



PANCAP

PAN CARIBBEAN PARTNERSHIP AGAINST HIV AND AIDS

SCALING UP THE CARIBBEAN'S RESPONSE TO HIV AND AIDS

REGIONAL POLICY ON HIV RELATED STIGMA AND DISCRIMINATION

2010

**REGIONAL
POLICY TO
REDUCE HIV
RELATED STIGMA
AND
DISCRIMINATION**



***PANCAP, Regional Policy to Reduce HIV Related
Stigma and Discrimination, June 2010***

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Partnership Against HIV and AIDS

**CARICOM - PAN CARIBBEAN PARTNERSHIP
AGAINST HIV and AIDS**

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ACRONYMS

AIDS	Acquired Immuno Deficiency Syndrome
ART	Antiretroviral therapy
ARV	Antiretrovirals
BCC	Behaviour Change Communication
BSS	Behaviour Surveillance Study
CAREC	Caribbean Epidemiology Centre
CARICOM	Caribbean Community
CBO	Community-Based Organization
CIDA	Canadian International Development Agency
CRN+	Caribbean Network of Persons Living with HIV
CRSF	Caribbean Regional Strategic Framework
CSME	CARICOM Single Market and Economy
CSO	Civil Society Organisation
DFID	British Department for International Development
ECHR	European Court of Human Rights
EU	European Union
FBO	Faith Based Organization
FSW	Female Sex Worker
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
GIPA	Greater Involvement of Persons Living with HIV
HFLE	Health and Family Life Education
HIV	Human Immuno Deficiency Virus
IACHR	Inter-American Commission on Human Rights
ICASO	International Council of AIDS Service Organisations
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
IDB	Inter-American Development Bank
IDU	Injecting drug use
ILO	International Labor Organization
KAP	Key affected population
LGBTI	Lesbian, Gay, Transgender and Intersex persons
MDG	Millennium Development Goals
MSM	Men who have Sex with Men
NAPs	National AIDS Programmes
NAZ	NAZ Foundation (India) Trust
NGO	Non-Governmental Organization
OVC	Orphans and Vulnerable Children
PAHO	Pan American Health Organization

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PANCAP	Pan-Caribbean Partnership Against HIV/AIDS
PICT	Provider Initiated Counselling and Testing
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
RST	UNAIDS Caribbean Regional Support Team
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infections
SU	Substance user
SW	Sex Worker
UK	United Kingdom
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USP	Universal Safety Precautions
UWI	University of the West Indies
UWP	United Workers Party
VCT	Voluntary Counseling and Testing
WB	World Bank
WHO	World Health Organization

1. INTRODUCTION

1.1 A CALL TO ACTION!

In 1987, the late Jonathan Mann, then director of the WHO Global Programme on AIDS, identified three phases of the HIV and AIDS epidemic:

- the epidemic of HIV,
- the epidemic of AIDS, and
- the epidemic of stigma, discrimination, and denial.

He noted that the third phase is “*as central to the global AIDS challenge as the disease itself*” (Mann 1987).

Twenty-nine (29) years¹ since the first reported case in the Caribbean stigma and discrimination continues to plague our highly religious highly moralistic societies which still cast the person living with HIV as 'a sinner', 'an outcast', or 'deviant'. The various metaphors associated with HIV have also contributed to the perception of HIV as a disease that affects “others,” especially those who are already stigmatized because of their sexual behaviour, gender, race, or socioeconomic status, and have enabled some people to deny that they personally could be at risk or affected (UNAIDS 2000).

At the XIV International AIDS Conference in 2002, Nelson Mandela said,

"Stigma, discrimination and ostracism are the real killers."

The legal and policy measures which have been adopted to respond to HIV have, in some cases contributed to stigma and discrimination. For example in the early stages, the national response to HIV and AIDS had often been justified as necessary to protect the “general population” as distinct from “high risk populations”. By differentiating between the “general population” and “high-risk populations” HIV and AIDS policies and programmes contributed to stigma and discrimination in that actions to prevent HIV spreading from the “high risk populations” to the general population were prioritized and resulted in a lack of resources for those at greatest risk.

Further, focusing on programmes for the “general population” may have reinforced the perception that it is less important to protect populations that practice “high-

¹ The first documented reported case was in Haiti in 1981. Source: Keeping Score II, A Progress Report Towards Universal Access to HIV Prevention, Treatment, Care and Support in the Caribbean, (2008) United Nations Joint Programme on HIV/AIDS, Caribbean Regional Support Team pg. 22

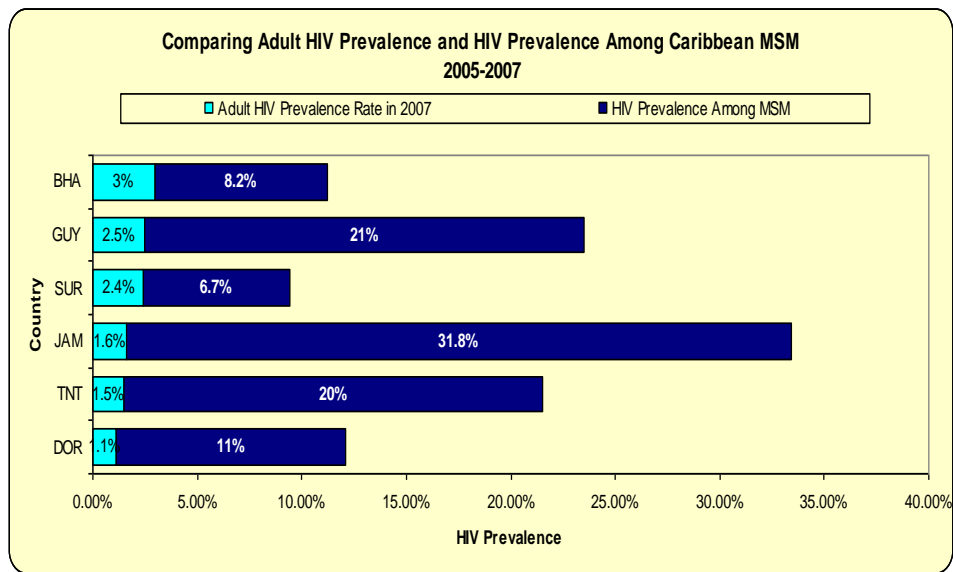
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risk” behaviours than the “innocent and unsuspecting” general population.²

This early perception failed to take account of the wider socio-economic and cultural factors exacerbating the vulnerability of already marginalized groups to increased risk of HIV transmission.

In the absence of focus on these “high risk populations” the impact of the disease particularly on those groups whose behaviour is criminalized and women and young girls labeled as promiscuous has been severe. Figure 1 and Figure 2 contains data from UNAIDS Caribbean Regional Support Team in an analysis of the 2008 UNGASS Reports from the Caribbean, Keeping Score II which illustrate the huge disparities in HIV prevalence rates among MSM and Sex Workers and that of the general population in select countries.

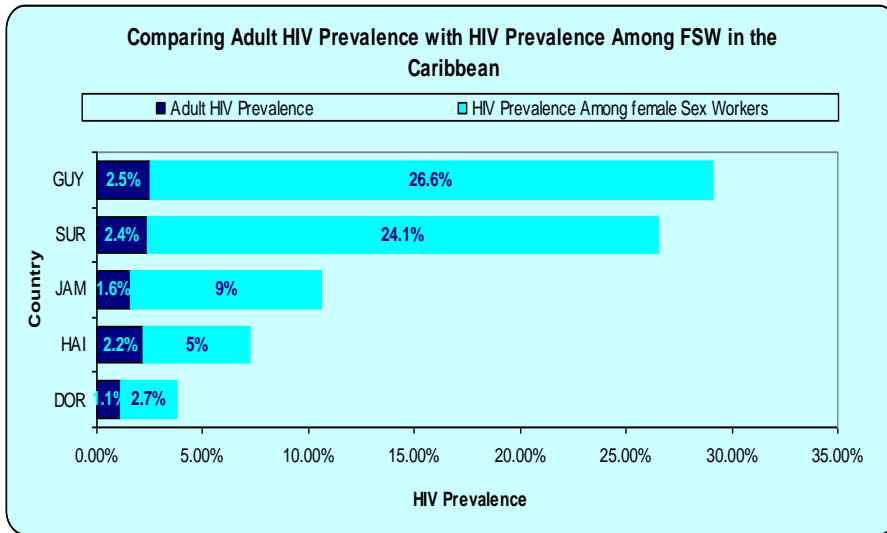
Figure 1 – Comparing Adult HIV Prevalence and HIV Prevalence among Caribbean MSM 2005-2007



Source: UNAIDS Report on the global AIDS epidemic, 2008

² Parker, R. Aggleton, P. ‘HIV/AIDS related Stigma and Discrimination: A Conceptual Framework and an Agenda for Action’ , Horizons Programme 2002, pg 6

Figure 2 – Comparing Adult HIV Prevalence with HIV Prevalence among FSW in the Caribbean

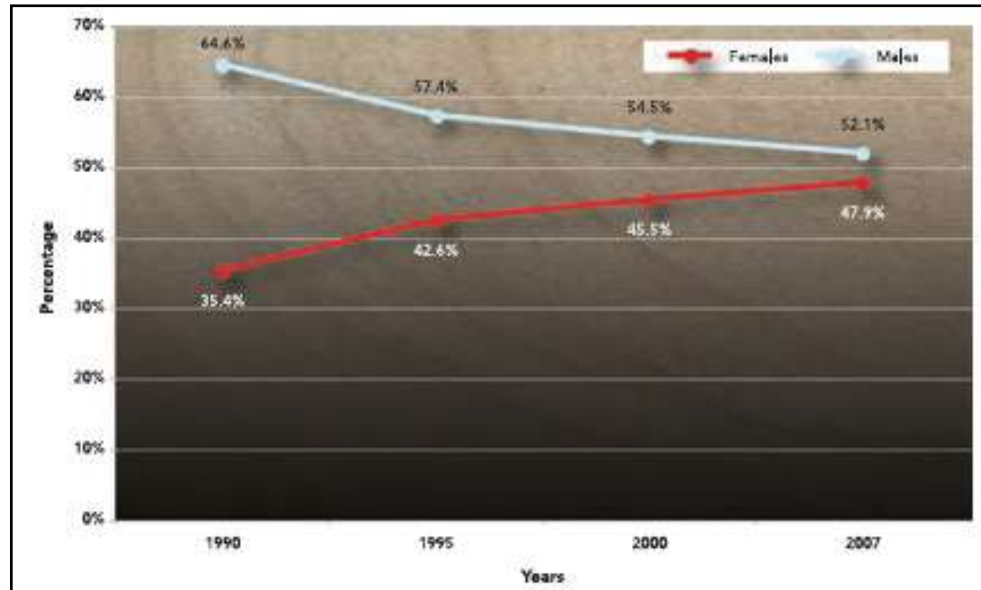


Source: UNAIDS Report on the global AIDS epidemic, 2008

Figure 3 illustrates the feminization of the disease, which is, that progressively more and more women, especially the young are becoming infected. UNAIDS/WHO estimate that during the period 1990-2007, the male to female ratio in the population living with HIV has altered year on year from 65% male to 35% female in 1990 to 52% male to 48% female in 2007. Therefore, the percentage of women living with HIV in the Caribbean has increased by nearly 40% in the past 17 years³.

³ Keeping Score II, A Progress Report Towards Universal Access to HIV Prevention, Treatment, Care and Support in the Caribbean, (2008) United Nations Joint Programme on HIV/AIDS, Caribbean Regional Support

Figure 3 - Estimated percentage of adults living with HIV in the Caribbean – males & females, 1990 – 2007



Source: UNAIDS Report on the global AIDS epidemic, 2008

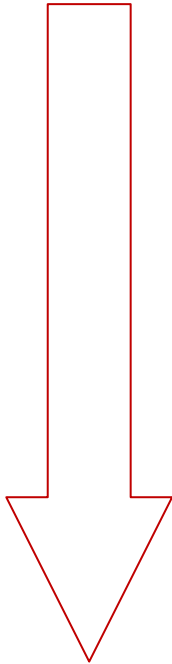
Other examples of stigmatizing and discriminatory legal and policy measures which have been adopted by various Governments in the region as appropriate responses to the epidemic include;

- compulsory screening and testing of the military, police and prisoners;
- compulsory notification of HIV cases;
- compulsory screening of pregnant women;
- screening of persons applying for visas and citizenship;
- mandatory testing of persons seeking work permits;
- pre-employment screening; and
- the introduction of criminal laws to punish the willful transmission of HIV.

