



Joint United Nations Programme on HIV/AIDS

UNAIDS

UNICEF • UNDP • UNFPA • UNDCP
ILO • UNESCO • WHO • WORLD BANK

HIV/AIDS RELATED

STIGMA AND DISCRIMINATION

**A REVIEW AND SUGGESTED WAYS
FORWARD FOR SOUTH ASIA**

October 2002

Preparation of this document:

This document was initially prepared as a background document to help provide a framework for discussion at the UNAIDS 4th South Asia Partnership Meeting in Kathmandu, October 2002. Information was collated from existing literature, implementing agencies and UN cosponsors. Proposed models of moving strategies that tackle HIV / AIDS related stigma and discrimination forward were discussed.

Following the workshop various suggestions were incorporated, through a consensual process. The document is designed to help policy makers and programme designers in the South Asia Region identify possible ways of tackling stigma and discrimination either in existing programmes or new programmes.

UNAIDS officer responsible for preparing the document: Craig Burgess,
Technical Officer, South Asia Inter Country Team, New Delhi, India

Acknowledgements

UNAIDS country offices (Bangladesh, India, Nepal, Pakistan and Sri Lanka)
Regional UN co-sponsors
Representatives from the donor community.
Family Health International (FHI)
CARE Bangladesh
Health Development Networks (HDN)

© Joint United Nations Programme on HIV / AIDS (UNAIDS) 2002.

All rights reserved. This document, which is not a formal publication of UNAIDS, may be freely reviewed, quoted, reproduced or translated, in part or in full, provided the source is acknowledged. The document may not be sold or used in conjunction with the commercial purposes without prior written approval from UNAIDS (contact UNAIDS Information Centre).

The views expressed in documents by named authors are solely the responsibility of those authors.

The designations employed and the presentation of the material in this work do not imply the expression of any opinion whatsoever on the part of UNAIDS concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers and boundaries.

The mention of specific companies or of certain manufacturers products does not imply that they are endorsed or recommended by UNAIDS in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters

1987 Jonathan Mann¹

There are three phases to the AIDS epidemic in any society:

*The first is the **epidemic of HIV infection** (entering the community silently and unnoticed).*

*Second is the **epidemic of AIDS**, which appears when HIV triggers life threatening infection.*

*Thirdly is the **epidemic of stigma, discrimination, blame and collective denial**, which makes it so difficult to effectively tackle the first two.*

14 years later....

2001 United Nations Declaration of commitment on HIV / AIDS

'Stigma, silence, discrimination and denial, as well as lack of confidentiality, undermine prevention, care and treatment efforts and increase the impact of the epidemic on individuals, families, communities and nations' (paragraph 13).

'By the year 2003, nations should ensure the development and implementation of multi-sector national strategies and financing plans for combating HIV / AIDS that address the epidemic in forthright terms; confront stigma, silence and denial; address gender and age based dimensions of the epidemic; and eliminate discrimination and marginalisation' (paragraph 37).

'By the year 2003, nations should enact, strengthen or enforce, as appropriate, legislation, regulations and other measures to eliminate all forms of discrimination against and to ensure the full employment of all human rights and fundamental freedoms by people living with HIV / AIDS and the members of vulnerable groups, in particular to ensure their access to, inter alia, education, inheritance, employment, healthcare, social and health services, prevention, support and treatment, information and legal protection, while respecting their privacy and confidentiality; and develop strategies to combat stigma and social exclusion connected with the epidemic' (paragraph 58).

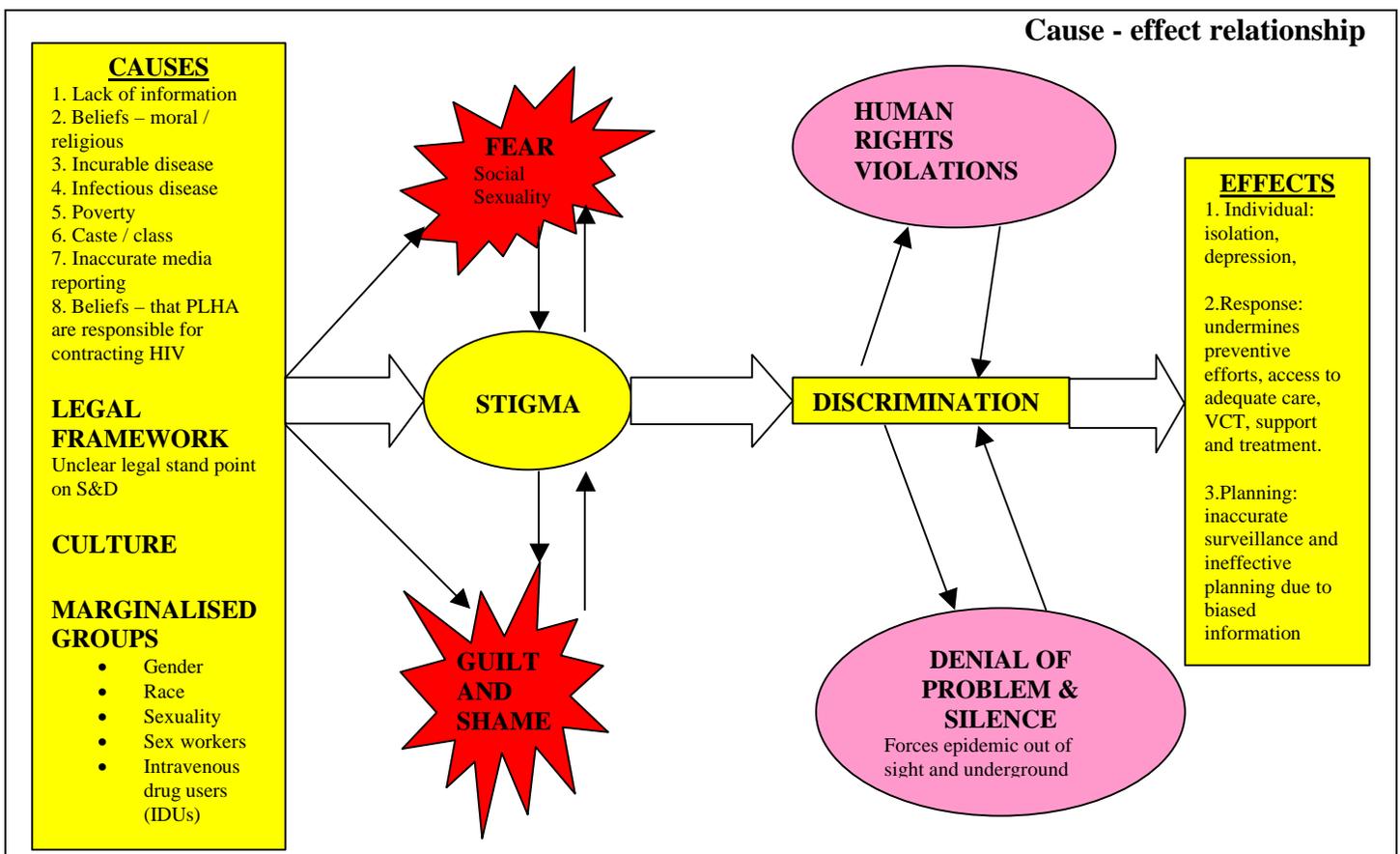
So what are we waiting for?

