CHAPTER - I

INTRODUCTION
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The existence and speedy spread of HIV and AIDS poses a serious challenge towards development of every nation across the globe. HIV and AIDS have the potential to damage the massive improvements that have been made in global health over the years. Apart from being a serious health problem, the multi layered consequences of the epidemic on the socio-economic fabric of whole nations, makes HIV /AIDS a potential development threat worldwide.

Beginning of its earliest days, the viral epidemic was accompanied by a social epidemic of comparable severity. Grounded in fear, ignorance, and social displeasure of groups heavily affected by HIV, the epidemic of stigma and discrimination commonly overwhelmed the ability and motivation of communities and countries to respond to HIV/AIDS. Throughout the counties people living with HIV frequently lost their jobs, homes, family, and access to health care or other public services. Recognizing the role of stigma and discrimination in blocking effective responses, Dr Jonathan Mann, the Head of the Global AIDS Programme at the World Health Organization (WHO) emphasized the need to protect the “human rights of people living with HIV”. In the first two decades of the epidemic, the countries that mounted the most successful responses recognized the need for strong measures to protect and promote the rights of people infected and affected by HIV. Yet many countries remained slow to accept this reality, with many failing to prohibit HIV-related discrimination. Indeed, laws and policies in many parts of the world institutionalized such discriminatory attitudes and practices. Dozens of countries imposed travel or entry restrictions on people living with HIV, many sought to criminalize HIV transmission or exposure, and leaders in different regions depicted people living with HIV as threats from which society needed to be protected. Although HIV is perhaps the most serious global health challenge of our time, it was clear from the earliest days that it was more than just a disease. It was quickly evident that social conditions have a profound effect on vulnerability to HIV; that the epidemic was undermining efforts to address poverty, hunger, and other health and development issues; and that economic conditions, social attitudes, and legal frameworks played a key role in a country’s ability to respond effectively. Taking account of the multi-dimensional nature of HIV and of the need for a genuinely multi-sectoral response, diverse
stakeholders in the global health and development fields determined that a new international response to HIV was essential. The world will be unable to achieve zero new HIV infections and zero AIDS-related deaths without achieving the third zero: eradicating discrimination by effectively addressing the harmful impact of stigma and discrimination, social and legal exclusion, and gender disparity.

1.1 HIV/AIDS and global scenario: An overview.

Thirty years ago in the United States, Centres for Disease Control and Prevention (CDC) declared the first official report of what would become known as the HIV epidemic. The initial CDC report gave little clue that the news foretold the most severe epidemic in modern times. Early signs of the disease were primarily confined to high-income countries, where new cases increased rapidly in the early 1980s. In reality, HIV had been spreading unnoticed for decades, especially in sub-Saharan Africa. Between 1981 and 2000, the number of people living with HIV rose from less than one million to an estimated 27.5 million [26–29 million]. HIV appeared at different times in diverse regions, but eventually came to affect every part of the world. From its early years, HIV gave rise to passionate community action to stalk the spread of infection and to care for those living with the virus. Yet despite the extent of the epidemic, the global community largely failed to respond during the epidemic’s first two decades. The present situation of global epidemic is 36.7 million [30.8 million–42.9 million] people were living with HIV at the end of 2016. Among the above 34.5 million [28.8 million–40.2 million] adults, 17.8 million [15.4 million–20.3 million] women (15+ years) 2.1 million [1.7 million–2.6 million] children (<15 years), (UNAIDS Factsheet 2017).

Although the burden of the epidemic continues to vary significantly between countries and regions, Sub-Saharan Africa remains most severely affected, with nearly 1 in every 20 adults (4.9%) living with HIV and accounting for 69% of the people living with HIV worldwide. Although the regional prevalence of HIV infection is nearly 25 times higher in sub-Saharan Africa in compare to Asia, almost 5 million people are living with HIV in South, South-East and East Asia combined. After sub-Saharan Africa, the regions most heavily affected are the Asia Pacific (5.1 million), Latin America (1.8 million) in 2016.
Global efforts to reinforce HIV prevention and treatment programmes are also shown the result of reduce in transmission of HIV. Since 2010, the annual number of new HIV infections (all ages) has declined by 16% to 1.8 million [1.6 million–2.1 million]. The pace of decline in new HIV infections, however, this is faraway to reach the Fast-Track Target agreed upon by the United Nations General Assembly in 2016: fewer than 500 000 new infections per year by 2020.

The pace of decline varied by age group and between men and women. Among children, new infections have declined 47% since 2010, while coverage of antiretroviral medicines provided to pregnant women living with HIV to prevent transmission to their children rose from 47% [38–55%] to 76% [60–88%] over the same period. Differences in the number of new HIV infections between men and women are more pronounced at younger ages: in 2016, new infections among young women (aged 15 – 24 years) were 44% higher than they were among men in the same age group. Since 2010, new infections among young women globally (aged 15–24 years) have declined by 17%, reaching 360 000 [210 000–470 000] in 2016. New infections also declined among young men (aged 15–24 years) during that time, falling by 16% to 250 000 [110 000–320 000] in 2016 (UNAIDS Factsheet 2017).

The result of the research conducted nine countries among the People Living with HIV Stigma Index, its reveals that in Rwandan 53% PLWHA (People living with HIV/AIDS) have been verbally insulted, in rural Zambia 33% of the PLWHA have experienced physical violence, and in Rwandan 65% PLWHA lost a job or income. Moreover, it has reported from the various countries the WLWHA (women living with HIV/AIDS) that basic rights of sexual and reproductive health has been denied. Almost 20% of women from Namibia reported that they had been coerced or forced into sterilization. Such deep-rooted social banishment and discriminatory actions discourage many people specially women from being tested for HIV or seeking other essential health care services. Detrimental social and gender norms further weaken HIV responses by underpin gender disparity and deepening the vulnerability of women and girls. In some countries, majority (60%) of women have experienced physical or sexual violence from their spouse or co-resident partner. In South Africa young women experienced an increase of intimate partner violence once after detection of HIV infection, while gender inequality within a relationship
increases the risk by 13.9%. UNAIDS (United Nations Program on HIV/AIDS) and its partners are working with countries to ensure responses are centred on women and girls; more than 60 countries have started implementing the UNAIDS Agenda for Women and Girls. In many areas, insufficient access to education reduces young girls’ life opportunities and increases their vulnerability. More countries are recognizing the need to implement programmes to reduce HIV-related stigma, although efforts remain inadequate. According to the UNAIDS Global Report 2010, the proportion of countries reporting programmes to address stigma and discrimination increased from 39% in 2006 to 92% in 2010, although a budget for these programmes was in place in less than half of these countries. Member States at the International Labour Conference adopted the first international labour standard on HIV and AIDS and the world of work in 2010, calling for stronger legal and policy frameworks and anti-stigma initiatives in the workplace.

In 1996, UNAIDS was launched, initially a pioneering collaboration of six United Nations agencies, UNAIDS would eventually expand to 10 cosponsors, supported by a secretariat and with a presence in more than 100 countries. In the 1990s, maximum number of countries also recognised the need for multi-disciplinary action, integrating various sectors and constituencies in national HIV strategies. Even as official action remained inadequate, the epidemic created significant social changes in 1981–2000. Especially in countries that began taking the epidemic seriously, human sexuality became a topic of open public discussion, helping establish a foundation for more effective prevention measures. The growing proportion of women and girls among people living with HIV highlighted the harmful consequences of gender inequality. The epidemic’s disproportionate impact on key populations focused growing attention on the social marginalization of sex workers, men who have sex with men, and people who use drugs, giving rise to human rights movements that would become more visible in the epidemic’s third decade. Over the first two decades, governmental inaction allowed the epidemic to become a global crisis, with especially harsh consequences in southern Africa. But the seeds had been sown for an unprecedented global movement that would reap historic results in the early 21st century.
The 2000 International AIDS Conference in Durban, the first held in a developing country, adopted the theme “Breaking the Silence” all the delegates demanded intensive global action to bring HIV treatments and proven prevention tools to settings that had long lacked access. As the epidemic’s second decade drew to a close, the United Nations Security Council held a special session on HIV, the first for any health issue, citing the epidemic’s potential impact on global security and encouraging countries to think of HIV/AIDS and global health in new ways. In 2001, member States gathered for an unprecedented Special Session of the UN General Assembly, for the first time in the epidemic’s history, global goals and targets were established for the response, unanimously endorsed by 189 countries. Performance indicators were put in place to monitor global progress towards agreed targets, and countries began submitting reports every two years on the extent to which their commitments had been kept.

