CHAPTER-3

STIGMA AND DISCRIMINATION AGAINST HIV/AIDS VICTIMS : A DENIAL OF BASIC HUMAN RIGHTS

All Human Rights begin with Human Dignity. Humans are the central subject of Human Rights and basic freedoms.

The human rights jurisprudence projects the picture of a human being bestowed with all human rights and fundamental freedoms essential for enjoyment of human dignity. The question of human rights has never had a greater significance than in the period from 1948 to date, not only for the intellectuals and elite, but also for the masses. Although the concept of human rights is old, its contents and scope are still debated. The notion of human rights is the most precious legacy of the classical and contemporary thought of culture and civilization. Few phenomena have made such a profound impact both in sweep and depth and few movements have acquired such a universal presence as the human rights movement. The concept of human rights is a dynamic one, which will find expanded expression and constantly cover new areas as human society continues to evolve to higher levels of development.

The original content and philosophy of fundamental freedom was limited in the main to civil and political rights of the individual often referred to as "First Generation Rights" which in large part called for negative obligations on the part of government to desist from interfering with exercise of individual liberties. The realization and enjoyment of the “first generation rights” was not possible without guaranteeing economic, social and cultural rights, this led to inclusion of economic, social and cultural rights popularly described as ‘Second Generation Rights’. These rights impose more positive duty on government to act for realization of these rights. The expanding comprehension of human rights has now travelled to encompass ‘Third Generation or Solidarity Rights’ that include right to self determination - a right regarded as belonging to people rather than individuals and right to development -right of considerable significance to people of developing

1. It was proclaimed in the full text of Vienna Declaration. Preamble, Clause 2.
countries. The third generation rights also include the right to international peace, the right to satisfactory environment favorable to sustainable development and the rights of the ethnic, religious and linguistic and sexual minorities. The journey thus travelled by the human rights movement has been really long and significant as it acknowledges the brotherhood and sisterhood of the human race.

A classical definition of human rights is precisely expressed by Cranston as follows: human right by definition is a universal moral right, something which all men, everywhere, at all times ought to have, something of which no one may be deprived without a grave affront to justice, something which is belonging to every human being simply because he is human.\(^3\) The principle of human rights represents one particular way of looking at human dignity. Human dignity is the quintessence of human rights. It is the wide comprehension of this aspect and appreciation of the amplitude of dignity of the individual, a unit of the human family, which must define the true scope of human rights. ‘All human rights for all’ and ‘the world is one family’ are the concepts which have depended on the expanded meaning of the human race in the global village\(^4\). The respect for human dignity is the clarion call of the current human rights movement. The preamble to the Universal Declaration of Human Rights recognizes this fact by implying that human rights and human dignity are, if not synonymous, then at least very closely linked. National constitutions and proclamations, especially those recently adopted include the ideal or goal of human dignity in their references to human right. One lexical meaning of dignity is ‘intrinsic worth’. Thus when the UN Charter refers to the ‘dignity and worth’ of the human person, it uses two synonyms for the same concept. The other instruments speak of ‘inherent dignity’ an expression that is close to ‘intrinsic worth’\(^5\).

Human rights, being the natural rights of the people, are first of all those rights which guarantee dignity of the people. This means that the people

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6. There are different opinions about the definition of human "dignity". Although we can not enumerate each of these, we can summarize the majority of them as emphasizing one or more of the following: the independent personality and worth of human beings: the essence of personhood, which is the essence of human beings when the worth of human beings is the general estimation of the peoples.
themselves are the main subject of human rights and fundamental freedoms. Human right stem from human dignity, something not granted to the people by the State or the law but which is nevertheless an inherent, absolute, and basic right of the people. A distinguished judge of International Court of Justice, Judge Tanaka, wrote in 1996: “The principle of protection of human rights is desired from the concept of man as a person and his relationship with society which cannot be separated from universal human nature. The existence of human rights does not depend on the will of a state, neither internally on its law or any other legislative measure, nor internationally on treaty or custom, in which the express or tacit will of a state constitute the essential element. A state or states are not capable of creating human right by convention. They can only confirm their existence and give them protection. The role of the state is no more than declamatory.”

Dignity as observed by L’Heureux-Dube is a difficult concept to capture in precise terms. At its least, it is clear that the constitutional protection of dignity requires us to acknowledge the value and worth of all individuals as members of our society. It recognises a person as a free being who develops his/her body and mind as he or she sees fit. At the root of the dignity is the autonomy of the private will and a person's freedom of choice and action. Human dignity rests on recognition of the physical and spiritual integrity of the human being, his or her humanity, and his value as a person, irrespective of the utility he can provide to others. The expression "dignity of the individual" finds specific mention in the Preamble to the Constitution of India. V.R. Krishna Iyer, J. observed that the guarantee of human dignity forms part of our constitutional culture.

There is also an opinion that "It is an agreement of existing dignity and worth of human being, it is the core of the element, forming the essence of a human personality and a specific worth of it." It is impossible to enumerate one by one the forming elements of human dignity and value: it naturally contains the freedom of human wishes and demands free manifestations of human rights: Human dignity makes the individual the standard of a society. It is the main principle of democracy. It is the worth of moral ethics, which is achieved the essence of human personality. Human dignity is nobility of a specific for the main aspect of a personality etc.

7. In the full text of the Vienna Declaration, it was proclaimed that "all human rights begin with human dignity. Humans are the central subject of human rights and basic freedoms.
In Francis Coralie Mullin v. Administrator, Union Territory of Delhi and others, Justice P.N. Bhagwati explained the concept of ‘right to dignity’ in the following terms:

"...We think that the right to life includes the right to live with human dignity and all that goes along with it, namely, the bare necessities of life such as adequate nutrition, clothing and shelter and facilities for reading, writing and expressing oneself in diverse forms, freely moving about and mixing and commingling with fellow human beings..... Every act which offends against or impairs human dignity would constitute deprivation pro tanto of this right to live and it would have to be in accordance with reasonable, fair and just procedure established by law which stands the test of other fundamental rights."

The Canadian Supreme Court in Law v/s Canada (Ministry of Employment and Immigration) attempts to capture the concept of dignity in these words:

"Human dignity means that an individual or group feels self-respect and self-worth. It is concerned with physical and psychological integrity and empowerment. Human dignity is harmed by unfair treatment premised upon personal traits or circumstances which do not relate to individual needs, capacities, or merits. It is enhanced by laws which are sensitive to the needs, capacities, and merits of different individuals. Human dignity is harmed when individuals and groups are marginalized, ignored, or devalued, and is enhanced when laws recognise the full place of all individuals and groups within Canadian society."

In the first Article of the Virginia Bill of Rights, 1776, often called the first declaration of human rights, it is stated that all people are born free and independent and have the right of their own life. The American Declaration of Independence states that all people are created equal and endowed with such inviolable rights as the right of life, freedom and the pursuit of happiness.

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10. See 1981, 1 SCC paragraph 8, p-68.
11. 1929 1 SCR 497, para 53.
Hence, it establishes that the right to freedom, equality and happiness are the inborn rights of all humans. In the French "Declaration des Droits de l'Homme et du Citoyen", 1789, Article 1 stresses that people have the right to be born and live free and equal; Article 2 proclaims that the right to all kinds of association with different political purposes is a natural right to be guaranteed. Article 2 also establishes the right to freedom, property, security and resistance. The Universal Declaration of Human Rights, 1948, states that "the dignity of all people in society, their equality and the inviolability of their rights are acknowledged to be the basis of freedom, justice and peace in the world."

As the ideological basis of human rights, human dignity is acknowledged universally. All people are born with human dignity and worth and have the right to seek happiness and lead lives worthy of their dignity. To respect and guarantee this right is the duty of the political power of every country. Being an ideological starting point for all human rights, respect for human dignity is the core of all basic rights and, a final purpose of all guarantees of basic rights.

