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Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development

Human rights and HIV/AIDS

Report of the United Nations High Commissioner for Human Rights*

Summary

In the present report, submitted to the Human Rights Council pursuant to its resolution 47/14, the United Nations High Commissioner for Human Rights recommends action necessary to achieve the societal enabler targets adopted by the General Assembly in its Political Declaration on HIV and AIDS: Ending Inequalities and Getting on Track to End AIDS by 2030: removing punitive legal and policy frameworks; reducing stigma and discrimination; and addressing gender inequalities and gender-based violence. Societal enablers are structural and systemic factors, including legal, cultural, social and economic that are critical to the effectiveness of the AIDS response. Implementing them would remove barriers in access to health services and enable individuals and communities to better protect their health and well-being.

Since 2017, much progress has been made in removing human rights-related barriers to HIV services by significantly increasing funding and programme implementation. The main gaps and challenges remaining in the HIV response are, however, mainly due to a continued failure to uphold human rights, especially the rights of people living with HIV, including women and girls and other groups living in situations of vulnerability, and to fund and implement required interventions at scale, such as human rights literacy, training and support; gender equality and prevention of violence; community-based human rights empowerment and monitoring; law and policy reform; and redress for harm.

* The present report was submitted after the deadline in order to reflect the most recent developments.

I. Introduction and overview of the HIV/AIDS situation

1. Just over 40 years since the identification of the first cases of HIV/AIDS – and with more than 36 million lives subsequently lost to the epidemic – much progress has been made, including the development of highly effective prevention and treatment modalities, including anti-retroviral medicines, to prevent disease and death as well as the transmission of HIV; pre-exposure prophylaxis; access to condoms; and voluntary male circumcision.

2. Nevertheless, HIV remains a major threat to global public health. In 2020, 37.7 million people were living with HIV globally, while 1.5 million new infections and 680,000 AIDS-related deaths were registered.[1] As at June 2021, only 28.2 million people had access to anti-retroviral therapy. Although global HIV incidence fell by 31 per cent between 2010 and 2020, this is far short of the 75 per cent target set by the General Assembly in 2020. If the current trend continues, the world will not end AIDS and other epidemics by 2030, as envisaged under target 3.3 of Sustainable Development Goal 3 (ensuring healthy lives and promoting well-being for all at all ages).

3. The global HIV response has suffered serious setbacks due to the coronavirus disease (COVID-19) pandemic. Socioeconomic and other inequalities that put people at higher risk of contracting HIV have worsened significantly. Access to anti-retroviral medicines, availability of testing and prevention services, and referrals for diagnosis and treatment all declined considerably owing to the prioritization of the COVID-19 response. Public health directives, particularly lockdown measures and curfews, reduced physical access to health services for HIV and other sexual and reproductive health services, while supply chain disruptions resulted in shortages of prevention commodities, such as condoms and lubricants.[2]

4. The UNAIDS Programme Coordinating Board adopted by consensus the Global AIDS Strategy 2021–2026 in March 2021. The strategy uses an inequalities lens to address the barriers and gaps that drive the epidemic, and prioritizes those who do not have access to HIV prevention or treatment. It identifies a set of societal enablers with respective targets, in its approach to addressing inequality.

5. In June 2021, the General Assembly adopted in its resolution 75/284 the Political Declaration on HIV and AIDS: Ending Inequalities and Getting on Track to End AIDS by 2030, with the aim of re-energizing efforts to end HIV by 2030 and accelerating progress towards the achievement of the Sustainable Development Goals, especially Goal 3. In the Political Declaration, Member States committed to urgent and transformative action to end social, economic, racial and gender inequalities, restrictive and discriminatory laws, policies and practices, stigma and multiple and intersecting forms of discrimination, including based on HIV status, and other human rights violations that perpetuated the global AIDS epidemic. Crucially, it refers to the same targets as the Global AIDS Strategy with regard to societal enablers.

6. In its resolution 47/14, the Human Rights Council requested the United Nations High Commissioner for Human Rights to prepare a report that described the actions being taken and to make recommendations on steps to be intensified or initiated to meet the innovative targets on societal enablers in the Political Declaration and address the remaining gaps. In preparing the present report, the Office of the United Nations High Commissioner for Human Rights (OHCHR) consulted with a range of stakeholders, mainly through a call for written inputs.[3] OHCHR particularly acknowledges the support provided by UNAIDS for the preparation of the report.

[1] UNAIDS Global AIDS Update 2021, *Confronting inequalities: Lessons for pandemic responses from 40 years of AIDS*, 2021.

[2] Global Fund, *Results Report 2021*, 2021 (available from www.theglobalfund.org/media/11304/corporate_2021resultsreport_report_en.pdf), p. 16.

[3] Submissions received are available from https://previous.ohchr.org/EN/Issues/ESCR/Pages/HIV-report-HRC-50th-session.aspx.

II. Societal enablers and their targets

7. Under the Political Declaration, States committed to meeting several targets covering three societal enablers: removing punitive legal and policy frameworks; reducing stigma and discrimination; and addressing gender-based inequalities and gender-based violence. The targets to be achieved by 2025 are (a) less than 10 per cent of countries with restrictive legal and policy frameworks leading to the denial or limitation of access to services; (b) less than 10 per cent of people living with and affected by HIV experiencing stigma and discrimination; and (c) no more than 10 per cent of women, girls and persons living with, at risk of or affected by HIV experiencing gender-based inequalities and sexual or gender-based violence.