1.2 HIV/AIDS and global commitments. UN General Assembly Special Session (UNGASS) on HIV/AIDS Declaration of Commitment 2001 by far the most comprehensive effort to address the HIV/AIDS pandemic, the Declaration of Commitment from the UNGASS sets out a number of policy and programmatic resolutions and recommendations many of which address both gender and women’s vulnerability.

Article 14 of the Declaration stresses “…that gender equality and the empowerment of women are fundamental elements in the reduction of the vulnerability of women and girls to HIV/AIDS”. This and other articles (articles 4, 6, 23, 37, 47, 53, 54, 59-62, 68, 75, 78, and 94) carry with them significant gender-based implications for policies and programmes which attempt to address this global crisis (Millennium Declaration and Development Goals : 2000)

Millennium Development Goal 3 - Promote Gender Equality and Empower Women. Target - Eliminate gender disparity in primary and secondary education preferably by 2005, and at all levels by 2015.

Millennium Development Goal (MDG) 6 - Combat HIV/AIDS, Malaria and other Diseases. Target - Halt and begin to reverse the spread of HIV/AIDS. The Millennium Declaration also commits states to “promoting gender equality and the
empowerment of women as effective ways to combat poverty, hunger and disease and to stimulate development that is truly sustainable”.

On more than one occasion (for example, International Women’s Day), Secretary General Kofi Annan has stated that Goal 3 of MDG is essential for the achievement of all the other Millennium Development Goals.

World Education Forum 2000. In Article 7, Paragraph ii of the Dakar Programme for Action, the participants in the forum made a commitment to ensure “that by 2015 all children, particularly girls, children in difficult circumstances and those belonging to ethnic minorities, have access to and complete, free and compulsory primary education of good quality”.

In Article 8, Paragraph vii, participants further committed to “implement as a matter of urgency education programmes and actions to combat the HIV/AIDS pandemic”.

Fourth World Conference on Women (“Beijing”) Declaration and Platform for Action 1995 Strategic objective C.3. – “Undertake gender-sensitive initiatives that address sexually transmitted diseases, HIV/AIDS, and sexual and reproductive health issues”. The Beijing Platform for Action, through Strategic Objective C.3., addresses the issue of “Gender and HIV/AIDS” quite comprehensively, setting out 16 “Actions to be Taken” in order to increase the gender-sensitivity of programmes and projects which address HIV/AIDS.

Article 3, of the Beijing declaration, outcome document re-states the importance of integrating a gender perspective into the HIV/AIDS response, highlights continuing problems relating to the epidemic, and recommends solutions for states and the international community.

International Conference on Population and Development Programme of Action 1994. In Article C of Chapter 7 (on Reproductive Rights and Reproductive Health), the ICPD Programme of Action addresses sexually transmitted diseases and the prevention of HIV from the perspective of women’s vulnerability to the epidemic, setting out key recommendations for addressing HIV through reproductive health services.

World Conference on Human Rights Declaration and Programme of Action (“Vienna Declaration”) 1993, Though the Declaration does not mention either gender
equity or HIV/AIDS specifically, it “recognizes the importance of the enjoyment by women of the highest standard of physical and mental health throughout their life span” (Article 41), and makes several other significant statements relating to women’s human rights and violence against women.

Convention on the Rights of the Child 1989, though the Convention does not mention either gender equity or HIV/AIDS specifically, it recognizes “the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health”.

Furthermore, it commits States Parties to ensuring “that no child is deprived of his or her right of access to such health care services” (Article 24).

In particular, Section 2(f) of Article 24 commits States Parties to developing “preventive health care, guidance for parents and family planning education and services”, which has broad-reaching implications for the issue of HIV/AIDS.

Convention on the Elimination of all Forms of Discrimination against Women (CEDAW) 1979, Article 12 of the Convention commits States Parties to “take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning”. Article 12 is also being used by a number of countries to call for HIV/AIDS prevention and care services.

PARIS/GENEVA, 1 December 2014 — On World AIDS Day 2014, mayors from around the world came together in Paris, France, to sign a declaration to end the AIDS epidemic in their cities. In signing the 2014 Paris Declaration, the mayors commit to putting cities on the Fast-Track to ending the AIDS epidemic through a set of commitments. Those commitments include achieving the UNAIDS 90–90–90 targets, which will result in 90% of people living with HIV knowing their HIV status, 90% of people who know their HIV positive status on antiretroviral treatment and 90% of people on treatment with suppressed viral loads, keeping them healthy and reducing the risk of HIV transmission.

20th International AIDS Conference in Melbourne, Australia in 2014 the 90-90-90 targets have become a central pillar of the global mission to end the AIDS epidemic. The targets reflect a fundamental shift in the world’s approach to HIV treatment moving it away from a focus on the numbers of people accessing
antiretroviral therapy and towards the importance of maximizing viral suppression among people living with HIV. The 90-90-90 target is “Ending AIDS” by 2020 December, the first 90 is about that people living with HIV is know their status, second 90 is about that people living with HIV who know their status are on treatment and third 90 is about that people in treatment are virally suppressed.

1.3 Overview and trend of HIV/AIDS in Asia:

Globally, in 2016, there were 36.7 million [30.8 million–42.9 million] people living with HIV. Regionally, 5.1 million [3.9 million–7.2 million] people are living with HIV in Asia and the Pacific. In 2016, there were an estimated 270 000 [190 000–370 000] new HIV infections in the region. New HIV infections decline by 13% in-between 2010 to 2016. In Asia and the Pacific, 170 000 [130 000–220 000] people died of AIDS-related illnesses in 2016. Between 2010 and 2016, the number of AIDS-related deaths in the region decreased by 30%. Treatment coverage was 47% [31–69%] among people living with HIV in Asia and the Pacific. An estimated 2.4 million [2.1 million–2.5 million] people had access to antiretroviral therapy in Asia and the Pacific in 2016. There were 15000 [7700–26000] new HIV infections among children in Asia and the Pacific in 2016 (UNAIDS Fact Sheet 2017).

Since 2010, there has been a 38% decline in new HIV infections among children in the region. For the most part, the countries featured in this report have concentrated HIV epidemics, with adult prevalence below 1% in the general population, but significantly higher HIV prevalence among key populations, like injecting drug user (IDUs), female sex workers (FSWs), and men who have sex with men (MSM). Indonesia has seen a rapid increase in prevalence. Additionally, there are often large regional differences in HIV prevalence within countries – for example, in China, over half the country’s PLHIV reside within just five of the 22 provinces (UNAIDS, 2016), and in India, 60% of PLHIV live in six of its 28 states (NACO, 2010).

Anti Retroviral Treatment (ART) coverage, voluntary confidential counselling and testing (VCCT) centres, and support services for PLHWA all require substantial financial and political commitment from governments. UNAIDS has attempted to measure the degree of investment priority that governments have given to support their national AIDS responses through the “Domestic Investment Priority Index”
(DIPI) (UNAIDS, 2010). It is calculated by dividing the percentage of government revenue directed to the AIDS response by the country’s HIV prevalence:

1.4 HIV/AIDS and INDIA: situation and analysis.

India’s first known HIV infection was diagnosed in a female sex worker in Chennai in February 1986. It is highly probable that HIV had been circulating for some years before that, since screening during 1986-87 found as many as 3%-4% of sex workers are infected in Vellore and Madurai, and 1% of STD patients are infected in Mumbai. As there were already over 20,000 cases in the world before any case was identified in India, screening for HIV infections began in India in 1985, almost as soon as tests for the HIV antibody were available. Across the world, country estimates have been revised with better data through community based and population surveys. In India, too, for the first time in 2006, HIV testing was a part of the National Family Health Survey (NFHS). The results of NFHS-III give us more accurate information about the estimates of those infected with HIV in the country.