¹ The late director of the Global Programme on AIDS

1. Introduction.

HIV / AIDS - related stigma and discrimination (S&D) not only make life unbearable for the estimated 4.2 million people living with the virus in South Asia. S&D are regarded by many as the greatest barriers preventing further HIV infections, providing adequate care, support and treatment. S&D issues are now illuminated by a profile raising spot light in the form of the UNAIDS World AIDS Campaign. This will help focus ways forward to find effective methods of translating S&D theories into *practical, country wide, measurable, impact based policies and programmes*

This paper reviews the links between causes and effects of S&D, provides a contextual framework for S&D issues with suggested strategies and actual regional initiatives (annex 1), identifies gaps in these responses and suggests potential models for intervention. It distills information and opinions from available literature and regional UN, donor and NGO contacts. The recommendations and annex 1 suggest practical strategies for programmes committed to reducing S&D in South Asia.



2. Stigma, discrimination and links with human rights.

Stigma is a *dynamic process* of devaluation, whose qualities are quite arbitrary, arising from the perception that there has been a violation of a shared set of shared attitudes, beliefs or values. It is linked to power and domination throughout societies, creating and reinforcing inequality where some groups are made to feel superior and others devalued

(especially where gender, sexuality or race are concerned). This process can therefore lead to prejudicial thoughts, behaviours and actions by individuals, governments, communities, health care providers, friends or families. Stigma is socially constructed and therefore needs *societal based interventions* to combat it, aimed at changing attitudes and behaviours.

Discrimination is *an action* that occurs when a distinction is made against a person. This results in his or her being treated unfairly and unjustly, on the basis of their belonging to a particular group. Combating discrimination requires providing a supportive legal environment. The causes of denial are rooted in psychological factors and although intricately linked with the effects of S&D, denial is not analysed here.

Freedom from discrimination is a fundamental right founded on the principles of natural justice. Human rights derive from the individual's relationship with the State and States have an obligation to respect, protect and fulfil human rights. For the last 50 years human rights have been globally recognised and codified through the UN human rights instruments. The non discrimination clauses that exist in several of these instruments² has been amended by the UN Human Rights Commission to include HIV / AIDS as a status that does not allow discrimination. The international human rights mechanisms that exist to monitor countries application of the conventions do exist and could be included in comprehensive strategies in South Asia.

Most interventions tackling S&D have their roots in applying human rights standards, but sometimes lack measurable action based and practical outputs that can be integrated into programmes. This may actually decrease the impact of wider multi-sector initiatives, inherent in more societal methodologies.

3. Causes and effects of S&D.

By analysing the relationship between the causes and effects of S&D, issues are dissected into manageable parts, clarifying potential solutions. It is clear that the causes of S&D are layered upon pre-existing societal stigma towards marginalised groups, are strongly related to knowledge of HIV transmission, have many cultural determinants (including wide societal acceptance of the inequities which perpetuate HIV-specific S&D) and are affected by the legal environment and are fuelled by misinformed beliefs and irresponsible inaccurate media reporting.

These all worsen fear, guilt and shame leading to worsening discriminatory behaviours resulting in human rights violations and increasing the problem of denial.

The effects may be summarised as causing isolation and depression, undermining preventive efforts, reducing access to adequate care, VCT and support along with causing inaccurate surveillance and decreasing the ability to plan responses effectively. Annex 1 gives a contextual framework showing more detailed effects of S&D, proposed strategies and examples of initiatives from the South Asia Region. The effects include:

² including the Convention on the Elimination of all forms of Discrimination Against Women, the Convention on the Rights of the Child and the Covenant on Economic, Social and Cultural Rights

1. **Legislative / Governmental:** restrictions on entry and residence on the basis of HIV status, penal codes on homosexuality, restrictions on rights to anonymity and marriage.
2. **Marginalised groups:** commercial sex workers (CSWs), men who have sex with men (MSM), transgender individuals, prisoners and migrant workers are all stigmatised by society already, making it even harder for them to gain access for support.
3. **People living with HIV / AIDS:** low visibility of PLHA fuels fear and ignorance and S&D make it difficult for PLHA to form support groups.
4. **Individual, immediate family and community:** depression, punishment, physical harm and rejection by communities and families (especially affecting women).
5. **Health services:** attitudes of Health Care Workers (HCWs) affect care seeking patterns of PLHA, confidentiality breaches, refusal or delay for support and care, testing without consent.
6. **Women:** women living with HIV / AIDS are denied treatment and shelter, rejected by families, more frequently than men living with HIV / AIDS.
7. **Youth and education institutions:** children living with HIV / AIDS experience bullying and may be segregated from activities.
8. **Work place:** dismissal and recruitment on the basis of HIV status, denial of pension schemes or medical benefits on basis of HIV status.
9. **Media services:** may reinforce stereotypes and images of fear, guilt and immorality.
10. **Religious institutions:** exclusion from services and segregation on basis of HIV status.

4. Context for action in South Asia.

The South Asia region is one of the most populous and has one of the greatest diversity of religions and cultures, which make it challenging to combat S&D. HIV prevalence rates may be lower than other regions, but South Asia's background of extreme vulnerability of women, epidemic spread from urban to rural areas, large numbers of men frequenting sex workers, low condom use and access, increased cross border mobility, human trafficking and injecting drug use are all great cause for concern.

India has localised epidemics within high risk groups spreading to the general population. Nepal has a concentrated epidemic with significant high HIV rates amongst risk groups. Although HIV rates are relatively low in Bangladesh, Pakistan and Sri Lanka, high risk behaviours are prevalent with highly vulnerable populations. It is thought that S&D are extremely prevalent in the region. This has often been blamed on existing attitudes to marginalised groups and infectious diseases as well as the relatively low profile of PLHA. One ongoing study is analysing patterns of S&D in 6 Asian countries³, however there is little published information that quantifies or analyses S&D in the South Asian context.

The regional contextual diversity makes broad policy making with general initiatives difficult and has often been blamed for *inaction* specifically addressing the issue of S&D. However, S&D are providing an explosive fuel for the regional epidemic and we cannot ignore the urgency to scale up existing strategies and devise new ones to tackle S&D. These may be taken from existing programmes in the South Asia Region or from initiatives from other regions that show sound principles.

³ Deakin University, funded by Ford foundation and using UNAIDS protocol

5. Proposed strategies and models for intervention.

KEY PROGRAMME GOALS OF PROGRAMMES TACKLING S&D:

1. Changing legal environment to prevent discrimination and ensuring enforcement.
2. Supporting marginalised groups and PLHA.
3. Changing attitudes towards PLHA and their families.
4. Encouraging supportive behaviour changes to compassion and constructive tolerance.
5. Increasing openness, breaking the silence and breaking down the fears and misconceptions that reinforce high risk behaviours.

It becomes clear using the contextual framework in annex 1 that interventions tackling S&D require multi-sector thinking and should be aimed at individual, community and governmental levels. Reviewing the literature, strategies from other regions and examples of initiatives in South Asia reveals some common attributes.

KEY ELEMENTS OF SUCCESSFUL PROGRAMMES TACKLING S&D

1. Analysis of causes and effects of S&D.
2. Communication and education aimed at changing attitudes and behaviour, not just imparting knowledge.
3. Establishing a more equitable policy context.
4. Legal challenges are encouraged to the highest levels.
5. Dignity and rights of individuals and marginalised groups are safeguarded.
6. Addressed from a human rights framework.
7. Communities empowered through a participatory and lobbying process.
8. Social marketing and social mobilisation.
9. Leaders (governmental, religious and community) have been sensitized and involved to create a more open society.
10. Marginalised groups and PLHA networks are involved with forming policy, designing and implementing programmes and allowed to build 'new identities' within society.
11. Identifies both prevention and care / support aspects.