Famous philosopher Kant wrote, "mental self-control, and independence become the basic of all people's dignity." At the time Kant wrote this, human dignity was a unique, absolute moral ethic meant to bring people together and make them into one body, such that nobody could thereafter be violated. Similarly, John Locke, on the dignity of human beings wrote, "The people themselves are the lords and owners of their unique personalities." Therefore, human dignity is not connected to any law; it is an absolute value to which all people are entitled. It is given to all people regardless of whether it is stated in the positive law and also whether they are HIV positive or not.

The principal of respect for human dignity implies ethical values in a moral sense but, in the legal sense, it implies the pre-eminence of the principal of natural law and, in case of a practical constitution, it is called a legal
validation which is the norm. The sanctity of human dignity is an ideological starting point of every basic right and provides the hierarchy of rights, the supreme organizing principle of national order, the objective of constitutional principles. Article 21 of the Indian constitution provides for the right to life and protection of a person’s dignity, autonomy and privacy. Until the decision of the Supreme Court in Maneka Gandhi v/s Union of India, a rather narrow and constricted meaning was given to the guarantee embodied in Article 21. But in Maneka Gandhi’s case, a seven judge bench decision, held that the expression person’s dignity and liberty in Article 21 is of the widest amplitude and covers a variety of rights which go to constitute the person’s dignity and liberty and some of them have been raised to the status of distinct fundamental rights and given additional protection under Article 19.

The Court thus expanded the scope and ambit of the right to life enshrined in Article 21 and sowed the seeds for future development of the law enlarging this most fundamental of the fundamental rights. Thus the Maneka Gandhi case became the starting point for a very significant evolution of the law culminating in the decisions in many other cases.

When human rights are defined as congenital and based on human dignity, they take on permanence, transcend national borders and become absolute inviolable and non-removable. As principles or values they provide the basis for determining the validity of every statute and interpreting the content of every statute. Indeed, human dignity should be the starting point for any state in the formulation or interpretation of laws. T.H. Marshall claimed that human rights eventually become the prerogative of the citizenry, their political and social rights.

The Vienna Declaration especially emphasizes that "human rights are universal, indivisible and interdependent and interrelated". Civil, political, economic and cultural rights must consequently be treated in fair and equal manner and with the same emphasis. It follows from this affirmation that

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16. 1978, 1 SCC 248
while the significance of national and regional particularities and various historical, cultural and religious background must be borne in mind it is the duty of states to promote and protect all human rights and fundamental freedoms. It is consequently no less important that human rights issues be considered in a spirit of universality, objectivity, non-selectivity, interdependence and equality.

Most of the ideals and notions of human rights jurisprudence has been incorporated in our Constitution. The notion of equality in our Constitution flows from the 'Objective Resolution' moved by Pandit Jawaharlal Nehru on December 13, 1946. While moving the Resolution he said, “Words are magic things often enough, but even the magic of words sometimes cannot convey the magic of the human spirit and of a Nation's passion.......(The Resolution) seeks very feebly to tell the world of what we have thought or dreamt of so long, and what we now hope to achieve in the near future". Thus the tenet of ‘inclusiveness’ which is engrained in Indian society, nurtured over several generations is the underlying theme of our constitution. When society displays inclusiveness and understanding for all, every person can be assured of a life of dignity and non-discrimination. Our legal system does not permit the statutory law to be held captive by the popular misconceptions about the PLHAs and other marginalised groups.

HIV/AIDS Victims : Sufferers of Human Rights Denial

‘Discrimination and Stigma affecting HIV/AIDS victims is as detrimental as virus itself.’

UN Deputy Secretary General, Louise Frechette on World AIDS Day, 2007. Despite the passage of a quarter-century since the HIV/AIDS infection was diagnosed, the stigma that surrounds it has not subsided. The number of persons who became victims of this affliction has swelled to such staggering sums, that it has aroused a lot of hysterical fears and a number of controversies and ethical questions related to the patient’s rights, doctor’s rights and the rights of the public at large. While some people think that PLHAs should be

isolated in quarantines, alienated from the rest of the world, others find no reason for this harsh treatment and discrimination against the infected patients. The stigma associated with HIV/AIDS has silenced open discussion on, both its causes and appropriate responses. Visibility and openness about HIV/AIDS are prerequisites for the successful mobilization of government, communities and individuals to respond to the epidemic. Concealment encourages denial and delays urgent action. It causes people living with HIV/AIDS to be seen as a ‘problem’, rather than as a means to curtail and manage the epidemic.

As discussed by Mann\textsuperscript{20}, HIV epidemic exists in three phases. In the first phase, the HIV/AIDS epidemic enters a community silently, unnoticed and often develops over many years without being widely perceived or understood. The second phase is the epidemic itself, the syndrome of infectious diseases that can occur because of HIV infection but typically after a delay of number of years. The third phase is a response to HIV/AIDS and that revolves around the social, cultural and political issues, this phase has been described as the most explosive phase resulting from the reactions that are characterized by exceptionally high levels of stigma, discrimination and at times collective denial. As the infection is viewed as the responsibility of the individual, tainted by a religious belief as to its immorality\textsuperscript{21} and/or thought to be contracted via a morally sanctionable behaviour, not well understood by the general community and viewed negatively by health care providers\textsuperscript{22}.

HIV is a biologically complex virus, but this complexity pales in comparison to the complexity of the social forces involved in the production and reproduction of stigma in relation to HIV/AIDS. However, factors related to stigma, discrimination and denial are poorly understood, and a very few systematic attempts made to understand this complex problem. Each country has responded to the consequences of this epidemic in its own way. Stigmatization associated with HIV/AIDS is underpinned by many factors, including lack of understanding of the illness, misconceptions about transmission modes, lack of access to treatment, irresponsible media reporting on the epidemic, the incurability of AIDS, and prejudice and fears relating to a

\begin{itemize}
\item See Mann J. AIDS - A Global Perspective, West Journal of Medicine, 1987; p447-62.
\end{itemize}
number of socially sensitive issues including sexuality, disease and death and drug use. Stigma can lead to discrimination and other violations of human rights which affect the well-being of people living with HIV/AIDS. All over the world, there are well-documented cases of PLHAs being denied the right to healthcare, work, education and freedom of movement, among others. Responses to HIV/AIDS can be placed along a continuum of prevention, care and treatment, and the negative effects of stigma and discrimination can be seen on each of these aspects of the response. Ideally, people should be able to seek and receive voluntary and confidential counseling and testing to identify their HIV status without fear or repercussions. Those who test HIV-positive should receive available treatment and care, and preventive counseling to protect others from infection and themselves from other opportunistic infections. People living with HIV/AIDS should be able to live openly and experience compassion and support within their communities. Their open examples would personalize the risk and experience to others, thereby would aid in prevention, care and treatment efforts.