The current HIV estimations bring to light an overall decline in adult HIV prevalence as well as new infections (HIV incidence) in the country, although dissimilarities exist across the states. The epidemic projections have revealed that the number of annual new HIV infections has declined by more than 50 percent during the last decade. This is one of the most important evidence on impact of the various interventions under the National AIDS Control Programme and scaled-up prevention strategies. The wider access and availability to ART has resulted in a decline of the number of people dying due to AIDS related causes. The trend of annual AIDS deaths is showing a steady decline since the roll out of the free ART programme in India in 2004.

Though the declining trends are apparent at national level as well as in most of the high prevalence state states, however on the other side some low prevalence and vulnerable states have shown rising trends in HIV epidemic, indicating towards urgent attention for prevention efforts in these areas. Due to massive prevention drive HIV prevalence is showing declining trends among Female Sex Workers both at national level and in most of the states. However, Men who have Sex with Men, Injecting Drug Users and Single Male Migrants are emerging as important risk groups in many states.
Adult HIV Prevalence: As per the India estimation 2015 report adult (15-19 years) HIV prevalence in India was estimated at 0.26 percent (0.22% – 0.32%). The adult prevalence is 0.22 percent among women and 0.30 percent among men in 2015. Among the states, Manipur has shown the highest estimated adult HIV prevalence (1.15%), followed by, Mizoram (0.80%), Nagaland (0.78%), Andhra Pradesh & Telanaga (0.66%), Karnataka (0.45%), Gujrat (0.42%) and Goa (0.40%).

Besides these states, Maharashtra, Chandigarh, Tripura and Tamil Nadu have shown estimated adult HIV prevalence greater than national prevalence (0.26%), while Delhi, Odisha, Bihar, Sikkim and West Bengal, have shown estimated adult HIV prevalence of 0.21- 0.25 percent and all other states/UTs have lower levels of HIV prevalence.

The adult HIV prevalence at national level has continued its steady decline from an estimated peak of 0.38% in 2001-03 through 0.34% in 2007 and 0.28% in 2012 to 0.26% in 2015. Similar consistent declines are noted both in males and in females at the national level (NACO & ICMR 2015).

People Living with HIV/AIDS (PLWHA): The total number of people living with HIV (PLHIV) in India is estimated at 21.17 lakhs (17.11 lakhs–26.49 lakhs) in 2015 compared with 22.26 lakhs (18.00 lakhs–27.85 lakhs) in 2007. Children (< 15 years) account for 6.54%, while two fifth (40.5%) of total HIV infections are among women’s.

Undivided Andhra Pradesh and Telangana have the highest estimated number of PLWHA i.e. 3.95 lakhs followed by Maharashtra 3.01 lakhs, Karnataka 1.99 lakhs, Gujarat 1.66 lakhs, Bihar 1.51 lakhs and Uttar Pradesh 1.50 lakhs. These seven States
together account for two thirds (64.4%) of total estimated PLWHA. Rajasthan 1.03 lakhs, Tamil Nadu 1.43 lakhs and West Bengal 1.29 lakhs are other States with estimated PLWHA numbers of 1 lakh or more. The estimated number of PLWHA in India has been more or less stable during 2013-15. Out of this estimation 1600000 people living with HIV are know their status (77% of total estimation). 49% of people who know their HIV status are in ART.

2015 HIV Estimates results reiterate the country’s success story in responding to HIV/AIDS epidemic. India has successfully achieved the 6th Millennium Development Goal (MDG 6) of halting and reversing the HIV epidemic. Between 2000 and 2015, new HIV infections dropped from 2.51 lakhs to 86 thousand, a reduction of 66% against a global average of 35% (NACO & ICMR 2015).

1.5 Women living with HIV/AIDS in India.

Global scale up of antiretroviral therapy has been the primary contributor to a 41% decline in deaths from AIDS related causes, from a peak from 1.9 million (1.7 million – 2.2 million) in 2005 to 1.0 million (830000 – 1.2 million) in 2016.

Despite the fact that 51% of people living with HIV globally are female, higher treatment coverage and better adherence to treatment among women have driven more rapid declines in AIDS related deaths among females; deaths from AIDS related illness were 27% lower among women and girls in 2016 than they were among men and boys.

However, HIV/AIDS related illnesses remain one of the leading cause of death among women of reproductive age (15-49 years) globally and they are the second leading cause of death for young women at age of 15-24 years in Africa.

As with China, India has a relatively low adult HIV prevalence of 0.3%. Yet due to its large population, over 2.4 million Indians, 880,000 of them women, are estimated to be living with HIV – the third largest number in the world, after South Africa and Nigeria (NACO, 2010). Nationally, heterosexual sex is the main form of transmission (87%), followed by Parent-to-child transmission (PTCT) (5%), transmission through injecting drug use (IDU) (2%) and blood transfusions (1%). FSW are a key population in India, as over 2% of adult males in 2006 reported they had paid for sex in the previous year. While HIV incidence among sex workers in the southern states has been declining, there has been a simultaneous increase in the
North East. There are currently eight districts where FSW have prevalence greater than 15%, and even in generally low prevalence states, there are 15 districts where the prevalence is over 5%. Overall, 39% of PLHIV in India are female, and of them, 90% are estimated to have acquired the infection from their husband or partner.

There were significant variations across States in key population’s coverage. Only 16% of FSW in Haryana, 46% in Rajasthan and around 50% in Arunachal Pradesh and Mizoram were covered by the targeted intervention programme. However, coverage was more than 90% in Assam, Goa, Maharashtra, Manipur and Meghalaya.

Among FSW, consistent condom use (CCU) with occasional clients (i.e., condom use during every time of sex in last one month) was 74% nationally, but in some States like West Bengal, CCU with occasional clients was as high as 96%. However, there were three States where CCU was 50% or less; Arunachal Pradesh (48%), Jharkhand (46%) and Mizoram (38%) (NACO & ICMR 2015).

The HIV prevalence among ANC clinic attendee’s still shows geographical differences continued to exist in the prevalence rates across different regions. Overall, 13 states have recorded prevalence higher than national average in 2017. In comparison, only 9 states recorded HIV prevalence more than national average in ANC HSS 2014-15. Three high prevalence states among ANC clinic attendees were from the north-eastern region of the country, with Mizoram (1.19%) recording the highest prevalence followed by Nagaland (0.82%) and Meghalaya (0.73%). HIV prevalence higher than national average was also recorded in the states of Tripura (0.56%), Manipur (0.47), Gujarat (0.44%), Andhra Pradesh (0.41%), Karnataka (0.38%), Bihar (0.38%), Delhi (0.38%) and Chhattisgarh (0.35%). The states of Rajasthan (0.29%), Odisha (0.28%), Telangana (0.28%) and Tamil Nadu (0.27%) recorded HIV prevalence similar to the national average. Figure 10 shows the state wise color-coded map of India for 2003, 2006, 2015 and 2017 rounds of HSS. As evident, the states of Mizoram and Nagaland continue to have a prevalence of 0.75% or more. Erstwhile high prevalence states of Andhra Pradesh, Karnataka, Maharashtra and Tamil Nadu have recorded lower prevalence over the years and all have recorded prevalence of 0.25%-0.50% in 2017 (NACO).
There were an estimated 3 crore pregnant women in India in 2016-176. In this period, around 1.7 crore pregnant women were tested for HIV at over 22,000 HIV counseling and testing facilities. Testing among pregnant women resulted in an HIV positivity of 0.05%. Three fourth of HIV tests occurred in ten States including Maharashtra, West Bengal, Karnataka, Uttar Pradesh, Tamil Nadu, Madhya Pradesh, Gujarat, Andhra Pradesh, Bihar and Rajasthan (Figure 9). State of Maharashtra alone contributes 13% of the total number of HIV tests in pregnant women, followed by West Bengal (9%) and Karnataka (8%).

