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„HIV/AIDS-related discrimination in Portugal“

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Acronyms

Acronyms	Meaning
ACIDI	The High Commissioner for Immigration and Intercultural Dialogue
ACM	Alto Comissariado para as Migrações
ACP Countries	African, Caribbean and Pacific Countries
ACT	Autoridade para as Condições no Trabalho
AIDS	Acquired Immunodeficiency Syndrome
APAV	Portuguese Victim Support Association
ART	Antiretroviral Therapy
AZT	Azidothymidine
BIAS map	Behaviours from Intergroup Affect and Stereotypes' Map
CAD	Anti-Discrimination Center
CAT	Convention Against Torture and Other Cruel Inhuman or Degrading Treatment or Punishment
CAT-OP	Optional Protocol of the Convention Against Torture
CCPR	International Covenant on Civil and Political Rights
CCPR-OP2-DP	Second Optional Protocol to the International Covenant on Civil and Political Rights Aiming to the Abolition of the Death Penalty
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CERD	International Convention on the Elimination of All Forms of Racial Discrimination
CESCR	International Covenant on Economic, Social and Cultural Rights
CESCR	Committee on Economic, Social, and Cultural Rights
CICDR	Comissão para a Igualdade e Contra a Discriminação Racial
CMA	High Commissioner for Migration
CMW	International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families
CNLCS	Comissão Nacional de Luta Contra A SIDA
CPLP	Community of Portuguese-Speaking Countries
CRC	Convention on the Rights of the Child
CRC-OP-AC	Optional Protocol to the Convention on the Rights of the Child on the Involvement of Children in Armed Conflict
CRC-OP-SC	Optional Protocol to the Convention on the Rights of the Child on the Sale of Children Child Prostitution and Child Pornography
CRI	Integrated Response Centres
CRPD	Convention on the Rights of Persons with Disabilities
DGS	Directorate General of Health
EU	European Union
GAT	Portuguese Group of HIV/AIDS Treatment Activists
GNP+	Global Network of People Living with HIV
GNR	Republican National Guard
GRID	Gay-Related Immune Deficiency Syndrome
HIV	Human Immunodeficiency Virus
HRL	Human Rights Law
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICPD	International Conference on Population and Development
ICW	International Confederation of Women with HIV
ILGA	International Lesbian, Gay, Bisexual, Trans And Intersex Association
ILO	International Labor Organization

Acronyms	Meaning
IPPF	International Planned Parenthood Federation
LGBTQIA+	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual
NGO	Non-Governmental Organization
NHS	National Health Structures
NPHA	National Program for Prevention and Control of HIV/AIDS
NT	Northern Territory: Anti-Discrimination Act 1996
OHCHR	Office of the United Nations High Commissioner for Human Rights
PCB	Programme Coordinating Board
PLWH	Persons Living with HIV/AIDS
PLWHA	Persons Living with HIV/AIDS
PrEP	Pre-Exposure Prophylaxis
PSP	And Public Security Police
PUID	People Who Use Injectable Drugs
QLD	Queensland: Anti-Discrimination Act 1991
SDGs	Sustainable Development Goals
SICAD	Additive Behaviours and Dependencies
SNS	National Health System
STDs	Sexually Transmitted Diseases
TB	Tuberculosis
TRIPS	Trade-Related Aspects of Intellectual Property Rights
UNAIDS	Joint United Nations Programme On 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 Sessions
UNICEF	United Nations Children's Fund
USA	United States of America
USAID	United States Agency for International Development
WHO	The World Health Organization
WHO/GPA	WHO’s Global Program on AIDS
WTO	World Trade Organization

Table of Contents

Chapter 1. Introduction

In 1983, the first case of human immunodeficiency virus (HIV) was diagnosed in Portugal beginning the 38-year long and still ongoing fight against the HIV and the acquired immunodeficiency syndrome (AIDS) epidemic. This thesis focuses on one of the ramifications of this epidemic, the discrimination dimension. From a human rights perspective, this study aims to understand how HIV/AIDS-related discrimination evolved throughout the years. To accomplish this, a brief introduction to the link between HIV/AIDS and Human rights will be provided in chapter 5, followed by the country case study analysis in chapter 6. In this chapter, the Portuguese response will be assessed to understand how the country addressed this issue, through a Human Rights perspective. In the next chapter, chapter 7, a brief analysis of the Portuguese main victories within the international sphere, will be provided. Additionally, some examples of the country's national policies were provided to showcase an example of an adequate response in areas Portugal is struggling with.

Therefore, as a conclusion, this master's thesis aims to understand HIV/AIDS-related discrimination, using Portugal as a country case study.

1.1 Description of the problem:

In 1982, the term AIDS[1] was used for the first time by scientists. A year later, the cause of AIDS was identified as the HIV.[2] HIV infection, is most commonly found in so-called marginalized groups – drug users, people in prisons, within the lesbian, gay, bisexual, transgender, queer, intersex, asexual (LGBTQIA+) community, people of colour, and people from low social and economic status, labelled as 'key populations'[3]. The World Health Organization (WHO) defines "key populations" as:

'people in populations who are at increased HIV risk in all countries and regions. Key populations include men who have sex with men; people who use drugs;

[1] 'HIV/AIDs Timeline | NPIN' <https://npin.cdc.gov/pages/hiv-and-aids-timeline> [accessed 13 January 2021].
[2] Ibid.
[3] 'HIV/AIDS' <https://www.who.int/news-room/fact-sheets/detail/hiv-aids> [accessed 13 January 2021].

people in prisons and other closed settings; sex workers and their clients; and transgender people.'[4]

It is worth noting that the description above is a generalization and varies from region to region, where other groups might be more prone to exposure, which requires a context-based definition[5].

Hence, the definition that will be used in this Master Thesis, which focuses on Portugal, will be a combination of the WHO definition (see above) and the definition adopted by the European Union, stated in the Dublin Declaration (2004)[6], which is implemented by the Portuguese Government in its National Programmes. The combination of these two definitions will then be adapted to the sampling that this study aims to analyse. It will translate as the following:

- Key populations include LGBTQIA+; Heterosexuals; people who use injectable drugs (PUID); people in prisons; sex workers; Migrants and Undocumented Migrants; Youth and Women.[7]

Prioritising "key populations" in the HIV/AIDS response with suitable interventions is significantly impactful to combat this epidemic and protect the dignity of people living with, or vulnerable to HIV/AIDS.[8]

Often, marginalized groups experience discrimination.[9] In the case of Persons Living with HIV/AIDS (PLWHA), "a chosen lifestyle" was preconceived as the cause of HIV/AIDS contraction. This led to the moralization of the disease, starting the

[4] Ibid.
[5] UNAIDS, 'END INEQUALITIES. END AIDS.' GLOBAL AIDS STRATEGY 2021-2026, 2021, p.7, https://www.unaids.org/sites/default/files/media_asset/global-AIDS-strategy-2021-2026_en.pdf, [accessed 8 April 2021].
[6] OSCE, 'Dublin Declaration on Partnership to fight HIV/AIDS in Europe and Central Asia', 2 March 2004, p.3, https://www.osce.org/files/f/documents/b/a/29873.pdf.
[7] WHO EUROPE, UNAIDS, 'Progress on Implementing the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia', February 2004, p.87, https://www.euro.who.int/__data/assets/pdf_file/0011/53858/E92606.pdf.
[8] WHO, 2020, p.2.
[9] WHO EUROPE, 2004, p.11.

narrative that this virus was a form of punishment for actions frowned upon by society.[10]

Besides moralization, other factors that can explain the discrimination towards PLWHA, such as the age of sexual consent laws, (age 14 years)[11], criminalization of key populations, and dissemination of misinformation regarding the virus. This discrimination can manifest itself in different forms, from targeted arrest of key populations, forced sterilization or abortion, discrimination of access to health care and appropriate information.[12]

This discrimination affected the victims at all levels, particularly with the deprivation of their Human Rights (i.e., right to dignity, right to health, right to work, right to information, and right to education). The role of civil society is crucial to combat these discriminatory barriers[13].

A change came in 1996, with Antiretroviral therapy (ART), changing the discourse on how to respond to HIV, bringing a state of hope, considering prior to ART, PLWHA lived in a constant state of fear.[14] Additionally, during this year, the WHO, in coordination with other five UN agencies (United Nations Children's Fund (UNICEF), United Nations Development Programme (UNDP), United Nations Population Fund (UNFPA), United Nations Educational, Scientific and Cultural Organization (UNESCO) and the World Bank)[15] established the Joint United Nations Programme on AIDS (UNAIDS). This was a turning point in how this epidemic was perceived and

[10] Xiaobin. Cao, Sheena G. Sullivan, Jje. Xu and Zunyou. Wu, 'Understanding Hiv-Related Stigma and Discrimination in a "Blameless" Population', *AIDS Education and Prevention*, 18 June 2006, p. 519, https://search-proquest-com.uaccess.univie.ac.at/docview/198018301/fulltextPDF/335165E7BA0A4305PQ/1?accountid=14682.
[11] Portuguese Penal Code, Law no. 48/95, Article no. 171.
[12] Marijana Grandits, 'HIV/AIDS and Human Rights', *Vienna Master of Arts in Human Rights*, Postgraduate Centre, p.10.
[13] WHO Europe, 'Action plan for the health sector response to HIV in the WHO European Region', 2017, p.16, https://www.euro.who.int/__data/assets/pdf_file/0007/357478/HIV-action-plan-en.pdf, (Accessed 11 April 2021).
[14] LISBOA, 'MAIS DE 30 ANOS DE VIH EM PORTUGAL
VIH', *o vírus do preconceito e discriminação, '*OVER 30 YEARS OF HIV IN PORTUGAL'*, the prejudice and discrimination vírus, pp. 1-2, https://www.lisboa.pt/atualidade/reportagens/vih-uma-historia-que-ainda-se-escreve*, (Accessed 11 April 2021).
[15] UNAIDS, 'UNAIDS an overview', p.1, https://data.unaids.org/publications/irc-pub03/una96-2_en.pdf, (Accessed 11 April 2021).

how it should be tackled. However, misinformation about the disease was still overwhelming, and discrimination surrounding HIV persisted.[16]

In 2016, the UNAIDS Programme Coordinating Board adopted a new strategy to eradicate the AIDS epidemic as a public health threat by 2030, with the motto "Leaving no one behind".[17] The 2016–2021 UNAIDS Strategy is an urgent appeal for action, aligned with the Sustainable Development Goals (SDG's): (i.) Good health and Well-being (SDG 3); (ii.) Reduce Inequality (SDG 10); (iii.) Gender equality (SDG 5); (iv.) Peace, Justice and Strong Institutions (SDG 16); and (v.) Partnership for the Goals (SDG 17).

The "leaving no one behind" motto, present in the SDG's and in the UNAIDS 2016-2020 Strategy aims to address the HIV-related discrimination, based on the legal, medical, political, and social measures taken by each country. This allows for an analysis of the violation of human rights and gender-related barriers.[18]

The 90–90–90 treatment targets, part of the 2016–2021 Strategy aims to (i.) 90% of PLWH to know their status; (ii.), 90% of PLWH who know their status to receive treatment, special attention to children living with HIV, which often are neglected and (iii.) and 90% of people on treatment have suppressed their viral load.[19] As a result, by 2019, Portugal achieved the three sets of goals, 92,2% of PLWH knew their status, 90,2% of them were receiving ART and 93% had suppressed their viral load.[20] The goal for 2030 is to achieve 95% in all three goals.[21]

Lastly, the current situation in Portugal comes as a result of the national and international community efforts, the health service provides effective diagnosis, means for HIV prevention, treatment and care are accessible, which helps PLWH to manage

[16] Ibid.
[17] UNAIDS *'On the Fast-Track to end AIDS'* , 2016-2021 Strategy, (2015), https://www.unaids.org/sites/default/files/media_asset/20151027_UNAIDS_PCB37_15_18_EN_rev1.pdf .
[18] Ibid.
[19] Ibid.
[20] SNS, '90-90-90', News, 8 July 2019, https://www.sns.gov.pt/noticias/2019/07/08/90-90-90/, (accessed 5 April 2021).
[21] Ibid

this chronic health condition and live long healthy lives.[22] Nevertheless, despite the major scientific advances, HIV discrimination continues to be present, turning this epidemic into a vicious circle. Because it is both the cause for human rights violations as a result of discriminatory behaviour towards PLWH, and it is driven by human rights violations, as mentioned above. Given that the majority of the key populations are composed by marginalized societies, which face institutionalized discrimination, being a human right violation in itself.[23]

Therefore, the proposed thesis aims to comprehend the evolution of discrimination in Portugal between 1983 and 2020, based on an interdisciplinary approach and an intersectional analysis. The latter will be presented to better understand the different levels of discrimination. The interdisciplinary approach will entail the analysis of previous academic work from different disciplines regarding HIV/AIDS, from a Human Rights perspective. Among these disciplines, law, psychology, international relations, and sociology will be presented. The reasoning behind this interdisciplinary approach is to better understand HIV/AIDS-related discrimination, which requires an analysis at all levels: civil, economic, cultural, political, social, sexual, and reproductive rights. However, this research will primarily focus on the following human rights: (i.) right to health, which will encompass sexual and reproductive rights, (ii.) principle of non-discrimination, (iii.) right to information, (iv.) right to work, and (v.) right to private life and confidentiality.

2. Stigma and Discrimination: Concepts and Theories

This thesis analyses HIV/AIDS-related discrimination in Portugal from a human rights perspective while simultaneously drawing on concepts from the social sciences – especially from sociology and psychology. This chapter was heavily influenced by the following authors: Miriam Maluwa, Peter Aggleton, and Richard Parker. Their interpretation of HIV/AIDS-related discrimination provided me with new social concepts necessary for the analysis of PLWH human rights. Additionally, social

[22] Ibid.
[23] International Covenant on Civil and Political Rights (adopted 16 December 1966, entered into force 23 March 1976) 999 UNTS 171, Article 26.

philosopher Pierre Bourdieu had an impactful contribution, as it helped me understand and instrumentalize the concept of stigma and discrimination.

Therefore, this chapter first provides the concept of stigma and discrimination with the relevant theories and secondly relates it to HIV/AIDS.

2.1. Stigma and Discrimination:

In this subchapter, the concept of stigma and discrimination will be explored and operationalized.

Stigma and discrimination often get confused or perceived as the same concept. However, stigma and discrimination are simultaneously distinct concepts and complement each other. Frequently, stigma can be the abstract idea that later develops into discrimination.[24]

To better understand stigma and discrimination, more in particular HIV/AIDS-related stigma and discrimination, a multidisciplinary approach is needed to understand the complexity of this issue. Therefore, as said above, disciplines such as sociology, social psychology, law, human rights, will be used throughout this study. This will be used not only to enrich this study but also to provide a better understanding of gaps between theory and practice.

Sociologist Erving Goffman argued that stigma is conceptualized by society, based on the idea of "different" or "deviant", which is then applied by society in the form of rules and sanctions, creating this way, as Goffman described a "spoiled identity".[25] In other words, stigma is a negative attribute projected onto people who are devalued by society due to being different.[26] However, looking at Goffman's understanding stigma as a static attitude instead of an ever-changing one, often due to resistance, limits one approach to stigma and discrimination.[27]

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[24] Richard Parker and Peter Aggleton, 'HIV and AIDS-Related Stigma and Discrimination: A Conceptual Framework and Implications for Action', *Social Science & Medicine*, vol. 57. no.1, 2003, p.14, (accessed on 13 April 2021).
[25] E. Goffman, 'Stigma: Notes on the management of a spoiled identity', *Simon & Schuster*, New York, 1963, cited in Parker and Aggleton, p.14.
[26] Parker and Aggleton, p.14.
[27] Ibid.

A stigmatized person is commonly considered shameful or deviant, which consequentially leads this person to be shunned, avoided, rejected, restrained, discredited, or penalized. So, stigma is the expression of social and cultural norms, which shape the relationships among people, setting boundaries that society deems as "normal" and "outsiders", or the "us vs. them".[28]

For further definition on what it means stigmatized, sociologist Alonzo and Reynolds stated that the "the stigmatized" is

a category of people who are pejoratively regarded by the broader society and who are devalued, shunned or otherwise lessened in their life chances and access to the humanizing benefits of free and unfettered social intercourse.[29]

Therefore, stigma is a powerful discrediting social label that drastically shapes how an individual perceives oneself and others.[30] In other words, stigma can be seen as the perception, and discrimination consequentially as the action.

Nonetheless, the meaning of discrimination might seem obvious for most of us, due to how commonly the term used in our day-to-day life.[31] Usually, when one tries to understand discrimination, it is to seek out patterns to recognize when it is more likely to occur, allowing this way the possibility to design a more effective action to overcome it.[32]

However, discrimination has been characterized by cross-cultural diversity and complexity, imposing this way one of the biggest challenges, and limiting our understanding of this phenomenon. This highlights the importance of questioning if this

[28] Theodore De Bruyn, et al., 'HIV/AIDS and Discrimination: A Discussion Paper', *Montréal: Canadian HIV-AIDS Legal Network*, 1998, p. 33.
[29] AA Alonzo, NR Reynolds, 'Stigma, HIV and AIDS: An Exploration and Elaboration of a Stigma Trajectory', *Social Science and Medicine*, vol.41, no.3, 1995, p.304, (accessed on 15 April 2021).
[30] Bruyn, et al., p. 33.
[31] Parker and Aggleton, p.14.
[32] Ananthi Al Ramiah, Miles Hewstone, John F. Dovidio, et. al., 'The Social Psychology of Discrimination: Theory, Measurement and Consequences', *Making Equality Count: Irish and International Research Measuring Equality and Discrimination*, 2010, p.84, (accessed on 15 April 2021).

posing obstacle is solely based on the inherent complexity or if it is due to the simplicity of existing conceptual frameworks.[33]

According to the Oxford Dictionary of Sociology,

This concept (discrimination)—which in common usage means simply "treating unfairly"—occurs most commonly in sociology in the context of theories of ethnic and race relations. Early sociologists (…) viewed discrimination as an expression of ethnocentrism—in other words, a cultural phenomenon of "dislike of the unlike".[34]

Furthermore, discrimination is defined by social psychologist Joshua Correll as,

behaviour directed towards category members that are consequential for their outcomes and that is directed towards them, not because of any particular deservingness or reciprocity, but simply because they happen to be members of that category.[35]

In this definition, the notion of deservingness plays a crucial role. Perpetrators believe their behaviours can be justified by the deservingness of the victims. This criterion, even though not objectively defined, has roots in inequality and societal norms, both historically and nowadays[36] (2021). Looking at the HIV/AIDS context, the notion of "deservingness" plays a crucial role, as it explains the moralization behind this virus.

Social philosopher Pierre Bourdieu aimed to analyse social systems of hierarchy and the perseverance of domination and how it reproduces over time without meeting strong resistance and often without conscious recognition from the ones who are subject to said domination.[37] This entails that social distinctions in society (i.e., among individuals, groups and institutions) are enhanced by cultural practices and meanings that embody the interests of the dominant part.[38] Therefore, power plays a crucial part in social life and is often used to affirm and legitimize the social structure, i.e., inequalities

[33] Parker and Aggleton, p.16.
[34] Marshall, G., 'Oxford dictionary of sociology', *Oxford and New York: Oxford University Press*, 1998., cited in Parker and Aggleton, p.16, (accessed on 13 April 2021).
[35] Correll et al., 2010, p. 46, cited in Ramiah and Hewstone, p. 85.
[36] Ramiah and Hewstone, p. 85.
[37] Bourdieu and Passeron, 1977, cited in Parker and Aggleton, p.18.
[38] Parker and Aggleton, p.18.

of status.[39] For Bourdieu, cultural socialization leads to competition for status or other valued resources according to society.[40] Thus explaining the actions of social actors who fight for strategies aimed at achieving their specific interests.[41]

This is important in the context of HIV/AIDS, as it helps understand the vulnerabilities of the key populations that are not exclusive to HIV/AIDS. It can also explain the moralization behind this epidemic. Since human beings tend to rationalize social aspects to legitimize their position, it is only natural to believe that this virus is a consequence of an action frowned upon by society. This not only legitimizes the discrimination and stigma towards PLWHA but also provides a false sense of safety, for example, if I am not a sex worker, I can not have HIV/AIDS. However, this justification is based on ignorance and misinformation that lasted decades. The reasoning for the long-lasting effect of these beliefs can be based on Bourdieu theory of maintaining the status quo that feeds this discrimination.

Within the concept of discrimination, two different kinds can be identified, direct and subtle, unconscious, or automatic. These different forms can manifest in a verbal and/or non-verbal hostility, as stated by Darley and Fazio[42], avoidance of contact, mention by Pettigrew and Tropp[43], aggressive approach behaviours by Cuddy[44], and refusal of access to opportunities, and overall equal treatment, as explained by Bobo[45].

Based on these two forms of discrimination, another theory that would help better understand discrimination would be the Social Identity Perspective by Tajfel and Turner[46], which focus on analysing basic, general processes that generate intergroup discrimination. It defines two different groups – the ingroup and the outgroup. The first is motivated to protect their self-esteem and achieve a positive and distinctive social identity. This can lead to discrimination of the latter group, which can be expressed by

[39] Ibid.
[40] Ibid.
[41] Ibid.
[42] Darley and Fazio, 1980, cited in Ramiah and Hewstone, p. 85.
[43] Pettigrew and Tropp, 2006, cited in Ramiah and Hewstone, p. 85.
[44] Cuddy et al., 2007, cited in Ramiah and Hewstone, p. 85.
[45] Bobo, 2001, cited in Ramiah and Hewstone, p. 85.
[46] Tajfel and Turner, 1979, cited in Ramiah and Hewstone, p. 86.

direct harm or by giving preferential treatment to the ingroup, also known as ingroup bias, proving, this way, a human tendency to discriminate.[47]

Still considering the two different forms of discrimination, the Behaviours from Intergroup Affect and Stereotypes' map (BIAS map) by Cuddy[48] provides insight into the specific ways that discrimination is targeted against members of a particular type of group (focussing on the notion of stereotype). It proceeds to explain that due to the status and competitiveness, it leads to stereotypical content attributed to the outgroup containing a mixture of competence, which predicts more passive tendencies, and warmth attributes, more impactful in social encounters as it predicts active behavioural tendencies.[49] The negative active and passive behaviours lead to discrimination, ranging from subtle to direct.[50]

Another important theory is the System Justification Theory[51], which helps explain why discrimination and inequality are tolerated and perpetuated.[52] This theory differentiates two groups – Low-Status groups and High-Status groups – according to how they are placed in society. It also refers to two very important concepts, "ego justification", referring to the positive distinctiveness, and "group justification", referring to the phenomena that, independently of it being a positive or negative distinction, the group believes the system is just and fair.[53] This acceptance is justified, in the case of the High-Status group, because it is perceived as a reward for their worthiness leading to the ingroup bias, as mentioned above. However, in the case of the Low-Status Group, it is perceived as a deserving punishment due to their internalized sense of personal or collective inferiority (internalized), which can lead to outgroup bias. The outgroup bias translates into the belief that the outgroup is superior and, therefore, ought to be privileged.[54]

[47] Ramiah and Hewstone, p. 86.
[48] Cuddy, et al., 2007, cited in Ramiah and Hewstone, p. 87.
[49] Ramiah and Hewstone, p. 88.
[50] Ibid, p. 87.
[51] Jost et al., 2001, p. 367, cited in Ramiah and Hewstone, p. 90.
[52] Ramiah and Hewstone, pp. 90-91.
[53] Ibid, p. 90.
[54] Ibid.

Symbolic violence is originally a Bourdieu concept, and it is noteworthy when talking about discrimination. It is the process whereby symbolic systems (i.e., images, practices, and words) encourages the dominant group's interest, establish distinction and hierarchies, and legitimizes it through the process of hegemony, convincing the dominated group to accept it. Hegemony is different from "rule", as the latter is based on direct coercion, whereas the first is achieved via a complex interlinking of social, cultural, and political forces, which creates the dominant meanings and values across the social spectrum.[55]

Moreover, Castells[56], differentiated between "legitimizing identities", presented by the dominant institutions of society, and "resistance identities", produced by the dominated group, when they build a new identity that redefines their position in society, transforming this way the social structure.[57]

Therefore, it is possible to affirm that discrimination is not merely about the difference but also in about to social and structural inequalities. It is part of a complex struggle for power that defines social life and is fabricated by concrete and identifiable social actors aiming to legitimize their dominant status within an unequal society.[58]

As stigma and discrimination are complex and culturally diverse, a couple of theories were provided, as shown below in table 1.