HIV stigma and discrimination undermines prevention efforts and access to treatment, care and support as people are afraid to get tested and know their status for fear of disclosure and the consequences resulting from *even the suspicion* of an HIV positive status. Fear of violence, loss of employment, ostracism by family and community, refusal of entry into school, dismissal from employment, inability to secure employment, inability to secure insurance, harassment, denial of services including health, transportation, housing are but a few of the realities faced by PLHIV and other key affected populations in the Caribbean on a daily basis.

This policy is a:

CALL TO ACTION by:



1. **Governments** (in particular)
 - a. National AIDS Programmes
 - b. Offices of Attorneys General
 - c. Ministries of Justice
 - d. Ministries of Education
 - e. Ministries of Health
 - f. Ministries of Economic and Social Development
2. **Regional Partners**
3. **Regional and National NGOs**
4. **Private Sector**
5. **Faith Based Organisations (FBOs)**
6. **Community Based Organisations (CBOs)**
7. **PLHIV and other Key Affected Populations**

TO ADOPT: appropriate legal and policy measures to reduce the levels of stigma and discrimination and violation of human rights perpetrated against;

FOR: persons living with HIV (PLHIV) and other key affected populations including, families of persons living with HIV, Orphans and Vulnerable Children (OVC), youth, women particularly young girls, Men who have sex with Men, Lesbian, Gay, Bisexual, Transgender and Intersex Persons (LGBTI) and other sexual minorities, Sex Workers (SW), Substance Users (SU), Prisoners, Persons with Disabilities, and Migrant and undocumented persons.

The identification of key affected populations will vary based on national priorities and prevalence. The groups listed above represent those who have been identified across the region who are most vulnerable to and affected by HIV and who are most often marginalized and have the greatest difficulty in achieving their rights to health.

2. GUIDING PRINCIPLES

2.1 **We**, the people of the Caribbean through this anti-stigma and discrimination policy seek to:

*A*ffirm that the realization of human rights and fundamental freedoms for all is essential to reduce vulnerability to HIV and the impact of AIDS;

*R*ecognize the essential role of persons living with HIV as the center of the response and that the meaningful involvement, participation and empowerment of PLHIV and other key affected populations will reduce the levels of HIV related stigma and discrimination;

*C*all upon all member states, regional and international partners, private sector, NGOs, FBOs and CBOs to enact legislation (in the case of member states) and otherwise to adopt policies, measures and practices:

Prohibiting discrimination of any kind, on the ground of sex, race, colour, age, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV and AIDS), sexual orientation or civil, political, social or other status;

Promoting protection of the value of human life;

Promoting respect for the dignity of all persons;

Promoting respect for diversity and uniqueness;

Advocating for the alleviation of social and economic inequities and fostering of social justice;

Encouraging the meaningful adherence to the GIPA principles and principles related to sexual orientation and gender identity⁴

⁴ The Global Fund to Fight Strategy in Relation to Sexual Orientation and Gender Identities, 19th Board Meeting 2009, GF/B19/4 Attachment 3 http://www.theglobalfund.org/documents/publications/other/SOGI/SOGI_strategy.pdf and see also ICJ 2007, “the Yogyakarta Principles: The Application of International Human Rights Law to Sexual Orientation and Gender Identity” available at www.yogyakartaprinciples.org

Promoting culturally and developmentally appropriate and medically accurate HIV and AIDS and Human Rights information and education.

3. POLICY OBJECTIVES

- 3.1 Reiterate strongly and without qualification Governments' firm commitment to reduce the incidence of stigma and discrimination and human rights violations perpetrated against PLHIV and key affected populations.
- 3.2 Define a framework for action in reducing the incidence of HIV and AIDS related stigma and discrimination setting out the role of each of the partners in achieving the principles laid out by this policy.
- 3.3 Generate a feeling of ownership among all segments of society to make the reduction of stigma and discrimination a truly regional effort.
- 3.4 Promote an enabling socio-economic and legal environment for prevention, care, treatment and support of PLHIV and other key affected populations and to ensure protection and promotion of their human rights, including the right to access health care, the right to education, employment and privacy.
- 3.5 Mobilise support from the peoples of the Caribbean region in creating an enabling environment to reduce stigma and discrimination and mitigate the personal and social impact of HIV and AIDS.

4. SETTING THE FRAMEWORK

4.1 Caribbean Diversity

The region is multiethnic and culturally diverse, with many languages--Spanish (60 %), French (20%), English (16%), with the remaining speaking Dutch and Creole. The population of the region is approximately 39 million people, with mainland states (Belize, Guyana and Suriname), and island states that vary in size, ethnicity and religion.

Population size in the island states varies from Anguilla with a population of 8,000 and Cayman Islands with 35,000 to Haiti with 8 million and Cuba with 11 million inhabitants.

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While the majority of the population is of African descent, there are also people of European and Asian ancestry, as well as indigenous populations such as Carib, Arawak, Garifuna and Taino peoples⁵.

The Caribbean peoples are also from diverse religious backgrounds - Christian, Hindu, Muslim and others. Religion has a huge influence in setting norms of “acceptable” behaviour. To a large extent the laws of most countries reflect the moral standard of the community which until recently were almost identical with Christian standards.

The diversity also extends to the legal systems of the region. Among the 15 CARICOM Member States and 5 Associated Members only Haiti and Suriname are not part of the English Speaking Commonwealth Caribbean. Notwithstanding there are divergences even within the Commonwealth Caribbean Countries.

The legal systems of Guyana and Saint Lucia are best described as “hybrid”, because Guyana has the influence of the Roman-Dutch tradition, while that of Saint Lucia has a mixed system, which comprises the French Civil Law, the Common Law and indigenous law, with the Civil Law aspect influenced by the Quebec Civil Code.⁶ Otherwise the legal systems of the English-speaking Caribbean countries are based on the English Common Law. Haiti’s legal system is based on Roman Civil Law and Suriname on the Dutch legal system incorporating French legal theory.

*“Despite differences between countries, the spread of HIV in the Caribbean has taken place against a common background of poverty, gender inequalities and a high degree of HIV-related stigma. Migration between islands and countries is common, contributing to the spread of HIV and blurring the boundaries between different national epidemics. Additionally, poor availability of HIV and AIDS data makes it difficult to gain a clear picture of each country’s situation”.*⁷

4.2 HIV and AIDS in the Caribbean Region

In 2008 an estimated 20,000 people in the Caribbean became infected with HIV and around 12,000 died of AIDS. The Caribbean continues to have the highest prevalence after sub-Saharan Africa. The prevalence rate is estimated to be between 0.7% and 1%, however behavioural data is not readily available and these estimates are not accurate.⁸ At one extreme, the Bahamas has the highest HIV prevalence in the entire western hemisphere (3%); at the other, Cuba has one of the lowest (0.1%). Trinidad and Tobago

⁵ HIV/AIDS in the Caribbean Region: A Multi-Organization Review, DFID, WHO/PAHO, GFATM, UNAIDS Secretariat and the World Bank November 2005

⁶ Antoine, Rose-Marie. Commonwealth Caribbean Law and Legal Systems, London: Routledge-Cavendish, 2008.

⁷ HIV/AIDS in the Caribbean Region: A Multi-Organization Review, DFID, WHO/PAHO, GFATM, UNAIDS Secretariat and the World Bank November 2005

⁸ UNAIDS 2008 Update

(1.5%) and Jamaica (1.6%).

The Caribbean has a mixture of generalized and concentrated epidemics. Women account for approximately half of all infections in the Caribbean. HIV prevalence is especially elevated among adolescent and young women, who tend to have infection rates significantly higher than males their own age. There are also extremely high prevalence rates recorded in relation to MSM and SW⁹.

Substantial differences in HIV burden are apparent within many Caribbean countries. There is a nearly sevenfold variation in HIV prevalence between the different regions of the Dominican Republic, with HIV prevalence especially elevated in the country's former sugar plantations (bateyes). In Haiti, HIV prevalence among pregnant women in 2006–2007 ranged from 0.75% in a sentinel antenatal site in the western part of the country to 11.75% in one urban setting¹⁰.

In summary the epidemiological features of the HIV epidemic in the Caribbean are¹¹:

- The first AIDS cases were reported in Haiti in 1981. Since that time the Caribbean has been confronted with a growing HIV epidemic;
- The Caribbean is the most HIV-affected region of the Americas;
- The HIV epidemic is a mosaic, with a number of different epidemics within countries and across the region;
- AIDS is the leading cause of death among 25-44 year-olds with 38 deaths due to AIDS-related illness occurring every day;
- HIV is disproportionately affecting the most vulnerable population groups;
- HIV is gradually affecting men and women almost equally;
- 20,000 new HIV infections occurred in the Caribbean in 2007 representing close to 1% of the total new global HIV infections.

29 years into the epidemic the Governments of the region have committed in various political declarations and successive national strategic plans to achieve a reduction in stigma and discrimination by creating an enabling environment which recognizes the rights of persons living with HIV and others made more vulnerable by HIV. The evidence shows, however, that there has been no real progress.

3.3 Stigma and Discrimination in the Caribbean

Stigma and Discrimination are considered by many experts to be the greatest barriers in preventing the spread and impact of HIV.

⁹ UNAIDS, 2009, Keeping Score II, Caribbean Regional Support, Team United Nations Joint Programme on HIV/AIDS

¹⁰ <http://www.avert.org/aids-caribbean.htm>

¹¹ UNAIDS, 2009, Keeping Score II, Caribbean Regional Support, Team United Nations Joint Programme on HIV/AIDS pg. 22

“HIV and AIDS related stigma may well be the greatest obstacle to action against the HIV and AIDS epidemic. An all out effort against stigma will not only improve the quality of life of persons living with HIV and those vulnerable to infection, but will meet the necessary conditions of a full-scale response to the epidemic.”¹²

3.3.1 Reinforcing Social Inequality

In an IDB study on stigma and discrimination in Latin America and the Caribbean, Aggleton, Parker and Maluwa (2003)¹³ drawing on research around stigma from the classical work of social psychologists Goffman (1963) to the more recent work of Link and Phelan (2001) argue that HIV and AIDS related stigma is not something that resides in the minds of individuals. Instead, it is a ‘social product’ with deep societal origins.

Stigma plays into and reinforces existing social inequalities including:

- inequalities of wealth
- gender inequality
- inequalities of nationality, ethnicity
- inequalities linked to sexuality and different forms of sexual expression

In a study of HIV Stigma and Discrimination in six (6) Caribbean Countries (Royes, H, 2007)¹⁴ also found that efforts to deal effectively with HIV related stigma and discrimination as well as the epidemic itself stumble in the face of the taboos against ‘sex/gender transgressors’ and in some cases against discussing issues of sexuality in general.” Taboos and secrecy related to sexuality, culture and morality based largely on Christian principles are deep rooted and drive the epidemic underground, increasing the challenges in addressing stigma and discrimination.

Stigma and discrimination must therefore be addressed in relation to other forms of social inequality and exclusion that disempower those most vulnerable to HIV.

3.3.2 Definitions

3.3.2.1 Stigma is defined as ‘a process of devaluation’ of people either living with or associated with HIV and AIDS.¹⁵

¹² Peter Piot, Former Executive Director, UNAIDS, United Nations Under Secretary General

¹³ Aggleton, Peter, R. Parker, M. Maluwa. 2003. *Stigma, Discrimination and HIV AND AIDS in Latin America and the Caribbean*, Inter- American Development Bank

¹⁴ Royes, Heather. PHD “PANCAP Survey of HIV/AIDS Stigma and Discrimination in six Caribbean Countries” (2007), also UNAIDS 2007 ‘Reducing HIV Stigma and Discrimination: a critical part of national AIDS Programmes’ Geneva, Joint United Nations Programme on HIV/AIDS.

