Abstract

Against the backdrop of the developing global epidemics of HIV and AIDS, demands have been made for a radical scaling up of the international response. Central among the steps that need to be urgently taken are efforts to combat stigma and discrimination. This article offers a conceptual overview of the relationship between the stigma associated with HIV and AIDS and discrimination and human rights, with the goal of demonstrating the interconnectedness of these concerns and describing elements of a future, and potentially more effective, programmatic response.

Sur toile de fond d'évolution des épidémies mondiales du VIH et du sida, une révision à la hausse radicale de la réponse internationale est attendue. Au cœur des mesures urgentes, des efforts doivent être mis en œuvre pour lutter contre la stigmatisation et la discrimination. Cet article présente un aperçu conceptuel du lien qui rattache la stigmatisation associée au VIH et au sida et la discrimination aux droits civiques. Notre objectif est de démontrer l'interconnexion de ces aspects et de décrire les éléments d'un futur programme de réponse susceptible d'être plus efficace.

Con la epidemia global del VIH y del SIDA como telón de fondo, se han hecho demandas por un incremento radical de la respuesta internacional en la lucha contra la epidemia. El esfuerzo para combatir el estigma y la discriminación asociados a la epidemia es una de las medidas urgentes que se deben tomar. Este artículo ofrece una revisión conceptual de la relación entre el estigma asociado con el VIH / SIDA, la discriminación y los derechos humanos, con el objetivo de demostrar la manera en la cual estas preocupaciones están interconectadas y de describir elementos para una respuesta potencialmente más eficaz en términos de programas futuros .

Articles

HIV- AND AIDS-RELATED STIGMA, DISCRIMINATION, AND HUMAN RIGHTS: A Critical Overview[1]

Miriam Maluwa, Peter Aggleton, and Richard Parker

All over the world, the epidemics of HIV and AIDS have been capable of bringing out the best and the worst in people: the best, when, in solidarity, people join together to combat government, community, and individual denial, and to offer support and care to people living with HIV and AIDS; the worst, when people are stigmatized and ostracized by their loved ones, their families, and their communities, and discriminated against individually as well as institutionally.[2,3]

Recent demands to radically scale up the international response to HIV and AIDS, and the recognition of their continued and damaging effects have created a resurgence of interest in HIV- and AIDS-related stigma and discrimination.[4] New studies describing the forms, contexts, and consequences of HIV- and AIDS-related stigma have been published, and both USAID and the Horizons Project (2000 and 2001) have commissioned recent briefings.[5] An Internet

---

Miriam Maluwa, is Law and Human Rights Adviser for UNAIDS, in Geneva, Switzerland; Peter Aggleton is Professor and Director of the Thomas Coram Research Unit, Institute of Education, University of London, UK; and Richard Parker is Professor and Chair of the Department of Sociomedical Sciences, Mailman School of Public Health, Columbia University, New York, USA. Please address correspondence to the authors at rgp11@columbia.edu.

forum on AIDS-related stigma has recently been established and meetings to develop elements of operational research agendas are underway.[6] As a prerequisite for ongoing, more focused action, it seems appropriate to review what has already been learned about the relationship between stigma, discrimination, and human rights.

At a United Nations (UN) Special Session on HIV and AIDS, the UN General Assembly unanimously endorsed a Declaration of Commitment on HIV/AIDS.[7] That Declaration called on states, by 2003, to enact, strengthen, or enforce legislation, regulations, and other measures to eliminate all forms of discrimination against people living with HIV and AIDS and against members of vulnerable groups and to ensure their full enjoyment of all human rights and fundamental freedoms. In particular, it stressed the necessity to ensure access to education, inheritance, employment, health care, social and health services, prevention, support, treatment, information, and legal protection, among other things, while respecting privacy and confidentiality and developing strategies to combat stigma and social exclusion connected with the epidemic.

Furthermore, the Declaration called on states, by 2003, to ensure the development and implementation of multisectoral national strategies for combating HIV and AIDS. These strategies must address the epidemic in forthright terms, confront stigma, silence and denial, address gender- and age-related dimensions of the epidemic, eliminate discrimination and marginalization, and involve civil society, the business sector, people with HIV and AIDS, vulnerable groups, people at risk, women, and young people in developing and implementing the strategies.

In this article, we discuss what AIDS-related stigma is, its origins, and its effects. Our goal is to show how HIV- and AIDS-related stigma and discrimination are closely tied to other inequalities and how they ultimately create and reinforce each other—that a synergistic relationship exists between multiple forms of inequalities and that these converge in relation to HIV and AIDS. By analyzing the kinds of stigma that many people living with HIV and AIDS experience, we hope to illustrate the close linkage between stigma

and discrimination, and to call attention to the significant human rights issues that lie at the core of effective local and international responses. Finally, we offer some suggestions about how best to challenge HIV- and AIDS-related stigma and discrimination wherever it occurs—both immediately and in the longer term.

