts on their ability to cope with infection. More needs to be done to fully understand gender differences in this context and tailor stigma and discrimination reduction programmes so that they address the different experiences of men and women. For example, there is a need to ensure that women have access to legal services and redress in cases of violence against them and in the context of property and inheritance rights. There is also a need to develop approaches tackling norms of masculinity which promote homophobia and domination or control over women.

81. **Greater attention to discrimination against children and young people:** Children and young people often experience stigma and discrimination differently from adults and need tailored support and empowerment strategies. Care and support for children affected by HIV should be provided in a manner that does not feed stigma and discrimination against these children and their families. There is a need to increase the institutional capacity of schools to address stigma and discrimination both in their policies and in the curricula. Reducing the discrimination that young

people experience in accessing HIV prevention and other sexual and reproductive health services is also imperative in order to reduce infections among this population.

82. **Improved monitoring and evaluation in the context of HIV-related stigma and discrimination:** Although HIV-related stigma and discrimination can be and is being measured, strategic information on the prevalence, causes and forms of stigma and discrimination are not systematically used in the “know your epidemic and response” analyses. There is an urgent need to develop meaningful stigma and discrimination indicators and to establish baselines in countries. There is also a need to invest more in programme evaluations and operational research to strengthen the evidence base of what works and what does not work in stigma reduction including with regard to the costs and cost-effectiveness of stigma and discrimination reduction.

83. **Strengthen capacity and empowerment to reduce stigma and discrimination:** One of the strengths of HIV responses around the world is the active engagement of civil society organisations and networks of people living with HIV and other key populations. These civil society actors are advocating for their rights and implementing many activities that reduce stigma and discrimination. However, more funding and capacity- building is required to strengthen the capacity of civil society actors to mobilise around their rights and to challenge stigma and discrimination in their communities. Funding should move from supporting these actors to implement small scale projects to comprehensively supporting them to be leaders in local, national and global responses to HIV-related stigma and discrimination.

Mindful of the common issues that are addressed in this document and the “Report by the NGO representative” (UNAIDS/PCB(26)/10.2) a number of consolidated draft decision points are being developed. These, along with any additional decision points that are specific to one of the two documents, will be included in the draft decision points (UNAIDS/PCB(26)/10.14) which will be made available approximately four weeks before the 26th Programme Coordinating Board meeting.

[End of document]

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