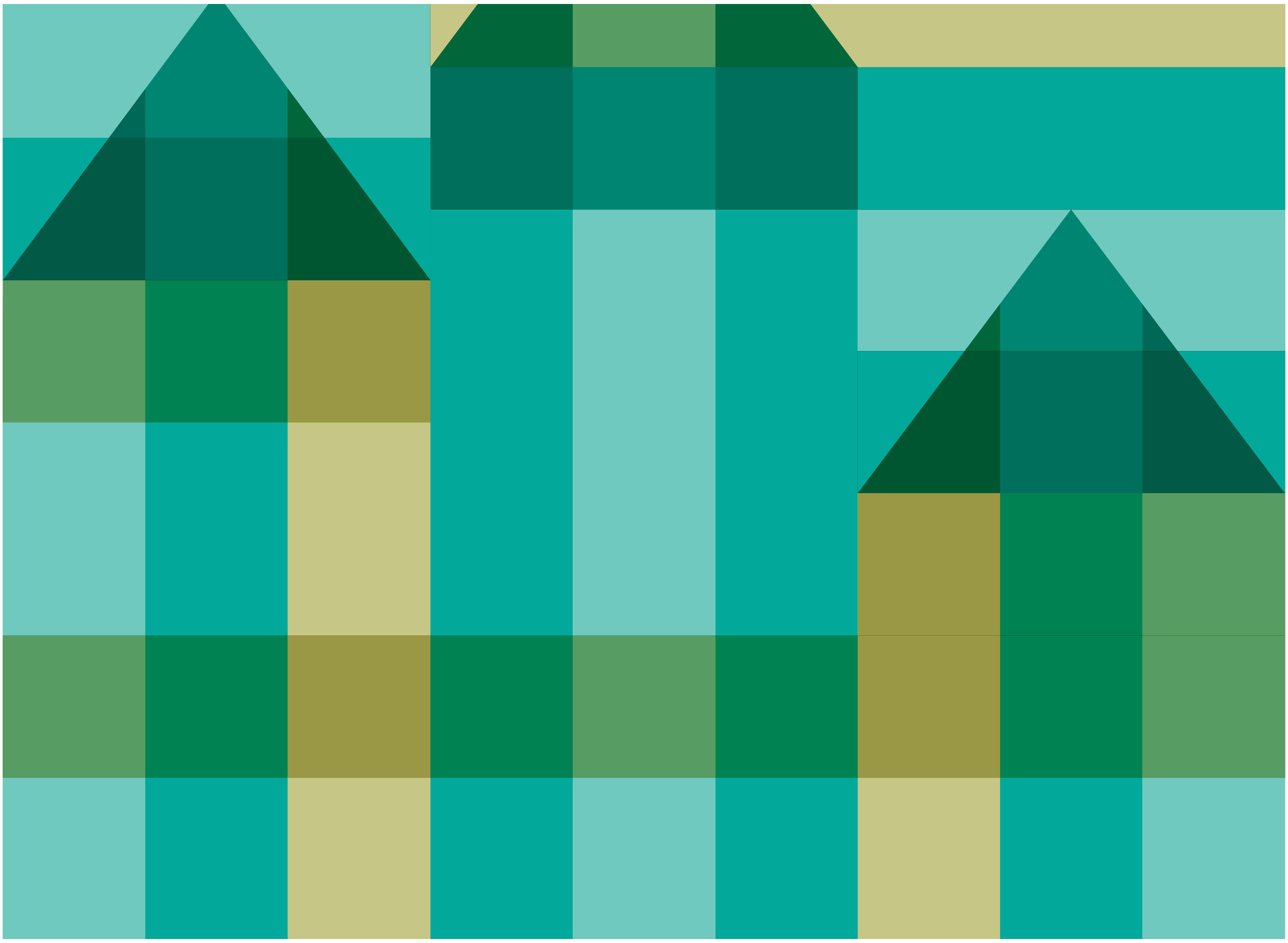
UNAIDS 2017 | REFERENCE

Confronting discrimination

Overcoming HIV-related stigma and discrimination in health-care settings and beyond



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Introduction

Irrational fears of HIV infection and negative attitudes and judgements towards people living with HIV persist despite decades of public information campaigns and other awareness-raising efforts. Populations at increased risk of HIV infection face high levels of stigma due to, among other things, their gender, sexual orientation, gender identity, drug use or sex work. Stigma towards people living with or at risk of HIV drives acts of discrimination in all sectors of society—from public officials, police officers and health-care workers to the workplace, schools and communities. In many countries, discriminatory laws and policies reinforce an environment of violence and marginalization. This stigma and discrimination discourages people from accessing health-care services, including HIV prevention methods, learning their HIV status, enrolling in care and adhering to treatment.

> ***"People living with HIV who perceive high levels of HIV-related stigma are 2.4 times more likely to delay enrolment in care until they are very ill."***

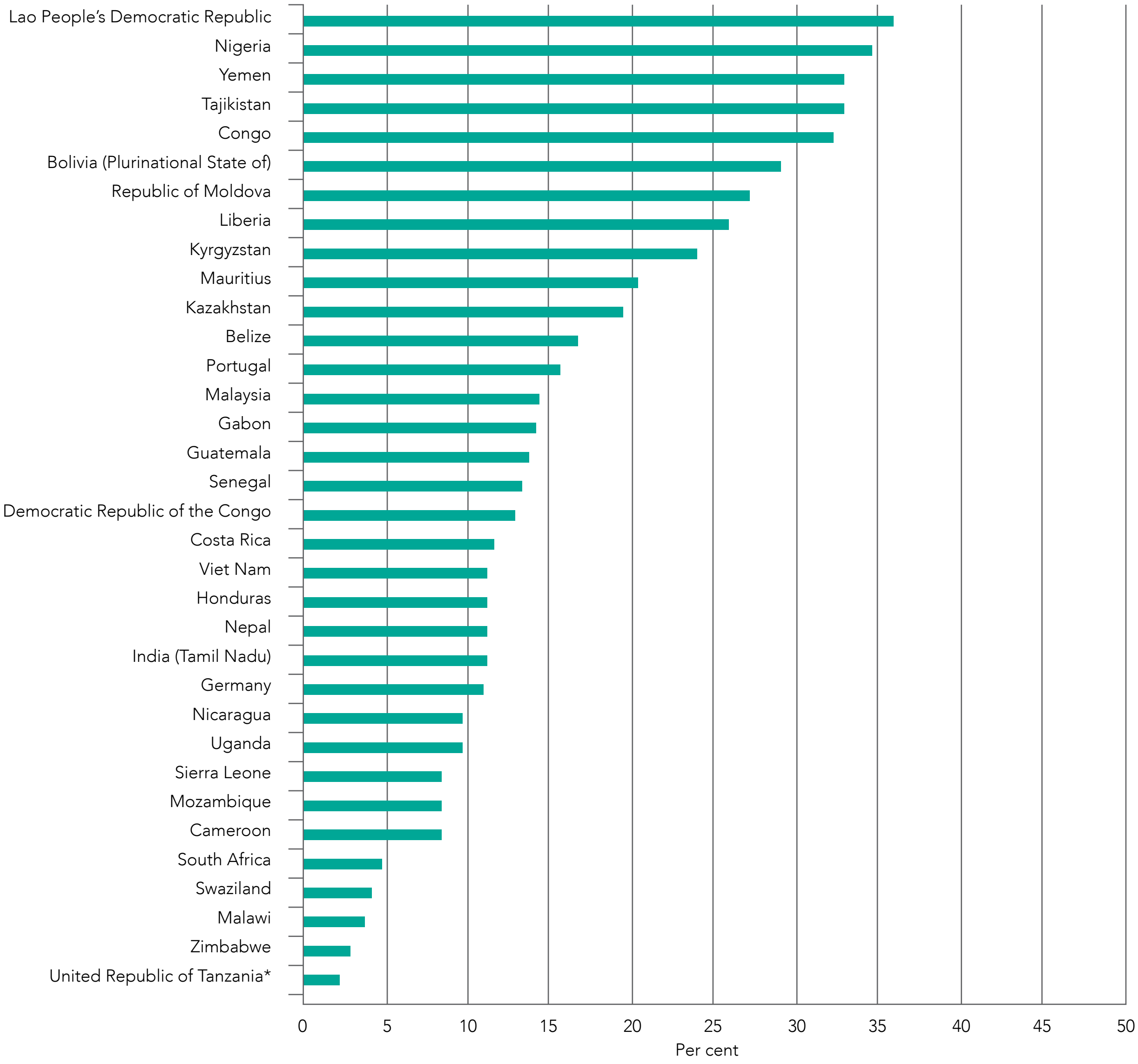
Studies on stigma and discrimination and health-seeking behaviour show that people living with HIV who perceive high levels of HIV-related stigma are 2.4 times more likely to delay enrolment in care until they are very ill *(1)*. In eight countries with available data, more than a quarter of people living with HIV reported that they had avoided going to a local clinic in the previous 12 months because of their HIV status (Figure 1) *(2)*. Such fears also discourage the uptake of prevention and testing services. For example, fear of the HIV-related stigma and discrimination that may result from an HIV-positive test result and having that result disclosed to others, either through self-disclosure or otherwise, has been identified as a disincentive to HIV testing in a range of settings *(3, 4)*.