S&D are social processes used to create and maintain social control and produce, legitimise and perpetuate social inequality. They must therefore be resisted and challenged by addressing social and community changes through community mobilisation and social transformation. To be more effective, future initiatives will have to involve all actors tackling social, cultural, political and economic factors.

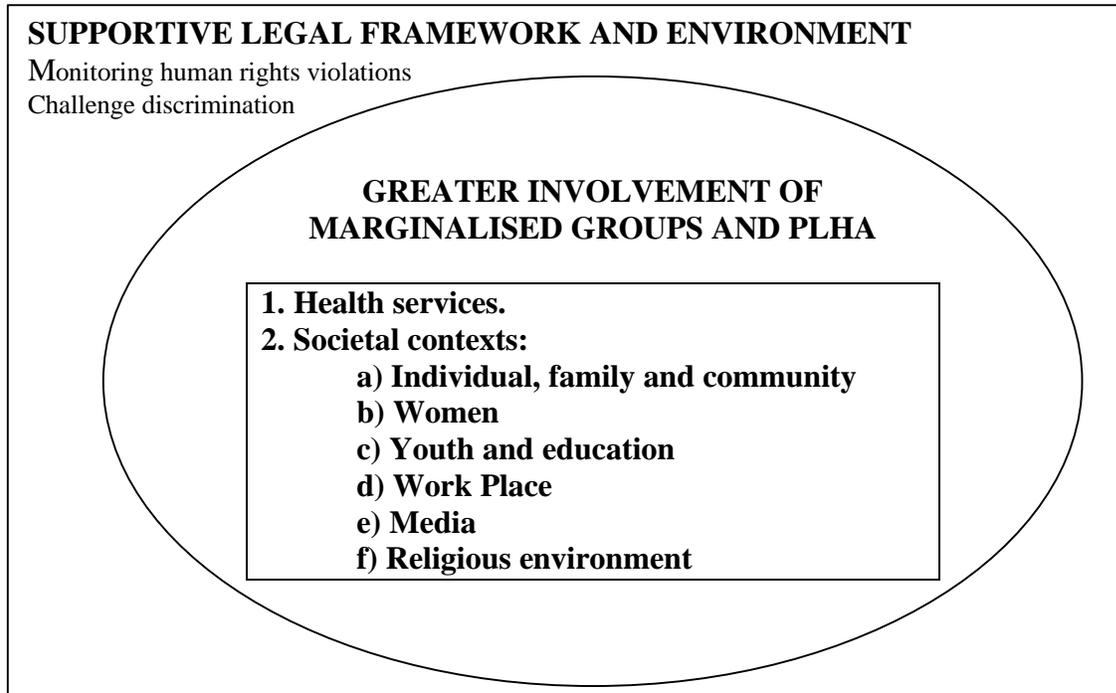
The contextual framework in Annex 1 helps classify various strategies but does not prioritise them. To be effective, all initiatives need to prioritise:

- a) enabling a legal environment to allow justice and the judiciary mechanisms for tackling discrimination.
- b) involving marginalised groups and PLHA in policy making, design and implementation of initiatives.

These two elements require individual strategies (suggested in annex 1), implemented by

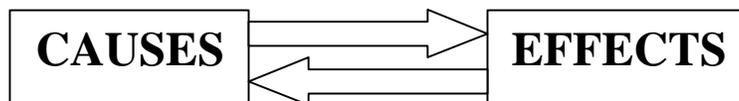
agencies with added advantages in the sectors. Initiatives addressing S&D in health services or any of the societal contexts (shown in the diagram below) should look at ways in which aspects of a) and b) can be incorporated into programmes.

Although agencies have different mandates and strengths, creating supportive legal frameworks and greater involvement of marginalized groups and PLHA provide common elements for response. The ‘cross cutting’ nature of these two prioritised elements may act as the catalyst for more multi sector, inter agency approaches through greater collaboration, information sharing and resource pooling.



Two ways of analysing initiatives tackling S&D within the health services and the various societal contexts include:

1. Identifying the causes and effects of stigma and discrimination in each context and exploring the linkages between them.



2. Analysing prevention and care & support initiatives and using this classification to look at ways of tackling S&D.



6. Gaps in responses.

Many general HIV / AIDS control programmes do produce ‘by-products’ that help tackle S&D. However, *if S&D are not specifically targeted as programme goals, then gaps in responses become apparent*. Several common gaps in responses to S&D were identified during the literature and programme reviews:

- Most initiatives are at individual and community levels, with few country wide programmes. Possible reasons include high staff turnover of governmental and UN staff and difficulty by smaller agencies in accessing funds for scaling up activities.
- By focusing on the human rights approach, many S&D initiatives lose the priority of the two main public health effects:
 - a) Stigma results in denial, leading to inaccurate disease surveillance, severely restricting ability to assess and plan health needs appropriately.
 - b) S&D decrease the access to treatment and counseling services.
- Although many initiatives take place in the health care setting, this sector remains one of the most frequently cited context for experiencing stigma by PLHA.
- Most initiatives are focused on an individual sector, with little cross cutting between the sectors. Reasons include NGOs not having the mandate or capacity to implement multi-sector programmes and poor inter-sector co-ordination and information sharing at country and regional levels on S&D issues.
- There does not appear to be effective country or region wide co-ordination systems for donors, civil society, UN and Governments to share information and co-ordinate initiatives on S&D.
- Few documented S&D reduction initiatives specifically focus on women, children and schools.
- Addressing accountability and behaviour changes for men from socially dominant groups who are adulterous, use commercial sex workers or have sex with men.
- Many Health Care Worker (HCW) training curriculae do not contain any social or legal dimensions, which are so important in understanding S&D.
- Initiatives often focus on imparting knowledge, without monitoring attitude or behaviour changes.
- In comparison to preventive programmes tackling S&D, care and support initiatives seem easier to implement and access resources for. Many NGOs find it more difficult to access funding for preventive S&D projects because outputs are regarded by donors as ‘softer’.

- There is little baseline measurement of prevalence of community based stigma
- There is little evidence of an effective ethical review process for S&D initiatives.

7. Measuring S&D and its impact.

Measurement of S&D and impact indicators may be complex and therefore difficult, but its importance cannot be over emphasized for some form of quality control:

1. To monitor programme progress over time
2. To plan resource allocation and focus effectively
3. To check that initiatives are not actually making S&D worse
4. To evaluate programme impact
5. To compare geographic areas and by activity (if measurement is standard) to identify more effective initiatives

Many organisations perceive monitoring and evaluating S&D programme impact, requiring the measurement of indicators, as stifling. Many experimental, creative ideas never develop into innovative projects for this reason. Indicator measurement is not only linked to programme monitoring, but also linked to accountability to donors.

This issue creates an unfortunate atmosphere where there is a disincentive to start programmes tackling S&D, as it relates to accountability and regularity of funding. Despite the dilemmas faced by many implementing agencies, there are several tools available for measurement.