¹⁵ Royes, (2007) pg. 6

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Analysis that focus on a stigmatized person as “possessing an undesirable difference” and the interventions that follow from them, have a number of significant weaknesses.

"Stigma has been identified as a complex, diverse and deeply rooted phenomenon that is dynamic in different cultural settings. As a collective social process rather than a mere reflection of an individual's subjective behaviour, it operates by producing and reproducing social structures of power, hierarchy, class and exclusion and by transforming difference (class, race, ethnicity, health status, sexual orientation and gender) into inequality" (POLICY Project, 2003a: 2).

*“Beyond their failure to recognize stigmatization as a process with which individuals and communities engage, they fail to account for (or intervene around) the social structures that give HIV and AIDS related stigma its meaning. Within a particular culture or setting, certain attributes are seized upon and defined as discreditable or not worthy within the context of HIV/AIDS. Undesirable differences and spoiled identities do not naturally exist; they are actively created by individuals and by communities. Stigmatization therefore describes a systematic process of devaluation rather than a “thing”.*¹⁶

Understanding Stigma as a process of devaluation rather than an internal attribute allows for the conceptualization of new approaches to programming and interventions: ways of responding to HIV related stigma and discrimination that engage societies, communities, and those who suffer stigmatization and discrimination.

Stigma may also emanate from within a person – self stigma or enacted stigma where the stigmatised person either believes and internalises the negative view of themselves or where out of fear the stigmatised person assumes that persons are or will stigmatize them and they remove themselves from the particular situation. For example a person who has received an HIV test may not return to their job for fear of co-workers and employers finding out about their status.

¹⁶ Aggleton, Peter, R. Parker, M. Maluwa. 2003. *Stigma, Discrimination and HIV AND AIDS in Latin America and the Caribbean*. Inter- American Development Bank

3.3.2.2 Discrimination

...discrimination may be described as a distinction, whether intentional or not but based on grounds relating to personal characteristics of the individual or group, which has the effect of imposing burdens, obligations, or disadvantages on such individual or group not imposed upon others, or which withholds or limits access to opportunities, benefits, and advantages available to other members of society. Distinctions based on personal characteristics attributed to an individual solely on the basis of association with a group will rarely escape the charge of discrimination, while those based on an individual's merits and capacities will rarely be so classed.¹

Not all distinctions, and not all unfavourable treatment, amount to unlawful discrimination. A leading definition of discrimination, which has been widely applied by Canadian courts and tribunals, was set out in *Andrews v Law Society of British Columbia*¹⁷, a Supreme Court of Canada decision in 1989 at caption.

Discrimination¹⁸

Any measure entitling any arbitrary distinction among persons depending on their confirmed or suspected HIV status or state of health and occurs when unfair and unjust treatment is meted out to a person because they belong to a particular group.

HIV related discrimination occurs on specific **grounds** and in specific **areas**. It can be the result of actions by **government** or **non-state** actors. In some civil law systems, constitutional prohibitions against discrimination apply not only to the state and state actors, but also to all private actors as well. In common law systems, it is generally

the case that constitutional provisions are applicable against the state (which can include all levels of government) and only the state, although other, non-constitutional statutes can and do apply to govern the conduct of non-state actors (private sector employers, landlords, etc).

How does it work?

Discrimination is stigma in action. Laws which require testing for employment, which restrict the movement of PLHIV and which restrict people's right to anonymity and confidentiality are discriminatory. Forcing a family member to leave their home, harassing persons who are suspected to have the disease, denial of access to state, community or religious spaces, dismissing someone from employment on the basis of their HIV status or perceived HIV status is discriminatory.

¹⁷ *Andrews v Law Society of British Columbia*, [1989] 1 SCR 143.

¹⁸ Most Commonwealth Caribbean Constitutions have a similar definition for discrimination. For example see Jamaica Constitution (Order in Council) 1962. Section 24 (3) In this section, the expression "discriminatory" means affording different treatment to different persons attributable wholly or mainly to their respective descriptions by race, place of origin, political opinions, colour or creed whereby persons of one such description are subjected to disabilities or restrictions to which persons of another such description are not made subject or are accorded privileges or advantages which are not accorded to persons of another such description.

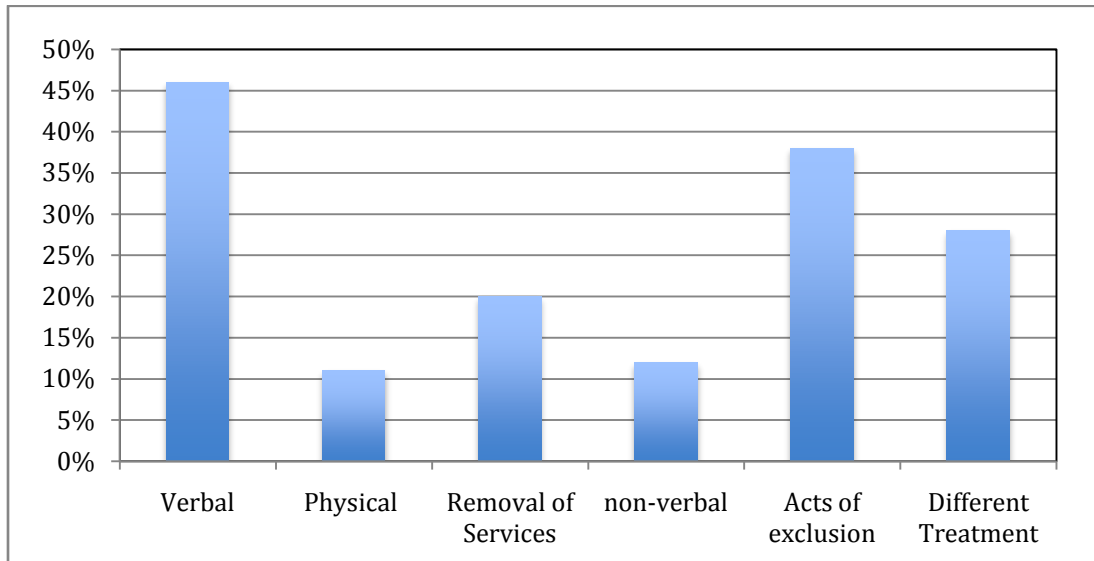
The discrimination is the act which follows or is influenced by the view of the perpetrator of the discrimination based on the social label attached to someone who is HIV positive or perceived to be a member of a ‘deviant’ group. In other words discrimination is fuelled by stigma.

Stigma reinforces social norms by defining deviance and confirming social exclusion. It is created by fear – fear that the people who are stigmatized threaten society and principally it is fed by ignorance – ignorance of the realities of sexual behaviour and the way in which the disease is spread.

3.3.3 Findings on Stigma and Discrimination

The levels of stigma and discrimination are still relatively high in the Caribbean¹⁹. Stigma and discrimination against those infected with and affected by HIV are widespread and are recognised as a major barrier to accessing prevention, testing and treatment²⁰. The Royes (2007) study²¹ found that the main types of abuse experienced was 1) *verbal abuse*, 2) *physical abuse*, 3) *avoidant behaviour*, 4) *exclusion from social interaction, employment, church*, 5) *threats of arrest and harassment*.

Figure 1: Main Types of Stigma and Discrimination (Royes (2007))



¹⁹ Source: National Assessment Reports on review of laws related to HIV and AIDS conducted in Dominica, Grenada, Guyana, St. Kitts and Nevis, Saint Lucia, St. Vincent and the Grenadines, Belize, Suriname, Jamaica, Barbados, Studies on stigma and discrimination in the Caribbean, Aggleton, Parker Maluwa (2003), Royes (2007) among others

²⁰ Keeping Score II, A Progress Report Towards Universal Access to HIV Prevention, Treatment, Care and Support in the Caribbean, (2008)

²¹ Royes, Heather PHD “PANCAP Survey of HIV/AIDS Stigma and Discrimination in Six Caribbean Countries” September 2007

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The main perpetrators were;

- 1) Family
- 2) Close community
- 2) Someone known to victim,
- 3) Health care workers,
- 4) School,
- 5) Workplace,
- 6) Youth,
- 7) General public, in that order.

Data from the National Assessment Reports on Laws and Policies related to HIV and AIDS conducted in CARICOM Members States between 2002 – 2009 under the Priority Area 1, Law Ethics and Human Rights of the Regional Strategic Framework 2002 – 2006 and other commissioned studies suggest the following range of abuses which occur against PLHIV and other key affected populations on a daily basis:

- Dismissal from employment
- Discrimination within the workplace
- High levels of discrimination within the health sector – breaches of confidentiality, refusal of services, death resulting from refusal to treat, ill-treatment, abuse
- Denial of housing
- Ostracism from family, community by threats, physical abuse, burning of residence
- Stoning of children
- Denial of entry into school
- Denial of insurance coverage, even in cases of perceived HIV status
- Denial of transportation
- Refusal of work permits
- Denial of registration of citizenship even in cases of descent
- Victimization and harassment, *inter alia*

4. A MODEL FOR ADDRESSING STIGMA AND DISCRIMINATION - The 3 'E's

In addressing stigma and discrimination the following must be given consideration: that stigma and discrimination occurs at two levels; the societal level and the individual level and; that the groups being targeted are not homogenous and that they practice stigma within and among themselves.

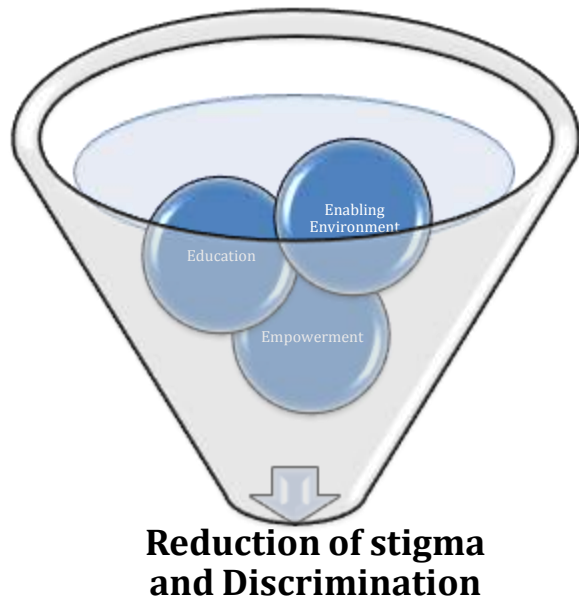
This policy is based on the following three essential strategies for tackling stigma and discrimination which include:

THE THREE "E"s

E EMPOWERMENT

E EDUCATION

E ENABLING ENVIRONMENT



This three-pronged approach is mutually reinforcing and addresses the wider societal interactions through the creation of an - **enabling environment** - communities, the persons and agencies interacting with persons made vulnerable by HIV through -**education** - those who suffer stigma and discrimination - **empowerment**. PLHIV and key affected populations must be empowered to understand and assert their rights, education of all must be continuous and the legal and policy environment must accord with the requirement to recognise and protect rights for all and recognise the particular circumstances of PLHIV and key affected populations to access prevention care, treatment and support.

5. ACTIONS FOR ADVANCING THE THREE 'E's

POLICY AREA 1

5.1 EMPOWERMENT

Rationale

Priority should be given to approaches that aim to strengthen capacity for resistance among stigmatized and marginalized groups, since empirical evidence indicates that some of the most effective responses to the HIV epidemic have been those where affected communities have mobilized themselves to fight stigma, discrimination, and oppression.²²

Empowering or “unleashing the power of resistance” of stigmatized populations through GIPA for example have enabled people living with HIV to demand recognition of their existence, needs, and rights. Organizing has also enabled those who are marginalized to challenge discrimination and to lobby for changes in laws and policies²³.

Facilitating the empowerment of stigmatized groups also allows them to move beyond their own internal stigma and takes them out of the role of the victim to one of an advocate.