8. The three above-mentioned targets are supported by a commitment to doubling investment in societal enablers (including the protection of human rights, reduction in stigma and discrimination, and law reform, where appropriate) in low- and middle-income countries to $3.1 billion by 2025. Furthermore, the Political Declaration commits States to the Greater Involvement of People Living with HIV/AIDS principle and to empowering communities of people living with, at risk of and affected by HIV, including women, key populations, adolescent girls and young people, to play their critical leadership roles in the HIV response.[4] This is to be achieved by, among other actions, increasing the proportion of HIV services delivered by communities, including by ensuring that community-led organizations deliver 60 per cent of programmes to support the achievement of societal enablers by 2025.

A. Legal and policy frameworks

9. Despite important progress in several countries, many States retain punitive and discriminatory laws relevant to HIV/AIDS and to key populations particularly vulnerable to HIV. According to UNAIDS, in 2021, 135 countries explicitly criminalized or otherwise prosecuted HIV exposure, non-disclosure or transmission; 24 countries criminalized and/or prosecuted transgender persons; 133 countries criminalized at least one aspect of sex work; and 71 countries criminalized consensual same-sex sexual activity. Some 65 countries criminalize possession of small amounts of drugs for personal use,[5] although more than 30 countries and 50 jurisdictions have adopted some form of decriminalization of drug possession for personal use.[6] However, in some countries the type or maximum quantities of drugs allowed for personal use are defined in ways that people who use drugs are frequently presumed to be trafficking.[7] A number of countries still place restrictions on entry into their territory for people living with HIV, while others require mandatory HIV testing, for example for marriage certificates or for performing certain professions. Legislation on sexual consent that undermines the right to health of adolescents and their sexual and reproductive health and rights is also reported.[8]

10. This array of criminal laws and the punitive use of administrative and other sanctions stigmatize already marginalized populations. This has serious consequences for people living with or at risk of infection with HIV, who are often reluctant to seek testing and treatment. Criminal laws directed at key populations vulnerable to HIV and the criminalization of HIV

[4] UNAIDS defines key populations as including gay men and other men who have sex with men, sex workers, transgender persons, persons who inject drugs and detainees and other incarcerated individuals.

[5] UNAIDS, 2021 World AIDS Day report: *Unequal, unprepared, under threat: why bold action against inequalities is needed to end AIDS, stop COVID-19 and prepare for future pa*ndemics, Geneva, 2021. p. 51.

[6] See www.talkingdrugs.org/drug-decriminalisation; see also A/HRC/47/40, para. 121.

[7] See submission by the International Drug Policy Consortium, Harm Reduction International, the Centre on Drug Policy Evaluation and Instituto RIA, para. 16.

[8] See submission by the United Nations Population Fund (UNFPA), pp. 3–4; see also Committee on the Rights of the Child, general comment No. 20 (2016).

exposure, non-disclosure and transmission undermine public health, increasing the risk of transmission and undermining education.[9]

11. Criminalizing sex work can, for instance, create barriers to access to health services and contribute to violence against sex workers, who are forced to work in isolation and in clandestine locations. The criminalization of third parties may also limit sex workers' access to support networks and proven safety mechanisms.[10]

12. People who inject drugs have a 35 per cent higher risk of acquiring HIV than the general population. People who use drugs are criminalized, marginalized and stigmatized in most countries, resulting in significant barriers to access to health services (including those for HIV) and in other human rights violations.[11] The criminalization of drug use and related activities have had a negative impact on HIV prevention and treatment. A lack of adequate harm reduction policies, or of policies that actively restrict the provision of essential harm reduction services, was flagged as a significant obstacle to meeting the societal enabler targets.[12]

1. Examples of relevant practice

13. Several countries have removed punitive laws that target or affect key populations, including Angola and Seychelles, which have decriminalized same-sex sexual activity, while New Zealand has removed travel restrictions relating to HIV.

14. The Global Fund has committed to supporting countries to take to scale concrete programmes that will help communities to address criminalization and other punitive policies, as well as punitive and illegal law enforcement. Since 2017, there has been a significant increase in funding for and the implementation of a number of programmes: to improve legal literacy and awareness of the human rights and relevant laws related to HIV and health; to provide legal services and support, including in the form of peer paralegals; to monitor and reform laws and policies; and to sensitize police. These programmes are most effective when combined, taken to scale and led by members of key populations. They empower communities to take on punitive laws and practices that prevent access to health services.

2. Recommendations

15. **The High Commissioner recommends that:**

(a) **States that have not yet conducted an assessment of the extent to which existing legal and policy frameworks comply with the human rights norms and gender equality norms applicable to the HIV response, and of their commitments under the Political Declaration, do so through a process involving the meaningful participation of stakeholders, including key populations, women and girls and young people;**[13]

(b) **States repeal, rescind or amend laws and policies that create barriers or restrict access to health services or that discriminate, explicitly or in effect, against people living with HIV, particularly key populations, women, girls and youth;**

(c) **States ensure that the development, implementation and monitoring of all legal and policy changes and programmatic interventions are undertaken with the meaningful engagement and leadership of community-led organizations;**

(d) **As part of national budgets for HIV, States allocate and utilize resources for:**

(i) **Legal literacy programmes for communities, key populations and marginalized groups;**

[9] UNAIDS, *Rights in a Pandemic: Lockdowns, rights and lessons from HIV in the early response to COVID-19*, 2020, p. 9.

[10] See submission by the HIV Legal Network and the Canadian Alliance for Sex Work Law Reform.

[11] Submission by Harm Reduction International, p. 2.

[12] Ibid., p. 1.

[13] See submission by the National Agency for the Control of AIDS (Nigeria), p. 2.