India is making efforts to achieve 90% or more antiretroviral treatment (ART) coverage of HIV-positive pregnant women to eliminate parent-to-child transmission of HIV. In 2016-17, 90% of identified HIV positive pregnant women were put on ART nationally. However, coverage of HIV-positive pregnant women with ART, against the estimated number of pregnant women in need of ART services, was at 41% nationally.

There were significant variations across States/UTs. Some North-Eastern states like Meghalaya, Nagaland and Mizoram as well as Haryana, Chandigarh and Chhattisgarh achieved ART coverage rate among pregnant women of 95% or more. States at the opposite side of the spectrum include Bihar, Jharkhand, Sikkim, Odisha, Gujarat, Kerala and Rajasthan, where ART coverage among pregnant women is less than 25%. This indicates that there is significant scope of improvement to ensure elimination of parent-to-child transmission of HIV by 2020.

1.5.1 Why Women are in risk of HIV/AIDS:

The impact of HIV and AIDS reaches far beyond the health sector with severe economic and social consequences and it has been found that it is much more severe on women than men. Women and girls seem to bear uneven burden of the epidemic psychologically, socially and economically.

There are a number of factors like biological, socio-cultural and economic, which make women more vulnerable to HIV and AIDS. The foremost cause of infection is through heterosexual transmission, women are at a biological disadvantage in contracting HIV. HIV is more easily transmitted from men to women than women to men; male-to-female transmission during sex is about twice as likely as female to male transmission (UNICEF, 2005; Zena A. Stein and Kuhn Louise
Women are more susceptible to HIV for biological reasons because viral concentration in semen is higher than that in vaginal fluids, and women have a larger mucous surface, which is exposed to the virus for longer durations. Biologically, young women appear to be more susceptible to HIV infection than older women; in sub-Saharan Africa, young women aged 15-24 were 2.5 times more likely to be infected as compared to young men. The gender dimensions relevant to HIV/AIDS penetrate a whole range of aspects of society, including the economic, legal, cultural, religious, political and sexual status of women. Riding on the back of existing gender disparities, HIV/AIDS exaggerates the situation of women, translating existing differences into harsher conditions on the ground – and into higher HIV prevalence for women. The dynamics of gender and HIV/AIDS does this by creating multiple mechanisms that exacerbate the vulnerability of women both to contracting the virus, coping with the infection and caring for others infected and affected by HIV/AIDS. Many of these links do not only manifest themselves as mechanisms of vulnerability, but also become factors that fuel the spread of the epidemic.

The determinant of HIV/AIDS infection can be grouped into macro level and micro level, cultural and biological factors. The macro level factors, such as governance and poverty levels, provide the gendered framework for actions taken by the individual woman and man. These actions are also structured by micro determinants, which can be grouped into factors related to the individual’s immediate environment, as well as biomedical factors.

( Figure – 1.1) Macro, Cultural and Micro determinates, Gender and HIV/AIDS
(Source : Commission on HIV/AIDS and Governance in Africa)
The figure 1.1 gives an impression of the different, complexly interrelated factors that form the context of vulnerability to infection at the individual level, as well as the route of the pandemic at the structural level.

The connection between gender disparity and vulnerability to HIV and AIDS is now well known. In fact, gender inequality and poverty are responsible for the spread as well as disproportionate impact of HIV and AIDS on women. “Faced with economic hardship, women and girls become more vulnerable to commercial sex, trafficking and transactional sex in which they have little power to negotiate safe sex” (UNICEF, 2005). In India, women generally enjoy very low economic and social position; the sex ratio of 940 women to 1000 men is one of the lowest in the world. This is the result of strong preference of male child and the widespread sex selective abortion, which is prevalent in the country. Similar gender disparities have been prevalent in education and employment sector as well.

These gender inequalities are reflected in the sexual relations between husband and wife, man play dominant role and are more likely to initiate, rule and control sexual interaction. In the Indian context, the condition of the women are so pathetic, even do not have control over their own bodies and they are unable to negotiate safe sex and ask men to use condom. The cultural norms and attitude of condoning multiple partnership or pre-marital or extra-marital sexual affairs of men in the society increases women’s risk of getting infected with the virus.

As a result of the low socio-economic status and inadequate educational opportunities, women and girls often lack basic information about HIV/AIDS. In India, knowledge and awareness about HIV/AIDS seem to be quite low, especially among women. The Behavioural Surveillance Survey conducted in 2001 found gender disparities in the knowledge about HIV and AIDS and the awareness was predominantly low among rural women in Bihar, Gujarat and Uttar Pradesh (NACO 2001). Furthermore cultural taboos like speaking about sex or showing interest in knowledge about sexual matters acts as a barrier to girls receiving HIV/AIDS related information from the elders or for that matter even from their peers.

The economic dependency on men is also one of the factors contributing to spread of HIV among women. Discriminatory inheritance rights, lack of access to and control over property and unequal access to education, healthcare and income earning
activities further weakens their position. In addition, the various forms of violence against women further increase the risk of contracting HIV as sex is often forced on them. Thus, poverty, early marriage, trafficking, sex work, migration, lack of education, gender discrimination and violence against women are some of the factors responsible for the spread of HIV among women and girls in the Asia and the Pacific region.

1.5.2 HIV/AIDS and impact on women and girls:

The impact of HIV/AIDS reaches far beyond the health sector with severe economic and social consequences and the impact is much more severe on women in compare to men. Women and girls bear the burden of the pandemic in many ways and the HIV/AIDS excessively affects them psychologically, socially and economically. The various ways in which women are being affected by the pandemic has been well documented by a number of studies undertaken, especially in Saharan Africa.

It has been found that women infected/affected by HIV/AIDS are likely to suffer additional burden of stigma, discrimination and isolation in the society. Often, women infected /affected with HIV/AIDS are blamed for their husbands HIV infection and illness of their child, alleged of infidelity by the family and society leading to rejection and expulsion by the family and community at large. The conditions of widows are more pitiable they are often thrown out their house and is often denied their property rights and is likely to face isolation and discrimination from the family and community members.

The illness and the death due to HIV/AIDS resulting in loss of family income, put additional burden on women, :not only does the demand for women’s labour at home increase, but the demand for women’s paid labour also increases” (Mahbub-ul-Haq, Human Development Centre, 2005; UNDP 2003; UNICEF 2005). To cope with the situation and support themselves s and their children, several of these women may have to use sex as one of the avenues of economic support. Throughout the world it has been found that mostly women are primarily responsible for care-giving of the sick. The burden of care and domestic work is shouldered not only by the female adults of the household, but also by girls who are often withdrawn from the school to share such responsibilities.
They face emotional exhaustion, fatigue and burn out, in addition to the depletion of financial resources to meet the rising medical expenses. Their role as a caregiver could be extremely taxing in terms of time as well as physical exertion. This would result in what is now termed as “time poverty” for women. In addition there is also an ‘empowerment cost’ when women’s time is taken away from other productive work to unpaid care of those who have AIDS related illnesses. There is an opportunity cost which women have to pay since their ability to participate in income generating activities, skill building and leisure activities are reduced drastically. (UNAIDS Task Team on Gender and HIV/AIDS).

1.6 HIV/AIDS related stigma and discrimination.

Globally, it is recognized that stigma and discrimination connected with HIV/AIDS are the utmost barriers to preventing new infections, providing essential and adequate care, support and treatment and reducing impact of HIV/AIDS. They are triggered by many forces, including lack of understanding about HIV/AIDS, misconception about mode of HIV transmission, prejudice, lack of treatment, the fact that AIDS is incurable, social fears about sexuality and fears relating to illness and death.

HIV-related stigma and discrimination is a global problem. People living with HIV/AIDS face stigma and discrimination in different contexts from within their families, communities, workplaces and health and educational settings. Stigma has been associated with disfiguring and a disease that society perceives to be caused by violation of social norms especially those related to sexual behaviours.

Stigma and discrimination have played important roles in fighting against HIV/AIDS because in most cases infected persons do not disclose their status and seek timely treatment due to fear of stigmatization and discrimination. HIV/AIDS infected persons are often turned away from health care services and employment and are refused use of public and community facilities. There also is evidence of secondary stigma experienced by close relations of PLWH or people working with them. This highlights the need for increased awareness and the necessity to provide support to the PLWH. The attempt to challenging stigma and discrimination will face many challenges but it is important to start from somewhere educating people about it because “If knowledge breeds comfort; and, if comfort can promote
compassion; then, perhaps, greater compassion from the non infected community can contribute to a higher quality of life for those persons currently affected”.