In 2015, the global community committed to ending the AIDS epidemic as a public health threat by 2030 as part of the 2030 Agenda for Sustainable Development. It is an ambitious yet achievable goal. Scale-up of the most effective services for preventing HIV infection and treating people living with HIV has already seen a 32% global decline in AIDS-related deaths and a 16% global decline in new HIV infections between 2010 and 2016; and 2016 also marked the first time more than half (53% [39–65%]) of all people living with HIV were accessing antiretroviral therapy *(5)*. Yet these gains are not distributed equally, and groups that face discrimination are often left behind—in many cases in fear of or facing discrimination, which drives them further away from accessing the services they need. Putting the world on track to ending AIDS as a public health threat by 2030 requires a persistent global effort to eliminate HIV-related stigma and discrimination alongside wider efforts to address marginalization and exclusion in health care.

This report compiles the latest body of evidence on how stigma and discrimination create barriers across the HIV prevention, testing and treatment cascades and reduce the impact of the AIDS response. The report also brings together best practices on confronting stigma and discrimination, providing a valuable resource for programme managers, policy-makers, health-care providers and communities. The evidence shows that the establishment of people-centred service delivery models, supportive legal and policy frameworks, monitoring and enforcement mechanisms, and sensitization training for health-care workers and other duty bearers can promote inclusion and increase access to services.

Avoiding the local clinic due to HIV status

Figure 1. Percentage of people living with HIV who say they have avoided going to a local clinic in the past 12 months because of their HIV status, countries with available data, 2011–2016



Source: People Living with HIV Stigma Index surveys, 2011–2016.

*Four regions other than Dar es Salaam.

Barriers caused by stigma and discrimination across the cascade of services

Greater appreciation of the preventative and therapeutic benefits of antiretroviral medicines inspired the development of the HIV testing and treatment cascade, which is also referred to as the HIV care continuum. The cascade tracks the progression from HIV testing to durable viral load suppression among people living with HIV, and it guides HIV programmes to achieve the 90–90–90 targets: 90% of people living with HIV know their HIV status, 90% of people who know their HIV-positive status are accessing antiretroviral therapy and 90% of people on treatment have suppressed viral loads.

In recent years, similar cascades have been developed to manage HIV prevention programmes at the local and national levels. In India, for example, analysis of the prevention cascade shows that nearly 90% of female sex workers received at least one service within the last 12 months, but only six in 10 were contacted twice, as per programme standards *(6)*. Just 52% received screening check-ups for sexually transmitted infections within the last three months *(6)*.

These cascades reveal the size of service gaps, and how these gaps combine to limit a programme's overall impact, but they do not reveal the cause of these gaps. The following sections document the barriers to accessing health-care services caused by stigma and discrimination across the prevention, testing and treatment cascades. These barriers can be legal, social, political, cultural, attitudinal or economic, and all of them affect the accessibility and acceptability of health-care services for people living with HIV and key populations. Confronting these barriers, reducing stigma and discrimination, and empowering people in need of services will be crucial to achieving the service coverage targets within the 2016 United Nations Political Declaration on Ending AIDS and ultimately ending AIDS as a public health threat by 2030.

The testing and treatment cascade

HIV testing and treatment services are most often provided by the public and private health-care systems. When health systems or health-care workers adopt stigmatizing attitudes and practices or discriminate against people living with HIV or people at high risk of HIV infection, those people are less likely to access services, hampering efforts to reach the 90–90–90 treatment targets (Figure 2).

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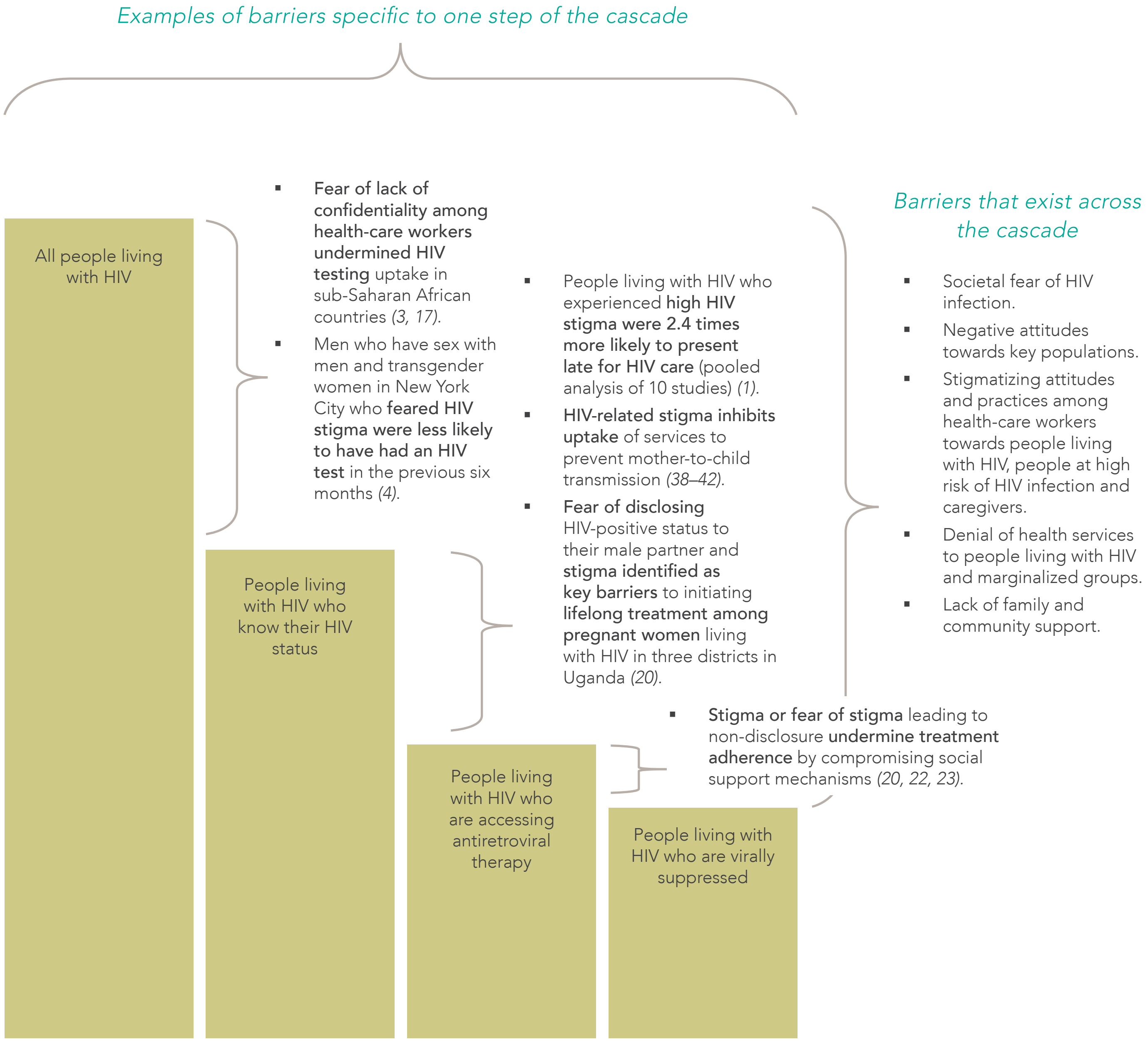
[1] Prevention services can include, among others, condom provision, screening check-ups for sexually transmitted infections and sexual and reproductive health education.

Stigma, discrimination and the testing and treatment cascade

Figure 2. Examples of stigma and discrimination that create gaps across the HIV testing and treatment cascade



Examples of barriers specific to one step of the cascade

- **Fear of lack of confidentiality among health-care workers undermined HIV testing** uptake in sub-Saharan African countries *(3, 17)*.
- Men who have sex with men and transgender women in New York City who **feared HIV stigma were less likely to have had an HIV test** in the previous six months *(4)*.

- People living with HIV who experienced **high HIV stigma were 2.4 times more likely to present late for HIV care** (pooled analysis of 10 studies) *(1)*.
- **HIV-related stigma inhibits uptake** of services to prevent mother-to-child transmission *(38–42)*.
- **Fear of disclosing** HIV-positive status to their male partner and **stigma identified as key barriers** to initiating **lifelong treatment among pregnant women** living with HIV in three districts in Uganda *(20)*.

- **Stigma or fear of stigma** leading to non-disclosure **undermine treatment adherence** by compromising social support mechanisms *(20, 22, 23)*.

Barriers that exist across the cascade

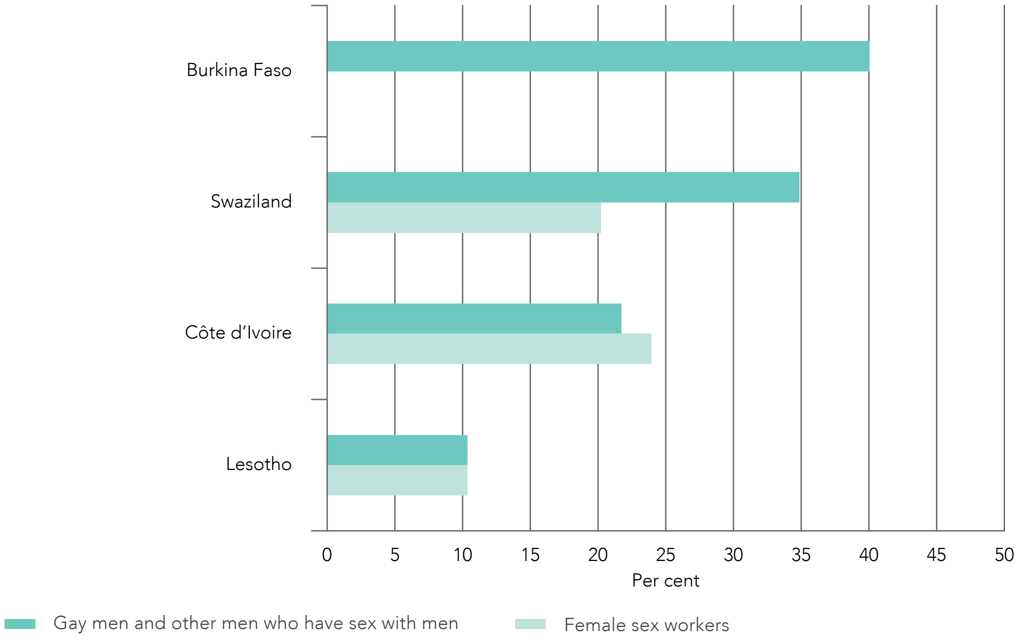
- Societal fear of HIV infection.
- Negative attitudes towards key populations.
- Stigmatizing attitudes and practices among health-care workers towards people living with HIV, people at high risk of HIV infection and caregivers.
- Denial of health services to people living with HIV and marginalized groups.
- Lack of family and community support.

