Joint United Nations Programme on HIV/AIDS

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FIGHTING HIV-RELATED INTOLERANCE: EXPOSING THE LINKS BETWEEN RACISM, STIGMA AND DISCRIMINATION[1]

[1] Prepared in consultation with the Office of the High Commissioner for Human Rights

THE GLOBAL EPIDEMIC

The last two years have seen a major increase in the scope and scale of the national, regional and international response to HIV/AIDS. There is a growing recognition that globally a major catastrophe is upon us. Whereas at the end of the 1980s, HIV had infected an estimated 10 million people, and approximately 1.5 million had died, throughout the 1990s over 40 million additional people were infected with HIV worldwide, and there were over 15 million deaths due to HIV/AIDS.[2]

It is important to recognize that the HIV/AIDS pandemic consists of multiple and overlapping epidemics, each with its own distinctive dynamics and character. These vary between regions and countries, as well as within national boundaries. At the end of 2000, 36.1 million men, women and children were living with HIV or AIDS, 25.3 million in sub-Saharan Africa alone. In the eight African countries with HIV prevalence of at least 15 per cent, on current trends approximately one third of today's population of 15 year-olds can expect to die from AIDS. In the Caribbean region, AIDS is already the primary cause of death among young men and women, and there are 11 countries in Latin America and the Caribbean where prevalence in the adult population is above 1%. There have been steep rises of new infections in other regions. In parts of Eastern Europe, for example, there were more infections in 2000 than in all previous years combined.[3]

The AIDS epidemic is an emergency threatening human welfare and prosperity throughout large parts of the developing world. Millions of people have become impoverished as a result of HIV/AIDS: children have lost their parents; families have lost their property; communities have lost teachers, health workers, business and government leaders; nations have lost their investments in decades of human resource development; and societies have lost untold potential contributions to social, economic, political, cultural and spiritual life. The epidemic is having a severe impact, reversing hard won development gains in life expectancy and health, as well as economic and social development.

Globally, the impact of HIV/AIDS has been far from even, and the most recent estimates highlight the continuing concentration of the epidemic in developing countries. Sub-Saharan Africa is by far the worst hit region, even though the number of new infections in a few countries shows signs of stabilizing. The southern part of the continent contains the majority of the world's hardest hit countries: in Botswana, Namibia, South Africa, Swaziland and Zimbabwe, between 20% and 26% of the population aged 15-49 is living with HIV or AIDS. In West Africa, Côte d'Ivoire and Nigeria are particularly badly affected: in the former, 10% of the adult population is infected with HIV, while in the latter an estimated 2.2 million people are living with HIV.[4]

Throughout Asia, rates of HIV infection are still comparatively low, but the epidemic is developing rapidly. By the end of the year 2000, more than 7 million people were believed to be infected with HIV.[5] Given that over half of the world 's population lives in this region, small differences in rates can make a dramatic difference to the absolute numbers of people infected and to the potential impact of the HIV epidemic. In India, for example, HIV infection rates are still low at 0.7% of the total adult

[2] http://www.unaids.org/epidemic_update/report/Epi_report.pdf and http://unaids.org/fact_sheets/ungass/word/FSoverview_en.doc
[3] http://www.unaids.org/epidemic_update/report/Epi_report.pdf and http://unaids.org/fact_sheets/ungass/word/FSoverview_en.doc
[4] http://www.unaids.org/epidemic_update/report/Epi_report.pdf
[5] http://www.unaids.org/epidemic_update/report/Epi_report.pdf

population. However, given the country's size, this translates to 3.7 million people.[6] In China, an explosive spread of HIV infection has been reported among injecting drug users in certain provinces, with prevalence rates of between 44% and 85% being reported among selected groups of drug injectors in Yunnan and Xinjiang. At the end of 1999, an estimated 500,000 people were living with HIV/AIDS in China.[7]

Throughout the countries of Eastern Europe and the former Soviet Union, rapidly developing epidemics have also been reported. The estimate number of adults and children living with HIV or AIDS in Eastern Europe and the countries of the former Soviet Union was 420,000 at the end of 1999. Just one year later, a conservative estimate put the figure at 700,000. Most of the quarter of a million adults who became infected in the year 2000 are men, the majority of them injecting drug users. HIV shows no sign of curbing its exponential growth in the Russian Federation.[8]

In Western Europe and North America, there is evidence that prevention efforts may have stalled. Available information indicates that the number of newly infected people in the year 2000 was no lower than that in 1999. Thousands of infections are still occurring through unsafe sex between men, due perhaps to growing treatment optimism, prevention programming failing to focus on the areas of highest priority and increased levels of sexual risk behaviour. Among injecting drug users too, and despite knowledge of how to control the epidemic through a focused package of interventions including syringe and needle exchange, there are signs of prevention failure, accounted for in part by political unwillingness to promote measures that have been shown to work.