(ii) **The training and sensitization of lawmakers, judicial officers and law enforcement agents on human rights relating to the protection of people living with HIV;**

(iii) **Funding for community-led organizations to support and advocate for law reform;**

(e) **Violence, abuse and discrimination against people from key populations be monitored, reported and addressed with a view to prevention and redress, in collaboration with key population-led organizations; this includes providing HIV-sensitive, readily available, affordable judicial, quasi-judicial and other mechanisms to address HIV-related human rights violations. Barriers such as cost, lack of legal literacy or legal representation should be eliminated;**

(f) **States end the practice of compulsory drug detention and drug treatment; repeal all mandatory minimum prison sentences for drug offences; ensure access to essential services for people who use drugs, including voluntary referrals to health, social, harm reduction and treatment services that are grounded in evidence, human rights and gender sensitivity;**[14] **apply a moratorium on admissions to compulsory drug detention centres and private treatment centres; and immediately release persons confined against their will in private or public drug treatment facilities;**

(g) **States implement, maintain and scale up non-discriminatory health and harm reduction measures in prisons, in accordance with best practices in public health and professionally accepted standards, and in consultation with detainee groups and community health organizations, to ensure operational success, taking into account the need for culturally appropriate and gender-specific programmes.**[15]

B. Stigma and discrimination

16. Although progress has been made in raising awareness of and reducing HIV-related stigma in some countries, stigma persists. According to UNAIDS, more than 25 per cent of persons aged between 15 and 49 years reported holding discriminatory attitudes towards people living with HIV in 52 of the 58 countries with recent population-based survey data, while more than 50 per cent overall held discriminatory attitudes in 36 of the 58 countries.[16] Discrimination in health-care settings is widespread, with the proportion of people living with HIV in 13 countries reporting denial of health services at least once in the previous 12 months ranging from 1.7 per cent to as high as 21 per cent.[17] In at least one third of reporting countries, more than 10 per cent of respondents across all key populations avoided seeking health care. People who inject drugs avoided seeking health care in three out of four countries reporting.[18]

17. One of the most consequential gaps in the HIV response is the inadequate attention paid to multiple and intersecting forms of discrimination. Experience and evidence from the HIV response show that intersecting inequalities and discrimination based on sexual orientation, gender identity, sex, race, health status, drug use, involvement in sex work, socioeconomic status and other grounds effectively hinder progress in ending AIDS.[19] Recent research on intersectionality and sex work found that gender diverse communities face multiple and intersecting forms of discrimination that can increase their vulnerability to violence and to HIV.[20]

[14] See submission by the International Drug Policy Consortium, p. 5.
[15] Submission by the HIV Legal Network and the Centre on Drug Policy Evaluation, pp. 3–4.
[16] UNAIDS Global AIDS Update 2021.
[17] See submission by UNAIDS.
[18] UNAIDS, *Unequal, unprepared, under threat*, World AIDS Day Report 2021, Geneva (2021), p. 53.
[19] Submission by UNAIDS, p. 1.
[20] Andrea L. Wirtz, Tonia C. Poteat, Mannat Malik and Nancy Glass, "Gender-Based Violence against Transgender People in the United States: A Call for Research and Programming", *Trauma, Violence, & Abuse*, vol. 21, No.2 (2018).

18. Stigma and discrimination negatively affect health outcomes and lead to social isolation, reduced quality of life and poorer mental health.[21] Key populations in particular face a range of barriers rooted in stigma and discrimination, including human rights violations, systematic disenfranchisement, social and economic marginalization and criminalization. Violence, harassment and punitive laws and policies prevent effective access to good quality health care. Even when they do have access, some stakeholders report poor quality health services, the prohibitive cost of good quality services and a failure to provide sexual and reproductive health services beyond HIV prevention as their main concerns.[22] One important challenge is a compartmentalized approach rather than a holistic one, which would remove legal barriers while ensuring access to human rights-based, stigma-free health services.[23]

19. Owing to stigma and discrimination, key populations continue to bear the brunt of the HIV epidemic. Compared to the general population, they remain at much higher risk of infection: 34 times higher for transgender women, 26 times higher for sex workers and 25 times higher for gay men and other men who have sex with men.[24] The Global Fund estimates that, with their sexual partners, they make up 65 per cent of new HIV infections globally and 93 per cent of infections outside of sub-Saharan Africa.[25] They have also not benefited from efforts to combat HIV/AIDS on an equal basis with others owing to the lack of focus on them.[26]

1. Examples of relevant practices

20. Despite the importance of acting on societal enablers, particularly stigma and discrimination, there have until recently been significant gaps in action and funding. For that reason, the Global Partnership for Action to Eliminate all Forms of HIV Related Stigma and Discrimination 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.

21. Co-led by the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Development Programme (UNDP), the United Nations Entity for the Gender Equality and the Empowerment of Women (UN-Women), the Global Network of People Living with HIV/AIDS (GNP+), the NGO Delegation to the UNAIDS Programme Coordinating Board and the Global Fund to Fight AIDS, Tuberculosis and Malaria, the Global Partnership has increased coordinated technical assistance to support country efforts to end stigma and discrimination in six settings: health care, justice, education, the workplace, humanitarian and community. As at 3 February 2022, 29 countries had joined.

22. Thailand has mobilized partners, including the private sector, to prevent and reduce HIV-related stigma and discrimination in the workplace with the full engagement of civil society groups. On the basis of evidence gathered on discriminatory business practices in civil society, three major private sector employers are undertaking a full review of their HIV policy and its implementation.[27]

2. Recommendations

23. **The High Commissioner recommends that:**

(a) **States develop and properly resource strategies and plans to address HIV-related stigma, discrimination and marginalization of key and other vulnerable**

[21] Submission by the Australian Federation of AIDS Organisations (AFAO), p. 2.

[22] Submission by the Sex Workers' Advocacy Network in Central Easter Europe and Central Asia (SWAN), p. 2.