Globally, stigma and discrimination are associated with lower uptake of HIV-preventive services, including under or non participation in HIV information meetings and counseling\textsuperscript{23} and also reduced participation in programmes to prevent mother to child transmission of HIV\textsuperscript{24}. Stigmatizing attitudes are associated with denial of risk and a lower likelihood of adopting preventive behaviours. Both the fear of stigma and stigmatizing beliefs which perpetuate the notion that HIV happens to others – keep people away from HIV testing in numerous contexts.\textsuperscript{25} Disclosure of HIV sero-status is a key to outcomes ranging from condom use to care-seeking. Numerous studies have found stigma and discrimination adversely affect disclosure to partners, health care providers and family members. A study among Tanzanian persons living with HIV found only half of respondents had disclosed their status to intimate partners.\textsuperscript{26} Among those who disclosed, the average time from knowing to

\textsuperscript{24} See Nyblade and M L Field, Community involvement in prevention of MTCT Initiatives. Issues and Findings from Community Research in Zambia and Bostawana.2005, Washington: ICRW.
\textsuperscript{25} See Kalichman, S.C; Development of a Brief Scale to Measure AIDS-related Stigma in South Africa, AIDS and Behavior, 2005, 9(2),p-135-143.
\textsuperscript{26} Tanzania stigma-indicators field testing group, Measuring HIV Stigma: Results of a field test in Tanzania.2005, Synergy: Washington DC.
disclosure was 2.5 years for men and 4 years for women. Stigma contributed to delayed disclosure. Stigma also compels people to conceal medicines, which results in inconsistent doses. In a survey of more than 1000 healthcare professionals working directly with HIV patients in 4 Nigerian states, 43 percent observed others refusing a patient with HIV hospital admission. In Jamaica, researchers found that more than two-thirds of newly diagnosed AIDS cases in 2002 tested late in progression of their illness, a phenomenon linked to stigma and homophobia. The remaining cases were reported as deaths, indicating patients failed to seek care and support as their disease progressed. The shame associated with AIDS—a manifestation of stigma that has been described by some writers as ‘internalized’ stigma—may also prevent PLHAs from seeking treatment, care and support and exercising other rights, such as working, attending school, etc. Such shame can have a powerful psychological influence over how people with HIV see themselves and adjust to their status, making them vulnerable to blame, depression, self-imposed isolation and suicidal tendencies. This may be exacerbated in cases where individuals are members of particular groups that are already isolated and stigmatized, such as IDUs, MSM, CSWs or migrants etc.

These patterns of non-disclosure and difficulty in seeking treatment, care and support themselves fuel stigma and discrimination. The stereotype and fear are perpetuated, as communities often only recognize PLHAs when they are in the debilitating and symptomatic final stages of AIDS, and denial and silence reinforce the stigmatization of these already vulnerable individuals. Non-disclosure of HIV/AIDS infection within families often leads to lack of forward planning, leaving orphans and other bereaved dependents economically deprived and often marginalized, if their association with HIV/AIDS becomes known.

Conceptual Contours of the Stigma and Discrimination

In order to identify potential solutions to HIV/AIDS related stigma and discrimination, it is necessary to understand what is meant by these concepts, how they are manifested, and what is the relationships between them. Stigma may be approached from a phenomenal perspective. Stigma incorporates an acknowledgement of cultural values; it is a depiction of life as an individual experiences it within the social cultural milieu. In the context of HIV/AIDS, stigma is associated with the medical progression of opportunistic infections, moral transgressions of both homosexual and heterosexual relationships and afflictions transmitted through the notion of risky group as opposed to risky behaviour. These descriptions have led to the notions of ‘us’ and ‘they’ where the latter are stigmatized through the values and attitudes based on moral judgments rather than the medical aspects of the infection. Stigma has been described as a dynamic process of devaluation that ‘significantly discredits’ an individual in the eyes of others. The qualities to which stigma adheres can be quite arbitrary—for example, skin colour, manner of speaking, or sexual preference etc. Within particular cultures or settings, certain attributes are seized upon and defined by others as discrreditable or unworthy. HIV/AIDS related stigma is multi-layered, tending to build upon and reinforce negative connotations through the association of HIV/AIDS with already-marginalized behaviours, such as sex work, drug use, homosexual and transgender sexual practice. It also reinforces fears of outsiders and otherwise vulnerable groups, such as prisoners and migrants. Individuals living with HIV/AIDS are often believed to deserve their HIV positive status as a result of having done something “wrong and immoral”. By attributing blame to particular individuals and groups that are “different”, others can absolve themselves from acknowledging their own risk, confronting the problem and caring for those affected. Stigma is expressed in language. Since the beginning of the epidemic, the powerful metaphors associating HIV/AIDS with death, guilt, punishment, crime, horror and ‘otherness’ have compounded and legitimated

stigmatization. This kind of language derives from, and contributes to, another aspect underpinning blame and distancing: people’s fear of life-threatening illness. Fear-based stigma is attributable to people’s fear of the outcomes of HIV infection—in particular, the high fatality rates (especially where treatment is not widely accessible), fear related to transmission, or fear stemming from witnessing the visible debilitation of advanced AIDS.

Stigma is deeply rooted, operating within the values of everyday life. Although images associated with AIDS vary, they are patterned so as to ensure that AIDS related stigma plays into, and reinforces, social inequalities. These inequalities particularly include those linked to gender, race and ethnicity and sexuality. Thus, for example, men and women are often not dealt within the same way when infected or believed to be infected by HIV. A woman is more likely to be blamed even when the source of her infection is her husband, and infected women may be less likely to be accepted by their communities. This process is linked to long-standing gender inequalities underpinned by ideas about masculinity and femininity that have historically resulted in women being blamed for the transmission of sexually transmitted infections of all kinds, and have guilt imputed to them out of assumed ‘promiscuity’. Similarly, the attribution of blame to homosexual people builds on long-standing stigmatization related to assumptions about their lifestyles and sexual practices. Racial and ethnic stereotyping also perpetuates AIDS related stigma.32 The epidemic has been characterized, for example, by racist assumptions about ‘African sexuality’ and perceptions in the developing world of the west’s ‘immoral behavior’. Finally, the vulnerability of HIV/AIDS of communities living in poverty has reinforced the existing stigmatization of those people who are economically marginalized.

32. For an examination of the links between racism, stigma and discrimination, see http://www.unhchr.ch.
Through these associations, stigma is linked to power and domination throughout society as a whole, creating and reinforcing inequality whereby some groups are made to feel superior and others devalued. The association of HIV/AIDS with already stigmatized groups and practices intensifies these pre-existing inequalities, reinforcing the production and reproduction of inequitable power relations. Pre-existing stigma compounds HIV/AIDS related stigma, not simply because already-stigmatized groups are further stigmatized through association with HIV/AIDS, but also because individuals living with HIV may be assumed to belong to marginalized groups. HIV/AIDS related stigmatization, is a process that affects both those infected or suspected of being infected by HIV and those affected by HIV/AIDS by association, such as orphans or the children and families of people living with HIV/AIDS.

Stigmatization can also occur on another level. People living with HIV/AIDS may themselves internalize the negative responses and reactions of others. Such a process results in what some people have called self or

'internalized' stigmatization. Self-stigmatization has links to what some writers have described as 'felt', as opposed to 'enacted', stigma, in that it primarily affects an individual’s sense of pride and worth. For people living with HIV/AIDS, this may be manifested in feelings of shame, self-blame and worthlessness which, combined with feelings of being isolated from society, can lead to depression, self-imposed withdrawal and even suicidal feelings. When stigma is acted upon, the result is discrimination. Discrimination consists of actions or omissions that are derived from stigma and directed towards those individuals who are stigmatized. The UNAIDS Protocol for Identification of Discrimination Against People Living with HIV\(^3\) refers to discrimination as any form of arbitrary distinction, exclusion, or restriction affecting a person, usually but not only by virtue of an inherent personal characteristic or perceived belonging to a particular group-in the case of HIV/AIDS, a person’s confirmed or suspected HIV-positive status-irrespective of whether or not there is any justification for these measures.