Stigma: An Old Idea

Interest in HIV- and AIDS-related stigma and discrimination is far from new. In *Sex and Germs: The Politics of AIDS*, Cindy Patton was one of the first to discuss how AIDS exploits peoples three primitive anxieties: fear of germs and disease, fear of death, and deep-seated worries about sex and sexuality.[8] Shortly thereafter, in *AIDS and its Metaphors*, Susan Sontag examined some of the similarities (as well as the differences) in the fears people have about AIDS and the fears they have about leprosy, tuberculosis, and cancer.[9]

In the late 1980s, Jonathan Mann pointed to three phases in the AIDS epidemic in any society: The first is the epidemic of HIV infection, which typically enters a community silently and unnoticed. The second is the epidemic of AIDS itself, which emerges when HIV triggers life-threatening infections. And the third epidemic is a combined reaction of stigma, discrimination, blame, and collective denial.[10] He, like others, was certain that it was this third epidemic that made dealing with the other two so difficult. In December 2000, at the 10th meeting of UNAIDS Programme Coordinating Board (PCB) held in Rio de Janeiro, Peter Piot, then the executive director of UNAIDS, renewed the effort to combat stigma and listed the top five most pressing items for the world community.[11] Additionally, UN Secretary General Kofi Annan, in his recent call for action, said that a radical scaling up of efforts to combat stigma and discrimination was needed to help "break the silence" surrounding HIV and AIDS in many countries.[12]

The Nature of Stigma

But what is stigma and where does it come from? The origins of the word can be traced to the classical Greek

where it was used to brand outcast groups with a permanent mark of their status.[13,14] Stigma has more recently been said to result from a quality that discredits the individual. Drawing from research on people with mental illness, physical deformities, or socially "deviant" behaviors, sociologist Erving Goffman has argued that the stigmatized individual is a person who possesses "an undesirable difference."[15] Society uses "stigma" to conceptualize what constitutes "difference" or "deviance." Stigmatization is society's response to a person who has a "spoiled identity," as defined by its rules and sanctions.[16]

Since the 1960s, the literature on stigma has grown substantially. Stigma has been applied to a variety of circumstances, ranging from urinary incontinence to leprosy, cancer, and mental illness.[17-22] Social psychologists interested in social categories and stereotypical beliefs have developed much of this rapidly expanding literature.[23,24]

Most of this work has, however, suffered from serious limitations. Definitions of stigma are often vague, and some authors ignore definitional concerns all together.[25] Others define stigma simplistically, describing stigma as, for example, "a characteristic of persons that is contrary to a norm of a social unit" or as a "mark" that links a person to undesirable characteristics such as stereotypes.[26,27]

Moreover, much of what has been published has focused on the social-cognitive (and therefore individualistic) aspects of stigma.[28-29] As a result, work has largely focused on stereotyping rather than on the structural conditions that exclude people from social and economic life. Stigma thereby has come to be seen as something *in* the person stigmatized, rather than as a designation that others attach *to* that individual.[30]

Stigma is, however, not a thing but a *process*. The qualities of the individual on which stigma operates (e.g., skin or hair color, a manner of speaking or acting) are essentially arbitrary. Particular cultures or settings fixate on certain attributes and define them as discreditable or unworthy. "Undesirable differences" and "spoiled identities" do not naturally exist but are created by individuals and by communities. Stigmatization is therefore a process of devaluation rather than a thing.

What Does Stigma Do?

To properly understand stigmatization and discrimination, in relation to HIV and AIDS or to any other issue, it is vital to examine how some individuals and groups become socially excluded. Stigma neither occurs naturally nor does it necessarily spring from the minds of individuals. Rather, stigma is always a reaction to a social history that influences when and where it appears and the forms it takes. Understanding this history can help us combat it better.

Much HIV- and AIDS-related stigma builds on and reinforces earlier prejudices. In many countries, for example, people with HIV and AIDS are often viewed as having engaged in illicit sex with sex workers (if they are men) or as having been "promiscuous" (if they are women). In some parts of the developing world, HIV may be seen as a "woman's disease," similar to many other forms of sexually transmitted infection.[31] In parts of the West, AIDS may be viewed as a disease contracted only by junkies or as a "gay plague."[32] Although these perceptions vary widely, they are not random. In fact, they are patterned to ensure that HIV and AIDS-related stigma plays into and reinforces existing social inequalities. These inequalities include those that regard women as inferior to men, that deny prostitutes and sex workers their rights, and that are linked to drug and substance use, to nationality and ethnicity, and to sexuality.