1. Survey tools used in various surveys are detailed in annex 2
2. Hostility index developed in study '*India HIV and AIDS-related Discrimination, Stigmatisation and Denial*'. UNAIDS Best practice collection. www.unaids.org
3. Two stigma scales measure the concept of tolerance towards a PLHA
4. Survey tools in annexes 1, 3 and 5 of '*Protocol for the identification of discrimination against people living with HIV*'. UNAIDS Best practice collection. www.unaids.org

'Measurement of S&D and programme impact' was cited as a very common reason for agencies not making advocacy or S&D reduction part of a project goal. These projects often take a long time to prove effectiveness and are based on changing long standing attitudes and behaviours.

Due to the regional contextual differences, it may be easier to develop standard 'dimensions' or aspects of stigma, rather than actually standardising all indicators.

8. Conclusion.

Although *documented* proven regional efforts to challenge S&D are rare, many general HIV reduction programmes do reduce S&D as a by-product. However, there are few initiatives in the region that purely focus on reducing S&D. This creates many gaps and these highlighted areas need urgently addressed.

Excuses given for delaying new programmes or scaling up existing initiatives tackling S&D include the complexity of the issue and the need for more research. Scaling up activities will require further financial inputs, overall co-ordination, more inter agency collaboration and information sharing. Strong leadership and political commitment are necessary to overcome this inertia quickly, as the window of opportunity is rapidly closing for South Asia.

Devising new programmes and initiatives, based on the contextual framework will require an environment of creativity and imagination. Any new or expanded strategies will have to consider the legal framework with advocacy as well as involving marginalised groups and PLHA at all stages of the initiative. The existing S&D interventions are predominantly implemented by NGOs and encouragement must be given to increase the significance of scale, with more UN and governmental support.

People may be able to live with HIV, but cannot live with stigma. The moral obligation therefore lies with all individuals and sectors of society to fight S&D. We cannot delay our commitment to combating S&D through greater multi-sector collaboration.

9. Recommendations for action.

1. S&D initiatives or 'strategically planned' activities with significant anti S&D by-products must be central to all HIV prevention, care and support programmes.
2. Multi-sector, comprehensive programmatic and societal approaches must be adopted.
3. Measurement of indicators and impact are available, but require standardisation.
4. Results of S&D initiatives need to be widely disseminated regionally.
5. Donors need to be willing to allow agencies to experiment with imaginative and innovative initiatives that may be slow to show empirical signs of improvement.
6. Regional co-ordination mechanisms need strengthening to allow greater exchange of information between countries and sectors involved with S&D programmes.
7. Participation of marginalized groups and PLHA must continue to be a priority.
8. Improve regional information flow by establishing a regional task force and creating a structured Stigma – AIDS e-space forum, as also used for UNAIDS Inter country Team for East and Central Africa along with Health and Development Networks (HDN).
9. Women and children remain the most vulnerable to the effects of S&D and programmes should prioritise analysing and addressing their needs.
10. Political and social leaders need to be more involved with strategies and programmes tackling HIV / AIDS that go beyond the purely legislative and governance domains.

References

World AIDS campaign 2002-2003. HIV / AIDS related stigma and discrimination. Fact sheet. www.unaids.org

An overview of HIV / AIDS related stigma and discrimination. Fact Sheet www.unaids.org

Aggleton P., Parker R. A conceptual framework and basis for action: HIV / AIDS stigma and discrimination. UNAIDS. Best practice collection. www.unaids.org

Parker R., Aggleton P. HIV / AIDS related Stigma and Discrimination: A Conceptual Framework and agenda for action. Population Council, Horizons programme. www.popcouncil.org/pdfs/horizons

Bharat S., India: HIV and AIDS-related Discrimination, Stigmatisation and Denial. UNAIDS Best Practice Collection. www.unaids.org

Protocol for the identification of discrimination against people living with HIV. UNAIDS Best Practice Collection. www.unaids.org

World Bank Regional HIV / AIDS South Asia overview. www.worldbank.org/sarAIDS

Consultation on stigma and HIV / AIDS in Africa: Setting the operational research agenda. Stigma – AIDS. Background document summarising electronic discussions on HIV / AIDS related stigma in Africa February – June 2001. www.hdnet.org

HIV / AIDS and Human Rights Guideline 6. OHCHR and UNAIDS. www.unaids.org

HIV / AIDS and Human Rights. International Guidelines. Second International Consultation on HIV / AIDS and Human Rights. UNAIDS OHCHR. www.unaids.org

Brown L., Trujillo L., Macintyre K. Interventions to Reduce HIV / AIDS Stigma: What have we learned? Population Council, Horizons programme, Tulane University. www.popcouncil.org/pdfs/horizons

Herek G. AIDS and Stigma a conceptual Framework and Research Agenda. Final Report from a Research Workshop Sponsored by the National Institute of Mental Health.

Stigma and HIV / AIDS in Africa: Setting the Operational Research Agenda. 4-6 June 2001. Dar-es-Salaam. UNAIDS, Health & Development Networks (HDN) and Swedish International Development Agency (SIDA). www.hdnet.org

Draft Proposals from ANNEA, NARESA, SAFAIDS, SANASO for the regional response to reduce HIV / AIDS related stigma. Available at www.hdnet.org

Reingold A, Krishman S., The study of potentially stigmatizing conditions: an epidemiologic Perspective. Found on search engine 'research and stigma and discrimination'

Pulerwitz J., Abstract on stigma research. www.hdnet.org

World Health Organisation / International Labour Office / League of the Red Cross and Red Crescent Societies, Guidelines on AIDS and first aid in the workplace, WHO AIDS series No.7. 1990

Stigma and Discrimination: The Consequences; Stigma and discrimination: Definitions and Concepts. Information sheet designed by Canadian AIDS society, 1999

Stigma and discrimination fuel AIDS epidemic, UNIADS warns. UNAIDS press release. www.unaids.org/whatsnew/press/eng/pressarc01/stigma_050901.html

Salmon K., Fighting against Stigma, culture and discrimination. SHAAN online. www.ipsnews.net/hiv/aids/section3_1.shtml

<http://psychology.ucdavis.edu/rainbow/html/aids.html> has many links addressing HIV related stigma and discrimination

Challenging HIV related Stigma and Discrimination in Southeast Asia: Past successes and future priorities. A literature review. Horizons Project of the population Council. www.popcouncil.org/pdfs/horizons

Advocacy for action on Stigma and HIV / AIDS in Africa. Regional Consultation Meeting on Stigma and HIV / AIDS in Africa. 4-6 June 2001, Dar-es-Salaam. www.hdnet.org

France N. Stigma and HIV / AIDS in Africa. Review of issues and responses based on literature review, focus group discussions and Stigma-AIDS email discussion forum. Health and Development Networks. www.hdnet.org

France N., Anderson S., Manchester J., Nabagala S. K. Stigma, denial and shame in Africa: barriers to community & home based care for people infected and affected by HIV / AIDS www.hdnet.org

HIV-AIDS and Human Rights. The International Guidelines on HIV / AIDS and Human Rights, an assessment of National responses improving access to HIV / AIDS treatment within the framework. International Council of AIDS Service Organisations

Herek G., AIDS and Stigma: 1999 Survey items. University of California, Davis.