HIV/AIDS related discrimination may occur at various levels like in family and community settings, which has been described by some writers as ‘enacted stigma’. This is what individuals do either deliberately or by omission so as to harm others and deny to them services or entitlements. Examples of this kind of discrimination against people living with HIV include: ostracization, such forcing women to return to their kin upon being diagnosed HIV-positive, following the first signs of illness, or after their partners have died of AIDS; shunning and avoiding everyday contact; physical violence; verbal discrediting and blaming; gossip; and denial of traditional funeral rites. Then there is discrimination occurring in institutional settings—in particular, in workplaces, health-care services, prisons, educational institutions\(^3\) and social-welfare settings. Extended forms of discrimination

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34. Protocol for the identification of discrimination against people living with HIV (UNAIDS) 2001. This protocol has been designed for two reasons:

(i) The identification of different forms of arbitrary discrimination, with a view to eliminate them, helps to respect, fulfill and protect human rights. This is an important goal in its own right, as recognized by the ongoing attention and deep commitment to human rights, across national and international communities.

(ii) Identification and elimination of arbitrary discrimination is an imperative in the control of HIV/AIDS. In this field, public health and human rights do not conflict with each other: instead, public health interests provide an additional and compelling justification for identifying and eliminating arbitrary discrimination on the grounds of HIV/AIDS status.

35. Two HIV-positive orphan children, Bency and Benson in Kerala were banished from their school and were denied admission. With the intervention of President of India, Dr. APJ Kalam, Union Health
against people living with HIV/AIDS within the health-care services include reduced standard of care, denial of access to care and treatment, HIV testing without consent, breaches of confidentiality including identifying someone as HIV-positive to relatives and outside agencies, negative attitudes and degrading practices by health-care workers. Discrimination at workplace results in the denial of employment based on HIV-positive status, compulsory HIV testing, exclusion of HIV-positive individuals from pension schemes, early retirement or medical benefits. In schools it leads to denial of entry to HIV/AIDS affected children, or dismissal of teachers. In the prisons mandatory segregation of HIV-positive individuals and exclusion from collective activities are the most common examples of discriminatory practices.

At national level, discrimination can reflect stigma that has been officially sanctioned or legitimized through existing laws and policies, and enacted in practices and procedures. These may result in the further stigmatization of people living with HIV/AIDS and, in turn, legitimate discrimination. A significant number of countries, for example, have enacted legislation with a view to restricting the rights of HIV/AIDS affected individuals and groups. These actions include the compulsory screening and testing of groups and individuals; the prohibition of people living with HIV from certain occupations and types of employment; isolation, detection and compulsory medical examination, treatment of infected persons, limitations on international travel and migration including mandatory HIV testing for those seeking work permits and the deportation of HIV-positive foreigners etc. Discrimination also occurs through omission, such as the absence of, or failure

36. A pregnant HIV-positive woman was denied treatment at government hospital Meerut (U.P.). Her husband was forced to perform the delivery after refusal by the hospital authorities. See The Tribune, 28th June, 2007.
37. An AIDS patient, Nitai Adhikary from west Midnapore, Kolkata was denied treatment and driven out of the hospital by the employees. He died after two months. (The Times of India, 29th May 2007) In a similar incident, Mohan an AIDS patient, discarded by family was lying unattended in the open outside local general hospital for past four months crying for mercy death. There he was bitten by stray dogs several times. See The Tribune, November, 2007 Fatehabad, Haryana.
38. The life insurance company (LIC) of India has added the HIV antibody test to the list of medical tests required for a policy application. PLHAs are denied life insurance on the grounds that it is supposed to cover "risk of loss" rather than actual loss. Since there is no effective treatment for HIV, the risk of loss of life is taken as "definite", compound to cancer or heart disease, for which there are well established medical interventions.
to implement laws, policies and procedures that offer redress and safeguard the rights of people living with HIV/AIDS.

Overcoming discrimination and stigma attached to HIV/AIDS is one of the most serious challenges of our time. Stigma is a catalyst for HIV transmission which needlessly increases the personal sufferings associated with the disease. In the year 2007 the World AIDS Campaign adopted the slogan...Live and Let Live, Stigma and Discrimination39......challenging the international community to speak up about the disease with pride rather than shame and to break down the walls of stigma and discrimination. It is obvious that shame and discrimination are the two feelings that PLHAs are unwillingly facing within their societies which enforces on them “social death which speeds up the actual physical death.”

**Stigma and Discrimination and Human rights: An Intimate Connection.**

Stigma and discrimination are interrelated, reinforcing and legitimizing each other. Stigma lies at the root of discriminatory actions, leading people to engage in actions or omissions that harm or deny services or entitlements to others. Discrimination is a violation of human rights. 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, inter alia, prohibit discrimination based on race, colour, sex, language, religion, political, opinion, property, birth or other status. Furthermore, the United Nations Commission on Human Rights has resolved that the term ‘or other status’ used in several human rights instruments ‘should be interpreted to encompass health status, including HIV/AIDS’, and that discrimination on the basis of actual or presumed HIV positive status is prohibited by existing human rights standards. Stigmatizing and discriminatory actions, therefore, violate the fundamental human right to freedom from discrimination. In addition to being a violation of human rights in itself, discrimination directed at people living with HIV/AIDS or those believed to be HIV infected, leads to the violation of other human rights, such as the rights to health, dignity, privacy, equality before the law, and freedom from inhuman, degrading treatment or punishment. A social environment

which promotes violations of human rights may, in turn, legitimate stigma and discrimination.

The Cycle of Stigma, Discrimination and Human Rights Violations

The violation of human rights encapsulated in discrimination increases the impact of the epidemic on people living with HIV/AIDS and those presumed to be infected, as well as their families and associates. For example, a person who is dismissed from his or her job because of being HIV-positive, beyond his illness, is faced with many additional problems, including lack of economic resources for his health care, as well as for the dependent family. People are more vulnerable to infection when their civil, political, economic, social or cultural rights are not respected. For example, women’s vulnerability to HIV infection is enhanced where they do not have the legal power to make choices in their lives and to refuse unwanted sex; or where children cannot realize their rights to education and information. Further, lack of access to appropriate HIV prevention and AIDS care services increases the vulnerability of other marginalized groups such as injecting drug users, refugees, migrants and prisoners etc.

Such stigma and discrimination and their consequential human rights violations may be addressed through the use of existing human rights mechanisms. As it provides a basis for accountability and an avenue for enforcing the rights of people living with HIV/AIDS and affected by it through procedural, institutional and monitoring mechanisms. The international human rights principles, provide a coherent, normative
framework to analyze and redress HIV/AIDS related discrimination. Under the human rights regime states are responsible and accountable, not only for the direct or indirect violation of rights, but also for ensuring that individuals can realize their rights as fully as possible. The International Guidelines on HIV/AIDS and Human Rights, clarify the obligations of states contained in existing human rights instruments and their application in context of HIV/AIDS.

The intimate connection between stigma, discrimination and human rights violations, requires simultaneous, multi-pronged and sustained action. In order to create an environment in which human rights violations of HIV/AIDS victims are no longer tolerated or practised, the implementation of programmes needs to be proactive in addressing stigma before it is manifested or enacted in various kinds of discriminatory action, rather than merely responding to it after it has occurred. The states have to develop and implement the laws and policies to protect the HIV/AIDS victims against discrimination. These approaches are interdependent and mutually reinforcing as responses in one setting (e.g., in health-care) may have consequences for the way in which people react in others (e.g., at home). As a tool for tackling stigma and discrimination, legal and policy reforms have limited impact unless supported by the values and expectations of communities and society as a whole. Regulation of the discriminatory actions that are the outcome of stigma, without addressing the understanding and attitudes that give rise to such actions, leads inevitably to an inadequate response. Stigmatization frequently occurs in contexts and settings not regulated by legislation, such as within families and everyday social encounters. An urgent action is needed in these environments to combat its occurrence.