Policy Statement

- Governments, regional partners, private sector, NGOs, FBOs and CBOs must ensure that the participation of networks of people living with HIV, and representatives from other key affected populations, are included in all aspects of programme design, planning, implementation, and evaluation of regional and national planning processes addressing HIV.
- National AIDS Programmes, need to work in close consultation with PLHIV and other key affected populations and technical partners to ensure that

²² See Parker, R. Aggleton, P. 'HIV/AIDS related Stigma and Discrimination: A Conceptual Framework and an Agenda for Action' 2002 referring to (Daniel and Parker 1993; Altman 1994; Epstein 1996; Parker et al. 1995; Stoller 1998).

²³ See UNAIDS and Canadian HIV/AIDS Legal Network, 2006 'Courting Rights: case Studies in Litigating the Human Rights of People Living with HIV' 2006 for examples of litigation and other strategies by persons living with HIV to secure, access to treatment, freedom from discrimination, prevention and care in prisons.

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comprehensive programmes are developed based on the best available local intelligence and to ensure that community needs are adequately addressed.

- National AIDS Programmes, NGOs, CBOs, and FBOs must recognize that PLHIV and other key affected populations are not homogenous groups (for example, youth may be in-school, out of school, in difficult circumstances, of differing ages) all requiring different and appropriate strategies for that target group.

Governments must:

- Enact laws to ensure that the human rights and dignity of those living with HIV and key affected populations are respected.
- Ensure that a positive HIV status whether perceived or actual or whether one is a family member of a person living with HIV, an orphan or vulnerable child, youth, a man who has sex with men, lesbian, gay, bisexual, transgender and intersex, sex worker, substance user, prisoner, person with disabilities, or migrant is not used as a reason for denying access to social services, including health care, education, religious services, or employment among others.
- Ensure that PLHIV and members of key affected populations whose rights have been infringed have access to independent, speedy and effective legal and/or administrative procedures for seeking redress.
- Ensure that access to public services does not require the disclosure of one's HIV status.
- Ensure the freedom of association of PLHIV and key affected populations to form support groups and advocate on their own behalf.
- Provide adequate social support based on needs assessment and equitable allocation of resources to PLHIV and key affected populations.
- Provide adequate, long-term funding for education and advocacy on HIV and human rights to National AIDS Programmes, PLHIV and other key affected populations.²⁴

PLHIV and key affected populations should

- Ensure that members are educated on their rights against discrimination, privacy, and the right to health among others and the available avenues for securing these rights including applications to Rights Commissions, shadow reporting,

²⁴ MacIntosh, J.M. 'HIV/AIDS Stigma and Discrimination: A Canadian Perspective and Call to Action' *Interamerican Journal of Psychology* – 2007, Vol. 41, Num. 1 pp 93-102

challenging discriminatory laws.

- ▶ Must educate themselves on their obligations in advancing the National and Regional Response.
- ▶ Should be organized to take advantage of opportunities to participate, raise funds, develop, influence programming, and advocate on their own behalf.

POLICY AREA 2

5.2 EDUCATION

Rationale

Actively challenging public attitudes which stigmatize persons living with HIV and key affected populations must be continuously pursued. Stigma can be reduced through a variety of direct intervention strategies including, information, counseling, coping skills acquisition and contact²⁵. Continuous education of government personnel, health care providers, PLHIV, other key affected populations, faith based organisations, and the general public is key in changing negative attitudes towards PLHIV and other key affected populations by clarifying modes of transmission and personalizing the risk, and respect for human rights.

Policy Statement

- ▶ Governments must ensure that all people have equal access to culturally sound, age and developmentally appropriate formal and non-formal HIV and AIDS information and education which should include sexual and reproductive health, the importance of respect for and non-discrimination against PLHIV and key affected populations, and basic human rights.
- ▶ Activities, designed to empower PLHIV and key affected populations, should complement ongoing efforts to change individual attitudes toward PLHIV and key affected populations through, for example, media campaigns promoting tolerance and compassion.
- ▶ Government, FBOs, NGOs, CBOs and private sector leaders must speak out in support of PLHIV and key affected populations.

²⁵ Brown, L. Trujillo, L. McIntyre, K. 'Interventions to Reduce HIV/AIDS Stigma: What have we Learned' Horizons Programme, Tulane University, 2001

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- Governments, FBOs, NGOs, CBOs and private sector must engage in basic human rights education on the indivisibility of rights and its application to all.
- PLHIV and key affected populations must be involved in the design and implementation of education programmes which should be adequate, accessible, sound, effective and culturally and developmentally appropriate.
- Persons engaging in education strategies and activities must ensure that behaviour change interventions are evidence-informed; based on the needs of the target populations and existing evidence on potential opportunities for and barriers to behaviour change.
- PANCAP and other regional institutions must ensure that key stakeholders working to address HIV – such as Government and UN officials, multi-lateral and bi-lateral partners, the media, civil society, NGOs, FBOs, private sector and organisations of people living with HIV and other key affected populations are aware of the actionable causes of stigma and discrimination.
 - In addition, they should advocate for funds to support national programmes that address these causes and support governments to prioritize such programmes in their national strategic plans and annual action plans.
- PANCAP and other regional institutions and support agencies, must develop targeted education interventions at the regional and national level where appropriate with a special focus on
 - The Judiciary
 - The Education sector
 - Health sector
 - Private sector
 - Legal fraternity
 - Security Forces including the Police
 - Prison authorities
 - PLHIV
 - Other key affected populations
 - Faith Based Organisations
 - Media

POLICY AREA 3

5.3 ENABLING ENVIRONMENT

5.3.1 THE LEGAL RESPONSE

The new Caribbean Regional Strategic Framework (CRSF) 2008 – 2012 places emphasis on developing an “enabling environment” which focuses on the “development of policies, programmes and legislation that affirm human rights and counter deep underlying social barriers...”.

Studies on HIV related stigma and discrimination in the Caribbean have drawn links between existing social inequality and culture including the vulnerability caused by poverty, gender inequities and the denial of human rights. International experience has shown that many of the impediments to an effective response are linked to a denial of human rights.

“A lack of human rights protection fuels the epidemic in a number of ways: ²⁶

- ▶ *The subordination of women and girls compounded by domestic violence, sexual coercion, and inability to negotiate safer sex has made them vulnerable to HIV infection and prevented them from getting the information, resources, and services that are necessary for their health. This has led to higher rates of infection among women and girls and has increased their vulnerability.*
- ▶ *Hostility toward gay, lesbian, bisexual, and trans-gendered people has created environments that are silent about their existence, fail to support them in their personal and social development, and deny them the information, resources, and services that are necessary for their health.*
- ▶ *Prisoners depend on the state to give them the resources to prevent infection with HIV and other diseases, to protect their privacy, to protect them from violence, and to provide them with health care. Failure to fulfill these rights has contributed to HIV transmission among prisoners and made the impact of HIV infection worse.*
- ▶ *Responses to drug use and sex work put a disproportionate emphasis on controlling these activities through criminal and public health law. This approach stigmatizes people who use illegal drugs or provide sexual services,*

²⁶ UNAIDS / IPU, Handbook for Legislators on HIV/AIDS Law and Human Rights, 1999 and also Patterson, David. “Programming HIV/AIDS: A Human Rights Approach A tool for International Development and Community-Based Organizations responding to HIV/AIDS” Canadian HIV/AIDS Legal Network, 2004

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and neglects or undermines alternative responses to drug use and sex work that prevents disease and promotes health”.

- ▶ Persons dismissed from employment on the basis of their HIV status are faced with many problems, including the extra economic burdens of health care, as well as providing for any dependent family²⁷;
- ▶ When economic, social or cultural rights are not respected persons are more vulnerable to infection. For example, a refugee may be separated from former sources of support (such as family), and more likely to engage in activities which place his or her health at risk (such as unsafe sex)²⁸; and
- ▶ Where civil and political rights are not respected, and freedom of speech and association is curtailed, it is difficult or impossible for civil society to respond effectively to the epidemic. In some countries peer education is hampered by laws that refuse official registration to groups with certain memberships (for example, sex workers)²⁹.

Addressing stigma and discrimination requires the creation of an enabling environment, guaranteed by protective laws and policies which recognise the rights of PLHIV and other key affected populations. The creation of this environment must be guided by a set of principles which recognise the basic entitlements or minimum standards of treatment which States and all other interested parties are obligated to observe and maintain. In other words, guaranteeing human rights is an indispensable weapon in the fight against the epidemic. These include not only the rights of PLHIV, their family members and other key affected groups, but also the rights of the general population to have access to information, preventive measures and means, treatment and care, and protection against harassment and discrimination.

The time is now to recognise the equality of all people and to create an environment, free from fear and discrimination.

²⁷ UNAIDS/IPU, Handbook for Legislators on HIV/AIDS Law and Human rights, 1999

²⁸ ibid

²⁹ ibid

POLICY AREA 5.3.2

5.3.2 Non- Discrimination and Equal Protection of the Law

Rationale

In relation to discrimination, the obligation to respect requires States not to directly or indirectly discriminate in law, policy or practice. The obligation to protect requires States to take measures that prevent third parties from discriminating. The obligation to comply requires States parties to Human Rights Conventions to adopt appropriate legislative, budgetary, judicial and other measures to ensure that strategies, policies and programmes are developed to address discrimination and to ensure redress to those who have been discriminated against³⁰.

The most relevant human rights principles for protecting the dignity of persons living with HIV and key affected populations, as well as preventing the spread of the infection, include:

- non discrimination;
- the right to health;
- the right to equality between men and women;
- the rights of children;
- the rights to privacy;
- the rights to education and information;
- the right to work;
- the right to marry and found a family;
- the right to social security assistance and welfare;
- the right to liberty; and
- the right to freedom of movement.

Many of the abovementioned rights are not currently contained in the Bill of Rights provisions of many Caribbean Constitutions which are the main source of human rights law; therefore there is little redress in the absence of specific ordinary legislation to a wide range of discriminatory practices perpetrated against persons living with HIV and other key affected populations.

Policy Statement

- Governments are encouraged in the absence of constitutional protections and or appropriate anti-discrimination legislation to enact broad anti-discrimination legislation or enact anti-discrimination legislation in accordance with the

³⁰ Roseman, MJ. Gruskin, S. "HIV and Human Rights in a Nutshell" International Council of AIDS Service Organisations and Program on International Health and Human Rights, 2004

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CARICOM Model Anti-discrimination Act to protect the rights of persons made vulnerable by HIV.

- ▶ Broad anti-discrimination legislation should at a minimum:
 1. Include the following grounds of non-discrimination:

“sex, gender, race, place of origin, political opinions, colour or creed, sexual orientation, age, disability, HIV or other health status, religion, pregnancy and conscience sex work or other status.”
 2. Be applicable against the State, and all other legal and juridical persons. This would therefore allow for redress against private entities whether, an individual or business concern.
 3. Define discrimination to be:

Any less favourable treatment of a person on the grounds, referred to above than another person is, has been or would be treated under comparable circumstances. And shall include discrimination which places a person, on the grounds referred to above in a less favourable position in comparison with other persons by means of an apparently neutral provision, criterion or practice, unless the said provision, criterion or practice have objective justification in view of achieving a lawful objective and the means for achieving this objective are appropriate and necessary.
 4. Both direct and indirect discrimination should be covered by the legislation. Indirect discrimination occurs when an apparently neutral condition or requirement has a disproportionately negative impact on an individual or group. For example, the requirement that all applicants for housing mortgages have life insurance would indirectly discriminate against people living with HIV in countries where life insurance is routinely denied to PLHIV.
 5. The areas to be covered may include but should not be limited to employment, housing, access to health services, admittance to schools, denial of insurance, among others
 6. Discrimination should be actionable criminally and civilly against the perpetrator of the discrimination or employer under the principle of vicarious liability.
 7. There should also be a sanction where a public official fails to perform his/her public duties on the basis of the grounds proposed.

