**UNAIDS Submission to the Office of the High Commissioner for Human Rights**

**Report to the Human Rights Council Report on Human Rights in the Context of HIV pursuant to HRC resolution 47/14**

The Secretariat of the Joint United Nations Programme on HIV/AIDS (UNAIDS)[[1]](#footnote-2) welcomes the opportunity to make this submission.

**The importance of the societal enablers**

Despite significant progress in reducing HIV infections and HIV-related mortality globally, significant inequalities exist within and between countries, as vulnerable and marginalized populations are left behind.

Decades of experience and evidence from the HIV response show that intersecting inequalities, including on the basis of sexual orientation, gender identity, sex, race, health status, involvement in sex work and socio-economic status, are preventing progress towards ending AIDS.[[2]](#footnote-3) 65% of new HIV infections in 2020 were among key populations and their sexual partners.[[3]](#footnote-4) In sub-Saharan Africa, six in seven new infections among adolescents occur among girls. Key and underserved populations are not only disproportionately affected by HIV, they also experience a range of barriers, including stigma, discrimination, human rights violations, systematic disenfranchisement, social and economic marginalization and criminalisation of practices that put them at risk.[[4]](#footnote-5) The new [Global AIDS Strategy 2021-2026](https://www.unaids.org/en/Global-AIDS-Strategy-2021-2026) uses an inequalities lens to identify and end inequalities that represent barriers to people living with and affected by HIV, countries, and communities from ending AIDS as a public health threat as required under SDG3.3.[[5]](#footnote-6)

Key to reducing these inequalities are the societal enablers to the HIV response, the 10-10-10s: targets relating to stigma and discrimination, gender-based inequalities and gender-based violence, and punitive and discriminatory laws and policies. These targets are a critical element in the new Global AIDS Strategy, adopted by consensus by the UNAIDS Programme Coordinating Board in March 2021.

Modelling indicates that failure to reach these targets will lead to an additional 2.5 million new HIV infections and 1.7 million AIDS-related deaths between 2020 and 2030.[[6]](#footnote-7) As the global response to HIV moves towards achieving the newly defined targets for 2025, it is vital that countries accelerate and scale-up concrete actions, provide sufficient funding and roll out adequate tools for measuring progress and ensuring community leadership in reaching the societal enabler targets of the 2021 Political Declaration on HIV (Political Declaration).

**Where are we now: the data.**

Under the UN General Assembly Political Declaration, member states are obligated to report against their commitments annually to UNAIDS under the Global AIDS Monitoring mechanism. 2022 will be the first year that that the reporting mechanisms will include indicators specifically for the societal enablers within the Global AIDS Strategy, with results published in July 2022. However, as many of the enablers reflect similar existing commitments, base-line data already exists for a number of targets.

*Enabling legal environments*

Despite important progress in law reform in a number of countries[[7]](#footnote-8) in many others still maintain punitive and discriminatory laws. In 2021, among countries with available data: [[8]](#footnote-9)

* 135 out of 180 explicitly criminalise HIV exposure, non-disclosure or transmission or otherwise prosecute based on general criminal laws.
* 24 of 168 criminalized and/or prosecuted transgender people.
* 133 out of 147 criminalized at least one aspect of sex work.
* 71 of 193 countries criminalized consensual same-sex sexual activity.[[9]](#footnote-10)
* 65 of 87 criminalized possession of small amounts of drugs for personal use.
* 108 required parental/guardian consent to access an HIV test among adolescents and young people and 40 countries reported having laws requiring parental/guardian consent for accessing hormonal or long-lasting contraceptives.[[10]](#footnote-11)
* 46 have HIV-related travel restrictions.

The target also calls for more than 90% of people living with HIV and key populations to have access to legal services, for more than 90% of countries to have mechanisms for people living with HIV and for key populations to be able to report abuse and discrimination and seek redress by 2025. In 2021, 95 of 131 reporting countries stated that government-established formal mechanisms were in place to report abuse and seek redress. In 53 countries, civil society reported that communities and/or nongovernmental organizations had established mechanisms to record and address individual complaints. Overall, 116 (60%) countries reported that a formal and/or informal mechanism existed to address cases or individual complaints of HIV-related discrimination.[[11]](#footnote-12) However, the target also requires that such systems be accessible. In 2021, civil society groups reported the following barriers: In 64 countries the mechanisms do not function, they are not HIV sensitive in 55 countries, affordability constraints in 31 countries, in 113 countries the awareness or knowledge of how to use such mechanisms is limited.[[12]](#footnote-13)

*Stigma and Discrimination*

Despite progress in some countries, HIV related stigma persists at extremely high levels. In 52 of 58 countries with recent population-based survey data, more than 25% of people aged 15–49 years reported holding discriminatory attitudes towards people living with HIV, and more than 50% held discriminatory attitudes in 36 of 58 countries.[[13]](#footnote-14) Health care settings represent a common setting for HIV-related discrimination, with the proportion of people living with HIV in 13 countries reporting being denied health services at least once in the previous 12 months ranging from 1.7% to as high as 21%.[[14]](#footnote-15) Across all key populations, at least one in three reporting countries stated that more than 10% of respondents avoided health care, including three in four countries for people who inject drugs.[[15]](#footnote-16)

*Violence and Gender Inequality*

Gender-based discrimination and violence against women and adolescent girls, as well as key populations, living with or at high risk of acquiring HIV remain pervasive globally. Globally, more than one in 10 (13%) of ever-married or partnered women (aged 15 to 49 years) have experienced physical and/or sexual violence by an intimate partner in the previous 12 months.[[16]](#footnote-17) Only seven of 43 countries with data available between 2015 and 2020 currently meet the 2025 target of less than 10%.[[17]](#footnote-18)

More than half of sex workers report having experienced physical violence in eight of 36 countries with recently available data. Women who inject drugs face high levels of physical and sexual violence, which contributes to their high risk of HIV, but they are often ignored by harm reduction programmes.[[18]](#footnote-19) There are no comprehensive nor systematic data on the number of victims of violence based on sexual orientation and gender identity, but a UN-appointed Independent Expert has estimated that there are millions every year.[[19]](#footnote-20) High rates of violence, including intimate partner violence, against transgender people and people who inject drugs have also been reported in the limited number of countries with relevant data are available.[[20]](#footnote-21) [[21]](#footnote-22) [[22]](#footnote-23) [[23]](#footnote-24) [[24]](#footnote-25) [[25]](#footnote-26) [[26]](#footnote-27)

Harmful gender norms persist across many countries. Among 36 countries with available data, the percentage of young women (aged 15 to 24 years) who agreed that a husband is justified to strike or beat his wife for at least one specific reason ranged from 3% to 80%. In only one country did less than 10% of men believe a husband was justified in striking or beating his wife, and in only 4 countries did less than 10% of women believe a husband was justified in beating his wife.[[27]](#footnote-28)

Women living with HIV are especially susceptible to institutional violence, mistreatment and reproductive rights violations in health-care settings, including coerced sterilization and obstetric violence and forced abortions have been reported in over 31 countries.[[28]](#footnote-29) [[29]](#footnote-30) A study in 2019 in seven countries in Latin America among women living with HIV found that more than 20% of women said they had felt coerced to undergo sterilization and/or abortion, and 48% said they had been denied cervical cancer or breast cancer services due to their HIV status.[[30]](#footnote-31)

**BEST PRACTICES AND GAPS**

**Human Rights Based Approach**

As noted in the Political Declaration, the HIV pandemic continues to confirm that the relationship between HIV and Human Rights is profound. A human rights-based response is necessary to successfully confront and remove those violations of human rights which increase vulnerability to HIV or which continue to impact on people living with HIV. Policies and programmes must be developed and implemented through a participatory process, in a manner that protects against discrimination, leaving no-one behind.

