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**Agenda item 10**

# Thematic Segment: Non-Discrimination

BACKGROUND NOTE

# BACKGROUND NOTE

## INTRODUCTION

1. At its 29th Meeting in December 2011, the UNAIDS Programme Coordinating Board (PCB) agreed that the subject for the thematic segment of the 31st PCB Meeting (11-13 December 2012) would be "non-discrimination".[1] In the Working Group on the Thematic Segment, it was acknowledged that there have been many important reports over the years which have detailed the devastating impact that HIV-related discrimination has had, and continues to have, on individuals and on the response to the HIV epidemic.[2] Rather than focus solely on the impact of such discrimination, the Working Group decided to use this Thematic Segment to highlight efforts to *reduce* discrimination. This focus is intended to build understanding of what can be done in terms of concrete initiatives and programmes and to encourage expansion of such efforts in national HIV responses.

2. In an effort to canvass fully the many components of HIV-related discrimination as well as to examine various approaches to reducing it, the UNAIDS Secretariat asked the Cosponsors to provide a brief description of the forms that discrimination takes in the sectors in which they lead/work. Secondly, in order to showcase a wide range of efforts to reduce discrimination, the Secretariat issued a call to PCB Members and Observers, Cosponsors and UNAIDS Secretariat regional and country staff to provide short descriptions of programmes in this area. Eighty-seven submissions were received.[3] This paper and its Annex are largely derived from these sources.[4]

3. Following the Thematic Segment, participants should have:
   a. Increased awareness and understanding of policy and programmatic actions that reduce HIV-related discrimination in various sectors, including health care, employment, education, justice and community;
   b. Improved understanding of what is needed to expand these actions within national HIV responses; and

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[1] See *Decisions, Recommendations and Conclusions of the 29th Meeting of the UNAIDS Programme Coordinating Board, 13-15 December 2011*, available at http://www.unaids.org/en/media/unaids/contentassets/documents/pcb/2011/12/20111216_29PCB%20decisions%20final_en.pdf. When choosing the theme for the 31st PCB, the PCB Bureau grouped the following three proposals together under the broad theme of "non-discrimination": populations at higher risk with a focus on non-discrimination and human rights (Sweden); effective programmes for men who have sex with men (China); and homophobia and transphobia as barriers for universal access to HIV attention, prevention and care (Mexico). For more information, see *Next Programme Coordinating Board Meetings, Document prepared by the PCB Bureau* UNAIDS/PCB(29)/11.25 http://www.unaids.org/en/media/unaids/contentassets/documents/pcb/2011/12/20111125_Next%20PCB%20meetings_en.pdf. These sub-themes have informed the preparations for the thematic segment and this background note.

[2] See, for example, *Non-discrimination in HIV-responses*, UNAIDS/PCB(26)/10.3. Available at http://www.unaids.org/en/media/unaids/contentassets/dataimport/pub/basedocument/2010/20100526_non_discrimination_in_hiv_en.pdf; Report by the PCB NGO Representative, 26th meeting of the UNAIDS PCB, UNAIDS/PCB(26)/10.2. Available at http://www.unaids.org/en/media/unaids/contentassets/dataimport/pub/agenda/2010/20100504_ngo_report_final_en.pdf; Report by the PCB NGO Representative, 29th meeting of the UNAIDS PCB, UNAIDS/PCB(29)/11.18.rev1. Available at http://www.unaids.org/en/media/unaids/contentassets/documents/pcb/2011/12/NGO%20Report_Rev1.pdf; *Report of the Global Commission on HIV and the Law: Risks, Rights, and Health*, Chapter 1, July, 2012. Available at http://www.hivlawcommission.org/resources/report/FinalReport-Risks,Rights&Health-EN.pdf

[3] As of 8 October 2012, UNAIDS had received 87 submissions in total from governments, civil society, Cosponsors and UNAIDS staff, with the following regional breakdown: Asia-Pacific: 13; Caribbean: 2; Global: 4; Eastern Europe and Central Asia: 9; Latin America: 12; Middle East and North Africa: 5; Sub-Saharan Africa: 31; Western Europe and Other States: 11

[4] See the Annex to this paper for more a complete description of the submissions received that are cited in the paper. All the submissions of programmes to reduce discrimination, as received in their original form, are available on the UNAIDS PCB website. The UNAIDS Secretariat expresses its appreciation to the many partners who have engaged in this effort.

c. Increased commitment to reducing HIV-related discrimination against people living with HIV, women and other key populations[5].

4. Towards these objectives, this Background Note outlines government commitments and obligations with regard to discrimination in the context of HIV; describes the main forms and prevalence of HIV-related discrimination in various sectors; provides examples of effective policies and programmes to reduce discrimination; and discusses strategies for expanding these policies and programmes in the context of national HIV responses. This Background Note is complemented by an Annex which provides more detailed descriptions of current discrimination reduction programmes and initiatives cited in this paper.[6]

## BACKGROUND

5. The PCB thematic segment on non-discrimination takes as its starting point the *Political Declaration on HIV/AIDS* (2011) in which UN Member States renewed their commitment to eliminating HIV-related stigma and discrimination.[7] These commitments relate to engaging people living with and affected by HIV to address stigma and discrimination[8]; creating enabling legal, social and policy frameworks[9]; ensuring non-discriminatory access to education, health care, employment and social services[10]; inclusion of programmes aimed at eliminating stigma and discrimination against people living with and affected by HIV in national strategies[11]; eliminating discrimination against women[12] and young people[13]; and calling on all actors in the world of work to eliminate stigma and discrimination and facilitate access to HIV prevention, treatment, care and support[14]. The *Declaration of Commitment on HIV/AIDS* (2001) and the *Political Declaration on HIV/AIDS* (2006) also contained extensive commitments relating to reducing discrimination in the context of HIV.[15] The thematic segment also draws on the *UNAIDS Strategy 2011-2015, Getting to Zero*, which envisions a world of "zero new HIV infections, zero AIDS related deaths and *zero discrimination".*[16]

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[5] "Key populations, or key populations at higher risk, are groups of people who are more likely to be exposed to HIV or to transmit it and whose engagement is critical to a successful HIV response. In all countries, key populations include people living with HIV. In most settings, men who have sex with men, transgender people, people who inject drugs and sex workers and their clients are at higher risk of exposure to HIV than other groups. However, each country should define the specific populations that are key to their epidemic and response based on the epidemiological and social context." *UNAIDS Strategy 2011-2015: Getting to Zero*, p. 62, footnote 41 (2011), available at http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2010/jc2034_unaids_strategy_en.pdf.

[6] This Background Note has been prepared with the assistance of a working group composed of member states, civil society and cosponsors in order to provide background for the Thematic Segment on Non-Discrimination at the 31st meeting of the UNAIDS Programme Coordinating Board.

[7] *Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS* (UN Resolution 65/277). June 2011, United Nations: New York. Available at http://www.unaids.org/en/media/unaids/contentassets/documents/document/2011/06/20110610_UN_A-RES-65-277_en.pdf.

[8] *Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS* (UN Resolution 65/277), para 57, June 2011, United Nations: New York. Available at http://www.unaids.org/en/media/unaids/contentassets/documents/document/2011/06/20110610_UN_A-RES-65-277_en.pdf

[9] *Id.* at para 77.

[10] *Id.*

[11] *Id.* at para 80.

[12] *Id.* at para 81.

[13] *Id.* at para 83.

[14] *Id.* at para 85.

[15] *Declaration of Commitment on HIV/AIDS*, United Nations General Assembly, para 37, 58, 66 (2001), available at http://www.unaids.org/en/media/unaids/contentassets/dataimport/publications/irc-pub03/aidsdeclaration_en.pdf; *Political Declaration on HIV/AIDS*, United Nations General Assembly, A/RES/60/262, para 29, 30, 31 (2006), available at http://data.unaids.org/pub/Report/2006/20060615_hlm_politicaldeclaration_ares60262_en.pdf.

[16] *UNAIDS Strategy 2011-2015: Getting to Zero* (2011). *Supra note 5*.

6. Furthermore, the Thematic Segment builds on the PCB agenda item on "non-discrimination in HIV responses", as well as the PCB NGO report on stigma and discrimination, of the 26th PCB meeting in June 2010.[17] At that meeting, the PCB called, among other things, on Member States to create an enabling legal environment and to implement and expand programmes to reduce stigma and discrimination.[18]

*Working definition of HIV-related discrimination*

7. Non-discrimination is one of the basic principles of international human rights law.[19] Thus, discrimination is a human rights violation and is prohibited by international human rights law and most national constitutions. The Commission on Human Rights (now the Human Rights Council) and the Committee on Economic, Social and Cultural Rights have elaborated on the principle of non-discrimination and have explicitly recognized HIV status as a prohibited ground of discrimination.[20] Based on existing human rights standards and international commitments, as well as the previous PCB agenda item on non-discrimination, a working definition of HIV-related discrimination is provided as follows:
   a. Discrimination in the context of HIV refers to *unfair or unjust treatment (an act or omission)* of an individual based on his or her real or perceived HIV status. Discrimination in the context of HIV also includes unfair or unjust treatment which increases vulnerability to HIV infection or to the impact of HIV. In addition to people living with HIV and depending on the social and legal context, key populations that may suffer from discrimination relevant to HIV vulnerability and impact include women, children, young people, migrants, refugees and internally displaced people, sex workers, people who use drugs, men who have sex with men, transgender people and people in prisons and other closed settings.
   b. HIV-related discrimination is closely linked to stigma, i.e. negative beliefs, feelings and attitudes towards people living with HIV and/or associated with HIV. However, it is important to note that even if a person feels stigma towards another, s/he can decide *not to act* in a way that is unfair or discriminatory. Conversely, a person may discriminate against another without personally holding stigmatising beliefs, for example, where discrimination is mandated by law or policy.
   c. HIV-related discrimination may also be closely related to gender inequalities. Power imbalances in society and individual relationships, harmful social norms, violence and marginalization may limit the ability of those affected to avoid HIV infection and/or to mitigate its impact.
   d. HIV-related discrimination may occur in families, workplaces, health-care facilities, prisons and other closed settings, schools, the uniformed services, places of worship, and in the context of social networks, housing, insurance,

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[17] *Non-discrimination in HIV-responses*; *Report by the PCB NGO Representative*, 26th meeting of the UNAIDS PCB, *See supra note 2*

[18] Please see *Decisions, Recommendations and Conclusions of the 26th Meeting of the UNAIDS Programme Coordinating Board.*Available at http://www.unaids.org/en/media/unaids/contentassets/dataimport/pub/agenda/2010/26pcb_decision_points_en.pdf.

[19] For instance, see Article 2 of the *Universal Declaration of Human Rights* http://www.un.org/en/documents/udhr/; Article 2 of the *International Covenant on Civil and Political Rights* http://www2.ohchr.org/english/law/ccpr.htm; Article 2 of the *Convention on the Rights of the Child* http://www2.ohchr.org/english/law/crc.htm; see also the *Convention on the Elimination of All Forms of Discrimination Against Women Discrimination.* http://www2.ohchr.org/english/law/cedaw.htm; *Convention on Elimination of All Forms of Racial Discrimination* http://www2.ohchr.org/english/law/cerd.htm; several articles in the *Convention on the Rights of Persons With Disabilities* http://www.un.org/disabilities/convention/conventionfull.shtml; several articles in the *Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families* http://www2.ohchr.org/english/law/cmw.htm.

[20] *The Protection of Human Rights in the context of HIV and* AIDS, Commission on Human Rights resolution 1999/49. Available at http://www.unhchr.ch/Huridocda/Huridoca.nsf/0/47a2677e0c36688c8025676300599ece?Opendocument. *General Comment No. 20*, Committee on Economic, Social and Cultural Rights, E/C.12/GC/20, (2009), available at http://www2.ohchr.org/english/bodies/cescr/comments.htm.

social support, travel, migration, asylum and refugee resettlement. Discrimination can be institutionalised through laws, policies and practices that negatively target people living with HIV and marginalized groups. Omission can also be a form of discrimination when, for example, the level of resources directed towards certain populations are not commensurate with the level of epidemic among them, and/or when HIV surveillance fails to track infections among these populations.

## FORMS AND PREVALENCE OF HIV-RELATED DISCRIMINATION AND POLICY AND PROGRAMMATIC RESPONSES BY SECTOR

8. The manifestations of HIV-related discrimination often cut across different sectors of society. However, its effects are felt by individuals where they live, work, access health care, go to school, and seek justice. Thus, it is important to devise specific strategies that will be effective for tackling HIV-related discrimination in those sectors. The following section provides a summary of the forms and prevalence of HIV-related discrimination, and presents an overview of the effective approaches to reduce discrimination.