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8. The legislation should allow for affirmative action for the benefit of persons living with HIV and other key affected populations.³¹
 9. Harassment on one or more prescribed grounds must also be prohibited.
 12. Incitement to discrimination through the publication or display of notices, symbols or hate messages, music in a public place must also be prohibited.³²
 13. Legislation should include provisions prohibiting coercing, threatening, or retaliating against persons asserting their rights under the legislation, and those helping them to do so.
 14. Legislation should specify that where there is a conflict with other legislation, the present legislation should prevail (exceptions should be specifically noted.)³³ The legislation needs to be at least as expansive as the Constitution, or else it could be seen as constitutionally deficient.
 15. Exceptions and exemptions should be framed narrowly. For example, in the area of life insurance the only exception should be on the basis of reasonable actuarial data, so that HIV is not treated differently from other analogous medical conditions.
- Respect for the inherent dignity of all persons and the right to equal protection of the law requires that persons living with HIV and other key affected populations should have access to public and private services, benefits and opportunities on a non-discriminatory basis. HIV testing should not be required as a precondition for such access.
 - Governments will adopt public measures to protect persons living with HIV and other key affected populations from discrimination in all areas of social and economic life including but not limited to employment, housing, education, childcare and custody and the provision of medical, social and welfare services.
 - Human rights principles require that laws and measures introduced to protect the public should not arbitrarily deprive individuals of enjoyment of their rights and freedom. There is no justification for penalizing an individual solely on the

³¹ In the context of racial discrimination, the OHCHR model legislation also notes that positive measures which have the purpose of ensuring adequate advancement of an individual or group of individuals need not be considered unlawful discrimination. OHCHR. Model National Legislation for the Guidance of Governments in the Enactment of Further Legislation Against Racial Discrimination (s. 3). See www.unhcr.ch/html/menu6/2/pub962.htm.

³² For example, the *Canadian Human Rights Act* (s. 13) has a general provision on hate messages.

³³ See *Bermuda Human Rights Act* (1981), section 30B

grounds of ill-health or infection nor for restricting the rights or freedom of persons solely on the ground that they are, or may be, infected with HIV.

POLICY AREA 5.3.3

5.3.3 Privacy and Confidentiality

Rationale

Confidentiality is at the heart of reducing stigma and discrimination against persons living with HIV in particular. It is the breach of confidentiality which typically leads to stigmatization or discrimination. Unlawful breaches occur every day and by persons who have a duty to protect. The small size of the populations of many of the countries of the region and our ‘gossip’ culture make it very difficult to address breaches of confidentiality in the absence of legislative duty and sanctions.

The lack of confidentiality or perceived lack of confidentiality has been stated as the main reason preventing many persons from accessing the free test sites at hospitals and clinics defeating one of the primary goals of the national programmes which is to encourage greater levels of testing. Addressing confidentiality is therefore critical.

Policy Statement

- Governments must enact laws providing protection for the confidentiality of patient information requiring everyone to respect rights of privacy and confidentiality and for making exceptions where these rights may be infringed including legislative requirements, court proceedings and where the patient has given consent.
- Countries where there is an absence of legislation or constitutional protections for privacy should enact specific legislation for the protection of medical records and other personal information. The Act should regulate the types of information to be protected and the circumstances allowed for disclosure. At a minimum the legislation should:
 1. Specifically declare medical information as “private or confidential information” or “personal/medical data subject to protection” and which will require the expressed consent in writing of the Patient or client as the circumstances require for its release to a third party.

This would require that insurance companies secure the written consent of patients to receive medical information. In relation to employment practices the implication would be that doctors must gain

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the consent of employees before passing on medical reports to the employer.

2. Create a duty to maintain confidentiality in relation to all medical information including the results of tests and information received on all forms from the clients or potential clients of insurance companies.
3. Provide that labeling of medical files should not be discriminatory (for example colour coding or any other distinguishing mark on the files of persons living with HIV)
4. HIV and AIDS information should be included within the definition of personal/medical data subject to protection and there should be a clear prohibition of the unauthorized use and/or publication of HIV related information on individuals, particularly in the media.

This prohibition must specifically include protection against the unauthorized disclosure of one's status or perceived status by media or media personnel. The sanction for breach in these circumstances should be criminal.

5. The legislation should also provide the patient with civil sanctions against the health care provider and their staff where there is a breach of confidentiality.
 6. The legislation should allow an individual to gain access to his or her medical records and to request amendments to ensure that such information is accurate, relevant, complete, and up to date.
- Medical confidentiality should not be regarded as breached -
 - In cases of anonymous and unlinked testing for surveillance purposes.
 - When responding to an order issued by a court of competent jurisdiction over a legal proceeding where the HIV status of an individual is in issue.
 - A person living with HIV is encouraged to disclose their status to a health care provider where it is necessary for their medical care.

POLICY AREA 5.3.4

5.3.4 Partner Notification

Rationale

There is evidence from the National Assessment Reports that there are many cases where PLHIV refuse to disclose to their partner/s and do not engage in safer sex practices exposing that partner to the risk of infection. In recognition of the principles of confidentiality health care providers are not allowed to disclose to the non-infected partner and in some cases that partner becomes infected.

It is therefore argued that the protection of confidentiality must be tempered with the necessity to disclose only in circumstances where it is the least restrictive available means of preventing harm that cannot otherwise be prevented to a third party. However, the potential dangers attached to disclosure of one's status must be preserved.

Policy Statement

- ▶ The patient should always have the right to disclose.
- ▶ Disclosure where the patient is unwilling, has refused or is unable to disclose to their partner should be dealt with by reference to appropriate contact tracing protocols where applicable.

POLICY AREA 5.3.5

5.3.5 Access to Prevention, Treatment, Care and Support Services

Rationale

Universal access is a global commitment to scale up access to HIV treatment, prevention, care and support. The movement, enshrined in the 2006 UN Political Declaration, is led by countries worldwide with support from UNAIDS and other development partners including civil society. The movement is guided by ambitious national targets set against key outcome areas – such as ART coverage, prevention of mother to child transmission, coverage of prevention programmes for '*most at risk groups*' and testing coverage.

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The international community, both Government and NGOs³⁴, have promoted the enactment of legislative protections guaranteeing access to anti-retroviral drugs.³⁵

Revised Guideline 6 (2002) International Guidelines³⁶ provides:

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

States should also take measures necessary to ensure for all persons, on a sustained and equal basis, the availability and accessibility of quality goods, services and information for HIV prevention, treatment, care and support, including antiretroviral and other safe and effective medicines, diagnostics and related technologies for preventive, curative and palliative care of HIV and related opportunistic infections and conditions.

States should take such measures at both the domestic and international levels, with particular attention to vulnerable individuals and populations.”

Even where governments in the region have made commitments to the targets for access to treatment which were set for 2010, there are still significant gaps.

Some countries in the region where treatment is free provide access only to nationals.³⁷ In other cases persons applying for work permits, and citizenship have been denied treatment on the basis on HIV status. The rationale is that the cost of treating ‘additional’ patients will be a drain on the countries’ financial resources and will compromise the National Response.

Policy Statement

- ▶ Countries must provide prevention, treatment, care and support services, which are ***stigma free, accessible, evidence informed, and culturally appropriate.***

³⁴ The International Guidelines on HIV and Human Rights: An Assessment of National Responses, (Toronto), ICASO May 2002

³⁵ In April 2002 UNCHR adopted two resolutions relating to access to medication. Resolution 2002/32 recognises that access to medication is a “fundamental element” for progressively realizing Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) which guarantees the human right to the highest attainable standard of health. This Resolution call upon states to take various initiatives among them adopting legislative and other measures, to safeguard access to medicines from restrictions by third parties, devoting resources to promote access, and ensuring their actions and policies are compatible with the right to health. The other Resolution No 2002/31 provides for the appointment of a special Rapporteur on the right to health. See www.unhchr.ch

³⁶ Revised Guideline 6 of the International Guidelines on HIV/AIDS and Human Rights

³⁷ Cayman Islands HIV and AIDS Policy on Discrimination

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- Treatment should not be denied on the basis of nationality, citizenship or other immigrant status.
- Governments must progressively provide access to affordable, high quality ART and prophylaxis to prevent opportunistic infections, for all PLHIV.
- Treatment care and support must conform to strict confidentiality standards. The physical design of service centres – laboratories, health centres for example should take account of the need for confidentiality in the provision of service to the client/patient.
- Governments must provide specialized treatment services for persons living with HIV in accordance with the Caribbean Treatment Guidelines as amended from time to time.
- Governments must provide access to information on how and where to access services regarding HIV treatment care and support. Education must be relevant, evidenced informed and culturally appropriate.
- Governments should ensure that the management of drugs and medical supplies, including procurement, storage and distribution of essential and ARV drugs, is constantly monitored and improved as necessary.
- PANCAP and other regional partners in collaboration with national governments should actively seek to ensure that national programmes are sufficiently resourced to provide first and second line treatment for PLHIV and medication for the treatment of OIs, so that that there is no break in the continuum of care at the end of funding cycles whether bi-lateral or multi-lateral.
- Governments are encouraged to establish referral systems for care and support including sustainable social protection and psychosocial support for PLHIV. This may include but is not limited to:
 - access to counseling,
 - nutrition,
 - housing support,
 - assistance for children of PLHIV and other OVC.

Social and other psychosocial support should be within existing social assistance programmes without creating a dependency.

- Governments are encouraged to work with civil society to address the gaps in access to services of some key affected populations, in particular substance users, MSM, LGBTI and sexual minorities, sex workers and prisoners to develop comprehensive models of appropriate service delivery, support increased capacity

and resources for services to ensure adequate access to prevention, treatment and care.

- ▶ Service providers should have demonstrated competency and experience in working with key affected populations particularly as these populations are not homogenous and the needs vary.
- ▶ In recognition of basic human rights and the reality of the Caribbean Single Market and Economy (CSME) these policies need to be reviewed.

POLICY AREA 5.3.6

5.3.6 Testing

Rationale

The issue of testing continues to be controversial stemming mainly from a basis of lack of understanding of the modes of transmission of HIV. In response to the proponents of widespread mandatory testing it should be noted that:

- ▶ Universal widespread testing does not present a practical approach because of the costs it would entail
- ▶ Importantly, HIV is a preventable disease; one can protect oneself from becoming HIV positive by taking appropriate precautions.³⁸

Mandatory or compulsory testing whether of the entire population or of specific groups, is generally opposed because it is unlikely to lead to changes in the behaviour necessary to impede the spread of HIV and because of the potential of invasion of privacy and discrimination.³⁹

UNAIDS asserts that testing without informed consent and confidentiality is a violation of human rights. Further that there is no evidence that mandatory testing achieves public health goals.

³⁸ "HIV Testing and Confidentiality", Ralf Jurgens, Canadian HIV/AIDS Legal Network, 1998

³⁹ Recommendation No. R (89) 14 of the Committee of Ministers to Member States on the Ethical Issues of HIV Infection in Health Care and Social Settings. The Council of Europe adopted a Resolution stating that:
"...in view of the impossibility of imposing behaviour modification and the impracticability of restrictive measures, compulsory screening is unethical, ineffective, unnecessarily intrusive, discriminatory and counter productive"

Policy Statement

- HIV testing of individuals should only be performed with the specific informed consent of that individual who is provided with adequate information about the nature of an HIV test, including the potential implications of a positive or negative result, in order to make an informed decision as to whether to take the test or not.
- In all cases testing should either follow a VCT or PITC approach. All persons receiving an HIV test should be counseled prior to and after the receipt of results.
- Governments are encouraged to ensure that this principle applies in all cases in particular with respect to testing of pregnant women, prisoners, police, and the military or other uniformed groups.
- Testing for entry into a country or the application of a work permit or residential status or citizenship should be specifically prohibited.
- Pre-employment testing and for continuation of employment should be prohibited by law.
- Anonymity must be maintained in all testing and continuation of care by use of a code and not the patient's name or other identifiable feature or fact.
- The results of an HIV test shall not be disclosed to a third party without the consent of the person testing, except as may be provided for in this Policy.
- Governments are encouraged to provide high quality, cost-effective, **confidential** and accessible VCT and PITC services that are adequate and accessible to key affected populations, in particular MSM, LGBTI and sexual minorities, sex workers, migrant populations and youth.
- Governments are encouraged to work in collaboration with civil society to set up counseling sites targeting key affected populations in order to expand coverage.

Regulation of testing services, including laboratories

- Governments should ensure that appropriate measures or law are adopted for the standardization and accreditation of public and private laboratories and other testing sites to secure confidentiality and quality assurance in testing and diagnostic management of HIV.