[55] Parker and Aggleton, p.18.
[56] Castells, 1997, cited in Parker and Aggleton, p.19.
[57] Parker and Aggleton, p.19.
[58] Ibid, p.22.

Table 1. Authors, Theories and Social Concepts:

Author	Theory	Social Concepts
Erving Goffman	Stigma is conceptualized by society	"spoiled identity"
Correll	-	Deservingness
Pierre Bourdieu	Social systems of hierarchy, cultural socialization, and power relations	Symbolic violence
Tajfel and Turner	Social Identity Perspective	Ingroup / Outgroup
Cuddy	BIAS Map	Stereotype
Jost and Banaji	System Justification Theory	Low status / High status; Ego justification / Group justification
Castells	-	Legitimizing Identities/ Resistance Identities.

Source: compiled by Sara da Silva Oliveira (2021).

In conclusion, stigma is the perception, and discrimination is the action to that perception. Our understanding of stigma and discrimination as a social process is important to better understand the relation of power and domination. This explains not only why stigma and discrimination exist but also why this behaviour persists over time.

2.2. The excluded ones: HIV/AIDS-related stigma and discrimination

In this subchapter, I will focus on stigma and discrimination related to HIV/AIDS. It is highly important to understand stigma and discrimination by itself, to then analyse the special relationship it has to HIV/AIDS, so better interventions to minimize and eradicate this behaviour can be implemented, and so good practices can be reproduced, taking into consideration each context.

As is the case with most life change events that alter the course of how our society is, a health crisis such as the HIV/AIDS[59] epidemic and more recently COVID-19 pandemic (2020- ongoing) brings out the best and the worst in humanity. According to Maluwa, Aggleton, and Parker, the best refers to the solidarity, people coming together to support and to reform the government, community, and overall individual

[59] HIV and AIDS will be written, throughout this thesis as "HIV/AIDS", to provide more reader-friendly text and in name of practicality.

denial.[60] The worst is in reference to the stigma and discrimination done by perpetrators against the ones who fall victims to this behaviour as well as the institutional discrimination.[61]

On December 20th 1987, at the informal briefing on AIDS, 42nd session of the United Nations General Assembly, in New York[62], Jonathan Mann (the founding Director of the World Health Organization's former Global Programme on AIDS)[63] gave a very impactful speech. He started by addressing the scientific advances for the past 6 years regarding HIV/AIDS (from 1981-1987) and the important role of access to information.[64] It is noteworthy that he mentions the role of schools and workplaces to diffuse adequate information. He then introduced a new conceptualization that became widely accepted: the three phases of the AIDS epidemic in any community.[65] The first phase consisted of the epidemic of HIV infection. The second phase, the AIDS epidemic. The third phase, the epidemic of social, cultural, economic and political responses to AIDS.[66] This thesis will focus on the third phase, described by Jonathan Mann as potentially the most explosive one, due to the alarmingly high levels of stigma, discrimination, and collective denial to acknowledge the third phase as a central aspect to combat this health crisis.[67] He proceeded to give examples of the challenges this third phase imposes, such as economic, given the rise in infant mortality, cancelling out the projected gains, and the fact that it affects people who are age-productive[68],[69]. The threat to free movement, compromising free travel between countries, open international communication, and exchange. He also added that the lack of information leads to a

[60] Miriam Maluwa, Peter Aggleton, and Richard Parker, 'HIV- and AIDS-Related Stigma, Discrimination, and Human Rights: A Critical Overview', *Health and Human Rights*, vol. 6, no. 1, 2002, p.1 (accessed on 15 April 2021).
[61] Ibid.
[62] Mann, J. (1987). Statement at an informal briefing on AIDS to the 42nd session of the United Nations General Assembly, New York, 20 October.
[63] Parker and Aggleton, p.13.
[64] Mann.
[65] Parker and Aggleton, p.13.
[66] Ibid.
[67] Ibid.
[68] Group of people who are at the age they can legally have a productive work life. This varies from country to country. In Portugal, the minimum legal age is 16 years old.
[69] Assembleia da República, Código de Trabalho, Lei n.º 7, artigo 68º, 2009, https://dre.pt/legislacao-consolidada/-/lc/75194475/201608230300/73439812/diploma/indice.

state of fear and anxiety. This resulted in a divided society that placed blame and morals on the disease, revealing deep-rooted prejudices.[70]

This contributed to the debate on how we should treat PLWHA. Mann argued that not including PLWH in society would pose a risk to everyone and that there is no logical reason to exclude them.[71] He continues to explain that how a person interacts with PLWH determines this person fundamental values and the success or failure of HIV/AIDS strategies. With this message of realism and tolerance,[72] he appeals to the international community to design adequate national strategies as this issue transcends borders.[73]

In Mann's discourse, when he addresses sexual human behaviour, he mentions sexual encounters that lead to the spread of the virus only concerning, from men and women, from women to men, and from men to men, neglecting to explore transmission from women to women, due to lack of data. This thesis will also focus on this selected group of sexual encounters for the same reason. It is also important to bear in mind that when Mann made this speech, by "men" and "women", he was referring to sex and not to the gender identity of the individual.

In 1988, Gregory Herek and Eric Glunt described the public reaction to HIV/AIDS in the context of the United States of America (USA) as an "epidemic of stigma."[74] Moreover, Cindy Patton[75] made an interesting remark regarding stigma. She stated that HIV/AIDS exposes people to their three primitive anxieties. The first one being the fear of germs and disease, the second one being the fear of death and own mortality, and the third being the deep-rooted worries concerning sexuality and sex.[76] The third is related to the fact that with HIV/AIDS, unprotected sexual encounters are

[70] Mann.
[71] Ibid.
[72] I personally dislike the term tolerance as it can have a negative connotation. I would recommend using the word "appreciation" when talking about accepting others we perceive to be different from us (us vs. them). Nevertheless, the term is written here to maintain Mann's words.
[73] Mann.
[74] G. Herek, E. Glunt., 'An Epidemic of Stigma: Public Reactions to AIDS.', *American Psychologist,* vol.43, no.11, 1988, pp. 886-891.
[75] S. Sontag, 'AIDS and its Metaphors', New York: Farrar, Straus and Giroux, 1988, cited in Miriam Maluwa, Peter Aggleton, and Richard Parker, p.3.
[76] Maluwa, Aggleton, and Parker, p.3.

one of the virus vessels of contamination, and in some countries was most prominent among men who have sex with men.

Stigma related to HIV/AIDS, but not exclusive to, can be differentiated into "felt" and "enacted" stigma.[77] The first one refers to the shame associated with the illness and the fear of being discriminated against based on the illness, the latter refers to actual experiences of discrimination.[78]

With that being said, HIV/AIDS-related stigma builds on prior prejudices, which can be an explanation as to why there is this cloud of moralization surrounding the disease. PLWH are considered responsible for the disease.[79] Moreover, the notion of right and wrong, correct or incorrect, are the beliefs that feed and drive HIV/AIDS-related stigma and can be extended to those who are perceived to be associated with the epidemic in any way. For example, if a PLWH had a sexual encounter with a sex worker, and this person identifies as male, then this disease comes as a punishment for engaging in illicit activities[80], however, if you identify as a woman, you would be considered promiscuous[81], and therefore deserving of the virus. In some Western countries, HIV/AIDS was perceived as a "junkie"[82] issue, so already degrading and projecting their morals onto PUID, and it was also perceived as the "gay plague"[83], using this health crisis as a vessel for homophobia. Most literature addresses the complexity of discrimination related to HIV/AIDS due to the rich diversity in cultural settings, which consequently makes it difficult to effectively design an adequate response.[84] This is stated in a 2000 USAID[85] Concept Paper that the apparent universality of HIV/AIDS-related discrimination is not transferable to the context due to

[77] Bruyn, et al., p. 34.
[78] Ibid, p. 33.
[79] Ibid.
[80] Maluwa, Aggleton, and Parker, p.5.
[81] Ibid.
[82] Ibid.
[83] Ibid.
[84] Parker and Aggleton, p.14.
[85] United States Agency for International Development.

its complexity and diversity.[86] Therefore, it is crucial to have an informative and context-based action.

Despite the diversity of perceptions around the world, they all reveal a pattern of stigma and discrimination prior to HIV/AIDS that the virus just helped reinforce. In each society, the ones who were already marginalized, stigmatized and discriminated against became the ones at the highest risk of contracting the HIV infection.[87] These existing social inequalities include but are not exclusive to, the ones who believe men are superior to women, the ones who refuse to see sex workers as right-holders, look down on PUID, and who discriminate based on nationality, ethnicity and sexual orientation and behaviour.[88] This translates into the power and domination relation in each community,[89] as explained more in-depth in the previous subchapter. This became so clear that in France, HIV/AIDS was referred to as a problem of "les exclus"[90], which translate into "the excluded ones". This shows a clear picture of the exclusion from society, a sense of not belonging and overall an intense feeling of loneliness felt by PLWHA. Thus HIV/AIDS made people who were already excluded from society even more vulnerable.

As addressed by Mann and Tarantola[91], vulnerability should be considered on three interdependent levels. Firstly, the personal level would focus on the environment and impactful factors on personal development. Secondly, program level, which demands close attention to the contribution of HIV/AIDS programs, if these are reducing or incising personal vulnerability. Thirdly, the societal level concentrating on the contextual factors that impact both personal and programmatic vulnerabilities.[92] Hence, HIV/AIDS-related stigma and discrimination overlaps vulnerabilities, therefore,

[86] USAID, 'USAID concept paper: Combating HIV/AIDS stigma, discrimination and denial: what way forward?', Unpublished paper, 23 June 2000, cited in Parker and Aggleton, p.14.
[87] Bruyn, et al., p. 21.
[88] Maluwa, Aggleton, and Parker, p.5.
[89] Ibid.
[90] Bruyn, et al., p. 21.
[91] J. Mann, D. Tarantola, et als, 'AIDS in the World II: Global Dimensions, Social Roots, and Responses', *New York: Oxford University Press,* 1996, p. 441.
[92] Bruyn, et al., p. 39.

an intersectional approach is needed. The groups that are perceived as more vulnerable to the infection are called key populations.

For an official definition, HIV/AIDS-related discrimination according to UNAIDS is

the unfair and unjust treatment of an individual based on his or her real or perceived HIV status. Discrimination breach fundamental human rights and can occur at a number of different levels including political, economic, social, psychological and institutional.[93]

When talking about stigma and discrimination related to HIV/AIDS, it usually translates into actions or inaction that are harmful or that deny a person services, goods, and entitlements.[94] This not only violates the human rights of PLWHA, but it also transcends to the family[95], if they remained in the person's life after the HIV status was revealed. This form of discrimination should not be expected only from individuals, communities, and families but as well as from governments, private organizations and institutions.[96]

HIV/AIDS-related stigma and discrimination produces and reproduces relations of power and control[97]. This power-control relation gives the "dominant group", as explained in the previous chapter, a sense of superiority and as a reaction, it devalues the "dominated group", which are left with a sense of inferiority.[98] Therefore, HIV/AIDS-related stigma and discrimination can not be reduced to one characteristic (HIV status), but poverty, racism, sexism, homophobia, for example, need to be considered. This entails that, in order to provide comprehensive protection of the rights of PLWH, it must also integrate measures to prevent discrimination on grounds that can be closely related to HIV infection. For example, discrimination based on sexual orientation, race, mental or physical disability, sex workers, PUID, and even children.[99]

[93] UNAIDS, 'Stigma and Discrimination', *Fact Sheet*, December 2003, p.1, (accessed on 14 April 2021).
[94] Maluwa, Aggleton, and Parker, p.5.
[95] Ibid, p.6.
[96] Ibid.
[97] UNAIDS, 'Stigma and Discrimination', *Fact Sheet*, December 2003, p.1, (accessed on 14 April 2021).
[98] Ibid.
[99] Bruyn, et al., p. 21.

Therefore, it is important to understand how HIV/AIDS-related stigma and discrimination are closely linked to other forms of discrimination, due to social inequalities (intersectionality)[100], which, in due course, creates and strengthens the different forms of discrimination, based on diverse characteristics, or in other words, it originates this synergistic relationship between multiple forms of inequalities.[101]

In summary, Jonathan Mann's interpretation of HIV/AIDS was presented. From the three phases, the third was the one I focused on. Additionally, Cindy Patton interpretation of HIV/AIDS-related stigma was also provided, showcasing the three primary human anxieties that leads to this phenomenon. Lastly, regarding vulnerabilities, I based myself on the authors Tarantola and Mann, introducing the concept of intersectionality as well.

Therefore, to properly address HIV/AIDS-related stigma and discrimination, we must frame our understanding of stigma and discrimination as a social process in relation to broader notions of power and domination.[102] Stigma produces and reproduces this relation of power and control, which sacrifices some groups of society by devaluing them in order for the other to keep its status of superiority, being this way linked with social inequality.[103] It is required to understand how individuals and groups come to be socially excluded and what are the forces that are creating and reinforcing this exclusion.[104] However, emphasis on community mobilization, leading to resistance to stigma and discrimination, and structural interventions with a human rights approach need to be the priority. This will allow creating a social climate in which stigmatization and discrimination themselves will no longer be accepted.[105] Addressing stigma and discrimination also entails leadership accountability and responsibility, advocacy and

[100] (According to the Oxford Dictionary) Intersectionality, n. - The interconnected nature of social categorizations such as race, class, and gender, regarded as creating overlapping and interdependent systems of discrimination or disadvantage; a theoretical approach based on such a premise.
[101] Maluwa, Aggleton, and Parker, p.1.
[102] Parker and Aggleton, p.13.
[103] Ibid.
[104] Ibid.
[105] Ibid.

respect for human rights.[106] It is then clearly established that HIV/AIDS discrimination is a violation of human rights, which will be further explored in the next sub-chapter.

2.3. Conclusion:

This concepts and theories are useful as it provides the necessary tools to understand HIV/AIDS-related stigma and discrimination. When analysing the country case study, Portugal's response to HIV/AIDS-related stigma and discrimination can be assessed from not only a legal and human rights perspective but also with a solid foundation of sociological theories to support this analysis. Furthermore, it contextualizes these concepts, as seen above, showing theory and practice and revealing gaps. Thus, the importance of a multidisciplinary and intersectional approach is an attempt to understand these gaps.

Finally, it first suggests that human rights are not enjoyed equally by PLWHA and the rest of society. Secondly, it provides concepts such as vulnerability, symbolic violence which give insight into the reasons for this inequality. This helps to comprehend the concept of key populations. Thirdly, it separates discrimination from the individual level, and the structural level. Thus, when analysing Portugal's case provides the basis for more critical thinking, as even discrimination at the personal level can be, to some extent, shaped by the State.

Therefore, this chapter provides a great starting point, with the necessary tools to answer both my research question and my sub-questions.

Chapter 3. Research Methodology:

3.1. Research question and sub-questions

For this Master Thesis, the following research question was developed:

Research question: How has HIV-related discrimination changed in Portugal, as seen from a Human Rights perspective?

In order to investigate the complexity of the issues inherent to the research question, two sub-questions were formulated:

[106] Ibid.

Sub-Research questions:

1- How has HIV-related discrimination changed from 1983-2020 in Portugal?

At first, it was important to understand how discrimination was felt at the beginning of the epidemic and throughout time, in order to understand which human rights violations were happening. This then helped to better tailor an adequate response based on this data.

2- What is the influence of international and national actors in combating HIV-related discrimination in Portugal?

In order to better comprehend the HIV/AIDS-related discrimination, it was important to identify the main national and international influential actors and their possible interaction in the fight against HIV/AIDS-related discrimination in Portugal.

3.2. Research design

This Master's thesis employs a qualitative approach, due to my intention of focusing my research design on the narratives throughout time regarding HIV/AIDS-related discrimination. The research design employed was a country case study that focused on HIV-related discrimination in Portugal[107].

The country case study presented was a 'critical case' according to Alan Bryman:

the researcher has a well-developed theory, and a case is chosen on the grounds that it will allow a better understanding of the circumstances in which the hypothesis will and will not hold.[108]

This case study also included a longitudinal element, as it aimed to analyse the different forms of HIV/AIDS-related discrimination throughout time, along with a critical analysis of the Portuguese case.

The Portuguese case study was chosen on the grounds of three personal reasons. Firstly, I am Portuguese, therefore, I had a particular interest in studying the context of

[107] This Master Thesis analysed the time period between 1983-2020. 1983 was the first diagnosed case in Portugal, determining this way the starting point of the time period for this study.
[108] A. Bryman, Social Research Methods, 2012, Oxford University Press, New York, p.70.

this country. Secondly, I have a deep interest in understanding the intersectionality dimension of discrimination, and HIV/AIDS-related discrimination was a great example of how different forms of discrimination intertwine and enhance each other. The last reason is due to the world's current living scenario of a global Health Crisis (COVID-19 pandemic) and me realising the need for a strong human rights-based response. This inspired me to explore how was and still is the case with HIV/AIDS, an epidemic that has been going on for the last 38 years. I also wanted to understand to which extent discrimination is delaying the final goal of eradication, in the particular case of Portugal.

3.3. Data Collection

Regarding data collection, both primary and secondary data were collected for the analysis. A table with the data sources was also developed (see Annex A).

Secondary data included insights from existing literature and meaningful academic work on the topic (articles, books), official reports both at the national level (i.e., government and non-governmental organizations (NGO)) and international level (UNAIDS, UNFPA, IAS, WHO, EU, among others), national legislation, international treaties, international, regional, and national conferences. All this data was searched through e-platforms, namely, University of Vienna Library, Minho University library, and Google Scholar. After being familiarized with the topic, the relevant data for this study were selected. This collection of data was used to explain and analyse the Portuguese study case and identify gaps in knowledge, which were addressed with this research.

Following this, it became clear that primary data collection was necessary in order to fully understand the complexity of this issue, by further exploring the context-based particularities and the structural aspects of HIV/AIDS-related discrimination in Portugal. For primary data collection, semi-structured interviews were conducted with different actors relevant to the fight against HIV/AIDS-related discrimination and selected with the intention to fill in the gaps in existing knowledge. The semi-structured approach was adopted to allow room for further exploration of topics, deemed important according to the interviewee while ensuring that the core of the questions was

addressed. Additionally, to provide an insight on areas or events of central importance to this study. It is noteworthy that questions were developed prior to the interviews, to ensure that the information gathered during interviews would be optimally useful to answer my research questions. These questions varied according to the interviewee, to optimize the information gathered during the interview. A table with the pre-defined interview questions was created (see Annex B).

Regarding sampling, the selection process of the interviewees was based on a generic purposive sampling process (non-random selection of participants according to the research question)[109], in combination with snowball sampling approach (a purposive sampling where existing participants recruit future interviewees)[110]. For this sampling group, the following were selected: representatives of national NGOs, academic experts, health practitioners that work directly with HIV/AIDS, and PLWH, who would be willing to share their stories. The contact was established through the connection of NGOs and other channels established prior to this research.

To ensure ethical research, when designing the interview informed consent forms, considering the sensitivity of the topic, the interviewees had two special clauses: an opt-out option, where the individual can withdraw his/her/their consent at any time of the research period, and an option for full anonymity. Additionally, all empirical data collection for this research was documented and safely stored in my one-drive account in the name of transparency and accuracy.

Regarding the informed consent forms, I based myself on the template form from the University of Edinburgh[111] and used the Alan Bryman, Social Research methods[112] for further support. Then I tailored it to the specific needs of my study, as mentioned above, and special clauses were added. For the English version, please see Annex C.

Between May and June 2021, eight organizations, two of them being state organizations, and six being NGOs, were contacted via email. A formal invitation was

[109] Bryman, pp. 422-424.
[110] Bryman, p. 424.
[111] Available here: https://www.ed.ac.uk/files/imports/fileManager/Interview_Consent_Form.pdf.
[112] Bryman, pp. 140-142.

sent together with the informed consent form. However, I only had two positive responses, one from a State organization and another from an NGO. Additionally, one health practitioner, an expert in the field of HIV/AIDS was also contacted through channels established prior to this study and positively responded. Therefore, one interview with members and experts from the Centre for Antidiscrimination (CAD), at the end of June, was conducted, another one at the beginning of July with the health practitioner, who choose to remain anonymous, and later, also in July, an interview with a representative from the National Programme for HIV/AIDS was conducted.

Due to COVID-19, all interviews were conducted via Zoom and Skype. The language used during the interviews was Portuguese.

3.4. Data processing

All the conducted interviews were recorded and stored in my one-drive account. An initial transcript was done with the support of a transcription software named Sonix[113]. Later on, this transcript was revised by me to ensure accuracy. As all interviews were conducted in Portuguese, the transcripts were then translated by me, from Portuguese to English.

3.5. Method of data analysis

Qualitative data analysis was implemented. All generated data, both primary and secondary data, were codified and underwent a thematic analysis, in order to identify patterns. This was implemented by considering PLWH as the independent variable, which will then be confronted with the following dependent variables: time period, and conditional characteristics (using an intersectional approach when analysing key populations), which would result in the human rights analysis of the output (identify human right violations and prioritization of human rights, according to the variables). In order words, the data was separated by time, and a colour scheme was used to differentiate between the different groups within the key populations. Later on, this data was analysed from a human rights perspective.

[113] 'Converta automaticamente áudio e vídeo em texto: Rápido, preciso e acessível', *Sonix* <https://sonix.ai/pt> [accessed 18 June 2021].

Additionally, I resorted to the mental exercise of mind-mapping, as it helped me to further understand how to analyse, identify gaps and puzzle the data together, in a fluent and cohesive manner. This also assisted me to identify the link between the generated concepts, and human rights, facilitating this way my output, of a human rights analysis, throughout the following chapters.

3.6. Research Experience

The research experience was in a nutshell, both demanding and fulfilling. As expected, there were several unforeseen challenges, which demanded adjustments to the original plan.

The first challenge I faced and was continuous throughout the entire experience was the management of time. This aspect was particularly hard, as between April-June I was working a full-time job in the field of human rights. This led to a severe delay and quick adjustments during my writing process, from the data collection to analysis to the writing. Additionally, the interview process was also quite challenging concerning time management, as many responses came late, and some of the interviewees did not have much flexibility of schedule due to their workload, which led to negotiations and push back.

Nevertheless, still, on the issue of interviews, another challenge was faced, leading to an adjustment of the original plan. Initially, there was the intention to interview a PLWH or a person affected by it, however, this was not possible. Regarding the sensitivity of the topic, no one was willing to share their story, which can also be assumed as a testimony in itself of how bad discrimination is still felt nowadays, and how cautious PLWH are about sharing their stories.

Another challenge faced was the management of content. The requirements for this Master's Thesis are 80-100 pages of content. Even though I narrowed the topic of my thesis, during the proposal stage as much as possible, during the writing process I struggled to provide all the key information to adequately respond to my research question, while respecting the page count. This challenge led to several changes to the initial plan content, as the topic of HIV/AIDS-related discrimination is a highly

complex topic that requires several perspectives, not only from different disciplines but also from different actors (i.e., NGOs, State actors, individual experiences). Therefore, I found the requirements of page count did pose a limitation to this research, however, and looking more positively, it also helped me to be concise, which provided a more reader-friendly text.

The last challenge I would like to mention was the COVID-19 pandemic. This had an impact on my interviews, which were initially planned to be conducted in person, but due to COVID-19 restrictions had to be online. However, this was beneficial for me, as it allowed more flexibility for scheduling, which as mentioned above was at times tricky. Another positive effect was it reduced the cost of this Master's Thesis. Unfortunately, no grant was provided for the writing of this thesis, and given that I was located in Vienna, I would have to support the travelling cost of not only from Vienna-Portugal but from my hometown, which is in the North of the country, to Lisbon, alongside the accommodation costs.

COVID-19 also had another beneficial outcome, as according to the restrictions imposed in Vienna, I had to work remotely, which saved me the time of the commute, which was then used to focus on my thesis.

However, as one can imagine, even though I have been trying to present the positive aspect of this pandemic, I must recognize the devastating factor it is having on the world and also on my personal life. It added a new layer of stress to an already stressful situation, which impacted my writing process, both at the motivational level and creativity-wise. I found it hard to keep my motivation with restrictive free movement, due to COVID-19 safety measures. My creativity also dropped as a consequence of being inside my home, for the majority of my time, since the beginning of the pandemic.