### Health care

9. HIV-related discrimination in health care settings remains highly prevalent and has been recognized as a major barrier to uptake and provision of HIV services.[21] HIV-related discrimination in health care settings can take multiple forms, affecting people living with HIV, their caregivers and/or members of other key populations including: [22]
   a. Refusal to admit someone to a health care facility;
   b. Refused, delayed or poor quality treatment, surgery or care;
   c. Making provision of treatment or care conditional, e.g. on taking an HIV test; bringing or informing a partner;
   d. Premature discharge;
   e. HIV testing without consent and/or not informing patients of HIV-positive results;
   f. Breaches of confidentiality within or outside the health care system;
   g. Discriminatory comments or behaviour, e.g. addressing clients in a judgmental or condemnatory manner, or using derogatory terms;
   h. Use of excessive precautions against infection, including marking the files or clothing of patients living with HIV or isolating them in separate waiting areas or wards when there is no clinical need to do so;
   i. Referring clients unnecessarily to other health workers;
   j. Compulsory or forced provision of treatment; and
   k. For women living with HIV, making treatment conditional on certain forms of family planning, as well as performing abortions, sterilizations and other medical procedures without informed consent.

10. Highly marginalized or criminalized key populations often experience harsh forms of discrimination in health care settings. Sex workers report experiencing abusive and hostile reactions from health workers.[23] Transgender people commonly report that

[21] See for example, *Understanding and Responding to HIV related stigma and discrimination in the health sector*, PAHO 2003, page 27. Available at http://www2.paho.org/hq/dmdocuments/2008/Stigma_report_english.pdf; UNAIDS (2009), *HIV-related Stigma and Discrimination: A Summary of Recent Literature*, available at http://data.unaids.org/pub/Report/2009/20091130_stigmasummary_en.pdf; *Non-discrimination in HIV responses*, *Supra note 2*; and *Report by the PCB NGO Representative*, 26th Meeting of the UNAIDS PCB, *Supra note 2.*

[22] See *Understanding and Responding to HIV related stigma and discrimination in the health sector*, page 27, *Supra note* 21.

[23] Scorgie F., Nakato D., et al., (2011), *I Expect to be Abused and I have Fear: Sex Workers's Experiences of Human Rights Violations and Barriers to Accessing Healthcare in Four African Countries*, African Sex Worker Alliance. Available at: http://www.plri.org/sites/plri.org/files/ASWA_Report_HR_Violations_and_Healthcare_Barriers_14_April_2011.pdf

health providers are uncooperative or hostile, sometimes withholding care.[24] Especially where they are criminalized, men who have sex with men can face severe forms of discrimination in access to health services.[25] People who use drugs are often discriminated against in their ability to access antiretroviral treatment (ARV) and may be denied access to harm reduction services.[26] People in prisons and other closed settings, asylum seekers and undocumented migrants are often denied HIV-related services or suffer from interruption of treatment, including ART, tuberculosis treatments and opioid substitution therapy.[27]

11. HIV-related discrimination against women in the context of health care is also widespread. Women living with HIV may be denied health services, in particular maternal and reproductive health services.[28] Girls and adolescents, as well as young people generally, can also face discrimination in trying to access health services.[29] When services are provided, women may face forced testing and breaches of confidentiality.[30] In addition, the criminalization of HIV transmission may act as a disincentive for women to get tested, reveal their status or access prevention of mother to child transmission services, due to fear and risk of prosecution.[31] Other violations of sexual and reproductive health rights, such as forced or coerced sterilization[32] and inadequate access to family planning services are also widely reported.[33]

Programmatic responses to HIV-related discrimination in health care settings

12. Sensitisation, support and training of health care staff, including administrators, managers and other support staff, to reduce HIV-related discrimination is critical. Effective programmes to reduce discriminatory practices among health professionals provide for:[34]
    a. Information on the modes of transmission of HIV and other infectious diseases, and the level of occupational risk; as well as appropriate procedures, equipment and supplies to prevent occupational exposure;
    b. Promotion of voluntary counselling, testing and care (including post-exposure prophylaxis) for health care staff;

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[24] UNDP (2012), *Lost in Transition: Transgender People, Rights and HIV Vulnerability in Asia Pacific Region*, available at http://www.undp.org/content/dam/undp/library/hivaids/UNDP_HIV_Transgender_report_Lost_in_Transition_May_2012.pdf
[25] *Report by the PCB NGO Representative*, 26th Meeting of the UNAIDS PCB, *Supra note 2*.
[26] Ralf Jürgens, Joanne Csete, Joseph J Amon, Stefan Baral, Chris Beyrer, (2010), *People who use drugs, HIV and human rights*, The Lancet, Volume 376, Issue 9739, Pages 475 – 485.
[27] UNODC/WHO/UNAIDS (2006), *HIV prevention, treatment and care in prisons: a framework for an effective national response*.
[28] *Report of the Global Commission on HIV and the Law: Risks, Rights, and Health*, Chapter 4, July, 2012.
[29] Global Commission on HIV and the Law, *Regional Issues Brief: Rights of Children and Young People to access HIV-related services*, p 4 (2011). Available at http://www.hivlawcommission.org/index.php/dialogue-documentation?task=document.viewdoc&id=3
[30] *Id,* page 65.
[31] *Id.*, page 66.
[32] See for example The International Community of Women Living with HIV/AIDS (ICW) (2009), *The Forced and Coerced Sterilization of HIV Positive Women in Namibia, a*vailable at http://www.icw.org/files/The%20forced%20and%20coerced%20sterilization%20of%20HIV%20positive%20women%20in%20Namibia%2009.pdf; African Gender and Media Initiative (2012), *Robbed of Choice*, *Forced and Coerced Sterilization Experiences of Women Living with HIV in Kenya*, available at http://kelinkenya.org/wp-content/uploads/2010/10/Report-on-Robbed-Of-Choice-Forced-and-Coerced-Sterilization-Experiences-of-Women-Living-with-HIV-in-Kenya.pdf; and *Forcibly Sterilized Woman Files International Case against Chile*, available at http://reproductiverights.org/en/press-room/forcibly-sterilized-woman-files-international-case-against-chile
[33] *Report of the Global Commission on HIV and the Law: Risks, Rights, and Health*, July, 2012, page 66.
[34] See Jain, A., and L. Nyblade (2012). *Scaling Up Policies, Interventions, and Measurement for Stigma-Free HIV Prevention, Care, and Treatment Services. Working Paper #3.* Washington, DC: Futures Group, Health Policy Project; WHO, ILO (2005) *Tripartite Meeting of Experts to Develop Joint ILO/WHO Guidelines on Health Services and HIV/AIDS. TMEHS-2005-04-0160-1-En.doc/v8*; UNAIDS (2007), *Reducing HIV Stigma and Discrimination: a critical part of national AIDS programmes. A resource for national stakeholders in the HIV response*; and WHO, ILO, UNAIDS (2010) *Joint WHO-ILO-UNAIDS policy guidelines on improving health workers' access to HIV and TB prevention, treatment, care and support services: A guidance note*.

c. Awareness of existing legislation, regulations and policies that protect the rights of health professionals and patients regardless of their HIV status;
d. Inter-personal skills to help health professionals understand the impact of HIV and the burden of discrimination, and provide them with the tools to communicate with patients, colleagues and others in a non-discriminatory manner;
e. Understanding ethical principles, e.g. do no harm, informed consent, confidentiality, duty to treat;[35]
f. Systems and processes that maintain privacy and confidentiality;
g. Support to self-assessment and continuous learning;
h. Awareness of the specific health and social needs of marginalized and key populations including migrants, sex workers, people who use drugs, the disabled, men who have sex with men and transgender people;[36] and
i. Development and enforcement of non-discrimination policies at health care settings.[37]

13. Tackling HIV-related discrimination in the health care sector also involves establishing and/or strengthening patient support groups and distributing patients' rights materials to enable people living with HIV and members of others key populations to demand non-discriminatory health care services. Community-based organizations can also play a key role in supporting patients to take up a service, doing exit interviews and providing feedback to those who deliver the health services.

**Employment**

14. HIV-related discrimination in the employment sector may involve laws, policies and/or practices that have the effect of impairing equality of opportunity and treatment for people living with HIV and members of other key populations and marginalized groups. HIV-related discrimination at the workplace includes:
    a. Denial of access to a job or to a specific occupation;[38]
    b. Mandatory pre- or post-employment HIV testing;[39]
    c. Discriminatory HIV-related screening practices;[40]
    d. Breach of confidentiality regarding HIV status;[41]
    e. Differential treatment in terms and conditions of work (denial of training, promotion and career advancement opportunities and exclusion from employment-related benefits, such as health insurance, pension and social security schemes);[42]
    f. Denial of reasonable accommodation;[43]
    g. Social stigma, exclusion and harassment;[44] and

[35] See Annex, para 2 – *Patient Rights Academy*, Submission to UNAIDS by Poland and the Institute of Patient's Rights and Health Education, August 2012.
[36] See Annex, para 3-5 – *Programme répondant aux besoins en matière de santé sexuelle auprès des HSH en Tunisie*, Submission to UNAIDS by ATL MST sida section de Tunis, August 2012 ; and Annex, para 6-8 – *Sisters with a Voice - Zimbabwe's National Sex Work Programme*, Submission to UNAIDS by CeSHHAR Zimbabwe, August 2012.
[37] Jain, A., and L. Nyblade (2012), *See Supra note 34.*
[38] See the Indian Andhra Pradesh High Court's judgment of 22 December 2005 *X v. The Chairman, State Level Police Recruitment Board,* Case No. 15981 of 2005.
[39] See UNAIDS and UN Department of Peacekeeping Operations, (2011), *On the Front Line: a review of programmes that address HIV among international peacekeepers and uniformed services 2005-2010*,; Livingstone High Court of Zambia's judgment of 27 May 2010, *Kingaipe et al. v. Zambia Air Force,* Case No. 2009/HL/86.
[40] See *Gary Shane Allpass v. Mooikloof Estates (Pty) Ltd*, (Case No. JS178/09), 16 February 2001.
[41] See the European Court of Human Rights in the case *I v. Finland,* Case No. 20511/03, Judgment of 17 July 2008.
[42] See decision of the Constitutional Court of Peru, Case N.° 04749-2009-PA/TC.; Bombay High Court of India in *S. Indian Inhabitant of Mumbai v. Director General of Police, CISF and others (unreported),* Case No. 202 of 1999, Judgment of 27 February 2004.
[43] For example, section 15(2) c) of the South African Employment Equity Act (Act No. 55 of 1998) requires employers to provide reasonable accommodation for all workers, including those living with HIV and AIDS. See also the South African Code of Good Practice on HIV and AIDS and the World of Work, 15 June 2012, at section 7.4.
[44] See a ruling by the Greek Supreme Court issued on 17 February 2009 (Case No. 676/2009); See also the Canadian Human Rights Tribunal in the case *Fontaine v Canadian Pacific Ltd,* Case No. TD 14/89, Judgment of 27 October 1989

h. Unfair dismissal[45].

15. HIV-related discrimination in the context of employment is also often linked to other grounds of discrimination.[46] Those already marginalized or disadvantaged in the labour market are hit hardest. These may include migrant workers, women, people with disabilities and other key populations, including men who have sex with men, transgender people, sex workers and people who use drugs.[47]

16. HIV-related discrimination in employment and occupation remains widespread.[48] A sample of findings from the PLHIV Stigma Index[49] reported: loss of employment or source of income (from 8% in Estonia to 45% in Nigeria); change in the nature of work or refusal of promotion (up to 28% of respondents in Kenya); and discriminatory reactions from employers and colleagues (up to 54% of respondents in Malaysia).[50]

Programmatic responses to HIV-related discrimination in employment settings

17. Means by which to reduce HIV-related discrimination in employment include: the creation of an enabling legal environment; establishment of workplace policies and enforcement mechanisms; sensitization of employers and workers' representatives; increase of employment opportunities for people living with HIV, women and other key populations; and establishment of social protection floors.

