**UNAIDS Submission to Independent Expert on protection against violence and discrimination based on sexual orientation and gender identity**

**Report to the Human Rights Council Report on realisation of the right of persons affected by violence and discrimination based on sexual orientation and gender identity to the enjoyment of the highest attainable standard of physical and mental health, in relation to SDG3**

**Introduction**

The Secretariat of the Joint United Nations Programme on HIV/AIDS (UNAIDS) welcomes the opportunity to make this submission.

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, harmful 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.

Decades of experience and evidence from the HIV response show that intersecting inequalities, including on the basis of sexual orientation, gender, gender identity, sex, race, health status, involvement in sex work and socio-economic status, are preventing progress towards ending AIDS.[[1]](#footnote-2) The new Global AIDS Strategy 2021-2026: [End Inequalities. End AIDS](https://www.unaids.org/en/Global-AIDS-Strategy-2021-2026) uses an inequalities lens to identify, reduce 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.[[2]](#footnote-3)

1. **HIV, Sexual Orientation and Gender Identity: The Data**

While substantial progress has been made in reducing HIV infections and AIDS related deaths, this progress has not benefitted all populations equally, with gay men and other men who have sex with men and trans persons among those left behind in the response. Since 2010, annual numbers of HIV infections have decreased by 31% and AIDS-related mortality has declined by 47%. However[, there is no evidence that annual infection](https://www.unaids.org/sites/default/files/media_asset/PCB47_CRP3_Evidence_Review_EN.pdf) numbers have decreased among transgender people while it is estimated that annual numbers of infections have actually increased by 25% for gay men and other MSM since 2010.

These two populations bear a disproportionate burden of global HIV infections. In 2020, 23% of new infections globally were among gay men and other MSM, while 2% of new infections were among transgender women.[[3]](#footnote-4) Outside of sub-Saharan Africa, 45% of new HIV infections were among gay men and other MSM and 3% of new infections were among transgender women. In terms of relative risk, in 2020 the risk of acquiring HIV was 34 times higher for transgender women than other adults, and 25 times higher for gay men and other MSM than other adult men.[[4]](#footnote-5) Overall, key populations[[5]](#footnote-6) (gay men and other men who have sex with men, transgender persons, sex workers and people who inject drugs) and their sexual partners accounted for 65% of HIV infections worldwide in 2020 and 93% of infections outside of sub-Saharan Africa.[[6]](#footnote-7)

Coverage of prevention programmes for transgender people and gay men and other men who have sex with men is still incredibly low. While data on access to treatment is sparse, the studies that do exist demonstrated that knowledge of HIV status was 33% lower among gay men and other men who have sex with men and transgender people compared to the general population.[[7]](#footnote-8)

The new Global AIDS Strategy includes targets on access to HIV related services, from prevention through to testing and treatment. Recognising the extreme levels of inequality facing LGBTI populations, for the first time the Strategy includes specific targets for each key population, including gay men and other men who have sex with men and transgender people. For example, in terms of testing and treatment, the Global AIDS Strategy requires countries to act to ensure that 95% of gay men and other men who have sex with men and trans persons living with HIV know their status, that 95% who know their status are on antiretroviral therapy and 95% on therapy have a suppressed viral load by 2025. From 2022 onwards UNAIDS will be monitoring, and asking countries to report on, coverage of services for each key population.[[8]](#footnote-9)

***Stigma, Discrimination and Violence***

Structural factors, such as [stigma, discrimination and violence based on sexual orientation and gender identity, and the criminalization of same-sex sexual behaviour and gender identity and expression](https://www.unaids.org/sites/default/files/media_asset/2020_global-aids-report_en.pdf) can severely impact the availability, access, acceptability, quality and uptake of HIV prevention, testing, treatment and care and support services. [Discrimination based on sexual orientation and/or gender identity intersects with other forms of discrimination for different groups](https://www.unaids.org/sites/default/files/media_asset/03-hiv-human-rights-factsheet-gay-men_en.pdf), including based on race, ethnicity, indigenous status, age, HIV status, gender, disability, and socioeconomic status, migrant status, drug use or involvement in sex work.[[9]](#footnote-10)