Numerous guidelines have been developed to assist countries in pursuing a rights-based approach to issues that impact upon HIV, including the [International Guidelines on Human Rights and Drug Policy](https://www.humanrights-drugpolicy.org/), the [International Guidelines on HIV and Human Rights](https://www.ohchr.org/Documents/Issues/HIV/ConsolidatedGuidelinesHIV.pdf), the [report](https://hivlawcommission.org/report/) and [supplement](https://hivlawcommission.org/supplement/) of the Global Commission on HIV and the Law and the African Commission on [HIV and the Law’s HIV, the Law and Human Rights in the African Human Rights System: Key Challenges and Opportunities for Rights-Based Responses](https://www.unaids.org/en/resources/documents/2018/HIV_Law_AfricanHumanRightsSystem) and WHO in 2017 released [Consolidated Guideline on Sexual and Reproductive Health and Rights of Women Living with HIV](https://www.who.int/reproductivehealth/publications/gender_rights/Ex-Summ-srhr-women-hiv/en/). UNDP, with the UNAIDS Secretariat and partners such as the HIV Justice Network and the International Association of Prosecutors, developed [guidance for prosecutors for limiting the overly-broad use of criminal law in HIV-related cases](https://www.undp.org/publications/undp-guidance-prosecutors-hiv-related-criminal-cases). UNAIDS has also developed a series of human rights fact sheets bringing together key evidence, data, norms and standards relating to a human rights-based approach to HIV[[31]](#footnote-32), as well as a comprehensive guidance for mainstreaming human rights in HIV programming ( [Fast-Track and Human Rights](https://www.unaids.org/en/resources/documents/2017/fast-track-human-rights)) and a guidance for [preventing and responding to HIV-related human rights crises](HIV-Related-Human-Rights-Crises.pdf%20(un.org).

An example of best practice for mainstreaming human rights within HIV programmes and broader health initiatives is in relation to WHO’s process for certifying countries for the elimination of, or for being on the path for the elimination of, vertical transmission of HIV, Hepatitis B and Syphilis. For a country to achieve validation, it needs to demonstrate respect and protection of human rights, gender equality and community engagement in the design, implementation, monitoring and evaluation of programmes for the elimination of vertical transmission of the three diseases. This condition is at par with other criteria for validation, such as the quality of EMTCT surveillance data and data quality, the quality of management systems used in testing services (Laboratory evaluation and assessment) and the quality, scope and accessibility of programmes and services needed to achieve and sustain EMTC.[[32]](#footnote-33)

**Community-led Response and Civic Space**

For decades, affected communities have been driving the global HIV response forward. People living with HIV, key populations, women and young people have worked together to expand the reach, quality and equity of health services by tirelessly campaigning for stronger action, raising the alarm about gaps and injustices, and putting people's needs at the centre of HIV programmes.

Community-led organizations raise awareness of obstructive laws and practices, pinpoint missed opportunities, reach marginalized communities and lead by example. Community-led monitoring systems are a valuable resource, leveraging the knowledge and networks of community organizations to strengthen the performance and accountability of HIV programmes.[[33]](#footnote-34) In a number of countries civil society organisations, including community-led organisations, launched legal challenges leading to the removal of laws criminalizing HIV exposure and transmission (Colombia and Mexico)[[34]](#footnote-35), consensual same-sex sexual activity (Botswana[[35]](#footnote-36), India[[36]](#footnote-37), Trinidad & Tobago[[37]](#footnote-38), Belize), gender identity and expression (Guyana[[38]](#footnote-39)) and led to Government taking action to end the involuntary sterilization of women living with HIV (Chile)[[39]](#footnote-40). Community-led advocacy, research and collaboration with Governments has led to legislative reform to remove laws requiring parental consent for HIV services (Peru [[40]](#footnote-41)), decriminalize sex work (Northern Territory and Victoria, Australia), decriminalize consensual same-sex sexual activity (Angola) and introduce protections for trans and other gender diverse persons (Argentina, Chile and Uruguay[[41]](#footnote-42), Pakistan[[42]](#footnote-43) among others). Community-led organisations have reduced stigma and discrimination and increased access to justice through sensitization campaigns, training health-care workers, developing charters of rights for patients living with HIV, developing and delivering legal empowerment courses among others, or helped direct people who use drugs to health services.[[43]](#footnote-44) [[44]](#footnote-45)

Under the 2021 Political Declaration states reaffirmed, and committed to, the Greater Involvement of People Living with HIV/AIDS principle (GIPA principle) and to empower communities of people living with, at risk of and affected by HIV to play a critical leadership role in the response, including in decision-making, planning, implementing and monitoring and are provided with sufficient technical and financial support, creating and maintaining enabling civil society space so that by 2025 community-led organisations deliver 60% of programmes to support the achievement of the societal enablers, among others.

It is critical that in this space, community involvement is through community-led organisations, not simply community-based organisations. For an organization to be considered community-led, the majority (at least fifty percent plus one) of governance, leadership, and staff must come from the community being served[[45]](#footnote-46). UNAIDS has worked closely with networks of people living with HIV, key populations, affected women and youth, UN agencies, UN Member States, and other stakeholders to develop meaningful definitions in this regard[[46]](#footnote-47):

*(a) Community-led organizations, groups and networks, whether formally or informally organized, are entities for which the majority of governance, leadership, staff, spokespeople, membership and volunteers, reflect and represent the experiences, perspectives, and voices of their constituencies and who have transparent mechanisms of accountability to their constituencies. Community-led organizations, groups, and networks are self-determining and autonomous, and not influenced by government, commercial, or donor agendas. Not all community-based organizations are community led;*

*(b) Community-led responses are actions and strategies that seek to improve the health and human rights of their constituencies, that are specifically informed and implemented by and for communities themselves and the organizations, groups and networks that represent them.*

Networks of People living with HIV and key populations have further articulated these principles with the following explanations:

Community-led responses are determined by and respond to the needs and aspirations of their constituents, and include a range of activities such as advocacy, campaigning and holding decision-makers to account; monitoring of policies, practices, and service delivery; participatory research; education and information sharing; service delivery; capacity building, and funding of community-led organisations, groups, and networks.