[23] Ibid., p. 1.

[24] See UNAIDS fact sheet for World AIDS Day, available at www.unaids.org/sites/default/files/media_asset/UNAIDS_FactSheet_en.pdf.

[25] Global Fund, *Results Report 2021*, p. 16.

[26] See submissions by Sisonke National Sex Workers Movement in South Africa, p. 2; and UNFPA, p. 1. See also submission by Trans and Intersex Rising Zimbabwe, p. 4.

[27] See submission by UNAIDS.

populations, including women and girls, adopting special measures where necessary to promote equality;

(b) **Plans and strategies specifically address multiple and intersecting forms of discrimination; interventions should be grounded in an intersectional approach, taking into account the effect of stigma and discrimination on participants' identities, and draw in community leaders from a variety of backgrounds, with a view to improving the ability of people to cope with intersectional discrimination and to reduce internalized stigma;**

(c) **States take action to reduce HIV-related stigma and discrimination through the Global Partnership;**

(d) **Financial and other resources be provided for the establishment of safe, community-led spaces for key population groups to build alliances, to organize and to showcase their lived experiences with a view to protecting their human rights;**

(e) **Targeted interventions for key and vulnerable populations be implemented, including:**

(i) **Providing or scaling up human rights-based, comprehensive sexual and reproductive health services for key populations;**

(ii) **Integrating key population-friendly services into all health facilities;**

(iii) **Training health-care providers on human rights and medical ethics related to HIV, including on gender-responsive approaches and sexual and reproductive health;**

(f) **The voices and lived experiences of key and other vulnerable populations be amplified, including in spaces that have traditionally excluded these communities; such initiatives can be supported through community empowerment initiatives and alliance-building with related movements and groups;**

(g) **In all interventions, plans and strategies, key populations and affected communities and groups be provided with opportunities to give meaningful input at all stages of planning, implementation and monitoring.**

C. Gender-based inequalities and violence

24. Harmful gender norms persist in many countries, and gender-based discrimination and violence against women and adolescent girls living with or at high risk of infection with HIV remain widespread. Women continue to be disproportionately represented among people living with HIV. According to UNAIDS, 53 per cent of all people living with HIV in 2020 were women and girls in sub-Saharan Africa, who also accounted for 63 per cent of all new HIV infections in that region that year. The Global Fund estimates that, every week, 5,000 adolescent girls and young women are infected with HIV in East and southern Africa, and that, in sub-Saharan Africa, the victims of six in seven new infections among adolescents are girls.[28]

25. No fewer than 35 per cent of women around the world have experienced physical and/or sexual violence by an intimate partner or sexual violence by a non-partner at some time in their lives. In certain regions, women affected by sexual and physical violence are 1.5 times more likely than other women to be infected with HIV. More than 50 per cent of sex workers report have experienced physical violence in 22 per cent of the 36 countries with recently available data. Often ignored by harm reduction programmes, women who inject drugs face high levels of physical and sexual violence, which contributes to their high risk of HIV. High rates of violence, including sexual violence, against transgender persons have also been reported in several countries.

26. Women and adolescent girls living with HIV are especially susceptible to gender-based violence – including forced and coerced sterilization, forced abortion and obstetric

[28] Global Fund, *Results Report 2021*, p. 21.

violence – and violations to their sexual and reproductive health and rights in health-care facilities.[29] A study in seven Latin America countries among women living with HIV found that more than 20 per cent reported feeling having been coerced to undergo sterilization and/or abortion, and 48 per cent reported having been denied cervical cancer or breast cancer services because of their HIV status.[30]

1. Examples of relevant practices

27. Through collaboration with Women4GlobalFund, women's rights groups in Uganda and Jamaica were supported by the Global Partnership to enhance South-South cooperation in the exchange of best practices to ensure that interventions address the gendered aspects of stigma and discrimination 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 to build understanding of key entry points to influence how the Global Partnership is rolled out in Uganda and Jamaica.

28. The national People Living with HIV network in Senegal held anti-stigma dialogues focused on women and girls and to develop a 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.

2. Recommendations

29. **The High Commissioner recommends that:**

(a) **States develop national strategies and plans to address discrimination against women and girls in all their diversity in their access to health services, including sexual and reproductive health services; these should be implemented in tandem with strategies to protect women and girls from gender-based violence, taking into account its interlinkages with HIV/AIDS, and all strategies and plans should be developed in consultation with women-led organizations and women and girls living with HIV, and be fully funded;**

(b) **Upscaling of actions to tackle unequal gender power dynamics, norms and practices, including increased investments into gender-transformative, community-led interventions, especially those shown to reduce both HIV and violence against women and girls, be prioritised;**

(c) **States increase investments into innovative data collection methodologies to inform policy and action on gender-based violence; access to effective and victim-centred remedies for gender-based violence should be made readily available and accountability for perpetrators enforced;**

(d) **States ensure that comprehensive sexuality education programmes are age-appropriate, evidence-based and scientifically accurate at all levels of education, including comprehensive information on sexual and reproductive health and rights, responsible sexual behaviour, prevention of early pregnancy and sexually transmitted diseases, including HIV;**[31]

(e) **Given that women-led responses, women's leadership and meaningful participation in decision-making in shaping the HIV response, building on evidence-based practices, are critical for an effective response, they be supported with adequate financial and other resources as necessary.**

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[29] Committee on the Elimination of Discrimination against Women, general recommendation No. 35 (2017), para. 18. See also www.ohchr.org/sites/default/files/Documents/Issues/Women/WRGS/SexualHealth/INFO_HIV_WEB.pdf.