Both structural discrimination (i.e. discriminatory laws, policies and institutionalized practices) and societal discrimination (i.e. due to rejection, mistreatment and social exclusion and lack of gender recognition by others) hinder HIV prevention, testing, treatment, care and support services and other sexual and reproductive health (SRH) services, including gender-affirming care.[[10]](#footnote-11) [[11]](#footnote-12)

Stigma and discrimination have also been found to have a profound negative impact on mental health for transgender people, which can affect their vulnerability to HIV and access to care.[[12]](#footnote-13) [[13]](#footnote-14) Transgender people, particularly trans women, have specifically referenced stigma as a powerful deterrent for accessing treatment or staying in care.[[14]](#footnote-15) Data reported to UNAIDS in the recent years shows that the percentage of transgender people who avoid seeking HIV testing due to stigma and discrimination ranges from 47% to 73%.[[15]](#footnote-16) For both gay men and other MSM and trans people, at least one in three reporting countries stated that more than 10% of respondents avoided health care.[[16]](#footnote-17)

Studies show that transgender women who have experienced stigma in health care are three times more likely to avoid health care than transgender women who have not experienced stigma.[[17]](#footnote-18) It is a similar situation for gay men and other MSM: surveys in sub-Saharan Africa found that between 10% and 40% of gay men and other men who have sex with men delay or avoid health care due to fear of stigma.[[18]](#footnote-19)

Lack of equal recognition before the law has been found to fuel stigma and discrimination against trans persons, while reforming laws to provide for a change of gender on identity documents can have a profound impact in reducing such stigma. A study on the impact of law reforms to allow change of gender on identity documents found that after the law was introduced, only 30% of survey participants reported experiencing discrimination based on gender identity, compared to 80% prior to the law reform. Prior to the legal change 48.8% of transgender women interviewed reported needing to abandon their education due to stigma. This dropped to 4% after the law was introduced.[[19]](#footnote-20)

Deeply entrenched stigma and prejudice against LGBTI people—and discriminatory laws and regulations that foster a climate where hate speech, violence and discrimination are condoned—perpetuate high levels of violence against LGBTI communities. Acts of violence range from daily exclusion and discrimination to torture and arbitrary killings. Significantly, there is no comprehensive and systematic data on the number of victims of violence, but as [the Independent Expert has estimated](https://undocs.org/A/HRC/38/43), there are millions every year.[[20]](#footnote-21) [Violence against transgender people is highly prevalent and widespread](https://www.unaids.org/sites/default/files/media_asset/04-hiv-human-rights-factsheet-transgender-gender-diverse_en.pdf).[[21]](#footnote-22) In a study in eight sub-Saharan African countries, 33% of the transgender women surveyed said that they had been physically attacked at some point in their lives, 28% had been raped and 27% said that they were too afraid to use health-care services.[[22]](#footnote-23) A 2020 systematic review of 74 quantitative data sets on intimate partner violence in transgender populations found a median lifetime prevalence of physical intimate partner violence among transgender individuals of 37.5%.[[23]](#footnote-24)

***Criminalization impacts the right to health***

LGBTI communities continue to be marginalized and criminalized for their gender identities and expression and sexual orientation. Where LGBTI persons are also involved in sex work or drug use, or are living with HIV, they are doubly criminalised for their livelihoods or health status. In 2021 UNAIDS reported that 24 countries criminalise and/or prosecute transgender persons and 71 countries criminalise same-sex sexual behaviour.[[24]](#footnote-25) As highlighted by the [Global Commission HIV and the Law](https://hivlawcommission.org/wp-content/uploads/2020/06/Hiv-and-the-Law-supplement_EN_2020.pdf), laws and policies used to discriminate against people living with HIV, TB or viral hepatitis, or to criminalise sex work, drug use, same sex relations or expressions of identity, are often enacted and enforced in the name of public health and safety. However, they usually result in undermining health outcomes, especially for marginalised groups.