Community-led organisations and responses are led by and for people living with HIV, key populations, women and young people. They are distinct from those that are community-based – “community-based” refers to *where* a response happens, regardless of who is implementing it, while “community-led” refers to *who* leads and implements the response.[[47]](#footnote-48)

For communities to be able to lead and participate in the response, civil society space must be protected.[[48]](#footnote-49) Laws and policies should protect and open civic space to community-led organizations rather than restrict it, reducing barriers to association and operation. For example, the ability to register an association has been a necessary element in achieving law reform.[[49]](#footnote-50) However, the International Centre for Non-Profit Law reported that, of the 265 measures in 91 countries related to civic space, 72% of those measures restricted civic space and constrained human rights defenders, including their ability to access international funding, access the courts or operate without burdensome restrictions.[[50]](#footnote-51) Shrinking civic space can serious threaten the ability of community-led organisations to operate in the HIV response. In 2021 78 countries reported to UNAIDS on regulations affecting community-led organisations., 22 countries reported there was a lack of social contracting or other mechanisms allowing funding of community-led service delivery from domestic funds, and 8 countries reported having "foreign agent" or other restrictions to access funding from international donors, 14 countries reported having restrictions on registration and 16 having cumbersome reporting..[[51]](#footnote-52)

The UN and donor organisations have an important role to play for enabling civic space for civil society. The Global Fund’s provision for technical assistance has helped increase the meaningful engagement of civil society and communities in their funding cycles.[[52]](#footnote-53) UNDP’s work to advocate with governments to allocate percentages of line ministry budgets to HIV[[53]](#footnote-54) and support for efforts to create legal and policy environments that support social contracting, for instance, has shown successes in extending funding to CSOs to provide HIV-related services.[[54]](#footnote-55)

**An intersectional approach**

A strong body of evidence shows that intersecting inequalities fuel the HIV epidemic and block progress towards ending AIDS. By reducing inequalities, we will be able to dramatically reduce new HIV infections and AIDS-related deaths. That, in turn, will contribute to a host of positive social and economic outcomes and accelerate progress towards sustainable development for all. Recent research on intersectionalities and sex work has found that gender diverse communities and migrant women face multiple and intersecting forms of discrimination that can increase their vulnerability to violence and to HIV.[[55]](#footnote-56) [[56]](#footnote-57) Interventions that are founded in an intersectional approach and look at how stigma and discrimination affect participants’ entire identities, and that bring in community leaders from a variety of backgrounds, have been found to improve the ability of people to cope with intersectional discrimination and reduce internalized stigma and HIV-specific medical distrust.[[57]](#footnote-58) [[58]](#footnote-59)

**Financing the societal enablers**

The Political Declaration also calls for greater investments in societal enablers, doubling from US$ 1.3 billion in 2019 to US$ 3.1 billion in 2025, and grow to 11% of total resource needs. Significant funding also needs to be targeted towards key populations. A study by PITCH and AIDSFonds in 2019 found that only 2% of the total amount spent responding to HIV went to HIV programmes targeting key populations in LMIC despite key populations and their partners accounting for more than half of new HIV infections globally.[[59]](#footnote-60) Some global efforts already exist to increase funding for societal enablers: the Global Fund investment in human rights programs in the 2017-2019 cycle constituted over 123 million.[[60]](#footnote-61) the Global Fund’s Breaking Down Barriers initiative has provided US$45 million in additional funds in 2017-2019 and another US$41 million in 2020-2022 to 20 countries to scale up evidence-based programming to reduce human rights-related barriers to HIV, TB and malaria services, in addition to increased human rights investments in grants in those countries amounting to US$32 million in 2017-2019, and circa US$38 million in 2020-2022.[[61]](#footnote-62) However greater sustainable international and domestic financing is necessary.

Funding is also necessary at short notice. Human rights violations and crises, such as arrests or snap legal changes, can often happen suddenly and communities need access to emergency resources to be able to respond, including ensuring safety of members of the community, access to legal services and to convene. UNAIDS has worked closely with communities to develop an emergency fund that can be accessed quickly by community-led organisations to protect vulnerable individuals and communities in times of crises.

**Evidence-based laws and programmes**

Where laws, policies and programmes are introduced or relied upon to reduce stigma and discrimination and improve HIV outcomes, it is critical that they are evidence-based. In 2018, twenty leading scientists developed and published a consensus statement on the science of HIV in the context of criminalisation, a statement that has since been endorsed by an additional 70 leading scientists from more than 46 countries.[[62]](#footnote-63) The consensus statement has been instrumental in overturning HIV criminalisation in the courts,[[63]](#footnote-64) and in advocacy efforts in relation to law reform and changes to prosecution and judicial.[[64]](#footnote-65) Other independent research has led to law reform on HIV criminalisation in Los Angeles and is ongoing in parts of Canada.[[65]](#footnote-66) [[66]](#footnote-67) Where there have been data gaps, there have been cases where Governments have commissioned research, such as in Victoria, Australia where research on the health and social needs of sex workers was supported by an advisory board of sex workers. The research was then used to inform government on the implementation of reforms on the decriminalization of sex work in Victoria.[[67]](#footnote-68)

The Global Commission on HIV and the Law’s findings and recommendations were based, in part, on interviews with more than 700 key informants and review of available data.[[68]](#footnote-69) [[69]](#footnote-70) An external evaluation found that the Commission had influenced other global processes, advanced substantive discussions relating to HIV and the law, and promoted collaborative learning and action for an enabling environment, including being cited by the Supreme Court of India when overturning the laws criminalizing same-sex sexual activity.[[70]](#footnote-71) [[71]](#footnote-72)

**Data and missing populations**

To leave no one behind, we need people-centred data collection that spotlights the inequalities that are hampering access to services. An ongoing challenge relates to a lack of data and information for vulnerable and marginalized populations, particularly key populations, both in terms of population sizes and data relating to health. Criminalisation, denialism, stigma and discrimination can lead to a negation of the existence, and reinforce invisibility of, key populations in different countries and sub-national regions.[[72]](#footnote-73) Countries that criminalize same-sex sexual behaviour are more likely to report implausibly low numbers of gay men and other MSM compared to countries that do not criminalize such behaviour.[[73]](#footnote-74) An analysis by UNAIDS, WHO and the Global Fund estimated that, among the 52 countries that provide population size estimates, more than 15 million people from key populations who would benefit from HIV prevention, care and treatment services are unaccounted for. Globally, the total number of people unaccounted for is likely much higher than this.[[74]](#footnote-75) The failure to include these individuals in national population estimates has a critical and damaging flow on effect on health care coverage in relation to the budgeting and roll out of life-saving health care services.

As noted by WHO, “efforts to improve the availability and quality of data about key populations must overcome a lack of political will and funding. In many settings, data collection is impeded by discriminatory legal frameworks that criminalize behaviours of key populations. This introduces complexities about the ethics of data collection practices, as necessary protections for the affected communities must be ensured. For instance, in situations where the safety and human rights of people from key populations cannot be assured, data collection should be avoided.”[[75]](#footnote-76) Community-led data collection and analysis is essential for ensuring inclusion of communities left behind in a manner that ensures the security and trust of communities. The [People Living with HIV (PLHIV) Stigma Index](https://www.stigmaindex.org/), developed by GNP+, ICW, IPPF and UNAIDS, is a best-practice community-led research initiative that gathers data on the various forms of stigma and discrimination experienced by people living with HIV. The PLHIV Stigma Index was developed to be used by and for people living with HIV. The PLHIV Stigma Index has been implemented in more than 100 countries with over 100,000 PLHIV participating in the process.[[76]](#footnote-77) Findings from the Stigma Index have led to the systematic scale up of action that has successfully reduced HIV-related stigma and discrimination, and launched a national investigation into the practice of forced sterilization.[[77]](#footnote-78) [[78]](#footnote-79)

In addition, investments are needed in pioneering data collection to inform policy and action on gender based violence, particularly on multiple and intersecting forms of stigma and discrimination. One such landmark study was undertaken in Latin America on violence against women living with HIV supported by UNAIDS, focused on women facing intersecting forms of discrimination, marginalization and stigma.[[79]](#footnote-80)

To obtain data from marginalized and stigmatized populations, particularly key populations, UNAIDS, WHO, FHI 360, and the US Centers for Disease Control and Prevention developed [Biobehavioural Survey Guidelines](https://www.who.int/publications/i/item/978-92-4-151301-2) for country-based integrated biobehavioural surveys (IBBS) of HIV and HIV-risk behaviours. The surveys ask questions that go to intersectionality including gender identity or sexual orientation, sex at birth, drug use, involvement in sex work educational attainment and marital status, as well as questions on stigma, discrimination and harassment and on uptake of HIV services and health outcomes. Collecting this type of multi-layered information is particularly important to understand the multiple and intersecting forms of stigma and discrimination, including structural, that impede the provision of and access to health services. It can also help to remove structural barriers as the data from the IBBS survey has been used successfully in strategic litigation challenging criminalisation of same-sex sexual activity.[[80]](#footnote-81)

Unfortunately country uptake of IBBS is limited. Between 2016 – 2020, only 64 countries reported survey data to UNAIDS on gay men and other MSM, 29 countries reported on transgender individuals, 66 reported survey data for sex workers and 25 reported data for people who inject drugs.[[81]](#footnote-82) As such, significant data and research gaps remain.