HIV- and AIDS-related stigma do not therefore spring from the minds of "bad" people but instead are linked to power and domination in the community as a whole. They play a key role in producing and reinforcing relationships of power and control. They cause some groups to be devalued and others to be considered superior. Ultimately, social inequality creates and reinforces stigma.

Stigma, discrimination and human rights violations

There is a substantial body of literature suggesting that stigma principally takes two forms—*felt* and *enacted* stigma.[33,34] Felt stigma refers to the shame associated with a potentially stigmatizing condition and the fear of being discriminated against. Enacted stigma, on the other hand, has to do with actual experiences of discrimination.[35] It is

unclear which is the more common: felt or enacted stigma. What is significant, however, is that both forms have important consequences for individuals and for how these people organize their lives.[36]

Within the context of HIV/AIDS, prejudiced thoughts frequently lead to actions or inactions that are harmful or that deny a person services or entitlements. Such responses may, for example, prevent a person living with HIV or AIDS from receiving health care or, alternatively, may terminate employment based on a person's HIV status. This is the definition of discrimination: When, in the absence of objective justification, a distinction is made against a person that results in that person's being treated unfairly and unjustly on the basis of belonging or being perceived to belong, to a particular group.[37]

The stigma associated with HIV and AIDS and the resultant discrimination frequently violates the rights of people living with HIV and AIDS, as well as the rights of their families. HIV- and AIDS-related stigma, discrimination, and human rights abuses can originate from governments, private organizations, and institutions, as well as from communities, families, and individuals.

The following serve as a few examples of the rights denied to people living with HIV and AIDS.[38]

The Right to Employment

The South African case of *Hoffmann* v *South African Airways* was an appeal from the Witwatersrand High Court concerning the constitutionality of South African Airways' (SAA) practice of not employing as cabin attendants people living with HIV. In the High Court, SAA defended its policy as promoting the safety and health of its passengers and its own competitive capacity. The High Court upheld SAA's defense. Fortunately, the Constitutional Court of South Africa set aside the decision of the High Court and held that SAA had infringed Mr. Hoffmann's constitutional right not to be unfairly discriminated against. The court further held that people living with HIV have been stigmatized and, as one of the most disadvantaged groups in society, deserve special protection by the law.[39]

The Right to Marry

Some jurisdictions require mandatory HIV tests before granting marriage licenses, thus denying those who test positive the right to marry. The Supreme Court of India has held that the right of an HIV-positive person to marry is suspended as long as the person is HIV-positive.[40]

The Right to Freedom of Movement

Some states require those returning to their countries to submit to HIV testing, whereas other states may use segregation, quarantine, or "rehabilitation" to restrict the movement of nationals and aliens living in their countries. Certain population groups have been denied the right to return to their countries or are refused visas or entry permission because of suspicions about their being HIV-positive.[41,42]

The Freedom from Inhuman and Degrading Treatment

Individuals may be segregated in schools and hospitals. Cases of degrading treatment are particularly prevalent in prisons where inmates may be forced into mandatory confinement, often being denied their basic needs, including access to sufficient medical care.

Each of these examples dramatically illustrates situations in which stigma has resulted in discriminatory action and violations of human rights and fundamental freedoms. Stigma, discrimination, and human rights violations form a vicious, regenerative circle. Conversely, condoning human rights violations can create, legitimize, and reinforce stigma that can, if left to fester, lead to discriminatory action and further human rights violations.

HIV- and AIDS-related stigma and discrimination compound the suffering of people living with HIV and AIDS and of the poor, members of minority groups, indigenous peoples, migrants, refugees, and internally displaced persons, men who have sex with men, prisoners, injection-drug users, those with disabilities, and other marginalized, vulnerable groups. This situation is even worse for women and children within these groups. HIV- and AIDS-related stigma and discrimination continue to erode the human rights of these individuals or groups, thus increasing their vulnera-

bility to HIV infection and lessening their ability to cope effectively with the disease should they become infected.[43]

Freedom from discrimination is a fundamental human right founded on universal and perpetual principles of natural justice. The core existing international human rights instruments—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—prohibit discrimination based on race; color; sex; language; religion; political or other opinion; national, ethnic, or social origin; property; disability; fortune; birth; or other status.[44-48] The right to nondiscrimination is also detailed in such regional instruments as the African Charter on Human and Peoples Rights, the American Convention on Human Rights, and the European Convention on Human Rights.[49-51]