18. *Enabling legal environment for the workplace* – Comprehensive national legislation can offer protection against HIV-related discrimination in job applications and employment. International labour standards[51] provide guidance for the development of legislation and policy to eliminate employment-related discrimination on the basis of real or perceived HIV status.[52] Programmes to establish or strengthen enforcement of relevant legal protections include sensitization of policymakers, judges, court staff, legal professionals and labour inspectors on the principle of non-discrimination as it relates to HIV.[53] Programmes providing support for law reform, coupled with initiatives to promote legal literacy and access to redress for discriminatory actions, have proven effective.[54]

19. *Social protection* – Effective social protection policies contribute to HIV prevention and mitigate the impact of the HIV epidemic. The ILO Recommendation No. 200 provides specifically that there should be no discrimination against workers or their dependents on the basis of real or perceived HIV status in accessing social security and occupational insurance systems and benefits afforded under these schemes.[55]

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[45] See for example the South African Labour Court in the case *Bootes v Eagle Ink Systems Kwazulu – Natal (Pty),* Case No. D781/05, Judgment of 17 August 2007.
[46] Conyers, et al., *A comparison of equal opportunity commission case resolution patterns on people with HIV/AIDS and other disabilities*, Journal of Vocational Rehabilitation 22 (2005) 171-178.
[47] *Non-discrimination in HIV responses*, 26th Meeting of the UNAIDS PCB, *Supra note 2.*
[48] *See Protection of Human Rights in the context of human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS),* United Nations General Assembly, A/HRC/16/69, 20 December 2010, at paras 5 and 10.
[49] GNP+, ILO, The PLHIV Stigma Index, 2012, *Evidence Brief on Stigma and Discrimination at Work: Findings from the PLHIV Stigma Index* The evidence brief covered nine countries in four regions: Argentina, Estonia, Kenya, Malaysia, Mexico, Nigeria, Philippines, Poland and Zambia.
[50] *See also* Adeyemo DA, AA Oyinloye. Predispositional Factors in Stigmatization and Discrimination Against HIV/AIDS Seropositive Persons in the Workplace: A Case Study of Osun State, Nigeria. *Journal of Social Sciences* 2007,15:279-92; Rao D, B Angell, C Lam et al. Stigma in the workplace: Employer attitudes about people with HIV in Beijing, Hong Kong, and Chicago. *Soc Sci Med* 2010;67:1541-49.
[51] See particularly the *ILO Discrimination (Employment and Occupation) Convention, 1958 (No. 111)* and the *ILO Recommendation concerning HIV and AIDS and the World of Work, 2010 (No. 200)*.
[52] *See Political Declaration on HIV/AIDS of* 2011, *Supra note 7.*
[53] *See* (ILO, 2010), *International Labour Law and Domestic Law: A training manual for judges, lawyers and legal educators*
[54] See Annex, para 12-13 – *Strengthening equal opportunity and treatment for people living with HIV and AIDS, and training for health workers on implementation of standard precautions and reduction of stigma and discrimination* (China), Submission to UNAIDS by the ILO, September 2012.
[55] *ILO Recommendation concerning HIV and AIDS and the World of Work, para 20, 2010 (No. 200)*.

The ILO Social Protection Floors Recommendation, 2012 (No. 202) affirms the principle of universality of protection, calling on countries to establish social protection floors that provide for equal access for all to basic social security guarantees.[56]

20. *Workplace policies* – Workplace HIV policies provide an enabling framework for the design and delivery of programmes to reduce HIV-related discrimination at the workplace. An essential component of effective programming is training "world of work" actors to develop, implement and monitor workplace policies to reduce HIV-related discrimination.[57]

21. *Empowerment of people living with HIV and other key populations* – People living with HIV and members of other key populations should be at the centre of efforts to reduce HIV-related discrimination in the world of work. They should be involved in the design and implementation of tailored national and sectoral workplace policies and programmes aimed at reducing HIV-related discrimination.[58]

**Education**

22. In the education sector, HIV-related discrimination can affect students, teachers and other education sector personnel living with HIV, as well as those indirectly affected by the epidemic, such as family members and friends of people living with HIV. Students living with or affected by HIV may face various discriminatory reactions from peers, educators, other parents and community members, including: [59]
    a. Bullying and harassment, physical or verbal violence, ostracism and rejection;
    b. Differential treatment from educators and other staff in the learning environment;
    c. Exclusion from physical and recreational activities, sanitation, school health care facilities, boarding accommodation, or campus residences;
    d. Denial of access to schools, educational programmes, loans, bursaries, scholarships or grade advancement; and
    e. Application of travel restrictions to students living with HIV denying them the right to study abroad.[60]

23. Educators, education planners and other education sector staff living with or affected by HIV may face:[61]
    a. Refusal of employment or dismissal from work;
    b. Compulsory HIV testing as a condition of employment;
    c. Violations of confidentiality regarding HIV status;
    d. Physical or verbal violence and harassment, ostracism and rejection;
    e. Restriction on participation in educational events, career advancement, or training programmes; and
    f. Limited medical, financial, or other support for affected family members.

[56] *ILO Social Protection Floors Recommendation, 2012 (No. 202).* See also Annex, para 15-16 – *Social security benefits for sex workers in Uruguay*, Submission to UNAIDS by Banco de Previsión Social, Uruguay, August 2012.
[57] See Annex para 14 – *Ensuring stigma- and discrimination–free workplaces through fundamental human rights, livelihood support and economic empowerment* (Tajikistan), Submission to UNAIDS by the ILO, September 2012.
[58] See Annex, para 9-11 – *Companies Committed to the HIV Response*, Submission to UNAIDS by Fundacion Husped, Argentina, August 2012.
[59] UNESCO (2008), *Addressing HIV-related stigma and discrimination*. EDUCAIDS Technical Briefs, available at http://unesdoc.unesco.org/images/0015/001584/158436E.pdf#25
[60] For more information, please see Report of the International Task Team on HIV-related Travel Restrictions, December 2008. Available at https://www.unaids.org/en/media/unaids/contentassets/dataimport/pub/report/2009/jc1715_report_inter_task_team_hiv_en.pdf
[61] UNESCO (2008), *Addressing HIV-related stigma and discrimination*. EDUCAIDS Technical Briefs, supra note 59.

24. HIV-related discrimination appears to be less prevalent in the context of education than other spheres of life, such as employment or housing.[62] However, adults and children living with HIV continue to be affected in many countries. For example, the *PLHIV Stigma Index* findings in the Asia Pacific region show that many people had decided, as a result of their HIV status, to withdraw from education and training, ranging from 3% of the Stigma Index respondents in Bangladesh to 47% respondents in Pakistan.[63]

Programmatic responses to HIV-related discrimination in the education sector

25. Effective strategies to reduce discrimination in education include efforts to:[64]
    a. Provide clear messages about the modes of transmission of HIV and challenge false ideas about the epidemic;
    b. Deliver age-appropriate, good quality and comprehensive HIV and sexuality education to increase knowledge and understanding of HIV prevention and treatment, eliminate fears and misconceptions, and reduce stigmatising attitudes;
    c. Promote life skills education to enable young people to maintain healthy lifestyles, resist negative pressures and avoid risk-taking behaviours;
    d. Provide teacher-training on HIV, gender, human rights and life skills, and on effective communication;
    e. Establish mechanisms for reporting and addressing discriminatory incidents, including discrimination related to HIV, gender, sexual orientation, poverty and disability;[65] and
    f. Promote a culture of tolerance and non-discrimination in schools, reinforced by codes of practice and guidelines.

26. The following programmatic actions are necessary at the community level in order to reduce discrimination in the context of education: [66]
    a. Engaging parents and community members in changing stigmatising attitudes and promoting a culture of tolerance;
    b. Involving people with HIV in HIV education and care activities; [67]
    c. Supporting the establishment of clubs and youth associations, and promoting school campaigns against HIV-related stigma and discrimination;
    d. Involving parents in education programmes and school committees to improve their knowledge of and attitudes about HIV; and
    e. Supporting advocacy at the community level to better understand stigma and discrimination and its impact.

**Justice**

27. The justice sector provides a major opportunity by which to protect people against HIV-related discrimination through protective laws, law enforcement and access to justice. However, in some contexts, the law is not protective, or if it is, is not enforced; law enforcement itself may be discriminatory and abusive; and people

[62] GNP+, ICW, IPPF and UNAIDS (2011), *The People Living with HIV Stigma Index, Asia Pacific Regional Analysis*, page 7, available at http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/20110829_PLHIVStigmaIndex_en.pdf
[63] *Id*.
[64] UNESCO (2008), *Supra note59*.
[65] See Annex, para 21-22 – *"Break the Norm" – reducing discrimination based on sexuality, gender identity and/or gender expression*, Submission to UNAIDS by RFSL Ungdom, Sweden, September 2012. See also Annex, para 17-19 – *Safe Environment and Non-discrimination in Schools in Ethiopia (SENSE)*, Submission to UNAIDS by Save the Children, Denmark, August 2012.
[66] UNESCO (2008), *Supra note 59.*
[67] See Annex, para 20 – *School outreaches by KENEPOTE members to enhance disclosure in order to reduce stigma and discrimination*, Submission to UNAIDS by Kenya Network of HIV-positive Teachers (KENEPOTE), August 2012.

living with HIV and members of other key populations may encounter difficulties in accessing the justice system.[68]

*Law*

28. In 2012, 101 countries (61% of countries reporting) report having laws that protect people living with HIV from discrimination. Unfortunately, it is difficult to monitor the level of enforcement of these laws. Furthermore, it is concerning that some one-third of countries do *not* report having such laws. It also appears that legal and regulatory frameworks rarely provide protection from discrimination for other key populations.[69] Furthermore, in 2012, non-governmental sources in 70% of countries and governmental sources in 60% of countries report having laws that "present obstacles for access to HIV prevention, treatment and care for key populations".[70]

*Law enforcement*

29. Police in many communities fail to adequately protect women from domestic violence or rape. They may also engage in abuses and illegal practices, often with impunity, towards men who have sex with men, transgender people, sex workers and people who use drugs, including harassment, extortion, arbitrary arrest, violence and rape. Such actions not only comprise a violation of human rights, but they also serve to drive key populations away from HIV treatment and other health services.[71] It also appears that overly-broad laws that criminalize HIV nondisclosure, exposure and transmission are often enforced selectively against migrants, sex workers and people of colour.[72] In prisons and other closed settings, individuals may be subjected to mandatory HIV testing, segregation on the basis of HIV-status, breach of confidentiality, lower access to work and other activities as well as poorer standards of health and HIV services than the surrounding community.[73]

*Access to justice*

30. Individuals, particularly those belonging to poor, marginalized and/or criminalized populations, often do not know and understand the law and their rights in relation to HIV. In addition, insufficient access to free or affordable HIV-related legal services and to transparent and accessible mechanisms to report cases of discrimination leaves those subjected to discrimination without recourse to redress. The lack of procedural safeguards and the lack of sensitization of judges to issues pertaining to HIV and the law are impediments to justice. While countries are reporting increased

[68] For more information on HIV and the legal environment, see Background Note from the 29th PCB Thematic Segment on *HIV and Enabling Legal Environments*, UNAIDS/PCB(29)/11.27, December 2011, available at http://www.unaids.org/en/media/unaids/contentassets/documents/pcb/2011/thematic%20segment_final_correction2Dec.pdf; see also Report by the PCB NGO Representative – 29th meeting of the UNAIDS PCB, UNAIDS/PCB(29)/11.18.rev1. Available at http://www.unaids.org/en/media/unaids/contentassets/documents/pcb/2011/12/NGO%20Report_Rev1.pdf
[69] Global AIDS Response Progress Reports, 2012.
[70] *Id*. For more information on laws that present obstacles to effective HIV responses, please see *HIV and the Law: Risks, Rights and Health*, Global Commission on HIV and the Law, July 2012, available at http://www.hivlawcommission.org/resources/report/FinalReport-Risks,Rights&Health-EN.pdf well as the Background Note from the 29th PCB Thematic Segment on *HIV and Enabling Legal Environments*, UNAIDS/PCB(29)/11.27, December 2011, available at http://www.unaids.org/en/media/unaids/contentassets/documents/pcb/2011/thematic%20segment_final_correction2Dec.pdf
[71] For more information, please see. For more information, please see Background Note from 29th PCB Thematic Segment on *HIV and Enabling Legal Environments*. *Supra note 70*.
[72] UNAIDS, UNDP and the Inter-Parliamentary Union (2007), *Taking Action against HIV: a handbook for parliamentarians*, No. 15, page 212, available at http://www.unaids.org/en/media/unaids/contentassets/dataimport/pub/manual/2007/20071128_ipu_handbook_en.pdf
[73] Please see UNODC/WHO, UNAIDS (2006), *HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings A Framework for an Effective National Response*; UNODC/WHO/UNAIDS (2009) *HIV testing in prisons*; Jürgens R, Nowak M., Day M. (2011), HIV and incarceration: prisons and detention, *Journal of the International AIDS Society* , 14:26

implementation of access to justice programmes in the context of national HIV responses,[74] it appears that the coverage of these programmes remains inadequate.