[30] Luciano, D., Negrete, M., Vázquez, M., Hale, F., Salas, J., Alvárez-Rudín, M. et al, *Estudio regional sobre violencia y mujeres con VIH en América Latina* (Managua, ICW Latina, HIVOS, Development Connections y Salamander Trust, 2019).

[31] See Committee on the Elimination of Discrimination against Women, general recommendation No. 36 (2017).

III. Gaps and challenges in the HIV response

30. Societal enablers relate to some of the most formidable barriers that people living with or at high risk of contracting HIV face. As acknowledged by the Human Rights Council in its resolution 47/14, the challenges for the HIV response are not confined to these domains. In the section below, the High Commissioner presents key gaps, namely, the failure to implement a human rights-based approach to HIV; the role of evidence-based approaches; the lack of comprehensive data, including on "invisible" populations; community participation; and financing. Determined and effective action on these will be necessary to achieve the aspirations outlined in the Political Declaration.

A. A human rights-based approach to health

31. Several international and regional human rights instruments recognize the right to health, including the International Covenant on Economic, Social and Cultural Rights, the Convention on the Rights of the Child and the International Convention on the Elimination of All Forms of Discrimination against Women. At the heart of many enduring challenges in the HIV context is the need to take a human-rights based approach to addressing HIV, the key tenets of which involve non-discrimination, accountability and participation. Taking such an approach to the right to health requires States to ensure that health facilities, goods and services are available in sufficient quantity, and are physically accessible and affordable, on the basis of non-discrimination. Health facilities, goods and services should be gender-sensitive and culturally appropriate, scientifically and medically appropriate, of good quality and respectful of medical ethics. Health authorities and other duty bearers should be held accountable for meeting human rights obligations in public health, and effective recourse should be available to prevent or remedy violations.[32] This must include mechanisms and measures to prevent and address reproductive rights violations against women and adolescent girls living with or at high risk of HIV and the elimination of coercive practices that undermine their rights to choose and to bodily autonomy. The meaningful participation of all stakeholders in policy, design, implementation and monitoring must also be ensured.

32. As demonstrated by some of the initiatives highlighted in the present report, there has been an encouraging recognition in recent years of the human rights imperatives of an effective response to HIV: UNAIDS adopted a strategy for 2021–2026, which focuses on ending inequalities, the Political Declaration focuses attention on societal enabler targets, and the Global Partnership was established in 2017. The Global Fund adopted a strategy for 2023–2028 with a strong focus on human rights. Through the Breaking Down Barriers initiative, the Global Fund has also channelled unprecedented levels of funding to programmes to remove human rights-related barriers to services and has focused on assessments, funding, scaling up and evidence of impact. Many challenges remain, however, including insufficient understanding of how to develop and implement programmes that achieve human rights change; inadequate human rights capacity at the national level in government and civil society to take programmes to scale; and continuing and increasing political pushback on rights-based responses and programming.

1. Examples of relevant practices

33. Jamaica has developed an online monitoring and evaluation platform to track progress in eliminating stigma and discrimination, together with a human rights scorecard, featuring 138 interventions to raise awareness and to improve complementarity, coherence and accountability around interventions.

34. In Kazakhstan, a website to collect data and document real-time human rights violations of people living with HIV and key affected populations has been piloted. The information obtained will be used to strengthen the designing of programmes addressing human rights barriers and to ensure access to justice.

[32] See Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000), para. 11.

2. Recommendations

35. **The High Commissioner recommends that States:**

(a) **Ensure the availability and accessibility of good quality health services, including sexual and reproductive health services, for everyone on an equal basis, ensuring that key and vulnerable populations, such as persons with disabilities, refugees and persons deprived of liberty, are prioritized;**

(b) **Train health personnel in respecting and protecting the health and health-related rights of people living with HIV, including those from key and vulnerable populations;**

(c) **Implement existing technical and other guidance on implementing a human rights-based approach to HIV/AIDS, including the International Guidelines on Human Rights and Drug Policy, the International Guidelines on HIV and Human Rights and the report and supplement of the Global Commission on HIV and the Law**.

B. Community leadership and civic space[33]

36. 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 policies, practices and service delivery; participatory research; education and information-sharing; service delivery; and capacity-building and funding of community-led organizations, groups and networks. 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.[34] Civil society actors, particularly community-led organizations, have been instrumental in raising awareness of the rights of key populations and of women and adolescent girls, and in ensuring their voice is heard. Such participation has challenged social norms and the organizational culture of regional and international organizations.

37. Community and civil society organizations play an important role in influencing how government budgets address health and in holding Governments accountable and transparent. They are often best placed to work with populations that are marginalized and excluded from mainstream health services, and serve an important function in representing the needs and interests of key and vulnerable populations in the design and implementation of programmes, and in monitoring quality and equitable access.[35] Civil society organizations, including community-led organizations, have, for example, been at the forefront of legal challenges leading to the repeal of laws criminalizing HIV exposure and transmission (Colombia and Mexico),[36] consensual same-sex sexual activity (Botswana,[37] India[38] and Trinidad and Tobago),[39] gender identity and expression (Guyana)[40] and to ending the involuntary sterilization of women living with HIV (Chile).[41]

[33] For further information on the issues discussed in the section below, see submission by UNAIDS.

[34] UNAIDS, "Establishing community-led monitoring of HIV services: principles and processes", Geneva, 2021.

[35] See www.theglobalfund.org/en/civil-society/.

[36] UNAIDS, *Communities at the Centre: defending rights, breaking barriers, reaching people with HIV services. Global AIDS update 2019*, Geneva, 2019, p. 132.

[37] Botswana Court of Appeal, *Attorney General v. Motshidiemang*, 29 November 2021.

[38] Supreme Court of India, *Navtej Singh Johar v. Union of India*, No. 76 of 2016, 6 September 2018.