In addition, recent resolutions of the UN Commission on Human Rights, have stated unequivocally that "the term or other status in nondiscrimination provisions in international human rights texts should be interpreted to cover health status, including HIV/AIDS," and has confirmed that "discrimination on the basis of HIV/AIDS status, actual or presumed, is prohibited by existing human rights standards."[52]

Discrimination against people living with HIV and AIDS, or those thought to be infected, is therefore a clear violation of their human rights. People living with or affected by HIV and AIDS are entitled to the same rights as all other members of society and to equal protection under the law. They must be legally protected from discrimination in all spheres of life—both public and private—including in health care, employment, education, travel, housing, and social welfare.

The Role of Human Rights in Combating Stigma and Discrimination

The links between human rights violations and stigma and discrimination must be clarified and then acted on for a number of reasons. First, freedom from discrimination is a

human right, which brings into play an existing framework of responsibility and accountability for state action. Human rights draw attention to states legal obligation to regulate the relationship between individuals living within their borders. Thus, governments are responsible and accountable for directly violating rights, as well as for ensuring that individuals are able to fully realize their rights. In short, states have obligations to *respect, protect,* and *fulfill* human rights.[53]

In the context of HIV/AIDS related discrimination, the obligation to respect requires states to ensure that their laws, policies, and practices do not directly or indirectly discriminate based on HIV or AIDS status.[54] The obligation to protect requires states to take measures that prevent HIV/AIDS related discrimination by third parties, and the obligation to fulfill requires states to adopt appropriate legislative, budgetary, judicial, promotional, and other measures that address HIV/AIDS related discrimination and that compensate those who suffer such discrimination.[55]

Second, a human rights framework provides access to existing procedural, institutional, and other monitoring mechanisms that should not only enforce the rights of people living with HIV and AIDS but should also counteract and redress discriminatory action. Since HIV- and AIDS-related discrimination lead to legal offences being committed, persons who discriminate can be held accountable by law, and redress can be provided where appropriate. Procedural, institutional, and other monitoring mechanisms have also been established at national, regional, and international levels. At the national level, these include the judicial system (courts of law) and national human rights institutions, such as National Human Rights Commissions, Ombudsmen, Law Commissions, and other administrative tribunals.[56,57] In the Lomé Declaration adopted on 16 March 2001 during the Third Regional Meeting of African National Human Rights Institutions, national human rights institutions noted with "deep concern the increasing and worsening misery, poverty and risks relating to the serious threat posed by pandemics such as HIV/AIDS," and emphasized "in view of the increasing challenges presented by HIV/AIDS, the need for intensified efforts to ensure univer-

sal respect for and observance of Human Rights and Fundamental Freedoms for all, to reduce vulnerability to HIV/AIDS and to prevent HIV/AIDS-related discrimination and stigma."[58]

At the Sixth Annual Meeting of the Asia Pacific Forum of National Human Rights Institutions, held in Colombo, Sri Lanka from 24 to 27 September 2001, the Asia Pacific Forum members concluded that HIV/AIDS should not be viewed solely as a health issue but also as a human rights issue "because of its serious economic, social and cultural implications." Forum members "committed themselves to combat discrimination and human rights violations on the basis of HIV/AIDS" and called on "the assistance of the United Nations, governments and NGOs in the performance of this task."[59]

National Institutions of Australia, Fiji, India, Indonesia, Mongolia, Nepal, New Zealand, Philippines and Sri Lanka, at the Workshop on HIV/AIDS and Human Rights: The Role of National Human Rights Institutions in the Asia Pacific, from 7 to 8 October 2001 in Melbourne agreed that "national human rights institutions for the protection and promotion of human rights, in partnership with people living with HIV/AIDS, the United Nations, States, NGOs and other stakeholders can play a central role in the realization of human rights in the context of HIV/AIDS as part of the global response to HIV/AIDS."[60]

At the international level, the six UN human rights treaty bodies monitor states compliance with their obligations to ensure respect for HIV-related human rights at the national level. The treaty bodies provide an important avenue for raising HIV-related human rights issues, elaborating relevant principles of international human rights law, and helping states to better understand and comply with their obligations.