Programmatic responses to HIV-related discrimination in the justice sector

*Law*

31. To ensure legal protection against HIV-related discrimination, the following programmatic actions are needed:[75]
    a. Reviews of laws (formal/codified, customary and religious), regulations and policies to assess whether these laws protect people living with HIV, women and other key populations from discrimination in the context of HIV;
    b. Advocacy and lobbying to generate political will for enacting and reforming legislation to ensure protection against HIV-related discrimination; [76] and
    c. Engagement of Parliamentarians, Ministries of Justice, Interior, Corrections, Migration, Women's Affairs, to fully enforce protective laws.

*Law enforcement*

32. To make legal protection a reality requires sensitization of law enforcement agents, including judges, police, prosecutors, prison authorities, labour inspectors, judicial authorities, defence lawyers, drug control agencies, as well as traditional and religious leaders, on non-discrimination in the context of HIV. [77] It also requires the production of regulations and guidelines that put protective laws into practice; allocating budgets for their implementation; communication on the laws and policies to relevant government departments and other public institutions; and monitoring the implementation and enforcement of the laws.

*Access to justice*

33. There are several programmatic efforts that help increase access to justice in the context of HIV-related discrimination, including:
    a. mechanisms to monitor and address cases of discrimination;
    b. HIV-related legal services; and
    c. Legal literacy programmes.

34. *Mechanisms to monitor and address cases of discrimination* – There can be various types of mechanisms by which to monitor and address discrimination – administrative, judicial, part of the work of National Human Rights Institutions, civil-society-led. Such mechanisms function best when their personnel are sensitized, they fully address discrimination in the context of HIV, they are highly accessible to and acceptable by those living with and affected by HIV and AIDS[78], as well as by other key populations, and they include a public awareness component.[79]

[74] Global AIDS Response Progress Reports, 2012
[75] For more information, please see UNAIDS, *Key programmes to reduce stigma and discrimination and increase access to justice in national HIV responses*, May 2012, available at http://www.unaids.org/en/media/unaids/contentassets/documents/document/2012/Key_Human_Rights_Programmes_en_May2012.pdf
[76] See Annex, para 28 – Submission to UNAIDS by UNAIDS Guyana, August 2012.
[77] See Annex, para 26-27 – Submission to UNAIDS by the Ministry of Health of El Salvador, August 2012.
[78] See Annex, para 34-36 – *Increasing access to justice for People Living with HIV and affected by HIV,* Submission to UNAIDS by HIV/AIDS Equity Tribunal, Kenya, August 2012.
[79] Boyko, A., K. Beardsley, and C. Wild. 2012. *Designing an HIV Discrimination Monitoring, Reporting, and Referral System—International best practices and current policy, practice, and opportunities in Ukraine*. Washington, DC: Futures Group, Health Policy Project. Available at http://www.healthpolicyproject.com/pubs/80_UkraineDiscriminationSystem.pdf

35. *HIV-related legal services* – Legal services include the provision of legal information and advice, legal representation, strategic litigation, and assistance in the context of religious or traditional legal systems.[80] HIV-related legal services may be delivered by many different providers and in a range of settings.[81] Key to the goal of increasing access to quality legal services is ensuring that there are sensitized, non-judgmental lawyers, paralegals or traditional leaders available and with the skills and knowledge to manage HIV-related cases.[82]

36. *Legal literacy* – Legal literacy programmes raise awareness about human rights and local laws in the context of HIV, with the aim of empowering individuals and communities to claim their right to non-discrimination in the context of the HIV response.[83] Networks of people living with HIV, women and members of other key populations can benefit from such programmes[84], but they are seldom sufficiently funded.

**Community**

37. HIV-related discrimination within communities remains highly prevalent. People living with HIV report, for example, being excluded from family gatherings and social and religious events; being forced to live in separate housing; being verbally abused; and being physically assaulted. People living with HIV who are already marginalized due to their social or legal status report experiencing particularly high levels, as well as more severe forms, of discriminatory reactions within communities.[85] Women and girls living with and affected by HIV may also face harsh discrimination within their communities. For instance, women who disclose their HIV status to their partners and family may face violence or abandonment.[86] Women can also be victims of gender-based violence, which increases their vulnerability to HIV.[87]

Programmatic responses to HIV-related discrimination within communities

38. Effective programmatic approaches in communities include strengthening networks of people living with HIV, other key populations and community groups so as to build the community's resources to challenge stigma and discrimination[88]; involving people living with HIV, other key populations and community members in non-stigmatizing HIV prevention and care activities; fostering interaction between people living with HIV, other key populations and community members; and media campaigns.[89] Engaging religious and community leaders, celebrities, sports stars, policy makers and other actors in discrimination reduction campaigns can also positively influence

[80] For more information, see Background Note from the 29th PCB Thematic Segment on *HIV and Enabling Legal Environments*, *Supra note* 70.
[81] IDLO, UNDP and UNAIDS (2009). *Toolkit: Scaling up HIV-related Legal Services*. Available at http://www.idlo.int/publications/hivtoolkit.pdf
[82] See Annex para 31-33 - *Strengthening and Expanding HIV-related legal services in Papua New* Guinea, Submission to UNAIDS by the International Development Law Organization, August 2012.
[83] See Annex, para 29-30 – *Crisis Intervention*, Submission to UNAIDS by Community Network for Empowerment (CoNE)-A State Level Network of Community Based Organisations of People Who Use Drugs, August 2012.
[84] See Annex, para 23-25 – *Moi, Femmes! Et mes droits?* Submission to UNAIDS by Réseau Ivoirien des Organizations de Personnes Vivant avec le VIH, August 2012.
[85] People living with HIV Stigma Index. For more information, see www.stigmaindex.org. See also *Report by the PCB NGO Representative*, 26th Meeting of the UNAIDS PCB, *Supra note 2.*
[86] *Report of the Global Commission on HIV and the Law: Risks, Rights, and Health*, July, 2012, page 65.
[87] See Annex, para 37-38 – *Life on the Edge*, Submission to UNAIDS by Women against Rape, Antigua, August 2012.
[88] See Annex, para 56-58 – *Provision of psychosocial support to people living with HIV and their families*, Submission to UNAIDS by UNAIDS Iran, October 2012.
[89] Please note that media may also give negative coverage of an issue and thus approaches involving media participation should be carefully considered before proceeding. Moreover, if media is used, it is critical to ensure that the participants' rights to privacy and confidentiality are protected.

attitudes and behaviours among the wider population.[90] Furthermore, entertainment and informational products such as films, plays, posters, comic books, brochures, and TV and radio spots or shows ("edutainment") can be very compelling. Such programmes have successfully been implemented in several countries, including Egypt[91], France[92], Germany[93], India[94], and Japan[95].

## STRATEGIES TO EXPAND THE REDUCTION OF HIV-RELATED DISCRIMINATION

39. In order to expand discrimination-reduction in the context of national HIV responses, it is necessary to: (a) institutionalize discrimination-reduction programmes at sufficient scale in relevant national strategies, (b) secure adequate funding for these programmes and (c) better engage people living with HIV and members of other key populations as forces against discrimination.

*Including discrimination reduction as an integral part of national AIDS responses*

40. Programmes to reduce HIV-related discrimination should be supported and expanded as needed in the national context; however, for this to happened they should be institutionalized within the national HIV strategy and other relevant strategies. This includes setting targets on discrimination reduction; including a comprehensive package of programmes to reduce discrimination in national strategies; setting indicators for measuring progress; and costing, budgeting, implementing and evaluating the programmes.

41. As requested by the PCB in 2010, the UNAIDS family has developed, and is developing, resources on planning, costing, monitoring and evaluating discrimination-reduction programmes in the context of HIV.[96] For instance, resources have been developed for national stakeholders that describe the actionable causes of stigma and discrimination as well as a range of programmes to address these.[97]

42. Furthermore, systematic measurement of stigma and discrimination is essential for planning strategic action and for monitoring progress in discrimination reduction.[98] Measurement tools are being improved and rolled out. These include improved indicators to measure HIV-related stigma and discrimination at community level.[99] These new indicators were field tested in 2011 and will be submitted for approval to

[90] See Annex, para 54-55 – *Changing Religious Attitudes, Changing Faith Perspectives: Theological Reflections on the Transformative Strategies of Sexual Minorities*, Submission to UNAIDS by INERELA+, August 2012.
[91] See Annex, para 39-40 –*Asmaa – Shaping public opinion related to people and women living with HIV*, Submission to UNAIDS by UNAIDS Egypt, September 2012.
[92] See Annex, para 41-46 – *Et si j'étais seropositive? Campaign*, Submission to UNAIDS by AIDES, France, August 2012Submission to UNAIDS by AIDES, France, August 2012.
[93] See Annex, para 47-49 – *Nation-wide campaign anti-discrimination to mark World AIDS Day called "Living together positively. Be safe!" ("Positiv zusammen leben. Aber sicher!")*, Submission to UNAIDS by AIDS Control Measures Organisation: *Bundeszentrale für gesundheitliche Aufklärung* (Federal Centre for Health Education), Germany, August 2012.
[94] See Annex, para 50-53 – Submission to UNAIDS by the National AIDS Control Organisation, Department of AIDS Control, Ministry of Health and Family Welfare, India, August 2012.
[95] See Annex, para 59-60 – *Poster Contest*, Submission to UNAIDS by the Ministry of Health, Labour and Welfare, Japan, August 2012.
[96] Please see *Decisions, Recommendations and Conclusions of the 26th Meeting of the UNAIDS Programme Coordinating Board, Geneva, Switzerland, 22-24 June 2010* at http://www.unaids.org/en/media/unaids/contentassets/dataimport/pub/agenda/2010/26pcb_decision_points_en.pdf
[97] *Reducing HIV Stigma and Discrimination: a critical part of national AIDS programmes, a*vailable at http://data.unaids.org/pub/Report/2008/JC1521_stigmatisation_en.pdf ; *Guidance Note on Key Programmes to Reduce Stigma and Discrimination and Increase Access to Justice in National HIV Responses*, available at http://www.unaids.org/en/media/unaids/contentassets/documents/document/2012/Key_Human_Rights_Programmes_en_May2012.pdf
[98] Jain, A., and L. Nyblade (2012), *Supra note 34.*
[99] Please see, http://www.unaids.org/en/resources/presscentre/featurestories/2009/november/20091130stigmaindicators/

the UNAIDS Monitoring and Evaluation Reference Group by the end of 2012. If approved, the indicators can be included in national monitoring and evaluation frameworks to inform expansion of effective discrimination reduction efforts and used to monitor progress by UN Member States.[100] Work is also on-going to develop a better tool by which to measure stigma and discrimination in health care settings.[101] Finally, the PLHIV Stigma Index has been used by national networks of people living with HIV in over 40 countries to measure the experience of stigma and discrimination among people living with HIV in different spheres of life. Not only is the Stigma Index yielding rich data but is also building a cadre of people living with HIV who can take on discrimination at national and community levels.

43. In order to assist in better costing of a wide range of programmes that can support human rights in the context of national AIDS responses, there has been developed a simple costing tool for such programmes, including programmes to reduce discrimination.[102] The *Human Rights Costing Tool* can be used to initiate a process to find out what efforts to reduce discrimination are being implemented in country, what their costs are, and how these can be brought into the national plan/national funding proposals for greater support and expansion.[103]

44. For programmes to reduce discrimination to be included in national AIDS responses, national planners and implementers must understand them and be willing to take them up. Since 2011, the UNAIDS Secretariat has partnered with the International HIV/AIDS Alliance on a project supported by the Ford Foundation to integrate concrete programmes to support HIV-related human rights, including non-discrimination, into national strategic plans. Workshops have been held with national strategic planners and civil society in Asia Pacific, East and Southern Africa and the Middle East and North Africa, with one planned for 2013 in Latin America. National counterparts have found these workshops very helpful in engaging in concrete and programmatic ways to respond to HIV-related human rights issues, including discrimination.[104]

45. Some countries are at the forefront in terms of including the reduction of HIV-related discrimination as a strategic objective of their national HIV strategy. For instance, South Africa has made the reduction of discrimination a major effort in its previous national strategic plan as well as its current one for 2012-2016.[105] Thailand's new national plan also makes discrimination reduction one of its strategic goals.[106] Not only should such efforts receive any needed support, but the challenges, opportunities and successes involved should be captured and used to inform the expansion of discrimination reduction efforts in other countries.