For example, transgender women in Argentina who had previously experienced discrimination in health-care settings (either from health-care workers or other patients) were three times more likely to avoid health-care services than transgender women who had not previously experienced discrimination in health care *(7)*. Indeed, 40.7% of respondents overall reported that they had avoided seeking health care because of their transgender identity *(7)*.

A study among street-based female sex workers in Saint Petersburg, Russian Federation, found that 30% had been refused medical care, and 58% said that they had not gone to a doctor when necessary because they were worried that doctors would treat them badly *(8)*. Similarly, female sex workers in Kenya who anticipated stigma from health-care workers were twice as likely to avoid non-HIV health services *(9)*. Surveys in four sub-Saharan African countries also showed that the percentage of people from key populations living with HIV who avoid or delay health care due to fear of stigma from health-care providers can be substantial: they range from 10% to 40% of gay men and other men who have sex with men and from 10% to 23% or more of female sex workers in Burkina Faso, Côte d'Ivoire, Lesotho and Swaziland (Figure 3) *(10)*.

Avoiding health care out of fear of stigma

Figure 3. Percentage of gay men and other men who have sex with men and female sex workers who made the decision to avoid or delay health care due to fear of stigma from health-care providers, selected countries, 2013



Source: Integrated biological and behavioural surveillance reports, 2013–2016.

Health-care provider surveys indicate that the fears of people living with HIV—and people who suspect they may be living with HIV—are often well-founded. HIV-related stigma and acts of discrimination against people living with HIV reported by health-care providers include the following:

- Unwillingness to care for patients living with HIV.
- Provision of a poorer quality of care to patients living with HIV (compared to other patients).
- Disclosure of HIV status without patient permission.
- Referral of patients with HIV because workers do not want to treat them.

In Thailand, health-care provider surveys in two provinces in 2013 revealed that 32.2% and 40.9%, respectively, of workers reported worrying about touching the clothing, bedding or belongings of people living with HIV. Similarly, 58.2% and 63.4%, respectively, worried about dressing the wounds of people living with HIV, and 61% and 66.2%, respectively, worried about drawing blood from people living with HIV *(11)*. At the same time, 48% and 55.4%, respectively, said they typically used unnecessary precautions when providing care for people living with HIV, with 34% and 42.2%, respectively, wearing double gloves *(11)*.

Measuring HIV-related stigma within the general population

A common measure of discriminatory attitudes used in population-based surveys globally is whether or not an individual would buy vegetables from a shopkeeper living with HIV, an action that has absolutely no risk of HIV transmission. Data from surveys conducted between 2011 and 2016 in 47 countries across seven regions show wide variations in the percentage of people expressing discriminatory attitudes (Table 1). Countries where multiple surveys have been conducted show declines over time *(12)*. In eastern and southern Africa, for instance, the percentage of people who would not buy vegetables from a shopkeeper living with HIV declined from 53.8% in 2003–2008 to 36.2% in 2010–2016. In western and central Africa, the decline in discriminatory attitudes has been less marked, down from 62% in 2003–2008 to 50.7% in 2010–2016. Overall, however, discriminatory attitudes persist globally: half of men and women (aged 15–49 years) in the 47 countries where surveys were conducted indicated that they would not buy vegetables from a shopkeeper living with HIV *(12)*.

Table 1. Percentage of men and women aged 15–49 years who would not purchase vegetables from a shopkeeper living with HIV, countries with available data, 2011–2016

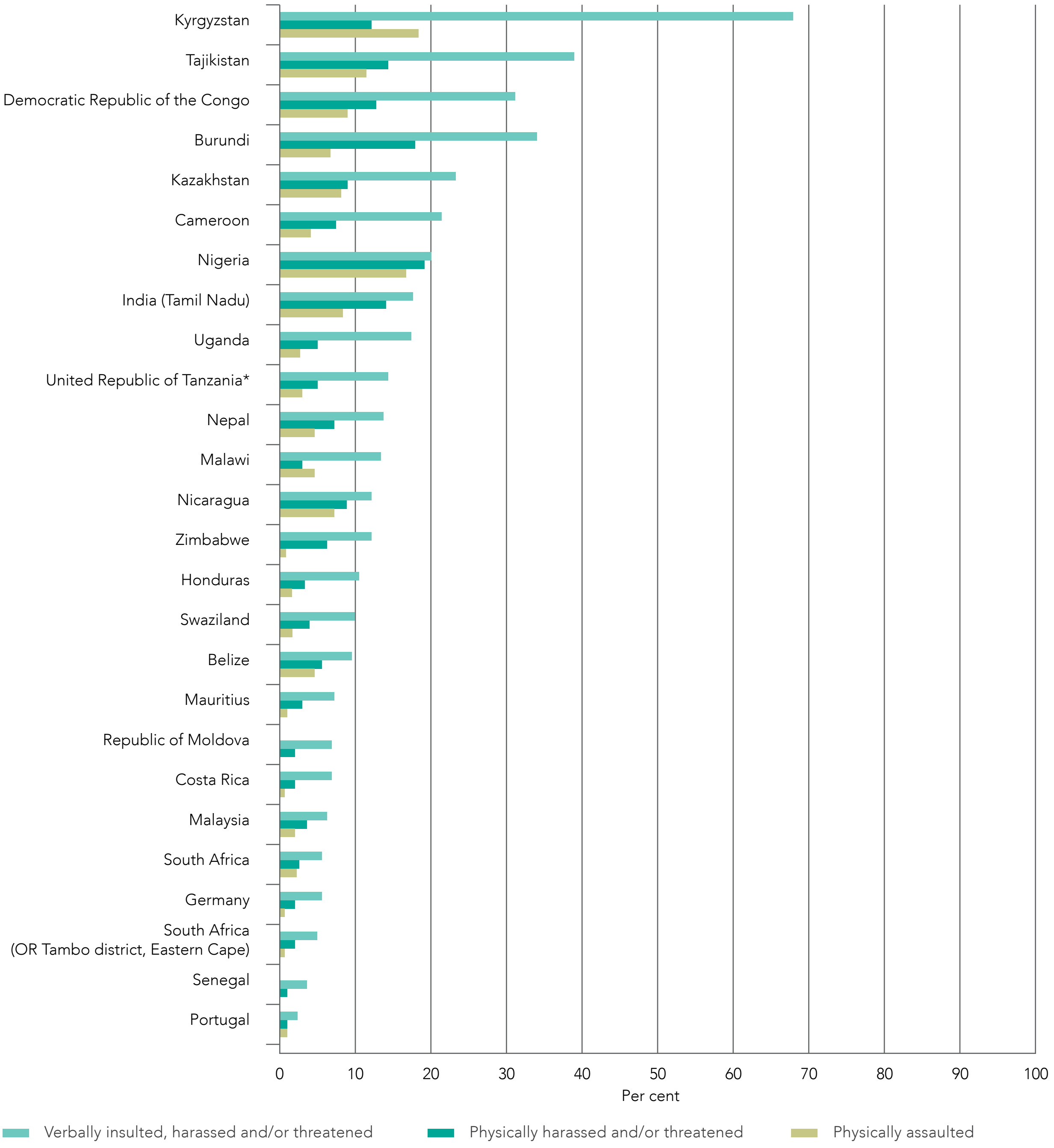
75–100%	50–74%	25–49%	0–24%
Egypt*	Afghanistan	Bangladesh*	Argentina*
Guinea	Benin	Belize	Barbados*
Iraq*	Bosnia and Herzegovina	Cameroon	Botswana
Jordan*	Comoros	Chad	Cambodia
Yemen*	Ethiopia	Congo	Cuba
	Gambia	Costa Rica*	Kenya
	Ghana	Côte d'Ivoire	Lesotho
	Haiti	Democratic Republic of Congo	Malawi
	Indonesia	Dominican Republic	Namibia
	Jamaica	Gabon	Rwanda
	Kazakhstan	Honduras	Zambia
	Kyrgyzstan	Mali	Zimbabwe
	Lao People's Democratic Republic	Mozambique	
	Liberia	Nepal	
	Mauritania*	Nigeria	
	Montenegro	Pakistan	
	Myanmar	Peru*	
	Niger	Togo	
	Republic of Moldova	Uganda	
	Senegal	Viet Nam*	
	Sierra Leone		
	Tajikistan*		
	Tunisia*		
	Ukraine		

Source: Population-based surveys, 2011–2016.

*Female respondents only

Violence experienced by people living with HIV due to their HIV status is alarmingly prevalent in much of the world (Figure 4) *(2)*. Violence directly harms people living with HIV, and the threat of violence discourages them from disclosing their HIV status to partners, family, health workers and the community. Hiding one's HIV-positive status limits opportunities to receive vital support and care, both of which are particularly crucial for treatment initiation and adherence.