In many countries all over the world, there are well-documented cases of people with HIV/AIDS being stigmatized, discriminated against and denied access to services on grounds of their HIV status. Gender-based stigma and discrimination require special mention. The power relations that underscore gender relations and that tightly intersect with discrimination against women and violence provides highly combustible fuel for the epidemic. UNAIDS defines HIV-related stigma and discrimination “a ‘process of devaluation’ of people either living with or associated with HIV and AIDS. Discrimination follows stigma and is the unfair and unjust treatment of an individual based on his or her real or perceived HIV status.”

Stigma often amplifies existing prejudices and inequalities. HIV/AIDS related stigma tends to be most demoralizing for people who are already socially marginalized and closely associated with HIV/AIDS, such as commercial sex workers, men who have sex with men, injecting drug users and even also prisoners.

Men and Women may experience different forms and consequences of stigma/discrimination. The survey among HIV-positive adults of South Africa revealed that men reported greater self-abasing beliefs and adverse social reactions to their HIV status than women. Conversely, other studies have shown that women are particularly vulnerable to stigma, including violence, one of the harshest and most damaging forms of stigma.

1.6.1 Stigma leads to Discrimination.

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. Discrimination, as defined by UNAIDS (2000) in the Protocol for Identification of Discrimination Against People Living with HIV, refers to 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 and 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 take place at different levels; it may in family and community settings, which has been described by some writers as ‘enacted stigma’. The discrimination is acted by any individual either deliberately or by omission so as to harm others and deny to them basic services or entitlements. Examples of such kind of discrimination are “ostracize, such as the practice of compelling women to return to their maternal houses upon being diagnosed HIV positive, following the first signs of illness, or after death of their partner by HIV/AIDS related illness; isolation from everyday contact; verbal teasing and harassment; physical violence; verbal discrediting and blaming; gossip; and denial of essential and traditional work like funeral rites” etc.

(Figure – 1.2 ) Conceptual framework for HIV/AIDS related stigma.
Then there is discrimination occurring in institutional settings like workplaces, health-care settings, educational institutions, social-welfare settings and even in prisons also. Such discrimination crystallizes enacted stigma in institutional policies and practices that discriminate against people living with HIV, or indeed in the lack of anti-discriminatory policies or procedures of redress.

1.6.2 Causes of Stigma and Discrimination.

There are many reasons why people stigmatize and no matter the causes of stigma and discrimination, they are always associated with the conditions and nature of the disease and behaviors that are considered immoral that can be controlled. According to Ogden and Nyblade, “This stigma is exacerbated by the seriousness of the illness, its mysterious nature, and its association with behaviors that are either illegal or socially sensitive” (e.g., commercial sex work and drug use). Also relevant is the perception that HIV infection is the product of personal choice: that one chooses to engage in "bad" behaviors that put one at risk and so it is "one's own fault" if HIV infection ensues (Ogden & Nyblade, 2005).

HIV is a Life-threatening Disease: People with HIV/AIDS are stigmatized and discrimination because the nature of the disease (being life-threatening, progressive and incurable). “People diagnosed with HIV/AIDS are susceptible to opportunistic infections, which are caused by microbes that usually do not cause illness in people with healthy immune systems” (Sowadsky, 1999). These opportunistic infections spread rapidly and can result in physical deformities which in turn create stigma, and its leads to discriminations.

Concept of Morality: Because HIV/AIDS is associated with behaviors that come with negative responses in society (homosexuality, injection drug use and promiscuity) (Aggleton, 2000; De Bryun, 1999; Macklin, 1988; Marshall, O’Keefe & Fisher, 1990; Milan, 2005; Ogden & Nyblade, 2005; Smart, 2005; Urwin, 1988), many people believe that “PLWHA are responsible for their predicament and that the disease is a punishment for their bad moral behaviour or misdeed”.

Fear of contagion due to insufficient knowledge: HIV/AIDS related stigma and discrimination occur naturally, they are created by individuals and communities because of their poor knowledge about the mode of HIV/AIDS transmissions and own fears of contracting with HIV/AIDS. It has been seen that those who have correct and
adequate knowledge about HIV/AIDS have less fear, and are more willing to associate with persons infected/affected with HIV/AIDS. Brown (et al. 2001) surveyed 320 Jamaican youth to improve attitudes towards PLWHA by encouraging acceptance and compassion. Their intervention included peer education and workshops, street interviews, conversations with PLWHA, and concerts. The effect was measured by the participants’ willingness to sit next to, eat with, and visit PLWHA. Results showed a significant increase in positive attitudes toward PLWHA and a reduction in the number of participants who sought isolation from PLWHA. Similar studies were done by the Research Triangle Institute (2000), they surveyed 7,493 adults through the internet to measure indicators of HIV/AIDS related stigma and knowledge of HIV transmission. The study reveals that respondents who were misinformed about HIV transmission gave stigmatizing responses, suggesting that increasing understanding about behaviors related to HIV transmission may result in lower levels of stigmatizing beliefs about PLWHA.

Irrespective of how one contracted HIV/AIDS, he or she experiences stigma as a result of at least one of the reasons discussed. In spite of the reasons why people stigmatize, every person who is stigmatized experiences some degree of stigma depending on how one contracted the disease.

1.6.3 Sources of Social Stigma and Discrimination.

To understand the ways in which HIV/AIDS related stigma and discrimination appear and the contexts in which they occur, first its need to understand how they interact with pre-existing stigma and discrimination associated with sexuality, gender, race, and poverty (Figure 1.3). HIV/AIDS related stigma and discrimination also interact with pre-existing fears about contagion and disease. Early AIDS metaphors as death, as shock, as retribution, as guilt, as disgrace have intensified these fears, reinforcing and legitimizing stigmatization and discrimination. The following are major sources of stigma and discrimination.
a) Sexuality: HIV/AIDS related stigma and discrimination are most closely related to sexual stigma, because the major mode of HIV transmission is sexual route and in most areas of the world, the HIV/AIDS primarily affected populations whose sexual practices or identities are different from the “norm.” HIV/AIDS-related stigma and discrimination has therefore appropriated and reinforced pre-existing sexual stigma associated with sexually transmitted infections, homosexuality, promiscuity, commercial sex, and sexual “deviance” (Gagnon and Simon 1973; Plummer 1975; Weeks 1981). The belief that homosexuals are to blame for the epidemic or that homosexuals are the only group at risk of HIV is still common. Promiscuous sexual behavior by women is also commonly believed to be responsible for the heterosexual epidemic, regardless of the epidemiological reality. In Brazil, for example, where surveillance data have shown high rates of HIV infection among monogamous married women, HIV-positive women are still widely perceived to be sexually promiscuous (Parker and Galvão 1996).

b) Gender: HIV/AIDS-related stigma and discrimination are also linked to gender-related stigma. The impact of HIV/AIDS related stigma and discrimination on
women reinforces pre-existing “economic, educational, cultural, and social disadvantages and unequal access to information and services” (Aggleton and Warwick 1999). In settings where heterosexual transmission is significant, the spread of HIV infection has been associated with female sexual behavior that is not consistent with gender norms. For example, commercial sex is widely believed as immoral female behavior, and female sex workers are often identified as “vectors” of the infection that put at risk their clients and their clients’ sexual partners. Similarly, in many settings, men are blamed for heterosexual transmission, because of assumptions about male sexual behaviour, such as men’s preference or need for multiple sexual partners.

c) Race and ethnicity: The existing racial and ethnic related stigma and discrimination also interrelate with HIV/AIDS related stigma and discrimination in the society, and the epidemic has been characterized both by racist assumptions about “African sexuality” and by perceptions in the developing world of the West’s “immoral behavior.” The racial and ethnic related stigma and discrimination influence to the marginalization of minority population groups, increasing their vulnerability to HIV/AIDS, which in turn exacerbates stigmatization and discrimination.