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[100] Please see A. Stangl, V. Go, C. Zelaya, L. Brady, L. Nyblade, L. Stackpool-Moore, J. Hows, L.Sprague5, L. Nykanen-Rettaroli and B. de Zalduondo (2010). *Enabling the Scale-up of Efforts to Reduce HIV Stigma and Discrimination: A New Framework to Inform Program Implementation and Measurement,* available at http://www.stigmaactionnetwork.org/atomicDocuments/SANDocuments/20120308233824-Stigma%20Framework%20Poster%20FINAL.pdf

[101] Jain, A., and L. Nyblade (2012). *Scaling Up Policies, Interventions, and Measurement for Stigma-Free HIV Prevention, Care, and Treatment Services. Working Paper #3.* Washington, DC: Futures Group, Health Policy Project.

[102] See UNAIDS (2012), *Human Rights Costing Tool*, available at http://www.unaids.org/en/resources/presscentre/featurestories/2012/august/20120806hrct/; and UNAIDS (2012), *The User Guide for the HIV-related Human Rights Costing Tool*, available at http://www.unaids.org/en/media/unaids/contentassets/documents/document/2012/The_HRCT_User_Guide_FINAL_2012-07-09.pdf

[103] See, for example, the process of implementation of the Human Rights Costing Tool in Jamaica: http://www.unaids.org/en/resources/presscentre/featurestories/2012/august/20120806hrct/

[104] UNAIDS, International HIV/AIDS Alliance (draft), *Making it work: Integrating Human Rights into National HIV Strategic Plans*

[105] See *National Strategic Plan on HIV, STIs and TB, 2012-2016*, Republic of South Africa, available at http://www.doh.gov.za/docs/stratdocs/2012/NSPfull.pdf

[106] *AIDS Zero, Thailand National AIDS Strategy 2012-2016*

*Funding of non-discrimination efforts and those engaged in them*

46. Studies have shown that programmes to reduce discrimination in the context of HIV (as well as other programmes related to human rights) may be referenced as guiding principles or cross-cutting issues in funding proposals and/or national plans, but are often not costed or budgeted for, and in such cases, do not appear to receive funding or be actually implemented.[107] Referring to programmes to support HIV-related human rights, which include discrimination reduction, the Technical Review Panel (TRP) of the Global Fund to Fight AIDS, Tuberculosis and Malaria stated in its 2012 report, that: "The TRP notes that human rights related actions (e.g. ensuring equitable access to quality services, removing human rights-related barriers and creating supportive environments) continue to be insufficiently addressed and articulated in Global Fund proposals."[108] There are opportunities to change this situation. The *Global Fund Strategy 2012-2016: Investing for Impact* includes, among other things, a commitment to investing in programmes that address human rights-related barriers to access.[109] As partners put together the new Global Fund funding model, they are considering how to better incentivize such programmes. In the same report cited above, the TRP recommended that "in order to ensure effective program implementation, applicants should be instructed that human rights-related issues be given due importance in the discussion of how the proposal will be implemented, and that failure to do so will jeopardize the application."

47. Furthermore, the new focus on strategic investment in the AIDS response provides hope that programmes to reduce discrimination will finally be given the attention and resources they deserve. One of the pre-requisites for investing effectively is identifying key drivers of the epidemic, including legal and socio-cultural factors, and assessing the extent to which HIV-related stigma and discrimination block the demand for and use of available services.[110] Under the strategic investment focus, countries are encouraged to put in place evidence-informed "basic programmes" as well as "critical enablers" necessary to ensure the maximum efficacy of such programmes.[111] Programmes to reduce discrimination are one type of critical enabler most needed to overcome barriers to service uptake.

48. Another issue is the *availability* of funders who actively fund such programmes and organizations that implement them. In the overall drop in funding for HIV, there is concern and indications that some of the hardest hit are civil society organisations working to support human rights, including non-discrimination, in the context of HIV. A report by Open Society Foundation indicates that many bilateral and private donors that formerly funded such groups in Southern Africa have decreased AIDS funding in general and/or have shifted funding to other issues. Few of the donors that do fund such groups provide *core* funding which is essential for many small organizations to

[107] UNDP, UNAIDS, the Global Fund to Fight AIDS, Tuberculosis and Malaria (2011)*, Analysis of key human rights programmes in Global Fund-supported HIV programmes*, available at http://www.undp.org/content/dam/aplaws/publication/en/publications/hiv-aids/analysis-of-key-human-rights-programmes-in-global-fund-supported-hiv-programmes/Analysis%20of%20Key%20HRTS%20Programmes%20in%20GF-Supported%20HIV%20Programmes.pdf

[108] GF/B26/ER 07; Report of the Technical Review Panel and the Secretariat on the Transitional Funding Mechanism, July 2012.

[109] See http://www.theglobalfund.org/en/about/strategy/

[110] UNAIDS (2012), *Investing for results. Results for people. A people-centred investment tool towards ending AIDS,* available at http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2012/JC2359_investing-for-results_en.pdf

[111] *Towards an improved investment approach for an effective response to HIV/AIDS*, B. Schwartländer et. al. The Lancet, 11 June 2011 (Vol. 377, Issue 9782, Pages 2031-2041 ). See also, *A New Investment Framework for the Global AIDS Response*, UNAIDS Issues Brief, October 2011, available at http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/JC2244_InvestmentFramework_en.pdf

be able to keep alive.[112] As the new funding model for the Global Fund emerges, it will be critical that funding for civil society organizations, including core funding, and for human rights related programmes, such as discrimination reduction, are maintained as priorities. It will also be crucial that the funding pool for organizations working in these areas is expanded beyond the small number of donors.

*Putting people living with and vulnerable to HIV at the centre of the response*

49. As countries strive to increase access to prevention and treatment as well as take advantage of new knowledge and modalities (e.g. male circumcision, PrEP, treatment for prevention, self-testing), it is essential that people living with and vulnerable to HIV have much greater support to take up available services. People living with HIV have developed the framework of Positive Health, Dignity and Prevention (PHDP) that, where operationalized, provides comprehensive support to taking care of their own health, remaining productive members of society, preventing the onward transmission of HIV and reducing both internalized stigma and social stigma and discrimination. Efforts to reduce discrimination are put in place as a central aspect of the PHDP framework and the participation of people living with HIV in such efforts is prioritized.[113] This framework builds on the many years of activism by people living HIV to demand and get recognition of the rights to non-discrimination, treatment, participation and sexual and reproductive health.[114]

50. Similarly many successes in reducing discrimination have been achieved through the work of members of key populations. Sex workers have organized to demand respect, freedom from violence, and appropriate police practices.[115] People who use drugs have demanded treatment for dependency, integrated services, and the right to harm reduction services.[116] Men who have sex with men and transgender people are working throughout the world in the context of LGBTI rights movements to fight criminalization, discrimination and violence based on sexual orientation and gender identity.[117] Advocates to reduce HIV-related discrimination should mainstream discrimination reduction throughout these various human rights movements. Moreover, though many of these activities are not explicitly to reduce HIV-related discrimination, they demonstrate that engagement, community mobilization and visibility often have that effect. Thus, an important component of successful programmes is to raise awareness and build capacity among those experiencing HIV-related discrimination so that they know their rights, know where to seek help and redress, and can mobilise to advocate for changes in discriminatory laws, policies and practices. This is social change from within.

## CONCLUSION

51. The HIV response has taught us that eliminating discrimination requires concerted and simultaneous action in different sectors of society. Successful efforts to reduce HIV-related discrimination include the following elements: understanding the forms of discrimination and their context; building the capacity of and engaging the groups that experience discrimination; sensitizing and training service providers; addressing layers of discrimination; ensuring mechanisms to report cases and get redress;

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[112] See *HIV and Human Rights: A Mapping of Donor Priorities and Trends in Southern Africa*, commissioned by Open Society Foundations and Opens Society Initiative of Southern Africa and developed by Julia Greenberg, the Fremont Center (in draft), October, 2012.
[113] See UNAIDS and the Global Network of People Living with HIV (GNP+) (2011) *Positive Health, Dignity and Prevention: A Policy Framework*, available at http://www.gnpplus.net/images/stories/PHDP/GNP_PHDP_ENG_V4ia_2.pdf
[114] See *Id*.
[115] See, for example, http://www.sangram.org/
[116] See, for example, http://www.ihra.net/human-rights
[117] See, for example, http://ilga.org/

involving different stakeholders such as National Human Rights Institutions, Law Commissions, Parliamentary committees; improving the legal environment; integrating efforts into national responses and expanding them; and monitoring and evaluating results.

52. World leaders and national governments have made clear commitments to eliminate HIV-related discrimination because it is harmful to the individuals who experience it and to the communities in which it occurs and because it has a negative impact on HIV prevention and treatment outcomes.[118] Many good programmes are being implemented by governments, civil society, private sector and intergovernmental organisations in various sectors. However, like the other components of effective national responses to HIV, reduction of HIV-related discrimination is a policy and programmatic response that requires sufficient commitment, funding, implementation and expansion. As the world gets closer to “ending AIDS”, efforts to reach “zero discrimination” will become increasingly essential to enable the AIDS response to reach all those in need.

[118]See *Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS* (UN Resolution 65/277). June 2011.*Supra note 7.* and Joint United Nations Programme on HIV/AIDS (2010), *UNAIDS 2011–2015 Strategy, Getting to Zero.Supra note 5.*

# ANNEX TO THE BACKGROUND NOTE ON NON-DISCRIMINATION

# SUMMARY EXAMPLES OF INITIATIVES AND PROGRAMMES TO REDUCE HIV- RELATED DISCRIMINATION – ORGANIZED BY SECTOR[119]

## INTRODUCTION

1. As part of preparations for the Thematic Segment on Non-discrimination in the context of HIV of the 31st meeting of the UNAIDS Programme Coordinating Board (December 2012), UNAIDS sent out a Call for Submissions on effective initiatives and programmes to reduce and/or provide redress for HIV-related discrimination. All of the case studies highlighted in this Annex are taken from the submissions received and are cited in the Background Note prepared for the Thematic Day.[120] For this Annex, the submissions have been summarized and edited for purposes of clarity and conciseness. The full length submissions can be found on the UNAIDS PCB website at www.unaids.org.

## HEALTH CARE

**Poland – Patients' Rights Academy**
Implementing Organization(s): Institute of Patient's Rights and Health Education

2. From January through December 2011, the Institute of Patient's Rights and Health Education implemented the "Patients' Rights Academy". The key objective of the project was to reduce the scale of social exclusion among people with mental disorders and people living with HIV by improving the quality of medical care that they receive. The project involved measures aimed at educating medical professionals about patients' rights and improving interpersonal relations between medical personnel and both the mentally ill and people living with HIV. The intention was that socially excluded patients should be treated by medical personnel with due respect to ensure that the fundamental rights of patients, i.e. the right to privacy and personal dignity, are observed in practice. During the one-year-programme, the Institute organized seven workshops and trained over 230 participants from the medical and NGO sectors. All the objectives were achieved by changing the attitudes and interpersonal relations with people who are socially excluded, including people living with HIV. After a series of training sessions for medical personnel, there were observed changes in attitudes. The training also highlighted the need for nurses to learn about patients' rights.

**Tunisia - Programme répondant aux besoins en matière de santé sexuelle auprès des HSH (Hommes ayant des rapport sexuels avec les Hommes) en Tunisie**
Organisation(s) d'exécution: ATL MST sida section de Tunis

[119] DISCLAIMER: The material herein does not necessarily represent the views of UNAIDS Secretariat or the UNAIDS Cosponsors nor has it been independently verified.
[120] The submissions cited in the Background Paper were chosen on four criteria: (1) type of programme (2) target audience (3) regional representation and (4) overall strength of submission. There are 24 submissions summarized in this annex, with the following regional break-down – Africa: 6; Asia-Pacific: 4; Caribbean: 2; Eastern Europe and Central Asia: 2; Global: 1; Latin America: 3; Middle East and North Africa: 3; and Western Europe and Other States: 3. The summarized submissions also have the following break-down by target audience: men who have sex with men and lesbian/gay/bisexual/transgender: 3; people living with HIV: 14 (including programmes addressing children and prisoners living with HIV); people who use drugs: 2; sex workers: 2; and women living with HIV: 3.

3. L'Association Tunisienne de lutte contre les MST/sida(ATL) de Tunis a initié ce projet en 2004 dans le cadre de son mandat d'appui à la mise en œuvre des activités de prévention et de soutien aux groupes exposés au risque VIH telles que définies dans la Stratégie Nationale VIH/sida. L'ouverture de l'espace de l'ATL MST/SIDA – section de Tunis, en lieu de sociabilité et de socialisation, a participé au développement personnel d'un nombre important d'hommes ayant des rapports sexuels avec des hommes. Il s'agit d'une expérience pionnière en Tunisie qui a contribué à exprimer les besoins urgents de ce groupe de la population. Dans un pays en transition post révolutionnaire l'ATL MST/SIDA – section de Tunis a réussi à donner la parole aux hommes ayant des rapports sexuels avec des hommes et à faire parvenir leur voix aux divers intervenants œuvrant dans le domaine de la promotion de la santé afin que ces derniers reconnaissent la nécessité de prendre en considération la question des rapports sexuels entre hommes dans la riposte aux infections sexuellement transmissibles et au VIH/sida, qui a progressivement permis d'humaniser la thématique malgré de nombreuses contraintes.