Figure 4. Percentage of people living with HIV who experienced different forms of violence due to their HIV status at least once in the previous 12 months, countries with available data, 2011–2016



Source: People Living with HIV Stigma Index surveys, 2011–2016.

*Four regions other than Dar es Salaam.

The People Living with HIV Stigma Index

The People Living with HIV Stigma Index is a survey that measures stigma and discrimination experienced by people living with HIV. The survey is conducted by people living with HIV, empowering communities to generate data and use it to advocate for stronger measures against stigma and discrimination. Since 2008, stigma indexes have been conducted in more than 90 countries *(13)*.

The full data sets from surveys conducted in 19 countries have been made available to UNAIDS. Together, these 19 countries represent approximately 23% of the estimated number of people living with HIV globally in 2016.[2] Analyses of these data found the following:

- Approximately one in five people living with HIV reported avoiding going to a local clinic or hospital due to HIV status (i.e. they feared stigma or discrimination related to their HIV status).
- A quarter of people living with HIV reported experiencing some form of discrimination in health care.[3]
- Approximately one in three women living with HIV reported experiencing at least one form of discrimination related to their sexual and reproductive health in health-care settings.[4]
- Approximately one in five people living with HIV reported having been denied health care (including dental care, family planning services or sexual and reproductive health services) *(2)*.

It should be noted that most People Living with HIV Stigma Index surveys recruit participants through HIV service providers. This suggests that some respondents may be more likely than the general population of people living with HIV to access health services, irrespective of their fear of stigma or experiences of discrimination or other deterrents. These figures therefore may underrepresent the scale of health care avoidance among people living with HIV.

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[2] The 19 countries are Belize, Burundi, Cameroon, Costa Rica, Democratic Republic of the Congo, Germany, Honduras, Malawi, Malaysia, Mauritius, Nepal, Nicaragua, Nigeria, Portugal, Republic of Moldova, Senegal, Swaziland, Uganda and Zimbabwe.

[3] These respondents reported one or more of the following: having been denied health care in the past 12 months due to HIV status, having been forced to submit to a medical or health procedure in the past 12 months due to HIV status (including HIV testing), or having a health-care professional tell other people their HIV status without consent.

[4] These respondents reported experiencing at least one of the following: advice from a health-care professional not to have a child due to their HIV-positive status, access to antiretroviral treatment that was conditional on the use of certain forms of contraception, and denial of sexual and reproductive health services within the previous 12 months due to their HIV status.

Avoiding HIV testing

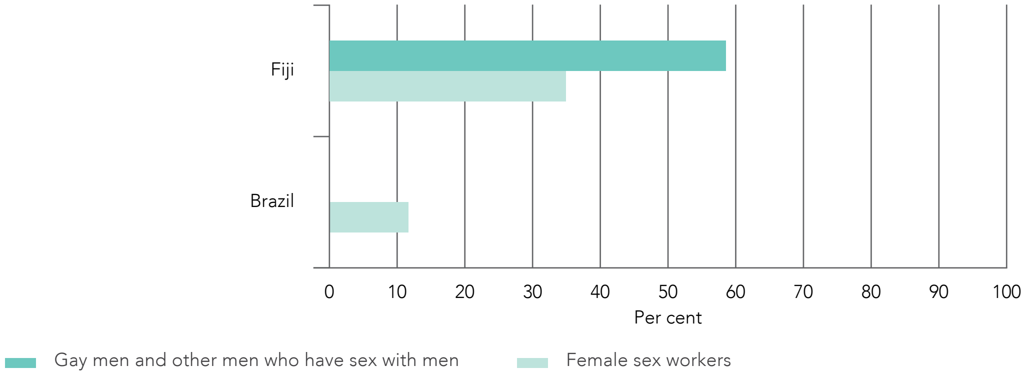
Since the risk of HIV acquisition is high among key populations, periodic HIV testing among these groups is critical to early diagnosis and rapid initiation of treatment and viral load suppression. World Health Organization (WHO) guidelines for HIV testing recommend that those at high ongoing risk of HIV, particularly key populations, should retest at least every 12 months *(14)*.

However, data from numerous countries show that many within key populations avoid HIV testing. For example, more than 10% of female sex workers in Brazil reported having avoided HIV testing due to fear of stigma from health-care providers; in Fiji, that number rose to 60% of female sex workers and more than 30% of gay men and other men who have sex with men (Figure 5). Similarly, a study among people who inject drugs in Thailand found that respondents were almost seven times as likely to avoid HIV testing if they had been previously refused treatment or services by health-care workers *(15)*.

> *"A quarter of people living with HIV reported experiencing some form of discrimination in health care."*

Avoiding HIV testing out of fear or stigma

Figure 5. Percentage of gay men and other men who have sex with men and female sex workers who avoided HIV testing due to fear of stigma from health-care providers, Fiji and Brazil, 2014–2016



Source: Integrated biological and behavioural surveillance reports, 2014–2016.

Confidentiality concerns deter testing

Fear of a positive test result and future HIV-related stigma is a powerful deterrent to HIV testing. Like all patient information, the results of an HIV test must be kept confidential by health-care workers: breaches of confidentiality undermine trust and have a very real impact on people's willingness to take an HIV test. Concerns about confidentiality of HIV testing and test results have been identified as a key barrier to accessing HIV testing across regions *(16–18)*.

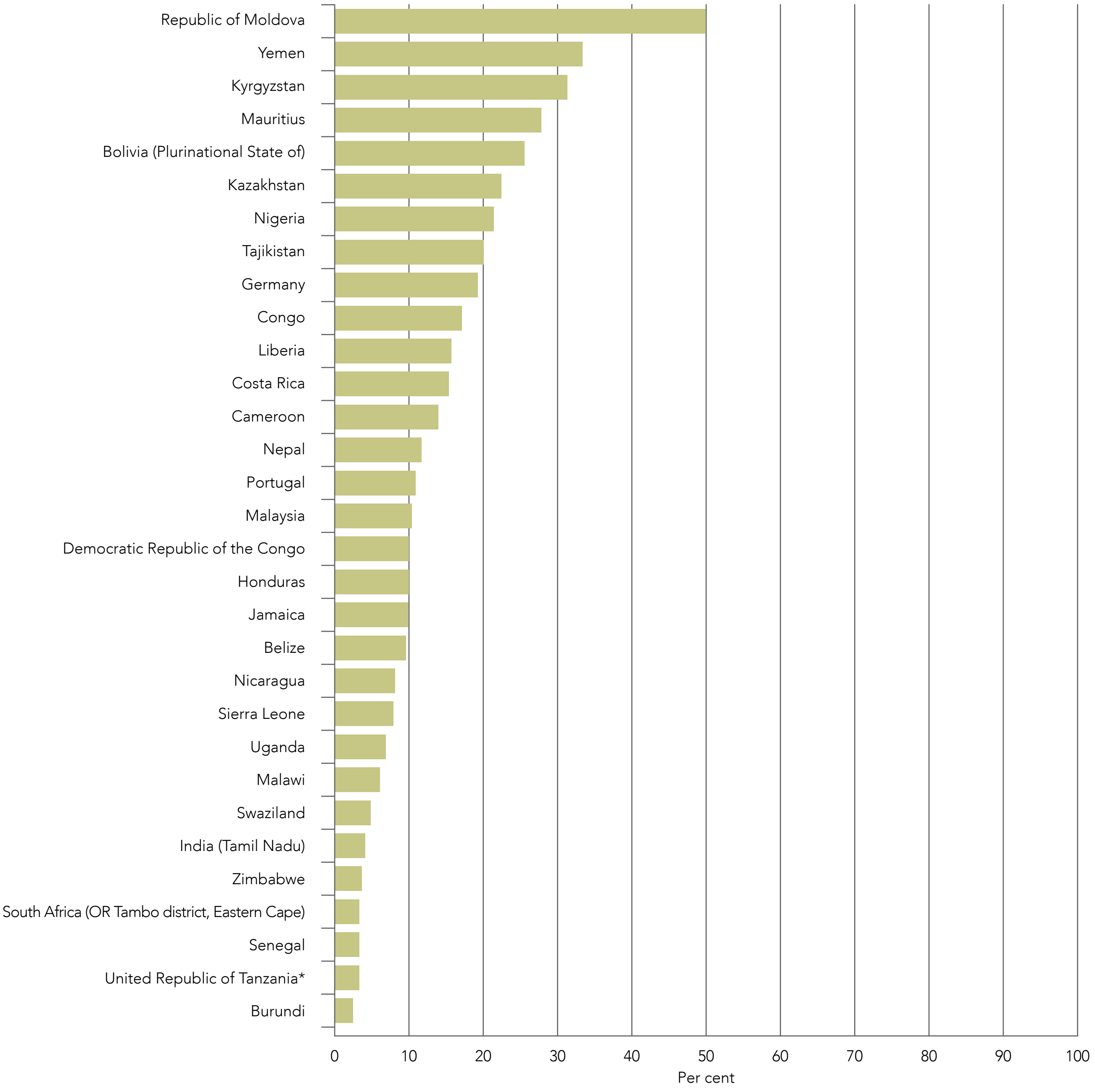
A systematic review of studies conducted in sub-Saharan Africa found that fears of the stigma and discrimination that could result from a potential breach in confidentiality included fear of social exclusion, lost social support and sexual partners, strained marital relationships (potentially resulting in abandonment, divorce or violence) and reduced chances of getting married *(3)*. Being seen at an HIV testing centre also was perceived to reflect sexual promiscuity and an HIV-positive status *(3)*.