d) Class: The HIV/AIDS epidemic has developed during the period of rapid globalization and growing divergence between rich and poor (Castells 1997). New forms of social exclusion associated with these global changes have reinforced pre-existing social disparities and stigmatization of the poor, homeless, landless, and jobless. As a result, poverty increases vulnerability to HIV/AIDS, and HIV/AIDS exacerbates poverty (Parker, Easton, and Klein 2000). HIV/AIDS-related stigma and discrimination interacts with pre-existing stigma and discrimination associated with economic marginalization. In the contexts, the epidemic has been characterized by assumptions about the rich, and HIV/AIDS has been effluents lifestyles.

e) Fear of contagion of disease: HIV/AIDS is a life-threatening infirmity that people are afraid of contracting. The various descriptions associated with HIV/AIDS have also contributed to the perception of HIV/AIDS as a disease that affects “others,” especially those who are already stigmatized because of their sexual behavior, gender, race, or socioeconomic status, and have enabled some people to deny that they personally could be at risk or affected (UNAIDS 2000; Malcolm et al.
People also lack for proper and accurate knowledge about mode of HIV transmission. The pre-existing sources, such as those related to gender, sexuality, and class, often overlap and reinforce one another. This interaction has contributed to the deep-rooted nature of HIV/AIDS-related stigma and discrimination, limiting the ability to develop effective responses. It has also created a vicious circle of stigma and discrimination, which works in two ways. First, because HIV/AIDS is associated with marginalized behaviors and groups, all individuals with HIV/AIDS are assumed to be from marginalized groups and some may be stigmatized in a way that they were not before. For example, in some settings, men may fear revealing their HIV status because it will be assumed that they are homosexual. Similarly, women may fear revealing their HIV status because they may be labelled as “promiscuous” or sex workers and stigmatized as such. Second, HIV/AIDS exacerbates the stigmatization of individuals and groups who are already oppressed and marginalized, which increases their vulnerability to HIV/AIDS, and which in turn causes them to be further stigmatized and marginalized.

1.6.4 Manifestation of stigma and discrimination.

HIV/AIDS related stigma and discrimination take different forms and are manifested at different levels societal, community and individual and in different contexts (UNAIDS 2000; Malcolm et al. 1998). The following examples highlight where HIV/AIDS-related stigma and discrimination have been most frequently documented and where there is the greatest potential for interventions to reduce or mitigate stigma and discrimination.

a) Policy and Legal factors:

HIV/AIDS-related Stigma and Discrimination in society is commonly manifested in the form of “laws, policies, and administrative procedures”, which are often justified as necessary to protect the “general population” (Kirp and Bayer 1992; Manuel et al. 1990). Examples of stigmatizing and discriminatory measures include compulsory screening and testing, compulsory notification of HIV/AIDS cases, restrictions of the right to anonymity, prohibition of PLWHA from certain occupations, and medical examination, isolation, detention and compulsory treatment of infected persons (Tomasevski et al. 1992; Gostin and Lazzarini 1997). One important example concerns limitations on international travel and migration. Despite
widespread agreement that laws to prevent freedom of movement of the PLWHA are ineffective public health measures, many countries have adopted policies restricting travel and migration. Discriminatory practices include mandatory HIV testing for individuals seeking work permits (AIDS Bhedbhav Virodhi Andolan 1993; Solon and Barrazo 1993), the requirement that individuals seeking tourist visas declare their HIV serostatus, and denial of entry to PLHA carrying medical drugs for HIV/AIDS treatment (Duckett and Orkin 1989). Foreigners have been deported from a diverse range of countries after the authorities have discovered that they are HIV-positive (Malcolm et al. 1998; AIDS Bhedbhav Virodhi Andolan 1993; Panos 1990). HIV/AIDS-related stigma and discrimination reinforces existing prejudice towards foreigners or marginalized groups. For example, travellers from countries worst affected by the epidemic, or whose appearance makes others think they are gay men or sex workers, may be subject to additional questioning and physical searches. Foreign nationals engaged in sex work may be deported because of the risk they are said to pose to local clients. Early on in the epidemic, there were many reports of African students in Europe and Asia being detained or deported in this way (Sabatier 1988).

Some governments, recognizing that such measures are ineffective, have introduced legislation to protect the rights of PLWHA to education, employment, confidentiality, information, and treatment (Kirp and Bayer 1992; Mann and Tarantola 1992; Mann, Tarantola, and Netter 1996). However, even when supportive legislation exists, it is not always enforced. The failure of governments to protect the rights of PLWHA through legislation or to enforce existing legislation has been described as a form of discrimination by neglect (Daniel and Parker 1993; Watney 2000), as has the failure to provide effective prevention, treatment and care for those most vulnerable to HIV/AIDS and for PLWHA.

b) Institutional factors:

i) Education and schools: The most pitiable consequence of HIV/AIDS epidemic is victimization of children those who are not responsible about the situation in any way. It has been found that, children infected by HIV/AIDS or from affected households are stigmatized and discriminated in educational settings in several countries. Discrimination against HIV-positive children in the USA and Brazil is
common they are prohibited from collective activities or expulsion from school, has led to non-discrimination legislation (Public Media Center 1995; Galvão 2000). However, less concern has been shown for young people who are alleged to be responsible for their HIV infection and who are already stigmatized and discriminated against because they are sexually active, homosexual, or drug users.

ii) Employment and the workplace: Such discriminatory practices as pre-employment screening, denial of employment to individuals who test positive, termination of employment of PLHA, and stigmatization of PLHA who are open about their HIV/AIDS status (Gostin and Lazzarini 1997; Panos 1990; Barragán 1992; Gostin 1992; Panos 1992; Shisam 1993; Omangi 1997) have been reported from developed and developing countries. There have been reports of workers refusing to work next to those with HIV or AIDS or those perceived to be PLWHA. Schemes providing medical assistance and pensions to employees have come under increasing pressure in countries seriously affected by HIV/AIDS, and some companies have used this as a reason to deny employment to PLWHA (Williams and Ray 1993; Whiteside 1993). However few companies have developed strategies to combat stigma and discrimination or defined their responsibilities towards employees with HIV (Jackson and Pitts 1991; Bezmalinovic 1996).

iii) Health Care Systems: Stigma and discrimination in health care settings is widely known, many incident has been reported about HIV testing without consent, breaches of confidentiality, and denial of treatment and care (AIDS Bhedbhav Virodhi Andolan 1993; Tirelli et al. 1991; Carvalho et al. 1993; Panebianco et al. 1994; Ogola 1990; Masini and Mwampeta 1993). In many health care settings, it has found that confidentiality has been broken, HIV status has been revealed to the relatives without their prior consent and even the information has been disclosed before media. (Panos 1990; Bharat et al. 2001; Singh 1991). Factors contributing to these stigmatizing and discriminatory responses include lack of knowledge, moral attitudes, and perceptions that caring for PLHA is pointless because HIV/AIDS is incurable.

iv) Religious Institutions: In some contexts, HIV/AIDS-related stigma and discrimination has been reinforced by religious leaders and organizations. The institution are busy with for maintain the status quo rather than, they challenge negative attitudes toward marginalized groups and PLWHA. At the international
symposium Religious Health Organizations Break the Silence on HIV/AIDS, organized by the African Regional Forum of Religious Health Organizations during the 13th International AIDS Conference in July 2000 (Singh 2001), it was noted that religious doctrines, moral and ethical positions regarding sexual behavior, sexism and homophobia, and denial of the realities of HIV/AIDS have helped create the perception that those infected have sinned and deserve their “punishment,” increasing the stigma associated with HIV/AIDS.

v) Cultural Context: In societies with cultural systems that place greater emphasis on “individualism”, HIV/AIDS may be perceived as the result of personal irresponsibility, and thus individuals are blamed for contracting the infection (Kegeles et al. 1989). In contrast, in societies where cultural systems place greater emphasis on collectivism, HIV/AIDS may be perceived as bringing shame on the family and community (Panos 1990; Warwick et al. 1998). The type of cultural system and where it fits along the continuum of individualism and collectivism will therefore influence the ways in which communities respond to HIV/AIDS and the ways in which stigma & discrimination are manifested. Local cultural beliefs and explanations about disease and the causes of disease may also contribute to HIV/AIDS-related S&D. For example, where illness is believed to be the result of “immoral” or “improper” behavior, HIV/AIDS may reinforce pre-existing stigma of those whose behavior is considered to be “deviant” (Warwick et al. 1998).