For example, the UN Human Rights Committee has addressed the issue of the right to privacy in the context of HIV/AIDS, noting that Article 17 of the International Covenant on Civil and Political Rights is violated by laws that criminalize private homosexual acts between consenting adults.[61] Specifically, the Committee has found that the "criminalization of homosexual practices cannot be consid-

ered a reasonable means or proportionate measure to achieve the aim of preventing the spread of HIV/AIDS . . . by driving underground many of the people at risk of infection . . . [it] would appear to run counter to the implementation of effective education programmes in respect of the HIV/AIDS prevention."[62] Importantly, the Committee has also held that the term "sex" in Article 26 of the Covenant, which prohibits discrimination on various grounds, should be understood to include sexual orientation.[63] The Human Rights Committee has also confirmed that the prohibition against discrimination thus requires states to review and, if necessary, repeal or amend their laws, policies, and practices to proscribe differential treatment that is based on arbitrary HIV-related criteria.[64] Of course, legally addressing and redressing HIV- and AIDS-related discrimination has its own challenges. There are major gaps in supportive legal frameworks, and many countries do not have antidiscrimination policies or legislation. Even where these exist, people may be unaware that discrimination is unlawful. Additionally, those subjected to discrimination may not know where or how to lodge a complaint, or no mechanism for redress may exist. Further, legal services may either be unaffordable or inaccessible to the most vulnerable communities. Nonetheless, a focus on discrimination is critical as it will ultimately shine a light on and force those who persist in perpetuating stigma to be held accountable and thus counter legitimizing stigma.

A Multipronged Response?

Clearly there is a need to establish community legal aid centers and services based in AIDS service organizations that can handle complaints and enforce HIV- and AIDS-related rights and address cases of discrimination.[65] In addition, existing legal-aid institutions must be trained in human rights and AIDS-related issues, as should members of associations of people living with HIV and AIDS so that these associations can provide in-house paralegal counseling.

But any law is ineffective unless a society as a whole supports its values and expectations. A society's expectations and values can either create and sustain stigma or discourage it from taking hold. For society to embrace and

therefore enforce a law, its members have to participate in its development, as well as to understand it. Thus, without an interaction between the law and the cultural and social values that closely govern people's lives and behavior, the fundamental changes required to alter the course of the epidemic remain unattainable. And it is on these cultural and social values that we will now focus. If much of HIV- and AIDS-related stigma and discrimination are rooted in existing prejudices and social inequalities, then human intervention can modify their nature and effect.

Past stigma reduction efforts appear often to have been developed from a model of "liberal enlightenment" in which those who supposedly know best (usually, communications experts and program planners) intervene to correct the "bad" thoughts and actions of others. This "banking" theory of pedagogy, as educationalist Paulo Freire once described it, sees the minds of those who are being educated as needing to be filled by interventionists who presume they know the truth about what is needed.[66] More rarely have the goals of interventions been designed to unleash the power of resistance to enable those stigmatized populations and communities to fight back. And as Kaleeba and colleagues have pointed out, it is the power of community to resist and to "take charge" (not, on the whole, behavioral interventions) that has made the greatest strides against the epidemic in many poor countries.[67]

It is therefore time to build on existing empirical evidence, as well as on the literature devoted to community organizing to develop new and stronger models for advocacy and change. What might these look like? If models of community mobilization, advocacy, and social change are important, they must operate alongside structural or environmental interventions aimed at transforming the context in which individuals and communities operate.[68,69] This approach has grown out of the assurance that human rights are respected, protected, and fulfilled and is key to successful intervention.

Importantly, while research has shown at best very limited results in influencing or changing stigmatizing attitudes through "empathy inducement," legal protections for

people living with HIV and AIDS, together with appropriate monitoring, reporting, and enforcement mechanisms (ranging from legal-aid services to hotlines for reporting acts of discrimination and violence), can powerfully and rapidly mitigate the worst effects of the unequal power relations, social inequality, and exclusion that lie at the heart of HIV- and AIDS-related stigmatization and discrimination.[70]

In fact, two examples drawn from very different parts of the world illustrate the potential importance of such approaches.

In Mumbai, India, for example, the Lawyers Collective successfully defended workers who were discriminated against and who lost their jobs because of their HIV status. Highlighting ongoing stigma, one of the significant related achievements of this case has been to uphold the "suppression of identity" clause, which allows persons with HIV/AIDS to file their cases under pseudonyms.[71]

In Costa Rica, there had been official resistance to antiretroviral therapy because it was assumed to be too expensive to provide. In response, the Patient Coalition, a small group of people living with AIDS, negotiated unsuccessfully with the government for an entire year. The group then took its cause to the Costa Rican Supreme Court in 1997. The court forced the government to begin offering antiretroviral drugs to people with HIV/AIDS. Today, many Costa Ricans with AIDS receive combination therapy and as a result can be more open about their serostatus.[72]

In elaborating any agenda for future research, the intimate symbiosis between stigma and discrimination makes it important to bear in mind the development of two kinds of alleviation strategies: those who work to prevent stigma or prejudicial thoughts being formed by individuals and those who address or redress the situations where stigma persists and/or is enacted through discriminatory action.