All over the world, children and young people are among the most affected by HIV/AIDS. Millions of children have been orphaned by AIDS, and tens of millions more will lose one or both parents to the pandemic over the next 10 years. Increasing numbers of children are living in households with an HIV-infected member, and children are taking on the responsibilities of caring for sick parents, generating income and producing food.[9] Women are more vulnerable to infection than men owing to a mix of biological and cultural factors. This is especially true for young girls. Studies among various African populations indicate that rates of HIV infection in young women aged between 15 and 19 may be many times higher than equivalent rates among young men.[10]

Unfortunately, to date there exists relatively little data on the relationship between HIV/AIDS, ethnicity and race. It has been argued that race is 'a central determinant of social identity and obligations [and] an empirically robust predictor of variations in morbidity and mortality'[11] With careful management, in some contexts reliable racially disaggregated data on HIV/AIDS could be an important tool for policy and programme development, but only relatively few countries produce information of this kind. In part, this reflects continued definitional problems with respect to racial categories and the lack of an internationally agreed uniform system of classification.[12] But it also reflects a complex balance between on the one hand the desire to ensure programmes overcome race-based inequalities and on the other hand the fear that

[6] http://unaids.org/fact_sheets/ungass/word/FSoverview_en.doc
[7] http://www.unaids.org/hivaidsinfo/statistics/june00/fact_sheets/pdfs/china.pdf
[8] http://www.unaids.org/epidemic_update/report/Epi_report.pdf and http://www.unaids.org/hivaidsinfo/statistics/june00/fact_sheets/pdfs/russianfederation.pdf
[9] http://unaids.org/fact_sheets/ungass/word/FSorphans_en.doc
[10] http://www.unaids.org/publications/documents/human/gender/una99e16.pdf
[11] Williams, D. R. (1997) Race and Health: Basic questions, emerging directions, *Annals of Epidemiology*, 7, pp. 322-333.
[12] Williams, D. R. (1996) Race/Ethnicity and Socioeconomic Status: Measurement and methodological issues, *International Journal of Health Services*, 26 (3) pp. 483-505.

the publication of race-based data will only serve to perpetuate stigma. However, systematic differentials of status between ethnic groups have a marked effect on HIV/AIDS-related vulnerabilities and the HIV response, and in turn intersect with gender, sexuality, age and other dimension of difference. In every context, therefore, there is a need for programme development to be sensitive to race-based stigma and its impact on both the dynamics of the epidemic and on access to prevention and care services.

Against the background of a growing epidemic, in July 2001 the UN General Assembly held a Special Session on HIV/AIDS. At the end of the meeting, delegates unanimously endorsed a *Declaration of Commitment on HIV/AIDS* which commits Member States *inter-alia* to dramatically increasing the level of funds available internationally to fight HIV/AIDS as well as to the achievement of specific targets in HIV prevention and care. A Global AIDS and Health Fund is to be established to help finance an urgent and expanded response to the epidemic based on an integrated approach to prevention, care, support and treatment, with due priority being given to the most affected countries. UNAIDS has estimated that HIV/AIDS spending in developing countries needs to rise to 7 to 10 billion dollars annually,[13] at least five times its current level. Mobilizing the additional resources needed requires a comprehensive domestic and international effort addressing aid, debt and national budgeting.

The UN General Assembly at its Special Session also called on States, by the year 2003, to enact, strengthen or enforce as appropriate, legislation, regulations and other measures to eliminate all forms of discrimination against, and to ensure the full enjoyment of all human rights and fundamental freedoms by people living with HIV/AIDS and members of vulnerable groups; in particular to ensure their access to, *inter alia,* education, inheritance, employment, health care, social and health services, prevention, support, treatment, information and legal protection, while respecting their privacy and confidentiality; and develop strategies to combat stigma and social exclusion connected with the epidemic

Furthermore, the Declaration called upon States to ensure by 2003, the development and implementation of multi-sectoral national strategies for combating HIV/AIDS that address the epidemic in forthright terms, confront stigma, silence and denial, address gender- and age-based dimensions of the epidemic, eliminate discrimination and marginalization, and involve civil society, the business sector, people with HIV/AIDS, vulnerable groups, people at risk, women and young people. Measures are to be taken to increase the capacities of women and adolescent girls to protect themselves from the risk of HIV infection, principally through the provision of healthcare services, including sexual and reproductive health, and through prevention education that promotes gender equality within a culturally gender-sensitive framework.

STIGMA, DISCRIMINATION AND HIV/AIDS – THE LINKS

Like other feared diseases, HIV/AIDS triggers widespread stigma and discrimination. However, the stigmas associated with HIV/AIDS do not arise from out of the blue, nor are they randomly patterned. They usually build upon and reinforce pre-existing fears and prejudices: about poverty, about gender, about sex and sexuality, and about race; and they frequently give rise to intolerance and sexist and racist discriminatory actions.