4. Le projet couvre 12 régions sur les 24 régions administratives de la Tunisie. 10498 HSH ont été ciblés par les interventions. Les principales actions réalisées incluent des enquêtes séro-comportementales qui ont permis de définir les besoins prioritaires de ce groupe, des programmes de prévention et de prise en charge sanitaire et psychosociale, des programmes de plaidoyer en terme de lutte contre la stigmatisation et l'exclusion des populations clés.

5. Le projet a, en outre, permis de sensibiliser et renforcer la formation du personnel médical et paramédical sur les questions VIH (modes de transmission, évaluation du risque, etc.), de renforcer les capacités et sensibiliser les populations clés à la nécessité de réagir face à la stigmatisation. Par ailleurs, un des piliers de ce projet a consisté en la réalisation de formations des éducateurs pairs sur la communication pour le changement de comportements. Les personnes vivant avec le VIH issues du groupe des HSH ont également bénéficié de formations sur la réduction de risques notamment sexuels, les compétences de vie, sur la prévention positive.

6. Enfin, les résultats concrets de ce projet ont permis de lancer l'initiative du premier observatoire agissant dans le domaine d'éthique, VIH et droits humains mis en place par l'ATL MST sida section de Tunis en 2011, dont l'opérationnalisation est actuellement en cours avec un premier atelier sur les discriminations liées au VIH en Tunisie qui aura lieu à la mi-octobre.

**Zimbabwe - Sisters with a Voice - Zimbabwe's National Sex Work Programme**
Implementing Organization(s): CeSHHAR Zimbabwe on behalf of National AIDS Council and supported by UNFPA and GIZ

7. "Sisters with a Voice" is Zimbabwe's National Sex Work Programme. It targets female sex workers across the country. The programme was started in 2009 in Harare and was expanded nationally in 2010. It is currently operating in 16 sites with 120 peer educators. By end of June 2012, the programme had reached over 8,000 women, with over half the women attending for more than 2 visits. The programme provides health education, HIV testing and counselling, supported referral for HIV treatment and care, syndromic management for sexually transmitted infections, contraception, condoms and legal advice.

8. Trained and supported peer educators undertake outreach not only to encourage access to health services and support the women in onward referrals to clinical services (for example, to HIV treatment services and gynaecological care), but also to sensitize the medical staff to ensure that the sex workers are not stigmatized or

discriminated. The peer educators are supported by a team of highly experienced outreach staff, coupled with sex worker interns who work with the outreach team for periods of up to a year at a time. The programme aims to reach a stigma-free and sex-worker friendly environment through socialization at static sites, peer group meetings and community mobilization, as well as through the engagement of two local human rights organizations and the victim-friendly unit of the Zimbabwe Republic Police. These organizations are continuously engaged to improve respect for and protection of sex workers' rights.

9. There are plans to expand the programme to a further 20 sites over the next 12 months, with cervical cancer screening and long-term family planning added to existing services. Advocacy for a more enabling environment will be intensified through further increased community mobilization and training of public health service providers, print media journalists and the police.

## EMPLOYMENT/WORLD OF WORK

**Argentina – Companies committed to the HIV response**
Implementing Organization(s): Fundacion Husped, UNAIDS, ILO, UNDP

10. Fundacion Husped has designed an initiative that incorporates the response to HIV in the work place with a cross-area strategy. The objectives are: a) non-discrimination towards employees living with HIV; b) HIV awareness and capacity building for company employees, their families and the community; and c) improvement in the employability of people with HIV. In the programme, companies are asked to sign a letter of commitment to non-discrimination in the context of HIV, and to sign and incorporate an anti-discrimination measure within their Ethics Codes that prohibits HIV-related discrimination and highlights confidentiality principles. Moreover, companies should provide information and training to their all employees about the importance of non-discrimination in the context of HIV.

11. To compliment this, Fundacion Husped also links people living with HIV to vacant job positions within member companies. To reinforce this strategy, Fundacion Husped has signed agreements with the recruitment departments of several companies. The programme covers any large, middle or small company working in Argentina; in some cases the companies have extended the initiative to their offices in Chile, Uruguay, Paraguay and Peru.

12. Currently, 25 companies have committed to the initiative, with 60,000 employees receiving information and training on HIV, human rights and non-discrimination. The programme also has a bi-monthly newspaper that is sent to more than 1000 human resource managers and social responsibility coordinators. Moreover, the information produced by the programme has reached over one million people. On 1 December 2012 (World AIDS Day), the programme will issue the "Non-discrimination in the workplace statement," signed by several Latin American companies. Furthermore, partnerships are underway with the National Labour Ministry, and other social institutions together with some Bi-National Chambers of Commerce, aiming to add new companies to this initiative, to conduct an impact evaluation and produce a good practices document.

**China - Strengthening equal opportunity and treatment for people living with HIV and AIDS, and training for health workers on implementation of standard precautions and reduction of stigma and discrimination**

Implementing Organization(s): ILO, Legal AIDS Centres in Beijing and Yunan, China Centre for Disease Control and Prevention in collaboration with the UN Theme Group

13. This health care sector programme aims to create a sustainable, integrated programme of action among institutional and community actors in China to address HIV-related discrimination in the workplace and contribute to the national programme on HIV and AIDS. To start, government, civil society, the UN and associations of people living with HIV jointly conducted a study on the nature and root causes of HIV-related employment discrimination in China. The study revealed that people living with HIV experienced prejudice, humiliation, deterioration of working conditions and relationships once employers and colleagues learned of their HIV-positive status.

14. Based on this study, various partners are taking action to reduce discrimination. For instance, the Chinese Government is considering the removal of mandatory testing requirements from the regulations governing medical examinations for recruitment of civil servants. Furthermore, a training manual on HIV and employment rights has been developed jointly by Yunnan University Legal Aid Centre and the ILO. Also, a forum on HIV and Human Rights and the Beijing Red Ribbon Forum to address HIV-related employment discrimination were held. With regard to redress for discrimination, legal aid hotlines have been established and are staffed by volunteer lawyers. The hotlines provide legal advice to people living with HIV and other vulnerable groups, and have served over 160 people in just 12 months. In addition, the ILO and Chinese Centre for Disease Control and Prevention have hosted training workshops to raise awareness of HIV and employment rights among people living with HIV, public interest lawyers, judges, government and community organizations.

**Republic of Tajikistan - Ensuring stigma and discrimination-free workplaces through fundamental human rights, livelihood support and economic empowerment**
Implementing Organization(s): ILO, National AIDS Center, Ministry of Labour and Social Protection, State Women Committee and Family Affairs, Employer`s Unions – agriculture sector, Healthcare Trade Unions, Tajik Network of Women living with HIV, religious leaders, micro-finance institutions and UN Joint Team on AIDS

15. HIV-related stigma and discrimination results in loss of jobs, denial of access to employment and social protection schemes, and reduced earnings among people living with HIV. The ILO programme in Tajikistan aims to increase the economic empowerment of people living with HIV and their families, sensitize law enforcement to the needs of people living with HIV and enable those living with HIV to access legal services. It also aims to involve national religious leaders in the HIV response and strengthen the private sector’s role in HIV workplace responses. Among its various activities, the programme has trained over 1,000 people living with HIV on how to boost their own business in rural areas; provided social activities related to stigma and discrimination in the workplace for both the formal and informal sectors; and intends to develop six sectoral workplace policies and programmes (agriculture, hotel/tourism, retail, transport, police and construction) on how to reduce HIV-related stigma and discrimination against people living with HIV.

**Uruguay - Social security benefits for sex workers, including transgender people**
Implementing Organization(s): Banco de Previsión Social (financial social security institution in Uruguay), NGOs working on HIV, LGBT and people with HIV issues (CIEI-SU, AMISEU, OVEJAS NEGRAS, Km 0, AMEPU, REDUTRASEX, ATRU, ALPECSE), UNAIDS and UNJTA

16. In 2009, a participatory discussion on the provision of social security benefits for sex workers was launched by the Banco de Previsión Social (BPS), the financial social security institution in Uruguay. Participants included LGBT and sex worker organizations. After several sessions, a new legal norm was formulated and proposed in August 2010. It included access to pension, labour rights, training opportunities, health and social benefits for female, male and transgendered sex workers. This represented innovative and ground-breaking legislation to reduce the vulnerability and environmental factors that increase the impact of HIV on most-at-risk populations. However, considering the socio-economic situation of the majority of sex workers, the collaborative work continued and other proposals were advanced in order to reduce the contributory fees for accessing social security. In February 2011, BPS and the Ministry of Economy and Finance decided to dramatically reduce the social contribution of sex workers, including them in the lowest paying category.

17. Also, in February 2011, BPS' highest authorities approved the new legal norm to provide social security to sex workers, which is now being implemented. The norm establishes much better conditions and access to social security for "precarious workers" including, but not limited to, male, female and transgender sex workers. The new legislation was launched at a press conference. It was presented as a strong response of the public authorities to situations of stigma and discrimination related to sex work, and, in particular, for transgender persons.

## EDUCATION

**Ethiopia and Save the Children Denmark - Safe Environment and Non-discrimination in Schools in Ethiopia (SENSE)**
Implementing Organization(s): Save the Children Denmark, Danish Institute for Human Rights (Technical Assistance), Organization for Social Services for AIDS – OSSA and Ethiopian Human Rights Commission

18. The *Safe Environment and Non-discrimination in Schools in Ethiopia* (SENSE) project started in 2009 and is implemented in the Bahir Dar and Debremarkos communities in Northern Ethiopia. The goal of the project is to reduce HIV-related stigma and discrimination of children living with or affected by HIV and AIDS. In addition to the education system, and in particular local school communities, the project involves the affected children and their families, civil society, associations of people living with HIV, government structures and offices, the HIV/AIDS Prevention and Control Office (HAPCO) and the Ethiopian Human Rights Commission.

19. The SENSE project builds on a baseline study that assesses concrete manifestations of HIV-related stigma and discrimination, including a study of knowledge, attitudes and practices related to HIV and AIDS, as well as on an analysis of the Ethiopian policy and legal framework. Most of the project activities centre on building capacities, community mobilization and creating mechanisms and tools to handle HIV-related stigma and discrimination, such as the *Code of Practice and Action*, (in development), as well as information and teaching materials for the education system.

20. Around 24,000 primary school pupils have benefitted from SENSE, including educational support and psychosocial support. This includes children in and out of school, as well as children affected by or living with HIV and children not affected by HIV, as supporting only children with HIV might be viewed as preferential treatment that could be the source of further stigma. There are also 4,700 school teachers, civil servants and civil society representatives who have been involved in awareness raising, community mobilization and capacity-building activities.

**Kenya - School outreach by Kenyan Network of HIV Positive Teachers to enhance disclosure in order to reduce stigma and discrimination**
Implementing Organization(s): Kenya Network of HIV Positive Teachers (KENEPOTE)

21. The Kenya Network of HIV Positive Teachers (KENEPOTE) conducts an advocacy programme in partnership with other networks of people living with HIV and the Government. The programme comprises a one day in-house training on advocacy, with a focus on HIV, stigma and discrimination. The teachers who attend the sessions are expected to reach at least 300 teachers and students per month with HIV messages. The advocates are also expected to provide quarterly reports and follow-up with the people they reached for referral to care and treatment services. Following the launch of the advocacy and outreach programme, there were 102 new disclosures in 2007 in comparison to 44 in 2006. Furthermore, at the end of 2011, KENEPOTE reported 373 new disclosures (115 men and 258 women). There is also increased commitment at the policy level to address stigma and discrimination in schools. For example, some school managers have been disciplined for stigmatizing HIV positive teachers. The programme has also started seeing self-reported discrimination cases after the *"Human Rights Counts"* legal rights training and increased referrals to KENEPOTE, other networks of people living with HIV and the Government AIDS Control Unit.