Thus, future work should focus on a multipronged response, combining community mobilization with legal and structural interventions that together support a rights-based approach to fight HIV- and AIDS-related stigmatization and discrimination. Addressing stigma and discrimination requires leadership accountability, and responsibility,

as well as advocacy and respect for human rights. Most important, however, it requires action that is grounded in the experience of individuals and the communities. Only in this way can we create a transformed social climate in which HIV- and AIDS-related stigmatization and discrimination will themselves no longer be tolerated.

References

1. An earlier version of this paper was given at SIDA/UNAIDS "Stigma and HIV/AIDS in Africa: Setting the Operational Research Agenda," 4–6 June 2001, Dar-Es-Salaam, Tanzania.

2. H. Daniel and R. Parker, *Sexuality, Politics and AIDS in Brazil* (London: Falmer Press, 1993).

3. D. Altman, *Power and Community: Organizational and Cultural Responses to AIDS* (London: Taylor and Francis, 1994).

4. United Nations, 2001 UN General Assembly Special Session on HIV/AIDS, retrieved from www.un.org/ga/aids/coverage; OAU (2001) Abuja Declaration on HIV/AIDS, Tuberculosis and Other Infectious Diseases, OAU/SPS/Abuja. At www.un.org/ga/aids.

5. United Nations, UNAIDS (2000) HIV and AIDS-related stigmatization, discrimination and denial: forms, contexts and determinants. Research studies from Uganda and India (prepared by Peter Aggleton), Geneva: UNAIDS; UNAIDS (2001a) Determinants of AIDS-Related Discrimination, Stigmatization and Denial in Uganda (prepared by Sophia Mukasa Monico, Erasmus Otolok Tanga and Augustus Nuwagaba), Geneva: UNAIDS; UNAIDS (2001b), Determinants of AIDS-Related Discrimination, Stigmatization and Denial in India (prepared by Shalini Bharat), Geneva: UNAIDS. U.S. Agency for International Development (USAID), "Combating HIV/AIDS Stigma, Discrimination and Denial: What Way Forward?" Unpublished Concept Paper (Washington, DC:, Author, 23 June 2000), see also www.popcouncil.org/horizons/horizons.html.

6. The address of the Internet forum on AIDS-related stigma is www.hdnet.org.

7. See note 4, 2001 UN General Assembly Special Session on HIV/AIDS.

8. C. Patton, *Sex and Germs: The Politics of AIDS* (Boston, MA: South End Press, 1985).

9. S. Sontag, *AIDS and its Metaphors* (New York: Farrar, Straus and Giroux, 1988).

10. J. Mann, Statement at an Informal Briefing on AIDS, presented at the 42nd Session of the United Nations General Assembly, New York, 20 October 1987.

11. P. Piot, Report by the Executive Director presented at the Programme Coordinating Board, Joint United Nations Programme on AIDS, Rio de Janeiro, 14–15 December 2000.

12. UN Secretary-General Proposes Global Fund for Fight against AIDS and other Infectious Diseases, statement presented to the African Summit on HIV/AIDS, Tuberculosis and Other Infectious Diseases,