Legal and policy reform have an important role to play in changing broader social values and in setting standards, both of which may lead to reduction of stigmatization and discrimination in community and institutional settings and for the development and implementation of effective HIV/AIDS prevention

41. These include the Universal Declaration on Human Rights; the Convention Against Torture, Inhuman and Degrading Treatment; the International Covenant on Civil and Political Rights; the International Covenant on Economic, Social and Cultural Rights; the International Convention on Elimination of All Forms of Discrimination Against Women; and the Convention on the Rights of the Child.
and care programmes. Overall, freedom from discrimination empowers individuals and communities to act, mobilize their resources, and respond collectively and positively to the HIV epidemic. Ultimately, stigma, discrimination and human rights provide three key entry points for successful work: preventing stigma, challenging discrimination and promoting and protecting human rights, including monitoring and redressing human rights violations.

**HIV/AIDS – A Human Rights Issue**

For many years the focus was on the medical implications of the epidemic, especially the search for cure and a vaccine. As these proved hard to find, the emphasis shifted to prevention. These approaches are necessary, but they should be pursued in parallel with the protection of the human rights of all infected and affected by the epidemic. A rights-based approach is the need of the day. As the number of people living with HIV/AIDS continues to grow all over the globe. The HIV/AIDS related human rights issues are not only becoming more apparent, but also becoming increasingly diverse. It is pertinent to find out that why has the epidemic spread so inexorably across the globe and why have countries failed to act- or acted so ineffectually- to stop the epidemic from progressing?. It has been acknowledged from the very beginning that HIV/AIDS is fundamentally tied to human rights abuses. But such acknowledgement has had surprisingly little impact on the global response to the epidemic, and this failure explains, to a large extent, why so little progress has been made in combating the disease.

HIV/AIDS epidemic is commonly thought to be related to “economic, social, and cultural rights”, as opposed to “civil and political rights”. However, many of the human rights abuses that increase HIV related violence, discrimination, harassment and imprisonment and censorship of health information are abuses of civil and political rights. The fact that these abuses

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42. “AIDS is no longer just a disease. It is a human rights issue.”-Nelson Mandela.

43. A rights-based approach implies being guided by the needs and rights of the community while simultaneously empowering those same communities to broaden their participation and strengthen their relationships with law, policy makers and partner organizations. Adapted from mainstreaming HIV/AIDS using community led Rights-Based Approach, ACCORD, Tanzania (www.acord.org).

have concrete impact on the health of individuals underscores what has been called the “indivisibility” of human rights norms i.e the notion that civil and political rights and economic, social, and cultural rights are mutually reinforcing and derive from a single principle: the fundamental dignity of each human being. In the 1980's, the relationship between HIV/AIDS and human rights was mainly understood as it was analyzed in the context of discrimination to which PLHAs are subjected. For PLHAs, the human rights concerns include mandatory HIV testing; restriction on international travel; barriers to employment and housing, access to education, medical care, health insurance and many other issues raised by names reporting, partner notification and confidentiality. These issues are grave, and almost 20 years into the epidemic, they have not been resolved. In some ways, situation has become even more complicated, as old issues appear in new places and present themselves in different ways like feminization of HIV/AIDS, problem of missing generations, responsibility towards AIDS orphans, recognizing the negative impact of the epidemic on economies of the nations.

The strong focus on such issues led to increased understanding of the importance of human rights for the people infected and affected by HIV/AIDS. The UN High Level Meeting in 2006, reaffirmed that “the full realization of all human rights and fundamental freedoms for all is an essential element in the global response to the HIV/AIDS pandemic.” It has been affirmed that human rights should occupy the center of the global struggle against HIV/AIDS. However this “essential element” remains a missing piece in the fight against the epidemic. HIV/AIDS victims suffer from violations of their rights when, for example, they face government condoned marginalization and discrimination in relation to access to health, education, and social services. Again, people are affected by HIV/AIDS when the structures and services that exist for their benefit are strained by the consequences of the pandemic and as a result fail to provide them with the support and services they need. These effects of the epidemic on people’s lives may be compounded by marginalization and stigmatization on the basis

of such attributes as race, migrant status, behaviors, or kinship that may be perceived as risk factors for HIV/AIDS infection. People affected by HIV/AIDS may progress toward the realization of their rights and better health if the enabling conditions exist to alleviate the impacts of personal, societal, and programmatic issues on their lives. This requires policies and programs designed to extend support and services to affected families and communities. Most perversely, the basic understandings are not reflected in law or in concrete policy terms which can provide non-discriminatory access within a supportive social environment for realization of rights of HIV/AIDS victims.

Children orphaned by HIV/AIDS illustrate this need.

Vulnerability to HIV/AIDS increases with the lack of power of individuals and communities to minimize or modulate their risk of exposure to HIV/AIDS infection and, once infected, to receive adequate care and support. Even in populations where HIV/AIDS has not spread widely, some individuals may be more vulnerable than others with regard to HIV. For example, gender and/or economic inequality may force a monogamous woman to engage in unprotected sex with her spouse, even if he is engaging in sex with others. Adolescent girls and boys may be vulnerable to HIV by being denied access to preventive information, education, and services. Mobile population’s vulnerability to HIV may be exacerbated by peer pressure to engage in multiple unprotected sexual encounters. Sex workers may have greater vulnerability to HIV if they cannot access services to prevent, diagnose, and treat sexually transmitted infections, particularly if they are afraid to come forward because of the stigma associated with their occupation. Reduction of vulnerability requires actions that enable individuals and communities to make choices in their lives and thereby effectively modulate the health risks to which they may be exposed.

Several years of experience in addressing the HIV/AIDS epidemic have confirmed that the protection and promotion of human rights is necessary for the protection of the inherent dignity of persons, the achievement of the public health goals of reducing vulnerability to infection, lessening the adverse impact of HIV/AIDS on those affected and empowering individuals and communities to respond effectively to HIV/AIDS. Furthermore, there is growing international consensus that a broadly based, inclusive response,
involving PLHAs in all its aspects, is a main feature of successful HIV prevention programmes. Another essential component of comprehensive response is the facilitation and creation of a supportive legal and ethical environment which is protective of human rights. This requires measures to ensure that governments, communities and individuals respect human rights and human dignity and act in a spirit of tolerance, compassion and solidarity. Since 1989 various UN agencies have called for drastic improvements as well as operationalisation of human rights of PLHAs exclusively. The first International Consultation on AIDS and Human Rights was organized by the United National Centre for Human rights in cooperation with the WHO which in the fifty-first session highlighted the need for guidelines that outline clearly how human rights standards apply in the area of HIV/AIDS. Such guidelines indicate concrete and specific measures, both in terms of legislation and practice to tackle widespread discrimination and victimization as well as overt gender-based violence to which vulnerable communities are subjected. The most significant step which occupied the center of the global struggle against HIV/AIDS and human rights violations of PLHAs was the adoption of the International Guidelines on HIV/AIDS and Human Rights, 2001. The key human rights principles linked to effective responses to HIV are recognized in almost all important international, regional and local human rights instruments. In addition both national and regional courts like the European Court of Human Rights, the African Court of Human and People’s Rights, the Inter-American Court of Human Rights etc have advocated for the protection of human rights of HIV/AIDS victims.