- Where testing is offered by private institutions or civil society organisations, Governments should ensure that these sites perform testing following appropriate protocols.

POLICY AREA 5.3.7

5.3.7 Public Health

Rationale

The three core public health functions are:

- The assessment and monitoring of the health of communities and populations at risk to identify health problems and priorities;
- The formulation of public policies designed to solve identified local and national health problems and priorities;
- To assure that all populations have access to appropriate and cost-effective care, including health promotion and disease prevention services, and evaluation of the effectiveness of that care.

In order for a national health system to respond to what is perhaps the greatest public health and developmental threat and achieve the three core functions of Public Health the information necessary to plan a targeted response to HIV and AIDS is vital.

Policy Statement

- Governments are encouraged to review public health laws which deem HIV or AIDS as a communicable, contagious or infectious disease as these classifications are medically incorrect.
- Governments are encouraged to ensure that HIV or AIDS may only properly be deemed a notifiable diseases under Public Health Acts or Regulations.
- Coding: All notifications of HIV serostatus should be by code or anonymous

POLICY AREA 5.3.8

5.3.8 Health Care Workers

Rationale

There have been many reports from health care settings of HIV testing without consent, breaches of confidentiality, and denial of treatment and care.

Failure to respect confidentiality by clearly identifying patients with HIV, according sub-standard and in some cases inhumane treatment has been recorded against the health sector across the region. Persons including, PLHIV, MSM, LGBTI and other sexual minorities and sex workers have been denied treatment due to stigma and died as a result⁴⁰.

The assumption that health care providers are always knowledgeable about HIV and understand the rigours of confidentiality is misplaced and must be addressed.

Reducing stigma and discrimination in health facilities requires not only addressing the attitudes and practices of health care providers but also addressing their need for HIV information, training in health care for people living with HIV, *and* supplies for universal precautions to prevent occupational exposure to HIV.

Policy Statement

- Duty to Treat - health care providers have a duty to treat all illnesses, including persons living with by HIV, within the limits of their competence. Where the health care provider feels that the patient's condition falls outside their sphere of competence, the health care provider has a duty to ensure that the patient is referred to a service which can deal with the condition.
- Health care providers have a duty to treat without regard to HIV status, sexual orientation, or status as a sex worker or nationality, citizenship or immigrant status.
- Governments are encouraged to provide and where necessary facilitate continuous training and education on basic, post-basic and continuing education on HIV, confidentiality, basic human rights, and Universal Safety Precautions for health care providers. Programmes in public health services must be directed at *all* employees from the cleaning staff to administrators and should include health care providers in pre-service and in-service training as everyone has a role to play

⁴⁰ Roseval, W. 'HIV/AIDS Stigma and Discrimination among Nurses in Suriname', *Interamerican Journal of Psychology* 2007. Vol. 41 Num 1 pp 67-74

in changing attitudes and behaviours.

- ▶ Health care providers who are accused of breaches of their duty to treat should be examined before professional boards or ethics committees and should be subject to sanctions. Governments should ensure that such bodies are established where they do not exist.
- ▶ Governments must ensure the provision of adequate supplies for universal precautions to prevent occupational exposure to HIV, develop, implement and train appropriate health care providers on a post exposure prophylaxis protocol and provide ART to support this programme.

POLICY AREA 5.3.9

5.3.9 Wilful or Deliberate Transmission of HIV

Rationale

The enforceability of provisions criminalizing the willful, deliberate or reckless transmission of HIV is highly debatable as the elements to prove the offence are burdensome. For example, breaching evidential rules against self incrimination, the operation of the window period in testing and proving that it was the accused who infected the complainant. These provisions have been reviewed and raise the following concerns:⁴¹

1. **Proof of the Offence**
The elements of the offence must be proved beyond a reasonable doubt. Therefore the prosecution has a burden to prove that at the time of the offence the accused was HIV positive. Further it must be proved that the complainant himself/herself is, as a result of that contact HIV positive. The prosecution must therefore show conclusively that the complainant at the time immediately preceding contact was HIV negative.
2. **Rules of Evidence**
There have been suggestions that there should be compulsory testing for those accused of transmitting HIV. However, bodily evidence taken without the consent of the accused and which are obtained in non compliance with strict and burdensome evidential rules are inadmissible in a court of law. Further, testing a person for HIV without their consent on the basis of an accusation raises serious constitutional infringements on the rights associated with liberty, security of the person and privacy.

⁴¹ Dalton HL, "Criminal Law" in: S Burriss et al., eds. *AIDS Law Today: A New Guide for the Public*. New Haven: Yale University Press: at 255.

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3. Compulsory testing has little value as it will only establish the accused's status at the time of the test. An HIV test performed within the window period (before 3 months from first contact) will usually result in a negative result which must be repeated to confirm the results. If there is transmission following the initial test then the second test as well may not produce a positive result. Therefore, where a complainant tests positive immediately preceding contact with the accused, then it is highly likely that the complainant was infected before said contact. If the complainant was negative before contact with the accused, then a test is only conclusive some three months following the contact and only where the complainant does not expose himself or herself to a further risk of infection within the window period.

Therefore it is very difficult to prove beyond a reasonable doubt that it was the accused's actions which caused the complainant's HIV infection. It may very well be impossible to prove that the complainant was HIV negative at the time of the offence (not some previous time) and it was the accused who infected them.

Policy Considerations

1. **Undermining Attempts to Promote Personal Responsibility**
Most provisions for willful transmission negative consent as a defense to the action. The effect of this is to create a false sense of security among people who are (or think they are) HIV negative, encouraging risky behaviour on their part.
2. **Undermining Public Health Initiatives**
Prevention campaigns focus on increasing testing among the general population. Many National AIDS Programmes are premised on providing access to quality care and treatment for PLHIV and increasing overall testing through the provision of VCT at more sites. The contradiction highlighted in the following article is instructive:

“Policy makers must consider the impact of criminalization on public health initiatives. A wise nation would consider whether in prosecuting individuals who put others at risk we advance the public health objectives. If, criminalization serves to undermine our overall public health response then we must seriously question whether the gains from criminalization are worth it.”⁴²

Criminalizing HIV Transmission

- Reinforces HIV and AIDS related stigma as criminal sanctions are generally accompanied by inflammatory and ill-informed media coverage contributing to misinformation and a perception that PLHIV are criminals and the public requires “protection” from them.

⁴²Dalton HL, “Criminal Law “in: S Burris et al., eds. AIDS Law Today: A New Guide for the Public. New Haven: Yale University Press: at 255.

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- Most critically the provision operates as a disincentive to testing as people will not seek counseling, testing, treatment and support if this would mean facing breaches of confidentiality thereby exposing them to discrimination, and other negative consequences.

“Coercive public health measures drive away the people most in need of such services and fail to achieve their public health goals of prevention through behavioural change, care and treatment”⁴³

- As the provision requires prior knowledge of status it is a good defense if someone is unaware of their status at the time of the act which operates as a major disincentive to test.

Every decision to engage in consensual sex always involves acceptance of personal responsibility

Policy Statement

- Countries, which have passed legislation on willful, deliberate, knowing, or reckless transmission of HIV should revise the legislation and consider its repeal.
- Governments, NGOs, CBOs, and private sector are encouraged to promote the acceptance of personal responsibility for the prevention of HIV transmission in advocacy and education programmes.

POLICY AREA 5.3.10

5.3.10 Adult Consenting Same Sex Intimacy

Rationale

While homosexuality is not considered illegal, eleven of the independent CARICOM states have laws in place that criminalize consensual sex between adult males. However, the UK Overseas Territories and Dutch laws relevant to Aruba and the Netherlands Antilles prohibit discrimination against individuals on the basis of their sexual orientation. The National Assessment Reports with the exception of Belize called for decriminalization of buggery, sodomy or unnatural acts as the case may be.

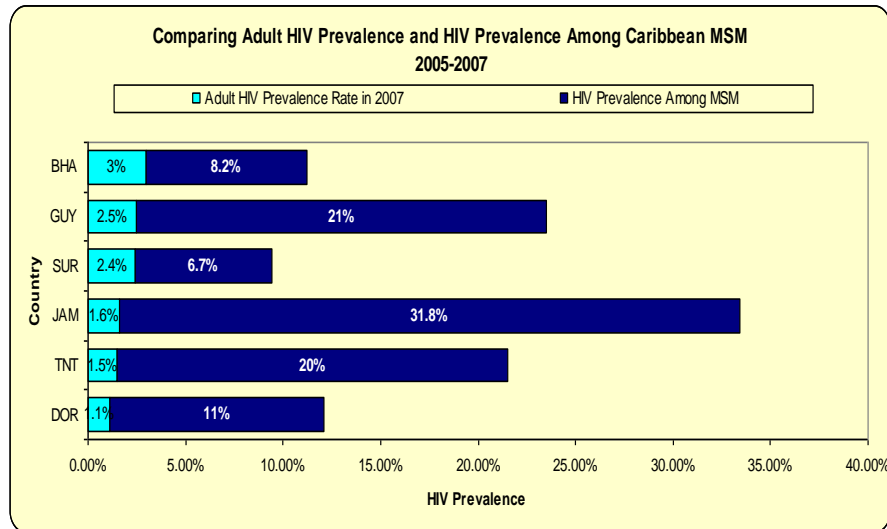
⁴³ UNAIDS ,Criminal Law, Public Health and HIV Transmission: A Policy Options Paper, June 2002 page 24

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The criminalization of buggery has been identified as the main source of discrimination against homosexuals who are denied employment, ridiculed, denied access to public transportation, refused access to medical services, beaten, killed and the list goes on. All this occurs against a backdrop perpetuated by churches, police and other key sectors of the society that they are immoral persons deserving of this kind of treatment.

This attitude may not be expressed positively by public authorities for example, the police but it is evident in the refusal of these authorities to deal with instances of abuse perpetrated against homosexuals. While the debate rages about the morality of same sex intimacy, HIV prevalence rates among MSM in the Caribbean has far outstripped general population prevalence. Figure 1 previously referred to at page 9 of this Policy provides a comparison of prevalence rates among MSM as opposed to the general population prevalence rates in select Caribbean countries.

Figure 1 – Comparing Adult HIV Prevalence and HIV Prevalence among Caribbean MSM 2005- 2007



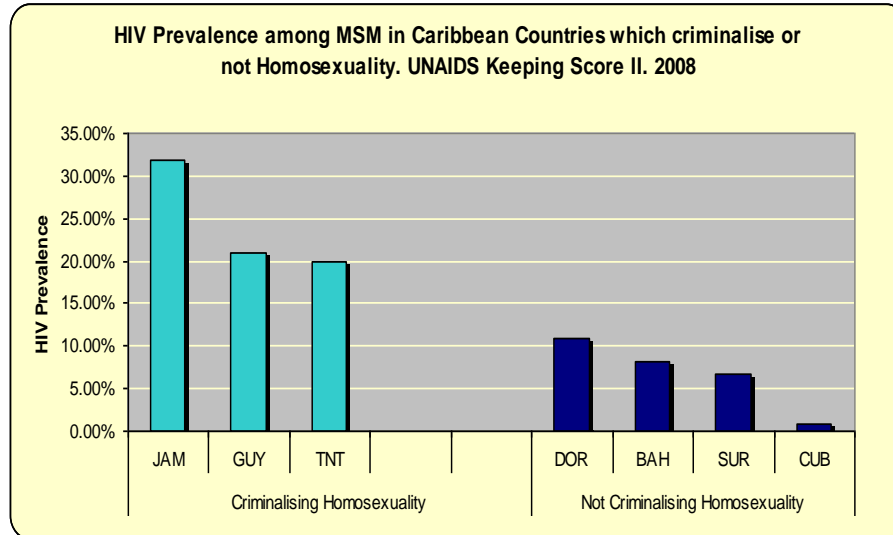
Source: UNAIDS Report on the global AIDS epidemic, 2008

Of significance also is the following graph (Figure 4) which illustrates the reduced impact of HIV in countries where adult consenting same sex intimacy is not criminalized. The graph is also illustrative of the impact of criminal sanctions and HIV seroprevalence among MSM.

