Introduction

Concepts of human rights including rights against wrongful discrimination are a dominant feature of current legal landscape. HIV/AIDS challenge respect for human rights in profound ways. The AIDS epidemic has been accompanied by epidemics of fear and discrimination against those with AIDS and infected with HIV. The prevalence and impact of AIDS and HIV infection have been apparently in and on particular groups and populations.

Definition of Stigma and Discrimination

Stigma generally refers to a negatively perceived defining characteristics used to set individuals and groups apart from the normalized social order (Gilmore & Somerville 1992). With regard to HIV/AIDS, the stigma may be the actual infection or may be based on behavior believed to lead to the infection.

Discrimination is the action or treatment based on stigma and directed towards the Stigmatized’ (Bunding, 1996). The stigmatized find themselves ostracized, rejected and shunned (Alonzo & Reynolds, 1995) and may experience sanctions, harassment, and even violence based on their infection or association with HIV/AIDS (APN, 1999; McGrath, 1992). Stigma and discrimination are closely linked and they are frequently referred to together. Because discrimination often involves action, it can often be more easily identified.

Contexts of Discrimination

Since the onset of the HIV epidemic, discrimination tends to fall into two categories: Legislative forms of discrimination which reflect stigma of contagion and Family/Immediate community - Isolation of both infected and affected due to fears of casual contact - Restriction on participation in local events - Refusal to allow affected children in local schools - Lack of support for affected bereaved family members, including orphans.

Workplace - Mandatory testing before hiring/refusal to employ - Involuntary periodic testing/dismissal on grounds of HIV status - Violations of confidentiality - Refusal to work with infected colleagues for fear of contagion.

Health sector - Refusal to treat - Violations of confidentiality - Provision of care in specific establishments (such as STD clinics that further stigmatize the client) - Advice given or pressure applied for HIV positive person to undergo treatment that would not be emphasized for others (e.g., abortion, sterilization).

Religion - Denial of traditional rituals (e.g., funeral practices, restricted access to marriage) - Restriction on participation in religious activities.

Media - Demonization by public health campaigns of specified ‘transmitters’ such as sex workers reinforcing division between ‘guilty’ and ‘innocent’ people living with HIV/AIDS. - Depiction of HIV/AIDS as death, perpetuating fear and anxiety rather than normalization - Reinforcement of stereotyped gender roles that perpetuates women’s vulnerability to sexual coercion and HIV infection.

Discrimination in rendering health care to patients with HIV/AIDS is seen in denial of care, especially obstetrics and surgical care to many.
patients (Bhargava, 1998). Fear of infection is also responsible for actions such as isolation of HIV patients, neglect and discrimination. Poor quality of testing facilities and mandatory testing in woman in case of HIV positive husbands are some of the other discriminating practices followed (Bharat, 1999). The patients right to confidentiality is often seen to be breached in both public and private hospitals. It is taken casually in all hospitals. Universal practices are never in place; instead the personnel often perform irrational procedures and activities like use of gloves and AIDS kit even in non invasive procedures and activities like giving food or medicines to the patients. These practices are often not only financial burden, but also discriminatory and stigmatizing for the patient and families. About 90% of people with HIV live in developing countries and have no access to any scientifically proven treatment for the infection. Greater access to the clinics was seen to reduce the risk of hospitalization of people infected with HIV. Greater accessibility to regular and low cost medical care is significant in reducing the suffering of full blown AIDS patients.

Reasons for Discrimination
Discrimination exists because most hospitals lack adequate knowledge about HIV/AIDS and consider themselves to be at great risk of contracting the infection. No special training programmes have ever been arranged for support staff in the hospital. These feelings of anxiety and fear result in their meting out derogatory behavior to the patients. There is a sense of insecurity due to inadequate protection by the society, which generates apathy and insensitivity to the cause.

Impact of Discrimination
Discrimination experienced within the health sector can prevent people with HIV/AIDS from seeking care if they feel they will receive unwelcome reception or their confidentiality will not be respected (Malcolm et al, 1998). Furthermore, the expectation of such treatment may reduce the number of people choosing to be tested. It causes psychological distress (Hising, 2001). Effective responses to HIV/AIDS are increasingly considered in terms of prevention - to - care continuum (MacNeil & Anderson, 1998). Prevention reduces the need for future care, and care and support activities also encourage prevention by raising awareness of the disease. Care can also bring people living with HIV/AIDS to the forefront of the community prevention efforts, helping others to perceive that they could be at risk, and encouraging them to seek testing and adopt safer behaviours (MacNeil & Anderson, 1998). This cycle, however, relies on a supportive environment in which people living with HIV/AIDS feel comfortable disclosing their status and where behaviour change is viewed favorably. Stigma and discrimination hinder the creation of such a supportive environment at all stages of the cycle.

Remedial Measures for Discrimination
Hospitals are still refusing care to HIV/AIDS patients. Health personnel need to be made sensitive to the issues, given appropriate incentives, protection, education and training according to uniform standards. Regular CME programmes should be arranged.

Even a proper understanding of the mechanisms of HIV transmission does not ensure tolerance or solidarity with infected people (D’Andrea C. et al, 1994). A well-designed education programme should include training in clinical management, health education and attitudinal change towards patients (Ezedinanchi, 2002). Design of curricula and IEC material for students and new health personnel should be taken up. Ideally, health providers should have grounding in counselling, support skills, an appreciation for wider social cultural issues related to HIV and the ability to refer to a variety of psychosocial, welfare and care services (Busza, 2001).

Conclusion
The clinical arena of HIV infection and AIDS is one in which the necessity to translate the theory of respect for human rights into the practices of respect for human rights is starkly raised. The AIDS epidemic is demanding reassessing of clinical ethics, so that it is not only the product of logic and reasoning in theory but also embodiment of compassion, humanity and respect for human right in practice.

References
**Thoughts on Charity**

The charity that hesitates to proclaim its good deeds, ceases to be charity, and is only pride and ostentation.

--- William Hutton

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