In context of HIV/AIDS, the UN Commission on Human Rights resolutions have stated quite unequivocally that the term “or other status” in

48. These Guidelines have been discussed in detail in Chapter-4.
49. Such as the Universal Declaration of Human Rights, the International Covenants on Economic, Social and Cultural Rights and on Civil and Political Rights, the International Convention on the Elimination of All Forms of Racial Discrimination, the Convention on the Elimination of All Forms of Discrimination against Women, the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment and the Convention on the Rights of the Child. Regional instruments, namely the American Convention for the Protection of Human Rights and Fundamental Freedoms and the European Convention on Human Rights, the African Charter on Human and People’s Rights also enshrine State obligations applicable to HIV. In addition, a number of conventions and recommendations of the International Labour Organization and WHO are particularly relevant instruments which highlights concerns regarding discrimination arising due to HIV/AIDS.
50. Herein after to be reffered as ECHR. It was established by the European Convention on Human Rights.
non-discriminatory provisions in international human rights texts should be interpreted to cover health status, including HIV/AIDS. The Commission has moreover, confirmed that “discrimination on the basis of HIV/AIDS status, actual or presumed, is prohibited by existing human rights standards.” The Human Rights Committee has also reiterated that the right to equal protection of the law prohibits discrimination in law or in practice in all fields regulated and protected by public authorities and that a difference in treatment is not necessarily discriminatory if it is based upon reasonable and objective criteria. The prohibition against discrimination thus requires States to review and, if necessary, repeal or amend their laws, policies and practices to proscribe differential treatment which is based on arbitrary HIV-related criteria.

Due to the integration of human rights approach in the fight against HIV/AIDS there is now an international consensus on identifying and eliminating arbitrary discrimination on the grounds of HIV/AIDS status. The non-compliance with human rights obligations by a state can lead to sanctions against it. A number of the international treaties, including the International Covenant on Civil and Political Rights also require participating States to submit periodic country reports to their monitoring committees and after review of the report, to appear at a face-to-face session with the concerned committee to ensure the protection of human rights of HIV/AIDS victims. Following this exercise, the United Nations publishes the committee’s ‘Concluding Observations and Recommendations’. Several of these committees also allow NGO’s to submit ‘shadow’ country reports, providing HIV/AIDS organizations with an opportunity to bring evidence of stigmatization and discrimination before these particular committees.

The States are obliged to protect individuals from discrimination not only by public authorities, but also by the private sector and private individuals in public activities. Initially, anti-discrimination legislation in various countries was confined to laws against discrimination on the grounds of race, sex, ethnic

52. Other groups singled out for discriminatory measures in the context of HIV, such as mandatory screening, are the military, the police, peacekeeping forces, pregnant women, hospital patients, tourists, performers, people with haemophilia, tuberculosis or sexually transmitted diseases (STDs), truck drivers and scholarship-holders. Their partners, families, friends and care providers may also be subject to discrimination based on presumed HIV status.
Disability discrimination came into focus much later. The development of anti-discrimination protection concerning disability arose as various groups within the disability movement developed a strong focus on rights, such as the right to life, equal treatment and non-discrimination. The recognition of such rights has formed the basis of anti-discrimination legislation protecting the disabled. Many States like U.S., U.K, Australia and Hongkong have expanded their interpretations of disability to include HIV status and protect PLHAs from discrimination in both the public and private sectors. Several other countries, such as Canada and Russia have constitutional guarantees of human rights with practical enforcement mechanism.\(^{54}\)

Right to non-discrimination can be justifiably restricted only in certain narrowly defined circumstances in the interests of a limited number of overriding goals (i.e., restricting donation of blood by those who have been confirmed HIV-positive or who have recently returned from a high-prevalence area).\(^{55}\) But simply justifying a discriminatory measure as necessary for public health aspect as is often done in the context of HIV/AIDS is not sufficient. It must satisfy two important criteria.\(^{56}\) Firstly, the measure must be taken in the interest of a legitimate objective like public health, the rights of others, morality, public order, and national security etc. Secondly in assessing the measure, its objective or purpose should be taken into consideration which is usually safeguarding public health, bearing in mind the limited range of modes of transmission of the virus. Thus, for example, it may be legitimate to impose a HIV test on blood donors. On the other hand, and for the same reasons, it is not legitimate to impose generalized screening at recruitment for work or in the work place. Similarly, while communication by doctors to the authorities of the number of people with HIV/AIDS in a strictly anonymous manner and on the basis of voluntary tests, for the purpose of establishing

\(^{54}\) Major disability laws include The Americans with Disabilities Act, 1990 [Herienafter: ADA], Disability Discrimination Act, 1992 in Australia, the Disability Discrimination Act, 1995 in the United Kingdom and the Hong Kong Disability Discrimination Ordinance, 1995. Russia, Kazakhstan, the Philippines and Vietnam have HIV-specific statutes, which cover a variety of issues including discrimination.

\(^{55}\) Under international human rights law, some rights-including the right to life and freedom from torture-cannot be restricted under any circumstances.

\(^{56}\) Where a restriction is State-imposed, international human rights law requires an additional, third criterion to be met: the restriction must be provided for and carried out in accordance with law. This means that the restriction must be according to specific legislation, which is clear, precise and accessible, in order that it is reasonably foreseeable that individuals will regulate their conduct in accordance therewith.
statistics may be legitimate. But communication of this information to the Ministry of Health without regard for anonymity and informed consent is not. Even when a measure is for a legitimate objective, the means employed to achieve it must be proportionate to the aim pursued. They should constitute the least restrictive means available. Similarly, police round-ups and mandatory testing of sex workers is a disproportionate measure. In short, a measure that stigmatizes people with HIV/AIDS will not be effective in relation to pursuit of the objective of safeguarding public health. The strategy to control this disease must be based principally based on prevention, and promotion of personal responsibility, as well as on care and health support. Coercive or punitive or discriminatory approaches aimed at identification and/or compulsory treatment of all people with HIV/AIDS, or suspected of it, hamper the remedial measures.

The stigma and discrimination related to HIV/AIDS status contributes to the spread of the disease and destabilize the attempts to arrest it. The susceptibility of the people to HIV/AIDS also increases due to human rights violations like poverty, inequality, violence and sexism. Equally, both the national and international experience have shown that a human rights approach reinforces the effectiveness of HIV/AIDS specific responses. Since the creation of the World Health Organization's Global Programme on AIDS in 1980, a number of international human rights standards require the states to protect the rights of the adults as well as of the children having a linkage to the epidemic. Two prominent rights in this regard are the right to the highest attainable standard of health including reproductive and sexual

57. For historical account of recognition of the importance of human rights in the fight against HIV/AIDS see "HIV/AIDS and human rights international guidelines," OHCHR and UNAIDS, 1996, Annex I, pp. 52-54
58. Article 24 of the convention on the Rights of the Child, 1989 requires governments to: "recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for treatment of illness and rehabilitation of health" the committee on the Rights of the Child issued General comment 3 on HIV/AIDS and the rights of the child and general comment 4 on adolescent health and development too reflected upon the implications of HIV/AIDS for the younger generations. The committee also stated that discrimination against adolescents on the basis of sexual orientation or HIV status is not acceptable.
59. The right to health for everyone was promulgated as a core value of the constitution of the world health organization at its establishment in 1946: "the enjoyment of the highest attainable standard of health is one of the fundamental rights, the international covenant on Economic, social and cultural rights; Vienna declaration and program of action, 1993; the convention on the elimination of all forms of discrimination against women etc.
60. A number of international agreements and standards address women's sexual and reproductive health rights. The Cairo Programme of action adopted at the international conference on population and development, 1994 addressed sexually transmitted diseases and the prevention of HIV from the perspective of women's vulnerability to the epidemic. It also set out key recommendation for addressing HIV through reproductive health services. The Beijing Declaration and platform for Action
health\(^{61}\) and the right to freedom from discrimination\(^{62}\) plus protection from violence\(^{63}\). Some other important rights having close relationship with the HIV/AIDS epidemic include the right to expression and information, right to liberty of movement, right to seek and enjoy asylum, right to participate in public affairs\(^{64}\) and cultural life\(^{65}\), right to liberty and security of person, education, work\(^{66}\), found a family\(^{67}\), right to privacy\(^{68}\), right to social security\(^{69}\), freedom from cruel, inhuman or degrading treatment and right to enjoy the benefits of scientific knowledge.\(^{70}\)

Besides all UN member states are obliged to take joint and separate action for the purposes of achieving universal respect for and observance of human rights and fundamental freedoms for all without any distinction.\(^{71}\)

Stigmatization of PLHAs leads to severe social consequences related to their rights, health care services, freedom, self-identity and social interaction. PLHAs are discriminated because their illness is associated with behaviours that are not acceptable by society, both as a product and producer of such behaviour.\(^{72}\) It is viewed as the responsibility of the individual, tainted by religious belief as to its immorality, not well understood by the general community and viewed negatively by health care providers. According to an

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61. The sexual rights include the right of all persons to the highest attainable standard of health in relation to sexuality, including access to sexual and reproductive health care services; to seek, receive and impart information in relation to sexuality; to have access to sexuality education; and other related rights.