Recent research shows that gay men and other MSM who live in countries that criminalize same-sex relations are more than twice as likely to be living with HIV as those living in countries without such criminal penalties, and those living in countries with severe criminalization are almost five times as likely to be living with HIV as those living in countries without such criminal penalties.[[25]](#footnote-26) Knowledge of HIV status among gay men and other men who have sex with men who are living with HIV was three times higher in countries with the least repressive lesbian, gay, bisexual and transgender people (LGBT) laws than in countries with the most repressive LGBT laws.[[26]](#footnote-27) Similarly, the criminalization of transgender and gender-diverse people is widespread, as is the imposition of other punitive laws, practices, and policies against this population. [Such laws help perpetuate stigma, discrimination, hate crimes, police abuse, torture, ill-treatment and family and community violence](https://www.unaids.org/sites/default/files/media_asset/04-hiv-human-rights-factsheet-transgender-gender-diverse_en.pdf).[[27]](#footnote-28) Conversely, there was a [positive correlation between better HIV outcomes and the adoption of laws that advance non-discrimination, the existence of human rights institutions and responses to gender-based violence](https://www.hivpolicylab.org/documents/reports/hlm/PRE-PRINT%20%20WHITE%20PAPER-Kavanagh%20et%20al-Law%20Criminalization%20%26%20HIV%20in%20the%20World-2021.pdf).[[28]](#footnote-29)

***Intersectionality***

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. For example, a recent review of research regarding gender-based violence against transgender people in the US discussed the intersections of gender identity and involvement in sex work. Social determinants including stigma and discrimination that lead to fewer employment opportunities, among other factors, has meant that between 20 – 75% of transwomen in the US engaging in sex work in their lifetime compared to 1% of cisgendered women. Transgender women involved in sex work report high levels of police harassment and violence and reduced ability for condom negotiation.[[29]](#footnote-30)

The Global AIDS Strategy, as referenced earlier, focuses on a high coverage of HIV and SRH services together with the removal of harmful punitive laws and policies, gender inequalities and stigma and discrimination. These targets address the inequalities on which HIV, COVID-19 and other pandemics thrive and put people at the centre, particularly those already marginalized including young women and girls, adolescents, sex workers, trans and gender diverse people, people who inject drugs and gay men and other men who have sex with men.

***Lack of Data on LGBTI Populations***

An ongoing challenge relates to a lack of data and information for LGBTI populations, both in terms of population sizes and data relating to health. Criminalisation, stigma and discrimination can lead to a negation of the existence of LGBTI communities in different countries or sub-national regions. A 2017 study comparing population size estimates for gay men and other MSM across 154 countries found that countries that criminalize same-sex sexual behaviour were more likely to report implausibly low numbers of gay men and other MSM compared to countries that do not criminalize such behaviour.[[30]](#footnote-31) An analysis by UNAIDS, WHO and the Global Fund of population size estimates estimated that, among the 52 countries that report population size estimates, more than 15 million people from key populations who would benefit from HIV prevention, care and treatment services are unaccounted for. It is estimated that approximately 50% of the population of gay men and other MSM, and approximately 80% of transwomen are missing from national population estimates, corresponding to 20 million missing gay men and other MSM and 6 million missing transwomen. 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.[[31]](#footnote-32) Transgender and gender-diverse people are also invisibilized due to stigma, discrimination, and criminalization, which results in a severe lack of data on transgender and gender-diverse people and their health.[[32]](#footnote-33)

For populations who are stigmatized, marginalized and criminalized, 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. In an effort to bridge research gaps, UNAIDS, GNP+, ICW and IPPF developed the [People Living with HIV (PLHIV) Stigma Index](https://www.stigmaindex.org/), a standardized tool to gather evidence on how stigma and discrimination impacts the lives of people living with HIV. The PLHIV Stigma Index was developed to be used by and for people living with HIV and was created to reflect and support the Greater Involvement of People living with HIV and AIDS (GIPA) principle, where PLHIV networks are empowered to lead the whole implementation of the PLHIV Stigma Index study. Since its launch, the PLHIV Stigma Index has been implemented in more than 100 countries with over 100,000 PLHIV participating in the process.[[33]](#footnote-34)