**Sweden – Break the Norm (BRYT)**
Implementing Organization(s): RFSL Ungdom (The Swedish Youth Federation for LGBTQ Rights)

22. The Swedish Youth Federation for LGBTQ Rights developed workshops on how to sensitize youth to issues relating to sexual orientation and gender identity. One part of the programme was to develop workshop methods for addressing discrimination and inequality out of a "norm-critical" approach – an approach where the norm defining what is "right" and "wrong" is questioned instead of seeing individuals deviating from the norm as a problem. The programme also included training-of-trainers which focused on building the skills and knowledge of workshop facilitators. The programme mainly focuses on discrimination based on sexuality, gender identity and/or gender expression, but other forms of discrimination are integrated throughout, such as discrimination based on HIV, race and faith.

23. Since 2005, more than 12,000 individuals have been educated in the programme. The methods have been used in schools, organizations, youth clinics and education institutions all over Sweden. Based on evaluations, the workshops have been an eye-opener for participants with regards to discrimination and other obstacles for vulnerable groups. The programme was the first ground-breaking approach in Sweden to tackle discrimination out of a norm-critical approach and has proven to be very successful.

## JUSTICE

**Cote d'Ivoire – *Moi, Femmes! Et mes droits?* Campaign against stigma and discrimination for women and girls in the HIV response**
Organisation(s) d'exécution: Réseau Ivoirien des organisations de Personnes Vivant avec le VIH (RIP+)

24. Le Réseau Ivoirien des organisations de Personnes Vivant avec le VIH dénommé RIP+ s'est engagé dans une action de lutte contre la stigmatisation et la

discrimination en faveur des femmes, filles, et de l'égalité des sexes dans le contexte de la réponse au VIH. Pour ce faire, il exécute un projet intitulé : « Moi, femmes ! Et mes droits ? » en collaboration avec le PNUD, l'ONUSIDA et le Ministère de la Santé et de la lutte contre le sida avec le soutien financier de la Fondation de France.

25. Ce projet intervient dans neuf localités de la Côte d'Ivoire (Abidjan, Biankouma, San Pédro, Tabou, Yamoussoukro, Bouaké, Ferké). Il s'articule autour de plusieurs axes d'intervention, notamment les activités de plaidoyer sur les droits des personnes vivant avec le VIH en général et des femmes infectées en particulier; l'édition de guide juridique sur la promotion des droits des femmes; la production de dépliants d'information sur les droits des personnes vivant avec le VIH; la formation en droit des femmes et les spots dans les radios locales suivis de séances de sensibilisation sur les Violences Basées sur le Genre (VBG) en rapport avec la stigmatisation et discrimination; et la création de centre d'écoute et la prise en charge juridique des personnes vivant avec le VIH survivants (es) de violence liées au statut VIH, en collaboration avec des associations de femmes juristes et l'association des jeunes avocats de Côte d'Ivoire.

26. Les résultats de ce projet sont nombreux, y compris la formation sur les VBG de 50 PVVIH issues des associations communautaires ; réalisation de 10 séances de sensibilisation et de consultations juridiques; la conception et distribution de 1000 dépliants sur les droits des PVVIH selon la législation ivoirienne; réception, écoute et orientation de 124 survivants de violences dont 112 femmes et 12 hommes sur les VBG; et préparation d'une proposition d'amendement de l'avant-projet de loi sur le VIH relative à la dépénalisation de la transmission du VIH pour son intégration potentielle dans le projet de loi sur le VIH.

**El Salvador – Reducing discrimination in prisons**
Implementing Organization(s): Ministry of Health

27. In 2006, the Ministry of Health started an intersectoral programme to address issues related to HIV in the prison system. This programme was based on a situational analysis conducted in 2005, which found that the human rights to health, education and treatment were being violated within the country's prisons. Moreover, it found that there is stigmatizing and discriminatory behaviour towards inmates living with HIV, as well as towards men who have sex with men and transgender persons.

28. The prison programme currently works in 26 prisons, reaching more than 26,000 prisoners. It includes a variety of different components such as disease prevention, health promotion, integral care and treatment, and tracking and monitoring. All components are based on the principle of human rights. Moreover, the programme provides for training of prison staff on HIV, human rights, gender and sexual diversity, and stigma and discrimination. Since the programme began, there have been several positive outcomes including: reduction of stigma and discrimination towards inmates living with HIV, men who have sex with men and transgender persons; improvement of health system in prisons, promoting health prevention (including condom distribution) and treatment, particularly for HIV and STIs; and technical assistance for programme monitoring within each prison.

**Guyana – Prevention of the passage of a bill to criminalize HIV transmission**
Implementing Organization(s): UNAIDS Guyana

29. In July 2009, an opposition member of the Guyanese Parliament presented a motion to the National Assembly, *The Criminal Responsibility of HIV Infected Individuals*,

which proposed criminalizing willful HIV transmission and exposure. The Minister of Health requested the support of the UNAIDS office in Guyana to help prepare arguments against the motion. After collaborating with the Minister of Health and UNAIDS Headquarters, the UNAIDS office in Guyana wrote and presented a position paper in the Parliament against the adoption of the motion. After this presentation, the Parliament adopted a decision to establish a "Special Select Committee of Parliament on the Criminal Responsibility of HIV Infected Individuals" (Special Select Committee) – a committee which would discuss and seek input from the public on the motion to criminalize HIV transmission and exposure. From August 2010 through July 2011, the UNAIDS office in Guyana convened several advocacy meetings with key constituencies, including faith leadership and networks of people living with HIV, as well as with the media, to speak about the motion. The UNAIDS office also submitted written arguments and made an oral presentation to the Special Select Committee about the motion. The Special Select Committee then requested UNAIDS to help prepare the Committee's report and recommendations. In September 2011, after a speech by the Chairman of the Special Select Committee, the National Assembly of Guyana voted against the adoption of the motion.

**India – Crisis intervention for key populations**
Implementing Organization(s): Community Network for Empowerment (CoNE) - A state-level network of community-based organisations of people who use drugs

30. The Community Network for Empowerment (CoNE) uses community-led crisis intervention as a method of confronting and resolving issues of violence, abuse, harassment, and discrimination that affect populations most at risk, particularly people who use drugs who have a higher risk of acquiring HIV and other blood borne viruses. The CoNE programme covers all the nine districts of Manipur, a high prevalence state in North East India. A trained team of high-risk individuals responds rapidly and in person to incidents of violence, abuse, harassment, and discrimination against high-risk group members. They provide practical support and ensure that the legal rights of the affected person are respected and that his/her health needs are addressed.

31. CoNE's activities include: responding to incidents of violence immediately as they occur; reporting and documenting the incidents of violence, as well as the actions of the crisis response system; counseling for individuals who have been involved in crisis to ensure they have adequate psychosocial, medical, and resource support in the immediate term; resolving family or community issues affecting those in high-risk groups; networking with legal aid organizations to support negotiations with authorities and to train individuals on their legal rights; advocacy and sensitization with pressure groups, law enforcement and other authorities; and building relationship with the media to improve public perception about high risk groups.

**International Development Law Organization (IDLO) - Strengthening and expanding HIV-related legal services in Papua New Guinea**
Implementing Organization(s): International Development Law Organization, with funding from the OPEC Fund for International Development, the Ford Foundation, the World Bank and AusAID

32. The Papua New Guinea (PNG) HIV Law Project is one of the countries supported by IDLO under the Global HIV Law Program. After extensive consultations in PNG to support project design, in March 2010, IDLO initiated the PNG HIV Law Project. The project targets people living with HIV, men who have sex with men, transgender people, people who sell sex and people vulnerable to gender based violence and

contributes to the enabling legal environment in PNG by providing legal aid services, conducting training and capacity building, and delivering legal literacy sessions.

33. The legal and policy environment in PNG is rights-focused; the challenge lies in implementation of laws and policy. This requires concentrated efforts to inform people of their rights (demand side) and ongoing initiatives to prepare and support law and justice sector actors to respond to HIV-related rights violations (supply side). Currently, a lack of awareness of rights within the broader community; and a lack of sensitivity within the law and justice sector, lends itself to discriminatory practices.

34. Between 2009 and 2012, IDLO also implemented similar projects in 16 other countries (Egypt, Jordan, Lebanon, Tunisia, Algeria, Morocco, Benin, Burkina Faso, China, Indonesia, Nepal, Guatemala, El Salvador, Peru, Mexico and Colombia). In each of the programmes, IDLO partnered/partners with a local legal aid service provider to scale up or establish HIV-related legal services, with a view to strengthening the legal enabling environment, enhancing knowledge about rights and increasing access to quality legal services. Each project has aimed to increase the capacity of lawyers (both project lawyers and other lawyers) to manage HIV-related legal issues; through training, capacity building, resources or manuals, and/or networks. Key to the goal of increasing access to quality legal services, is ensuring there are sensitized, non-judgmental lawyers available, equipped with the skills and knowledge to manage HIV-related cases

**Kenya – Increasing access to justice for people living with HIV and affected by HIV**
Implementing Organization(s): HIV/AIDS Equity Tribunal

35. The HIV/AIDS Equity Tribunal has the powers of a Kenyan subordinate court of law, can exercise jurisdiction over civil matters, and issues legally binding decisions. It can consider issues as defined under the Kenyan HIV/AIDS Prevention and Control Act of 2006. The Tribunal's objective is to combat stigma and discrimination facing people living with HIV/AIDS in family, community, workplace, education, and health care settings. It is first legal court of its kind anywhere in the world.

36. The Tribunal started hearing cases in January 2012. Most complaints have involved stigma and discrimination within military, police, local authorities and private sector workplaces. Only one hearing emanated from the religious sector, with an advisory sought from an organization dealing with key populations. There have been an equivalent number of family and community-related cases that have required psychosocial support. Many complaints are also tied to social, cultural and religious practices. The Tribunal is currently exploring how to integrate hearings that cut across family and community stigma and discrimination, such as loss of household and family support for bereaved women. Issues around divorce and disinheritance for women in sero-discordant relationships have also generated significant complaints and are considered for intervention.

37. Plans are in place to have more sittings in Nairobi to cope and manage the increased workload and demand for services. In addition, the Tribunal has organized to hold hearings at decentralized structures to bring its services closer to the people. The Tribunal has also started to create as much public awareness as possible about its scope and mandate, as well as to forge collaborative linkage with the National AIDS Control Council and its affiliates.

## COMMUNITY

**Antigua – Life on the Edge – training advocates against sexual assault**

Implementing Organization(s): Women against Rape (WAR), funded by the Caribbean HIV/AIDS Alliance

38. In 2010, Women against Rape (WAR) trained five Spanish-speaking women to be advocates against sexual assault. The training was a three day programme which aimed to help the advocates gather pertinent information regarding Spanish-speaking survivors of gender-based violence, educate survivors on safety, respond to crisis calls and guide survivors through the necessary processes after they have experienced violence, including access to post-exposure prophylaxis (PEP) to prevent HIV infection. WAR saw a need for such training as it recognized that there is stigma and discrimination against Spanish-speaking women in accessing health care services especially if they are perceived to be sex workers or are HIV positive.

39. The advocates have participated in a variety of outreach and empowerment activities including radio programmes to educate the Spanish-speaking community about gender-based violence, its link to HIV, the management of violence in relationships and contact information of organizations that would provide support and empowerment, such as WAR. There is no documented policy for PEP in the public sector for survivors of sexual assault/ sexual violence which greatly increases the risk of transmission of STIs/HIV and undesired pregnancy. The advocates are still reaching out to vulnerable communities and providing education around gender-based violence, informing individuals of organizations that provide assistance and responding to crisis calls. The programme is successful as individuals who once may have felt unsupported now feel that they have a system of organizations that is working for their best interests.

**Egypt – Feature Film “Asmaa” and shaping public opinion related to rights of people living with HIV, combating stigma, and promoting the empowerment of women**

Implementing Organization(s): Script Writer/Director Amr Salama, Actress and Goodwill Ambassador Hind Sabry; and New Century Productions

40. The programme involved the development of a feature film based on a true story of a woman living with HIV to address HIV-related human rights issues. In partnership with a production company, creative writer and director Amr Salama and superstar actress Hind Sabry, the movie “Asmaa” was launched in late 2011. The movie was screened and received awards at more than seventeen international film festivals, as well as several regional and global meetings. It highlights issues of HIV, discrimination, quality health care, and the situation of women in the Middle East. Moreover, the movie was screened in movie theatres in Egypt for over six weeks, reaching at least 0.5 million individuals. Viewership continues to increase as the movie is distributed through TV channels.