Empowerment for the Greater Involvement of people Living with HIV / AIDS in South Asia. A report on a GIPA initiative of the UNDP South and South West Asia Programme on HIV & Development and SAHARA

HIV / AIDS Awareness and behaviour. UNDP Department of Economic and Social Affairs Population Division ST/ESA/SER.A/209

Ashar Alo Society, Bangladesh asharalo@bangla.net

SEA-AIDS email group forum and Shohokogi Bangladesh forum

ANNEX 1. EFFECTS, PROPOSED STRATEGIES AND SOME INITIATIVES FROM THE SOUTH ASIA REGION

LEGISLATIVE / GOVERNMENTAL ENVIRONMENT		
Effects	Proposed strategies	Examples from South Asia Region
<ul style="list-style-type: none"> • Lack of legal framework integrating human rights, law and ethics into the overall response to HIV • Lack of administrative, procedural policy and enforcement of legal infrastructure • Travel entry and residence restrictions with some deportations on basis of HIV status in Bangladesh, India, Pakistan and Sri Lanka¹ • Mandatory testing and isolation practices • Lack of anti discrimination legislation covering the private sector • Denial of access to drugs against opportunistic infections and ARV's • Denial of entry to PLHA who carry medical drugs for HIV treatment 	<ol style="list-style-type: none"> 1. Train and support existing legal aid institutions, lawyers collectives and activist movements to: <ol style="list-style-type: none"> a) lobby measures for access to drugs b) protect rights of PLHA to education, employment, confidentiality, information and treatment c) advocate for social change d) strengthen medical confidentiality 2. Sensitisation of politicians, administration of Justice, Judiciary and Police on rights of PLHA. 3. High profile political leader involvement. 4. Provide para-legal counseling and advice at various levels. 5. Policy to enforce promotion and provision of condoms by bar and brothel owners. 	<p>India: Lawyers Collective, a Mumbai NGO, has helped influence Supreme Court decisions</p> <p>Sri Lanka: The NSACP moved to make the 'HIV/AIDS Law and Ethics Sub-committee' of the National AIDS Committee and was functional by 1994.</p> <p>India: FHI multi centre assessment of the level of community based stigma with INP+ and lawyers groups</p> <p>India: Lawyers Collective lobbied for antiretroviral treatments for patients who contracted HIV through Government blood products³</p> <p>Pakistan: AIDS Prevention Society of Pakistan (APSOP) has lobbied various Government Departments</p> <p>Pakistan: Policies on Blood Banks and AIDS control program reflect a human rights approach.</p> <p>India: Lawyers Collective upheld the 'suppression of identity' clause, allowing a PLHA to file their case under a pseudonym.</p> <p>Pakistan: Right to health is recognized in Article 38 of constitution</p> <p>Sri Lanka: The draft National AIDS Policy takes a strong 'rights' based approach.</p> <p>India: Supreme court decision on PLHA has no right to marry⁴ has been challenged by Lawyers Collective</p>

1 www.aidsnet.ch/immigration study by Geramn AIDS organisation

2 for example: promoting needle exchange programmes, sexually explicit material or portraying homosexuality in a positive light.

3 From SAHARA (Indian NGO)

4 Mr. X v Hospital Z, (1998) 8 SCC 296

ANNEX 1. EFFECTS, PROPOSED STRATEGIES AND SOME INITIATIVES FROM THE SOUTH ASIA REGION

<ul style="list-style-type: none"> • Compulsory notification of cases • Homosexuality legalities – penal codes may punish certain behaviours • Inconsistent prostitution laws • Restrictions on the right to anonymity, marriage, founding a family on basis of HIV status • Prevention of health education providing clear and explicit risk reduction messages² 	<p>6. Encorporating ‘right to health’ in constitutions</p> <p>7. Advocacy with the existing national human rights mechanisms</p>	<p>Pakistan: Strong community lobbying and APSOP has influenced Govt policy to increase access to treatment and cheaper prices for opportunistic infections drugs</p> <p>India: a man was jailed on the basis of his positive sero-status in Goa in the early 1990’s. A group of activists lobbied successfully for his release</p> <p>Bangladesh: civil society and media lobbies have helped influence various HIV related legislative procedures⁵</p> <p>Sri Lanka: HIV Law and Ethics Network of the NGO Law and Society Trust published 10 publications on HIV and Human rights. These addressed S&D for use by different groups including police officers and help in the on going training of police officers on HIV/AIDS that is being conducted by the Police Narcotics Bureau, in partnership with the National STD/AIDS Control Programme and UNAIDS.</p> <p>India: Senior Parliamentarians visit PLHA networks and care homes, pledge their support and facilitate local officials to provide support to NGOs (eg. Allotment of land and Rs.10 lakhs to Freedom foundation in Bangalore)</p> <p>India: Legislative Assembly for a on HIV / AIDS in Karnataka and Assam in 2002</p> <p>Sri Lanka: The NSACP conducted a workshop for the judiciary to which UNAIDS provided technical support that addressed the role of the judiciary related to stigmatised populations such as sex workers. The high court judges clearly indicated that there is no legal provision to arrest sex workers or HIV positive persons although they admitted that some junior Magistrates still send them into remand prison and are released by high court judges on appeal only subsequently.</p>
---	--	--

⁵ Daily Star report 14th September, 2000

ANNEX 1. EFFECTS, PROPOSED STRATEGIES AND SOME INITIATIVES FROM THE SOUTH ASIA REGION

GREATER INVOLVEMENT OF PEOPLE LIVING WITH HIV / AIDS AND MARGINALISED POPULATIONS		
Effects	Proposed strategies	Examples from South Asia Region
<ul style="list-style-type: none"> • Low visibility of PLHA fuels fear and ignorance • Environment has made it difficult for PLHA to form strong organizations • No advantage of disclosure (PLHA often avoid disclosure of their status, making it difficult to organize and collaborate effectively) <p>Marginalised groups are stigmatised by society already⁶. They include:</p> <ul style="list-style-type: none"> • Men who have sex with men (MSM) • Commercial sex workers (CSWs) • Intravenous Drug Users (IDUs) • Transgender individuals • Prisoners • Refugees and migrant workers • Victims of trafficking <ul style="list-style-type: none"> • Programmes targeting marginalised groups may actually make stigmatisation worse by reinforcing association of these groups with 	<ol style="list-style-type: none"> 1. Creation of ‘resistance groups’ and networks of PLHA and marginalised populations to strengthen: <ol style="list-style-type: none"> a) peer support b) treatment and care options c) effective responses to problems and issues related to their rights d) income generation e) personal harm reduction strategies f) public speaking opportunities and impact 2. Increase exposure of PLHA and marginalised populations to communities and policy⁸ by increasing involvement in <ol style="list-style-type: none"> a) decision making b) public policy formulation (eg. Governmental ministries and civil society organisations) c) implementation 	<p>India: Mumbai and Calcutta sex worker groups have successfully challenged police persecution and challenged decisions through formation of ‘resistance groups’ and networking</p> <p>India: UNAIDS funded book showing issues of transgender individuals distribution</p> <p>India: NGO Community Development Services established a Sex Worker Welfare Society, helping to increase the voice of the commercial sex workers</p> <p>India: DMSC has helped sex workers form group that is self regulatory and helps monitor children of CSWs, creating environment where groups can address stigma</p> <p>India: SFDRS in Pontecherri help lobby legal institutions so children do not to have to put the names of their fathers on various application forms</p> <p>Regional: UNDP and APN+ published guidelines for PLHA who want to speak out in public giving encouragement and tips⁹</p> <p>Regional: SAHARA, UNDP, UNAIDS and 17 regional PLHA organizations coordinated GIPA initiatives as a pilot project and aims to increase the use of GIPA principles region wide through a participatory process</p> <p>Pakistan: UNAIDS and UNDP are supporting GIPA principles in various NGO initiatives</p>