Fear of HIV-related stigma due to a potential HIV-positive status disclosure was also found to be a deterrent to HIV testing among men who have sex with men and transgender women in New York City. Higher anticipated HIV stigma was associated with a lower probability of having had an HIV test in the previous six months, with 32% of study participants reporting not having had an HIV test in the past six months *(4)*.

Breaches of confidentiality in health-care settings occur with alarming frequency in some countries. In seven of 31 countries with available data, one in five people living with HIV reported that a health-care worker had disclosed their HIV status without consent (Figure 6) *(2)*.

Breaches of confidentiality

Figure 6. Percentage of people living with HIV who reported that a health-care professional had ever disclosed HIV status without consent, countries with available data, 2011–2016



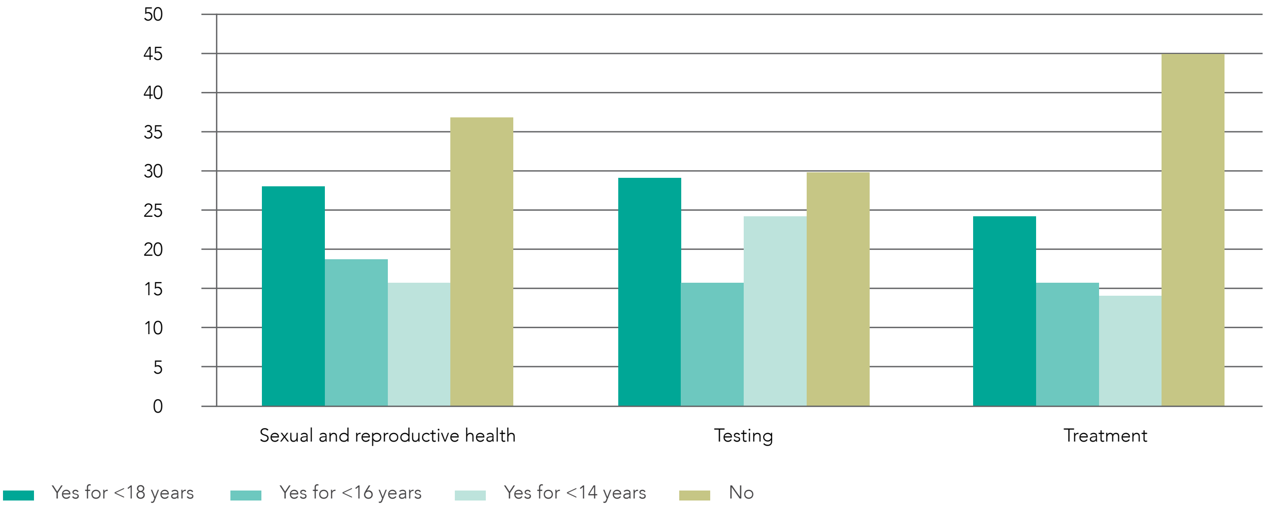
Source: People Living with HIV Stigma Index, 2011–2016.

*Four regions other than Dar es Salaam.

In certain circumstances, the law may create barriers to confidentiality, particularly for young people wishing to access services without parental permission. Young people (aged 15–24 years) face a triple threat in relation to HIV: they tend to be at a higher risk of infection, particularly women in sub-Saharan Africa; they are less likely to know their HIV status compared to older populations; and they are less likely to be on treatment or be virally suppressed. In eastern and southern Africa, young women (aged 15–24 years) accounted for 26% of new HIV infections in 2016 despite making up just 10% of the population *(5)*. Ensuring confidential access to services is therefore crucial. However, age of consent laws for medical services in many countries require persons under 18 to obtain parental consent in order to access sexual and reproductive health services, HIV testing and treatment, making it impossible for young people to access services confidentially. Of the 106 countries that have provided data to UNAIDS on age of consent laws, 29% require parental consent for a child under 18 to access HIV testing, 25% require parental consent for HIV treatment and 28% require parental consent to access sexual and reproductive health services (Figure 7) *(19)*.

Age of consent laws create barriers to services

Figure 7. Percentage of reporting countries with laws requiring parental consent for adolescents to access sexual and reproductive health services, HIV testing and treatment (n=106)



Source: UNAIDS 2017 National Commitments and Policy Instrument.

Delaying initiation of HIV care and treatment

The same fears of disclosure that discourage HIV testing also can discourage people living with HIV from enrolling in care and initiating antiretroviral therapy. A review of ten studies from low-income and middle-income countries found a significant association between stigma and late presentation for HIV care, with people living with HIV who perceived high HIV-related stigma being 2.4 times more likely to present late for HIV care *(1)*.[5] A survey of pregnant women living with HIV in three districts of Uganda found that fear of disclosing HIV-positive status to male partners was a key barrier to initiating lifelong antiretroviral therapy *(20)*.

In New York City, African immigrants, previously incarcerated adults, young men who have sex with men and transgender women living with HIV revealed that stigma was a powerful deterrent to entering and staying in HIV care *(21)*. For these key populations, anticipated discrimination and internalized stigma led them to remain hidden and potentially disengaged from care. These concerns were magnified among African immigrants with undocumented migrant status, with the potential loss of social and family support contributing to members of this group choosing not to disclose their HIV status to families and communities *(21)*.

Treatment adherence

The objective of antiretroviral therapy is to reduce levels of HIV in the body to undetectable levels, which protects the body's immune system and greatly reduces the possibility of onward transmission of the virus. Durable viral suppression requires steady adherence to treatment.

Studies have found that HIV-related stigma at the "intrapersonal, interpersonal and structural" levels compromise the ability of people to adhere successfully to antiretroviral therapy *(20, 22)*. One explanation for this is that stigma interferes with psychological processes, such as adaptive coping and social support, that help people adhere to treatment *(23)*.

Meanwhile, health-care provider surveys in Thailand reveal that attitudes about HIV among health-care facility staff may prevent them from adequately caring for people living with or affected by HIV. Such attitudes include the belief that HIV is punishment for bad behaviour, that people become infected with HIV because they engage in irresponsible behaviour, that most people living with HIV do not care if they infect other people, and that it can be appropriate to sterilize a woman living with HIV, even if that is not her choice. In some cases, health-care providers explicitly stated that they would prefer not to provide services to members of key populations, including gay men and other men who have sex with men, sex workers, people who inject drugs, transgender people and migrants *(11)*.

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[5] High stigma was defined if the study participants mentioned that they had experienced stigma or scored a mean above the overall mean of the items that were used to assess stigma and discrimination.

It has been shown that the support of family, friends and communities are essential to adherence. Additional support interventions also contribute to better adherence and therefore better health *(24)*. These interventions include the following:

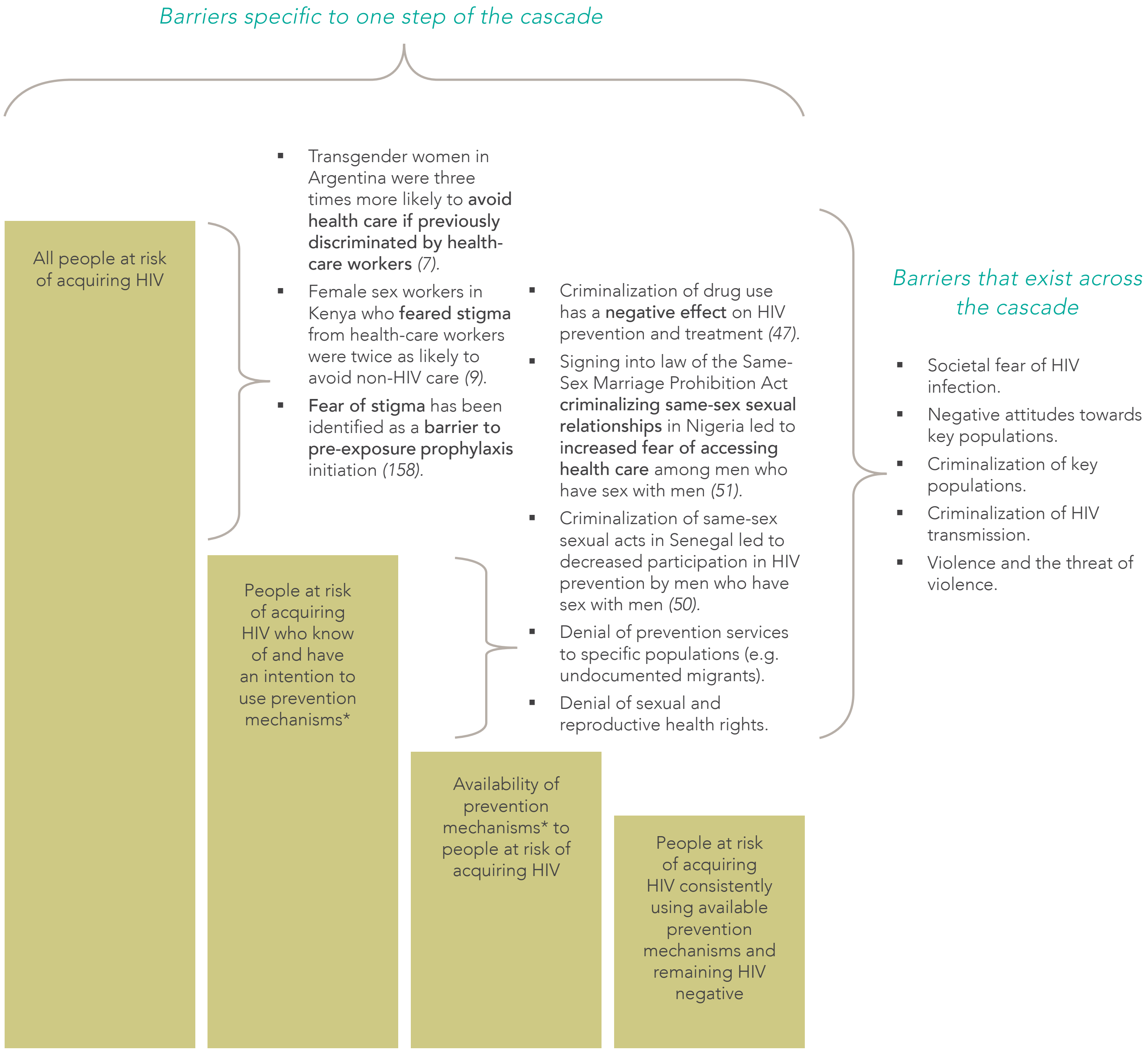
- Adherence counselling.
- Accompaniment by an adherence partner/buddy or a peer educator.
- Support from community-based health workers and nongovernmental organizations.
- Incentives and enablers for people living with HIV and their caregivers (including food, transport and income-generation opportunities).

