

Key Questions

- ✘ Do the concepts of “innocent”/”guilty” or “sinful” assist public health decision-makers and human rights practitioners in dealing with the AIDS Epidemic effectively?
 - ✘ Should these concepts impact on decisions about resource allocation?
- ✘ What is the relationship between “pre-existing” stigma and AIDS stigma?
- ✘ How does stigma impact on access to health care services and accessing testing and treatment in a timely manner?
- ✘ What is the relationship between fear, prejudice, stigma and discrimination?
- ✘ How can the law and human rights deal with stigma and AIDS discrimination?

Incidence vs. Prevalence

- ✘ The incidence of disease refers to new cases of disease.
 - + Incidence information is used to study risk to the population
- ✘ Prevalence of disease refers **to the total number of cases of disease that exist in the population**, either during a period of time or at a specific point in time.
- ✘ As the duration of disease increases, for example, the prevalence of the disease must increase as well.
- ✘ (Image of the tap)

Incidence vs. Prevalence

Example from Wikipedia:

- a.) Consider a disease that takes a long time to cure, and that was spread widely in 2002, but whose spread was arrested in 2003. This disease will have a high prevalence and a high incidence in 2002; but in 2003 it will have a low incidence, although it will continue to have a high prevalence because it takes a long time to cure so the fraction of affected individuals remains high.
- b.) In contrast, a disease that has a short duration may have a low prevalence and a high incidence.

Rewarding the Reckless

On 'SA in plea to donors on Aids'

“It is tragic that Africa wants enormous sums of money for anti-retroviral treatment and yet it would cost nothing to stop Aids if men and women would be faithful to their partners in a lifelong relationship. Huge sums already donated by Western countries have not made people in recipient countries responsible. Perhaps it is time for “tough love” – give priority to those infected through no fault of their own and not reward the reckless.”

Rewarding the Reckless: Analysing assumptions



Who, according to the NSP are “at higher risk”?

1. Women
2. Adolescents and young adults
3. Children 0-14 years
4. People with disabilities
5. People in prisons
6. MSMs
7. Sex workers
8. Mobile, casual and atypical forms of work
9. Refugees
10. IDUs

Generalised vs. Concentrated epidemics

- ✘ UNAIDS/WHO definition:
 - + **Generalized** HIV epidemic: HIV prevalence consistently $>1\%$ in pregnant women)
 - + **Concentrated** HIV epidemic: HIV prevalence consistently $>5\%$ in at least one defined subpopulation, e.g. intravenous drug users (IDUs); sex workers (SWs), men who have sex with men (MSM), and $<1\%$ in pregnant women in urban areas

Source: Guidelines for second generation HIV surveillance. Geneva, World Health Organization and Joint United Nations Programme on HIV/AIDS, 2000 (WHO/CDS/CSR/EDC/2000.5 & UNAIDS/00.03E)

The Biological dimension

- ✘ What are the biological markers/characteristics that would make the following groups more vulnerable to HIV?
 - + Men-who-have-sex-with-men (MSMs)
 - + Sex workers
 - + Intravenous Drug-users

MSMs

- ✘ Unprotected anal sex – greatest risk is receptive partner
- ✘ MSM and IDU overlap – increase sexual risk-taking

Sex Workers

- ✘ Lots of concurrent, multiple partnerships

IDUs

- ✘ Using contaminated needles – directly into blood stream
- ✘ Sexual risk-taking

The Social Dimension

- ✘ What is the impact of sexual orientation, race, nationality and class on HIV/AIDS in a society where “white, middle-class, professional, straight and nationalist” are seen as the norm (or the utopia)?

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What is the impact on the LGBTI (Lesbian, Gay, Bisexual, Transgender, Intersexual) community?

Sexual minorities

- ✘ Homophobia
- ✘ Lack of education
- ✘ Lack of access to adequate and sensitive health care services
- ✘ Use of criminal law

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- ✘ What is the impact of sexual orientation, race, nationality and class on HIV/AIDS in a society where “white, middle-class, professional and straight” are seen as the norm (or the utopia)?

What is the impact intravenous drug-users (IDU) community?

IDUs

- ✘ Stigma
- ✘ Lack of education
- ✘ Lack of access to adequate and sensitive health care services
- ✘ Use of criminal law

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- ✘ What is the impact of sexual orientation, race, nationality and class on HIV/AIDS in a society where “white, middle-class, professional, straight and nationalist” are seen as the norm (or the utopia)?

What is the impact on sex workers?

Sex Workers

- ✘ Sexual moralism
- ✘ Lack of education
- ✘ Lack of access to adequate and sensitive health care services
- ✘ Use of criminal law

What effect does the use of criminal law have on sex workers?