[13] http://unaids.org/fact_sheets/ungass/word/FScost_en.doc

In many countries, people with HIV/AIDS are perceived as having had sex with sex workers or prostitutes (if they are men), or as having been 'promiscuous' (if they are women). In many parts of the world, HIV is seen as a 'woman's disease', like many other forms of sexually transmitted infection. Elsewhere, HIV/AIDS may be viewed as a 'junkies' disease or as a 'gay plague'. And all over the world, HIV/AIDS is largely associated with Black people and with Africa.

HIV/AIDS-related stigma and discrimination therefore plays into, and reinforces, existing social stereotypes and inequalities – inequalities that make women seem inferior to men, inequalities that deny prostitutes and sex workers their rights, inequalities linked to drug and substance use, inequalities of sexuality, and inequalities of race. HIV/AIDS-related stigmatisation is not something that simply springs from the minds of individuals, it is instead linked to power and domination in the community as a whole, playing a key role in producing and reproducing relations of power and control.

Stigmatisation often leads to discrimination, that is, where a distinction is made against a person that results in their being treated unfairly and unjustly on the basis of their belonging, or being perceived to belong, to a particular group. HIV/AIDS-related stigma is intimately linked to discrimination as, for example, when a person's prejudiced thoughts lead them to doing something, or omit to do something, that harms or denies services or entitlements to another person.

Freedom from discrimination is a fundamental human right founded on principles of natural justice that are universal and perpetual. The basic characteristics of human rights are that they inhere in individuals because they are human, and that they apply to people everywhere in the world. All international human rights instruments and the African Charter[14] prohibit discrimination based on race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, fortune, birth or other status.

Recent UN Commission on Human Rights resolutions,[15] have unequivocally stated that the term 'or other status' in non-discrimination provisions in international human rights texts should be interpreted to cover health status, including HIV/AIDS, and has confirmed that 'discrimination on the basis of HIV/AIDS status, actual or presumed, is prohibited by existing human rights standards.' Discrimination against people living with HIV/AIDS, or those thought to be infected, on whatever grounds, is therefore a clear violation of their human rights.

The stigma and discrimination that people with HIV/AIDS face are unusually multiple and complex. Individuals tend not to be stigmatised and discriminated against *only* on the grounds of HIV/AIDS status, but also in accordance with what this connotes. Recent UNAIDS sponsored research in India and Uganda shows that women with HIV/AIDS may be doubly stigmatised both as 'women' and as 'people living with HIV/AIDS' when their identity becomes known.[16] Likewise, Black people with HIV/AIDS find themselves stigmatised as both 'infected' and 'Black' (and by extension, Black women with HIV/AIDS as 'infected', 'women' and 'Black'). This compounding of HIV/AIDS-related stigma and discrimination by gender, race, sexuality and other factors is important, both for our understanding of social

[14] The right to non-discrimination is enshrined in Article 2 of the Universal Declaration on Human Rights; International Covenant on Civil and Political Rights; International Covenant on Economic Social and Cultural Rights; Convention on Elimination of All Forms of Discrimination Against Women; Convention on the Rights on the Child; the African Charter).
[15] Commission on Human Rights, Resolutions 1999/49 and 2001/51.
[16] http://www.unaids.org/publications/documents/human/law/ugandaindiabb.pdf

responses to the epidemic, and for the forms of concrete action that can be taken to prevent it happening and ameliorate its effects through inter alia, urgently identifying mechanisms at national level to address these issues.

Ultimately, it is at community and national level that HIV/AIDS related stigma and discrimination is most effectively combated. . Monitoring and fostering of the responsibility of States in the area of human rights within the context of HIV/AIDS, in particular in addressing stigma and discrimination, will depend on the extent to which communities and community leaders advocate for inclusiveness and equality irrespective of HIV status. This will also depend on the existence of institutions and structures that can investigate violations of human rights that occur in the context of HIV/AIDS; conduct public inquiries or hearings focusing on systematic violations of persons living with HIV/AIDS, particularly due to stigma and discrimination, and receive and, where appropriate redress complaints human of HIV/AIDS related discrimination.

POVERTY, RACE AND HIV/AIDS – THE LINKS

HIV/AIDS has caused a development crisis in sub-Saharan Africa and has made deep inroads into economic and social development in Asia, Latin America, the Caribbean and Eastern Europe. Such is the destruction and destabilization caused by the epidemic that in January 2000 the UN Security Council considered HIV/AIDS as a global security issue. In many countries, the AIDS epidemic has undermined the institutions and human resources on which a society's future health, security and progress depend. In the hardest hit countries, over one-quarter of the medical staff who are needed to help those living with HIV/AIDS are themselves infected. In some countries, experienced teachers are dying faster than new teachers can be trained. Heavy industry and the military suffer, because men who have to work away from their homes often have higher rates of infection than the general population. Where high prevalence and poverty coincide, the impact is greatest.