In an environment of discrimination and violence, however, such support may not be available.

The prevention cascade

The paths of HIV transmission—such as unprotected sexual intercourse or sharing injecting equipment—have been clear since the early days of the epidemic, and communication and education on how to avoid these paths would appear to be a simple strategy for HIV prevention. However, those at highest risk of HIV infection face considerable barriers to services. Frequently used pejorative terms such as "junkie" and "addict" dehumanize people who use drugs and reinforce stereotypes of unpredictable and violent people who are unable to exercise agency and self-determination *(25)*. A systematic review of studies conducted between 2004 and 2014 revealed that lesbian, gay, bisexual and transgender people have difficulty accessing health services as a result of heteronormative attitudes imposed by health professionals *(26)*. Similarly, high levels of perceived stigma among sex workers have been shown to negatively affect their health, independent of the health risks of sex work itself *(27)*.

Figure 8. Examples of stigma and discrimination that create gaps across the HIV prevention cascade



- Transgender women in Argentina were three times more likely to **avoid health care if previously discriminated by health-care workers** *(7)*.
- Female sex workers in Kenya who **feared stigma** from health-care workers were twice as likely to avoid non-HIV care *(9)*.
- **Fear of stigma** has been identified as a **barrier to pre-exposure prophylaxis** initiation *(158)*.

- Criminalization of drug use has a **negative effect** on HIV prevention and treatment *(47)*.
- Signing into law of the Same-Sex Marriage Prohibition Act **criminalizing same-sex sexual relationships** in Nigeria led to **increased fear of accessing health care** among men who have sex with men *(51)*.
- Criminalization of same-sex sexual acts in Senegal led to decreased participation in HIV prevention by men who have sex with men *(50)*.
- Denial of prevention services to specific populations (e.g. undocumented migrants).
- Denial of sexual and reproductive health rights.

- Societal fear of HIV infection.
- Negative attitudes towards key populations.
- Criminalization of key populations.
- Criminalization of HIV transmission.
- Violence and the threat of violence.

*Structural, behavioural, biomedical

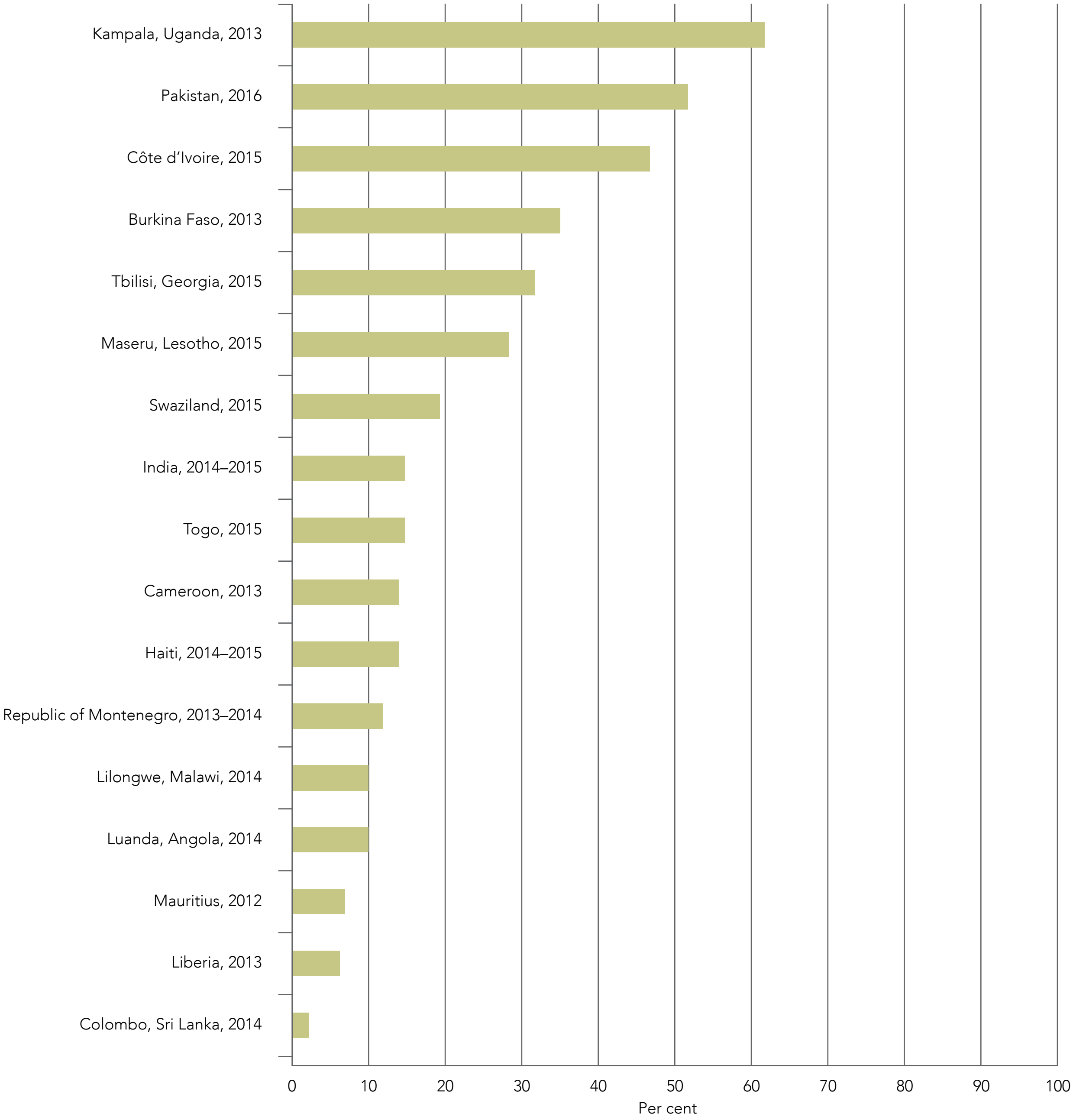
Source: adapted from Hargreaves JR, Delany-Moretlwe S, Hallett TB, Johnson S, Kapiga S, Bhattacharjee P et al. The HIV prevention cascade: integrating theories of epidemiological, behavioural, and social science into programme design and monitoring. Lancet HIV. 2016;3(7):e318 -22.

Stigma towards key populations is reinforced by criminal laws and other structural barriers, which in turn fuel violence, exploitation and a climate of fear that hinders efforts to provide condoms, harm reduction and other primary prevention methods at sufficient levels of coverage. Often such violence is carried out with impunity—sometimes even by law enforcement agents themselves. For example, transgender women in Argentina who had been exposed to police violence were twice as likely to avoid health care than were transgender women who had not been exposed to such violence *(7)*, and a 2015 study showed that women who inject drugs report high rates of sexual violence from police and law enforcement agencies *(28)*. In a number of countries, most notably the Philippines, anti-drug policies are being implemented in an increasingly violent manner, including extra-judicial killings of alleged drug dealers and users *(29)*.

The prevalence of violence experienced by sex workers, men who have sex with men and people who inject drugs is often high, but it varies by country. Among men who have sex with men surveyed in 17 countries, for instance, the percentage who had experienced physical violence in the previous 12 months ranged from 2.6% in Colombo, Sri Lanka, to 61.7% in Kampala, Uganda (Figure 9) *(30)*. More than half of people who inject drugs surveyed in Pakistan and female sex workers surveyed in seven locations across South Africa reported experiencing physical violence in the previous 12 months (Figures 10 and 11) *(31, 32)*.

Violence faced by men who have sex with men

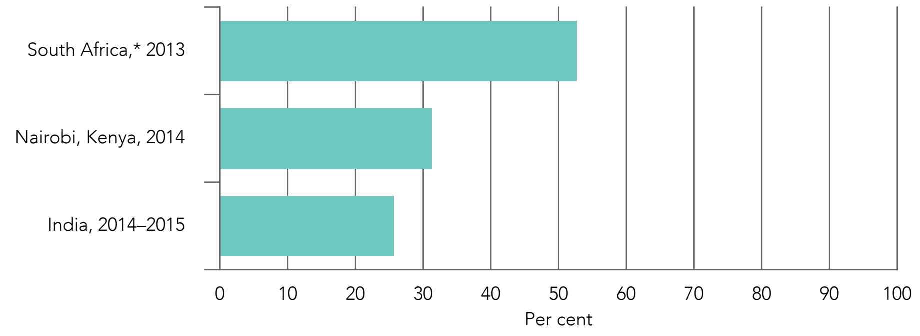
Figure 9. Percentage of men who have sex with men who ever experienced physical violence, countries with available data, 2012–2016



Source: Integrated biological and behavioural surveillance surveys, 2012–2016.