[39] High Court of Justice of Trinidad and Tobago, *Jason Jones v. Attorney General of Trinidad and Tobago*, Claim No. CV2017-00720, 12 April 2018.

[40] Caribbean Court of Justice, *Quincy McEwan, Seon Clarke, Joseph Fraser, Seyon Persaud and the Society against Sexual Orientation Discrimination (SASOD) v. Attorney General of Guyana*, 13 November 2018.

[41] See Organization of American States, "IACHR welcomes friendly settlement agreement signed in F.S. case, Chile", press release 221/21, 27 August 2021.

38. Civic space has come under increasing pressure in recent years, particularly in response to the COVID-19 pandemic, which has seen that space contract dramatically as countries have taken public health measures that restrict the activities of civil society beyond what was necessary to address the health crisis. Shrinking civic space threatens the ability of community-led organizations to operate and contribute to the HIV response. In 2021, 22 of 78 countries reporting to UNAIDS noted a lack of social contracting or other mechanisms allowing funding of community-led service delivery from domestic funds; eight countries reported having "foreign agent" or other restrictions placed on access to funds from international donors; 14 countries reported had restrictions on registration, while another 16 noted cumbersome reporting requirements.[42]

39. Funding of civil society organizations, particularly community-led organizations, has also fallen significantly, with a severe impact on key populations that tend to be the main beneficiaries of community-led programmes. In addition, many countries do not finance community-led organizations or human rights programming in the context of HIV.[43] The legal barriers faced by community-led organizations and the lack of meaningful involvement of people living with HIV, and of support for community-led initiatives, continue to be major obstacles to implementing effective human rights-based interventions.

1. Examples of relevant practice

40. Community-led advocacy, research and collaboration with Governments has led to legislative reform to repeal laws requiring parental consent for HIV services (Peru),[44] to decriminalize consensual same-sex sexual activity (Angola) and to introduce protections for trans and other gender-diverse persons (Argentina, Chile, Uruguay[45] and Pakistan[46]). Community-led organizations have reduced stigma and discrimination and increased access to justice through recourse to sensitization campaigns, training health-care workers, developing charters of rights of patients living with HIV, and developing and delivering legal empowerment courses, or helped to direct people who use drugs to health services.[47]

2. Recommendations

41. **The High Commissioner recommends that:**

(a) **States establish and/or strengthen transparent participation, social dialogue or multi-stakeholder mechanisms at the community, subnational and national levels, ensuring that participation outcomes inform policies and programmes relating to the HIV response;**

(b) **Formal participation structures be made accessible to and inclusive of individuals and groups that are criminalized, marginalized or discriminated against, including key populations, women and girls and young people. Specific permanent mechanisms for the participation of groups that have been historically excluded, or whose views and needs have been inadequately addressed in decision-making processes, should be developed;**

(c) **Measures be taken to ensure that the above-mentioned structures and mechanisms provide meaningful opportunities for participation, so that they are, at a minimum:**

(i) **Co-designed with relevant rights holders, particularly people living with HIV, including key populations and women and girls;**

(ii) **Impartially channel the views of rights-holders into actual decision-making processes;**

[42] See https://lawsandpolicies.unaids.org.
[43] Submission by Love Alliance, p. 2.
[44] UNAIDS Global AIDS Update 2021, p. 302.
[45] UNAIDS Global AIDS Update 2019, *Communities at the Centre: the response to HIV in Western and Central Africa*, 2019, p. 126.
[46] UNAIDS Global AIDS Update 2021, p. 157.
[47] Submission by UNAIDS.

(iii) **Provided with an adequate budget and human resources with expertise on the different groups for which participation is to be encouraged and enabled;**

(iv) **Accessible, inclusive, gender-responsive and representative;**

(d) **Financial, human and other resources be allocated, on a sustainable basis, to build the capacity of rights holders to participate and to claim their rights through education, awareness-raising, access to free legal aid and other support, and to facilitate regular communication between rights holders and duty bearers at the community, local and national levels;**

(e) **Community-led organizations, including key-population led and women-led organizations, be empowered through laws, policies and funding to operate freely, provide services, advocate, lead action on societal enablers and access to legal systems. Short-term emergency funding should be made readily available to community-led organizations and a stable, long-term funding base established to enable them to function effectively;**[48]

(f) **Community-led monitoring of human rights violations and the application of protective laws and measures be supported and promoted.**

C. Evidence-based interventions and data collection

42. The fundamental features of an evidence-based approach include decision-making processes that use the best available peer-reviewed evidence; the systematic use of data and information systems; community engagement in assessment and decision-making; conducting sound evaluation; and the dissemination of findings to key stakeholders and decision-makers.[49]

43. The use of evidence-based interventions is an important contributor to good health outcomes, facilitating crucial insights into the role played by other relevant factors, such as gender-based violence, punitive laws and policies, stigma and discrimination.[50] For instance, scientific advances, coupled with a science-based legislative and policy environment, are able to positively influence cultural perceptions of disease. In addition, clear scientific findings that HIV is non-transmissible by people living with HIV who have sustained viral suppression, nor transmissible to people who using pre-exposure prophylaxis (PrEP), are additional reasons for repealing laws that criminalize potential sexual exposure or transmission of HIV.[51]

44. Peer-reviewed studies have shown that repealing harmful criminal laws that affect key populations and people living with HIV is fundamental to an effective HIV response, significantly reducing HIV incidence. According to modelling estimates, the decriminalization of sex work could avert as many as 33 to 46 per cent of HIV infections among sex workers and their clients over a decade.[52] Decriminalizing same-sex sexual relations could contribute to increasing HIV viral suppression by 8.1 per cent, while the decriminalization of drug use has been found increased knowledge of HIV status and viral suppression by 14 per cent.[53] Changing parental consent laws and lowering the age for adolescents to have independent access to HIV and other sexual and reproductive health

[48] UNAIDS, *Holding the line: communities as first responders to COVID-19 and emerging health threats* (2021), p. 58.