In subsistence, small-scale agriculture in sub-Saharan Africa, labour shortages exacerbated by HIV/AIDS combined with declining household incomes are compounding food and livelihood insecurity and contributing to changes in farming practices and farming systems. Morbidity and mortality have already cut the production of many crops by more than 40% in households affected by AIDS. The burden on women is particularly great, as they are often the primary care givers. The rapidly increasing number of children orphaned by AIDS poses major challenges for their well-being, as well as for the development of the communities in which they live.[17]

But why and how does poverty make people vulnerable to HIV/AIDS? According to recent evidence from the World Bank, most people with AIDS are poor,[18] and according to the 1997 UNDP Human Development Report, poverty 'offers a fertile breeding ground for the epidemic's spread and infection sets off a cascade of economic and social disintegration and impoverishment.' Households with few financial assets may find themselves unable to seek treatment for sexually transmitted infections, and the existence of untreated sexually transmitted diseases increases the risk of contracting HIV/AIDS, and poor women and young people may need to resort to compensated unprotected sex[19] to provide for their families.

[17] D. Topouzis and J. du Guerny (1999) *Sustainable Agricultural/Rural Development and Vulnerability to the AIDS Epidemic.* Geneva, UNAIDS & FAO.
[18] World Bank (2000) *Confronting AIDS*. New York, Oxford University Press.
[19] The term 'compensated sex' covers a wide range of practices, ranging from sex work and prostitution to situations in which an individual receives small gifts, food and shelter in return for sexual favours.

Moreover, in the face of disintegrating family and community structures, people may be encouraged to live only for the present and to use sex to satisfy a range of other emotional needs.

The links between poverty and HIV/AIDS are bi-directional. On the one hand, poverty contributes to vulnerability to HIV and exacerbates the impact of HIV/AIDS**.** On the other hand, the experience of HIV/AIDS by individuals, households and communities that are poor readily leads to an intensification of poverty. Thus, HIV/AIDS frequently impoverishes people in such a way as to intensify the epidemic itself.[20]

Levels of poverty vary considerably across nations as well as within countries. This sheds light on the links between poverty, racism and racial discrimination and HIV/AIDS. Given the global patterning of the epidemic, it is clear that HIV/AIDS is a disease whose impact is that disproportionately great among both the poor and people of colour – affecting the populations of countries of Africa, Asia, Latin America and the Caribbean far more than other parts of the world.[21]

In a recent statement, Helene Gayle, as Head of the US CDC's National Center for HIV, STD and TB Prevention, stated that 'Around the world, there is a strong correlation between poverty and health.' She went on to say that within the USA, 'African-Americans are more likely than whites to contract acquired immune deficiency syndrome, or AIDS' and once diagnosed are 'less likely to receive adequate treatment.'[22] Epidemiological evidence from the USA shows the progress of the epidemic over time. In the early 1980s, most AIDS cases occurred among white people. However, cases among Black people increased steadily such that by 1996, more cases were reported among Blacks than any other racial/ethnic population. Cases among Hispanics, Asians/Pacific Islanders, and American Indians/Alaska Natives also rose.[23] In consequence, of the 322,865 persons in the USA reported to be living with AIDS at the end of the year 2000, 61% were Black or Hispanic.

While the majority of countries do not maintain such detailed data on racial and ethnic differentials in HIV/AIDS incidence and prevalence among those that do, a similar pattern frequently prevails. In Canada, for example, white people have historically represented the largest proportion of reported AIDS cases, yet this proportion has declined over the last 10 years. In 1991, the proportion of reported AIDS cases among whites was 88.6%. In 1999, the proportion of cases dipped to 66.1% among whites, with a corresponding increase in the proportion of reported AIDS cases among other ethnic groups. The increase has been most notable among Aboriginal persons and the Black population since 1994. Aboriginal persons and Blacks comprise approximately 2.8% and 2.0% of Canada's population respectively. In 2000, they accounted for 9.2 % and 8.3% of reported AIDS cases, respectively

[20] Collins, J. and Rau, B. (2000) *AIDS in the Context of Development*. UNAIDS/UNRISD
[21] http://unaids.org/fact_sheets/ungass/word/FSoverview_en.doc
[22] http://www.aegis.com/news/ads/1999/AD991444.html
[23] HIV and AIDS — United States, 1981–2000 MMWR June 1, 2001 / Vol. 50 / No. 21, p 430-433.

suggesting that both Aboriginal persons and Blacks were over-represented in reported cases of AIDS in 2000.[24]

In Australia, overall rates of HIV notification are reported as being broadly similar in the indigenous and non-indigenous population. However, compared with the non-indigenous population, rates of notification for all bacterial STIs (such as gonorrhoea and syphilis) are substantially higher among indigenous Australians, and the combined rate for bacterial STIs is stable in the indigenous population, whereas it is declining in the non-indigenous population. Diagnosed HIV infections among indigenous people also differ from the pattern in non-indigenous people in that a higher proportion has occurred in women (26% versus 8% for the non-indigenous cases). Such differences in epidemiology are related both to the poor socio-economic standing of indigenous peoples within Australia, and to the historic under-development of education, prevention and health services to meet their needs.[25]