Violence faced by female sex workers

Figure 10. Percentage of female sex workers who experienced physical violence in the past 12 months, selected countries, 2013–2015

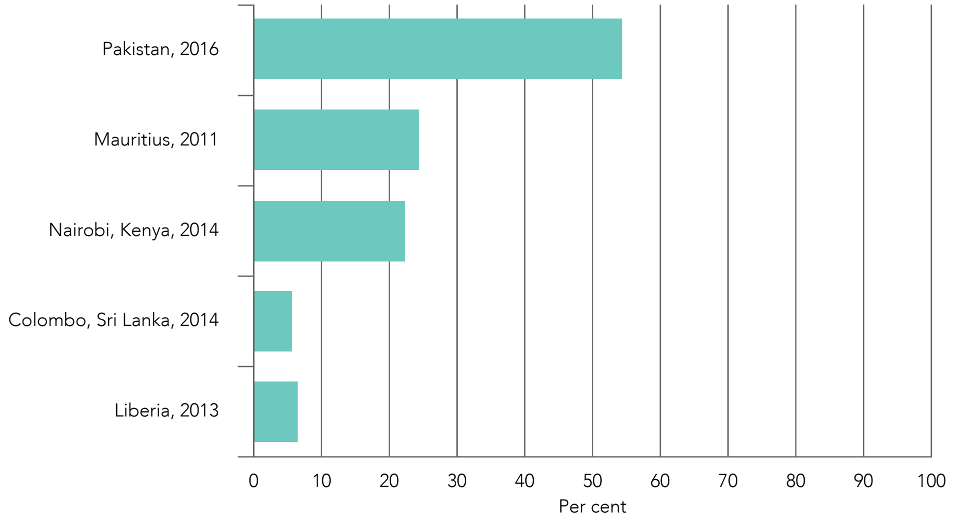


Source: Integrated biological and behavioural surveillance surveys, 2013–2015.

*Beaufort West, East London, George, Gauteng, Kwazulu Natal, Limpopo, North West.

Violence faced by people who inject drugs

Figure 11. Percentage of people who inject drugs who ever experienced physical violence, selected countries, 2011–2016



Source: Integrated biological and behavioural surveillance surveys, 2011–2016.

> ***“In some regions, women who experience intimate partner violence are 1.5 times more likely to acquire HIV than women who have not experienced such violence.”***

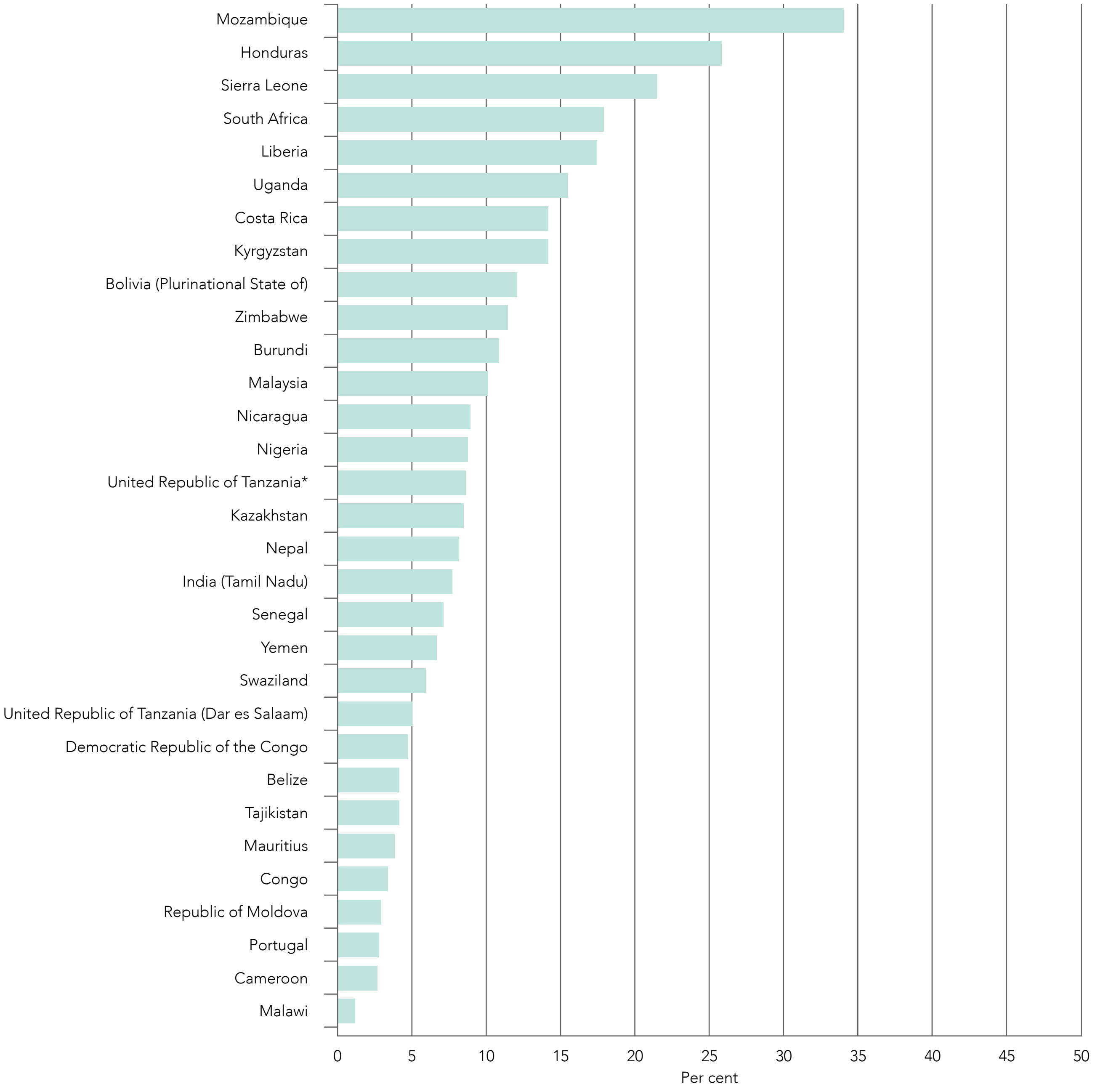
Stigma, discrimination and violence against women and access to health care

Violence against women is one of the more extreme forms of discrimination; it is estimated that nearly 30% of women globally experience physical or sexual violence by an intimate partner at least once in their lifetime *(33)*. Such violence can affect women’s ability to insist on safer sex or use HIV prevention, testing and treatment interventions *(34–36)*. In some regions, women who experience intimate partner violence are 1.5 times more likely to acquire HIV than women who have not experienced such violence *(33)*.

The involuntary sterilization of women living with HIV, forced abortions and criminalization of the vertical transmission of HIV and other reproductive health-related discrimination has been reported by women living with HIV, including advice not to have children, inappropriate treatment and failure to provide care during labour. In some cases, the provision of antiretroviral therapy is made dependent on the use of some form of contraception (Figure 12) *(2)*.

Coerced contraception

Figure 12. Percentage of people living with HIV who reported their ability to obtain antiretroviral therapy was conditional on the use of certain forms of contraception, countries with available data, 2011–2016



Source: People Living with HIV Stigma Index surveys, 2011–2016.

*Four regions other than Dar es Salaam.

Discrimination can have particularly profound effects on efforts to eliminate the vertical transmission of HIV. Women who have faced discrimination or who perceive or expect HIV-related stigma in health-care settings may be less likely to access prenatal and postnatal treatment and care. Where they do access such care, they may be deterred from using HIV services.

Some HIV programmes focused on pregnant women have been known to emphasize coercive measures directed towards the risk of transmitting HIV to the fetus. This can include mandatory prenatal and postnatal testing, followed by coerced abortion or sterilization. Such programmes seldom empower women to prevent perinatal transmission, and they can overlook the care needs of women *(37)*. Research shows that stigma and discrimination impede the retention of pregnant women in programmes to prevent mother-to-child transmission, erode the confidence that women have in the protection offered by antiretroviral therapy provided during pregnancy and reduce their access to early infant diagnosis *(38–42)*.