Nevertheless, I deeply enjoyed working on this project, as it fulfilled my main personal goals, which were to better understand why discrimination happens, why it happens on the grounds of illness, in particular HIV/AIDS, and to demystify some pre-

ideas I had about my county. I am therefore grateful for how this experience has shaped my process and findings.

4. All Human Rights for All Human Beings: HIV/AIDS-related discrimination

The following chapter, as it can be read from the title, 'All Human Rights for All', was inspired by the title of the Vienna Manual on Human Rights[114]. This study will now show the findings regarding how human rights integrated the response to the HIV/AIDS epidemic, namely in the context of HIV/AIDS-related discrimination. Starting with Jonathan Mann's contribution, followed by human rights in the context of HIV/AIDS, and the importance of considering Social and economic factors when designing a response. It will finish with the implications for the States of applying a human rights approach.

Human rights are defined by the Office of the United Nations High Commissioner for Human Rights (OHCHR) as universal and inalienable rights that are inherent to all human beings and indivisible and interdependent, regardless of nationality, sex, ethnic origin, colour, religion, language, or any other status, ranging from the right to life to right to education, work health and freedom.[115] There is an intimate connection between HIV/AIDS-related stigma and discrimination, and human rights. Stigma can often lead people to do, or not do something that denies access to services or goods for another person, i.e., terminate a person's employment on the grounds of their HIV status, which is in fact an act of discrimination, given that a distinction was made against a person, and consequently, this person was treated unfairly and unjustly.[116] Hence, HIV/AIDS-related stigma and discrimination must be tackled as a human rights issue.

4.1. Jonathan Mann main contribution

Jonathan Mann recognized the international human rights law (HRL) as a comprehensive framework, where public health practitioners could rely on

[114] 'Research Centre Human Rights » All Human Rights for All' <https://human-rights.univie.ac.at/en/publikationen2/allhumanrightsforall/> [accessed 24 July 2021].
[115] 'OHCHR | What Are Human Rights' <https://www.ohchr.org/en/issues/pages/whatarehumanrights.aspx> [accessed 15 July 2021].
[116] UNAIDS, https://data.unaids.org/publications/fact-sheets03/fs_stigma_discrimination_en.pdf

responsibility when addressing the causes of HIV/AIDS threats to health and trauma.[117] This rights-based approach to public health, in particular to HIV/AIDS, provides additional tools to encourage the government to act towards achieving its public health goals, and to identifying failures of public health programs, so these can be tailored more efficiently.[118] A rights-based approach also creates a bridge to other important social movements, i.e., the women's movement, that also play an important role in the fight against HIV/AIDS-related stigma and discrimination.[119]

In 1999, Mann identified three points that related human rights to health: firstly the potential burden on, or violation of human rights caused by public health policies, secondly the adverse effect of human rights violations on the mental, physical and social well-being, and lastly the role that protection of human rights has on the promotion of health.[120] He favoured a human rights analysis over an emphasis on social determinants of health, given that he believed the latter emphasized the role of economic factors in sickness, however, neglected other issues such as social marginalization, childhood experiences, racial and gender inequalities. Additionally, he saw in the human rights framework an opportunity to change the political and societal status quo.[121]

An important conclusion we can draw from the HIV/AIDS context is that understanding or measuring health by only looking in terms of access to hospitals, clinics and medicines is too superficial. The social environment has a huge impact on determining vulnerabilities and lack of progress to end the epidemic.[122]

4.2. Human Rights in the context of HIV/AIDS-related discrimination

This subchapter addresses the human rights regarding HIV/AIDS, and the importance of considering the social and economic factors.

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[117]David Patterson and Leslie London, 'International Law, Human Rights and HIV/AIDS', *Bulletin of the World Health Organization*, 2002, p. 6.
[118]Patterson and London, p. 6.
[119]Ibid.
[120] Elizabeth Fee and Manon Parry, 'Jonathan Mann, HIV/AIDS, and Human Rights', *Journal of Public Health Policy*, 29.1 (2008), pp. 54–71 <https://doi.org/10.1057/palgrave.jphp.3200160>.
[121] Ibid.
[122]Mark Heywood and Dennis Altman, 'Confronting AIDS: Human Rights, Law, and Social Transformation', *Health and Human Rights*, 5.1 (2000), 149–79 <https://doi.org/10.2307/4065226>.

4.2.1. Sexual and Reproductive rights

In 1994, at the International Conference on Population and Development (ICPD), an agenda was developed and then adopted, providing the General Comment 22 on the right to sexual and reproductive health by the Committee on Economic, Social, and Cultural Rights (CESCR) in 2016.[123] Sexual and reproductive health rights are essential to effectively combat HIV/AIDS stigma and discrimination, and the epidemic in itself, with a special focus on youth and key populations.[124] It is part of the three strategies UNFPA's bases itself on, when approaching HIV: firstly the promotion of human rights and reduction of inequalities, secondly the integration of HIV responses into sexual and reproductive health care, and lastly the prevention of sexual transmission of HIV.[125] Addressing HIV is also fundamental to UNFPA's mission of realizing human rights and gender equality in accessing sexual and reproductive health.[126]

With that being said, regarding women's and girl's vulnerability to HIV, it is safe to say that this is also driven by gender inequalities, i.e., gender-based violence, which can limit their ability to negotiate safe sex.[127] Moreover, young people are disproportionally affected by HIV, coming in second place globally as the cause of death among teenagers, in 2016.[128] This vulnerability can be understood based on the lack of access to comprehensive sexual and reproductive health information, services and exclusion from decision making, regarding their own sexual life, and State policies, that regulate their sexuality.[129]

4.2.2. Principle of Non-discrimination

Regarding the principle of non-discrimination, it is also one of the most central human rights, when addressing HIV/AIDS-related stigma and discrimination, but it is not the only one, as discrimination directed at PLWH or persons perceived to be HIV-

[123] Lucía Berro Pizzarossa, 'Here to Stay: The Evolution of Sexual and Reproductive Health and Rights in International Human Rights Law', *MDPI*, 2018, p.1.
[124] 'HIV & AIDS | UNFPA - United Nations Population Fund' <https://www.unfpa.org/hiv-aids> [accessed 15 July 2021].
[125] Ibid.
[126] Ibid.
[127] Ibid.
[128] Ibid.
[129] Ibid.

infected, leads to other violations of human rights, (i.e., health, dignity, privacy, equality before the law, freedom from inhumane, degrading treatment or punishment).[130]

With that being said, the principle of non-discrimination is based on the recognition of equality for all people, and it is enshrined in the Universal Declaration of Human Rights but can also be found in other human rights instruments, such as the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights, the Convention Against Torture, Inhuman and Degrading Treatment, the International Convention on Elimination of All Forms of Discrimination Against Women, and the Convention on the Rights of the Child. On a regional level, and in a way that is relevant for this thesis, it can also be found in the European Convention on Human Rights. Moreover, the United Nations Commission on Human Rights, determined that the term "or other status", should include HIV/AIDS, when interpreted. Additionally, it also stated that any form of discrimination on the basis of presumed or actual HIV-Positive status, according to existing human rights standards, is prohibited.[131] Therefore, HIV/AIDS-related stigma and discrimination is a violation of the fundamental human right of freedom from discrimination.[132] A social environment that legitimizes stigma and discrimination is in itself a social environment that promotes human rights violations.[133]

4.2.3. Right to Privacy and Confidentiality

The right to privacy and confidentiality also plays a crucial role, when protecting PLWHA, as when successfully implemented can offer some protection against other forms of discrimination.[134] Even though the goal is not to eliminate discrimination by hiding and omitting persons HIV status, casting them onto the "shadows", given the

[130] P. Aggleton, and UNAIDS, *HIV-Related Stigma, Discrimination and Human Rights Violations: Case Studies of Successful Programmes*, UNAIDS Best Practice Collection (Geneva: UNAIDS, 2005).
[131] Ibid.
[132] Ibid.
[133] Ibid.
[134] Heywood and Altman, pp. 149–179.

context, this right is extremely important, especially in regard to personal safety, whether physically, psychologically, monetarily, among others.[135]

Additionally, in 1999, the UN Human Rights Committee stated the right to privacy in the context of HIV/AIDS, by referring to Article 17 of the International Covenant on Civil and Political Rights (ICCPR), claiming that criminalizing private homosexual acts between consenting adults, is in fact a violation of human rights, and it is not acceptable as a preventive measure for the epidemic. The Committee also clarified that sexual orientation falls under the term "sex" in article 26 of the ICCPR, regarding the prohibition of discrimination.[136]

The right to confidentiality and the right to non-discrimination were endorsed primarily for public health reasons. Thanks to a few progressive epidemiologist alerting about the consequence's discrimination had on key populations, such as casting them away from society. This social exclusion led to key population not accessing adequate health care, which in itself is a contra productive way of tackling the epidemic.[137]

In addition to sexual and reproductive rights, right to non-discrimination, right to privacy and confidentiality, another right is vital, the right to bodily autonomy, integrated in the civil and political rights. A few more examples of human rights that were violated on the basis of a persons with HIV status are: Right to Employment, Right to Marry (some jurisdictions required mandatory HIV test in order to grant marriage licenses), Right to Freedom of Movement (some countries required mandatory testing for entry, quarantine, segregation, or even "rehabilitation" to restrict the movement of nationals and aliens, within the borders), and Freedom from Inhuman and Degrading Treatment (particularly prevalent in prisons).[138]

4.2.4. Right to Health

According to the International Covenant on Economic, Social and Cultural Rights (ICESCR), states under article 12, 'the States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of

[135]Maluwa, Aggleton, and Parker, pp. 1–18 <https://doi.org/10.2307/4065311>.
[136]Ibid.
[137]Heywood and Altman, pp. 149–179.
[138]Maluwa, Aggleton, and Parker, pp.1-18.

physical and mental health.'[139] Even though, in 2000, CESCR made a General Comment on the Right to Health[140], however, the definition, or a mechanism to ensure a progressive realization of this right, according to "the highest attainable standard" is still missing.[141]

4.2.5. Social and Economic Factor

The report made by the World Bank, in 1997, presented empirical evidence about the unequal distribution of wealth within countries, and countries with low per capita income were strongly associated with high rates of HIV infection.[142] Additionally according to a report by UNDP, that was published in 1998, poverty and sustainable livelihoods can undermine human rights by inciting social unrest and violence and enhancing the precariousness of social, economic and political rights.[143]

The lack of protection of human rights, namely, the civil, political, economic, social or cultural rights may also reveal, directly or indirectly links to the HIV epidemic. It may worsen its impact and increase vulnerabilities, i.e., women's vulnerability to HIV is enhanced when they are deprived of legal power, for example to refuse unwanted sex.[144] Another example would be when the right to freedom of speech and freedom of association is not secured, it makes it impossible for civil society to mobilize themselves, in order to effectively respond to the epidemic.

Moreover, human rights approaches in Western countries, historically, have a tendency to prioritize civil and political rights over socioeconomic and developmental rights, which in the context of HIV/AIDS reflected the preoccupations with individual rights and protection of citizens from state interference (American civil libertarianism)[145]. However, for many countries in the global South, this narrow concept of rights fails to engage with the full picture of social, political and cultural rights,[146]

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[139] 'OHCHR | International Covenant on Economic, Social and Cultural Rights' <https://www.ohchr.org/en/professionalinterest/pages/cescr.aspx> [accessed 15 July 2021].
[140] 'General Comment No. 14: The Right to the Highest Attainable', 21.
[141] Heywood and Altman, pp. 149–179.
[142] Ibid.
[143] Ibid.
[144] Aggleton and UNAIDS, 2005.
[145] Patterson and London, p. 6.
[146] Ibid.

proving that the "one size fits all" approach is not only not sufficient, but also has several long-term negative consequences.[147] Therefore, there is a reinforced need for a rights-based approach to include development, integrating socioeconomic rights in the HIV/AIDS response.

4.3. Human Rights Approach: States

Human rights violations consequential of HIV/AIDS-related stigma and discrimination, can be addressed through existing human rights mechanisms. The existing Human Rights legal tools, as seen above, provide recognition, demands for accountability and the enforcement of PLWH basic human rights. This allows for persons who felt discriminated against to challenge this action through procedural, institutional and other monitoring mechanism. Thus, enforcing Human Rights, while also allowing recourse for countering and redressing the discriminatory action in question.[148]

Procedural, institutional, and other monitoring mechanisms have been established at the national, regional, and international level. Focusing on the national level, it includes the judicial system (courts of law) and national human rights institutions, i.e., National Human Rights Commissions, Law Commissions, Ombudsmen, and other administrative tribunals.[149]

Given that HIV/AIDS-related stigma and discrimination can be considered legal offenses, as is the case in Portugal, the perpetrator can and should be held accountable by law, and redress, when appropriate, can be provided.[150]

Hence, the international human rights principles offer a comprehensive, normative framework, within which one can analyse and redress HIV/AIDS-related stigma and discrimination.[151] This entails, that States are responsible and accountable, on one hand, for direct and indirect violation of human rights, on the other hand for

[147]Heywood and Altman, pp. 149–179.
[148]Aggleton and UNAIDS, 2005.
[149]Maluwa, Aggleton, and Parker, pp. 1–18.
[150]Ibid.
[151]Aggleton and UNAIDS, 2005.

ensuring that individuals can fully realize their rights.[152] Human rights draw this way attention to states legal obligation to regulate the relationship between individuals living within their borders, which means that States have the obligations to respect, protect, and fulfil human rights.[153] In other words, in the context of HIV/AIDS-related stigma and discrimination, the State obligation to respect requires States to ensure that their policies, practices, and laws, do not directly or indirectly discriminate based on HIV/AIDS status.[154]

Regarding the obligation to protect, it requires States to take measures that prevent HIV/AIDS-related stigma and discrimination by third parties.[155] Lastly, the obligation to fulfil, requires States to adopt appropriate budgetary, promotional, judicial, legislative, and other measures that will effectively, or as much as possible, address HIV/AIDS-related stigma discrimination, while compensating those who suffer from said discrimination.[156]

In 1996, an international expert consultation group (human rights experts, representatives of national HIV/AIDS programmes, PLWHA, and NGO's), organized by UNAIDS in collaboration with the Office of the United Nations High Commissioner for Human Rights, prepared the International Guidelines on HIV/AIDS and Human Rights[157]. This was done with the expectation to clarify the obligations of States, within the existing human rights instrument, and how these should be applied in the context of HIV/AIDS.[158] This document consisted of twelve concise paragraphs, and was included, in 1997, in the report of the consultation table of the 53rd session of the Commission of Human Rights.[159]

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[152] Ibid.
[153]Maluwa, Aggleton, and Parker, pp. 1–18.
[154]Ibid.
[155]Ibid.
[156]Ibid.
[157] *International Guidelines on HIV/AIDS and Human Rights 2006, Consolidated Version*, ed. by Joint United Nations Programme on HIV/AIDS and United Nations (presented at the International Consultation on HIV/AIDS and Human Rights, Geneva, Switzerland: UNAIDS, 2006).
[158] Ibid.
[159]Patterson and London, p. 6.

The International Guidelines on HIV/AIDS and Human Rights was then published in 1998,[160] and consisted of two main objectives. The first one being to express the need for human rights principles to underline a positive response to HIV/AIDS, and the second one to promote action-oriented measures, implemented by the government, in the areas of administrative policies, practices and law, in order to achieve HIV/AIDS-related public health goals, while ensuring human rights protection.[161]

Additionally, in 1999 and again in 2001, States were asked to report on the measures they had taken, to promote and implement these guidelines, and tools to assist and support specific groups implementing said guidelines, within their area of responsibility, were also designed.[162] Complex issues were further addressed in the commentary that accompanies these guidelines, on areas such as confidentiality and disclosure of HIV status, upholding the international legal principles.[163] It was also noted that, according to international human rights law, States are allowed to restrict certain personal freedoms, (derogatory rights), i.e., right to liberty of movement, as long as the restriction is place is[164]:

- Provided and carried out in accordance with the law.[165]
- Based on legitimate interest.[166]
- Proportional and the least intrusive and least restrictive measure possible.[167]

Even though, States are not legally bound to implement the guidelines, the General Assembly's annual review of States' progress in meetings, and the monitoring instruments developed to measure compliance, are tools to encourage government action.[168] This ''reality check'', is also important to ensure governments are not

[160] *International Guidelines on HIV/AIDS and Human Rights 2006, Consolidated Version*, ed. by Joint United Nations Programme on HIV/AIDS and United Nations (presented at the International Consultation on HIV/AIDS and Human Rights, Geneva, Switzerland: UNAIDS, 2006).
[161]Heywood and Altman, pp. 149–179.
[162]Patterson and London, p. 6.
[163]Ibid.
[164]Ibid.
[165]Ibid.
[166]Ibid.
[167]Ibid.
[168]Ibid.

introducing laws, policies or practices that increase stigma and discrimination, and thus, increase the HIV infection and associated harms.[169]

Also in 1999, UNAIDS in collaboration with Inter-Parliamentary Union published the Handbook for Legislators on HIV/AIDS, Law and Human Rights.[170]

Later on, in 2002, the UNAIDS, in collaboration with the High Commission for Human Rights, held another international consultation, in order to revise the sixth guideline[171], where access to prevention, treatment, care and support, is addressed. With the revision, it was recommended that domestic legislation should incorporate safeguards and flexibilities in international agreements, i.e., international property agreements, with the ultimate aim to ensure and promote PLWHA access to prevention, treatment, care and support.[172] Due to the global outcry regarding the high cost of the necessary drugs and treatments of HIV/AIDS, World Trade Organization (WTO) stated that the Property Rights should not prevent or pose obstacle to measures aim to protect public health.[173] This lead to the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) Council, the body responsible for administering the TRIPS agreement, to decide in 2002 to postpone until 2006 the deadline for the transition period in which the Global South countries did not have to provide patent protection for pharmaceuticals.[174]

Regarding the findings from the United Nations General Assembly Special sessions (UNGASS), in 2008, addressing the Human rights in the Global response to HIV/AIDS, the responsibility of all sectors of the government, was recognized. Thus, not only the health sector but also the political, economic, social, and cultural factors were also addressed, given the impact it has on both the causes and consequences of

[169]Ibid.
[170]Patterson and London, p. 6.
[171] *International Guidelines on HIV/AIDS and Human Rights 2006, Consolidated Version*, ed. by Joint United Nations Programme on HIV/AIDS and United Nations (presented at the International Consultation on HIV/AIDS and Human Rights, Geneva, Switzerland: UNAIDS, 2006).
[172] Patterson and London, p. 6.
[173]Ibid.
[174]Ibid.

HIV.[175] Laws and Policies that presented obstacles to an effective human right based HIV/AIDS response, i.e., criminalization of sex work, drug use and consensual sex between persons who identify as men, and HIV transmissions needed to be revised, as well as policies that prevented access to condoms and needle exchange programmes for persons deprived of liberty, required parental consent for legal minors to access HIV-related care and services.[176] This also allowed NGOs, to use the described data to demand for law and policies reforms, and also allowed research to study said data, in order to identify issues that remain poorly understood.[177] Additionally, it also facilitated the identification of Governments shortcomings in the fulfilment of human right, hopefully leading to a refocusing of efforts.[178]

Despite being a comprehensive framework, International Human Rights law in the context of HIV/AIDS has some limitations. Even though international Human Rights treaties include monitoring mechanisms, individual complaints procedures concerning the States behaviour, the provisions for enforcement, are generally weak, in comparison, for example to trade agreements.[179][180]

Additionally, The International Guidelines on HIV/AIDS and Human Rights, places disproportional responsibility on the governments to prevent discrimination, neglecting the impact of, but not exclusive to, large corporations, international agencies and religious power brokers.[181]

4.4. Conclusion

In conclusion, stigma, discrimination, and human rights violations consist of this regenerative vicious cycle, where socioeconomic factors originate vulnerabilities, and with the added weight of the disease create new inequalities.[182]

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[175]'Human Rights in the Global Response to HIV: Findings From Th... : JAIDS Journal of Acquired Immune Deficiency Syndromes' <https://journals.lww.com/jaids/Fulltext/2009/12012/Human_Rights_in_the_Global_Response_to_HIV_.5.aspx> [accessed 15 July 2021].
[176]Ibid.
[177]Ibid.
[178]Ibid.
[179]Patterson and London, p. 6.
[180]Ibid.
[181]Heywood and Altman, pp. 149–179.
[182]Ibid.

Therefore, the importance of a human rights approach when addressing HIV/AIDS-related discrimination and stigma, as human rights law helps States to adequately respond to the challenges of the epidemic, by providing a framework they can base on their laws and policies.[183] It also provides tools for NGOs and advocacy groups to monitor States performance, and appropriately reform and tailor their policies and programmes according to the context.[184] Lastly, human rights also state the obligations of public health practitioners to protect and promote health at the population level.

It is crucial for a rights-based approach, that people infected and affected by HIV/AIDS, are meaningfully involved in the development and implementation of effective programmes and policies.[185]

With that being said, the following chapter will present the findings regarding the Portuguese case.

Chapter 5. Contextualization of HIV/AIDS-related discrimination in Portugal

In this chapter the Portuguese case will be studied. Starting with findings regarding the international human right's legal framework. Then an overall description of Portugal's context, in other to better understand this countries performance in regard to how the HIV/AIDS epidemic has been and it is being tackled, for the purpose of identifying the efforts in regard to HIV/AIDS-related discrimination, and what consequences may have occurred. Followed by a close look at the National Program for Prevention and Control of HIV/AIDS (NPHA). As the legal framework has a significant impact on those affected and infected by HIV/AIDS, the national legal framework will be analysed next. After a picture of the Portuguese case has been designed (context and legal level), this chapter will dive in depth and look at the specificities of the key population in Portugal.

[183]Patterson and London, p. 6.
[184]Ibid.
[185]Ibid.

5.1. International Community:

The following sub-chapter, the main events within the international community will be identifies. Firstly, within the UN framework and followed by the regional framework.

Regarding the international legal framework, Portugal has signed several human rights instruments, concerning discrimination, showcasing its commitment to resolve this issue. Within the UN system Portugal has ratified the following treaties:

Table 2. Portugal Ratification of International Treaties:

Treaty	Signature	Ratification
CAT - Convention against Torture and Other Cruel Inhuman or Degrading Treatment or Punishment	04/02/1985	09/02/1989
CAT-OP - Optional Protocol of the Convention against Torture	15/02/2006	15/02/2013
CCPR - International Covenant on Civil and Political Rights	07/10/1976	15/06/1978
CCPR-OP2-DP - Second Optional Protocol to the International Covenant on Civil and Political Rights aiming to the abolition of the death penalty	13/02/1990	17/10/1990
CEDAW - Convention on the Elimination of All Forms of Discrimination against Women	24/03/1980	30/07/1980
CERD - International Convention on the Elimination of All Forms of Racial Discrimination	-	24/08/1982
CESCR - International Covenant on Economic, Social and Cultural Rights	07/10/1976	31/07/1978
CMW - International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families	-	-
CRC - Convention on the Rights of the Child	26/01/1990	21/09/1990
CRC-OP-AC - Optional Protocol to the Convention on the Rights of the Child on the involvement of children in armed conflict	06/09/2000	19/08/2003
CRC-OP-SC - Optional Protocol to the Convention on the Rights of the Child on the sale of children child prostitution and child pornography	06/09/2000	16/05/2003
CRPD - Convention on the Rights of Persons with Disabilities	30/03/2007	23/09/2009

Source: compiled by Sara da Silva Oliveira (2021), based on the UN Treaty Body Database.[186]

By signing and ratifying the treaties mentioned above, Portugal is proving to the international community its commitment to solve discrimination, in the general context. This can also be understood, as the influence that the international community has on Portugal, as this country is usually very keen on adopting resolutions and recommendations very quickly.

[186] OHCHR, *UN Treaty Body Database*, United Nations Human Rights Treaty Bodies, [database], https://tbinternet.ohchr.org/_layouts/15/TreatyBodyExternal/Treaty.aspx?CountryID=139&Lang=EN, (accessed 3 May 2021).