Figure 4 – HIV Prevalence in Caribbean Countries which Criminalize or not Homosexuality

(The term 'homosexuality is misplaced here, generally the reference should be to criminal sanctions against same sex intimacy)

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Source: UNAIDS Caribbean Regional Support Team 2009

From a strict legal standpoint one must determine the rational basis for a criminal sanction.⁴⁴ The irrationality of criminalizing same sex intimacy between males and not between females was generally found in the National Assessment Reports to be unfair and without merit. Most Reports recommended the decriminalization of consenting adult intimacy between males in private.

There is also little evidence from the countries of the region that the law has been used to successfully prosecute persons.

Policy Statement

- Countries are encouraged to repeal laws criminalizing consensual same sex in a private place.
- Anal intercourse like other sexual acts practiced between consenting adults in privacy should no longer carry criminal sanctions but should be an aggravating factor in the commission of sexual offences.
- Countries are encouraged to remove legal barriers preventing access to appropriate HIV-related services by and encourage the promotion and guarantee of the human rights of, including protection from discrimination against MSM, LGBTI and other sexual minorities.

⁴⁴ Gubbay CJ of the Supreme Court of Zimbabwe in *Banana v. The State* (2000) 8 BHRC 345

Regional Policy on HIV Related Stigma and Discrimination

- NGOs and CBOs are encouraged in collaboration with MSM, LGBTI and other sexual minorities to develop public awareness campaigns to promote the inclusion of MSM, LGBTI and other sexual minorities and decrease homophobia.
- FBOs must denounce violence against MSM, LGBTI and other sexual minorities as actions which are contrary to the principles of respect and dignity and that MSM, LGBTI and other sexual minorities should not be judged on the basis of their sexual orientation or gender identity, that they are entitled to freedom to worship and should be accepted within the church.
- Services for MSM and LGBTI should provide the following :
 - Information and education about HIV and other sexually transmitted infections, and sustained individual-level and group-level support for safer sex and safer drug use to reduce risk of exposure to HIV
 - Provision of, and education about the use of, condoms and water-based lubricants
 - Confidential, voluntary HIV counseling and testing
 - Detection and management of sexually transmitted infections
 - Referral systems for legal, welfare and health services
 - Safer drug-use commodities and services
 - Appropriate antiretroviral and related treatments, HIV care and support
 - Services to prevent and treat viral hepatitis

POLICY AREA 5.3.11

5.3.11 Sex Work and Soliciting

Rationale

Sex work in the Caribbean is multifaceted, covering a range of activities including brothel, club, tourist-oriented, and street-based sex work, exotic dancing, and escort services. Predominantly women, and some men, and transgender persons provide sexual services and labour to local and foreign men and women, and significant activity takes place within the tourist industry⁴⁵. There is a generalised sense that sex work is illegal, however, in many Caribbean countries it is the procurement of sex work that is illegal and not the act itself. However, the sense of illegality combined with societal disapproval

⁴⁵ PANCAP 2009, Prostitution, Sex Work and Transactional Sex in the English, Dutch, and French- Speaking Caribbean, A Literature Review of Definitions Laws and Research.

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of sex work sustains the emotive atmosphere that has challenged policy development related to decreasing sex worker vulnerability to HIV⁴⁶.

Modern approaches to sex work stress decriminalization and emphasize regulation of the industry by occupational safety and health controls that will benefit both workers and their customers.

Policy Statement

- Governments are encouraged to decriminalize sexual-economic exchanges between consenting adults including solicitation.
- Governments are encouraged to ensure that sex workers are able to access comprehensive, acceptable, quality, user-friendly HIV prevention, treatment, care and support services including⁴⁷.
 - Reliable and affordable access to commodities, including high-quality male and female condoms, water-based lubricants and contraceptives, and other requirements for health, such as food, sanitation and clean water
 - Access to voluntary HIV testing and counseling, with treatment, effective social support and care for sex workers who test positive for HIV
 - Access to high-quality primary health care, TB management, sexual and reproductive health services, especially sexually transmitted infection management and prevention of mother-to-child transmission of HIV
 - Access to alcohol and drug-related harm reduction programmes, including sterile needles/syringes and opiate-substitution therapy
 - Integration of HIV services with all relevant welfare services, including social support mechanisms for sex workers and their families
- Governments are encouraged in collaboration with NGOs and CBOs working with sex workers and sex worker organisations to develop programmes to reduce violence, abuse, and discrimination perpetrated against sex workers.
- Governments are encouraged to remove all legal barriers restricting public health authorities, NGOs and CBOs from conducting education activities and supplying condoms and other sexual and reproductive health care products.

⁴⁶ UNIFEM, UNAIDS 2009, Gender Equality, Human Rights and Sex Work I the Caribbean Policy Considerations in the Context of HIV and AIDS.

⁴⁷ Global Fund Information Note: Sexual Orientation and Gender Identities (May 2010)

POLICY AREA 5.3.12

5.3.12 Employment/ Workplace

Rationale

Every country has reported cases of discriminatory practices in employment such as:

- pre-employment screening;
- denial of employment to individuals who test positive;
- termination of employment of PLHIV;
- stigmatization of PLHIV who disclose their status;
- employees refusing to work next to persons living with HIV or those perceived to be living with HIV.

Individual countries have adopted National Policies on HIV and AIDS in the Workplace and there are many examples of sector and enterprise level policies. These efforts need to be sustained and scaled up.

Policy Statement

- Government and Regional Business Coalitions should encourage the development and implementation of national, sector and enterprise level policies on HIV in the Workplace developed in accordance with the PANCAP Model HIV in the Workplace Policy and ILO Recommendation Concerning HIV and AIDS and the World of Work, 2010⁴⁸.

Governments must enact legislation;

- Prohibiting discrimination against workers or employees on the basis of real or perceived HIV status and or sexual orientation.
- Prohibiting the consideration of an employee's or potential employee's HIV status in the recruitment, promotion, conferral of benefits or termination of employment.
- Extending protection against discrimination to contractual status, recognized dependents and access to health care insurance, pension funds and other entitlements.
- Prohibiting disclosure of HIV status to an employer or other employee except with expressed consent.

⁴⁸ ILO Ninth Session Geneva 17 June 2010

POLICY AREA 5.3.13

5.3.13 Insurance

Rationale

The insurance industry has practiced widespread discrimination against persons living with HIV. They have been denied insurance simply on the basis of their status; confidentiality is routinely breached; entitlements have been reduced; and policies are subject to cancellation or exclusion on the basis of HIV.

In an extreme case the spouse of a deceased PLHIV who has repeatedly tested negative since the death of the spouse was refused coverage on the basis that “*she is at high risk of contracting HIV*”⁴⁹

Policy Statement

- ▶ With the availability of treatment an HIV test should not be a requirement for life, medical, home and all classes of business insurance.
- ▶ Insurance companies should be encouraged to develop a code of conduct setting out procedures for dealing with confidential medical information within the insurance industry.

POLICY AREA 5.3.14

5.3.14 Prisoners

Rationale

Prison populations continue to suffer from high HIV prevalence rates. Prison authorities have a moral and legal duty to prevent the spread of diseases among inmates and to staff and the public. Although sexual activity is illegal within the prison systems in the Caribbean, both consensual and coerced sexual activity occur in prison.

⁴⁹ See National Assessment Report for St. Kitts and Nevis 2007

Policy Statement

- ▶ Governments must ensure that testing of prison inmates is voluntary and not mandatory or compulsory.
- ▶ Prison authorities must protect the confidentiality of an inmate's medical records and HIV test results which should not be disclosed except on a need to know basis by medical personnel of the prison.
- ▶ Governments must ensure that HIV positive prisoners have access to confidential and adequate treatment care and support services.
- ▶ Prison authorities are encouraged to develop and implement a comprehensive education programme on HIV for staff and inmates including, HIV transmission, STIs, and human rights.
- ▶ Governments are encouraged where appropriate to provide educational materials, bleach, access to sterile needles, razors, and disinfectants to inmates to safeguard against the transmission of HIV or other infectious disease.
- ▶ Prison authorities should receive training in universal safety precautions and be provided with the necessary equipment to practice universal safety precautions.
- ▶ Prison authorities should provide a full complement of HIV services including the provision of condoms.

POLICY AREA 5.3.15

5.3.15 Education and Youth

Rationale

Children infected or affected by HIV through infected family members have been stigmatized and discriminated against in educational settings in many countries.

Some have been excluded from school, ridiculed, harassed, some have been stoned and others forced to leave the school notwithstanding cases where the child is below the compulsory age for attending school.⁵⁰ There are reports of pre-schoolers being denied access to paid school meals and ostracized from the remainder of the school for 'the safety of other students and teachers'.

⁵⁰ Under 16 in most jurisdictions See for example the Education Act Cap 18.01 of the Revised Laws of Saint Lucia 2001.

Access to sexual and reproductive health by minors and vulnerable children is restricted by the age of consent in many countries notwithstanding evidence of early sexual initiation.

Policy Statement

- Children and youth with HIV should enjoy the same rights as adults in respect of access to information, privacy, confidentiality, respect, informed consent and prevention.
- Governments must provide age and developmentally appropriate sexual and reproductive health and life skills education in all primary and secondary schools which enables children and youth to deal positively and responsibility with their sexuality and rights.
- Governments and civil society in collaboration with children and youth should ensure adequate access to user-friendly, confidential, sexual and reproductive health services including, HIV, STIs, sexual health advice, counseling, including condoms. The provision of these measures should reflect an appropriate balance between the rights of the child, safety and the best interest of the child and the rights and duties of parents or guardians.
- Countries are encouraged to give consideration to the circumstances where the best interest of the child requires the non-involvement of parents or guardians (for example where the parent is the abuser) before accessing sexual and reproductive health services and to develop appropriate protocols and legal protections to address this issue.
- Regional partners are encouraged to review the adequacy of the HFLE curriculum in terms of HIV and AIDS prevention education component.
- Governments must amend existing legislation or enact laws to specifically prohibit the exclusion of a child from school on the basis of his or her perceived HIV status, sexual orientation or pregnancy.
- Persons employed in child care agencies as well as informal and formal adoptive parents and persons providing services to children should receive training in order to deal effectively with the special needs of children living with or affected by HIV, including psycho-social support, protection from mandatory testing, discrimination, abuse and abandonment.
- Governments are encouraged through the National AIDS Programmes to agree on a package of support for OVC in particular foster care, education, books, medical treatment and protection.

POLICY AREA 5.3.16

5.3.16 Research

Rationale

HIV research is necessary to inform policies and programmes and to identify and explain existing gaps. Programmes should be evidence-informed and therefore more relevant and effective. Research on key affected populations is particularly weak in the region and is required.

Policy Statement

- ▶ Regional organisations and partners are encouraged to mobilize resources for the conduct of research that is relevant and useful focusing on the impact of HIV on the key affected populations.
- ▶ All partners are encouraged to utilize the most cost-effective method for conducting research which may include adopting a regional rather than a national approach.
- ▶ Regional partners, Governments, academia, NGOs, CBOs and the private sector should create a forum for sharing scientific information and ensure that research results are retrievable and easily accessible by identifying a repository for research. Access by NGOs, CBOs and subjects of the research must be guaranteed.
- ▶ Where research is conducted by an external agency or on behalf of external agencies or partners the findings must be shared with the National AIDS Programmes of the respective participating country and any target population who may have been the subject of the research.
- ▶ Governments and entities conducting research must ensure that HIV related research involving human subjects satisfies the ethical and human rights considerations of both the partner and the national based institutions in accordance with international best practice and having respect for national and cultural norms and sensitivities through the establishment of ethical committees or review boards.
- ▶ PLHIV should have access to clinical trials conducted only in terms of acceptable research protocols which adequately protect the rights of research subjects prior to, during and after the trials.

POLICY AREA 5.3.17

5.3.17 Legal Support Services

Rationale

The creation of a supportive legal framework is insufficient to ensure the protection of laws against stigma and discrimination. Access to justice, to affordable, confidential and ethical legal support services is necessary.