In a recent case study conducted by UNDP, a woman from the Indian city, Kanpur, expressed her struggle for not being able to prepare last rites for her HIV infected husband who died, “I was not allowed to bless the body of my husband after his death. Since he was HIV-positive, I was prevented from placing his body in the Ganges River. I felt so ashamed because I was not able to honor my husband.” The death ritual is a sacred and valuable ritual that is cherished primarily among Indian Hindus. It is a rite of passage that is believed to bring prosperity and comfort in the afterlife of the deceased. Cremation of the body, which is a part of the ritual, is considered necessary to spiritually release the body from earth. The denial of such practice, however, for HIV-positive people, can cause spouses to fear unrest and discomfort, believing the body will never be at peace. This is emotionally traumatizing for Indian women, who are often the victims of this practice.
vi) Family Systems: Family is ideally a major source of practical and emotional support for PLWHA. However, in majority cases negative family attitudes and reactions are common towards PLWHA. They are often experience stigma & discrimination in the home, especially women PLWHA are often more likely to be badly treated than men or children (Bharat and Aggleton 1999). Negative community and family responses to women with HIV/AIDS include blame, rejection, and loss of children and home (Parker and Galvão 1996; Bharat and Aggleton 1999; Henry 1990). Since HIV/AIDS-related stigma and discrimination underpin and interact with pre-existing stigma and discrimination, families may reject PLWHA not only because of their HIV status but also because of HIV/AIDS is associated with promiscuity, homosexuality, and drug use (Panos 1990; Misra 1999; Mpundu 1999; Mujeeb 1999). In several occasion, HIV/AIDS related stigma and discrimination has been extended to families, neighbors and friends of PLWHA. This ‘secondary’ stigmatization and discrimination has played an important role in creating and reinforcing social isolation of those affected by the epidemic, such as the children and partners of PLWHA.

Individual Context: In individual level PLWHA are suffered by self stigma. Due to HIV/AIDS related stigma and discrimination, the PLWHA felt isolated and they no longer feel part of society and are unable to gain access the services and support they need (Daniel and Parker 1993). This has been also called internalized stigma. In extreme cases, this has led to premature death through suicide (Gilmore and Somerville 1994; Hasan, Farag, and Elkardawi 1994).

Although the existing law protect PLWHA’s rights and confidentiality, however due to widespread negative community and family responses, many people choose not to know or disclose their HIV status. The Individuals who are already marginalized due to their life styles become more apprehensive about negative or hostile reactions from others, regardless of their HIV status (Daniel and Parker 1993; Panos 1990; Public Media Center 1995), reflecting the interaction between HIV/AIDS-related and pre-existing sources of stigma & discrimination. Fear of telling the family about their homosexuality has been mentioned by HIV positive men in Mexico and Brazil as equal to the fear of revealing their HIV status. Similar fears have been reported from a range of countries by sex workers and injecting drug users (Castro et al. 1998a; Castro et al. 1998b; Terto 1999). Even when the family response
is positive, fear of stigmatization and discrimination by the community may mean that an individual’s HIV status is not revealed outside the home.

(Figure – 1.4) Schematic of Innocence to guilt continuum. (Ogden and Nyblade 2005).

1.6.5 Degree of stigma:

The degree and intensity of stigmatization against PLWHA depends on a number of factors relating to how one contracted the disease. Ogden and Nyblade (2005) created a model called the “schematic of innocence- to- guilt continuum” (Figure 1.4) which explains that there is a kind of continuum from presumed “guilt” to presumed” innocence” in people’s minds.

Therefore, all people with HIV experience some degree of stigmatization. Where one falls along this continuum will determine, to a significant extent, the type and degree of stigmatization received from one’s family and the wider community.
(Brimlow, Cook & Seaton, 2003; Macklin, 1988; Ogden & Nyblade, 2005; Phelan, 2001; Smart, 2005; UNAIDS, 2000; Urwin, 1988).

The model suggests that people who were infected through drug use or sexual relations with same-sex partners are likely to experience more stigma than those infected through blood transfusions.

The continuum indicates the ways in which HIV and AIDS related stigma interacts with pre-existing stigmas; in addition to creating stigma where none previously existed, HIV/AIDS can create double stigma, the pre-existing stigma associated with an unapproved behavior (such as injection drug use or “immoral” sex) in combination with the stigma of living with HIV. In the four countries where Ogden and Nyblade’s study was carried out (Ethiopia, Tanzania, Vietnam, and Zambia), injection drug use and commercial sex are widely regarded as social evils. This association was deep-rooted in the minds of the public as well as in legislation and policy. Because HIV often is associated with these pre-existing stigmatized groups, HIV itself has started to be referred to as a social evil. This linkage between HIV, drug use/sex work, and social evils therefore not only affects those who engage in these behaviors, but all people living with HIV, serving to magnify HIV and AIDS-related stigma and the misery it creates. Consequently, people who contract HIV/AIDS through such acts receive a high degree of stigma. Within the above model, sex workers (people who earn money by providing sexual services), men, unmarried women and drug users are people who fall within the “presumed guilt” category and are more likely to receive higher degree of stigmatization than children, women who got it from their husbands and health workers infected on duty.

In conclusion, the main causes of stigma and discrimination relate to inadequate knowledge, the nature and condition of HIV/AIDS, sexual norms and a lack of recognition of stigma. Fear of contamination due to lack of insufficient knowledge combines with fears of death to perpetuate beliefs in casual transmission and, thereby, creating stigma. The knowledge that HIV can be transmitted sexually combines with an association of HIV with socially improper sex behaviors and enables PLWHA to be stigmatized for their perceived immoral behavior. How much PLWHA are stigmatized depends on a number of issues relating to how they contracted the disease. Children, health workers and married women (who contracted
from their husbands) are more likely to receive compassion and are less stigmatized than men, unmarried women, sex workers and injection drug users who are often blamed for their contraction. The degree or intensity of stigma may vary depending on how one got the disease; similarly, HIV stigma comes in many forms and expressions across contexts.

1.7 Human Rights and HIV/AIDS.

A poor respect for human rights increases the prevalence and exacerbates the impact of HIV/AIDS. The UN General Assembly Declaration of Commitment on HIV/AIDS of June 2001 places human rights at the heart of the international response to the epidemic and sets goals and targets based on human rights law in a number of key areas. It calls on states to take measures to reduce discrimination against people living with HIV/AIDS as well as members of vulnerable groups. Empowering women is essential for reducing vulnerability, and strategies, policies or programmes that recognise the importance of family in reducing vulnerability should be strengthened or developed. Strategies are needed for educating and guiding children and young people which take into account cultural, religious and ethical factors, and which reduce their vulnerability by ensuring access for both girls and boys to primary and secondary education; by ensuring safe and secure environments especially for young girls; and by expanding friendly and qualitative information and sexual health services.

1.7.1 Stigma, Discrimination and Human Rights: Inter relations.

Discrimination of any individual for any reason is itself 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 guidelines. The Universal Declaration of Human Rights prohibit discrimination based on race, colour, sex, language, religion, political or other 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 include 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 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.

There are many direct and indirect links between the HIV epidemic and lack of protection of human rights. Violations of rights may worsen the impact of HIV, increase vulnerability, and hinder positive responses to the epidemic. International human rights principles provide a rational, normative framework within which to analyse and redress HIV/AIDS related discrimination. 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, published in 1998 by UNAIDS and the Office of the United Nations High Commissioner for Human Rights, clarify the obligations of states contained in existing human rights instruments and how they apply in the context of HIV/AIDS.