Furthermore, Portugal has accepted the inquiry procedure for

- CAT, Art.20 - Inquiry procedure under the Convention against Torture, on the 9th of February 1989,
- CEDAW-OP, Art. 8-9 - Inquiry procedure under the Optional protocol to the Convention on the Elimination of All Forms of Discrimination against Women, on the 26th of April 2002,
- CESCR-OP, Art.11 - Inquiry procedure under the Optional Protocol to the International Covenant on Economic, Social and Cultural Rights, on the 28th of January 2013,
- CRC-OP-IC, Art.13 - Inquiry procedure under the Optional Protocol to the Convention on the Rights of the Child, on the 24th of September 2013,
- CRPD-OP, Art.6-7 - Inquiry procedure under the Convention on the Rights of Persons with Disabilities, 23rd September 2009.[187]

In 1996, the UNAIDS was created and became the main actor within the UN system, responsible for providing assistance to countries in order to strengthen their long-term capacity to tackle the HIV/AIDS crisis.[188] Superseding this way the WHO's Global Program on AIDS (WHO/GPA), which had led the fight against AIDS since 1986.[189] UNAIDS brought a new conceptualization on how to tackle this challenge by combining the expertise of five different agencies[190], with the explicit aim to recognize the different social dimensions of the HIV/AIDS epidemic. [191]

Additionally, the Commission on Human Rights, in its Resolution 1999/49 and 2001/51, stated unambiguously that,

> that discrimination on the basis of HIV or AIDS status, actual or presumed, is prohibited by existing international human rights standards, and that the term "or

[187] Ibid.
[188] UNAIDS, 'UNAIDS an overview', p.1, https://data.unaids.org/publications/irc-pub03/una96-2_en.pdf, (Accessed 11 April 2021).
[189] Ibid.
[190] United Nations Children's Fund (UNICEF), United Nations Development Programme (UNDP), United Nations Population Fund (UNFPA), United Nations Educational, Scientific and Cultural Organization (UNESCO) and the World Bank.
[191] Parker and Aggleton, p.14.

other status" in non-discrimination provisions in international human rights texts should be interpreted to cover health status, including HIV/AIDS.[192]

This expresses clearly that discrimination against PLWH, or those perceived to be infected, is a violation of human rights.[193].

Additionally, on the 10th Program Coordinating Board (PCB) Meeting of the UNAIDS, on December 14-15, 2000, in Rio de Janeiro[194], Peter Piot highlighted the importance to an all effort to combat HIV/AIDS discrimination, both by leaders and by each of us individually.[195] He believed that by removing this layer of discrimination, we would overcome the most felt challenges at the local community, national and international level, to ensure that PLWH enjoy all their rights.[196] Also, in addition, a year later, in 2001, the former UN Secretary General Kofi Annan, highlighted the urgent need to "break the silence", regarding the high HIV/AIDS-related stigma and discrimination in many countries.[197] Later in 2002, 2003 and again in 2013, UNAIDS choose HIV/AIDS-related discrimination as the theme for the Worlds AIDS Campaign[198], bringing awareness to the urgency of the continuing persistence of these concerns, both programmatically and conceptually.

Continuing within the UN's framework, at the United Nations Special Session on HIV and AIDS, the UN General Assembly unanimously endorsed a Declaration of Commitment on HIV/AIDS,[199] calling on states to enact, strengthen and enforce regulations, legislation and other measures, to eliminate all forms of discrimination

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[192] Commission on Human Rights, Resolutions 1999/49 and 2001/51.
[193] Maluwa, Aggleton, Richard Parker, p.6.
[194] UNAIDS, 'Report of the Third Ad Hoc Thematic Meeting of the Programme Coordinating Board of UNAIDS', Rio de Janeiro, 14-15 December 2000, https://unaids-test.unaids.org/sites/default/files/unaids/contentassets/dataimport/governance/pcb02/pcb_10_00_06_report_en.pdf.
[195] Ibid.
[196] Ibid.
[197] UN, 'SECRETARY-GENERAL PROPOSES GLOBAL FUND FOR FIGHT AGAINST HIV/AIDS AND OTHER INFECTIOUS DISEASES AT AFRICAN LEADERS SUMMIT', *Statements and Messages, 26 March 2001,* [Press Release], https://www.un.org/press/en/2001/SGSM7779R1.doc.htm, (accessed 10 April 2021).
[198] UNAIDS, 'WHAT IS WORLD AIDS DAY?', World AIDS Day, https://www.unaids.org/en/World_AIDS_Day
[199] United Nations General Assembly, 'Declaration of Commitment on HIV/AIDS', *UN General Assembly Special Session on HIV/AIDS,* June 2001, https://www.unaids.org/sites/default/files/sub_landing/files/aidsdeclaration_en_0.pdf.

against PLWH, and vulnerable groups, in combination with ensuring the full enjoyment of their Human rights, as well as the design and implementation of multisectoral national strategies, for combating HIV/AIDS, by the year 2003[200].

By multisectoral national strategies, it was expected to create a strategy that would address the epidemic in straightforward terms, combat stigma, denial, silence, and discrimination, as well as mindfully address the gender and age-related dimensions of HIV/AIDS, and certify the involvement of PLWH, key populations, civil society and the business sector, in the development and implementation of said strategy.[201]

The need to ensure access to employment, social and health services, health care, treatment, prevention, support, education, information, and legal protection, while preserving the respect for privacy and confidentiality, accompanied by the development of adequate strategies to combat stigma and social exclusion closely related with the epidemic, was particularly stressed.[202]

Later, in 2005, UNAIDS released the 'HIV - Related Stigma, Discrimination and Human Rights Violations'[203], highlighting how important it was to combat HIV/AIDS related stigma and discrimination, in order to fully tackle this epidemic, while also providing examples of successful programmes, Human rights and legal approaches, and antidiscrimination measures. In the following year, the Office of the United Nations, the High Commissioner for Human Rights and UNAIDS, jointly released a consolidated version, of the Second International Consultation on HIV/AIDS and Human Rights 23-25 September 1996, Geneva, and the Third International Consultation on HIV/AIDS and Human Rights, 25-26 July 2002, Geneva.[204] Providing recommendations and

[200] Ibid.
[201] Maluwa, Aggleton, and Parker, p.1.
[202] United Nations General Assembly, 'Declaration of Commitment on HIV/AIDS', *UN General Assembly Special Session on HIV/AIDS*, June 2001, https://www.unaids.org/sites/default/files/sub_landing/files/aidsdeclaration_en_0.pdf.
[203] UNAIDS, 'HIV-Related Stigma, Discrimination and Human Rights Violations: Case Studies of Successful Programmes', *UNAIDS Best Practice Collection*, 2005.
[204] UNAIDS, 'International Guidelines on HIV/AIDS and Human Rights 2006, Consolidated Version', presented at the International Consultation on HIV/AIDS and Human Rights, Geneva, Switzerland, 2006.

guidelines for State Action as well as HIV/AIDS and Human rights and stating clearly the international human rights obligations.[205]

Additionally, WHO regional office for Europe, designed the European Action Plan for HIV/AIDS, 2012–2015, stating the reduction of vulnerability and removal of structure barriers when accessing services, i.e., addressing the social determinants of health, as a priority for action.[206] During this time period, the European Commission made a speech on the Urgent need to overcome HIV/AIDS-related stigma and discrimination, as well as the need for a human rights approach.[207]

Focusing on regional instruments, within the European framework, Portugal became the 19th member State of the Council of Europe on the 22nd of September 1976, ratifying the European Convention of Human rights.[208] The European Social Charter was signed on the 3rd of May 1996, ratified on the 30th of May 2002, and collective complaint procedure was accepted on the 20th March 1998.[209] On the 7th of May 2002 the Framework Convention for the Protection of National Minorities was ratified.[210] The Council of Europe Convention on Action against Trafficking in Human Beings, was signed by Portugal on the 16th of May 2005, ratified on the 27th February 2008, entering into force on the 1st of June 2008.[211]

Moreover, on the 7th of December 2000, led by the European Commissioner for Justice, António Vitorino (Portuguese), the Charter of Fundamental Rights of the European Union was proclaimed[212], enshrined into primary EU law an extensive

[205] Ibid.
[206] WHO Regional Office for Europe, 'European Action Plan for HIV/AIDS 2012-2015', Copenhagen, 2011.
[207] European Commission, 'Speech: HIV AIDS and Human Rights: The urgent need to overcome stigma and discrimination', *Press Corner*, 27 May 2013, https://ec.europa.eu/commission/presscorner/detail/en/SPEECH_13_466, (accessed 23 May 2021).
[208] Council of Europe, Portugal // 47 States, one Europe, [webpage], https://www.coe.int/en/web/portal/portugal, (accessed 3 May 2021).
[209] Ibid.
[210] Ibid.
[211] Ibid.
[212] 2021 Portugal.EU, Portugal's Journey in the European Union, [webpage], https://www.2021portugal.eu/en/news/portugal-s-journey-in-the-european-union/, (accessed 3 May 2021).

selection of fundamental rights every EU citizen and resident should enjoy.[213] With the Treaty of Lisbon coming into force, on the 1st of December 2009, it became legally binding.[214]

In 2004, the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia[215], was the first in a serious of regional declaration with focus on HIV, highlighting this issue as an important political priority for European and Central Asian countries, to be adopted.[216] It states the commitment of all signatories to act together in combating the HIV/AIDS epidemic, laying down a number of actions, in order to achieve this commitment as fast as possible.[217] All signatories also assumed the commitment to closely evaluate and monitor the implementation of the actions stipulated in the Dublin Declaration, in combination with the Declaration of Commitment of the United Nations General Assembly Session on HIV/AIDS, as well as call upon the EU and other important regional institutions and organizations, in close collaboration with UNAIDS, in order to establish appropriate forums and mechanisms, with the involvement of PLWH and civil society, to asses regional level progress, every two years.

Furthermore, in 2014 the European Commission, launched an enhanced Action plan in EU and neighbouring countries for 2014-2016.[218]

Still within the international realm, the Community of Portuguese-speaking Countries[219] (CPLP), is noteworthy. It is an international organization, created on the 17th of July 2016, formed by Lusophone countries, whose objective is the 'deepening of

[213] FRA, 'Charter of Fundamental Rights of the European Union', *EU Charter of Fundamental Rights,* [webpage], https://fra.europa.eu/en/eu-charter, (accessed 3 May 2021).
[214] Ibid.
[215] OSCE, 'the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia', https://www.osce.org/secretariat/29873.
[216] European Centre for Disease Prevention and Control, 'Monitoring Implementation of the Dublin Declaration', *Prevention and Control*, https://www.ecdc.europa.eu/en/all-topics-zhiv-infection-and-aidsprevention-and-control/monitoring-implementation-dublin> (accessed 23 May 2021).
[217] Ibid.
[218] European Commission, 'Fight against HIV/AIDS: launch of enhanced Action plan in EU and neighbouring countries for 2014-2016', *Press Release,* 14 March 2014, https://ec.europa.eu/commission/presscorner/detail/en/IP_14_267, (accessed 23 May 2021).
[219] Comunidade dos Países de Língua Portuguesa (CPLP).

mutual friendship and cooperation among its members'.[220] Regarding the Intra CPLP agreements, in the HIV/AIDS context there is the Cooperation Agreement between the Member States Of The Community Of Portuguese-Speaking Countries On Combating HIV/AIDS, in article 1, it is stated the promotion of policies that defend human rights in the face of discrimination and stigma associated with HIV/AIDS.[221]

Thus, it can be inferred that the international community has prioritized a human rights approach regarding the response to HIV/AIDS, in particular the related discrimination. As seen from the previous chapters, Portugal has been compliant with international recommendations, resolutions and treaties, positioning in a good ranking when it comes to a response based on this measure. However, in the beginning, up until the 2000s, Portugal had one of the highest incidences in Europe, of HIV infection, and therefore, attached discrimination, which is still currently an unsolved problem.

Therefore, in the next subchapter the Portuguese case findings will be presented.

5.2. Portugal: putting people at the centre of the HIV/AIDS response?

The aim of the following sub-chapter is to illustrate the evolution of HIV/AIDS in Portugal, throughout the years, to understand if and how the HIV/AIDS-related discrimination has been properly addressed.

The first case of AIDS, in Portugal, was in 1983.[222] Within Western Europe, in 2001, Portugal had the highest incidence rate of AIDS and Tuberculosis (TB) in EU[223], therefore, the national health plan, considered the HIV epidemic as a priority, leading to multiple intervention strategies, integrated in the various levels of prevention, increasing the survival and quality of life of individuals infected in Portugal.[224]

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[220] 'CPLP - Comunidade Dos Países de Língua Portuguesa - Objectivos' <https://www.cplp.org/id-2763.aspx> [accessed 24 May 2021].
[221] CPLP, 'ACORDO DE COOPERAÇÃO ENTRE OS ESTADOS MEMBROS DA COMUNIDADE DOS PAÍSES DE LÍNGUA PORTUGUESA SOBRE O COMBATE AO HIV/SIDA', 2003.
[222] Paula Santana and Helena Nogueira, 'The Geography of HIV/AIDS in Portugal', *Fennia - International Journal of Geography*, 182.2 (2004), p. 96.
[223] Ibid, p. 104.
[224] António Nogueira and others, 'Time-Trends in Human Immunodeficiency Virus Infection in Portugal: 1984-2013', *Arquivos de Medicina*, 29.6 (2015), p. 148.

However it is important to bear in mind, that when Portugal presented a more favourable scenario, in regards to HIV infection control, was mainly due to the decrease in incidence among persons who use injectable drugs, largely due to the implementation of the program "Troca de Seringas", which translates into syringe exchange, designed to stop the syringe sharing.[225] This program was implemented in 1993, and is still running today, having undergone some slight tailoring to best fit the needs of the community.[226]

This program was further addressed in the interview conducted for the purpose of this study, João Brito, the coordinator of Portuguese Group of HIV/AIDS Treatment Activists (GAT) and the Anti-Discrimination Center (CAD), that explained that the program "Troca de Seringas", was a success and it is often presented in the international conferences as an example to follow.[227] This Program consisted of a development of a kit for safe injectable drug consumption, in order to prevent sharing of needles. It was developed in close collaboration with the PUID community, 'Nothing for us, without us'.[228] Additionally, Ana Duarte, Coordinator of CAD on behalf of SER+, where she is responsible for the investigative field, mentioned the two most significant outcomes of this program. The first one being the reduction of cases of infections, not only HIV, (intended outcome) from 60% of HIV infections to currently only 2%.[229] The second one was the decrease of discrimination, as it legitimized persons from this community, previously seen as criminals and outcast.[230] Allowing PUID to have access to a trained health technician (in a NGO or a pharmacy), who makes the exchange of the syringe, removes the shame and guilt and legitimizes a persons need, without popularizing this behaviour. She stated that ignoring, and out casting PUID community, is a methodology that only aggravates the issue.[231] João Brito concluded by referring the existence of a mobile unit of consumption, which is in itself also had a great impact, the physical unit, is currently located in Lisbon.[232]

[225] Ibid, p. 151.
[226] Interview conducted by Sara Silva Oliveira, CAD, 18.06.2021.
[227] Ibid.
[228] Ibid.
[229] Ibid.
[230] Ibid.
[231]Ibid.
[232]Ibid.

Based on this interview, it is clear that this program was a success not only in reducing the impact of HIV infection on the PUID community, but also reducing the stigma and discrimination regarding this group, showing an example of public policy that had a holistic approach and most importantly included the affected community, which as it can be seen by the results, is an important element to ensure the effectiveness of an intervention program.

Universal access to the antiretroviral therapy (ART), implemented in the 1990's, underwent some tailoring in regard to monitoring quality and equity of this service, to ensure more efficiency.[233] In 1995, AIDS associations publicly advocated for the disease to be declared as chronic, as this would allow the drug prescription to be fully supported by the National Health Structures (NHS).[234] Furthermore, the significant increase in access to ART, tripling between 2003-2010 (from 75 in 2003, to 240 in 2010, per 100 000 inhabitants), turned the disease officially into a chronic one, instead of a fatal one.[235] Therefore, this shows that universal access and financial support from the government, regarding the access to ART, had a significant impact, as it considered the social and economic factors of the populations. By doing so, the government is not discriminating on the bases of national and economic means.

In 1997, International Lesbian, Gay, Bisexual, Trans and Intersex Association (ILGA), organized a Memory and Solidarity march in honour of the victims of HIV/AIDS.[236] And in 1998, it was celebrated for the first time in Portugal the Global Day Against AIDS, with the main aim to promote prevention and bring awareness to the epidemic.[237] In the same year 1998, a state-owned Anonymous Screening Center was inaugurated in Lisbon, constituting the first free and confidential HIV/AIDS screening center.[238] It should be noted that the first AIDS tests provided confidentially and free of

[233] Nogueira and others, pp. 151-152.
[234] Ana Cristina Santos, 'Sexualidades politizadas: ativismo nas áreas da AIDS e da orientação sexual em Portugal', *Cadernos de Saúde Pública*, 18 (2002), p. 604, <https://doi.org/10.1590/S0102-311X2002000300004>.
[235] Ibid, p. 603.
[236] Ibid, p. 598.
[237] Ibid, p. 603.
[238] Ibid.

charge date back to 1993 and were carried out at the Laura Ayres Center in Coimbra.[239] In 2000, Universal access to testing, implemented by national health services, encouraging voluntary screening, especially among key populations, leading to a reduction in risk behaviors, transmission, and allowing early initiation to treatment, reducing this way mortality.[240] This universal access to testing had a significant impact, particularly among the migrant community, as someone, regardless of their legal status could now get tested.

Regarding testing policies, in Portugal, it is non-mandatory, anonymous, confidential and for free, however, mistrust in health services regarding confidentiality, freedom from discrimination and exclusion, and lack of information regarding said services,[241] still pose some of the reasons why people choose not to undergo testing.

The HIV prevention strategies and programs developed until the early 1990s, were generally not very sensitive to the social and cultural factors underlying the transmission of the infection, prioritizing a cognitive-behavioral approach, putting individual psychology, through the dissemination of information, which at the time was deemed a sufficient way of tackling the epidemic.[242] However, it was later proven that this approach by itself, is in fact insufficient.[243]

Therefore, "mix of HIV prevention approaches" are recommended, as stated in international guidelines of UNAIDS. This approach provides a transversal and multidisciplinary way of addressing different psychosocial and time scales, aiming at an integrated and synergetic intervention, which takes into consideration the micro meso and macro-generating providing of the infection risks.[244] Shifting this way, as Auerbach et al. put it, from an emergency approach to a long-term response, including also prevention on a supraindividual scale, for better understanding of social and cultural

[239] Ibid.
[240] Nogueira and others, p. 151.
[241] Sónia Dias and others, 'Factors Associated with HIV Testing among Immigrants in Portugal', *International Journal of Public Health*, 56.5 (2011), 559–66 <https://doi.org/10.1007/s00038-010-0215-7>.
[242] Octávio Sacramento, 'Indivíduos, estruturas e riscos: panorâmica da prevenção primária do HIV em Portugal', *Cadernos de Saúde Pública*, 32 (2016), p.2, <https://doi.org/10.1590/0102-311X00129715>.
[243] Ibid.
[244] Ibid.

dimensions (sexism, homophobia, racism, stigmatization, legal framework, public policies, etc…)[245] Four types of challenges were anticipated in the development of these programs, as stated by Auerbach[246]:

- Conceptual and methodological aspects related to intervening, standardizing and evaluating effects regarding the social conditions of HIV/AIDS.
- Due to the slow process of social change, results can only be seen from medium to long term.
- Resistance from society in supporting political decisions or interventions aimed at improving the social conditions of heavily marginalized groups.
- Financial cost.

The incidence rate of HIV infections increased until 1999, regarding men, and 2000, regarding women, and then decreased until 2013.[247] The higher mortality rates were registered in 1996, with a significant decreased for men since 2003 and for women, since 1996.[248] Regarding key populations, for PUID, the decrease period started in 1997, for heterosexuals, the decreased happened in 2002, however, in regard to men who have sex with men, it steadily increased until 2011.[249] A gradual reduction in the proportion of individuals diagnosed with AIDS in the total number of infected, was observed, this proportion was almost 50% by the end of the 1990's, and by 2013 drop to 20%.[250]

In the context of the international sphere, in 2010, CPLP in collaboration with UNAIDS formalized their cooperation with a Memorandum of Understanding, which sought out to mobilize political, financial and technical support for civil societies networks and organizations, and to enable channels for sharing experience and developing a South-South technical cooperation.[251] This agreement, took place on the

[245] Ibid.
[246] Ibid, p.3.
[247] Nogueira and others, p. 148.
[248] Ibid.
[249] Ibid.
[250] Ibid, p. 151.
[251] 'CPLP and UNAIDS Sign Cooperation Agreement in Response to the AIDS Epidemic' <https://www.unaids.org/en/resources/presscentre/featurestories/2010/march/20100317cplp> [accessed 18 May 2021].

III CPLP Congress on HIV/AIDS and Sexually Transmitted Diseases, held in Portugal.[252]

In the following year, 2011, the Draft Resolution No. 133/XII, was designed, recommending the Government to take measures to combat HIV/AIDS infection in Portugal, and views on how to eradicate it.[253] In this resolution, it was stressed that key populations (namely, PUID, men who have sex with men, sex workers, some migrant/ethnic communities and inmates), needed particular attention.[254]

Among the recommendations given, the respect for human rights was stressed, as well as the need to reduce vulnerabilities, it also pointed out the importance of efficiently addressing social determinants that underline HIV/AIDS, and call for the elimination of discrimination and stigma, in order to ensure the effectiveness of the policies addressing HIV/AIDS and strengthening the community systems.

As objectives, the Parliamentary Health Committee, unanimously approved the intention to draw up a draft resolution on HIV/AIDS on world AIDS Day, following a recommendation by the GAT, to recommend to the Government to adopt measures to combat HIV/AIDS infection in Portugal, with a view to its eradication, based on UNAIDS targets for zero new HIV infections, zero HIV/AIDS related deaths, and zero discrimination.[255] Also it was highlighted the need to generate a widespread consensus and commitment among all parties with parliamentary representation, government, opinion leaders, and relevant partners, including PLWH and their communities, health professionals, NGOs, the pharmaceutical industry, education system, academics and researchers, on the necessary measures to plan, implement and evaluate the HIV/AIDS action plan in Portugal.[256] The increase of new infections is associated with social exclusion, to which key populations are subjected to,[257] a consequence of HIV/AIDS-related discrimination.

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[252] Ibid.
[253] Assembleia da República, PROJECTO DE RESOLUÇÃO N.º 133/XII/, 2011, file:///C:/Users/Utilizador/Downloads/Resolucao_VIHSIDA_FINAL.pdf
[254] Ibid.
[255] Ibid.
[256] Ibid.
[257] Santana and Nogueira, p. 96.

Later on, in 2013, the Stigma index was designed, an initiative that emerged in 2005, by the collaboration between, Global Network of People living with HIV (GNP+), International Confederation of Women with HIV (ICW), International Planned Parenthood Federation (IPPF) and UNAIDS[258], bringing awareness to the central role discrimination and stigma play in this epidemic.

On 29th of May 2017, Mr. Loures, visited CheckpointLX, a community-based centre, design to provide support for men who have sex with men, by offering free, confidential and rapid testing, not only for HIV but other sexually transmitted diseases (STDs), alongside counselling and referral to health care, and commended Portugal for putting people at the centre of its response to HIV/AIDS.[259] In the same year, the Minister of Health disclosed that pre-exposure prophylaxis (PrEP) would be made available for key populations through the national health system (SNS).[260]

However, according with the interview with João Brito, regarding PrEP, which he considers a milestone in the context of combating HIV/AIDS, said that he works in a service that since 2017 has been referring people for PrEP, and he explain the challenges he faces, which will be stated now.[261] João Brito, explained that even though he has been referencing people for this treatment, and the deadline after the first consultation of 30 days is not being met, and people have waiting periods of 8 months up to a year.[262] This is extremely concerning, as people can covert while waiting for a treatment that would prevent them from getting this infection at a 99.9% odds, which he considers a form of discrimination against people who are vulnerable or at risk of contracting HIV, as they could remain with a negative Status.[263] This is creating, as expected, a big discontent and frustration among the community.[264] The second

[258] Pedro Silvério Marques, Ana Luísa Duarte and Pedro Águas, 'VIH: Acabar com o Estigma Apresentação do Estudo Stigma Index Portugal', *Assembleia da República*, (2013), p.2, <https://www.gatportugal.org/public/uploads/eventos/VIH%20Portugal%20-%202013/AR_Stigma.pdf>.
[259] 'Portugal: Putting People at the Centre of the AIDS Response | UNAIDS' <https://www.unaids.org/en/resources/presscentre/featurestories/2017/may/checkpointlx> [accessed 18 May 2021].
[260] Ibid.
[261] Interview conducted by Sara Silva Oliveira, CAD, 18.06.2021.
[262] Ibid.
[263] Ibid.
[264] Ibid.

challenge he expressed is the lack of data. Currently, there is no data available on how many people started treatment, how many converted in the waiting period, and those who abandoned it. This has been going on since 2017[265], 4 years have passed for the time proposed to be studied in the thesis. Ana Duarte completed his thought by providing the example of Doctors who claim this is not an emergency because people can use other preventive measures such as condoms.[266] Which, as she recalled, is a similar scenario to the fight for the birth control pill, as similar comments were said at the time.[267] She concluded that this is based on the stigma and discrimination still present, as prejudice is still very much felt.[268] João Brito concluded by saying that this is not related to cost, (as the pill is cheaper than a condom), agreeing with Ana Duarte on this being based of crippling moralism.[269]

Therefore, even though in theory, Portugal has had a commendable performance of making PrEP available to key populations, in practice, and according to the above mentioned experts, it is not meeting the expectations to which it has been praised in the international realm. As seen from the arguments presented above, HIV/AIDS-related discrimination is a major challenge faced by Portugal, and it is having a significant impact in the prevention and intervention sector.