**The Global Partnership for Action to Eliminate All forms of HIV-related Stigma and Discrimination (Global Partnership)**

Despite the evidence on the importance of taking action on the societal enablers, particularly stigma and discrimination, till recently, there have been significant gaps in action and funding. For this reason, the Global Partnership was formed in 2017 to harness the combined power of governments, civil society, bilateral and multilateral donors, academia and the United Nations to eliminate HIV-related stigma and discrimination and to inspire countries to take action to remove critical barriers to HIV services.[[82]](#footnote-83) Given the interrelated nature of the 10-10-10 targets, the Global Partnership is a vehicle for action across all societal enablers, not just stigma and discrimination.

Co-led by UNAIDS, UNDP, UNWomen, GNP+, the PCB NGO Delegation, and the Global Fund for HIV, Tuberculosis and Malaria, the Global Partnership has increased coordinated technical assistance and leveraged synergies of action to support country efforts to end stigma and discrimination across six settings: healthcare, justice, education, workplace, humanitarian and community. As of 3 February 2022, twenty-nine countries had joined. The Global Partnership has supported action on law reform in Benin, Burundi, CAR, Angola, Iran and Kazakhstan and Ukraine, on stigma and discrimination reduction in Thailand, Nepal, Iran, Central African Republic, Jamaica, South Africa, Papua New Guinea and many others. Action has been taken to reduce stigma and discrimination faced by women and girls in Senegal, Uganda and Jamaica. For further details please see below in the section on Stigma and Discrimination and **Annex 1**.

**SPECIFIC TARGETS**

**Removing punitive and discriminatory laws**

The first societal enabler calls on countries to remove discriminatory and punitive laws and policies that create barriers to accessing HIV services including the removal of laws criminalizing sex work, drug use and possession for personal use, consensual same-sex sexual activity and HIV criminalisation.

The way in which a country removes criminal laws is critical to ensuring the barriers to services are removed. For example, in addition to criminalizing the sale of sex, the criminalization of any aspect of sex, including targeting the clients of sex workers has been repeatedly shown to negatively affect sex workers’ safety and health, including reducing condom access and use and increasing the rates of violence. [[83]](#footnote-84) [[84]](#footnote-85) [[85]](#footnote-86) [[86]](#footnote-87) Evidence-based modelling has shown that decriminalization of all aspects of sex work would avert 33-46% of new HIV infections among female sex workers and their clients over ten years.[[87]](#footnote-88) Decriminalisation of drug use and possession for personal use is critical for ensuring access to HIV services. However, where criminal sanctions are replaced with significant fines or other severe administrative penalties, or where thresholds for personal use of drugs are too low, the impact can be similar to that of criminalisation.[[88]](#footnote-89) Of particular concern is the continued use of compulsory drug detention centres, a practice that has repeatedly been found to violate human rights.[[89]](#footnote-90) More general laws, such as vagrancy laws or petty offence laws have also been utilized to target people from key populations, with similar impacts to the more specific criminal laws. The African Court of Human Rights recently released an advisory position calling for the removal of petty offences laws given their discriminatory impact, including on sex workers.[[90]](#footnote-91)

The policing associated with punitive laws can have a similar negative impact. Aggressive policing of sex work has been found to be associated with an 87% increase in risk for HIV and sexually transmitted infections among sex workers and a nearly three-fold increase in the risk of sexual or physical violence.[[91]](#footnote-92) Repressive policing of drug use is linked with increased risk of HIV infection, needle sharing and avoidance of harm reduction programmes.[[92]](#footnote-93)

Where law reform is achieved through legislative process, by consulting and working closely with communities, it is more likely the reforms will protect and fulfil their rights, and give full effect to decriminalization. The recent decriminalization of sex work in Victoria was the result of close collaboration with sex worker organisations in every step of the process, including a sex worker advisory panel supporting research health and social needs of sex workers and transparent and open consultative processes.[[93]](#footnote-94) The resulting legislation not only decriminalised sex work, but also included important elements necessary to ensure people can benefit from decriminalization, such as removing the requirement for registration and committing to destroy the register and providing government funding to sex-worker led organisations to give effect to the new laws, through training and sensitization for duty bearers and empowering sex workers to understand their rights, as well as monitoring implementation.[[94]](#footnote-95)

Law reform may also take a step-by-step process. Over a period of four years, sustained campaigning by Peruvian nongovernmental organizations, supported by legal and technical support from UN agencies, has gradually dismantled the restrictions for adolescents to access SRHR services. Between 2016 and 2020 a number of laws and regulations that gradually led to a situation where adolescents aged 14 years and older can access HIV testing without consent. Critical to this was civil society campaigning, alliance building between different Government departments and civil society, and technical and advocacy support from UN agencies.[[95]](#footnote-96)

Judicial challenges have been successful in many countries around the world in removing human rights barriers to realizing the right to health, setting vital new legal precedents. A number of challenges were mentioned above in the section on civil society. However, such an avenue is only possible if communities are aware of their rights, have meaningful access to justice and judicial mechanisms. Accountability and oversight mechanisms help realize people’s right to health and ensure that breaches of those rights are remedied. Courts and legal services need to be affordable and accessible to all, and communities should be able to bring cases as individuals and as organisations.

UN agencies have an important role to play in supporting access to justice, including through training, development of standards, and in amicus briefs. Recently, UNAIDS intervened as an amicus in a case that resulted in the Government taking action to end forced sterilization of women living with HIV[[96]](#footnote-97) and one that led to the decriminalization of HIV exposure and transmission.

UNDP and the UN Refugee Agency (UNHCR) supported the judiciary in South Sudan to deploy mobile courts in various states to address the lack of justice services, personnel and facilities, and large case backlogs. In Sudan, the Ministry of Justice added people living with HIV as beneficiaries for legal aid services and deployed a legal counsellor to support each of the branches of the Sudanese People Living with HIV Care Association.

In Kyrgyzstan, UNDP, the UNAIDS Secretariat and the Global Fund supported 26 civil society organizations working on HIV and TB to launch REACT, an electronic system to register human rights violations. The platform documents cases of rights violations among patients and key population groups, and brings those cases to the attention of justice sector authorities. Through REACT, civil society organizations registered 263 cases of rights violations among key population groups in January–August 2020 in Kyrgyzstan.