Abuja, Nigeria, April 2001; retrieved from www.un.org/ga/aids.
13. A. Malcolm, P. Aggleton, M. Bronfman, J, Galvão, P. Mane, and J. Verrall, "HIV-Related Stigmatization and Discrimination: Its Forms and Contexts," *Critical Public Health* 8/4 (1998): 347–370.
14. G. Marshall, *Oxford Dictionary of Sociology* (Oxford and New York: Oxford University Press, 1998).
15. E. Goffman, *Stigma: Notes on the Management of a Spoiled Identity* (New York: Simon and Schuster, 1963).
16. See note 15.
17. K. Sheldon and L. Caldwell, "Urinary Incontinence in Women: Implications for Therapeutic Recreation," *Therapeutic Recreation Journal* 28 (1994): 203–212.
18. J. Opala and F. Boillot, "Leprosy among the Limba: Illness and Healing in the Context of World View," *Social Science and Medicine* 42 (1996): 3–19.
19. B. L. Fife and E. R. Wright, The Demensionality of Stigma: A Comparison of its Impact on the Self of Persons with HIV/AIDS and Cancer, *Journal of Health and Social Behavior* 41 (2000): 50–67.
20. P. W. Corrigan and D. I. Penn, "Lessons from Social Psychology on Discrediting Psychiatric Stigma," *American Psychologist* 54 (1999): 765–776.
21. For an excellent overview of the literature on stigma in sociology, see B. G. Link and J. C. Phelan, "Conceptualizing Stigma," *Annual Review of Sociology* 27 (2001): 363–385.
22. J. C. Phelan, B. G. Link, A. Steuve, and B. Pescosolido, "Public Conceptions of Mental Illness in 1950 and 1996: What is Mental Illness and is it to be Feared?" *Journal of Health and Social Behavior* 41 (2000): 188–207.
23. J. Crocker, B. Major, and C. Steele, "Social Stigma," in D. T. Gilbert and S.T. Fiske (Eds.), *The Handbook of Social Psychology* vol. 2 (Boston, MA: McGraw-Hill, 1998), pp. 504–553.
24. See note 21.
25. See note 21.
26. M. C. Stafford and R. R. Scott, "Stigma Deviance and Social Control: Some Conceptual Issues," in S. C. Ainlay, L. M. Becker, and L. M. Coleman (Eds.), *The Dilemma of Difference* (New York: Plenum, 1986), p. 80.
27. E. Jones, A. Farina, A. Hastorf, H. Markus, D. T. Miller, and R. R. Scott, *Social Stigma: The Psychology of Marked Relationships* (New York: Freeman, 1984).
28. M. Oliver, *The Politics of Disablement* (London: Macmillan, 1990).
29. See note 21.
30. See note 21.
31. See note 13.
32. See note 8.
33. See note 21.
34. See note 13.
35. Information retrieved from www.aidslaw.ca/Maincontent/issues/discrimination/e-info-da2.pdf.
36. G. Scambler, *Epilepsy* (London: Routledge, 1989).

37. UNAIDS has defined HIV/AIDS-related discrimination as being "Any measure entailing any arbitrary distinction among persons depending on their confirmed or suspected HIV serostatus or state of health." See www.aidslaw.ca/Maincontent/issues/discrimination/e-info-da2.pdf. See T. de Bruyn, *HIV/AIDS and Discrimination: A Discussion* (Montreal: Canadian HIV/AIDS Legal Network and Canadian AIDS Society, 1998).
38. Examples of other rights that may be denied or affected include the right to health; the right to liberty and security of a person; the right to privacy; the right to education; the right to social security, assistance and welfare; and the right to benefit from scientific progress.
39. *Hoffmann* v *South African Airways* (SAA), 2001 (1) SA 1 CC. The Court ordered SAA to make an offer of employment immediately to Mr. Hoffmann, and to pay the costs of the application in both the High Court and the Constitutional Court. For the full judgment, see www.concourt.gov.za/judgments/2000/saa.pdf.
40. Judgment pronounced by the Supreme Court of India in *Mr. X* v *Hospital Y Authority*, [reported in (1998) 8 SCC 296]. Considering that at present there is no cure for HIV, in effect the decision in *Mr. X* implies the Petitioner's fundamental right to marry was completely infringed, and he could not ever marry.
41. See http://travel.state.gov/HIVtestingreqs.htm for a list developed by the U.S. Department of State of about 60 countries that require HIV tests and conditions that are applied.
42. See also J-Y Carlier, *The Free Movement of Persons Living with HIV/AIDS* (Luxembourg: EU HIV/AIDS Programme in Developing Countries, European Commission, 1999); Deutsche AIDS Hilfe, *Quick Reference, Travel and Residence Regulations for People with HIV and AIDS* (Berlin: Author, 2000), retrieved from www.aidshilfe.de; Swiss Federal Department of Foreign Affairs, retrieved from www.hivnet.ch and http://travel.state.gov/HIVtestingreqs.html.
43. This refers to increased likelihood of infection with HIV and/or increased likelihood of suffering needless consequences of HIV infection and AIDS.
44. United Nations General Assembly, adopted on 10 December 1948 under Resolution 217 A (III).
45. United Nations General Assembly, adopted on 10 December 1984 under Resolution 39/46 of December 1984; entered into force on 26 June 1987.
46. United Nations General Assembly, 21st Session, G.A resolution 2200 (XXI), UN GAOR, Supplement No. 16, UN Doc. A/6316 (1966); entered into force 23 March 1976.
47. United Nations General Assembly, 21st Session, adopted on 16 December 1966 under G.A. Res. 2200 (XXI); UN GAOR , Supplement No. 16 at 49, UN Doc. A/6316 (1966).
48. United Nations General Assembly, GA Resolution 34/180 of 18 December 1979; entered into force 3 September 1981.
49. United Nations General Assembly, adopted on 26 June 1981; entered into force 21 October 1986.
50. United Nations General Assembly, adopted 22 November 1969; entered into force 18 July 1978