In 2018, Masoud Dara, coordinator from WHO Regional Office for Europe, highlighted that the Portugal achieved almost all the objectives (2/3) set out by UNAIDS, the 90-90-90, to be achieved by 2020, which thus puts Portugal alongside countries, such as Denmark, Sweden, Iceland, Northern Ireland, and Great Britain.[270] The Assistant Secretary of State for Health, Fernando Araújo, considers that this is a "historic day".[271]

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[265] Ibid.
[266] Ibid.
[267] Ibid.
[268] Ibid.
[269] Ibid.
[270] Lusa, 'Portugal é um país "exemplar" na luta contra o VIH', *PÚBLICO* <https://www.publico.pt/2018/07/05/sociedade/noticia/portugal-entre-os-paises-europeus-mais-bem-sucedidos-na-luta-contra-o-virus-1836945> [accessed 18 May 2021].
[271] Ibid.

Additionally, in the same year, on October 10th, the mayors of Almada, Amadora, Loures, Portimão, Sintra, Odivelas, and Oeiras signed the Paris Declaration to end the epidemic in the cities, adding to a total of 10 Portuguese cities who are committed to use Fast-Tracking, in order to achieve the 90-90-90 goals, set by the UNAIDS.[272] According to UNAIDS, Portugal has been a pioneer in its responses to the epidemic, due to its progressive drug policies, enabling legal environments, free HIV treatment for all, including migrants with unregulated legal status, community-based programs and promoting better integration regarding health care services.[273]

However, according to an interview, João Brito, claimed that he is suspicious of the data behind the accomplishment of the three 90-90-90, goals set out by the UNAIDS, because according to annual reports of HIV infection show that Portugal continues to have one of the highest incidence rate in Europe.[274] He continued explaining that another conclusion can be withdrawn from those reports, and that is Portugal also has de latest infection detection (up to 50% of the new diagnosis are considered late detection), which makes it difficult to properly grasp the actual impact of this infection in numbers.[275] He then concluded, that based on this information he does not understand how the first 90 (by 2020, 90% of all PLWH will know their status) and he has serious doubts if in fact Portugal reached this goal.[276] However, this contradicts the international praise Portugal has been receiving, as seen above, which entails a closer look at the Portuguese National Legislation, in order to understand why such gap, exist and its connection to discrimination. This will be done later on in the chapter.

Additionally, Ana Duarte, also commented on the 90-90-90 goals set out by the UNAIDS. She started by explaining how she believes that the issue of discrimination has only recently be dealt in a serious manner.[277] To explain her bold statement, she

[272] 'More Portuguese Cities Commit to the Fast-Track' <https://www.unaids.org/en/resources/presscentre/featurestories/2018/october/portugal-fast-track-cities> [accessed 18 May 2021].
[273] Ibid.
[274] Interview conducted by Sara Silva Oliveira, CAD, 18.06.2021.
[275] Ibid.
[276] Ibid.
[277] Ibid.

gives the example of UNAIDS, and how the 90-90-90 goals, are targeting diagnosis, screening and treatment, neglecting discrimination and overall, the quality of life of PLWH, even though some organizations at the international level stressed the need for a fourth set of goals targeting discrimination, which has yet to be adopted.[278] Ana Duarte acknowledged the existence of the three 0s goals, in which discrimination is addressed, however she explained that both national and international policies and goals are always targeting prevention and treatment.[279] According to her she believes the root cause of this barrier lies in the international level and Portugal resonates with it, as the Portuguese government tends to only provide funding regarding prevention that is related to diagnosis and treatment.[280] She concluded by mentioning that the design of an updated version of the Stigma index (first version released in 2013), is, as far as she can remember, the first thing the Directorate General of Health (DGS) has funded in the field of discrimination.[281] Ana Duarte hopes this new study will prove that stigma and discrimination still exist in Portugal, and how it is affecting the national health goals of achieving the 90-90-90, as effective treatment is not sufficient to eradicate this epidemic, as stigma and discrimination do tend to push PLWH away from health services (testing and treatment).[282]

With that being said, could this lack of investment in the area of discrimination help understand the gap between Portugal's performance and its actual performance?

As a conclusion, between 1990 and 2000, Portugal had the highest incidence rate in Europe, turning HIV into a priority for the national health plan. This entailed preventive measures and public policies with the aim of reducing the infection rate. Civil society manifestations, regarding the fight against AIDS also gained significance in the late 90's. The "Troca de Seringas" is a great example, often presented as a success both nationally and internationally, as it incorporated both a holistic approach, input from the affected community and respect for human rights. Portugal can also be commended on its inclusive policies regarding testing and access to ART. However,

[278] Ibid.
[279] Ibid.
[280] Ibid.
[281] Ibid.
[282] Ibid.

there is some issues that the international community considers Portugal's performance as an example to follow, which when speaking with national experts were shown to have big challenges and overall, not so great efficiency. The two cases mentioned in this chapter was the accomplishment of the 90-90-90 goals set by the UNAIDS, and the concerning situation regarding access to PrEP.

Thus, we can infer that when Portugal assumed a position which considered social and economic factors, respect for human rights and involvement of the affected community, with the target not only to prevent but also to abolish discrimination, were considered as a success. However, when an intervention was only focusing on the prevention aspect, it tended to face significant challenges. On another note, it is also seen a gap between theory and practice and between international perception of Portugal's performance and its actual performance and produced results. Therefore, this study will now look into the National Programme for Infection, HIV, AIDS and Tuberculosis, in order to understand how these issues are approached and if in fact, Portugal has an adequate State response to tackle HIV/AIDS-related discrimination, in order to further understand the gap between theory and practice.

5.3. Nacional Programme for HIV/AIDS

In the following sub-chapter I will address public policies, the context leading up to the Nacional Program for HIV/AIDS, and its biggest victories and challenges.

The case with any public policy, is that it always involves institutions, as they play a decisive role in the different stages regarding said policy.[283] The implementation of public policies requires financial resources, health system responsibility and organization, training of technicians, specific legislation among others, which showcase the complexity HIV/AIDS has in the public policy sphere.[284] Portugal has a tendency to implement centralized, top-to-bottom public policies.[285] It is noteworthy that National

[283] Everton Dalmann, 'Análise Comparativa das Políticas Públicas de Combate ao HIV/AIDS no Brasil e em Portugal', *Departamento de Ciência Política e Políticas Públicas*, (2015), p. 40, <https://repositorio.iscte-iul.pt/bitstream/10071/10368/1/Tese%20Final%20Everton%20Dalmann%20p%c3%b3s%20defesa%20%281%29.pdf>.
[284] Ibid, p. 50.
[285] Ibid, p. 51.

Programs, as states institutions reveal the administrative context of the public policies, of said country.[286]

Therefore, it is important to understand the Portuguese context, as was explained in the previous sub-chapter. With that being said, two years after the first diagnosis of HIV in Portugal, in 1985, the Ministry of Health set up the AIDS Working Group in order to have a better grasp of the country's situation.[287] It operated within the framework of the Centre for Epidemiological Surveillance of Communicable Diseases of the National Institute of Health, which had an advisory status, instead of a deliberative one, and that's why it should not be considered as the institution responsible for the implementation of public policies in the fight against HIV/AIDS.[288]

Thus, and considering the advance of the epidemic, in 1990 the AIDS working Group was reformulated, creating a new structure Comissão Nacional de Luta Contra a SIDA[289] (CNLCS), now responsible for the definition and implementation of national public policies to combat HIV/AIDS.[290]

In 1993, the Minister of Health approved the first national HIV/AIDS intervention program known as the National Program for HIV/AIDS, with focus on the prevention, diagnosis and treatment of HIV/AIDS, and responsible for promoting campaigns aimed at HIV/AIDS prevention.[291] For example, between 1991-93, campaigns that appealed for solidarity towards PLWHA, aimed at the general public, with the goal to decrease discrimination and social exclusion.[292] The campaigns implanted, were not very effective, as this was implemented in a very generalist way, which is a clear neglect of the UNAIDS recommendations in 2001, where it was stressed it is relevant that campaigns should be aimed at the profile of the target population and tackle the particular characteristics of the most vulnerable groups.[293]

[286] Ibid, p. 52.
[287] Ibid, p. 55.
[288] Ibid, p. 142.
[289] In English: National Commission Against AIDS.
[290] Dalmann, p. 142.
[291] Ibid, p. 143.
[292] Ibid.
[293] Ibid, p. 52.

In 1998, by a joint order of the Ministers of Labour, Health, Solidarity and the Secretary of State for Youth, District Commissions to Fight AIDS, were created in response to the need for a decentralization of the coordination and implementation of actions developed under the National Plan to Fight AIDS.[294]

During the interview with a member of NPHA, Joana Bettencourt stated that the work done with the PUID community was deemed as a success, with the Program "Troca de Seringas", which was funded by NGOs that worked closely with the target community, as well as the general public.[295]Additionally in this regard, the decriminalization of drugs was also a milestone in the Portuguese performance when responding to HIV/AIDS-related discrimination.

In 2007, the National Civil Society Forum for HIV was created, after the European Council resolution, where it instigated countries to create civil society forums, showcasing the influence the international community has on Portugal, as it was one of the first countries to adopt this.[296]

The "National Program for the Prevention and Control of HIV/AIDS Infection 2007 - 2010", had as an objective the decrease of at least 25% of AIDS related deaths and new HIV cases.[297] The national response to HIV infection is part of the internationally established commitments, namely the European Centre for Disease Prevention and Control (ECDC), WHO-Europe, UNAIDS, Global Fund and CPLP, set out based on multiple statements including the UN Declaration of Commitment – UNGASS and the Dublin Declaration.[298]

Nevertheless, until 2010, Portuguese public policies faced some limitations, such as a model of slow and fragmented public reactions often taken under emergency conditions, with administrative measures that did not translate into concrete actions, where prevention campaigns were characterized by direct or indirect moralizing

[294] Ibid, p. 144.
[295] Interview conducted by Sara Silva Oliveira, NPHA, 22.07.2021.
[296] Ibid.
[297] Direção Geral da Saúde, 'Programa Nacional para a Infeção VIH/SIDA Orientações Programáticas', (2012), p.2, <http://www.sermais.pt/media/86/File/VIH_SIDA/ProgramaNacionalParaInfecaoVIHSIDA.pdf>.
[298] Ibid, p.3.

messages and did not include messages of solidarity and awareness of non-discrimination, no special attention was given to the psychosocial aspects of AIDS, and the legal mechanisms for the notification and evaluation of systems were not developed, and the disease was managed within the framework of pre-existing services in public network.[299]

Therefore, the role of civil society was crucial at this time to fill in the gaps, that public services were not yet prepared to adequately provide and answer to. These limitations, and its consequences, may still linger today, and may be one of the explanations as to why, even though in theory Portugal has every tool to reduce discrimination regarding HIV/AIDS, in practice, it fails to do so.

Regarding the "HIV/AIDS Prevention and Control Program 2012-2016" it aims to, among other goals, to promote the desired change of behaviors and attitudes, both at the various levels of prevention and to counteract stigma and social discrimination.[300] The Program adopts the fundamental principles enshrined in the "three ones" policy: national leadership, an extended multisectoral plan and a monitoring and evaluation system, assuming also a vision that is coincident with UNAIDS, and the set out goals: zero new infections, and zero deaths related to AIDS, as well as zero cases of discrimination.[301] The program is guided by the values expressed in the Universal Declaration of Human Rights, i.e., right to work, principle of non-discrimination, principle of equality, right to private life, the right to freedom and security and the right to confidentiality.[302] And has as objectives, decreasing vulnerabilities and the impact of the epidemic, especially in regards to stigma and discrimination, while upholding human rights.[303] Thus, coordination with CAD to learn about discrimination and cooperate in the action on these cases, plays a crucial role.[304]

The issue of Labour also gained a fundamental importance. According to the Interview with Joana, it was established the Labor Platform against AIDS, which is a

[299] Dalmann, p. 145.
[300] Direção Geral da Saúde, p.3.
[301] Ibid.
[302] Ibid, p.4.
[303] Ibid, p.8.
[304] Ibid, p.10.

structure that involved more than 100 companies and multinationals based in Portugal, that compromised to respect PLWH rights in the context of work, by signing the Code of Conduct Companies and HIV. This platform is constituted by employers' confederations, trade unions, and the International Labor Organization (ILO).[305] And regarding the HIV/AIDS Prevention and Control Program of 2012-2016, also among the objectives was the increase of the number of companies that subscribed to the Code of Conduct Companies and HIV.[306]

Later, in 2013, the study Stigma Index was developed. This is an international project designed and implemented by PLWH, and aimed at people infected or affected by HIV, with the main objective to gather information relating to stigma and discrimination that PLWH experienced, and to inform about the rights they were entitled to, whether in the context of labour, health, or personal circle.[307] According to Joana, this was a very important study, as the gathering of this information helped to better understand where intervention was most needed (i.e., capacity building, campaigns).[308]

In the same interview, when asked about the biggest supporters of the program and the biggest challenges, the following was addressed. Firstly, the role of civil society, namely NGOs, were considered to be an important ally, as NGOs are the sector that has done most of the work in regards to fighting HIV/AIDS-related discrimination and stigma, and that they have great influence in the design of legislation and the development of intervention projects.[309] Portugal has several NGOs that work in the context of HIV/AIDS-related stigma and discrimination, i.e., Portuguese League Against AIDS[310], AIDSPORTUGAL, SOL- HIV/AIDS Child Support Association[311], HUG Association[312], Ser+ and Gat, that have a joint project, the "CAD", which is HIV Anti-Discrimination Center, with the main objective of ensuring, promoting and

[305] Interview conducted by Sara Silva Oliveira, NPHA, 22.07.2021.
[306] Direção Geral da Saúde, p.10.
[307] Marques, Duarte and Águas.
[308] Interview conducted by Sara Silva Oliveira, NPHA, 22.07.2021.
[309] Ibid.
[310] Liga Portuguesa Contra a SIDA.
[311] SOL- Associação de Apoio às crianças VIH/SIDA.
[312] Associação ABRAÇO.

implementing the fundamental rights of people with HIV infection, viral hepatitis, and the most vulnerable populations, promoting the fight against stigma and discrimination.

Regarding the obstacles posed to the implementation of measures, the general population was the hardest to comply, as HIV/AIDS is perceived by them as a distant issue, applicable only to the key population, and they can not relate to[313], therefore is not their problem, and according to what was seem in the conceptual and theoretical framework, if the dominant group believes the system is fair, it will be less willing to be involved in the creation of a solution. This always happens when a new measure is designed, according to the interviewee, there is this fear of the consequences of said measure in the population.[314] The example provided was the consumption rooms[315], as people were concerned the crime rates would spike, therefore the general public showed some resistance.[316] This fear lessens over time of the implementation.

Moreover, another kind of challenge was identified during the interview, where lack of resources was identified as a cause of resistance regarding implementation. The example provided was the program "Troca de Seringas", as when the responsibility shifted from the pharmacies and NGOs to the health centres. Well, the third one was the concern that they would not be able to provide response, based on their resources.

In 2015, a good example of international influence over national policies can be shown. WHO recommended that PLWH, regardless of their viral load, should have access to ART, which Portugal quickly implemented.[317]

Lastly during this interview, it was stressed that Portugal holds a position where it prioritizes the defence and protection of human rights regarding PLWH, as it is prescribed in the Portuguese constitution, providing a very favourable legal environment[318], which will be explored more in depth in the following sub-chapter. The

[313] Interview conducted by Sara Silva Oliveira, NPHA, 22.07.2021.
[314] Ibid.
[315] Currently there is a mobile unit in Lisbon, since 2018, and a physical one also in Lisbon, since May 2021. An application process was also submitted to create one in Porto.
[316] Interview conducted by Sara Silva Oliveira, NPHA, 22.07.2021.
[317] Ibid.
[318] Ibid.

interviewee concluded that stigma and discrimination is still an unsolved issue, continuing to be a priority in both national and international programs.[319]

Therefore, in this sub-chapter, public policies were briefly addressed, and the context of the national program was provided along with its victories and challenges. However, as stated above, discrimination is still and issue, and giving the praise the Portuguese Legislation has received, the next sub-chapter will look at it, in order to better comprehend the gap existent between a good legislation and bad practices.

5.4. National legal framework

The legal context plays a significant role in the wellbeing of PLWH and vulnerable to HIV, provided that it ensures the protection of human rights. Therefore, the principle of non-discrimination, the principle of equality, the principle of dignity, including the right to the reservation of intimacy and private life, the right to medical secrecy, the right to work, the right to freedom, physical integrity and security are fundamental rights to PLWH, and will be particularly looked at in this sub-chapter, followed by a brief description of the law limitations identified in the study 'Stigma Index', from 2013. A new version is being developed this year (2021), however for the purpose of this study, it will not be addressed again as it does not meet the time framework (1983-2020), that this thesis aims to study.

During the 90's, some legislation was drafted and implemented that is worth mentioning. In 1991, the Supreme Court declared that it was no longer mandatory, for people with HIV, to indicate the specific reason that made it impossible for people to appear before the courts, and it is only necessary to indicate that the absence is justified due to illness.[320] This was an impactful step has the right to medical confidentiality is crucial to PLWH, in order for them to protect themselves of any consequence resulting from prejudice, stigma and discrimination. Two years later, at the initiative of the Ministry of Employment and Social Security, the Council of Ministers approved Decree-Law No. 412/93[321], which determined that 25% of the net results from the game

[319] Ibid.
[320] Dalmann, p. 143.
[321] Ministério do Emprego e da Segurança Social, Decreto de Lei nº 412/93, 1993, https://dre.pt/web/guest/pesquisa/-/search/540249/details/normal?q=412%2F93.

Joker, by the Holy House of Mercy, will be attributed to HIV/AIDS projects. In 1996, ART was provided for free, under the Order No. 280/96[322] of the Ministry of Health. Lastly in 1998, Decree-Law No. 216/98[323] was approved, establishing conditions for access to disability pensions for PLWH, which was an attempt to lessen the economic barriers PLWH face. This decree-law has been revoked.

In 2001, a very important law, within the context of HIV/AIDS prevention was passed, and was heavily praised in the international sphere. The legislation in question is the Law No. 30/2000[324], decriminalizing the acquisition or possession of drugs and psychotropic drugs for the purposes of own consumption. The sanitary intervention, in the context of drug addiction, falls under Service in Additive Behaviours and Dependencies (SICAD), from the Ministry of Health.[325] This body is also responsible for regulating and supporting integrated response centres (CRI).

The implementation of this law, significantly impacted PUID community, as it not only decreased the spread of HIV infection, but it also provoked a social change, where PUID, previously seen as criminals, after were seen as people who need the support and help form civil society.

The first legislation stating what should be considered discrimination, categorizing them as offenses, was only created in 2006, Law 46/2006[326], during the European Year Against Discrimination.[327] In the initial version, discrimination would only be considered on the ground of disability. This shows the impact that international actors have on Portugal's approach to discrimination.

In the context of sexuality and gender identity, in 2011, a very important law was passed in favour of the transgender community, which is part of the key population in

[322] Ministério da Saúde, Despacho nº 280/96, 1996, https://dre.pt/web/guest/pesquisa/-/search/1067275/details/normal?q=280%2F96.
[323] Ministério do Trabalho e da Solidariedade, Decreto de lei nº 216/98, 1998, https://dre.pt/web/guest/pesquisa/-/search/423250/details/normal?q=216%2F98.
[324] Assembleia da República, Lei n.º 30/2000, 2000, https://dre.pt/web/guest/pesquisa/-/search/599720/details/normal?q=30%2F2000.
[325] Sacramento, p.6.
[326] Assembleia da República, Lei n.º 46/2006, 2006, https://dre.pt/web/guest/pesquisa/-/search/540797/details/normal?q=46%2F2006.
[327] Marques, Duarte and Águas, p.8.

the HIV/AIDS context. The Law No. 7/2011,[328] which regulates legal gender recognition. Later in 2018, Law No. 38/2018, stated the right to self-determination of gender identity and gender expression and the protection of each person's sexual characteristics, including the principle of non-discrimination.

In the following year, 2012, the Resolution of the Assembly of the Republic No. 123/2012, was approved and under the article 30, it states the contribution to the cooperation with ACP Countries[329] to develop and strengthen their national programmes to combat HIV/AIDS at all levels (i.e., gender dimension, legal frameworks, context-based approach, universal access to sexual and reproductive health) with the involvement of all relevant actors.

In the Portuguese Legislation, Discrimination is defined in Article 3, Law no. 93/2017[330], as the following:

- any distinction, exclusion, restriction or preference on account of the factors referred to in Article 1[331], which has as its purpose or effect the annulment or restriction of the recognition, enjoyment or exercise, on equal terms, of rights, freedoms and guarantees or social and cultural economic rights[332].

Furthermore, it proceeds to define different forms of discrimination:

- (a) 'direct discrimination': where a person or group of persons is treated unfavorably on the basis of the factors referred to in Article 1, in particular in relation to that which is, has been, or may be given to another person or group of persons in a comparable situation;[333]

[328] Assembleia da República, Lei n.º 7/2011, 2011, https://dre.pt/web/guest/pesquisa/-/search/278187/details/normal?q=Lei+n.%C2%BA%207%2F2011.
[329] ACP Countries – African, Caribbean and Pacific Countries.
[330] Assembleia da República, Lei nº.93, artigo 3º, 2017, https://dre.pt/pesquisa/-/search/108038372/details/maximized.
[331] Article 1, Object,
This Law establishes the legal regime for preventing, prohibiting and combating any form of discrimination on grounds of racial and ethnic origin, colour, nationality, ancestry and territory of origin.
[332] Assembleia da República, Lei nº.93, artigo 3º, 2017, https://dre.pt/pesquisa/-/search/108038372/details/maximized.
[333] Ibid.

- (b) 'indirect discrimination', on account of the factors referred to in Article 1, an apparently neutral provision, criterion or practice places a person or group of persons at a disadvantage, in particular compared to another person or group of persons, unless that provision, criterion or practice is objectively justified by a legitimate objective and the means used to achieve it are appropriate and necessary;[334]
- (c) 'discrimination by association': which occurs on grounds of relationship and/or association with the person or group of persons to whom they are assigned or who have the factors indicated in Article 1;[335]
- (d) 'multiple discrimination' means that resulting from a combination of two or more factors of discrimination, and in this case the objective justification permitted under point (c) shall be in place for all the factors concerned.[336]
- (e) 'harassment': behavior relating to the factors referred to in Article 1, occurs for the purpose or effect of violating the dignity of a particular person or group of persons and creating an intimidating, hostile, degrading, humiliating, destabilizing or offensive environment.[337]

Here it is shown how the Portuguese national legislation broadens the concept of discrimination, which is useful when analysing HIV/AIDS discrimination, as direct discrimination is not always the case that PLWH face.