41. “Asmaa” has been a catalyst for discussion on HIV-related discrimination issues. Media debates around HIV-related issues, the status of women, quality of care and medical ethics mounted significantly – 230 articles have been published in national, regional and global media. Moreover, at least 34 top-rated television programmes were aired debating the issues portrayed in the film and medical ethics related to the care of people living with HIV. The movie also created a platform for policy debates and has been a catalyst for change. For example, a memorandum of understanding is currently being discussed between UNAIDS and Cairo University School of

Medicine to facilitate a supportive health-care setting for people living with HIV and to improve attitudes amongst health care professionals.

**France – “Et si j’étais séropositif?”**
Organisation(s) d’exécution: AIDES France

42. AIDES France a lancé ce projet le 24 octobre 2006 en amont de la Journée Mondiale de Lutte contre le Sida du 1er décembre. Ce projet a été pensé en partant du principe que changer les mentalités et les comportements, notamment sur un enjeu de société comme celui de la discrimination des personnes séropositives, ne peut se faire du jour au lendemain, par le simple biais d'une campagne publicitaire. La mission d'AIDES sur ce sujet est avant tout de transmettre un message, d'exposer un problème, de dénoncer des injustices auprès du plus grand nombre, guidé par la croyance que cela puisse progressivement faire évoluer les mentalités et la société.

43. Les objectifs de la communication de la campagne "célébrités" ont été de porter un message de tolérance vis à vis des personnes séropositives et de questionnement pour chacun quant à son respect de l’autre; de rappeler au plus grand nombre que les personnes séropositives sont toujours victimes de stigmatisations et de discriminations; de sensibiliser l'opinion publique pour, à terme, favoriser un changement des comportements à l’égard des malades et enfin d’adresser aux personnes séropositives un message de soutien faisant part de leurs difficultés quotidiennes et les assurer de la mobilisation de la société.

44. Cette campagne "célébrités" a suscité l'enthousiasme des médias français avec un effet de démultiplication presse considérable. L’agence et AIDES n’ont pas simplement demandé à des personnalités de soutenir la cause comme cela se fait habituellement. Elles ont demandé aux célébrités les plus populaires, celles qui sont quasiment des institutions dans leur domaine, de mettre en jeu leur popularité au service de la démonstration du propos.

45. À l'occasion de la campagne présidentielle de 2007, AIDES a souhaité impliquer les candidats et donc le futur président sur une meilleure prise en charge des personnes séropositives et plus globalement la place dans la société des malades touchés par des pathologies lourdes.

46. Une nouvelle version de la campagne nommée alors "candidats" a donc été développée avec pour objectif d’interpeller les présidentiables et l’opinion publique sur ces questions, grandes absentes du débat présidentiel, et d'obtenir des candidats des engagements concrets, dont notamment, l’accès à la Couverture Maladie Universelle pour toute personne précarisée résidant en France.

47. La mise en œuvre de la campagne "célébrités" s’est faite à travers la réalisation de conférence de presse réunissant des partenaires, militants et journalistes; l’implication de grands médias; la réalisation de panneaux publicitaires par des partenaires clés; le soutien de nombreuses villes en mettant à disposition gracieusement des panneaux publicitaires. Enfin de nombreuses parutions presse gracieuses; la diffusion des Cartes postales et affichettes à travers plus de 70 villes en France et les diffusions sur Pink TV d'une pastille d'animation. Quant à la mise en œuvre de la campagne "candidats", cette dernière s’est faite à travers l’utilisation des portraits des candidats, sans leur demander leur avis mais en les prévenant de l'imminence de la campagne, et leur faire porter ce message: Voteriez-vous pour moi si j'étais séropositif (ve)? La campagne "candidats" force l'attention des intéressés, et fait entrer le sida dans le débat présidentiel. Tous les candidats ont annoncé leur

fierté de figurer sur la campagne et ont témoigné de leur solidarité pour la cause des séropositifs

**Germany – Nation-wide campaign anti-discrimination to mark World AIDS Day called "Living together positively. Be safe!" (“*Positiv zusammen leben. Aber sicher!“)***
Implementing Organization(s): Federal Ministry of Health (BMG); Federal Centre for Health Education (BZgA); partnering with the German AIDS Relief Organisation (DAH) and the German AIDS Foundation (DAS)

48. Over the past two years, the new World AIDS Day campaign of the Federal Centre for Health Education (BZgA), entitled "Living together positively. Be safe!”, has been calling for greater respect and tolerance towards people living with HIV. The campaign presents a wide variety of lives lived with HIV and addresses the German population at large. Using billboards, city lights, post cards and a cinema and TV spot, the campaign's topic has moved living with HIV into public awareness. Moreover, an intensive thematic discourse has been held in the social media. This is an integrated campaign with an extensive reach, with 135.7 million contacts counted between 2010 and 2011.

49. The campaign brings together many people who advocate respect, tolerance and support for people living with HIV and who join the fight against exclusion and ignorance. Prime examples include the HIV-positive ambassadors of the campaign: people who share the stories of their lives with HIV - talking about their families and friends, treatment and medical care for HIV, or their experiences in the world of work. These accounts offer impressive insights into the multifaceted reality of their lives. Their stories, pictures and videos as well as additional campaign information are available at www.welt-aids-tag.de .

50. Discussions in the social media have been lively, positive and constructive. This has helped reduce discrimination and stigmatization. Moreover, the importance of getting tested for HIV has been effectively communicated. This campaign has had a sustainable opinion-forming effect and has provided better circumstances for people to live openly with HIV. Through its motivational personal stories, the campaign has given people living with HIV and their families new courage and lowered prevention barriers in the population.

**India – multi-media campaign against stigma and discrimination for youth**
Implementing Organization(s): National AIDS Control Organisation, Department of AIDS Control, Ministry of Health and Family Welfare

51. The Indian National AIDS Control Organisation planned a multi-media campaign in 2009 for the north-east region of India. The campaign aimed to capitalize on the locally popular entertainment channels among youth in order to increase awareness of HIV prevention and treatment services, as well as to address issues regarding stigma and discrimination towards people living with HIV. Injecting drug use is a major driver of the HIV epidemic in this region of India. Most of the people who inject drugs fall in the age group of 21-30 years, and the majority initiates drug use during their adolescence.

52. The campaign used a combination of methods that appealed to youth, such as music competitions and football tournaments. Awareness of the campaign was further amplified through TV, radio, newspapers and outdoor media. The campaign messages were developed and disseminated by the youth themselves; they focused on drug use, unprotected sex, stigma and discrimination, and awareness of HIV-

related services. Faith based organizations, women groups and youth groups were sensitized and involved in the campaign. A special effort was made to reach out to out-of-school youth in these states through training of youth clubs at district, block and village levels.

53. With regard to the outcomes of the campaign, critical indicators of knowledge and attitude towards HIV and AIDS are significantly higher among groups exposed to the campaign (89%). Higher proportion of exposed respondents were aware of services like anti-retroviral therapy (exposed = 51 % whereas non-exposed = 9 %), HIV counseling and testing services (exposed = 64 % whereas non-exposed = 10 %) and prevention from mother to child transmission of HIV (exposed = 40 % whereas non-exposed = 3 %). Exposed respondents (86%) agreed that a normal relationship can be maintained with a friend or neighbour who is HIV positive. Similarly, 84% opined that a positive teacher could continue to teach students in schools. Also, 87% of the respondents exposed to the campaign had no problem with buying fruits and vegetables from a HIV positive vendor.

54. Due to the positive response during the first round of the campaign in 2009, the campaign was scaled up to all states of the northeast region in the third round, and various strategies were used to increase the coverage and scope of the campaign.

**INERELA+ – Changing Religious Attitudes, Changing Faith Perspectives: Theological Reflections on the Transformative Strategies of Sexual Minorities**
Implementing Organization(s): INERELA+ (funded through Norwegian Church Aid)

55. INERELA+ currently runs a programme that aims to sensitize high-level Christian and Muslim religious leaders from Malawi, South Africa and Zambia on the issues related to and rights of sexual minorities. Religious leaders, using the lens of HIV and vulnerability to HIV, receive comprehensive sex, sexuality and gender education using the SAVE methodology.[121] Participants are mentored in terms of examining how both theology and practice have embedded stigma and discrimination towards sexual minorities within their institutional, theological and cultural frameworks. In particular, the programme focuses on explaining how these understandings further stigmatise sexual minorities and expose them to increased levels of violence and livelihood vulnerability, and thus to HIV infection and transmission. Drawing on their authority within communities, religious leaders can use their training and experience to develop a doctrinal and pastoral framework that can be used to change social attitudes and ethical responses to sexual minorities. Furthermore, in creating increasingly safe spaces within a religious community, discrimination and stigmatization has the potential of being reduced.

56. INERELA+ also has two future projects that address discrimination towards sexual minorities. In recognition of the integral role that law enforcement plays in access to justice for sexual minorities, INERELA+, along with partner organizations, is piloting a project for sex, sexuality and gender training and mentoring for police officers. The pilot will focus on a single police station in Katlehong, South Africa. The police station project will include on-going mentoring from trained religious leaders of INERELA+. Another INERELA+ project, Masego, is currently in the feasibility study stage. The aim of this project is to provide a safe house for lesbian women and their children after these women have survived “corrective rape”. The feasibility study is being

[121] For more information on the SAVE methodology, please see www.inerela.org.

conducted in South Africa and, if implementation proves successful, the model will be rolled out to Zambia and Malawi in the second phase.

**Iran – Provision of psychosocial support to people living with HIV and their families**
Implementing Organization(s): Afray e Sabz; Kheyrieh Reyhaneh Alnabi Fatemeh Alzahra Institute; Hamdelan e Khamoosh; Yaran e Mosbat (IRCHA); Clinic Ejtemai Madadkari Baran; Payam Roshani; Haadian Charity; Sherkat e Jamee Talaei Aria; Rahjooyan Ehyae Tandorosti; Payam Avaran Hamyari; Kheyrieh Monadian Salamat Institute; Moaseseh Khairieh Teflane Moslem; Moaseseh Hemayat az zendegi e salaam,Takamol; and Bandar Abbas Positive Club (Yaran e Mosbat )

57. In 2006, as a part of a tripartite agreement between the Centre for Diseases Control of the Ministry of Health, UNAIDS and UNDP, the 'Positive Clubs' were established. These Positive Clubs were designed to use community resources (non-governmental organizations) and the specialist, technical assistance of medical universities in order to provide services and psychosocial support, as well as to increase the participation of HIV-positive individuals in prevention programmes. Two objectives of the project were: (a) to cover 10% of people living with HIV through promoting and implementing the principle of Greater Involvement of People living with HIV (GIPA), and (b) to build capacity for NGOs to deliver effective HIV services through training sessions.

58. Currently, there are 14 Positive Clubs within Iran, covering more than 10% of diagnosed people living with HIV. The main activities include, but are not limited to: group therapy and psychiatry visits for people living with and affected by HIV; workshops and education sessions on topics relevant to living with HIV; vocational training for people living with HIV; creation of booklets, posters and public installations to raise awareness about living with HIV: conferences to advocate for extended engagement of religious figures in psychosocial and spiritual support programmes for people living with HIV and their family members; provision of dental care and visual aid glasses for people living with HIV; and collection of strategic information relevant to people living with HIV.

59. According to Global Fund on AIDS, Tuberculosis and Malaria, the funders of the project, the Positive Clubs achieved a performance rating of A1, the maximum possible. There is evidence that the Positive Clubs have helped improve other aspects of the national response (e.g. increasing VCT, adherence to treatment), which has allowed the Clubs to expand their reach. In addition, the success and dedication of people living with HIV and civil society organizations within the Clubs have increased their profile in the society and in eyes of decision makers. A major outcome of the work is that these community-level entities, through UNAIDS technical support, capacity-building and advocacy, have developed very constructive and balanced working relationships among various stakeholders in the HIV response.

**Japan – Poster Contest**
Implementing Organization(s): Japan Foundation for AIDS Prevention

60. Since 2001, the Japan Foundation for AIDS Prevention has organized a yearly poster contest in order to provide the opportunity to think about the HIV and how to reduce stigma and discrimination related to HIV. The programme has two components: (a) HIV education through the poster contest and (b) raising public awareness around World AIDS Day. The contest has four categories: elementary school students, junior high school students, high school students, and an open category. The best poster is chosen from each category, and then an overall winner is picked from amongst the category winners. Around 500 people apply to this poster contest every year, and the

poster that wins first prize is used for publicity around World AIDS Day. In 2011, the contest accepted 28 applications in the elementary school category, 148 in the junior high school category, 151 in the high school category, and 164 in the open category.

61. The winning World AIDS Day poster is printed by Ministry of Health, Labour, and Welfare and distributed to local government, hospitals, and movie theatres. To reach the younger generation, in addition to the distribution of the printed poster, all the prize winning posters are electrically distributed through the AIDS prevention information network.

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