- ✗ Increases stigma of profession
- ✗ Limits access to health care, legal and social services
 - + Access safer sex education?
 - + Access to condoms?
 - + Access to STI/HIV testing and treatment?
 - + Mobilisation?
- ✗ Increase exploitation and abuse of sex workers by clients, partners, brothel-owners, pimps and the police
 - + Barriers to legal recourse
- ✗ Sex workers often have no choice but to live in dangerous, squalid conditions – these conditions attract social and criminal ills
- ✗ May force sex workers to relocate often – social disintegration



Increase the risk of contracting HIV



What effect does the use of criminal law have on sex workers?

- ✘ New York – condoms as “criminal paraphernalia”
- ✘ Current Bill in the New York State Legislature would prohibit using “possession of a condom” as evidence of illegal sex work.

NEW YORK STATE ASSEMBLY BILL A10893/S01289A

Summary

New York State Bill A10893/S01289A would stop police and prosecutors from using possession of condoms as evidence of prostitution. Currently, police and courts can use the fact that a person has or is carrying condoms to prove that they are engaging in criminal activity. Sex workers report that they are more likely to be arrested if they carry condoms. Police officers regularly confiscate condoms from people they allege are engaged in prostitution to use as evidence against them at trial. As a result people are hesitant to carry condoms to protect themselves and others, for fear that it will lead to arrest or be held against them in court. Sound public health policy would encourage condom use by eliminating the fear that carrying a condom will be used against you by police or in a court of law.

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What is the impact on poor people?

Poverty

- ✘ Access to adequate health care services (state of SA's public health care sector)
- ✘ Education
- ✘ Survival sex and transactional sex

Poverty

(a) Poverty

Poverty operates through a variety of mechanisms as a risk factor for infection with HIV and AIDS. Its effect needs to be understood within a socio-epidemiological context. It works through a myriad of interrelations, including unequal income distribution²⁷, economic inequalities between men and women which promote transactional sex²⁸, relatively poor public health education and inadequate public health system²⁹. Poverty-related stressors arising from aspects of poverty in townships such as poor and dense housing, and inadequate transportation, sanitation and food, unemployment, poor education, violence, and crime, have also been shown to be associated with increased risk of HIV transmission³⁰.

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What is the impact on women?

Gender/GBV

(b) Gender and Gender-based violence

South Africa has one of the highest rates of violence against women, with over 53 000 rapes reported to police in 2000, translating into a rape reporting rate of 123 women per 100 000 population³¹. Sexual violence is linked with a culture of violence involving negative attitudes (e.g. deliberate intention to spread HIV) and reduced capacity to make positive decisions or to respond appropriately to HIV-prevention campaigns. More significantly, the experience of sexual assault has also been linked to risks for HIV infection³². Equally interesting, two recent studies conducted among men in a township community and in an STI clinic both showed that men with a history of sexual assault were also at significantly higher risk for HIV transmission than their counterparts without such a history³³. In South Africa, the gender system fosters power imbalances that facilitate women's risks for sexual assault and sexually transmitted infections (STIs)³⁴. South African men, like men in most societies, possess greater control and power in their sexual relationships³⁵.

Gender/power relations

Women with the least power in their relationships are at the highest risk for both sexual assault and HIV infection, both stemming from the inability of women to control the actions of their sex partners³⁶. Men who have limited resources and lack the opportunity for social advancement often resort to exerting power and control over women³⁷. Importantly, sexist beliefs and negative attitudes toward women are held by men who have not been sexually violent as well as men who have a history of sexual violence. In fact, negative attitudes toward women are so pervasive there is evidence that they are

often held by women themselves³⁸. Power and control disparities in relationships create a context for men to have multiple concurrent partners and fuel their reluctance to use condoms. Unfortunately, men's attitudes toward women impede HIV preventive actions and can culminate in the acceptance of violence against women. Qualitative studies in South Africa consistently show that men believe they are more powerful than women and that men are expected to control women in their relationships. There is also evidence that men often hold attitudes that accept violence against women including beliefs that women should be held responsible for being raped. One in three men receiving STI clinic services endorsed the belief that women are raped because of things that they say and do and half of men believed that rape mainly happens when a woman sends a man 'sexual signals'³⁹.

Gender/Culture

(c) Cultural Attitudes and Practices

The relationship between culture and HIV is under-researched. There is some evidence that cultural attitudes and practices expose South Africans to HIV infections. First, gender inequalities inherent in most patriarchal cultures where women are accorded a lower status than men impact significantly on the choices that women can make in their lives especially with regards to when, with whom and how sexual intercourse takes place⁴⁰. Such decisions are frequently constrained by coercion and violence in the women's relationships with men. In particular, male partners either have sex with sex workers or engage in multiple relationships, and their female partners or spouses are unable to insist on the use of condoms during sexual intercourse for fear of losing their main source of livelihood.