According to Portuguese legislation, some discriminatory actions are considered crimes, as stated for example under the Decree-Law No. 48/95, Article 240, regarding Racial, Religious or Sexual Discrimination, where discrimination is considered a crime when committed by a constitution of organizations[338] or the disclosure to the public of materials that incite discrimination, violence against a person or group, or hatred, based

[334] Ibid.
[335] Ibid.
[336] Ibid.
[337] Ibid.
[338] Assembleia da República, Código Penal, Decreto-Lei n.º 48, artigo 240º, 1995, https://dre.pt/web/guest/legislacao-consolidada/-/lc/73922379/202106252127/73280923/element/diploma.

on their ethnicity, race, religion sex or sexual orientation.[339] This Decree-Law was amended by Article 2 of Law No. 19/2013[340], effective since 23 March of 2013.

Hate crimes, also fall under this category and can be defined as the effective practice of acts of violence motivated by the victim's certain characteristic (as mentioned above), or belonging to a particular group, usually marginalized.[341] When this crime is expressed through arm of physical integrity and murder, the application of the highest penalty is possible.[342]

Others are considered offenses, when the individual is prevented from exercising his/hers/theirs[343],[344] rights, namely but not exclusive to, the access to goods and services, employment, vocational training, education (both public and private) and health system.[345]

The Portuguese legislation protects individuals from discrimination in the form of offence, in agreement with the sanction provided, for example, Law No. 93/2017, (mentioned above) 23 of August, it lays down the legal regime for preventing, prohibiting, and combating discrimination on grounds of racial and ethnic origin, color, nationality, ancestry and territory of origin[346].

The Assembly of the Republic shall, pursuant to Article 161 of the Constitution, according to the sanctions provided,

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[339] Ibid.
[340] Assembleia da República, Lei n.º 19, artigo 2.º, 2013, https://dre.pt/web/guest/legislacao-consolidada/-/lc/141459984/202107111125/73871548/element/diploma?q=decreto+de+lei+48%2F95#66469815
[341] APAV, 'Discriminação', *Intervenção*, [webpage], https://apav.pt/uavmd/index.php/pt/intervencao/discriminacao, (accessed 11 April 2021).
[342] Ibid.
[343] Considering Intersectionality, and the LGBTQIA+ community, this thesis aims to be as gender inclusive as possible, and language is essential to those who are subject to both symbolic and physical assault, as well as to better understand our identifications. In this context, the indefinite nature of theirs, refers not only with respect to gender, but also towards a whole range of binary distinctions that structure our thought.
[344] Marcos, Norris, Andrew, Welch, 'Gender pronoun use in the university classroom: A post-humanist perspective', *Transformation in Higher Education*, vol. 5, 2020, p.10, (accessed 7 May 2021).
[345] APAV, 'Discriminação', *Intervenção*, [webpage], https://apav.pt/uavmd/index.php/pt/intervencao/discriminacao, (accessed 11 April 2021).
[346] Assembleia da República, Lei nº.93, artigo 4º, 2017, https://dre.pt/pesquisa/-/search/108038372/details/maximized.

- the right to normal access of an economic activity, sell, lease or sub-lease of real estate, free access to public spaces,[347]
- access to health care, from both private and public entities,[348]
- access to education, both public and private,[349]
- freedom from segregation into classes as an internal measure of the entity, prohibition of any practice or measure by a body, official or agent of both direct and indirect administration of the State, including the Autonomous Regions and local authorities, that would condition or limit the exercise of any right, and prohibition of an act, with the intention of disseminating threatening, degrading and/or discriminatory information to the public.[350]

All the mentioned above falls under Article 4[351].

Any citizen, who was confronted with a situation of discrimination, whether this individual was the victim or not, can report it to the competent authority.[352] Regarding crimes, both the crime of discrimination itself and hate crimes, are considered public crimes and, therefore, anyone can report them to the authorities, the Police or Public Prosecutor.[353] However, in respect to the offenses, there are two specific situations that are worth mentioning:

- If the discriminatory act was committed at the workplace or by the employer, in this case the authority responsible for receiving said complaint, would be the Authority for Conditions at Work[354] (ACT).[355]
- the Commission for Equality and Against Racial Discrimination (CICDR)[356], which works with the High Commissioner for Migration (CMA)[357], should receive all the other complaints from discriminatory situations.[358]

[347] Ibid.
[348] Ibid.
[349] Ibid.
[350] Ibid.
[351] Ibid.
[352] APAV, 'Discriminação', *Intervenção*, [webpage], https://apav.pt/uavmd/index.php/pt/intervencao/discriminacao, (accessed 11 April 2021).
[353] Ibid.
[354] Autoridade para as Condições no Trabalho (ACT).
[355] APAV, 'Discriminação', *Intervenção*, [webpage], https://apav.pt/uavmd/index.php/pt/intervencao/discriminacao, (accessed 11 April 2021).

Furthermore, the right to not be discriminated, involves the principle of equality, which is enshrined under article 13 of the constitution of the Portuguese Republic, and under article 26, which provides legal protection against any form of discrimination.[359] Formal equality, read as equality before the law, applicable to everyone.[360]

Regarding the right to private life, is enshrined in the Portuguese Constitutions of the Republic, under article 26/1[361], moreover, the right of personality is directly linked to the principle of dignity, which presupposes the person should benefit from space of privacy, i.e., domestic, family, sexual or affective life context.[362] The right to private, can be understood has having two "sub-rights", the first one is the prevention of stranger's access to information regarding private and family life, the second one that no one can disclose the information about the others private life, enshrined under the Article 80º of the Civil Code.[363] Which is fundamental for PLWH, as many times their status is used as blackmail. This is stated under article 26/2, stressing that effective safeguards the misuse of intimate information relating to persons and families, of becoming publicly known.[364] Thus, at the criminal level, the crime of violating someone's private life is under article 192º, and, for the violation of secrecy under article 195º, both in the Penal Code.[365] This is also applicable to medical secrecy, which goes hand in hand with the need for legal, informed and expressed consent for any medical procedure, failure to respect this can constitute an offense on the grounds of physical integrity (enshrined as a fundamental[366] right, under article 25º/1, Constitution of the republic) and freedom.[367] However, it is understood that regarding medical

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[356] Comissão para a Igualdade e Contra a Discriminação Racial (CICDR).
[357] Alto Comissariado para as Migrações (ACM).
[358] APAV, 'Discriminação', *Intervenção*, [webpage], https://apav.pt/uavmd/index.php/pt/intervencao/discriminacao, (accessed 11 April 2021).
[359] SER+, 'Direito à reserva sobre a intimidade da vida privada', *Direitos e Obrigações conexos com a infeção pelo VIH e à SIDA*, p.15, <http://www.sermais.pt/media/86/File/VIHDireito/Direitos_Obrigacoes_conexos_Infecao_pelo_VIH.pdf >.
[360] Ibid, pp.15-16.
[361] Ibid.
[362] Ibid, p.1.
[363] Ibid, pp. 1-2.
[364] Ibid, p.3.
[365] Ibid.
[366] Fundamental rights are classified as legal positions of individuals against the State.
[367] SER+, p.3.

secrecy, there is no real absolute secrecy, as conflicts between private interest and general interest may arise, and the common good prevails, assuring that assessment of the following three principles was done, adequacy, necessity and proportionality.[368]

Regarding consent, the possibility for revocation is enshrined under article 81/2 of the Civil Code, prioritizing this way personality rights over any contract.

Regarding the right to work, the National Data Protection Commission considers that HIV-positive persons, as a jobseeker, are not obliged to provide information concerning them or to be tested, as this can not be used to prevent someone from getting a job or to substantiate their dismissal.[369] This is stated under the Code of Conduct on HIV/AIDS, from ILO.[370] According to Portuguese law, under article 14º (non-discrimination) no one can be fired under grounds of sickness, however, under article 333º of the Labour Code, it is allowed on extreme cases, the reduction of activity or suspension of contract, taking into account the primary interests of the worker and the safety duties.[371]

With that being said, now the limitations of law, recognized in the 2013 Stigma Index will be indicated.

Firstly, the typification of cases of discrimination does not include, neither specifically nor directly the discrimination at the personal level (i.e., from family members).[372] Which when addressing HIV/AIDS-related discrimination, would be important, as there are many cases of family members discriminating against PLWH.

Secondly, the lack of a sanction applicable to Public Services, in the event of non-compliance obligation, regarding non-discrimination. As mentioned in the interview conducted for this study, Ana Duarte, explained that there are still many situations of discrimination when it comes to dentists, even though, as mentioned in another

[368] Ibid, pp. 5-7.
[369] Ibid, p. 11.
[370] International Labour Office, 'An ILO code of practice on HIV/AIDS and the world of work', 2001, https://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/publication/wcms_113783.pdf.
[371] SER+, p. 20.
[372] Marques, Duarte and Águas, p.111.

interview with Joana, informed that an order from the Secretary of State was issued, to extend the national oral health promotion programs (i.e., dental checks) to PLWH.[373] When confronted with the question as to why discrimination can be felt, in the context of oral health, she explained that even though Portugal Legislation is really good, there needs to be a bigger investment in training professionals, as many times in their professional life they were not trained to be sensitized to these situations, leading to irrational fear.[374]

Therefore, I agree with Joana, that cases of discrimination need to be identified, and based on that to inform and train professionals, both on how to deal with these situations and about the applicable legislative framework, instead of sanctioning, as this discrimination is based on fear and ignorance.

The third limitation mentioned, is the lack of dissemination of information in a continuous and consistent way, focused on target audience, regarding the rights recognized by the law. This is both the case for PLWH affected by it, or services and individuals committing discrimination.

Therefore, in this sub-chapter, the most impactful legislation, regarding PLWH, in the context of HIV/AIDS-related discrimination, were identified, following with a brief analysis of some of the fundamental rights of PLWH, and concluding with showcasing the limitations of law, regarding this form of discrimination, identified in the Stigma Index. Unfortunately, and due to lack of data, this was the only analysis regarding limitation of law, that was provided.

As a conclusion, it is safe to assume that, in legislative terms, the Portuguese law is in fact very satisfactory, however, it failed to prevent and irradicate discrimination, in the context of HIV/AIDS. This gap between a good legal framework and bad individual practices, shows that in fact, it is important to have a strong legal framework, but now more investment towards awareness, sensibilization and training should be done. As most of the discrimination felt nowadays is based on old beliefs, that can date prior to the epidemic, and HIV/AIDS, gave it a place to be amplified, and according to the

[373] Interview conducted by Sara Silva Oliveira, CAD, 18.06.2021.
[374] Interview conducted by Sara Silva Oliveira, NPHA, 22.07.2021.

dominant group justified. Therefore, this form of discrimination, is mostly based on fear and ignorance, so, I believe that further sanctioning, will in fact not eradicate stigma, but with the appropriate training tools, especially training focused on human rights, could potentially significantly decrease this stigma and discrimination.

Nevertheless, addressing HIV/AIDS discrimination through legal tools most present challenge is the misinformation regarding about antidiscrimination laws, which leads to people being unaware of the steps they can take to seek remedy. Therefore, the importance of NGO's, such as Portuguese Victim Support Association (APAV), mentioned before. Additionally, legal services can be unaffordable or even inaccessible to most vulnerable communities[375], which is a violation of human rights in itself[376]. Which further proves the emergency for a focus on discrimination related to HIV/AIDS, in order to demand accountably and legitimize the stigma PLWH may undergo.[377]

However, laws can prove to be ineffective, unless, the society as a whole supports its values and expectations, which can start by involving civil society in the development and enforcement of anti-discriminatory laws, creating this way a much needed interaction between law, culture, and social values, providing a better comprehension of the goal in question[378], and therefore an easier transition towards acceptance.

In the next sub-chapter, the findings regarding the key populations in Portugal will be presented.

5.5. Key Population in Portugal

In this subchapter, key populations will be studied in four different categories, firstly migrants, including those with unregular status, secondly those groups who are included in the key populations, based on their sexual behaviour, such as men who have

[375] Maluwa, Aggleton, and Parker, p.6.
[376] International Covenant on Civil and Political Rights (adopted 16 December 1966, entered into force 23 March 1976) 999 UNTS 171.
[377] Maluwa, Aggleton, and Parker, p.6.
[378] Ibid.

sex with men and heterosexuals, women[379], and sex workers. Thirdly, the PUID community and lastly the Prisoners, which unfortunately, due to lack of trusting data, will be a brief review.

Bearing in mind the following definition of Key Populations, used in this Master thesis,

- Key populations include LGBTQIA+; Heterosexuals; people who use drugs (PUID); people in prisons and other closed settings; sex workers; Undocumented Migrants; Women.[380]

5.5.1. Migrants

In the following sub-chapter, this study will be focusing on migrants, as they tend to present high rates of undiagnosed HIV infection.[381]

This can be explained based on factors associated with sex work, exposing these individuals to violence, aggravated in women's case, inconsistent condom use and a high number of sexual partners, which are considered high risk behaviors, regarding the infection.[382] This adds to the layer of discrimination attached to migrant-related factors, i.e., social exclusion, irregular status, and overall lack of awareness regarding health rights and available services.[383] In these particular cases, migrants are faced with a "triple stigma", the first related to their migrant status, second related to their work activity, as sex work is still to this day frown upon by society, and lastly their HIV status, and the fear of being discriminated and the potential personal and social consequences attached to this can pose a barrier to HIV testing and accessing other health related services.[384] In spite of Portugal providing free, confidential and anonymous testing and treatment, regardless of their legal status, as mentioned before,

[379] By women, it is meant the general female population, as they are considered key populations, for being firstly biologically more exposed to it, and also considering the gender dimension of HIV/AIDS-related discrimination, such gender-based violence.
[380] WHO EUROPE, UNAIDS, 'Progress on Implementing the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia', February 2004, p.87, https://www.euro.who.int/__data/assets/pdf_file/0011/53858/E92606.pdf.
[381] Dias and others, p. 559.
[382] Sónia Dias and others, 'Health Services Use and HIV Prevalence Among Migrant and National Female Sex Workers in Portugal: Are We Providing the Services Needed?', AIDS and Behavior, 21.8 (2017), p. 2317 <https://doi.org/10.1007/s10461-016-1511-x>.
[383] Ibid.
[384] Ibid.

however, there is still low rates of testing among this community, and lack of awareness and fear of discrimination, can be assumed to highly influence this phenomena.[385]

Another factor that can further explain this phenomenon is health service professionals also having a limited knowledge of the legal framework regarding access to health and its applicability, which my lead to further exclusion of the migrant community and intensifies their fear of being reported to the authorities, when they have irregular status.[386]

A member of CAD, in an interview conducted for this study, revealed that in fact Portugal has a very good policy of integrating immigrants, as we will see more in detail below, however this does not mean they enjoy the same rights as a national citizen[387]. Ana Duarte proceeded to explain the case of HIV, and how even if a person is undocumented, equal access to treatment is still ensured, which is not the case in other countries.[388] Nevertheless, as showed above, bureaucratic challenges still apply. She provided the example of someone who can't access health services because they do not have a citizen number.[389] The reason why this individual does not have access is because the administrative staff working in the health services often do not have the training or knowledge on how to deal with any situation that steps outside the "standard situation".[390]

Therefore, there are situations that although they are provided for in the law then at the practical level it is not applied for lack of awareness and knowledge of the law. And from the point of view of the immigrant, (someone who already has difficulty in the language and navigating the system), makes it difficult to exercise his/hers/theirs rights, which migrants are often unaware they have.

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[385] Ibid, p. 2319.
[386] Cristianne Maria Famer Rocha and others, 'MIGRAÇÃO INTERNACIONAL E VULNERABILIDADE EM SAÚDE: TÓPICOS SOBRE AS POLÍTICAS DE SAÚDE E DE SAÚDE SEXUAL E REPRODUTIVA EM PORTUGAL', *Hygeia - Revista Brasileira de Geografia Médica e da Saúde*, 8.15 (2012), p.193, <http://www.seer.ufu.br/index.php/hygeia/article/view/17881> [accessed 19 May 2021].
[387] Interview conducted by Sara Silva Oliveira, CAD, 18.06.2021.
[388] Ibid.
[389] Ibid.
[390] Ibid.

In Portugal, due to the increase of foreign-born residents, mainly from Brazil, Portuguese-speaking African countries, and Eastern European countries, since 2001, immigrants are entitled to health care, i.e., free health care to pregnant women, such us antenatal care, as well as to recent mothers, family planning programs and to persons with transmissible diseases, regardless of their legal status.[391] Free antiretroviral treatment is also offered to HIV patients, not excluding immigrants.[392] However, the high proportion of undiagnosed and late diagnosis of HIV, among immigrants, represents a significant challenge[393] for the State to achieve its health goals. According to a study made in 2010, the majority of immigrants rely on NHS, when they experience any kind of issue related to HIV, and that many reported a lack of information regarding health services.[394] The lack of awareness and availability of health services represent a barrier, providing adequate information, i.e., where to access health services in the area of HIV, is a must in order to ensure the proper and timely use of said services and national entities in cooperation with civil society, need to take upon the responsibility to provide suitable information.[395] In other words the right to information must be respected and upheld by the State.

Differences within the migrant group regarding testing were spotted, between women and men (gender dimension). Women[396] were more likely to be tested, and this might be explained due to the fact that if they are at a reproductive age, are most likely to use sexual and reproductive health services, where HIV test is offered as a routine procedure.[397]

However, according to an interview conducted for the purpose of this thesis, with a Doctor who works in HIV matters since 1990, the interviewee stated that its only routine procedure for key populations.[398] Additionally, it was stressed that there is an added discrimination factor from health practitioners against people who have HIV, and

[391] Dias and others, p. 564.
[392] Ibid.
[393] Ibid.
[394] Ibid.
[395] Ibid.
[396] This explanation is based on sex and not gender identity.
[397] Dias and others, p. 564.
[398] Interview conducted by Sara Silva Oliveira, Annon, 16.07.2021.

that is the question of race, the interviewee claims is much harder for someone of color[399], which makes sense from an intersectional point of view, adding another layer of discrimination to this group.

Even though, regardless of legal status, one can access these services, this study clearly shows a meaningful decrease of persons getting tested, if they are undocumented, as they use health services less frequently.[400] Another gap was showed between Latin Americans and Africans, and Eastern Europeans and Asians, as the first one tended to have higher rates of testing, than the latter.[401] This can be understood based on language barriers, as the first ones speak Portuguese, whereas the latter is less likely to.[402]

Being older than 25 years old, and having a high level of education, was also proved to be associated to higher rates of testing.[403]

Therefore, involving community-based partners in HIV testing initiatives, alongside cultural mediators as well as peer educator, is vital, as it establishes a trusting relationship, and brings a much needed inside knowledge to the design of preventive measures, thus increasing awareness, promoting testing, providing adequate information,[404] and effectively replying to the needs of this group.

Regarding the context of legislation, in 1990, the Assembly of the Republic approved the Basic Health Law[405], which recognizes the right of individuals to provide global health care. This right is carried out through a universal, general NHS, taking into account the economic and social conditions. Later in 2001, with the Order No. 25,360/2001[406], a significant step was taken towards promoting universal access to health services for the immigrant community, providing equal treatment for both pharmaceutical assistance and health care. However, at this moment, this was only

[399] Ibid.
[400] Dias and others, p. 564.
[401] Ibid.
[402] Ibid.
[403] Ibid, p.565.
[404] Sónia Dias and others, (2017), p. 2320.
[405] Assembleia da República, Lei nº 48/90, 1990, https://dre.pt/web/guest/pesquisa/-/search/574127/details/normal?l=1.
[406] Diário da República, II Series, no. 286, 2001.

applicable for foreign citizens legally residing in Portugal, although if they can submit a document proving they have been living in the country for longer than 90 days, they would be entitled to these rights.[407]

The Decree-Law No. 173/2003[408] introduced the payment of moderator fees to all citizens who pay the Social Security tax, but exceptions do exist, exempting from payment children under 12 years old, youth in consultation at the Adolescent Care Center, pregnant women, as well as women in family planning consultation, people who live with chronic diseases, unemployed persons, provided they are registered in the employment center and beneficiaries of subsidies on the basis of economic challenges.[409]

The promotion of access to health services is included in the Plan for the Integration of Immigrants (PII), which determines a set of nine specific measures to ensure better integration of immigrants in the health area with the participation of thirteen Ministries.[410] Therefore, in 2003 the Health Office of the National Immigrant Support Center was created in close collaboration between the Ministry of Health and the Alto Comissariado para a Imigração e o Diálogo Intercultural[411] (ACIDI), with the objective to identify challenges faced by the migrant community, to provide adequate information regarding their rights to health, and refer, when necessary, individuals to social aid and health care services.[412]

Regarding minors who are immigrants and unlegalized nationals, they are covered by Decree-Law No. 67/2004[413], which regulates the creation of a national registration, which then allows access to NHS services, providing the same rights as national minors.

[407] Rocha and others, p.194.
[408] Diário da República, I Série – A, no. 176, 2003.
[409] Rocha and others, p.194.
[410] Ibid, p.195.
[411] The High Commissioner for Immigration and Intercultural Dialogue.
[412] Rocha and others, p.195.
[413] Diário da República, I Série -A, n.º 72, 2004.

A year later, in 2005, the Constitution of the Portuguese Republic established the right to health and health protection, under article 64, Diário da República, I Série - A, no. 155, for all citizens.[414]

In conclusion, it is visible that once again, the legislation provides a good tool, however, is not being properly implemented, in the sense that information about the rights of this community do not reach migrants. Additionally, it is reflected that the fear of discrimination turns people away from diagnosis and treatment, however, regarding this group, there are two added factors of discrimination, if a person has an unregular status, or if it is a person of color, which leads to racist discrimination. In case the individual that has both of these characteristics, it is understandable as to why this person would avoid seeking help based on the fear of being discriminated against, as this has been this person's experience prior to diagnosis.

5.5.2. Sexual beings, not criminal beings

With the initial thought that HIV/AIDS, in the start of the epidemic, was called "GRID" for "Gay-related Immune Deficiency Syndrome"[415], the following sub-chapter will briefly address the persons that are considered key populations, on the grounds of their sexual behaviour, but first and foremost consensual sexual encounters should be destigmatized and normalized.

In other to better understand Portuguese sexual behaviour and how this society perceives sex in general, a quote from Professor of Sociology Boaventura de Sousa Santos, 'one of the main characteristics of Portuguese society is the internal heterogeneity of both the principles of regulation and the logics of emancipation', which in other words, he was trying to bring attention to how deeply the Judeo-Christian tradition has shaped the main modelling axes of such heterogeneity, showcasing the deep rooted influence of religion in this matters.[416]

[414] Diário da República, I Série - A, no. 155, Artigo 64º, 2005.
[415]Thomas J. Coates, 'The Fight Against HIV Is a Fight for Human Rights: A Personal Reflection', *JAIDS Journal of Acquired Immune Deficiency Syndromes*, 82 (2019), 91 <https://doi.org/10.1097/QAI.0000000000002165>.
[416] Boaventura de Sousa Santos, 'Pela Mão de Alice – O Social e o Político na Pós-Modernidade.', Porto: Afrontamento, 1995.

Concerning sexual and reproductive rights, in 1996 the International Conference on Population and Development, represented a milestone in the adoption of a comprehensive definition of sexual and reproductive health and their rights, highlighting the right of people to achieve the highest level of sexual and reproductive health. In 2002, the European Parliament, reinforcing the commitments made at the Cairo and Beijing Conferences, adopted the Resolution on Sexual and Reproductive Health Rights, which recommends that Member States provide accessible sexual health services, adequate and quality reproductive products, with particular attention to the most vulnerable groups.[417] Two years later, the Parliamentary Assembly of the Council of Europe adopted the European Strategy Resolution for the promotion of sexual and reproductive health and rights, which calls for the development of a European strategy to promote these rights and to prepare, develop and implement comprehensive national health strategies, as well as recommendation.[418]

In the Portuguese Constitution it is established that it falls under the State's responsibility to guarantee the right to family planning and the promotion of a healthy, rewarding and responsible sexual and reproductive life, under the umbrella of individual freedom.[419] The State is also responsible for organizing legal and technical structures that allow free access to all citizens, without discrimination, as well as dissemination of information, free care, confidentiality of consultation, prevention of unwanted pregnancies and the fight against STDs.[420]

Regarding sexuality, Portugal HIV prevention measures have consisted of the distribution of information and condoms, social and marketing strategies, putting the individual at the centre, not always deprived of moralization, pushing accountability onto the person, to adopt safer sexual practices.[421] It is also important to point out the lack of diversified images, reinforcing i.e., stereotypes regarding gender norms, being in

[417] Rocha and others, p.194.
[418] Ibid.
[419] Ibid.
[420] Diário da República, I Série - A, no. 155, 2005.
[421] Sacramento, p.4.

itself contra productive. However, unlike other countries, in Portugal this kind of campaigns don't incite much public debate, either in media, civil society or in academia.