In Nigeria, people living with HIV, lawyers and civil society groups have formed a network of lawyers to provide legal advice and representation to people living with HIV, people belonging to sexual minorities, sex workers and people who inject drugs.[[97]](#footnote-98) In Mozambique, Namati, a legal empowerment NGO deploys grass roots health advocates to identify and solve health service problems by working with community members and health workers. Between 2013 and 2019 the health advocates addressed more than 5400 concerns at health facilities, 75% of which were resolved successfully. Complaints included issues relating to disrespectful treatment, breaches of privacy among others.[[98]](#footnote-99)

**Stigma and discrimination**

As mentioned above, to spur action on stigma and discrimination, the Global Partnership was developed in 2017. In 2020, to support the Global Partnership countries, UNAIDS developed [country guidance for effective programming to eliminate HIV-related stigma and discrimination in six settings](https://www.unaids.org/sites/default/files/media_asset/eliminating-discrimination-guidance_en.pdf). The recommendations include implementing programmes to empower populations “being left behind" with legal literacy and access to redress services, and removing laws criminalizing drug use or possession for personal use, all aspects of sex work, sexual orientation, gender identity, and HIV exposure, non-disclosure and transmission. A variety of approaches are required, from legal protections and standard setting, to training and sensitization, monitoring and accountability. Countries have developed and disseminated Patient’s Charters of Rights (Central African Republic)[[99]](#footnote-100), organized South-South Trainings between Africa and Asia for drafting of country plans (Thailand),[[100]](#footnote-101). Peer-led processes and peer support processes have led to local actions for women and men living with HIV.[[101]](#footnote-102) [[102]](#footnote-103) For more information see **Annex 1.**

Faith-leaders also have a critical role to play in reducing stigma and discrimination. In Kenya, supported by UNAIDS, Inerela+ and the Ecumenical Advocacy Alliance, a joint dialogue between people living and HIV and religious leaders around stigma spearheaded joint advocacy efforts and changed how religious leaders and people living with HIV relate. It led to joint advocacy actions around gender-based violence, HIV stigma and a change in language used by religious leaders to non-judgmental and non-stigmatising. After the dialogue and interventions people living with HIV reported feeling understanding and love from the congregation and leaders and a desire to support others in the congregation.[[103]](#footnote-104) Funding for a faith sector action plan on stigma and discrimination has been secured through the Global Fund grant.

Legal protections against stigma and discrimination are a critical element in reducing discrimination. A number of countries that have opened legal avenues for changing gender markers and names without the requirement of undergoing gender-reassignment surgery.[[104]](#footnote-105) In recent years others have introduced protections against discrimination on the basis of sexual orientation and gender identity.[[105]](#footnote-106) [[106]](#footnote-107).

In reporting[[107]](#footnote-108) to UNAIDS on whether there were legal protections against discrimination, 72 (n=129) had none for transgender people, 107 (n=126) had none for sex workers, 66 (n=131) had none for sexual orientation, 117 (n=195) had none for people who use drugs, and 19(n=105) had none for HIV status.

**Gender equality and violence against women, girls, key populations and people living with HIV.**

Recent global reports and evaluations of the UN Joint Programme on HIV/AIDS attest to the need to redouble efforts on integrating gender-responsive approaches and addressing gender-based violence and sexual and reproductive health and rights.[[108]](#footnote-109) The new Global HIV/AIDS Strategy and Political Declaration on HIV/AIDS adopted in 2021 seek to address these gaps by placing gender equality and women’s empowerment at the centre of ending inequalities and for effectively ending AIDS as a public health threat by 2030. Among the priority areas is scale-up of promising and good practices that tackle unequal gender power dynamics, norms and practices, including increased investments in gender-transformative community-led interventions[[109]](#footnote-110), especially those shown to reduce both HIV and violence against women; starting early in HIV, SRH and violence prevention and transforming gender norms by working with adolescent girls and boys; investing in women-led responses, women’s leadership and meaningful participation in decision-making in shaping the HIV response, building on promising practices supported by the UNAIDS Secretariat[[110]](#footnote-111); integrating strong gender components in comprehensive sexuality education programmes (shown to have five-fold better results in preventing STIs[[111]](#footnote-112)); legal reforms such as changing age of consent laws for adolescents and young people to freely access HIV, contraceptive and other essential health services; and strengthened enforcement, access to justice and accountability for violence against women and other human rights violations against women and adolescent girls living with and at risk of HIV.

Action under the Global Partnership on Stigma and Discrimination is also supporting increasing gender equality and reducing violence (see Annex 1).

Furthermore, the flagship gender-responsive initiative, *Education Plus[[112]](#footnote-113),* on the empowerment of adolescent girls and young women in sub-Saharan Africa is being rolled out under the leadership of UNAIDS, UNESCO, UNFPA, UNICEF and UN Women, centred on a multi-sectoral integrated package of services to, inter alia, accelerate HIV prevention and advance gender equality.

Priority actions include: repealing discriminatory laws and policies that increase women’s and girls’ vulnerability to HIV; protecting their sexual and reproductive health and rights and ensuring access to justice and remedies for violations; preventing and responding to gender-based violence and its interlinkages with HIV/AIDS; and transforming harmful gender norms and masculinities that undermine the health and wellbeing of both men and women.[[113]](#footnote-114) For instance, a global systematic review of sexual and reproductive health interventions involving men and boys found that only 8% of them included components to transform gender relations and unequal power dynamics.[[114]](#footnote-115)

The role of community-led organisations in research and data collection is critical in this space. ICW with the support of UNAIDS documents cases of coerced sterilization of women living with HIV to advocate for policy change and law reform that ensures the sexual and reproductive rights of WLHIV are observed. Cases have been presented to law courts and national human rights institutions for redress.[[115]](#footnote-116) ICW will be expanding this work in 2022 with a global level assessment to be utilized to highlight the persistence and scope of obstetric violence and forced and coerced sterilization among WLHIV and to advocate for change.

**Conclusions and recommendations**

1. **Employ a human-rights based approach to achieving the societal enablers, with the full and meaningful participation of community-led organizations, without any discrimination, taking into account multiple and intersecting forms of discrimination, leaving no-one behind.**
2. **Ensure that the development, implementation and monitoring of all legal and policy changes and programmatic interventions are with the meaningful engagement and leadership of community-led organisations.**
3. **Ensure that community-led organisations are empowered, through laws, policies and funding, to operate freely, provide services, advocate, lead on societal enablers and access legal systems.**
4. **Ensure the collection of data from all populations, disaggregated by gender, in collaboration with community-led organisations and in a manner that protects the safety and security of vulnerable and marginalized populations.**
5. **Promote community-led monitoring of human rights violations and of application of protective laws and measures**
6. **Reform laws in a manner that achieves the aim of removing the barriers to enjoying the highest attainable standard of health, including the removal of laws criminalizing same-sex sexual activity, all aspects of sex work, possession of drugs for personal use, gender identity and expression, specific and overly broad criminalisation of HIV exposure, non-disclosure and transmission, laws imposing travel restrictions, laws requiring parental or spousal consent to access HIV and SRH services, as well as vagrancy and petty offence laws, and punitive administrative penalties.**
7. **End the practice of compulsory drug detention and drug treatment.**
8. **Take action to reduce HIV-related stigma and discrimination through the Global Partnership for Action to Eliminate all Forms of HIV Related Stigma and Discrimination.**
9. **Increase access to justice for all individuals and communities, including reducing barriers such as cost, lack of legal literacy or legal representation.**
10. **Repeal discriminatory laws and policies that increase women’s and girls’ vulnerability to HIV, including laws barring their access to voluntary HIV testing such as those requiring spousal, parental or guardian’s consent.**
11. **Apply a gender transformative approach to all actions in relation to the societal enablers.**
12. **Protect, respect and fulfill the sexual and reproductive health and rights of women and girls;**
13. **Prevent and respond to gender-based violence and its interlinkages with HIV/AIDS;**
14. **Violence against people from key populations should be prevented and addressed in partnership with key population-led organizations. All violence against people from key population groups should be monitored and reported, and redress mechanisms should be established to provide justice**
15. **Transform harmful gender norms and masculinities that undermine the health and wellbeing of both men and women**
16. **Integrate strong gender components in programmes for comprehensive sexuality information and education**
17. **Increase domestic and international funding for the societal enablers to USD$3.1billion by 2025.**