In South Africa, racism historically deprived many Black people of education and access to healthcare, and the legacy of apartheid can still be felt at all levels of society. Recent evidence from antenatal surveys shows very high levels of HIV infection, and these surveys over-represent Black women by virtue of their extensive use of public health facilities. Investigations are being undertaken to conduct sentinel surveillance amongst private sector clinic attendees as a means of better understanding HIV prevalence rates amongst women from other population groups. Pervasive perceptions that HIV/AIDS is a Black disease, and the lack of public attention to levels of infections in other groups, fuels both a kind of fatalism and a false sense of security in groups whose self-perception is that they are less affected.

Ultimately, as with so many other health and development issues, it is vital to recognise that better monitoring of the magnitude and nature of health differentials enhances our understanding of their causes, and assists the development of more effective programmes and interventions.

GENDER, RACE AND HIV/AIDS – THE LINKS

In most societies, dominant gender constructions and ideologies determine how and what men and women know about sexual matters and sexual behaviour. As a result, girls and women are often poorly informed about reproduction and sex, while the expectation is often that men know much more, and are more sexually experienced.[26]

Gender norms are frequently linked to attitudes and behaviours that contribute to risk of and vulnerability to HIV. For example, the high value place on virginity in some cultures may encourage older men to seek out younger women, or it may encourage unmarried women to practice anal sex so as to protect their 'virginity'. HIV-related risks are often greater in situations where women are socialized to please men, not say 'no' to unwanted sex, and defer to male authority. In addition, there are a number of growing gender-related concerns that have important consequences for HIV prevention, including rape and violence against women, female genital mutilation, the lack of social support for single women, , forced sterilisation andwife inheritance are.[27]

[24] AIDS/HIV Ethnicity in Canada HIV Epi. Update, May 2001. Canada Bureau of HIV/AIDS, STD and TB.
[25] Commonwealth of Australia (1997) *The National Indigenous Australian's Health Strategy, 1996-7 – 1998-9.*
[26] UNAIDS (1999) *Gender and HIV/AIDS: Taking stock of research and programmes* and http://unaids.org/fact_sheets/ungass/word/FSgender_en.doc
[27] UNAIDS (1999) *Gender and HIV/AIDS: Taking stock of research and programmes*

Until recently, efforts to understand the risk of HIV from a gender perspective have generally focused on women. There has been a marked lack of attention to the ways in which power, roles and dominant social expectations also put men at risk. Men generally have higher reported rates of partner change than women do, and the condoning of this often begins during adolescence. The use of drugs and alcohol has been identified as contributing substantially to men's vulnerability to HIV, as has injecting drug use. Additionally, employment-related migration can add to men's vulnerability by disrupting marital and family ties, as well as bringing about changes in self-concept and male identity. These factors may in turn contribute to greater sexual risk through unprotected sex with non-regular partners.

All over the world, women's enhanced physiological risk of HIV infection is compounded by economic need, lack of employment opportunity, poor access to education, training and information, and local traditions. In rural areas, women tend to be even more disadvantaged due to reduced access to resources and health services, together with the sometimes judgmental attitudes of health care staff. A combination of these factors prevent women from having choices and from making decisions about their lives, and especially about sexual risk and family health. Low income, income inequality, and the low status of women are all associated with high levels of HIV.[28]

Among the broader political and policy realities that create a context of vulnerability to HIV/AIDS are gender- and age-related discrimination. Gender-related discrimination is often supported by laws, policies and customs that prevent women from owning land, property and other productive re-sources, and which deny women equal adult status with men. Research shows that this broader context frequently contributes to the feminization of poverty, heightens women's economic vulnerability to HIV infection, and creates significant barriers to women's ability to seek and receive care and support when they themselves are infected.[29]

But as stated earlier, factors such as socio-economic position and membership of a particular ethnic, racial or religious group leads to different forms of discrimination for women and men, girls and boys. *Intersectionality* is therefore central to an understanding of how gender, race, age, social background and sexuality combine together to determine who is infected and, once infected, who is able to access medications and health care. For example, characterizing the trafficking of women as solely an issue of gender discrimination while ignoring the racial, ethnic and class dimensions of the problem, ignores essential elements of explanation.[30] Likewise, an adequate analysis of domestic violence must take into account the socio-cultural background of victims and the impact of other factors such as race, ethnic group or religious affiliation.