62. See, CEDAW and DEVAW. The principle of non-discrimination in international human rights law attaches to distinctions "of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status". The term 'other status has been interpreted to include factors which "can affect individuals' ability to exercise their rights" such as health status including sexual orientation and HIV/AIDS.

63. The special Rapporteur on the right to health, Paul Hunt, has underline the effect of discrimination on gender grounds when addressing women's rights to sexual and reproductive health in these terms, 'discrimination based on gender hinders women's ability to protect themselves from HIV infection and to respond to the consequences of HIV infection. The vulnerability of women and girl to HIV and AIDS is compounded by other human rights issues including inadequate access to information, education and services necessary to ensure sexual health; sexual violence; harmful traditional or customary practices affecting the health of women and children (such as early and forced marriage); and lack of legal capacity and equality in areas such as marriage and divorce.'

64. Article 25 of the UN Covenant on Civil and Political Rights.

65. Article 15 of the UN Covenant on Economic, Social and Cultural Rights.


67. Article 15 of Universal Declaration of Human rights.

68. Article 17 of the Covenant on Civil and Political rights.


70. For detailed analysis of such rights see United Nations "HIV/AIDS and human rights international guidelines."

71. The Universal Declaration of Human rights states that "everyone, as a member of society... is entitled to realization, through national effort and international cooperation and in accordance with the organization and resources of each state, of the economic, social and cultural rights indispensable for his dignity and the development of his well-being.

72. See Green G.; Attitudes towards people with HIV: Are they as stigmatizing as people with HIV perceive them, Social Science Medical Journal 1999; 41: 557-68.
opinion poll conducted in US among Americans, it was observed, 'it's people's own fault if they get AIDS'. Such responses disrupt an individual's social interactions and thereby lead to a feeling of isolation. AIDS also evokes anxiety because of its association with death. People in AIDS group reported lower levels of social support in response to bereavement, as compared to those in cancer group indicating the social stigma attached to HIV/AIDS that does not get erased even after death. As a result of the social impact of HIV/AIDS epidemic, studies on HIV/AIDS related stigma have been conducted globally, especially in Europe, US, Australia, Africa and Asia including India to document the forms of the stigma and the resulting discrimination in varied settings, particularly in health care setting. These studies attempt to understand the complexity of stigma using both qualitative and quantitative research approaches.

A study has shown that a wide range of feeling exhibited by clinicians about HIV positive who often made moral and non clinical attributions about individuals' past "misbehaviour," and "misconduct". A few providers reported fear of touching HIV/AIDS patients, while others reported that disclosure about patient’s status often occur without the patient’s knowledge, consent or counseling, hospital practices, such as a separate AIDS ward, HIV diagnoses on open charts, and the conspicuous use of biohazard labels serve to discriminate HIV/AIDS patients; and hospital policy is often unclear to clinicians and the hospital practices often have discriminatory consequences. Such inconsistent knowledge, beliefs and standards of care for HIV positive patients by hospital staff should urgently be addressed through comprehensive training to focus on HIV/AIDS care standards, universal safety precautions, patients' sensitivity and modified standards.

As a result of collaborative efforts of Yale University, USA and NARI, Pune, India, for the first time an implicit association Test (IAT) has been developed to measure stigma associated with HIV/AIDS as a fatal disease or
as a sexually transmitted disease or as an infectious disease.76 This test specifically suits Indian culture. It is a self administered test, designed to examine thoughts and unconscious feelings of health care providers that exist while treating patients with HIV/AIDS. The IAT is mainly used to assess attitudes related to race and gender issues in the western countries, and reveal the existence of discrepancy between our implicit and explicit attitudes. Once this method is standardized, it would serve as a useful tool to measure HIV/AIDS stigma in other settings also.

HIV/AIDS stigma and discrimination exists at both individual and societal levels, and all attempts to eradicate the stigma and discrimination need to target at these two levels. It is imperative to design intervention and education programme to impart information for individuals at varied levels to reduce the stigma attached to HIV/AIDS. There is an urgent need that the public policies address issues of treatment and prevention to reduce the stigma attached to HIV/AIDS and also to establish social norms based on acceptance and respect for HIV infected persons. Initiatives in this direction have been made across all continents, keeping in mind the foremost issue of human rights that includes by its very definition social acceptance, respect, compassion and support without blame. A change in attitudes of service providers through greater knowledge and political will is considered as the most significant approach to challenge the existing stigma in health care settings and in the community as well. Emphasis on the eradication of HIV/AIDS related stigma and discrimination would enable in creating a social climate conducive to a rational, effective and compassionate response to this epidemic.77 Public health managers and the government need to address the various types of HIV/AIDS stigmatization78 mainly the theologically/morally based blame on those who are infected.

The human rights approach would prove to be a long term investment for preventing HIV/AIDS related stigma and discrimination. It would bring a better understanding of the rights of the individual, who is at risk of exposure and condemnation because of stigma, and the rights of the rest of the society

77. GIPA World AIDS Day 2004: Project for personal stories from PLHAs. See http:www.gnpplus.net.
for the development of large scale effective administrative, legal and public health programmes. It would emphasize on minimizing the erosion of the social, economic, cultural and political impact of the HIV/AIDS pandemic. Further it would curtail the spread of infection; reduce people’s vulnerability to HIV; and promote community and family based care to HIV/AIDS cases in an enabling environment without any stigmatization and discrimination.\(^79\)

Realizing the importance of this approach, United Nations framed its public health policy in human rights terms which was anchored in international law through treaties and declarations such as the Universal Declaration of Human Rights and other tools like the International Guidelines on HIV/AIDS and Human Rights\(^80\) and the Declaration of Commitment on HIV/AIDS\(^81\) etc as these standards are extremely important in defining connections between HIV/AIDS and human rights. The groundbreaking contribution of this era lies in the recognition of the applicability of international human rights to HIV/AIDS and therefore to the ultimate responsibility and accountability of the state under international law for issues relating to rights, health and well being of the individuals. A framework with following elements is required in dealing with HIV/AIDS related discrimination: accountability, advocacy, approaches to programming.

*Accountability:* Governments are responsible for promoting and protecting both public health and human rights. None of the international human treaties specifically mentions HIV or the rights of individuals in the context of HIV/AIDS, yet all international human rights mechanisms responsible for monitoring government action have expressed their commitment to explore the implications of HIV/AIDS for governmental obligations. In the past several years increasing attention has been paid to HIV/AIDS in government reports on their human rights obligations. Governments' obligations towards

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80. The International Guidelines on HIV/AIDS and Human Rights identify actions that governments should take to identify actions that governments should take to respond to HIV/AIDS based on their agreed to obligations arising from international human rights level. The guidelines were developed through a consultative and participatory process involving government representatives, human rights advocates and PLHAs. Although the guidelines do not have the legal status of a treaty, they have legitimacy and governments are urged to adopt them.
81. The Declaration of Commitment on HIV/AIDS was adopted at UN General Assembly special session in 2001. Such declarations are not "binding" but they do show how the international communities are thinking about these issues. Further, they establish standards for each government to measure its policies and actions against it.
human rights are understood in three ways: obligations to respect rights, protect rights and fulfill rights.