1.7.2 Human Rights and universal access.

To ensure the full enjoyment of all human rights and fundamental freedoms by people living with HIV and members of vulnerable groups; promoting access to HIV education and information; full protection of confidentiality and informed consent; intensifying efforts to ensure a wide range of prevention programmes, including information, education and communication, aimed at reducing risk-taking behaviours and encouraging responsible sexual behaviour, including abstinence and fidelity; expanded access to essential commodities, including male and female condoms and sterile injecting equipment; harm-reduction efforts related to drug use; expanded access to voluntary and confidential counselling and testing; safe blood supplies; and early and effective treatment of sexually transmitted infections; developing strategies to combat stigma and social exclusion connected with the epidemic.

Depending on the legal and social situation and the nature of the epidemic in country, some groups may be more vulnerable to infection and impact because of their legal status or lack of human rights protection, e.g. women, children, minorities,
indigenous people, poor people, migrant-workers, refugees, sex workers, people who use drugs, men having sex with men, and prisoners.

These groups should have equal access to HIV prevention information, education, and commodities, and to HIV care, support and anti-retroviral treatment; should not be subject to sexual violence or coercion, where applicable; and should be able to participate in the formulation and implementation of HIV and AIDS policies that affect them.

Therefore those who are living with HIV or otherwise affected by it, the following rights should be protected.

- Non-discrimination and equality before the law: right not to be mistreated on the basis of health status, i.e. HIV status.
- Right to health: right not to be denied health care/treatment on the basis of HIV status.
- Right to liberty and security of person: right not to be arrested and imprisoned on the basis of HIV status.
- Right to marry and found a family, regardless of HIV status.
- Right to education: right not to be thrown out of school on the basis of HIV status.
- Right to work: right not to be fired on the basis of HIV status.
- Right to social security, assistance and welfare: right not to be denied these benefits on the basis of HIV status.
- Right to freedom of movement, regardless of HIV status.
- Right to seek and enjoy asylum, regardless of HIV status.

1.7.3 The International Guidelines on HIV/AIDS and Human Rights.

1. States should establish an effective national framework for their response to HIV/AIDS which ensures a co-ordinated, participatory, transparent and accountable approach, integrating HIV/AIDS policy and programme responsibilities across all branches of government.

2. States should ensure, through political and financial support, that community consultation occurs in all phases of HIV/AIDS policy design, programme implementation and evaluation and that community organizations are enabled to carry out their activities, including in the field of ethics, law and human rights, effectively.
3. States should review and reform public health laws to ensure that they adequately address public health issues raised by HIV/AIDS, that their provisions applicable to casually transmitted diseases are not inappropriately applied to HIV/AIDS and that they are consistent with international human rights obligations.

4. States should review and reform criminal laws and correctional systems to ensure that they are consistent with international human rights obligations and are not misused in the context of HIV/AIDS or targeted against vulnerable groups.

5. States should enact or strengthen anti-discrimination and other protective laws that protect vulnerable groups, people living with HIV/AIDS and people with disabilities from discrimination in both the public and private sectors, ensure privacy and confidentiality and ethics in research involving human subjects, emphasise education and conciliation, and provide for speedy and effective administrative and civil remedies.

6. States should enact legislation to provide for the regulation of HIV-related goods, services and information, so as to ensure widespread availability of qualitative prevention measures and services, adequate HIV prevention and care information and safe and effective medication at an affordable price.

7. States should implement and support legal support services that will educate people affected by HIV/AIDS about their rights, provide free legal services to enforce those rights, develop expertise on HIV-related legal issues and utilise means of protection in addition to the courts, such as offices of ministries of justice, ombudspersons, health complaint units and human rights commissions.

8. States, in collaboration with and through the community, should promote a supportive and enabling environment for women, children and other vulnerable groups by addressing underlying prejudices and inequalities through community dialogue, specially designed social and health services and support to community groups.

9. States should promote the wide and ongoing distribution of creative education, training and media programmes explicitly designed to change attitudes of discrimination and stigmatisation associated with HIV/AIDS to understanding and acceptance.
10. States should ensure that government and the private sector develop codes of conduct regarding HIV/AIDS issues that translate human rights principles into codes of professional responsibility and practice, with accompanying mechanisms to implement and enforce these codes.

11. States should ensure monitoring and enforcement mechanisms to guarantee the protection of HIV-related human rights, including those of people living with HIV/AIDS, their families and communities.

12. States should co-operate through all relevant programmes and agencies of the United Nations system, including UNAIDS, to share knowledge and experience concerning HIV-related human rights issues and should ensure effective mechanisms to protect human rights in the context of HIV/AIDS at international level.

Universal Human Rights are strongly linked with the spread and impact of HIV on individuals and communities around the world. A lack of respect for human rights fuels the spread and exacerbates the impact of the HIV/AIDS, while at the same time HIV undermines progress in the realization of human rights. This link is evident in the inconsistent incidence and spread of the HIV/AIDS among certain groups which, depending on the nature of the epidemic and the prevailing social, legal and economic conditions, include women and children, and particularly those living in poverty. It is also visible in the fact that the overwhelming burden of the epidemic today is borne by developing countries, where the HIV/AIDS threatens to overturn vital achievements in human development. HIV/AIDS and poverty are now mutually reinforcing negative forces in many developing countries.

The rights of people living with HIV often are violated because of their presumed or known HIV status, causing them to suffer both the burden of the HIV/AIDS and the consequential loss of other rights. Stigmatization and discrimination may obstruct their access to treatment and may affect their employment, housing and other rights. This, in turn, contributes to the vulnerability of others to infection, since HIV-related stigma and discrimination discourages individuals infected/affected by HIV from contacting health and social services. The result is that those most needing information, education and counselling will not benefit even where such services are available.
HIV related stigma and discrimination is a global problem. Women are significantly more likely to experience HIV/AIDS related discrimination in every level after a positive diagnosis. Women are often blamed for bringing HIV into the family and may be subjected to violence by their spouse or in-laws.

A number of factors make women and girls more vulnerable to HIV/AIDS. They include social norms which deny women sexual health knowledge and practices that prevent them from controlling their bodies or deciding the terms on which they have sex. Compounding women’s vulnerability is their limited access to education, economic opportunities and autonomy, and the various household and community roles they are saddled with.

Life for HIV infected women is never easy; they manifest profound physical and psychological consequences. Women bear a ‘triple jeopardy’ impact of HIV/AIDS: “as person infected with HIV, as mothers of child, and as carers of partners, parents or orphans with AIDS”. Women living with HIV/AIDS (WLWHA) are at particularly high risk of living a painful, shameful life of exclusion. Millions have been discarded from their family, friends and partners, many have lost their lives and unable to live their life. In spite of the burden of HIV/AIDS the world is paying less attention to the issues raised by WLWHA. Their voices remain unheard. Women are often even more susceptible to the stigma associated with HIV/AIDS and are frequently referred to as ‘vectors’, of ‘diseased’. Discrimination for women can dispirit them from seeking vital medical and psychological care they need during the illness. HIV related stigma and discrimination in women is associated with denial from friends and family, society, feelings of uncertainty and loss, low self esteem, fear, anxiety, depression and even suicidal ideation.

Many countries have signed up to international human rights frameworks that oblige them to respect and protect the rights of all people regardless of HIV status and gender. Despite this, HIV positive women are often subject to humiliating and discriminatory treatment, causing blame, isolation and shame, and leading to restricted freedom of choice. Gender inequalities can lead to the abuse of women’s sexual and reproductive rights, while also undermining their legal, economic and political rights. Women’s unequal social, economic, and legal status is increased by a positive HIV status, and vice versa. Violations of reproductive rights faced by HIV
positive women include not being allowed the freedom to decide to have children or not to have children, or to decide birth spacing. In many countries, women are also debarred from their property rights, dispossessed from land and homes by in-laws, stripped of possessions, or subject to widow inheritance in order to retain access to their property.

HIV-related stigma and discrimination continue to be experienced across the world, impeding access to and scale-up of HIV prevention, treatment, care and support programmes. While many individuals, organizations and governments have worked diligently to reduce HIV-related stigma and discrimination, such efforts are not implemented at a scale necessary to have a significant impact on HIV outcomes, thus stigma and discrimination continues to fuel HIV transmission.