UNAIDS, WHO, FHI 360, and the US Centers for Disease Control and Prevention have developed [Biobehavioural Survey Guidelines](https://www.who.int/publications/i/item/978-92-4-151301-2) for researchers conducting country-based integrated biobehavioural surveys (IBBS) of HIV and HIV-risk behaviours. BBS provide specific population-level estimates for the burden of HIV disease and HIV-related risk factors and estimates for the coverage of prevention and treatment services for populations at increased risk for HIV. Key populations are the primary focus of the Guidelines, as they are often hidden and difficult to measure within general population-based surveys. The surveys ask questions that go to intersectionality – not simply gender identity or sexual orientation, but also sex at birth, whether they use drugs or are involved in sex work, educational attainment, marital status. The surveys also ask about feelings of shame and experiences of stigma, discrimination and harassment. The surveys further inquire about service uptake, SRHR and then perform diagnostic tests to obtain data on HIV and other sexual health issues. Collecting this type of multi-layered information is particularly important in order to understand the multiple and intersecting forms of stigma and discrimination, including structural, that impede the provision of and access to health services.

While these important demographic tools are available, unfortunately country uptake is limited. Between 2016 – 2020, only 64 countries reported survey data to UNAIDS on gay men and other MSM and only 29 countries reported on transgender individuals.[[34]](#footnote-35) As such, significant data and research gaps remain. To leave no one behind, we need people-centred data collection that spotlights the inequalities that are hampering access to services. It is critical to understand who are the most affected and unable to access services.

***Inclusion of LGBTI and Gender Diverse People in Decision-making Processes***

Since the beginning of the HIV epidemic, communities most affected, including LGBTI people have been driving the global HIV response forward. However, after more than 40 years, there are still many challenges to the meaningful participation of these populations. Among 146 countries reporting participation of key populations in developing national policies, guidelines and/or strategies relating to their health, 26 countries reported that there were no participation of gay men and other men who have sex with men and 54 countries reported no participation of transgender people.

A core focus of UNAIDS’s work and a central strategy in the Global Strategy is supporting and promoting the meaningful participation of LGBTI communities to lead the AIDS response at all levels.

The [Global AIDS Strategy 2021–2026](https://www.unaids.org/sites/default/files/media_asset/global-AIDS-strategy-2021-2026_en.pdf) was the result of extensive analysis of HIV data and an inclusive process of consultation with countries, communities and stakeholders. Throughout the strategy development process, the participation and engagement of 10,000 stakeholders from 160 countries, including LGBTI individuals and other key populations,[[35]](#footnote-36) was prioritized, resulting in the inclusion of issues related to LGBTI communities throughout. The Global AIDS Strategy contains strong targets in relation to community-led responses and key-population led responses, critical to ensure gay men and other men who have sex with men and trans persons are not left behind. They are:

30% of testing and treatment services to be delivered by community-led organizations,

80% of service delivery for HIV prevention programmes for key populations to be delivered by community-led organizations

80% services for women to be delivered by community-led organizations that are women-led.

60% of the programmes supporting the achievement of societal enablers to be delivered by community-led organizations.[[36]](#footnote-37)

UNAIDS has been working with countries to increase the proportion of services led by communities. As part of this strategy, UNAIDS convened a task team with different stakeholders, including LGBTI representatives, to develop a standardized definition of community-led response. Participants also developed definitions of “community-led organisations”, sub-definitions for “key population-led responses” and “key population-led organisations”, and called for sub-definitions for “women-led responses” and “women-led organisations”.

UNAIDS also facilitated civil society engagement in the development and negotiation of the [2021 Political Declaration on HIV/AIDS](https://www.who.int/news/item/11-06-2021-new-hiv-aids-political-declaration-seeks-to-end-inequalities-and-get-on-track-to-end-aids-by-2030), including through the creation of a Multistakeholder Task Force with representatives of different affected communities. At the end of the process, more than 3,000 representatives from people living with HIV, key populations, including LGBTI and GNC people, and other affected communities were engaged in consultations, surveys, meetings and other activities led by communities and supported by UNAIDS in all regions of the world.