More generally, women's education and training links closely to poverty and to race. International treaties and declarations have established the right to education, including the right to educational opportunities. Despite these guarantees, there is evidence that women from disadvantaged racial, ethnic, immigrant and indigenous communities have lower rates of literacy, secondary school attendance and graduation, access to higher education, and enrolment in scientific and other training

[28] UNAIDS (1999) *Gender and HIV/AIDS: Taking stock of research and programmes* and http://unaids.org/fact_sheets/ungass/word/FSgender_en.doc
[29] Ankrah EM, Schwartz M, Miller J. Care and support systems. In: Ankrah EM, Long LD, eds. *Women's experiences with HIV/AIDS: an international perspective*. New York, Columbia University Press, 1996, pp. 264-293.
[30] Carolyn Hannan (2001) Keynote Address at CSW 45th session, 6-16 March 2001. Geneva.

programmes.[31] In the USA, for example, recent research shows that Black women are three times more likely to die while pregnant than white women, and are four times more likely to die during child birth.[32] All over the world, but particularly in some developing countries, there is evidence that at school, girls may experience sexist harassment and abuse from teachers and other pupils that can prevent them taking full advantage of the opportunities offered, with negative consequences for social standing, educational achievement and self esteem.[33]

While various human rights instruments prohibit state-sanctioned violence against individuals, the *de facto* position of many women remains largely unchanged. Women in situations of armed conflict, indigenous women, refugees and displaced women, women of certain religious groups, women in migration and trafficked women, are among those most vulnerable to racism, racial discrimination, xenophobia and related intolerance, with attendant HIV/AIDS-related risks.[34] The impact of war on women and young girls can be particularly severe. Recent research in Bosnia, Croatia and Rwanda has revealed how rape and other forms of sexual abuse are frequently used as weapons of war.[35] The intersections between gender, racial discrimination and xenophobia are stark in these and related instances.

RACISM, RACIAL DISCRIMINATION AND HIV/AIDS – THE LINKS

Article 1(1) of the International Convention on the Elimination of Racial Discrimination defines racism as

> 'Any distinction, exclusion, restriction or preference based on race, colour, descent, or national or ethnic origin which has the purpose or effect of

[31] Integrating Gender into the Third World Conference against Racism, Racial Discrimination, Xenophobia and Related Intolerance. UNIFEM Background Paper.http://www.unifem.undp.org/hr_racism.html
[32] National Center for Health Statistics (1998) *Health, United States, 1998 with Socioeconomic Status and Health Chartbook* App. II, pp. 419, 444.
[33] Human Rights Watch (2001) *Scared at School – Sexual violence against girls in South African schools* http://www.hrw.org/reports/2001/safrica/
[34] Jane Real, Asia-Pacific Women and Law and Development Network.
[35] Human Rights Watch (1996) Shattered lives: sexual violence during the Rwandan genocide and its aftermath. http://www.hrw.org/summaries/s.rwanda969.html

> nullifying or impairing the recognition, enjoyment or exercise, on an equal footing, of human rights and fundamental freedoms; in the political, economic, social, cultural or any other field of public life.'

Wherever racism appears it leads to a

> 'generalised and definitive valorization of biological differences, whether real or imagined, favourable for the racist, devaluing the other, with the aim to justify an aggression or privilege.'[36]

But what are the origins of racism and related forms of intolerance, and how do they link to broader forces? The roots of much contemporary racism and racial discrimination can be found in the legacy of colonialism. Colonialism intensified earlier ethnic-, religious- gender-, caste- and class-based dominance across much of the developing world; and set different ethnic, religious and racial communities against each other by preferentially treating communities that 'cooperated', and arbitrarily establishing nation-states based on colonial boundaries.

Beyond colonialism, however, racism and allied inequalities link to more contemporary concerns such as discriminatory public policy, the structuring of labour markets, and differences in access to systems of governance. Labour markets may be racially segmented as a consequence of past public policy, through inequalities of development, or because of the efforts of specific groups to protect their own prestige and advantage with respect to certain kinds of work. Moreover, public policies of various kinds and market segmentation may lead to the physical segregation of groups, further reinforcing racial prejudice.[37]

Because of the intersections between race and class, social and economic inequalities may themselves breed xenophobia, related intolerance and violence. Throughout the world, socially and economically privileged groups may seek to main their status by using ethnicity and cultural differences to highlight the supposed 'inferiority' of others. Inter-ethnic rivalries within and between some African states, as well as in parts of South East Asia and the former Yugoslavia have triggered wars that have had disastrous consequences for political and economic stability, and exposed countless thousands of individuals to HIV/AIDS-related risks.[38]

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[36] Aissata De Diop. Panel Discussion at the CSW 45th session, 6-16 March 2001, Geneva.

[37] UNSRID (2001) http://www.unrisd.org/racism/dynamic.htm

[38] J. Benjamin (2001) Conflict, Post-conflict, and HIV/AIDS – The Gender connections: Women, war and HIV/AIDS: West Africa and the Great Lakes. Paper presented at the World Bank, International Women's Day, March 8, 2001 http://www.theirc.org/wcrwc/advocacy/wc_j-benjamin_worldbank_0301.html

All over the world, 'race' and xenophobia can be used to legitimate privilege and inequality. In the field of HIV/AIDS, such concerns play out in complex ways. Xenophobia and related forms of intolerance, for example, often make it hard for some regions and countries to learn from the innovation and success of others. Frequently technical advice from 'abroad' is rejected on the grounds that 'things are different here'. While interventions for prevention, care and impact alleviation should always play to local specificities and concerns, cultural difference should never be used as an excuse for failing to listen to, and learn from, others.