Second, there are several sex-related cultural beliefs and behavioural practices such as rites of passage to adulthood especially among male youth, rites of marriage such as premarital sex, virginity testing, fertility and virility testing, early or arranged marriages, fertility obligations, polygamy, prohibition of post-partum sex and also during breastfeeding, and rites related to death such as levirate (or spouse inheritance) and sororate (a widower or sometimes a husband of a barren woman marries his wife's sister) are also believed to spread HIV infection⁴¹.

HIV infection is also believed to occur during some of the traditional health practices conducted by traditional healers when they use unsterilised sharp instruments such as knives, blades, spears, animal horns and thorns during some of the healing practices and/or recommend sex with a virgin as part of their treatment of patients.

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What is the impact on foreign migrants?

Foreign migrancy

- ✘ Links between HIV vulnerability and migration demonstrated
 - + Conditions associated with migration

Source: Vearey, J. (2008) International migrants: linkages between migration, access to ART and survivalist livelihood strategies in the City of Johannesburg, South Africa *African Journal of AIDS Research* 7(3) 361 - 374

Foreign migrancy

(i) Refugees

The disruption of services and support systems caused by conflict or unrest in their home countries means that many refugees have limited information about HIV and AIDS, and they are often not familiar with local services or systems in South Africa. In addition, while their legal status guarantees the right to access HIV-related information and services on the same level as South Africans, barriers such as language, cultural traditions and xenophobia often preclude their ability to access these services. Therefore targeted programmes are necessary to ensure that refugees and asylum seekers have access to information and services – including prevention, care, support and treatment – as an integrated component of the national response to HIV and AIDS.

Foreign migrancy

(e) Mobility and labour migration

Poverty and unemployment are linked to economic disempowerment and this affects sexual choice-making and exposure to wider sexual networks. Over and above gender vulnerability that flows from economic disempowerment, individuals who engage in work-seeking, mobile forms of work or migrant labour are at increased vulnerability to HIV as a product of higher likelihood to have multiple sexual partners, higher exposure to sex for exchange of money, amongst other risk factors⁴⁷. Mobile individuals include informal traders, sex workers, domestic workers, cross-border mobility, seasonal agriculture workers, migrant workers (e.g. mine-workers, construction workers, and soldiers), long-distance truck, bus and taxi drivers, travelling sales persons and business travellers⁴⁸. These forms of mobility are pervasive in southern Africa. Various studies have illustrated the higher likelihood of mobile groups to be HIV positive⁴⁹. Migration patterns in South Africa have shifted from being predominantly male migration, to a trend towards increasing mobility and migration by women. Mobility and migration not only increase vulnerability to HIV of mobile individuals, but also sending and receiving communities⁵⁰.

Questions

- ✘ Is all human decision-making rational?
 - + Decisions about sex?
- ✘ How do stigma and attributing blame impact on stemming HIV?
- ✘ What is the relationship between prevention and treatment, and how do these impact on stigma?
 - + Elizabeth Pisani “Sex, drugs and HIV” – let’s get rational” – TED talk,
<http://www.youtube.com/watch?v=LoXAAEy6YQU>

History of HIV

- ✘ 1981 - identification of the disease by U.S. clinicians (1981), and defining it as an immune disorder characterized by a decline of immune function and of T cells, and notably CD4 T cells,
- ✘ 1982 - the identification of risk groups then called the "4 H's"



Source

Robert C Gallo "A reflection on HIV/AIDS research after 25 years" *Retrovirology* 2006, 3:72

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- ✘ 1982 - the identification of risk groups then called the "4 H's"
 - + hemophiliacs,
 - + heroin addicts,
 - + homosexuals and
 - + Haitians

Source

Robert C Gallo "A reflection on HIV/AIDS research after 25 years" *Retrovirology* 2006, 3:72

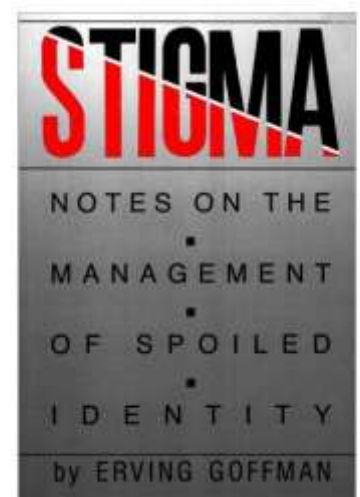
Fault lines – Paul Farmer

“HIV may not have come from Haiti, but it was going to Haiti. Critical reexamination of the Caribbean AIDS pandemic showed that the distribution of HIV does not follow national borders, but rather the contours of a transnational socioeconomic order. Furthermore, much of the spread of HIV in the 1970s and 1980s moved along international “fault lines,” **tracking along steep gradients of inequality**, which are also paths of migrant labor and sexual commerce.