**Annex 1: The Global Partnership for Action to Eliminate all Forms of HIV-related Stigma and Discrimination**

**Global Partnership Countries’ Best Practices in Reaching 10-10-10 Targets**

The Global Partnership for Action to Eliminate All Forms of HIV-Related Stigma and Discrimination (Global Partnership) aims to accelerate the removal of HIV-related human rights barriers and inequalities by eliminating the underlying stigmatizing and discriminatory practices, policies and laws across six settings (community, health, justice, education, workplace, and emergency/humanitarian). By building and leveraging political commitment and key synergies, providing catalytic technical support, and promoting targeted advocacy for policy and legal change, the Global Partnership (GP) ensures an intersectoral, coordinated, country-led and scaled up response. The Global Partnership is a community-led and driven initiative, co-convened by UNAIDS, UNDP, UN Women, GNP+, the PCB NGO Delegation and the Global Fund; advised by a Technical Working Group[[116]](#footnote-117); and supported by a “community of practice”[[117]](#footnote-118) at regional and country level. Bringing together the collaborative efforts of key stakeholders to end stigma and discrimination (S&D), and other human rights-related barriers, the Global Partnership provides an excellent platform to support countries in the implementation of the Global AIDS Strategy and the achievement of its 10-10-10 targets. To date 29 countries[[118]](#footnote-119) have joined the Global Partnership. Through its strategic guidance and catalytic technical support, the GP has had the following impact on the ground, in support of the achievement of the societal enabler targets.

1. **Less than 10% of PLHIV and KPs experience S&D**

Advocacy: The GP’s community-led and partnership-based #MoreThan anti-discrimination campaign serves as an advocacy and education tool and as political leverage to garner country, donor and partner support. It fights internal stigma through personal stories by highlighting that everyone is more than their HIV status, empowers communities to know their rights, informs and strongly engages stakeholders on setting- and key population- specific S&D reduction interventions (including for addressing the intersectional nature of HIV-related S&D) and mobilizes political commitment through championing country best practices.

* Through the #MoreThan campaign for International Workers’ Day, Thailand mobilized the Ministry of Labor, the Employers Conferderation of Thailand (ECOT), and the private sector (e.g. PCS Security & Facility Services Ltd.) to participate in the campaign and publicly commit to eliminating HIV-related S&D, through videotaped advocacy messages. This is in line with the national code of conduct on HIV prevention & management in workplace adopted early 2021.

National & Regional Synergies: The GP leverages regional & national resources especially from Global Fund (GF) and PEPFAR, opportunities for knowledge-sharing and collaboration, and partnerships, to streamline and accelerate implementation of S&D programming and ensure greater accountability from partners & stakeholders. For ex., 11 of the GP countries[[119]](#footnote-120) are part of the GF Breaking Down Barriers (BDB) initiative, allowing for sustained and comprehensive programmatic responses and leveraging the collective efforts to drive impact.

* Synergies forged with the Focal Country Collaboration among GF, PEPFAR & UNAIDS to accelerate S&D action in select Global Partnership countries (Jamaica, Mozambique, Thailand, Cote d’Ivoire, South Africa) and with the CDC through the CDC-UNAIDS Global Co-operative Agreement to advance implementation of prioritized interventions in 3 countries (Mozambique, Thailand, Cote d’Ivoire).
* Country coordinating mechanisms (CCMs) have been leveraged as multistakeholder platforms to coordinate the GP’s implementation to ensure joint and coordinated action in eliminating S&D in Papua New Guinea, Thailand, South Africa & Uganda, among others
* South-South trainingsorganized by Thailand’s Department of Disease Control - for stakeholders from Africa and Asia have led to synergies and guidance in drafting country action plans on eliminating S&D and developing and integrating S&D reduction interventions into national & sub-national HIV programs.
* Asia Pacific: Southeast Asia Stigma Reduction Quality Improvement Learning Network (QI) accelerated implementation of national- and facility-level HIV-related S&D reduction activities in region through routine measurement, quality improvement methods, and peer learning and exchange.

Strategic Guidance: Through catalytic technical support, the Global Partnership ensures S&D reduction strategies are embedded into leadership, action plans, and interventions.

* In Jamaica with support from the BDB initiative,[[120]](#footnote-121) the country collaboratively developed a 5-year operational plan aligned with the GP’s 6 settings and existing documents, such as the GP’s Guidance for Addressing S&D, the National Strategic Plan and GF’s Baseline Assessment to ensure complementarity of processes in removing human rights and S&D barriers. Jamaica has also already completed a Human Rights Scorecard[[121]](#footnote-122) to assess implementation, increase awareness and improve alignment and accountability around interventions. In Thailand, despite limited resources, strong leadership and commitment from the government and civil society led to the development and implementation of a costed, multisectoral 5-year action plan to eliminate HIV-related S&D.
* In WCA, shared experiences and knowledge have led to streamlined processes/models of national action plans in 7 countries (Senegal, Côte d'Ivoire, the Democratic Republic of the Congo, Liberia, Gambia, Guinea and the Central African Republic) providing accountability and accelerating implementation of interventions.
* In CAR, a Zero Discrimination Platform with 30+ members was relaunched to oversee and support implementation of joint activities. To ensure civil society’s meaningful participation, a distinct civil society platform was also established to foster dialogue, implement and follow-up on specific community & advocacy activities.

Actors and community advocates capacitated: to generate and/or use evidence to implement interventions that reduce S&D barriers. In GP countries that are part of the BDB initiative, mid-term assessments have documented progress in scaling up S&D reduction programmes and emerging evidence of impact of community-led programmes.

* Thailand: stakeholder collaboration led to the scale up of interventions in healthcare settings and engagement of communities. Its 3-by-4 package of interventions has been key to removing barriers to healthcare access, sensitizing health personnel and monitoring HIV stigma & discrimination in health facilities.
* Thailand: the country has mobilized partners, and the private sector to prevent and reduce HIV S&D in the workplace settings with the full engagement of civil society groups (Thai Network of Youth Living with HIV and the Foundation for AIDS Rights). Based on evidence gathered around discriminatory business practices by civil societies,3 major private sector employers are undertaking a full review of their HIV policy and its implementation.
* In Nepal and Laos PDR, training modules on reducing S&D have been developed by and for communities of PLHIV and key populations to ensure interventions respond to their needs.
* Iran: emergency workers have been trained to ensure provision of S&D free HIV services in emergency settings.