Yet the opposite kind of situation can be just as serious. For example, there can be a temptation for powerful governments, international development agencies or other international bodies to seek to impose 'ready made' solutions on less developed nations. Underpinning such action are often ideas about the 'backwardness' and lack of development of Third World nations, who need to be assisted by the North to realise their potential. Frequently racist assumptions make it seem natural that what has worked well among those who 'know', has universal applicability. As a result, local priorities, issues and concerns come to be downplayed, limiting intervention and programme success.

Xenophobia and racism interact in complex ways with HIV/AIDS. Like many other sexually transmitted infections – most notably syphilis in 15th and 16th century Europe – HIV/AIDS was first perceived as a disease of 'outsiders'.[39] Who counted as an 'outsider' depended on where you were situated. In the early 1980s for much of the world AIDS was seen as closely linked with the USA, including, for example, among gay and other homosexually active men in Europe and Australia,. In the eyes of some African and Asian leaders, HIV and AIDS have been viewed as diseases of the West – linked to the weakness of family structures, liberal social values and moral decline. With the passage of time, and for diverse reasons, in most countries of the world AIDS has come to be associated with sub-Saharan Africa.

Xenophobia and racism are evident, not only with respect to the presumed 'origins' of HIV/AIDS, but also with respect to more general forms of stigmatization and discrimination that have followed in the wake of the epidemic. Throughout history, racial stigmatization and discrimination are powerful weapons used cross-culturally to police and maintain ethnic boundaries, and it is hardly surprising that these functions should have been reproduced in the course of the HIV/AIDS epidemic.

Importantly, xenophobia and racism have not only imbued dominant images and cultural constructions of the epidemic, they have also been reproduced within it. Thus, people with HIV/AIDS from minority ethnic groups have frequently been blamed for their condition – being seen not as individuals living in contexts of marginalisation and inequality, but as the causes of their own misfortune. This kind

[39] Gilman, S. (1988) *Disease and Representation: Images of illness from madness to AIDS*. New York, Cornell University Press.

of approach can be seen in responses all over the world, and undoubtedly underpins general indifference to the plight of some of the most heavily affected communities.

Poverty—often in tandem or conjunction with racial oppression—has become one of the major sources of vulnerability, as well as of stigma and discrimination, as HIV/AIDS epidemics have 'matured'. [40] In many countries, numerous health problems derive from the legacies of colonialism, racism and apartheid. They include migrant labour, the rural-urban drift, lack of housing, informal settlements and lack of educational opportunity. Diseases such as tuberculosis, pneumonia, measles, polio and gastro-intestinal infections are strongly associated with poverty, even when they are rare among elite sectors of the population.

Within such contexts, it is perhaps hardly surprising that the incidence of HIV/AIDS will increase rapidly. In conditions of extreme poverty, sex for money or other forms of reward may be a not unreasonable survival strategy from the perspective of those living in extreme poverty. In circumstances where everyday survival is more important than what might happen in two or three years time, it is hardly surprising that 'planning for the future' may not take the same form as it does in more affluent circumstances. These are undoubtedly some of the reasons why, all over the world, it is the poor and disenfranchised – and within them racially stigmatised minorities – who suffer the most.

Racial divisions within society intersect with those of gender and sexuality to the systematic advantage of some groups and the disadvantage of others. As seen above, women and sexual minorities within racially oppressed groups are frequently doubly disadvantaged by virtue of gender and sexuality as well as by ethnicity. This creates multiple vulnerability to HIV/AIDS. Moreover, xenophobia, racism and poverty breed social exclusion by cutting individuals and communities off from one another, and from the forms of civil association that can lead to people taking greater control over their own lives. They can enable groups to feel that HIV/AIDS has nothing to do with them, and that it is someone else's problem. They can help make it seem sensible to postpone until tomorrow, actions that should be taken today. And they can cut across the forms of social solidarity that have shown themselves as central to any successful response.[41]

WAYS FORWARD

Much has been learned in recent years concerning the relationship between racism, racial discrimination, xenophobia, related intolerance and HIV/AIDS, both as the

[40] Parker R.G., Easton D., Klein, C. (2000). Structural barriers and facilitators in HIV prevention: A review of international research. *AIDS*. 14 (Suppl. 1):S22-S32.