Like TB, HIV infection is entrenching itself **in the ranks of the poor or otherwise disempowered.**”

Source: Paul Farmer “Social Inequalities and Emerging Infectious Diseases” Emerging Infectious Diseases Vol. 2, No. 4—October-December 1996 259

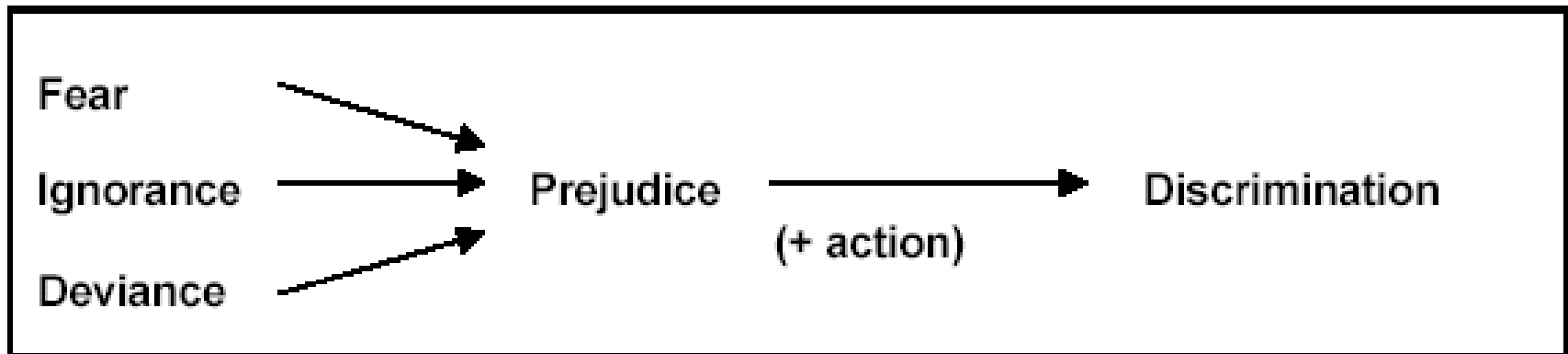
What is Stigma?



- ✘ Erving Goffman pioneered the study of stigma.
 - + theoretical underpinnings that frame most stigma research.
 - + Book: “Stigma: Notes on the Management of Spoiled Identity”
- ✘ Goffman described stigma as "an attribute that is deeply discrediting within a particular social interaction.”
- ✘ His explanation of stigma focuses on society's attitude toward people who possess attributes that fall short of public expectations.
- ✘ According to Goffman, a person who is stigmatized is "reduced in our minds from a whole and usual person to a tainted, discounted one."
- ✘ Certain kinds of diseases carry more stigma than do others.
- ✘ According to Goffman and other researchers, diseases associated with the highest degree of stigma share common attributes:
 1. The person with the disease is seen as responsible for having the illness
 2. The disease is both progressive and incurable
 3. The disease is not well understood among the public
 4. The symptoms cannot be concealed.

Source: The Body “HIV/AIDS Stigma”
<http://www.thebody.com/content/art12405.html>

Discrimination Continuum



* Figure 1: Understanding discrimination

Source: Ross Jennings, Jowie Mulaudzi, David Everatt, Marlise Richter and Mark Heywood "Discrimination and HIV/AIDS" October 2002, paper researched and written for the South African Department of Health.

Prejudice

Prejudice is typically enacted only when the object of discrimination is perceived as vulnerable and defenceless.

Discrimination

Discrimination entails the combination of an element of action, with a pre-existing sentiment of prejudice, or in other words “to discriminate against someone is to treat them unequally or differently to other people”.

AIDS Discrimination

To treat PWAs differently or unequally to other people because of their HIV status



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Fourteenth session

Agenda item 3

**Promotion and protection of all human rights, civil,
political, economic, social and cultural rights,
including the right to development**

Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Anand Grover*

Source:

"Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health Anand Grover" April 27, 2010
http://www2.ohchr.org/english/bodies/hrcouncil/docs/14session/A_HRC_14_20.pdf

Special Rapporteur on Health

2. The Special Rapporteur believes that the criminalization of private, consensual sexual interaction between adults represents a significant impediment to the realization of the right to health of all persons, particularly those against whom the law is directed. He emphasizes that all human rights are universal, indivisible, interdependent and interrelated.² The criminalization of private, consensual sexual conduct between adults infringes on not only the right to health, but also various other human rights, including the rights to privacy and equality. In turn, infringement of these human rights impacts indirectly on the right to health.

Source:

"Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health Anand Grover" April 27, 2010
http://www2.ohchr.org/english/bodies/hrcouncil/docs/14session/A_HRC_14_20.pdf

What should our response be?

✘ Paul Farmer "This I believe"

<http://www.youtube.com/watch?v=xJpZnUjtorI>