Mechanisms addressing Human Rights Violations in Place and Improved Enabling Environments

* Thailand adopted a national code of conduct on HIV prevention & management in workplace in 2021 and its Department of Labour will be compiling relevant ministerial regulations and related HIV laws that will be disseminated to the private sector to promote non-discriminatory business practices, as result of their collaboration with the GP.
* CAR: the National Charter for Quality of Care & Patients was adopted and includes specific provisions against S&D, including based on HIV status and sexual orientation, in any health service delivery setting. The Charter is being disseminated in health centres and dedicated sensitization and trainings are being organized periodically for medical staff and healthcare providers.
* Jamaica: Development of monitoring and evaluation online platform to track progress in eliminating S&D and completion of Human Rights Scorecard featuring 138 interventions (over 10 entities) to increase awareness and improve complementarity, coherence & accountability around interventions.
* In Kazakhstan, a website to collect data and document real time human rights violations of PLHIV and key affected populations has been piloted. The information obtained will be used to strengthen programme design addressing human rights barriers and ensure access to justice.

1. **Less than 10% of women and girls, PLHIV and KPs experience gender inequality & violence**

Through the expertise of its co-leads, Technical Working Group partners and strategic collaborations such as with Women4GlobalFund (W4GF), the Global Partnership brings in a gendered lens to ensure interventions in all settings directly address the rights and needs of women and girls living with HIV in all their diversity

Advocacy

* Senegal: the Senegal National PLHIV Network (RNP+) held anti-stigma dialogues focused on women and girls and to develop an advocacy strategy for advocating with women lawyers’ associations and women's rights organizations to reduce the discrimination experienced by women and girls living with and affected by HIV in the country.

National and Regional Synergies

* Through the collaboration with W4GF, women’s rights groups in Uganda and Jamaica were supported to enhance south-south collaboration in the exchange of best practices to ensure interventions address the gendered aspects of S&D and that they uphold the rights and needs of women and girls in all their diversity. Country-level webinars were held to bring together a wide range of civil society, community and technical partners, and implementers, and build understanding of key entry points to influence how the Global Partnership rolls out in Uganda and Jamaica.
* In Uganda, collaboration with OHCHR led to the development of training manuals for health care providers on human rights-based approaches to sexual and reproductive health and rights (SRHR) services. The manuals will be used to build the capacity of healthcare workers in providing access to SRHR services - free of stigma and discrimination - for women living with HIV.

Actors Capacitated: to generate and/or use evidence to implement interventions that reduce gender inequalities

* Uganda: a community-led scorecard in 56 districts was piloted by ICW-EA to support local leaders and decision-makers in implementing interventions for the elimination of HIV-related S&D against women and girls. ICW-EA also became a sub-recipient of the Global Fund grant to implement interventions to monitor violence against women and HIV-related stigma and discrimination at community level, to provide psychological support to people living with HIV and economic empowerment for young women and girls affected by HIV.

1. **Less than 10% of countries have punitive laws and policies**

Advocacy

* Kazakhstan: ties established between PLHIV community and parliament to facilitate advocacy around repeal of discriminating laws. Shadow reports have also been drafted by civil society and communities to create visibility on issues touching upon stigma and discrimination, which in turn support advocacy with the government. For instance, an advocacy paper on access to opioid substitution therapy was drafted to advocate and meet with members of Parliament in September 2021.
* Ukraine: through GF grants, significant support is provided for community-led advocacy around law reform, including a Fight for Health platform for engaging with parliamentary members and capacity building of community representatives. Technical support provided on legal reform, including reviewing HIV Law and decriminalizing HIV transmission.

Legal Support

* Angola: the GP provided technical support for legal and policy review, which informed a proposed new legal provision allowing adolescents of 14 years, and those below 14 years with sufficient maturity, to consent independently to HIV testing services.
* Ghana: LGBTQI coalition was supported in drafting memorandum to Parliament highlighting the damaging impact of proposed anti LGBTQ+ Bill.
* Mozambique: the BDB mid-term assessment documented significant scale up of paralegal and legal support. Paralegals helped secure the release of 45 sex workers, who were detained by a community safety council for possession of condoms, and helped remove girls from premature unions in the Zambezia, Manica and Tete provinces.

Capacitated Actors

* Kazakhstan: capacity-building trainings for PLHIV and community representatives were conducted to strengthen their capacity to navigate international and local human rights instruments, as well as improving the efficiency of their engagement with lawmakers.

Improved Legal Environments

* In WCA, HIV law reforms are under way in Benin, Burundi and CAR with the support of HIV Justice Network.
* Angola: the new Penal Code has made impressive progress on eliminating punitive laws. In addition, a request was made for the Ministry of Justice and Human Rights to revise the HIV Law.
* Iran: HIV anti-discrimination bylaw was adopted for healthcare settings binding them to protect PLHIV and most at-risk populations from S&D.
* Kazakhstan: in 2020, the new Code on People’s Health and System of Health Care came to force, prohibiting HIV-related discrimination in workplaces.

1. UNAIDS works to support countries, communities, and other stakeholders to remove human rights barriers and improve societal enablers such as laws, policies, reduction of stigma and discrimination and violence, gender norms and inequalities, and promote the health and wellbeing women and girls, and men and boys, trans and other gender diverse persons in all their diversity in order to end AIDS as a public health threat by 2030. [↑](#footnote-ref-2)
2. Throughout the Strategy, the term “ending AIDS” is used to refer to the full term “ending AIDS as a public health threat by 2030”, which is defined as a 90% reduction in new HIV infections and AIDS- related deaths by 2030, compared to a 2010 baseline. [↑](#footnote-ref-3)
3. Key populations are groups of people who are more likely to be exposed to HIV or are living with HIV. Their engagement is critical to a successful HIV response. In all epidemic settings, key populations at higher risk of HIV infection include gay men and other men who have sex with men, transgender people, people who inject drugs, sex workers and their clients, and people in prisons and other closed settings. [↑](#footnote-ref-4)
4. WHO/The Global Fund TFATM, State of Inequality: HIV, Tuberculosis and Malaria, Geneva, 2021. p. 7 [↑](#footnote-ref-5)
5. The 10 Sustainable Development Goals which are explicitly linked to this Strategy are SDG 1 No Poverty; SDG 2 Zero Hunger; SDG 3 Good Health and Well-Being; SDG 4 Quality Education; SDG 5 Gender Equality; SDG 8 Decent Work and Economic Growth; SDG 10 Reduced Inequalities; SDG 11 Sustainable Cities and Communities; SDG 16 Peace, Justice and Strong Institutions; and SDG 17 Partnerships for the Goals. [↑](#footnote-ref-6)
6. Special analysis by Avenir Health using data from UNAIDS/WHO/UNICEF HIV services tracking tool, November 2020; and UNAIDS epidemiological estimates, 2020 (https://aidsinfo.unaids.org/). [↑](#footnote-ref-7)
7. Countries that have recently ended criminalization of same-sex sexual relations include Angola, Bhutan, Botswana, Gabon and India. Pakistan reformed its laws related to transgender persons. Belgium, Chile, France, Greece, Iceland, Luxembourg, Portugal and Uruguay are among the countries that have opened legal avenues for changing gender markers and names without the requirement of undergoing gender-reassignment surgery. The Philippines, Colombia, Mexico, the state of Illinois (United States of America) reformed their laws criminalizing HIV, and Malawi opted not to include criminal provisions in its new HIV law. Some countries, however, have moved in the opposite direction, amending their laws in ways that allow for harsher sentences in cases of HIV exposure. Angola and New Zealand removed their remaining restrictions on entry, stay and residence based on HIV status and as of March 2020, sex work had also been legalized or decriminalized in Aruba, parts of Australia, Austria, Bonaire, Ecuador, Germany, Greece, the Netherlands, the state of Nevada (United States of America), Niue, Peru, the Plurinational State of Bolivia, Saint Maarten, Switzerland, Taiwan, Turkey and Uruguay, according to research by the Global Network of Sex Work Projects [↑](#footnote-ref-8)
8. UNAIDS. Unequal, unprepared, under threat. UNAIDS. Geneva; 2021. p. 51. [↑](#footnote-ref-9)
9. This number includes countries where the law only applies in certain settings, e.g. the military. [↑](#footnote-ref-10)
10. UNAIDS. Confronting Inequalities. UNAIDS. Geneva: 2021. p.160 [↑](#footnote-ref-11)
11. UNAIDS. Confronting Inequalities. UNAIDS. Geneva: 2021. p.159 [↑](#footnote-ref-12)
12. UNAIDS. National Commitments and Policy Instrument. Available at <https://lawsandpolicies.unaids.org>, accessed 16 February 2022. [↑](#footnote-ref-13)
13. UNAIDS. Confronting Inequalities. UNAIDS. Geneva: 2021. Analysis of Population-based surveys 2015-2020. [↑](#footnote-ref-14)
14. People Living with HIV Stigma Index surveys, 2013-2018. [↑](#footnote-ref-15)
15. UNAIDS. Unequal, unprepared, under threat. UNAIDS. Geneva; 2021. p. 53. [↑](#footnote-ref-16)
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17. UNAIDS. Unequal, unprepared, under threat. UNAIDS. Geneva; 2021. p. 138 [↑](#footnote-ref-18)
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29. Global AIDS update 2021. Geneva: UNAIDS; 2021; and Women, Business and the Law. Washington DC: World Bank; 2021 (https://www.worldbank.org/content/dam/sites/wbl/documents/2021/02/WBL2021\_ENG\_v2.pdf) [↑](#footnote-ref-30)
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32. Global guidance on criteria and processes for validation: Elimination of Mother-to-Child Transmission of HIV, Syphilis and Hepatitis B virus 3rd edition. WHO, 2021. [↑](#footnote-ref-33)
33. Establishing community-led monitoring of HIV services. Principles and processes. Geneva: UNAIDS; 2021