[41] See, for example, N. Kaleeba, J. Namulondo Kadowe et al (2000) *Open Secret: People facing up to HIV and AIDS in Uganda*. London, ActionAid. Strategies for Hope Series 15. and *Comfort and Hope: Six case studies on mobilizing family and community care for and by people with HIV/AIDS.* http://www.unaids.org/publications/documents/responses/community/una99e10.pdf

determinants of class and gender-related vulnerabilities, and as the stigmatising and discriminatory effects of the epidemic. While important questions remain to be answered, an agenda for action seems clear. Central to this, must be the dramatic scaling up of local and national programmes to counter racism, racial discrimination, xenophobia and related forms of intolerance in the context of HIV/AIDS.

Programmatic experience – with respect to combating racism and in relation to HIV/AIDS prevention and care – clearly shows that the most successful approaches are those that: (a) emphasize respect for, and the promotion and protection of human rights (b) confront culture, class, gender and race in open debate, (c) are inclusive and participatory, and (d) promote partnership and the involvement of a wide range of agencies and actors.

- Challenging racism, racial discrimination, xenophobia and related forms of intolerance in the context of HIV/AIDS requires commitment at many levels including by governments, civil society, communities and individuals. The context for such action is the paradigm shift that has occurred in understanding and responding to the epidemic. HIV/AIDS is much more than a health problem; it touches human conditions, human security, human rights and social and economic development.

In all aspects, access to objective, evidence-based information is essential to enable informed decision-making. In this regard, it is a means of overcoming prejudice and safeguards the right to information**.**

A human rights framework is essential to encourage a reduction in HIV/AIDS-related stigma and discrimination. The spread and impact of HIV is fuelled when human rights are violated; protection, respect and fulfillment of human rights is vital to reducing vulnerability to infection and to lessening the adverse impact of the disease.

Urgent action must therefore be taken to

- Promote non-racist and anti-racist understandings of the epidemic, and support governments, communities and individuals in moving beyond xenophobic understandings of HIV/AIDS as ‘someone else’s problem’

- Promote a commitment to prevention and care within communities that have sought to ‘distance’ themselves from HIV/AIDS through past xenophobic and racist stereotypes of the epidemic and its causes

- Tackle HIV/AIDS-related racism, racial discrimination, xenophobia and related forms of intolerance wherever they occur, but especially in relation to health, education, employment, work and migration

- Openly challenge the 'double' and sometimes 'multiple' discriminations that poor people, women, lesbians and gay men of colour face in relation to HIV/AIDS

- Initiate dialogue to assess the use of 'culture' and 'tradition' as a rationale for the continuation of social practices that place individuals at heightened risk for HIV/AIDS, while strengthening positive elements of cultural tradition in promoting resilience to HIV and its impacts

- Use human rights instruments such as the Universal Declaration on Human Rights,[42] the Convention Against Torture, Inhuman and Degrading Treatment,[43] the International Covenant on Civil and Political Rights,[44] the International Covenant on Economic, Social and Cultural Rights,[45] the International Convention on Elimination of All Forms of Discrimination Against Women[46] and the Convention on the Rights of the Child (as well as regional instruments such as the African Charter on Human and People's Rights[47] and the American Convention on Human Rights), to reduce HIV/AIDS risk and vulnerability and promote greater racial equality

- Promote the active involvement of the Committee on Elimination of Racial Discrimination (CERD), other treaty bodies and the greater UN human rights machinery in further defining the links between HIV/AIDS, racism, racial discrimination, xenophobia and related intolerance, while applying human rights principles, standards and norms

Action against HIV-related stigma and its links to racism and intolerance also needs to be strengthened through a deeper understanding of its impact, in particular:

[42] Adopted by the General Assembly on 10th December 1948 under Resolution 217 A (III)
[43] Adopted by the General Assembly on 10th December 1984 under Resolution 39/46 of December 1984. Entered into force on the 26th June 1987.
[44] Adopted by the General Assembly under G.A resolution 2200 (XXI), UN GAOR, 21st session, Supplement No. 16, UN Doc. A/6316 (1966). Entered into force 23 March 1976.
[45] Adopted by the General Assembly on 16 December 1966 under G.A. Res. 2200 (XXI); UN GAOR , 21st Session, Supplement No. 16 at 49, UN Doc. A/6316 (1966).
[46] Adopted by the General Assembly under GA Resolution 34/180 of 18 December 1979. Entered into force 3 September 1981
[47] Adopted on 26 June 1981. Entered into force 21 October 1986

- The development of new and stronger forms of data collection and analysis to illuminate the relationship between poverty, gender, sexuality and race as determinants of HIV/AIDS-related vulnerability

- Action to document how xenophobia, racism and racial discrimination directly affect the availability of HIV/AIDS-related prevention and care

- Action to document the racist and xenophobic basis of HIV/AIDS-related stigma and discrimination, and the role of gender, sexuality and other factors in affecting the forms that such stigma and discrimination take.

Only by concerted action on a variety of fronts, drawing upon and playing to the unique strengths of the UN system and beyond, can we hope to make the progress that is so badly needed. The World Conference against Racism, Racial Discrimination, Xenophobia and Related Intolerance provides an excellent opportunity to commence this process.