[49] Ross C. Brownson, Jonathan E. Fielding and Cristopher M. Maylahn, "Evidence-based public health: a fundamental concept for public health practice", *Annual Review of Public Health*, vol. 30 April 2009, p. 177.

[50] Submission by Sisonke, p. 3.

[51] Submission by Treatment Action Group, p. 4.

[52] Kate Shannon, Steffanie A. Strathdee, Shira M. Goldenberg, Putu Duff, Peninah Mwangi, Maia Rusakova et al. "Global epidemiology of HIV among female sex workers: influence of structural determinants", *The Lancet*, vol. 385, No. 9962 (2015), pp. 55–71.

[53] Matthew M. Kavanagh, Shadrac C. Agbla, Marissa Joy et al, "Law, criminalization and HIV in the world: have countries that criminalise achieved more or less successful pandemic response?", *BMJ Global Health*, vol. 6, No. 8 (2021).

services have been shown to enable dramatic increases in the uptake of HIV testing in this group.[54] There are numerous studies that attest to the effectiveness of various stigma and discrimination interventions on reducing stigma and improving HIV outcomes.[55] Underpinning the specific actions that the High Commissioner recommends in the present report is the principle that the HIV response should integrate an evidence-based approach.

45. Evidence-based planning, policy design, monitoring and accountability require comprehensive, good quality and up-to-date data. Disaggregation by income, age, gender, race, ethnicity, marginalized identity, sexual orientation, health status and other distinctions as locally relevant helps to identify inequalities and, ultimately, to understand why they exist. Such a human rights-based approach to data collection can help to show who is being denied services and provide evidence for policy change. Other critical information to emerge includes the identity and size of populations and groups who have been or are at increased risk of being left behind in the HIV response and the barriers they face in receiving treatment. Inclusive gender analysis to inform policies and investments is integral to a human rights-based approach and should be strengthened as a cross-cutting dimension of improving the availability of quality, relevant data and strategic information.

46. Lack of data and information on key populations and other vulnerable groups remains a challenge, particularly with respect to population size and health. Criminalization, stigma and discrimination often lead to institutional invisibility; indeed, in some countries, officials explicitly deny that key populations exist.[56] Countries that criminalize same-sex sexual behaviour are more likely to report low numbers of gay men and other men who have sex with men compared to other countries.[57] It is estimated that, among the 52 States 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 and that the total global figure of missing populations is probably much higher. The absence of these populations from national population estimates directly affects budgetary allocations for health coverage and funding for programmes aimed at reaching key populations as part of the HIV response.

47. The collection of data from certain populations may compromise their safety; it should therefore be conducted in partnership with communities and in a manner that protects the safety and privacy of vulnerable and marginalized individuals and groups.[58] In the Eastern Europe and Asia region, the invisibility and exclusion of trans persons has led to a lack of analysis of the burden of HIV among them and to a dearth of specific HIV programmes and funding shortages.[59] The lack of adequate data on people who use drugs remains a challenge, as it involves, in most settings, measuring the size of a "hidden" population.[60] The absence of these populations from national population estimates directly affects budgetary allocations for health coverage and funding for programmes to reach key populations as part of the HIV response.

1. Examples of relevant practice

48. The People Living with HIV Stigma Index, developed by the International Community of Women Living with HIV/AIDS, the International Planned Parenthood Federation, GNP+ and UNAIDS is a community-led research initiative for the collection of

[54] Britt McKinnon and Ashley Vandermorris, "National age-of-consent laws and adolescent HIV testing in sub-Saharan Africa: a propensity-score matched study", *Bulletin of the World Health Organization*, vol. 97, No. 1 (2018), pp. 42–50.

[55] UNAIDS, *Evidence for eliminating HIV-related stigma and discrimination: Guidance for countries to implement effective programmes to eliminate HIV-related stigma and discrimination in six settings*, 2020.

[56] Sara L. Davis, *The Uncounted: Politics of Data in Global Health* (Cambridge, Cambridge University Press, 2020), p. 46.

[57] Sara L. Davis, William C. Goedel, John Emerson and Brooke Skartvedt Guven, "Punitive laws, key population size estimates, and Global AIDS Response Progress Reports: an ecological study of 154 countries", *Journal of the International AIDS Society*, vol. 20, No. 1 (2017), pp. 1–8.

[58] See submission by UNAIDS.

[59] Submission by the Eurasian Coalition on Health, Rights, Gender and Sexual Diversity (ECOM), p. 6.

[60] www.unodc.org/res/wdr2021/field/WDR-2021-Methodology.pdf.

data on the various forms of stigma and discrimination that people living with HIV experience. The Stigma Index, developed to be used by and for people living with HIV, has been implemented in more than 100 countries, with more than 100,000 people living with HIV participating in the process.[61] Findings from the Stigma Index have allowed the systematic upscaling of action to reduce HIV-related stigma and discrimination.[62]

49. A set of biobehavioural survey guidelines for country-based integrated biobehavioural surveys of HIV and HIV-risk behaviours was developed by UNAIDS, WHO, FHI 360 and the United States Centers for Disease Control and Prevention. The survey questions seek to elicit information on intersectional discrimination, including in relation to gender identity or sexual orientation, sex at birth, drug use, involvement in sex work, level of education and marital status. The data from the survey have been used successfully in strategic litigation challenging the criminalization of same-sex sexual activity.[63]