51. United Nations General Assembly, adopted 4 November 1950; entered into force 3 September 1953.
52. Commission on Human Rights, Resolutions 1999/49 and 2001/51.
53. UN Committee on Economic Social and Cultural Rights General, The right to the highest attainable standard of health, adopted 11 August 2000. E/C.12/2000/4, Comment 14. Paras. 34–37; see also www.unhchr.ch/html/menu2/6/cescr.htm.
54. Governments should ensure that national laws, policies and their activities and programmes directly or indirectly affecting prevention, care and support take full account of human rights principles, and should review and reform that might hamper the ability of its population to take preventive action against infection or hinder access to services for care, treatment and support.
55. 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.
56. National level HIV/AIDS-related litigation has had a significant role in HIV/AIDS response, including in areas of discrimination; access to care and treatment; criminal law; family law; and prisons. For examples, see www/tac/prg/za/; E. Carrasco, "Access to Treatment as a Right to Life and Health," *Canadian HIV and AIDS Policy Law Review* 5 (2000) 4; retrieved from www.aidslaw.ca/maincontent/otherdocs/Newsletter/vol5no42000/ carrascodurban.htm
57. "The World Conference on Human Rights reaffirms the important and constructive role played by national institutions for the promotion and protection of human rights, in particular in their advisory capacity to the competent authorities, their role in remedying human rights violations, in the dissemination of human rights information, and education in human rights. The World Conference on Human Rights encourages the establishment and strengthening of national institutions, having regard to the 'Principles relating to the status of national institutions' and recognizing that it is the right of each State to choose the framework which is best suited to its particular needs at the national level." Vienna Declaration and Programme of Action, World Conference on Human Rights, Vienna, 25 June 1993 (A/CONF.157/24. Part I. Para. 36).
58. The Lomé Declaration urges "national human rights institutions, in consultation with relevant partners, to ensure that national laws, policies, practices respect human rights in the context of HIV/AIDS;promote effective programmes for preventive of HIV/AIDS; ensure effective programmes for care and support for persons infected and affected by HIV/AIDS; including through improved and equitable access to safe and effective medication for the treatment of HIV/AIDS related illness; intensify research for a cure of AIDS." Retrieved from www.unhchr.ch/html/menu2/lomedec.htm.
59. Retrieved from http://nhri.net/pdf/APF6Concluding%20Statement.pdf.
60. Retrieved from www.unaids.org/humanrights/Melbourne1001_

WorkshopReport.pdf and http://nhri.net/AsiaPacificRegional.htm.
61. Communication No. 488/1992, Nicholas Toonen V Australia, (Views adopted on 31 March 1994, 50th session). See Report of the Human Rights Committee Volume II General Assembly Official Record Forty-ninth session (Geneva, 18 October to 5 November 1993);Fiftieth session (United Nations Headquarters, 21 March to 8 April 1994) Fifty-first session (Geneva, 4 to 29 July 1994), (A/49/40). Retrieved from www.Unhchr.ch/tbs/doc.nsf, Para. 8.2, pp. 226–237.
62. See note 61, Para. 8.5.
63. See note 61, Para. 8.7.
64. See note 61, Para. 11.
65. For example: *Alter Law* in the Philippines and the *Lawyers Collective HIV/AIDS Unit* in Mumbai, India. These are groups of lawyers specializing in HIV/AIDS related cases and offering free legal service in this area.
66. P. Freire, *The Pedagogy of the Oppressed* (New York: Continuum, 1970).
67. N. Kaleeba, J. Kadowe, J. Kalnaki, and G. Williams, *Open Secret: People Facing Up to HIV and AIDS in Uganda* (Oxford: ActionAid, 2000).
68. M. Sweat and J. Dennison, "Reducing HIV Incidence in Developing Countries with Structural and Environmental Interventions," *AIDS* 9 (1995), Suppl. A, S225–257.
69. R. Parker, D. Easton, and C. Klein, "Structural Barriers and Facilitators in HIV Prevention: A Review of International Research," *AIDS* 14 (2000), Suppl. 1, S22–S32.
70. R. Parker and P. Aggleton, *HIV and AIDS-Related Stigma and Discrimination: A Conceptual Framework and Implications for Action* (Washington DC: Horizons Project, April 2001).
71. Retrieved from www.hri.ca/partners/lc/about/cases.shtml.
72. Retrieved from www.aegis.com/news/panos/1998/PS980901.html.