***Political Commitments for Tackling HIV-related Stigma, Discrimination and Criminalisation***

In recognition of the importance of creating enabling legal environments and reducing stigma and discrimination, including for gay men and other MSM and trans and other gender diverse people, the [Global AIDS Strategy 2021-2026](https://www.unaids.org/en/Global-AIDS-Strategy-2021-2026) lays out targets dedicated to the societal enablers of the HIV response, known as the 10-10-10 targets. These targets aim to remove the social and legal impediments that limit or deny access or utilization of HIV services. Specifically, the targets set for the implementation of the Global AIDS Strategy include that, by 2025:

* Less than 10% of people living with HIV and key populations will experience stigma and discrimination;
* Less than 10% of people living with HIV, women and girls and key populations will experience gender-based inequalities and gender-based violence; and
* Less than 10% of countries will have punitive laws and policies that result in denying or limiting access to HIV services. This includes removing laws that criminalise same-sex sexual activity, drug use and possession for personal use, sex work and HIV criminalisation.

The more detailed targets can be found in the Global AIDS Strategy. Modelling has shown that failure to realise the above targets will lead to 2.5 million new HIV infections and 1.7 million AIDS-related deaths by 2030.[[37]](#footnote-38)

The UN General Assembly adopted the above societal enablers in the [2021 Political Declaration on AIDS](https://www.unaids.org/sites/default/files/media_asset/2021_political-declaration-on-hiv-and-aids_en.pdf), adopted by the General Assembly in June 2021, as well as recognised the need to increase investments in the enablers to US$ 3.1 billion in low- and middle-income countries by 2025.

Despite the evidence on the importance of reducing stigma and discrimination, action in this area has been minimal. For this reason, the [Global Partnership for Action to Eliminate all Forms of HIV-related Stigma and Discrimination](https://www.unaids.org/sites/default/files/media_asset/global-partnership-hiv-stigma-discrimination_en.pdf) (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.[[38]](#footnote-39) Co-led by UNAIDS, UNDP, UNWomen, the Global Network of People Living with HIV, 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 at 3 February 2022, twenty-nine (29) countries had joined the Global Partnership.[[39]](#footnote-40)

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 guidance articulates how stigma and discrimination operate in each setting, who is affected, and suggested programmes that can be implemented to address stigma and discrimination based on available evidence and best practice. 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.

Recognizing that discrimination in health care settings is a major barrier to achieving the SDGs, UN entities adopted a [Joint Statement](https://www.who.int/news/item/27-06-2017-joint-united-nations-statement-on-ending-discrimination-in-health-care-settings) committing to support Member States to, among other things, implement non-discrimination guarantees in laws, policies and regulations and removing laws that criminalise or otherwise prohibit gender expression and same sex conduct among others.

**Conclusion and Recommendations**

Since the height of the HIV pandemic in 2005, phenomenal progress has been made in many parts of the world to reduce HIV infections and AIDS-related mortality, through the provision of prevention, testing and treatment services. However, for gay men and other MSM and transgender persons, that progress has not been equally enjoyed, violating their right to the highest attainable standard of physical and mental health. Human rights barriers such as stigma, discrimination, violence and criminalisation and other multiple and intersecting inequalities and discrimination affect the provision of and access to services and prevent individuals from being able to protect their own health and seek assistance when needed, leading to a situation where, since 2010, HIV infections have not declined for trans women and have risen for gay men and other MSM by 25%, in stark contrast to the declines seen in the rest of the population.

To reduce these disparities and to ensure ending AIDS by 2030 means ending AIDS for all, without discrimination, it is essential to reduce these underlying inequalities and remove the human rights barriers that prevent access to services, including for prevention, testing and treatment. To this end, the Global AIDS Strategy recommends, and countries have committed to:

1. Ending the criminalisation of consensual same-sex sexual activity and repealing laws that de facto criminalise trans persons, as well as ending criminalisation of sex work, drug use and HIV exposure, non-disclosure and transmission.
2. Reducing stigma and discrimination on the basis of sexual orientation, gender, gender identity, HIV status, involvement in sex work, drug use and other characteristics protected under international human rights law, including among healthcare workers, law enforcement and the community.
3. Reducing physical and sexual violence against key populations, including gay men and other men who have sex with men trans persons, people living with HIV and women and girls.
4. Increase the proportion of community-led HIV services and ensure relevant networks and communities are sustainably financed, included in HIV response decision-making, and can generate data through community monitoring and research.
5. Reducing support for inequitable gender norms.
6. Ensuring HIV services are gender-responsive.
7. Increasing coverage of HIV prevention, testing and treatment services for Key Populations
8. Provision of access to one or more social protection benefits
9. Ensure key populations and people living with HIV have access to mechanisms to report abuse and discrimination and seek redress.
10. By 2025:
    1. 90% of trans people have access to HIV services integrated with or linked to STI, mental health, gender-affirming therapy, IPV programmes, and SGBV programmes that include PEP, emergency contraception and psychological first aid
    2. 90% of gay men and other men who have sex with men have access to 90% have access to HIV services integrated with (or linked to) STI, mental health and IPV programmes, SGBV programmes that include PEP and psychological first aid.

1. 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-2)
2. 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-3)
3. UNAIDS, Confronting Inequalities: Lessons for pandemic responses from 40 years of AIDS. Geneva: 2021. p. 24. [↑](#footnote-ref-4)
4. UNAIDS, Confronting Inequalities: Lessons for pandemic responses from 40 years of AIDS. Geneva: 2021p. 23. [↑](#footnote-ref-5)
5. 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-6)
6. UNAIDS, Confronting Inequalities: Lessons for pandemic responses from 40 years of AIDS. Geneva: 2021p. 23. [↑](#footnote-ref-7)
7. UNAIDS, Seizing the Moment. Geneva: 2020, p.73 [↑](#footnote-ref-8)
8. UNAIDS. End Inequalities. End AIDS. Global AIDS Strategy 2021-2026. Geneva. 2021. P. 83. [↑](#footnote-ref-9)
9. HIV and Gay Men and Other Men Who Have Sex with Men: Human Rights Fact Sheet Series, 2021, p. 1. https://www.unaids.org/sites/default/files/media\_asset/03-hiv-human-rights-factsheet-gay-men\_en.pdf [↑](#footnote-ref-10)
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18. Integrated biological and behavioural surveillance reports in Burkina Faso, Côte d’Ivoire, Eswatini, Lesotho 2013–2016. [↑](#footnote-ref-19)
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33. During the International AIDS Conference 2018 in Amsterdam, The Netherlands the latest version of the tool was launched. The makeover reflects the latest context in the HIV response globally. The revision process was supported by Population Council and PEPFAR and launched as the PLHIV Stigma Index 2.0. [↑](#footnote-ref-34)
34. UNAIDS Internal Data [↑](#footnote-ref-35)
35. The consultation process involved UNAIDS’ staff, the Cosponsors, civil society, people living with and affected by HIV, young people, faith institutions, ministers of health, finance and gender and parliamentarians, scientists, donors and the private sector. [↑](#footnote-ref-36)
36. Please refer to page 141 of the Global AIDS Strategy 2021-2026 for the full text of the targets. [↑](#footnote-ref-37)
37. UNAIDS, End Inequalities. End AIDS. Global AIDS Strategy 2021-2026. UNAIDS, Geneva. 2021. P. 28 [↑](#footnote-ref-38)
38. The Global Partnership is co-convened by heads of agencies of the Global Network of People living with HIV (GNP+), the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Entity for Gender Equality and the Empowerment of Women (UN Women), and the United Nations Development Programme (UNDP), and with leadership and technical support of the nongovernmental organization delegation to the UNAIDS Programme Coordinating Board (PCB). In September 2021, the Global Fund formally joined as co-convener of the Global Partnership. This will strengthen coordination and increase the scale of technical assistance and investments to eliminate HIV-related stigma and discrimination, including in the 28 countries that have joined the Global Partnership. [↑](#footnote-ref-39)
39. For a list of Partnership countries see: www.hivglobalpartnership.org [↑](#footnote-ref-40)