⁶ mandatory testing often without counseling or follow up

⁷ For example urban rural divide in knowing about HIV / AIDS Bangladesh 64% urban versus 23% rural and Nepal 67% urban versus 23% rural

⁸ makers to help underscore the link between managing the epidemic within marginalised groups and managing the general response to the epidemic

⁹ Lifting the Burden of Secrecy. A manual for HIV positive people who want to speak out in public. APN+

ANNEX 1. EFFECTS, PROPOSED STRATEGIES AND SOME INITIATIVES FROM THE SOUTH ASIA REGION

<p>HIV AIDS</p> <ul style="list-style-type: none"> Rural populations are more vulnerable to S&D because of lower HIV / AIDS awareness⁷ 		<p>Pakistan: AIDS Prevention Society (PAPS) in Baluchistan strengthen capacity of NGOs to use GIPA initiatives. This has increased community acceptability and accessibility to treatment.</p> <p>Pakistan: Gender and Reproductive Forum (GRF) in Sind helped empower PLHAs and family members, through GIPA principles</p> <p>Pakistan: New Light AIDS Control and Awareness Group in Punjab helped create an enabling environment for PLHA to understand and learn more about HIV issues</p> <p>Sri Lanka:NEST and UNAIDS helped coordinate and provide assistance in getting a PLHA to the UNAIDS PCB - NGO section.</p> <p>Nepal: Prerana NGO created as a self help group – peer education, networking, media interaction</p> <p>Sri Lanka: UNAIDS has helped develop a project proposal to empower a PLHA that secured funding from the UNDP. It has successfully advocated to get PLWHA into various sub-committees of Governmental Bodies such as the National AIDS Committee and the CCM for GFATM.</p> <p>India: ‘People living with HIV’ have initiated the Positive Speakers Bureau to address issues of S&D through developing communication and public speaking skills of PLHA. 20 speakers will be trained.</p> <p>India: ‘People plus’ provided an opportunity for PLHA to talk about the difficulties faced with S&D. A senior member of Parliament actively participated in the launch of an exhibition in an effort to support the reduction of stigma. The results were also incorporated into a book and exhibitions of pictures at various national and international events. This resulted in powerful advocacy messages.</p> <p>India: INP+ is a member of the Theme Group on HIV in India and Country Coordination Mechanism of the Global Fund. This provides opportunities for PLHA groups to input to the design and governance of programme response. State INP+ networks are also members of the SACS executive committees.</p>
--	--	---

ANNEX 1. EFFECTS, PROPOSED STRATEGIES AND SOME INITIATIVES FROM THE SOUTH ASIA REGION

HEALTH SERVICES		
Effects	Proposed strategies	Examples from South Asia Region
<ul style="list-style-type: none"> • Stigma and fear¹⁰ is present amongst many HCW's¹¹ • S&D prevent behaviour seeking care for opportunistic infections, STI's, TB and reduces access • Treatment or care may be refused • Confidentiality may be breached • PLHA may be isolated in hospitals or wards • PLHA may be forced to undergo unnecessary medical examinations • Surgical procedures may be delayed or cancelled • Patients may be tested without consent • Relatives asked to give hands on care • Bed signs, charts and prescriptions may be labeled unnecessarily • Universal precautions may only be used selectively • Confidentiality and secrecy may add an air of mystery, thereby further increasing ignorance and myths 	<p>Initiatives aimed at four levels:</p> <p>1. Care Provider Training and sensitisation of HCW's and med students at all levels on:</p> <ol style="list-style-type: none"> a) basics of HIV and nature of its potential chronic nature. b) access to treatment of opportunistic infections, ARV's and PEP. c) legal social issues. d) Universal Precautions. e) importance of confidentiality f) condom promotion and dissemination centred around healthcare facilities g) supporting PLHA and marginalised groups <p>2. Client Training and counseling on</p> <ol style="list-style-type: none"> a) VCT options b) Disclosure timing <p>3. Hospital management</p> <ol style="list-style-type: none"> a) Establish and provide adequate funding for comprehensive HIV / AIDS care including counseling staff and clients b) encourage staff to know their HIV status c) establish PLHA friendly hospitals with 	<p>India: Various NGO initiatives collected names of health workers and institutions breaching the 'right to treatment' for PLHA</p> <p>India: SHARAN / Pop Council establish 'Gold Standard' or PLHA 'friendly' hospitals. This initiative makes services more attuned to the needs of PLHA. Pre and post test counseling, confidentiality, importance of informed consent. Efforts also include staff education and training for Universal Precautions.</p> <p>India: SAHARA focus on PLHA facing delays in surgical procedures and lobbying through legal channels</p> <p>India: New Delhi – discussing the results of baseline research on care, stigma and discrimination of PLHA with staff from three hospitals has led to increased interest and action Gold standards produced for care of PLHA</p> <p>Sri Lanka: NEST and UNAIDS helped lobby against referral of PLHA to one single hospital. This led to recognition that segregation leads to S&D. The National STD/AIDS Control Programme took the leadership to mobilise the Ministry of Health (MoH) to then issued a circular that all PLHA should be treated as anyone else in any hospital. This was following the HIV/AIDS Care NGO, NEST's lobby against referral of PLHA to one single hospital. This led to recognition that segregation leads to S&D. UNAIDS helped move the issue informally through the Law and Ethics Committee of the</p>

¹⁰ of death, contagiousness, lack of treatment

¹¹ Bharat S., India: HIV and AIDS-related Discrimination, Stigmatisation and Denial. UNAIDS Best Practice Collection. www.unaids.org

ANNEX 1. EFFECTS, PROPOSED STRATEGIES AND SOME INITIATIVES FROM THE SOUTH ASIA REGION

	<p>hospital specific policies and adequate supplies for Universal precautions.</p> <p>d) comprehensive care and services with VCT and post test follow up care.</p> <p>e) Ensure codes of ethics and professional conduct against discriminatory practices are in place. Enforced, if necessary, by hospital committees.</p> <p>f) include HIV AIDS treatments as part of ‘essential drugs’ lists.</p> <p>8. Ratification of anti-discrimination legislation within public and private health care services.</p> <p>4. community</p> <p>a) promotion of and training in family home and community based care and prevention</p> <p>b) include local and traditional healers in initiatives.</p>	<p>MOH. Another circular was issued later on the procedure related to burial of HIV bodies that respected its dignity. Prior to this PLHA who had died were disfigured with bleach powder and coffins were nailed down¹² before handing to the next in kin.</p> <p>Sri Lanka: APASCO and UNAIDS have helped blood banks establish a human rights approach</p> <p>India: Mumbai, Positive Peoples foundation and ARCON help Maharashtra HCWs address needs of PLHA in a non discriminatory environment and develop training curriculae for HCWs.</p> <p>India: FHI helped strengthen training courses in health establishments to use Universal Precautions and change attitudes to caring for PLHA</p>
--	--	--

¹² Busza, J. 1999. Challenging HIV related Stigma and Discrimination in South East Asia: Past Successes and Future Priorities. Bangkok: Population Council