Advocacy and training on human rights and available protection at law should accompany legal reform addressing HIV related stigma and discrimination. The recent judgment from the Supreme Court of India⁵¹ brought by the NAZ Foundation against the Government challenging the constitutionality of the sodomy laws in India was preceded by a long, intense advocacy and training programme on human rights and HIV targeting the judiciary. This lesson is instructive for the Caribbean.

Policy Statement

- PLHIV and key affected populations must maintain a sustained programme on advocacy around the issues of human rights concentrating first on their members to empower them, followed by key programme and community leaders, the judiciary, police and the general population.
- PANCAP and regional partners are encouraged to build on the gains achieved by the Champions for Change by developing targeted advocacy strategies addressing the human rights of PLHIV and key affected populations with a focus on:
 - The Judiciary
 - Legal fraternity
 - Security Forces including the Police
 - Prison authorities
 - Faith Based Organisations
 - Media
 - Medical Fraternity
- Governments are encouraged to ensure the provision of legal aid for PLHIV and key affected populations.
- Governments and regional partners are encouraged to support a reporting and complaint mechanism for PLHIV and other key affected populations to report

⁵¹ *NAZ Foundation v. Govt. of NCT of Delhi*, 160 Delhi Law Times 277 (Delhi High Court 2009). Available at: http://www.ilga.org/news-upload/Delhi_high_court_decision.pdf

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abuses and seek redress. Where possible these mechanisms should be incorporated into legal aid clinics given appropriate training and safeguards for confidentiality and the prevention of stigma.

- Governments and NGOs are encouraged to increase access to legal information and services for PLHIV and other key affected populations, and working with human right commissions or legal aid services to ensure proper representation for those experiencing HIV related discrimination.

POLICY AREA 5.3.18

5.3.18 Media

Rationale

The media is an effective tool to either increase or decrease stigma and discrimination perpetrated against PLHIV and other key affected populations. The role of the media is largely dependent of the interaction of the Regional and National Response including the interaction with civil society with the media to provide accurate information for education and dissemination.

Policy Statement

- The public has the right to balanced and informed coverage, information and education on HIV and related issues in particular human rights. The media, in collaboration with other relevant organisations should play a leading role in educating the public on HIV provide that they maintain confidentiality.
- Media houses are encouraged to develop a code of conduct addressing confidentiality and ensuring the non-exposure either by name, image, place of residence, place of work, or other identifying characteristic of a person whose status may expose them to stigma and/or discrimination.
- Media programmes should be designed to challenge attitudes of discrimination and stigmatization associated with HIV and AIDS.
- Regional Partners, Governments, NGOs and CBOs should clearly articulate the critical issues concerning HIV through the preparation of information packages for the media to promote non-stigmatizing, informed media coverage.
- The media and the advertising industry should be sensitive to HIV and human

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rights issues and should reduce sensationalism in reporting and the inappropriate use of language and stereotypes, especially in relation to disadvantaged and vulnerable groups.

- HIV media programmes should be designed to be accessible to all people, including those with audio-visual disabilities.
- Media houses should engage in continuous HIV education and are encouraged to adopt the provisions of the ILO Recommendation Concerning HIV and AIDS and the World of Work 2010.

6. MOVING FROM POLICY TO ACTION

6.1 ACTORS and ROLES

ACTORS	ROLES
PANCAP	Owner Lead the Regional Response Advocate at the Political Level Mobilize resources Develop Model Laws Monitor and Evaluate Policy Review Policy
Regional Partners⁵²	Mobilize resources Develop Protocols and expand operation of Policy Advocate to RSAs Provide technical assistance
Regional NGOs	Advocate for implementation at regional and national level Provide technical assistance Lead focus area action (eg. CCC – FBOs)
Governments	Enact legislation Provide services at the standards indicated in keeping with available resources Develop country level policies Tailor to country needs
NGOs/CBOs/FBOs	Advocate for adoption and implementation Provide services at standards indicated Make appropriate recommendations for country realities
PLHIV/KAP	Make appropriate recommendations for country realities Advocate for adoption and implementation Implement appropriate activities Monitor and evaluate policy Participate in review

⁵² See CRSF List of International and Regional Agencies active in the Caribbean pg 58

7. POLICY REVIEW

This Policy shall be subject to review every three (3) years to take account of scientific and educational advancements and to reset the priorities within the 5 year planning schedule of the Caribbean Regional Strategic Framework.

7. Glossary

Acquired Immune Deficiency Syndrome or AIDS:

A cluster of medical conditions, often referred to as opportunistic infections and cancers and for which, to date, there is no cure.

Anonymous testing: An HIV testing procedure whereby the individual being tested does not reveal his true identify. An identifying number or symbol is used to substitute for the name and allows the laboratory or centre conducting the test and the person on whom the test is conducted to match the test results with the identifying number or symbol.

BCC Behaviour change communication (BCC) is an interactive process for developing messages and approaches using a mix of communication channels in order to encourage and sustain positive and appropriate behaviours. BCC has evolved from information, education and communication (IEC) programmes to promote more tailored messages, greater dialogue and fuller ownership. Participation of the workplace stakeholders is vital at every step of planning and implementation of the behaviour change programmes to ensure sustainable change in attitudes and behaviour.

Compulsory or mandatory HIV testing:

HIV testing imposed upon a person attended or characterised by the lack of, or vitiated, consent.

Gender identity: Gender identity is understood to refer to each person's deeply felt internal and individual experience of gender, which may or may not correspond with the sex assigned at birth, including the personal sense of the body (which may involve, if freely chosen, modification of bodily appearance or function by medical, surgical or other means) and other expressions of gender, including dress, speech and mannerisms.

HIV testing: Any laboratory procedure done on an individual to determine the presence or absence of HIV infection;

HIV transmission: The transfer of HIV from one infected person to an uninfected person, most commonly through sexual intercourse, blood transfusion, sharing of intravenous needles and during pregnancy, childbirth and breastfeeding;

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Key affected populations:

A term used to indicate people and communities who are most vulnerable to and affected by specific diseases such as malaria, tuberculosis and HIV and who are the most often marginalized and have the greatest difficulty in achieving their rights to health. This includes children affected by HIV and AIDS, women and girls, youth, men who have sex with men, injecting and other drug users, sex workers, people living in poverty, prisoners, migrants and migrant labourers, people in conflict and post conflict situations, refugees and displaced persons.

MSM

(Men who have sex with men):

MSM is an umbrella term constructed by development and health workers in recognition of the fact that sex between men occurs in diverse circumstances and among men whose experiences, lifestyles, behaviors and identities vary greatly. The term refers to the act of sex between men and so may involve men who identify as homosexual, gay, bisexual, transgendered or heterosexual.

Opportunistic infections:

Illnesses caused by various organisms, some of which may not cause disease in persons with normal immune systems. Opportunistic infections common in persons diagnosed with AIDS include Pneumocystiscarinii pneumonia; Kaposi's Sarcoma; cryptosporidiosis; histoplasmosis; other parasitic, viral, and fungal infections; and some types of cancers.

Person living with HIV:

An individual whose HIV test indicates, directly or indirectly, that he is infected with HIV.

Pre-test counselling: The process of providing an individual information on the biomedical aspects of HIV and AIDS and emotional support to any psychological implications of undergoing HIV testing and the test result itself before he/she is subjected to the test.

Post-test counselling: The process of providing risk-reduction information and emotional support to a person who submitted to HIV testing at the time that the test result is released.

Prophylactic: An agent or device used to prevent the transmission of a disease.

Screening: measures whether direct (HIV testing), indirect (assessment of risk-taking behaviour) or asking questions about tests already taken or about medication, designed to establish HIV status.

Regional Policy on HIV Related Stigma and Discrimination

- Sexuality:** Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviors, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors. (World Health Organization: Defining Sexual Health, 2006)
- Sexual orientation:** Sexual orientation is understood to refer to each person's capacity for profound emotional and sexual attraction to, and intimate and sexual relations with, individuals of a different sex (heterosexual) or the same sex (homosexual) or more than one sex (bisexual). LGBTI (lesbian, gay, bisexual, transgender and intersex): LGBTI is an acronym commonly used in English speaking countries as a more inclusive descriptor of the 'gay community' – often viewed as a useful way to refer to people who are not heterosexual. Global Fund Information Note: Sexual Orientation and Gender Identities (May 2010)
- Sexual minorities:** Sexual minorities refer to people whose sexual orientation, gender identity, and/or consensual adult sexual behaviors do not conform to majority norms and values. Sexual minorities therefore includes gay men and other men who have sex with men (MSM), lesbian women and other women who have sex with women (WSW), and individuals, including heterosexual people, who are transsexual, transgender, and intersex, as well as female, male, and transgender sex workers.
- Sex workers:** Sex workers include female, male and transgender adults and young people who receive money or goods in exchange for sexual services, either regularly or occasionally. Sex work varies between and within countries and communities. Sex work may vary in the degree to which it is more or less 'formal' or organized, and in the degree to which it is distinct from other social and sexual relationships and types of sexual/economic exchange.
- Voluntary HIV testing:** HIV testing done on an individual who after having undergone pre-test counselling, willingly submits himself/herself to such test.

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UNAIDS and Canadian HIV/AIDS Legal Network, 2006 ‘*Courting Rights: case Studies in Litigating the Human Rights of People Living with HIV*’ 2006 for examples of litigation and other strategies by persons living with HIV to secure, access to treatment, freedom from discrimination, prevention and care in prisons.

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UNAIDS, 2007 Reducing HIV Stigma and Discrimination: a critical part of National AIDS Programmes, A Resource for National Stakeholders in the HIV Response. 2007, Geneva, United Nations Joint Programme on HIV/AIDS

Keeping Score II, A Progress Report Towards Universal Access to HIV Prevention, Treatment, Care and Support in the Caribbean, (2008) United Nations Joint Programme on HIV/AIDS, Caribbean Regional Support Team

UNAIDS, 2009, Overview of HIV Infection and AIDS Epidemic in the Caribbean, October 2009, United Nations Joint Programme on HIV/AIDS, Caribbean Regional Support Team

Waldron, E.R. Barbados Report on the Legal Ethical and Socio-Economic Issues Relevant to HIV/AIDS in Barbados, June 2004

Appendix 1

POLICY SUMMARY

SCOPE:

All CARICOM Member States,⁵³ CARICOM Associate Members⁵⁴ and the Dominican Republic

INTENDED USERS

2. Governments (in particular)
 - g. National AIDS Programmes
 - h. Offices of Attorneys General
 - i. Ministries of Justice
 - j. Ministries of Education
 - k. Ministries of Health
2. International and Regional Partners
3. Regional and National NGOs
4. CBOs

METHODS USED TO COLLECT/SELECT DOCUMENTATION

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT DOCUMENTATION

The following documents were requested and made available by PANCAP:

- a) National Assessment Reports on the Legal and Ethical Issues related to HIV and AIDS conducted between 2002 – 2008
- b) Caribbean Regional Strategic Framework
- c) Country National Strategic Plans
- d) Country Policies including, Workplace Policies, Policies on HIV and Education, Policies on Discrimination, Policies and Protocols for treatment and care of HIV and STIs, etc

⁵³ Antigua and Barbuda, The Bahamas, Barbados, Belize, Dominica, Grenada, Guyana, Haiti, Jamaica, Montserrat, Saint Lucia, Saint Kitts and Nevis, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago.

⁵⁴ Anguilla, Bermuda, British Virgin Islands, Cayman Islands and Turks and Caicos Islands

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The following documents were also considered

- e) International Guidelines and policy statements including the International Guidelines on HIV/AIDS and Human Rights 2006, UNAIDS/IPU Handbook for Legislators on HIV/AIDS Law and Human Rights, among others
- f) International Human Rights Instruments, treaties, conventions, protocols
- g) Studies on Stigma and Discrimination in the Caribbean
- h) Studies on the policy areas considered

NUMBER OF SOURCE DOCUMENTS

Approximately 50 reports, publications and other documents have been considered.

QUALIFYING STATEMENTS

The Anti-Stigma and Discrimination Policy is a model.

The Policy document sets out the standards to be applied in addressing stigma and discrimination. Countries are encouraged to apply these standards as appropriate in their national context. However, this policy should be treated as a minimum standard and applied accordingly.