There are four specific intervention vectors that can be identified: the first one is male responsibilities, the second female vulnerabilities, the third youth sexuality and lastly marginalized sexual cultures (LGBTQIA, sex workers).[422] Therefore one of the priorities must be dismantling the "hegemonic masculinity" ideal, the myths and beliefs that dictate youth sexuality and its relationship with condoms and provide an adequate sexual and gender education in primary and secondary schools.[423]

Even though the Portuguese legal framework stipulates mandatory sexual education, in all educational establishments, it's taught in a way that reproduces sexist models and lack of acceptance of different sexual identities.[424] Ana Duarte, in our interview agreed and claimed that sex education in Portugal is a myth, due to its poor execution and if it was done properly.[425]

Despite the changes that have occurred in the field of sexuality, towards increasing acceptance, gender continues to be a key variable, when understanding sexual behaviors. So, according to Campbell, traditional masculinity, which is associated with lack of prevention (condom use), explains some sexual behaviors in society, namely the recourse to paid sex, most associated with older, less educated men, who are less aware of the risk their behavior carries[426].

Regarding men who have sex with men, there has been some structural changes, particularly at the legislative level, (recognition of same-sex marriage in 2010, adoption by same-sex couples in 2015), which helps combat stigmas and social exclusion. However, currently there is a challenge that HIV/AIDS and LGBTQIA+ NGOs are

[422] Ibid, p.5.
[423] Ibid.
[424] Ibid.
[425] Interview conducted by Sara Silva Oliveira, CAD, 18.06.2021.
[426] Sofia Aboim, 'Risco e prevenção do HIV/Aids: uma perspectiva biográfica sobre os comportamentos sexuais em Portugal', *Ciência & Saúde Coletiva*, 17.1 (2012), p.110 <https://doi.org/10.1590/S1413-81232012000100013>.

trying to address, the access to PrEP, which is not only exclusive to this group, but for everyone who has been in a high-risk situation or belongs to the key populations.

Regarding sex work, most public initiatives are concentrated in the coastal part of the country, (i.e., Self-Esteem project), neglecting the interior of the country. The legal uncertainty regarding sex work (it is not criminalized but is also not formally considered a professional activity), accentuates social exclusion, and leaves this group unprotected, aggravating the situation, when the sex worker is also an undocumented immigrant.[427]

Therefore, there is a clear link between moralization of sex behaviour and discrimination. Portuguese society needs to deconstruct the heteronormative and the gender roles associated with it, as well as becoming more informed about sexuality in general. Better laws regarding sex work, and sex education in school, namely the curriculum should also be addressed by the State. Tackling discrimination against consensual sexual encounters, outside of what the dominant group perceives as normal, therefore justifiable, and worthy, in comparation to the others, that are unworthy and perverted. Only by truly addressing discrimination based on gender identity, and sexuality can a response to HIV/AIDS related discrimination really be impactful and effective.

5.5.3. Drug users: say no to a second-hand needle

In the following sub-chapter, the PUID community will be analyzed, in other to better understand the impacts of the policies that Portugal implemented, and that are praised within the international community.

The Portuguese HIV prevention strategy among PUID, consists mainly of an intervention that includes measures to reduce risks and minimize harm, i.e., a set of comprehensive public health procedures in which the focus is not on the cessation of drug use, but the reduction of risks and health damage, for themselves and for third parties, which may arise from addictive behaviors.[428] According to Collins et al., the main guideline principles of this model are the recognition of risk factors as social

[427] Sacramento, p.6.
[428] Ibid.

constructions, not falling onto moral issues and maintaining a clear pragmatic orientation, which are adaptable to the characteristics and contingencies of different scenarios.[429] This way, by removing the heavy and many times crippling moralization surrounding HIV/AIDS, Portugal is more capable of providing effective and targeted responses to this community.

In the late 1990's the subject of drug use in Portugal was highly debated and the judicial system was overwhelmed with drug related crimes.[430] In 1998 the Prime Minister organized a panel with academics and health practitioners to design a comprehensive national drug strategy, based on the concept of harm reduction and humanistic values, already challenging the criminalization of drug use.[431]

In 2000, there were counted 131 casualties related to drug use (2.3-6.4 per 1000 population aged 15 to 64 years old, were known to be using drugs, and new cases of HIV-related with drug addiction was 1430, amounting to 14% of people who indicated treatment within the public network).[432] It is important to bear in mind, that given the fact that up to this moment drugs were still criminalized, this pushed people away from accessing health services, so the number mentioned above is only a estimative of the data available.[433]

From July 2001, the Law 30/2000 was enforced, decriminalising drug use and possession (with a period of 10 days' supply of drugs and with the purpose for personal use), furthermore, the referral of users identified by law enforcement to the Drug Addiction Dissuasion Commissions.[434] It also had a very impactful consequence of changing the perception of drug users from criminals to someone who requires help[435], however discrimination still can be found against these groups, particularly when they are infected with HIV.

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[429] Ibid.
[430] Paula Vale de Andrade and Ludmila Carapinha, 'Drug Decriminalisation in Portugal', *BMJ (Clinical Research Ed.)*, 341 (2010), <https://doi.org/10.1136/bmj.c4554>.
[431] Ibid.
[432] Ibid.
[433] Ibid.
[434] Ibid.
[435] Ibid.

As a result of the implementation of the Law 30/2000, in 2005 PUID decreased to .5-3.0 per 1000 population aged 15 to 64, as well as the number of deaths related to drug use, from 131 in 2001, to 20 in 2008, and the new diagnoses of HIV-related to drug addiction from 1430 in 2000 to 352 in 2008.[436] This shows that policies based on moralization and abstention, with the aim of ending drug consumption, do not in fact work, and this approach has a much more effective result, as can be seen from the numbers presented.

Another very significant milestone was the Project "Troca de Seringas", or in English, Syringe Exchange, which is considered one of the "core approaches" in reducing risk and minimizing the damage caused by the use of drugs intravenously.[437]Due to the proactive provision for close intervention, street teams are crucial in the development of a preventive culture, contributing to inhibit the risks associated with consumption and sexuality in the context of drug addiction and for the therapeutic institutionalization of drug users. Additionally, the exchange of syringes is also carried out by pharmacies other primary health care units.

Regarding the political level, some gaps which are undermining the effectiveness of the HIV prevention measures, in the context of PUID, can be identified. The first gap to be addressed is the lack of a network of facilities for assisted consumption or supervised consumption, inaugurating the first as a mobile setting, in 2019[438], despite the fact that it has been legally contemplated since 2001, under the Decree-Law No. 183/2001[439]. The second gap is the strong, systemic, and widespread resistance to facilitate syringes and condoms in prisons[440], considering that prisoners are included in the key populations.

[436] Ibid.
[437] Sacramento, p.7.
[438] 'Inside Portugal's First Mobile Safe Consumption Site' <https://idpc.net/alerts/2019/07/inside-portugal-s-first-mobile-safe-consumption-site> [accessed 20 May 2021].
[439] Presidência do Conselho de Ministros, Decreto-Lei n.º 183/2001, 2001, https://dre.pt/web/guest/pesquisa/-/search/362322/details/normal?q=183%2F2001.
[440] Sacramento, p.7.

This shows that the gap of implementation of the existing legal framework, opposes a significant barrier to effectively prevent HIV, and is tightly related to discrimination, in particular the latter gap mentioned.

It is also worth mentioning that the work developed by civil society, in respect to drug policies, can be verified a high participation from associations dedicated to the defending human rights, in particular regarding the LGBTQIA+ community[441], showcases once more the intersectionality of discrimination, and that one person can't be reduced to only one characteristic that society frowns upon, and therefore feels legitimized to discriminate against.

Therefore, even though Portugal's approach was commendable during the early 2000s, efforts towards this community need to continue, especially when this community overlaps with other vulnerable factor, as it is the case with prisoners, which will be addressed in the following sub-chapter.

5.5.4. Prisoners: no freedom, no rights?

As mentioned before, this last sub-chapter will provide a brief overview of prisoners with HIV. This will be based on the interviews conducted for the purpose of this study, which will show the perspective of experts who work in the area of HIV and had, at some point of their careers, to deal with the issue of HIV/AIDS-related discrimination towards prisoners.

Ana Duarte, who worked in close proximity with prisons for four years, expressed how complicated the context is.[442] She claimed that you are not only deprived of the right to freedom, but other rights, such as the right to privacy (i.e., analysis results), right to health (access to medication, consultations)[443].

As seen before, the issue of confidentiality and privacy is very important from PLWH. The interviewee stated that in theory the only people who should have access to clinical results are prison's clinical team, however in practice it is not the case, because

[441] Santos, 2002, p. 603.
[442] Interview conducted by Sara Silva Oliveira, CAD, 18.06.2021.
[443] Ibid.

the ones who give the medication are often for example the guards, which are untrained people in this specific area of health and therefore depends on the individual sensitivity.[444] She continued by saying that there are certainly guards who respect the right to privacy, however, there are other people that don't, and weaponize it against the person (i.e., blackmail).[445]

Regarding the right to health, even though it is in the law, in practice it plays out very differently. Ana Duarte explained that there was a change in the law that improved the situation, in the sense that the hospital's specialty consultants would have to organize and go to the prisons and not the other way around, which in her opinion, works better, since the hospital has a greater capacity to organize and move than the other way around.[446] According to her, before, people often missed their appointments and ran out of medication.[447]

Additionally, João Brito also referred that research concerning discrimination inside prisons, needs to involve prisoners themselves, and that he is not familiar with any study conducted in this sense.[448] He continued by explaining that CAD received some complaints from prisoners, that they had finished the medication, that their last consultation was more than six months, and they didn't have a scheduled appointment yet, or if it was scheduled, they could not go, which is a form of discrimination.[449] João Brito also stressed that what is being done outside the prison setting should be replicated within prison societies.[450]

Ana Duarte completed João Brito thought, regarding the lack of data, being due to the opacity in this environment. In other words, it's very difficult for inmates, even those who want to speak, to be heard outside, and that it is very difficult to prepare a study in prison, as there are obstacles to everything. As she put it, ‘it's a very militarized medium, yet they themselves say that our business was security, and if there is any

[444] Ibid.
[445] Ibid.
[446] Ibid.
[447] Ibid.
[448] Ibid.
[449] Ibid.
[450] Ibid.

conflict of time, everything else is accessory', by accessory, it was meant the health consultations.[451]

Furthermore, Ana Duarte, talked about a project she worked on with the prisoners on the awareness-raising, and worked with the guards and technicians.[452] It was to create condom dispensing boxes in some places in the prison, to avoid "embarrassment" of having to ask for an appointment in clinical services.[453] According to her, this was completely boycotted, essentially by the guards, because they could not comprehend the need for condoms in an all-men prison.[454]

She concluded by stating that it is a complicated context where people's rights are not guaranteed.[455]

The interview conducted with a Doctor from the public sector, who deals with HIV/AIDS, confirmed that indeed the process regarding prisons are very chaotic, and many miss consultations due to lack of organization and resources.[456]

Therefore, based on this brief overview, it is clear that more in depth investigation in the context of HIV/AIDS-related discrimination in prisons, must be done, and it must include the true testimony of the prisoners. For this to happen, a safe space needs to be provided, as well as a thorough assessment of risk, to not put anyone in danger. The State should pay more attention to the complaints CAD is receiving and take a more hands on attitude when human rights are at risk.

5.6. Conclusion

In this chapter Portuguese context was studied, starting with presenting the findings regarding international human right's framework, followed by the findings of the Portugal's context. Then a close look at the National Program for Prevention and Control of HIV/AIDS and the national legal framework was presented. Lastly, the findings regarding the specificities of the key population in Portugal, was provided.

[451] Ibid.
[452] Ibid.
[453] Ibid.
[454] Ibid.
[455] Ibid.
[456] Interview conducted by Sara Silva Oliveira, Annon, 16.07.2021.

From the Portuguese context it is noted that between 1990 and 2000, Portugal had the highest incidence rate in Europe, turning HIV into a priority, leading to preventive measures and public policies with the aim of reduction the infection rate, civil society manifestations, regarding the fight against AIDS also gained significance in the late 90's. Portugal also assumed a position which considered social and economic factors, respect for human rights and involvement of the affected community, with the target not only to prevent but also to abolish discrimination,. However, whenever an intervention was only targeting prevention, it tended to face significant challenges. Additionally, it is visible that the legislation provides a good tool, however, is not being properly implemented, and properly explained to the general society, but most importantly to those to which this legislation affects, protects, or profits actions. Also, it is reflected that the fear of discrimination turns people away from diagnosis and treatment, and that in most cases, people are not only discriminated on the grounds of their HIV status, but also other characteristics. Therefore, there is a clear link between moralization and discrimination.

On another note, it is also seen a gap between international perception of Portugal's performance and its actual performance and produced results. Therefore, in the next chapter this study will identify the main victories Portugal had, according to the international community, and some international examples will be explored, regarding the areas Portugal is facing challenges.

Chapter 6. Portugal: From praise to practice

In the following Chapter, the main victories in the context of the Portuguese approach to combat HIV/AIDS-related discrimination, will be identified, following by presenting the most significant forms of discrimination present in the country. It will conclude by proving international examples, of countries that were praised on their approaches to these forms of discrimination.

6.1. Portugal as an example to follow?

As seen previously in this thesis, Portugal has been highly praised within the international community for its comprehensive approach to tackling the HIV/AIDS

epidemic. Due to the objective of this thesis, this sub-chapter it will only be mentioned the findings regarding the main measures that had a positive impact in combating HIV/AIDS-related discrimination.

According to the interview conducted for the investigative purposes of this study, João Brito stated that he does not find in the Portuguese legislation, a law that favours or criminalizes HIV, with the exception of a general law that prevents someone to cause harm to the health of other.[457] This can in fact be instrumentalized against PLWH, and Portugal should carefully look into said law, and measure the impact is having on PLWH. However, this law also protects PLWH on the grounds of discrimination, according to João Brito.[458]

Ana Duarte continues by claiming the non-criminalization is a vital issue, mentioning also another very crucial area of HIV/AIDS-related discrimination, the issue of non-disclosure, that in Portugal is not criminalized[459], which entails that people are free to choose whether or not they want to reveal their status, accounting they do not pose a threat to third parties, i.e., unprotected sexual encounters where the viral load is high and transmissible. She admits this is something where Portugal can serve as an example. Ana Duarte highlighted the important matter of not looking at the infection as an isolated issue, and neglect to address other issues closely linked with HIV/AIDS infection and related discrimination, i.e., consumption of drugs and sex work.[460] Which Portugal has decriminalized both, serving as example to follow, however, the latter presents several issues, as mentioned before, because even though it is not criminalized it is also not considered a profession, which leaves this group in a vulnerable position, and overall unprotected.

Nevertheless, regarding PUID community the decriminalization of drugs and the "Troca de Seringas", (both described and explained in the previous chapter), had a very positive impact, not exclusive to, but for the purpose of this study, in reducing

[457] Interview conducted by Sara Silva Oliveira, CAD, 18.06.2021.
[458] Ibid.
[459] Ibid.
[460] Ibid.

HIV/AIDS-related discrimination. Thus, it is understandable why is so often mentioned within the international context as an example to follow.

Regarding the right to health, Portugal has a very good legislation, ensuring universal, free, and confidential access to testing and treatment. However, as seen before, even though this does not discriminate for example, on the grounds of economical means, the stigma and discrimination felt by PLWH, still to this day, needs to be addressed with more attention. Only by eliminating the of the stigma and discrimination surrounding HIV/AIDS, can increase the testing and access to treatment, which would then lead to a better control of the epidemic and even to its end, as purposed by UNAIDS, by 2030. Nonetheless, regarding goals set out by UNAIDS, in particular case the 90-90-90 strategy, Portugal was praised on its performance, as it achieved said goals, while also tackling the current pandemic (COVID-19). However, as explain before, national experts are suspicious of this victory.

Regarding the non-regulation of serological status, it is not criminalized, which is a very good example to be followed by the international community.

Another great accomplishment of Portugal public policy, in regard to HIV/AIDS-related discrimination, which was achieved by the impact of CAD, was the regulation for people with HIV/AIDS to access municipal swimming pools[461]. Which might seem like a small victory, however, it showcases the level of discrimination present in the country.

Following CAD's impact of victories in the fight against HIV/AIDS discrimination, Ana Duarte, also mentioned the removal of HIV to access careers in the fireman brigade, in the police force with the republican national guard (GNR) and public security police (PSP), and park rangers[462]. As the regulations for access before reflected the regulations to access a career in the armed forces.

This highlights the impact of civil society, more in particular the role of NGOs in advocating for PLWH or vulnerable to get infected, fighting for their human rights.

[461] Ibid.
[462] Ibid.

So, as seen above, Portugal has several victories which it can be proud of and serve as an example. However, it is important to stress that HIV/AIDS discrimination, often adding to discrimination based on other grounds (race, sexuality, etc…) is still present and needs to be properly addressed. Therefore, in the following chapter we will look at the international examples, that Portugal should consider adopting.

6.2. Lessons to be learnt from the international sphere

Portugal has two forms of structural discrimination, one is specific but not exclusive to the Portuguese case, and the other one is a global issue that should be addressed by States as soon as possible. The first form of structural discrimination identified is regarding health or more particularly, life insurance. The second one is regarding the access to a career in the armed forces, which requires a negative HIV status to enrol. With that being said, and after seeing how Portugal can serve as an example within the international community, the following sub-chapter purpose is to identify good practices in other countries regarding HIV/AIDS-related discrimination, that Portugal should consider adopting.

Starting with the structural discrimination regarding the access to a career in the Armed Forces, which is a violation of Human Rights (right to work), I would like to acknowledge that in fact is extremely difficult to negotiate with military agencies, but that this should not discourage advocating for PLWH human rights, it just means that extra effort and attention must be devoted to said issue.

Following the other form of structural discrimination in Portugal, insurances. According to Ana Duarte, a person with HIV, in the majority of situations can not buy a life insurance, for example to buy a house[463] (right to housing), which in itself is a violation of human rights. Therefore, three situations can occur, in the first one the PLWH lies about their status, in the second one the insurance is refused, or in the third, the prices and benefits are raised significantly[464]. Well, this is a very clear violation of the principle of non-discrimination, and consequently it also discriminates a person with a less favourable economic situation. However, as the interview CAD members

[463] Ibid.
[464] Ibid.

informed me, a revision of a bill regarding insurance policies is being currently reviewed (2021), and they are hopeful for a satisfying result, that would show the hard work CAD, Ombudsman, and other NGOs and parliamentary groups with political intervention, will be reflected in the outcome of the bill[465].

With that being said, a good example can be found in Australia, with the Northern Territory: Anti-Discrimination Act 1996 (NT)[466], that prohibits discrimination, mentioning insurance policies. And the Queensland: Anti-Discrimination Act 1991 (QLD)[467] that also prohibits insurance from practicing any form of discrimination.

Another issue that Portugal, even though has decriminalized, needs special attention, sex work. As Ana Duarte said, during our interview, 'people are left without rights, they are not arrested, but they also have no rights, so they are unprotected'.[468]

New Zealand is a great example, in the context of sex work, as it is not against the law to pay for sexual services, operate a brothel or work as a sex worker.[469] However, this is not applicable to any third party facilitating underage sex work (under 18 years old), or to be a sex worker on a temporary visa, i.e., if you are visiting the country.[470] The New Zealand Model (known globally as such), is praised for its aim to uphold sex workers human rights.[471] In practice, sex workers can decide on their work conditions, and have an absolute right to refuse clients, with no need to provide reasonings[472], which accounts for sexual violence, i.e., rape. It is regulated by the Ministry of Business Inovation and Enterprise, Ministry of Health, Ministry of Justice among others.[473] In this law, the same labor rights given to any worker, regardless of their occupation is also applicable to sex work, i.e., access to health care and workplace protection.[474] Within the Prostitution Reform Act, passed in 2003, besides

[465] Ibid.
[466] 'A Quick Guide to Australian Discrimination Laws', p. 6.
[467] Ibid.
[468] Interview conducted by Sara Silva Oliveira, CAD, 18.06.2021.
[469] 'NZPC > The New Zealand Model' <https://www.nzpc.org.nz/The-New-Zealand-Model> [accessed 23 May 2021].
[470] Ibid.
[471] Ibid.
[472] Ibid.
[473] Ibid.
[474] Ibid.

decriminalizing sex work, it also stressed the need for safe sex practices[475], linking this to HIV. This decriminalization is supported by the UN, WHO, Amnesty International, as they do advocate for it.[476]

Therefore, this is a great example of a law that not only decriminalizes, but also offers protection, what is missing in Portugal, while upholding human rights, and reducing discrimination, which relates to HIV/AIDS-related discrimination demystifying prior prejudice against this group.

As can be seen from the described above, these countries can serve as examples for Portugal to upgrade its response to HIV/AIDS-related discrimination, as they show how in practicality this can work, while respecting human rights, and reducing both the impact of the epidemic and the forms of discrimination attached to it, that unfortunately are not exclusive to HIV/AIDS, (i.e., the stigma regarding sex work).

6.3. Conclusion

As it can been seen, Portugal has a very good and comprehensive legislation when it comes to HIV/AIDS in itself, however, more attention regarding HIV/AIDS-related discrimination needs to be paid. While addressing HIV/AIDS-related discrimination it is important to not view it as an isolated issue and put effort into the other forms of discrimination faced by the key populations. The notion of intersectionality is therefore crucial when designing an approach to HIV/AIDS-related stigma and discrimination. This can also be an answer as to why, in theory Portugal does have all the necessary tools to end HIV/AIDS-related discrimination, but seems to fall short. There are some success cases, at the international level, regarding issues that Portugal, to this day is still struggling with, which should inspire the country to tailoring it to its own needs.

Lastly, and as a current topic throughout this thesis, HIV/AIDS-related discrimination is a violation of human rights, that leads to further violations. It has become a vicious cycle, between being the cause of discrimination, while at the same time being the consequence of discrimination (the vulnerability of key populations).

[475] Ibid.
[476] Ibid.

Therefore, in the next chapter, a closer look will be taken in regards to Human Rights approach and violations in the context of HIV/AIDS-related discrimination.

7. Conclusions

7.1 Answers to the Sub-Research questions:

In this subchapter, the answer to my sub-research questions is going to be provided. Regarding my first sub-research question, the answer is a summary of my findings, and it is split into four parts, according to each decade. For my second sub-research, the main actors from my findings are going to be separated into two different tables, international and national.

1- How has HIV-related discrimination changed from 1983-2020 in Portugal?

7.1.1. 80s Decade

In 1983 the first case of HIV was diagnosed in Portugal. Bearing in mind the political climate change, from a dictatorship to a democracy in the late 1970s, the Portuguese population was more open-minded[477]. This can be seen in the case of the LGBTQIA+ community, as during the dictatorship they were persecuted by police and subjected to raids. With the democratization, more gay-friendly places appeared from the shadows.[478] However, with the first case of HIV infection in 1983, there was a social alarm and the LGBTQIA+, particular the gays were associated with HIV[479], which added a new layer of discrimination to this group. Thus, despite Portuguese society becoming more open-minded, the discrimination of society in general towards this group grew substantially, as well as within the LGBTQIA+ community. The discrimination felt within the community continued, even when highly effective therapies were developed (1996-97).[480]

[477] 'VIH: O Vírus Do Preconceito e Discriminação - MUNICÍPIO de LISBOA' <https://www.lisboa.pt/atualidade/reportagens/vih-uma-historia-que-ainda-se-escreve> [accessed 11 April 2021].
[478] Ibid.
[479] Ibid.
[480] Ibid.

Within the medical field, doctors and nurses also discriminated against PLWHA, as they were scared and ignorant about the infection.[481] My interviewee also supported this idea by stating, 'There was a lot of fear about how it was transmitted, for example, mattresses in the hospitals of people with HIV were burned.'[482]

The official authorities took a long time to react[483], as only two years later, in 1985, the AIDS working group and the HIV/AIDS case notification system was created to have a better grasp of the country's situation.