To respect a right means that a government cannot violate human rights directly in laws, policies, programmes or practices. For example, governments cannot arbitrarily deny HIV infected prisoners the same standard of medical care that is offered to other prisoners. To protect a right the governments must prevent violations by others and provide affordable and accessible redress. States must ensure that private employers do not discriminate against HIV infected employees and provide avenues for redress if they are fired because of their HIV status. To fulfill a right means that governments must take measures that move towards the realization of rights. These measures should be legislative, administrative, budgetary and could include some other types of action also. For example a state may adopt a policy to provide antiretroviral treatment to all individuals in need, yet due to resource constraints it may be able to cover only a small percentage of the population. The government should take measures to progressively extend coverage i.e., soliciting support from donors and/or reassessing budget priorities. This is known as "progressive realization," and governments must move quickly and effectively toward the realization of all human rights.

The International Guidelines on HIV/AIDS and Human Rights is another important source for helping to hold governments accountable. The 12 Guidelines take existing human rights norms and mould them into a series of practical, concrete measures that states can adopt to respond to the HIV/AIDS epidemic. These guidelines attempt to translate international human rights standards into application at the national level by promoting reform of laws and legal support services; promoting governmental responsibility for multi-sectoral coordination and supporting involvement and participation of private and community sectors in the response.

82. The South African Human Rights commission was the first national human rights body in the world to publicly endorse and adopt the International Guidelines on HIV/AIDS and Human Rights. Further, the commission addressed HIV/AIDS as a human rights issue at its first national conference. The commission addressed HIV/AIDS as a human rights issue at its first national conference. One of the outcomes of the conference was a resolution stating that discrimination against PLHAs violated the South African constitution. This was made possible due to the efforts of the AIDS Law Project/AIDS Legal Network, South Africa that held the government accountable for upholding its political commitment in implementing the guidelines.
**Advocacy:** To raise awareness about the links between HIV/AIDS and human rights, human rights activists turn to advocacy. Advocacy often depends upon researching, documenting and then denouncing abuses through campaigns and published reports. Human rights groups and HIV/AIDS activists document human rights abuses related to HIV/AIDS like stigma, discrimination, denial and neglect and call attention to them. Advocacy can happen at international as well as national level. For example, activists can ask governments for information on how are they meeting targets under the Declaration of Commitment or how are they implementing the International Guidelines on HIV/AIDS and Human Rights in their programmes and policies?83

**Approaches to programming:** Human rights-based approaches to HIV/AIDS programming help realize human rights themselves as well as improve access to HIV/AIDS health care information, services and treatment. Policies, programs and responses are likely to be effective, sustainable, inclusive and more meaningful for people living with and affected by HIV/AIDS when they are based on the normative frame of international human rights. Human rights based approaches to HIV/AIDS integrate mechanisms for full participation and decision-making of affected communities, in order to promote the autonomy and empowerment of PLHAs. The first-hand experience and knowledge of people living with HIV/AIDS provides the expertise necessary to reduce stigma and discrimination in the design and implementation, as well as in the oversight of HIV/AIDS programmes.84

The links between stigma, discrimination and human rights must be more clearly recognized and acted upon because of several reasons. First,
because freedom from discrimination is a human right. There is already existing a framework for responsibility and accountability of action. This need not be created afresh within the context of HIV/AIDS. National governments are responsible and accountable not to directly or indirectly discriminate in law, policy or practice rather the obligation to protect requires them to take measures that prevent third parties from discriminating. The obligation to fulfill requires them to adopt appropriate legislative, budgetary, judicial, promotional and other measures to address discrimination and ensure that compensation is paid to those who suffer discrimination.

Second, a human rights framework enables access to procedural, institutional and other monitoring mechanisms for enforcing the rights of PLHAs and for countering and redressing discrimination. Since HIV/AIDS related discrimination leads to the commission of legal offences, persons who discriminate can be made accountable under the appropriate law and redress can be provided. Relevant procedural, institutional and other monitoring mechanisms exist at national, regional and international levels. At the national level these include the courts of law, national human rights commissions, ombudsmen, law commissions and other administrative tribunals etc.

Despite much rhetoric, real action on HIV/AIDS and human rights is still lacking. On paper the place of human rights in the response to HIV is well established. However, in practice, there have been few efforts at national level to secure legal and human rights protections for PLHAs. As of 2006, only one-third of countries worldwide had adopted legal measures outlawing discrimination against PLHAs. There has also been little investment in basic human rights initiatives such as legal campaigns for PLHAs, HIV related audit of national legislation and law enforcement; training in non discrimination, confidentiality and informed consent for health care workers, police, judges and social workers. An evaluation of implementation of the Declaration of Commitment on HIV/AIDS, undertaken in 2006 in 14 countries, concluded that “human rights abuses of vulnerable population continue unabated,

85. For example, the adoption of legislation to ensure equal access to health care and health related services provided by third parties, to control the marketing of medicines and medical equipment, and to ensure that medical practitioners and other health professionals meet appropriate standards of education, skill and ethical codes of conduct.
denying them access to services and effective tools for preventing HIV infection and to life saving AIDS drugs that will keep them alive.  

Given the close linkage between stigma, discrimination and human rights, it is important at all times to keep in mind the need for a multi-leveled complementary alleviation strategy that includes two facets. First, efforts to prevent the stigmatization of people and/or communities living with and affected by HIV/AIDS, and second, actions to address or redress the situation when stigma persists and is acted upon in the form of discriminatory actions that lead to negative consequences or the denial of entitlements or services to others, and thus human rights violations. Together with a new emphasis on community mobilization aimed at unleashing resistance to stigmatization and discrimination, structural interventions aimed at promoting a right-based approach to reducing HIV/AIDS related stigmatization and discrimination should be given high priority in future work. Only in this way a transformed social climate could be created in which stigmatization and discrimination would no longer be accepted or acceptable.

Non discrimination and health for all is an important item in the human rights agenda. Various constitutions guarantee these rights and the international covenants emphasize the point to enlarge its meaning and scope. It can be no longer be doubted that this is a basic human right which needs to be adequately and urgently addressed and protected. The goal of linking HIV/AIDS and human rights is to contribute to advancing human well-being. The HIV/AIDS is posing a serious threat to human development as it is spreading dangerously fast. Urgent strategies are needed to meet the threat. Such a resolve was made in the recent UN Millennium Summit Declaration but the need is to honour the pledge. Right against discrimination and torture is an aspect of ‘right to life’ guaranteed in the international instruments like Article 5 of the UDHR, Article 7 of ICCPR and the UN Convention Against Torture and other Cruel, Inhumane and Degrading Treatment and Punishment. India signed the treaty on 14 October 1997, “to uphold the greatest values of Indian civilization and our policy to work with other members of international community to promote and protect human rights.” However even after

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86. Realization of human rights and fundamental freedom for all is essential to reduce vulnerability to HIV/AIDS UNGASS on HIV/AIDS, DoC, 2006, para. 58
announcement of its intention to ratify the treaty, that ratification by India is still awaited. The World Health Organization also declares that ‘non discrimination and the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being’. The need is to emphasise on non discrimination, which is a wider concept encompassing ‘equality’ and also something more. Human rights in 21st century must beckon non discrimination, equality and justice. Nobel Prize Laureate, Elie Wiesel has observed that ‘one cannot, one must not, approach public health today without looking into human rights component.