ANNEX 1. EFFECTS, PROPOSED STRATEGIES AND SOME INITIATIVES FROM THE SOUTH ASIA REGION

INDIVIDUAL, FAMILY AND IMMEDIATE COMMUNITY		
Effects	Proposed strategies	Examples from South Asia Region
<ul style="list-style-type: none"> ● Rejection by family and / or community leads to isolation, depression and exclusion ● Primary (individual) stigma after diagnosis ● Secondary stigma extends to family, friends and neighbours leading to double burden of providing care and hiding status ● PLHA associated with promiscuity, homosexuality and drugs ● Low access to services and support ● Punishment and physical harm 	<ol style="list-style-type: none"> 1. Increase family and social support through: <ol style="list-style-type: none"> a) Community mobilisation and participation encouraging community ownership b) Counselling, psycho social support and creation of self help groups c) Promotion of openness and acceptance in families d) Peer group networks and membership / education e) Coping skills acquisition (individual and immediate family) f) Home care services including VCT and follow up care g) Provide support for individuals and their families to disclose their status 2. Increase awareness of community members on HIV / AIDS issues through: <ol style="list-style-type: none"> a) mass campaigns (radio most effective) b) Behavioural Change Strategies c) Training community members as health educators d) greater involvement by women and high profile community members 3. Education messages should include: <ol style="list-style-type: none"> a) Raising awareness of Access to treatment (opportunistic infections and ARV's) b) rights of PLHA c) Video / posters / leaflets / poetry / plays / songs / drama / testimonials /documentaries in public areas / meeting places , workshops, role models 4. Sensitisation of community leaders and youth groups on rights of PLHA 5. Support community legal aid centres 	<p>India: numerous examples of home care services provided by NGO's (eg SAHARA)</p> <p>Pakistan: AWARD¹³ work in NWFP. PLHA at personal and family levels facilitate home based support/care and teach prevention at family level. Identifying needs of PLHA's</p> <p>India: Family Health International (FHI) NGO funding two pilot interventions addressing community based stigma</p> <p>India: 'Positive life' have produced videos specifically addressing S&D for use in community settings</p> <p>India: FHI training courses for HCW's for home based approach to care</p>

¹³ All Women Advancement and Resource Development

ANNEX 1. EFFECTS, PROPOSED STRATEGIES AND SOME INITIATIVES FROM THE SOUTH ASIA REGION

WOMEN		
Effects	Proposed strategies	Examples from South Asia Region
<ul style="list-style-type: none"> • Women living with HIV / AIDS are treated with more stigma and discrimination than men or children¹⁴ • Women living with HIV / AIDS denied shelter and refused property rights more than men • Women living with HIV / AIDS rejected by their partners, families and communities more than men • Women living with HIV / AIDS are denied access to treatment more than men • Women have less financial and negotiating power • Women living with HIV / AIDS receive less care and support than men • Women living with HIV / AIDS are often blamed for husband's diagnosis • Women know less about preventive strategies than men ¹⁵ • Women are more economically dependent • Women are often regarded as no economic asset to the family • Women are often excluded from religious practices especially widows, women unable to conceive or not bearing sons 	<ol style="list-style-type: none"> 1. Counter prejudices through BCC strategies 2. Health education 3. Encourage more women to participate in all aspects of HIV / AIDS interventions: a) planning b) policy making c) implementation 	<p>India: Women's groups have successfully lobbied for changes in inheritance rights¹⁶</p> <p>India: National consultation on women with HIV / AIDS 2002. Presentation and recommendations specific to women's vulnerabilities to HIV + women's concerns regarding S&D.</p> <p>Nepal: WOREC NGO provided information booths at transit points for information dissemination to empower women for safe mobility and address potential discrimination</p>

¹⁴ Bharat and Aggleton 1999

¹⁵ For example in Nepal only 1 in 3 ever married women has ever heard of HIV / AIDS and in Bangladesh there is a 19% gap between men and women's knowledge of HIV (HIV AIDS awareness and behaviour UNDP report ST / ESA / SER.A / 209)

¹⁶ Horizons

ANNEX 1. EFFECTS, PROPOSED STRATEGIES AND SOME INITIATIVES FROM THE SOUTH ASIA REGION

YOUTH AND EDUCATION		
Effects	Proposed strategies	Examples from South Asia Region
<ul style="list-style-type: none"> • Children’s attitudes are easily influenced • Denied schooling • segregated classes and activities • bullying • Exclusion of children from activities • Children may be orphaned and abandoned, increasing vulnerability to stigmatisation and discrimination • Negative children may be reared by in-laws whilst positive children may be shunned 	<ol style="list-style-type: none"> 1. Teacher / HCW joint initiatives to encourage: <ol style="list-style-type: none"> a) disseminate information about healthcare, HIV, support b) small group discussions about illness and reactions involving empathy c) role play involving empathy and reactions 2. Encourage debate and challenges within higher education establishments 3. Establish school based youth friendly health services including HIV / AIDS prevention 3. Promote life skills education and counseling to help HIV infected children with stigma 	<p>Regionally: UNICEF have produced 6 videos on young people affected by the epidemic with some powerful testimonies</p> <p>Regionally: PANOS and Save the Children have just released a book entitled ‘Unheard stories’ with testimonials from young people</p>

ANNEX 1. EFFECTS, PROPOSED STRATEGIES AND SOME INITIATIVES FROM THE SOUTH ASIA REGION

WORK PLACE		
Effects	Proposed strategies	Examples from South Asia Region
<ul style="list-style-type: none"> • Mandatory testing • Dismissal and recruitment on basis of HIV-status • Breaches of confidentiality • Refusal to work with PLHAs • Denial of schemes providing medical assistance or pensions to employees on basis of HIV status • PLHA who are fired may have to resort to selling sex • Tourist and food industries particularly noted for HIV related S&D 	<ol style="list-style-type: none"> 1. Establish, disseminate and enforce non discriminatory HIV / AIDS policies and practice to define responsibilities towards the employee. 2. Establish a monitoring system on work place policy and practice on human rights 3. Establish legal networks, with referral services, to combat stigma and discrimination 4. Sensitise management and workers at all levels through: <ol style="list-style-type: none"> a) education programmes and b) exposure to PLHA 5. Business coalitions to support workplace interventions 	<p>India: Mumbai Lawyers Collective successfully defended HIV + workers who were discriminated against and lost their jobs The collective also raised public awareness about HIV / AIDS through public rallies and mobilised public opinion against stigma and discrimination.</p> <p>India: A study of seven large Mumbai based businesses revealed that none had a policy on AIDS. Employment related discrimination. Industrial Response to AIDS (IRTA) has produced a booklet on corporate policy on AIDS</p> <p>ILO: helped produce Code of Practice on HIV / AIDS and the world of work provides basic principles to guide policy development</p> <p>Regional: Dissemination of WHO / ILO / League of the Red Cross and Red Crescent Societies, Guidelines on AIDS and first aid in the workplace, WHO AIDS series No.7. 1990</p> <p>India: National Business Coalition was launched in December 2000 by prime minister</p> <p>India: Maharashtra Business Coalition launched in 2001 as first step towards increased interventions in the work place in Maharashtra</p>