Nevertheless, in 1987, an important change happened: Azidothymidine (AZT) medication was made available for free in hospitals under the SNS. It is worth mentioning the crucial role activists played in the introduction of accessible treatments. NGOs such as Abraço[484] and GAT were crucial. The emergence of organizations that fought against HIV/AIDS and discrimination can be understood as a reaction to the late response from the official entities, as there was a gap between demand and supply of testing and treatment. Thus, demand in this context being the needs of PLWHA and the supply the adequate and effective response from the State.

7.1.2. 90s Decade

Regarding the 90s decade, in 1990, the National Commission Against AIDS was created. In 1991, the Supreme Court declared that it was no longer mandatory to disclose the HIV status as to why they could not appear before the courts (the justification of absence is due to illness). Showing this way an effort to reduce discrimination from justice officials. Additionally, between 1991-93, campaigns aimed at the general public were developed, with the goal to decrease discrimination and social exclusion. However, these were not very efficient as they were generally not very sensitive to the social and cultural factors underlying the transmission of the infection.

[481] Ibid.
[482] Interview conducted by Sara Silva Oliveira, CAD, 18.06.2021.
[483] 'VIH: O Vírus Do Preconceito e Discriminação - MUNICÍPIO de LISBOA' <https://www.lisboa.pt/atualidade/reportagens/vih-uma-historia-que-ainda-se-escreve> [accessed 11 April 2021].
[484] Hug Organization.

Later in 1996, a very important step taken towards decreasing discrimination, universal access to ART was granted. Here, it was noticeable the impact State support had on PLWHA, especially those who are in less favourable economic positions as it considered the social and economic factors of PLWHA.

In 1997, there is a change in society, and ILGA organized a Memory and Solidarity march in honour of the victims of HIV/AIDS. Additionally, in 1998, it was celebrated for the first time the Global Day Against AIDS. The mobilization of civil society brought awareness to the issue of discrimination and a chance for PLWHA to be heard and seen. In legal terms, in the same year, conditions for access to disability pensions for PLWH were granted, showing once again the State efforts to lessen the economic barriers. District committees against AIDS were created with the aim to decentralize the States response.

Nevertheless, a year later, 1999 was marked as the year with the highest diagnosed new cases of HIV, with 3339 cases. This is partly a result from more accessible testing. It is also important to bear in mind that at the end of this decade the subject of drug use (i.e., heroine, among other injectable drugs) was being highly debated in Portugal.

7.1.3. 2000s Decade

Concerning the 2000s decade, in 2001, Portugal had the highest incidence rate of AIDS and TB within Western Europe. However, in 2001, this changed with the Law 30/2000 that decriminalised all drug use and possession. This lowered both the transmission among PUID and the discrimination felt by this community. In the same year, equal treatment for both pharmaceutical assistance and health care was provided to the immigrant community. Even though at this moment this was only applicable to migrants with regular status, it already shows the State efforts to eliminate discriminatory barriers imposed on this group.

Later, in 2002, the national network of HIV counselling and testing centres were set up providing free confidential anonymous voluntary testing. Three years later, in 2005, the national coordination for HIV/AIDS infection was approved, and the Constitution of

the Portuguese Republic establishes the right to health and health protection for all citizens.

In 2006, for the first time, a description of discrimination was provided in the law (Law 46/2006), considering acts of discrimination as offences. This was a huge step, as now PLWHA who faced discrimination were now protected under the Portuguese Legislation. Later in 2007, the National Action Plan to Combat the Spread of Infectious Diseases in prison was approved, the National Council for HIV/AIDS infection and the National Civil Society Forum for HIV/AIDS were created.

Furthermore, in 2008, the Ordinance regulating the allocation of financial support to civil society organizations for the development of projects in the area of HIV/AIDS infection was approved. Towards the end of the decade, in 2010, CAD was created to assist with the response to HIV/AIDS discrimination. Additionally, same-sex marriage was legalized as an attempt to decrease stigma and discrimination towards the LGBTQIA+ community.

Moreover, it is interesting to reflect that between 2003-10 there was a significant increase in access to ART, and the disease was officially declared chronic. Nevertheless, until 2010 Portuguese public policies faced some limitations. For example, a fragmented model where administrative measures did not translate into concrete actions, leading to a gap between what was being done in theory and what was happening in practice. Prevention campaigns also carried, directly or indirectly, moralizing messages, and legal mechanisms for the notification and evaluation of systems were not developed, being supported by pre-existing services in public network.

7.1.4. 2010s Decade

Lastly, concerning the last decade. In 2011, Law No. 7/2011 regulated legal gender recognition, respecting, and ensuring the gender identity of individuals. This was a massive victory for the transgender community, and it shows the State's attempt to reduce discrimination surrounding this group, which is part of the key populations.

In 2012, the national programme for HIV/AIDS was integrated into the DGS, and the HIV/AIDS Prevention and Control Program 2012-2016 was approved. In the following year, 2013, the Stigma Index was designed to bring awareness to the central role discrimination and stigma plays in this epidemic. Later in 2015, adoption by same-sex couples was legalized, which helped to combat stigma and social exclusion. Additionally, in 2018, Law No. 38/2018 stated the right to self-determination of gender identity, expression, and sexual characteristics.

In 2019, PrEP was approved to be distributed for free by the hospitals of the SNS. However, according to the interviews, the implementation has not been successful, and there is a severe crisis regarding the necessary collection of data for adequate implementation. This is being interpreted by the community as a lack of interest from the government, rising frustrations.

7.1.5 Conclusion

As shown above, there is a clear change regarding discrimination from 1983 to 2020. In the 80s, LGBTQIA+ community struggled the most with discrimination which can be explained according to Goffman theory of Stigma. LGBTQIA+ community was perceived to have a 'spoiled identity' and, therefore, deserving of the virus, as explained by Correll. The discrimination among the LGBTQIA+ community towards PLWHA can be understood through Cuddy's theory of 'BIAS Map'. Discrimination was also felt by health practitioners, which can be understood as a demonstration of fear and ignorance. In this decade, the State was slow to respond, and activists and NGOs intervened, marking this way the long-felt presence of these actors throughout the years.

In the 90, the State became more active, however, the campaigns were done in a poorly manner, and did not consider the social and economic factors of PLWH. The moralization aspect of this campaign recalls Bourdieu's concept of symbolic violence, which led to social movements giving a voice to PLWHA. This can be understood according to Castells theory as these social movements are a clear example of resistance identities.

Nevertheless, in the 2000s decade, the situation seemed to improve as the State took action to lessen the discriminatory effects felt by PUID, Migrants, LGBTQIA+, and Prisoners. It also introduced discrimination into its legislation. However, there was an implementation gap, as shown above.

Lastly, in the 2010s decade, Portugal focused on protecting LGBTQIA+ community members through its legislation, however, in similarity to the previous decade, there is a disconnect with the Portuguese population. In other words, even though legally, Portugal has a strong law, the Portuguese society is still very discriminatory against PLWH. The justification for this phenomenon varies from case to case, but Jost and Banaji System Justification Theory, with the social concepts of 'Low status / High status; Ego justification / Group justification' can help understand it. Thus, Portuguese society still perceives PLWHA as a low-status group and believes discrimination is needed to justify its high status. This discrimination translates into ego justification. However, it is important to highlight that this discrimination is not only based on a person's HIV status but also other characteristics, deemed by the high-status group, as deserving of punishment.

2- What is the influence of international and national actors in combating HIV-related discrimination in Portugal?

Table 3. Influence of international actors in combating HIV-related discrimination in Portugal?

International actor	Influence on Portugal's Response to HIV/AIDS-related discrimination
Jonathan Mann	He initiated the international debate about HIV/AIDS-related stigma and discrimination. Additionally, he brought the human rights approach to HIV/AIDS response. Its influence is undeniable in the Portuguese fight against HIV/AIDS-related discrimination.
UNAIDS	UNAIDS has a significant influence on Portuguese responses, I only refer to the main summary of my findings. UNIADS and Portugal collaborated in the development of the Stigma index. Additionally, the 90-90-90 goals, the 0-0-0 goals, and HIV/AIDS guidelines. UNAIDS also praised Portugal's response, which can be understood as positive reinforcement, motivating the country to continue following UNAIDS recommendations.

UNFPA's	The right to sexual and reproductive health. This influence can be seen on Portugal's focus providing legal protection to the LGBTQIA+, Sex workers, and Women and Girls.
UN Human Rights Committee	Provided the right to privacy in the context of HIV/AIDS, which Portugal has adopted in its legislation.
WTO	The TRIPS, allowing for more affordable treatment, also positively influenced (but it is not the only factor) Portugal's decision for free treatment and diagnosis.
IPPF	Collaboration in the development of the Stigma Index study.
ICW	
GNP+	
European Council Resolution	The National Civil Society Forum for HIV was created based on the EC's recommendations.
ILO	Labour Platform against AIDS and the Code of Conduct Companies and HIV were adopted due to its influence
WHO	Among the many aspects in the Portuguese response that were influenced by this actor, I would like to highlight a direct and immediate influence: WHO recommended that PLWH, regardless of their viral load, should have access to ART, which Portugal quickly implemented.
ECDC	The national Portuguese response to HIV infection is part of the internationally established commitments by ECDC.
European Year Against Discrimination	Even though, not an actor, Law 46/2006 describing discrimination as an offense was developed and approved this year. There is a clear correlation between Portugal's action and the international climate.
CPLP	Cooperation Agreement between the Member States of CPLP, including promotion of policies that defend human rights in the face of discrimination and stigma associated with HIV/AIDS.

Source: compiled by Sara da Silva Oliveira (2021).

Table 4. Influence of national actors in combating HIV-related discrimination in Portugal?

National actor	Influence on
National Programme for HIV/AIDS	Public Policies, Campaigns.
CAD	The main actor that receives complaints regarding HIV/AIDS-related stigma and discrimination. Sharing this information with NPHA, for a more adequate response.

SER+	To recommend to the Government to adopt measures to combat HIV/AIDS infection in Portugal, with a view to its eradication, based on UNAIDS targets for zero new HIV infections, zero HIV/AIDS-related deaths, and zero discrimination
GAT	
ILGA	Social movements, bringing awareness and allowing a space for PLWHA to be heard.
Ministry of Labour	District Commissions to Fight AIDS ART was provided for free, under Order No. 280/96
Ministry Health	
Secretary of State for Youth	
Council of Ministers	Decree-Law No. 412/93, donating the profits of the gambling game 'Joker' towards the HIV/AIDS cause.
Ministry of Employment and Social Security	

Source: compiled by Sara da Silva Oliveira (2021).

Therefore, it is clear that Portugal was heavily influenced by international actors. It can also be assumed that Portugal praises itself as a State who prioritizes the rule of law, the promotion and respect for human rights. Additionally, in the national context, NGOs and activists had a significant impact in promoting change and decreasing discrimination. As seen with the first sub-research question, official authorities had a delayed response, which lead to NGOs and activists to advocate for the rights of PLWHA. National actors who are State actors also had a significant impact, even though more delayed than the NGOs and Activists, should be recognized.

Furthermore, Portugal can also be seen as a pioneer at the international level with its decriminalizing drug policies. However, due to the limitations of the study, the influence of national actors on other countries was not explored.

7.2. Answer to the Research question:

My answer to the research question is going to be split into the main human rights addressed during this study. Based on the above answers to the sub-questions, I turn now to answer the main research question.

How has HIV-related discrimination changed in Portugal, as seen from a Human Rights perspective?

7.2.1. Principle of Non-discrimination.

As it was shown, discrimination has changed throughout time and is still felt nowadays. Currently, discrimination is mainly based on individual interaction. However, there are two forms of structural discrimination that the State needs to address urgently. First, the access to the armed forces, which discriminates on the grounds of the HIV status and violates consequentially the right to work. Portugal would be a pioneer if it could eliminate this form of structural discrimination, as this is the case in every country in the world. Secondly, companies that grant contracts for life insurance, which tends to refuse or significantly increase the benefits regarding a person's HIV status. This can violate other human rights, for example, the right to housing.

Despite what was mentioned above, Portugal does have good, broad legislation regarding discrimination involving the principle of equality[485]. Nevertheless, the State has failed to ensure the right from freedom of discrimination, both at the structural level and at the individual level. Thu, even though Portugal's efforts must be recognized, it has not successfully fulfilled its obligations according to Human Rights Law.

7.2.2. Right to Health:

In 1990, the Basic Health Law was approved, recognizing the right to universal health care, and taking into account the economic and social conditions. In 2001, universal access to health services was extended to the immigrant community. The right to health was established under the constitution in 2005. Overall, Portugal has very good legislation regarding the right to health, and the constitution also attributes the responsibility to the State to guarantee the right to family planning and the promotion of a healthy, rewarding, and responsible sexual and reproductive life[486]. This entails that the State is responsible for organizing legal and technical structures to provide free access to health service to all citizens, without discrimination, to dissemination of relevant information, to the confidentiality of consultation, to prevention of unwanted pregnancies and to the fight against STDs. Regarding sexuality and gender identity, in

[485] Assembleia da República, Lei nº.93, artigo 3º, 2017, https://dre.pt/pesquisa/-/search/108038372/details/maximized.
[486] Assembleia da República, Lei n.º 120/99, 1999, https://dre.pt/web/guest/pesquisa/-/search/423065/details/normal?q=vida+sexual+e+reprodutiva.

2011, legal gender recognition was achieved, and in 2018 the right to self-determination of gender identity and gender expression and the protection of each person's sexual characteristics, including the principle of non-discrimination, was granted.

Therefore, Portugal has fulfilled its obligation under HLW regarding Health. However, there is still a gap in implementation due to a lack of information and knowledge about the legislation, both by health practitioners and by PLWH. This demands more training of professionals, particularly in the field of human rights.

7.2.3. Right to Information

Portugal has failed to fulfil its obligations under HRL, as there is a lack of awareness regarding access to health services. It also failed to provide adequate public campaigns deprived of moralizing messages and sensitivity to the characteristics of the key populations.

7.2.4. Right to Private Life and Confidentiality

This right is enshrined in the Portuguese Constitutions. The legalization of same-sex marriage also falls under the right to private life. Additionally, the non-criminalization of HIV infection and the non-disclosure are victories for the Portuguese State.

7.2.5. Right to Work

The National Data Protection Commission considers that PLWH are not obliged to provide information, as jobseekers, concerning their Status or to be tested, and this can not be used to prevent someone from getting a job or to substantiate their dismissal. Currently, Portugal seems to be fulfilling its obligations regarding the right to work, but I disagree for two reasons. First, the access to the Armed forces, and second the lack of protection provided to sex workers, therefore failing to fulfil its obligations.

Lastly, in the context of the prison, the State is failing to protect and ensure prisoners' rights associated with HIV/AIDS-related stigma and discrimination

7.2.6. Conclusion

In conclusion, even though the NPHA program is guided by the values expressed in the Universal Declaration of Human Rights, and a clear effort is being

made by the State to promote and respect human rights, Portugal still has to be held accountable in the areas it is failing. Therefore, in spite of the international praise Portugal has received on its response, in reality much still needs to be done to fully eradicate discrimination towards PLWH and respect and promote their human rights.

7.3. Final Statement

HIV/AIDS-related discrimination has essentially changed in a way that now is less visible. Stigma and discrimination still exist, whether internalized, or on the individual level, or the structural level. This can be explained through different, mainly psychological and sociological, theories. However, I want to highlight the fear factor and how it strangely has not changed much in the last 38 years. As one of the interviewees stated, when the fear factor in a community increases, human rationality and empathy tends to weaken. This can be seen throughout the entire HIV/AIDS epidemic, but also with the COVID-19 pandemic. In my opinion, humanity needs to learn from its past mistakes and learn to adapt and better react to a health crisis. HIV/AIDS has a heavy stigma attached to it that translates into significant discrimination and serious human rights violations, as it mainly impacts already marginalized groups. And as seen from the theories demonstrated, this discrimination is used as a justification for the morals and power that the high-status groups hold over the low-status group. We need to turn the resistance identities into legitimizing theories to overcome these phenomena. The human rights framework is an essential tool to achieve this goal.

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Annex A. – Table with Data Sources

RQ and Sub-questions	Primary Data Sources	Secondary Data
How has HIV-related discrimination changed in Portugal, as seen from a Human Rights perspective?	- Interview conducted with CAD - Interview conducted with the National Program for HIV/AIDS - Interview conducted with a health practitioner.	- Existing literature and meaningful academic work from sociology, psychology, human rights, international relations, philosophy. - Official reports from national NGO's, State Reports, International organizations, in particularly within the UN system (i.e., UNAIDS, UNFPA, WHO.) - International, regional and national treaties, and conferences.
How has HIV-related discrimination changed from 1983-2020, in Portugal?	-Interview conducted with CAD - Interview Conducted with the National Program for HIV/AIDS - Interview Conducted with a health practitioner.	- Existing literature and meaningful academic work with a focus on the Portuguese Context - Official reports from national NGO's, State Reports, -Media articles reporting on the HIV/AIDS epidemic.
What is the influence of international and national actors in combating HIV-related discrimination in Portugal?	Interview conducted with CAD - Interview conducted with the National Program for HIV/AIDS	- International, and regional treaties, and conferences. - Media articles reporting on the HIV/AIDS epidemic.

Annex B.- Table with Interview Questions

Interview questions	
Interview conducted with Centre of Antidiscrimination (CAD)	1. How has HIV-related discrimination changed from 1983-2020, in Portugal? 2. Could you please elaborate on the project to exchange syringes? 3. Based on your experience, what have been the greatest advances in the fight against discrimination and the biggest obstacles you have faced in your career? 4. In your opinion if HIV/AIDS were topics given in sex education would discrimination decrease? 5. Portugal has some international victories, for example the syringe exchange and the fulfilled of the 90-90-90 goals set by the UNAIDS. Do you think Portugal influences the international policies? 6. How does international dynamics interfere with Portuguese policies?
Interview conducted with the National Program for HIV/AIDS	1. What were the main public policies implemented by the National Program to Combat HIV/AIDS, with respect to discrimination? 2. What were the biggest obstacles faced by the program, in relation to the implementation of some campaign or policy? 3. Are Portuguese policies pioneers in the international community? 4. Any national policy that Portugal should use as an example, within the international sphere, i.e., insurance?
Interview conducted with a health practitioner.	1. Based on your experience, could you please illustrate how discrimination of HIV/AIDS affected persons has evolved throughout the years?

Annex C. – Consent Form

Consent Form for Participation in Interview Research

Individual ☐ / Academic Expert ☐ / NGO☐ / Media ☐/ State Organization ☐

Research Project Tittle:

Research Investigator:

Research Participant's Name:

Research Organization Name (If applicable):

Contact Information

If you have any further questions or concerns about this study, please contact:

Researcher Name	B.A. Sara Silva Oliveira	Dr. Brigitte Holzner (Supervisor)
Phone Number	+351 919513785	
E-mail:	sarasilvaoliveira24@gmail.com	brigitte.holzner@chello.at

I would like to express my most sincere gratitude for agreeing to be interviewed as part of the above research project.

This consent form is necessary to ensure that you understand the purpose of your involvement and that you agree to the conditions of your participation.

The interview will take approximately, 30 minutes to 60 minutes. There is no risk anticipated is associated with your participation, however, you have the right to stop the interview or withdraw from the research at any time, prior to publication.

Therefore, I kindly ask you to sign this form to certify that you approve the following:

- The interview will be recorded, and a transcript will be produced.
- You will be sent the transcript and given the opportunity to correct any factual errors.
- The transcript of the interview will be analysed by me, Sara da Silva Oliveira, as research investigator.
- Access to the interview transcript will be limited to Sara da Silva Oliveira, and Dr. Brigitte Holzner, the research project supervisor.
- The actual recording will be safely stored, for the purpose of research only.
- Any variation of the conditions above will only occur with your further explicit approval.
- Any summary interview content, or direct quotations from the interview, that are made available through this academic publication or other academic outlets will use the quotation agreement below.

Quotation Agreement:

With regards to being quoted, please put a X next to any of the statements that you agree with:

- I wish to review the notes, transcripts, or other data collected during the research pertaining to my participation. ☐
- I wish to be quoted under my organization's name. ☐
- I wish to be quoted under my own name, when expressing personal opinions, or informing about my work ☐
- I agree to be quoted directly. ☐
- I agree to be quoted directly if my name is not published and a made-up name (pseudonym) is used.☐
- I wish full anonymity ☐
- I agree that the researcher may publish documents that contain quotations by me. ☐

All or part of the content of your interview may be used;

- In academic papers, and/or policy papers ☐
- On academic feedback events☐
- In an archive of the project as noted above☐

By signing this form, I agree that;

1. I am voluntarily taking part in this project. I understand that I don't have to take part, and I can stop the interview at any time.

2. The transcribed interview or extracts from it may be used as described above.

4. I don't expect to receive any benefit or payment for my participation.

5. I can request a copy of the transcript of my interview and may make edits I feel necessary to ensure the effectiveness of any agreement made about confidentiality.

6. I have been able to ask any questions I might have, and I understand that I am free to contact the researcher with any questions I may have in the future.

_____

Full Name of Research Participant

_____ _____

Participant's Signature Date

_____ _____

Researcher's Signature Date

Abstract (EN)

The HIV/AIDS epidemic carries a heavy stigma that translates into discrimination. HIV/AIDS-related discrimination leads to serious human rights violations. Therefore, this Master thesis primarily focused on the following human rights: (i.) right to health, which will encompass sexual and reproductive rights, (ii.) principle of non-discrimination, (iii.) right to information, (iv.) right to work, and (v.) right to private life and confidentiality. Using Portugal as a country case study, I aimed at analysing the evolution of discrimination in Portugal between 1983 and 2020, from a human rights perspective based on an interdisciplinary and intersectional approach. HIV/AIDS-related discrimination has essentially changed to become less visible, however, stigma and discrimination are still felt by people living with HIV. Several theories were presented to explain this phenomenon, highlighting power relations and the fear and ignorance factor of stigma and discrimination in the Portuguese society. Responses to the HIV/AIDS epidemic in Portugal are a result of the national and international community's efforts to provide accessible and effective means for HIV/AIDS diagnosis, prevention, treatment, and care. Portugal's response shows a clear effort to promote and respect human rights, however, it has not been successful in every area. Therefore, despite the internationally praise Portugal has received on its response, in reality much still needs to be done to fully eradicate discrimination towards people living with HIV and respect and promote their human rights.

Key words: HIV/AIDS-related Discrimination, Stigma, PLWH, Key population, Human Rights.

Abstrakt (DT)

Die HIV/AIDS Epidemie trägt ein schweres Stigma, welches sich oft auf Diskriminierung überträgt. HIV/AIDS bezogene Diskriminierung führt zu ernsthaften Menschenrechtsverletzungen. Deshalb ist diese Master Arbeit primär auf die folgenden Menschenrechte ausgerichtet: (i.) das Recht auf Gesundheit, welches sexuelle und reproduktive Rechte umfasst, (ii.) das Prinzip des Diskriminierungsverbots, (iii) das Recht auf Information, (iv.) das Recht zu arbeiten und (v.) das Recht auf ein Privatleben und Vertraulichkeit. Mit Portugal als Fallbeispiel habe ich die Evolution der Diskriminierung zwischen 1983 und 2020 als Analysefokus aus einer Menschenrechtsperspektive basierend auf interdisziplinären und intersektionellen Betrachtungsweisen herangezogen. HIV/AIDS bezogene Diskriminierung hat sich essentiell verändert, und wurde weniger sichtbarjedoch sind Stigmen und Diskriminierung noch immer wahrnehmbar für Personen, die mit HIV leben. Um dieses Phänomen zu erklären wurden mehrere Theorien präsentiert, , welche die Machtverhältnisse und den Angst- und Ignoranzfaktor der portugiesischen Gesellschaft betonen. Reaktionen zur HIV/AIDS Epidemie in Portugal sind Resultate von den Bestrebungen nationaler und internationaler Gemeinschaften, um zugängliche und effektive Methoden der HIV/AIDS Diagnose, Prävention, Behandlung und Pflege anzubieten. Portugals Antwort zeigt eine klare Bestrebung Menschenrechte zu fördern und zu respektieren, jedoch ist momentan nicht in jedem Bereich Erfolg zu finden. Trotz des internationalen Lobs, den Portugal auf seine Antwort bekommen hat, muss in Realität noch viel getan werden, um Diskriminierung gegenüber HIV-infizierten Personen vollkommen auszumerzen und ihre Menschenrechte zu fördern.

Schlagwörter: HIV/AIDS-bedingte Diskriminierung, Stigma, PLWH, Schlüsselbevölkerung, Menschenrechte.