    (https://www.unaids.org/sites/default/files/media\_asset/establishing-community-led-monitoring-hiv-services\_

    en.pdf). [↑](#footnote-ref-34)
34. UNAIDS, Communities at the Centre. UNAIDS. Geneva, 2019. p.132 [↑](#footnote-ref-35)
35. Attorney General v Motshidiemang, Botswana Court of Appeal, 29 November 2021 [↑](#footnote-ref-36)
36. Johar v Union of India No 76 of 2016, Supreme Court of India, September 2018 [↑](#footnote-ref-37)
37. Jones v Attorney General of Trinidad and Tobago. High Court of Justice. Claim CV2017-00720. April 2018 [↑](#footnote-ref-38)
38. Quincy McEwan, Seon Clarke, Joseph Fraser, Seyon Persaud and the Society Against Sexual Orientation Discrimination (SASOD) v The Attorney General of Guyana, Caribbean Court of Justice Nov 2018 [↑](#footnote-ref-39)
39. Inter-American Commission on Human Rights Press release 2021 in the case of FS v Chile, case 12,956 (https://www.oas.org/en/iachr/jsForm/?File=/en/iachr/media\_center/preleases/2021/221.asp). [↑](#footnote-ref-40)
40. UNAIDS. Confronting Inequalities. UNAIDS. Geneva: 2021. p.302 [↑](#footnote-ref-41)
41. UNAIDS, Communities at the Centre. UNAIDS. Geneva, 2019. p.126 [↑](#footnote-ref-42)
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43. UNAIDS, Communities at the Centre. UNAIDS. Geneva, 2019. pp.91, 134 [↑](#footnote-ref-44)
44. The Global Fund, UNAIDS and UNDP (2021). Public financing of service provision by civil society organisations in national responses to HIV, TB and malaria.9 [↑](#footnote-ref-45)
45. UNAIDS. Global AIDS Strategy 2021-2026 — End Inequalities. End AIDS. Geneva: 2021. p.141, footnote 35 [↑](#footnote-ref-46)
46. The following definitions were presented to the UNAIDS Programme Coordinating Board, after extensive constituent consultation and input, by a MultiStakeholder Task Team on Community-Led Responses. They are undergoing final review after which they will be presented to the next Programme Coordinating Board in June 2022. The definitions were conceived as umbrella terms, inclusive of the leadership of people living with HIV, key populations, women and youth in all their diversity. The definitions can be accessed here: <https://www.unaids.org/en/resources/documents/2020/PCB47_Report_Task_Team_Community-led_AIDS_Responses>   [↑](#footnote-ref-47)
47. Agenda item 4 Progress Report on Defining and Measuring Community-Led Responses. UNAIDS, 2019. Available at: <https://www.unaids.org/en/resources/documents/2019/PCB45_Community-led-Response>

    For a network or organization to be considered community-led, the majority of governance, leadership, and staff must come from the community, and there must be clear processes for transparency and accountability between the network or organization and the community it serves. [↑](#footnote-ref-48)
48. The UN Human Rights Council and the High Commissioner for Human Rights have identified various prerequisites for an enabling civic space for civil society, including (i) an enabling legal framework that respects the safety of all persons, protects rights to public participation, equality and non-discrimination to ensure inclusiveness of even the most marginalized, and promote access to justice for violations of these rights; (ii) an inclusive political environment that promotes participation, transparency and accountability; (iii) access to information; (iv) platforms for civil society to participate in decision-making; and (v) strengthened civil society actors, with access to capacity building, technical support and financial resources. See ICNL and UNDP (2021) Legal Frameworks for Civic Space: A Toolkit [↑](#footnote-ref-49)
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117. The Global Partnership’s community of practice is composed of both UNAIDS’ and GNP+’s regional and country coordinators. UNAIDS’ coordinators provide tailored guidance and assistance to countries and regions (or specific communities e.g., LGBTI+) in advancing the Global Partnership's implementation. GNP+ coordinators are also key partners for in-country implementation and are involved at all levels through national consultations, advocacy campaigns and capacity building. They ensure that communities and advocates are capacitated to meaningful engage with national/international entities for their rights, advocate for policy & legal reform (through targeted anti-discrimination campaigns) and implement interventions. Together these coordinators have built a body of expert knowledge and experience, forming the Global Partnership’s “community of practice.” [↑](#footnote-ref-118)
118. Angola, Argentina, Central African Republic, Costa Rica, Cote d’Ivoire, Democratic Republic of the Congo, Ecuador, Gambia, Guatemala, Guinea, Guyana, Iran, Jamaica, Kazakhstan, Kyrgyzstan, Laos, Lesotho, Liberia, Moldova, Mozambique, Nepal, Papua New Guinea, Philippines, Senegal, South Africa, Tajikistan, Thailand, Uganda, Ukraine. [↑](#footnote-ref-119)
119. Cote d’Ivoire, Democratic Republic of the Congo, Jamaica, Kyrgyzstan, Mozambique, Nepal, Philippines, Senegal, South Africa, Uganda and Ukraine [↑](#footnote-ref-120)
120. Such national strategic plans for comprehensive responses to human rights-related barriers have also been developed with support from the BDB initiative, e.g. in Kyrgyzstan, Nepal, Senegal, South Africa, Uganda and Ukraine. [↑](#footnote-ref-121)
121. featuring 138 interventions (across 10 entities) [↑](#footnote-ref-122)