ANNEX 1. EFFECTS, PROPOSED STRATEGIES AND SOME INITIATIVES FROM THE SOUTH ASIA REGION

MEDIA		
Effects	Proposed strategies	Examples from South Asia Region
<ul style="list-style-type: none"> • Reports are sensationalized and often based on death / fear / guilt / immorality • Negative images of PLHA • Scape goating • Reinforce stereotypes 	<ol style="list-style-type: none"> 1. Develop media HIV / AIDS reporting policies and guidelines 2. Train journalists and editors with such non stigmatising guidelines 3. TV is now the most often cited source of information¹⁷ 4. Increase media coverage of public figures disclosures or involvement with PLHA 5. Media networks should be held accountable for reporting practices through monitoring mechanisms regionally and country wide 	<p>Region: UNDP facilitated workshop and policy guidelines helped create a network of editors and form a statement of commitment by top media editors for responsible reporting and dissemination of HIV related issues along with guidelines on best practice.¹⁸</p> <p>Bangladesh: One study analyzing newspaper clippings showed improvements - migrant workers becoming less stigmatised after journalist sensitization initiatives</p> <p>Sri Lanka: As early as 1993, the media started discussing issues of S&D. The lead article of the National Newspaper 'Island' on December 1st, 1993 was titled 'AIDS patients have rights too'.</p> <p>India: Attitudes towards PLHA in India through mass media TV documentary of a PLHA's life. Study (using focus group interviews) showed that media effort increases acceptance and decreases stigma. Volunteers more willing to work in AIDS field.</p> <p>Sri Lanka: The NGO, Alliance Lanka recently did a study on newspaper cuttings analysis and analysed the trends related to S&D.</p> <p>India: 1996 mass media TV documentary India: NACO broadcast HIV / AIDS talk show on TV including PLHA in the discussions in 2002</p> <p>Sri Lanka: The UNAIDS Goodwill Ambassador, Mr. Sanath Jayasuriya, Captain of the Cricket Team in his post appointment interview specifically made a statement against discriminating against person living with HIV which was highly publicised by the media and is thought to have had a decisive impact on the manner the attitudes of young people on PLWHA.</p>

¹⁷ Mrs Jetwani, Indian media group research

¹⁸ HIV and development talking to the media, a report of Country Consultation. UNDP HIV and development project South and Southwest Asia

ANNEX 1. EFFECTS, PROPOSED STRATEGIES AND SOME INITIATIVES FROM THE SOUTH ASIA REGION

RELIGIOUS ENVIRONMENT		
Effects	Proposed strategies	Examples from South Asia Region
<ul style="list-style-type: none"> • HIV related S&D may be reinforced by moral stances on sex, sexuality, sin, punishment • Denial of rituals • Restrictions on participation • Segregation of congregation 	<ol style="list-style-type: none"> 1. Sensitise religious leaders through education and training. 2. Train religious leaders in counseling skills and rights of PLHA. 3. Integrate holistic care and support programmes in service and education activities support groups for infected and orphans. 	<p>India: State AIDS Control Society (SACS) in J&K encourages work with Imams (Islamic leaders) addressing HIV as part of the Friday sermons at mosques. The messages show HIV as a threat to young people and address the need for Muslims and HCWs not to discriminate against PLHA. However, messages have also included advocating earlier marriage for young women in HIV prevention messages.</p> <p>India: FHI have helped engage PLHA with the Christian association of India</p>

ANNEX 2 ATTEMPTING TO MEASURE S&D

Definition	The percent of respondents expressing accepting attitudes towards PLHA
Numerator	The number of respondents who report on accepting or supportive attitude on all four component questions
Denominator	Total number of respondents who have heard of HIV / AIDS
Measurement Tools	UNAIDS general population survey; DHS AIDS Module: FHI BSS (adult); FHI BSS (youth); MICS (UNICEF)
What it measures	This is an indicator based on answers to a series of hypothetical questions about men and women with HIV. It reflects what people are prepared to say they feel or would do when confronted with various situations involving PLHA
How to measure it	<p>Respondents in a general population survey are asked a series of questions about PLHA, as follows:</p> <ol style="list-style-type: none"> 1. If a member of your family became sick with the AIDS virus, would you be willing to care for him or her in your household? 2. If you knew that a shopkeeper or food seller had the AIDS virus, would you buy fresh vegetables from them? 3. If a female teacher has the AIDS virus but is not sick, should she be allowed to continue teaching at the school? 4. If a member of your family became infected with the AIDS virus, would you want it to remain a secret? <p>Only a respondent who reports an accepting or supportive attitude on all four of these questions enters the numerator. The denominator is all people surveyed.</p>
Strengths and limitations	<p>Methodologically, this is a relatively easy way to construct an indicator of attitudes to PLHA. A low score on the indicator is a fairly sound indication of high levels of stigma, and for that reason alone it is worth measuring</p> <p>There are, however, difficulties in interpreting indicators based on hypothetical questions, and a high score on the indicator is harder to understand. It could mean there is little real stigma attached to HIV. Or it could mean that people know they should not discriminate, and therefore report accepting attitudes. This may not change their behaviour, which may continue to be discriminatory towards PLHA. Changes in the indicator could therefore reflect a reduction in stigma or simply a growing awareness that it is not nice to own up to one's prejudices. That in itself may also reflect the respondent's limited personal experience with someone who is HIV infected</p> <p>The proposed indicator is similar to an earlier measure developed by WHO, but questions have changed following field testing to better reflect situations in which PLHA actually suffer from stigma. Field tests revealed that responses are greatly affected by the exact wording of the indicator. When the gender of the teacher was not specified, for example, one country registered very high levels of discriminatory attitudes on that question, for example. Further investigation showed that the negative attitudes were related to recent news reports of male teachers infecting female</p>

ANNEX 2 ATTEMPTING TO MEASURE S&D

	<p>pupils with HIV.</p> <p>The earlier WHO indicator has been little used, calling into question the utility of this measure. It is possible that it was little used because so little programming effort to date has gone in to reducing stigma surrounding HIV in most countries. As the power of stigma to obstruct prevention and care efforts becomes ever clearer, however, it is likely that more national AIDS programmes will turn their attention to this area. It is expected, therefore, that use of this indicator will increase.</p> <p>It has been suggested that this indicator be used to measure differences in discrimination or stigma by gender. Although some research suggests that women are more likely than men to be treated and viewed harshly if they have HIV or AIDS, other recent surveys have shown little difference in response to gender specific questions about stigma and discrimination.</p>
Use of indicator	Core indicator for all epidemics
Tools	Surveys (UNAIDS, DHS, FHI, UNICEF)
Other possible indicators suggested	<ol style="list-style-type: none"> 1. Reduction of proportion of negative articles in Newspapers per month. 2. Numbers treated in general hospitals as apposed to being treated in referred infectious disease hospital. 3. Questionnaires related to attitudes of general population etc. 4. Numbers of people wrongfully arrested due to HIV status. 5. Numbers of people against whom complaints have been made because there zero-status. 6. Numbers of men and women going for VCT. 7. Numbers of men and women open about their status. 8. % AIDS funerals attended by at least 75% of village population divided by % of AIDS funerals (CARE International) 9. % of community going for VCT. 10. % of people testing positive and disclosing status to various categories of people. 11. % of people using AIDS ‘hotline’ services 12. % of people joining support groups (by sex) 13. % of people with HIV who report they delay seeking care 14. % of people who seek care far away 15. % of people who report self segregation of personal items 16 number of court cases filed related to S&D and success rate thereof (decisions / rulings).