2. Recommendations

50. **The High Commissioner recommends:**

(a) **That civil society organizations, including community-led organizations and those representing key populations, be provided with the financial and technical resources to support them in building capacity for research and other evidence-gathering methods, and for evidence-based advocacy;**

(b) **The allocation of resources to institutionalize and augment capacity for data collection and data management, particularly in developing countries, which should include resourcing to support organizations led by key populations, and other marginalized groups, in the collection of data, including through community-led monitoring;**

(c) **That States ensure the free, active and meaningful participation of stakeholders, especially community-led organizations, key populations, women and girls, youth and other vulnerable and marginalized populations, through the entire data collection process; data should be collected in a manner that protects the safety and security of vulnerable and marginalized populations;**

(d) **That disaggregated data be analysed, disseminated and utilized for HIV policy formulation, impact assessment, advocacy, programming and information-sharing on good practices, ensuring that the rights of key populations and other marginalized groups are protected and that inequalities are addressed.**

D. Financing societal enablers

51. Total HIV funding for low- and middle-income countries continues to decline; in 2020, the shortfall in the overall amount needed to effectively respond to HIV was estimated at 30 per cent.[64] As shown by the funding gap between needs and the resources available for key populations, estimated at 80 per cent, insufficiency of funding for HIV programmes and interventions for key populations has also been a consistent trend. Although individuals from key populations, together with their partners, account for more than half of new HIV infections globally, only 2 per cent of the total amount spent responding to HIV actually went to HIV programmes targeting key populations in low- and middle-income countries.[65] Moreover, as UNAIDS notes, national HIV responses in low-income countries are heavily dependent on external funding, while many middle-income countries have struggled to

[61] See submission by UNAIDS.

[62] See "Stigma and discrimination among health care providers and people living with HIV in health care settings in Thailand: comparison of findings from 2014-2015 and 2017", Department of Disease Control, Ministry of Public Health (Thailand), October 2019.

[63] See submission by UNAIDS.

[64] The Global Fund, Results Report 2020,, p. 15.

[65] See PITCH, AIDSFonds, "Fast-Track or Off Track? How insufficient funding for key populations jeopardises ending AIDS by 2030", 2019. Available athttps://aidsfonds.org/assets/work/file/Factsheet%20general.pdf.

transition to primarily domestically financed responses.[66] The negative impact of the coronavirus disease (COVID-19) pandemic on the availability of resources for HIV has underscored the need for innovative approaches to health investment, as well as global solidarity and international cooperation.

52. Since 2017, the Global Fund has implemented the Breaking Down Barriers initiative, which is aimed at translating human rights principles into concrete programmes that have an impact on the lives of those affected by HIV, tuberculosis and malaria,[67] by funding and implementing at-scale programmes that remove human rights-related barriers to dedicated health services. By taking such programmes to scale, the Global Fund supports countries in meeting the societal enabler targets. In the 20 countries involved in the Breaking Down Barriers initiative, Global Fund investments in programmes to reduce human rights-related barriers have increased more than tenfold, from $10.6 million in the 2014–2016 funding cycle to $78.2 million in 2017–2019 to approximately $130 million in 2020–2022. The Global Fund has focused its efforts on scaling up programming to reduce human rights-related barriers to HIV services across its full portfolio; ultimately, the level of investment in the 90 countries with approved grants rose from $87 million in 2017–2019 to $172 million in 2020–2022.

1. Examples of relevant practice

53. The Debt2Health mechanism of the Global Fund is designed to encourage domestic financing by converting debt repayments into life-saving investments in health. Under individually negotiated "debt swap" agreements, a creditor nation foregoes repayment of a loan when the beneficiary nation agrees to invest part or all of the forgiven debt into a programme supported by the Global Fund. The Global Fund reports that debts exchanged under Debt2Health agreements total close to 200 million euros, with the support of Australia, Germany and Spain.[68]

2. Recommendations

54. **The High Commissioner recommends that States:**

(a) **Allocate and ring-fence budgetary resources for societal enablers, including stigma and discrimination reduction, the elimination of gender-based violence, reducing gender inequalities and harmful gender norms, increasing access to justice and action to support law reform;**

(b) **Take measures to close any funding gaps for key population needs in the HIV context, including increased and ring-fenced funding for interventions to meet their specific needs;**

(c) **Allocate funds to community-led and community-based organizations to lead on activities to implement societal enablers, particularly those targeting key and vulnerable populations;**

(d) **Ensure the disaggregation of allocated and spent budgets by functional and programmatic classifications, ensuring that spending on societal enablers is clearly identifiable in the overall budget and available in readily accessible formats to the public;**

(e) **Develop sustainable programming to support a transition from donor funding to domestic financing for HIV services, particularly societal enablers.**

[66] Ibid.

[67] See submission by the Global Fund.

[68] The Global Fund, "Spain, Three African Countries and the Global Fund Launch New Debt2Health Initiative", 29 November 2017.

IV. Conclusions

55. **Implementing societal enablers and other human rights interventions is indispensable to meeting the objective of ending AIDS by 2030. Sufficient funding for them is vital, and States should, where applicable, put in place measures to transition from dependence on external funding to more sustainable domestic resourcing for the HIV response. Furthermore, the grave situation that key and other vulnerable populations face makes an unassailable case for reaching first those who are furthest behind and ensuring no one is left behind – fundamental principles of the 2030 Agenda for Sustainable Development and, indeed, the human rights framework. The most successful interventions are well known, and these include ensuring equitable access to good quality health services for all, making sure everyone is counted and can participate in decision-making processes concerning their needs and rights, addressing stigma and discrimination and upholding the human rights of women and girls. The world now needs the political will to push through a coordinated, global HIV response based on solidarity and shared responsibility.**