A number of negative experiences while giving birth have been reported by women living with HIV, including:

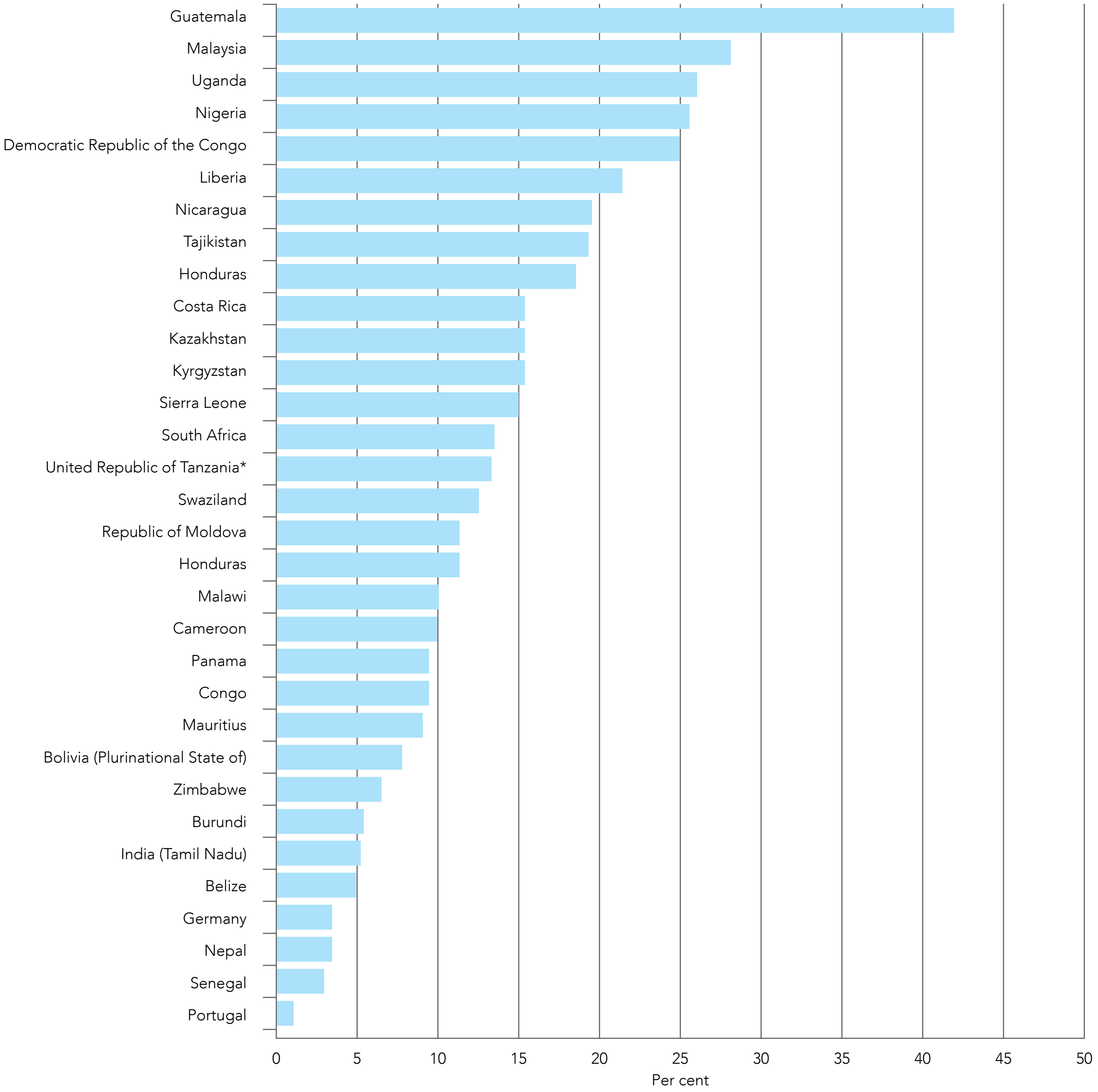
- Staff neglecting them before, during and after their delivery.
- Staff abusing them during labour because they had become pregnant.
- Staff refusing to touch them or their newborn baby.
- Severe delays before receiving attention.
- Requests to leave hospital earlier than other women *(43)*.

Women living with HIV have also reported that they were required to undergo a caesarean delivery if their HIV status was known, but that the caesarean was not free of charge, was prohibitively expensive and no other option was provided *(43)*.

In 22 of 30 countries with available data, more than 10% of women living with HIV reported having been coerced by a health-care professional regarding methods of giving birth because of their HIV status; this rose as high as 42% among women living with HIV in Guatemala (Figure 13) *(2)*.

Women coerced regarding methods of giving birth

Figure 13. Percentage of women living with HIV who reported having been coerced by a health-care professional in the previous 12 months regarding method of giving birth because of HIV status, countries with available data, 2011–2016

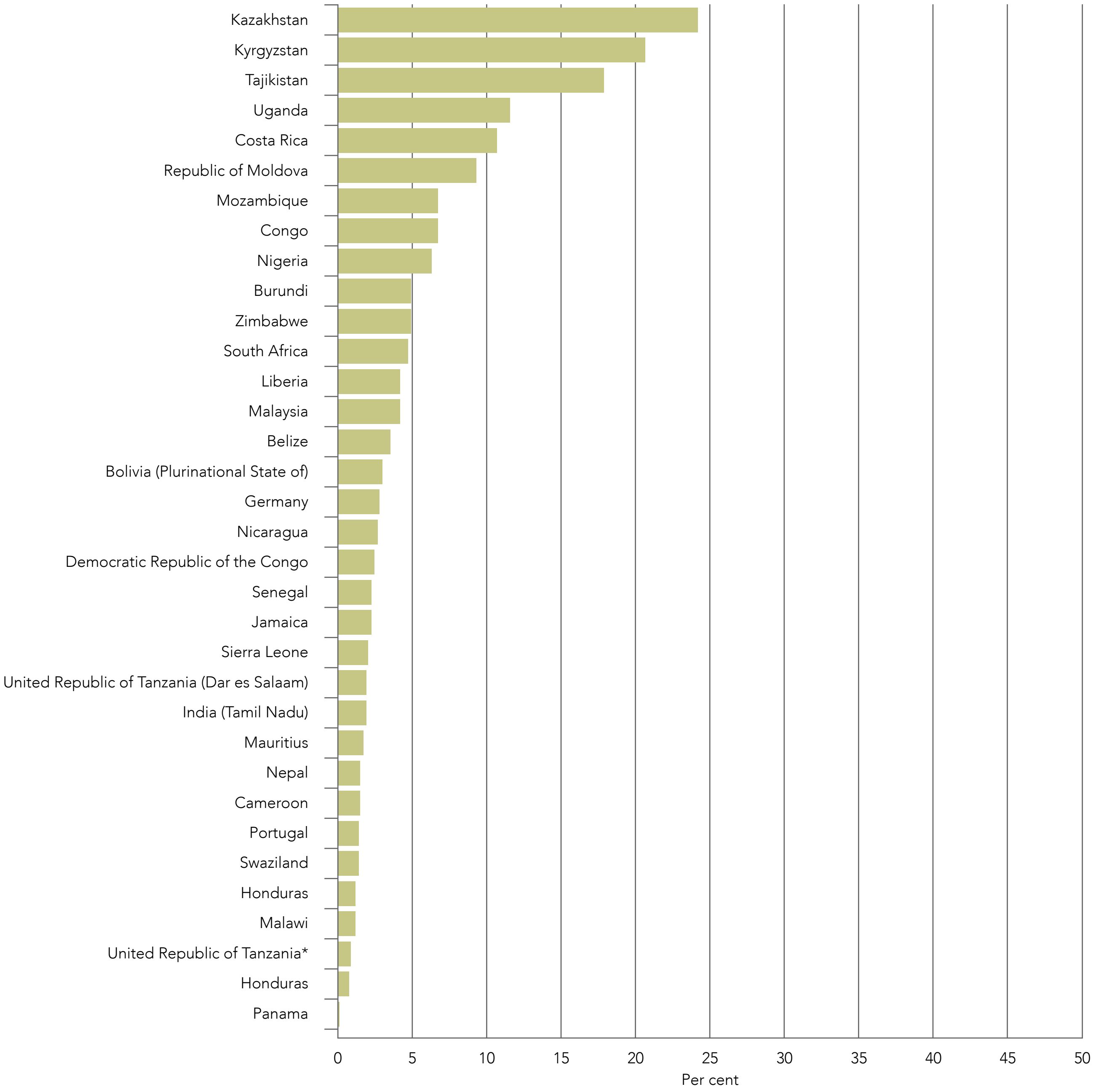


Source: People Living with HIV Stigma Index surveys, 2011–2016.

*Four regions other than Dar es Salaam.

Coerced terminations of pregnancy

Figure 14. Percentage of women living with HIV who reported having been coerced by a health-care professional in the previous 12 months to terminate a pregnancy because of HIV status, countries with available data, 2011–2016



Source: People Living with HIV Stigma Index surveys, 2011–2016.

*Four regions other than Dar es Salaam.

Criminalization of key populations

Societal stigma towards key populations—chiefly sex workers, people who inject drugs, transgender people and gay men and other men who have sex with men—has driven legislation and policies in many countries that use criminal punishment against members of these populations.

Such criminalization is prevalent across the globe. Civil society organizations and academic institutions have reported that 72 countries criminalize same-sex sexual activity, with 32 countries retaining the death penalty for drug offences and over 100 countries criminalizing some aspect of sex work *(44 –46)*. Among countries that reported data to UNAIDS in 2017, 44 out of 100 reported they have laws that specifically criminalize same-sex sexual activity;[6] 17 out of 116 countries reported they criminalize or prosecute transgender people;[7] and 84 out of 110 countries reported they criminalize some aspect of sex work *(19)*. Regarding drug use or possession of drugs, 78 out of 90 countries reported that drug use or possession of drugs for personal use is a criminal offence or grounds for compulsory detention, and nine out of 107 countries reported they impose the death penalty for drug-related offences *(19)*.

Multiple studies have shown that the criminalization of drug use—including incarceration, street-level policing, punitive drug paraphernalia laws and practices and prohibitions or restrictions on evidence-informed HIV prevention interventions—has negative effects on HIV prevention and treatment efforts *(27)*. These negative effects include decreased access to needle and syringe programmes, increased multiperson use of injecting equipment and an increased burden of HIV among people who inject drugs. At the same time, these studies found no compelling evidence that decriminalization leads to increased drug use *(47)*.

> ***“Misuse of criminal law often negatively impacts health and violates human rights. Overly broad criminalization of HIV exposure, non-disclosure and transmission is contrary to internationally accepted public health recommendations and human rights principles. Criminalization of adult consensual sexual relations is a human rights violation, and legalization can reduce vulnerability to HIV infection and improve treatment access. Decriminalizing possession and use of injecting drugs and developing laws and policies that allow comprehensive harm reduction services have been shown to reduce HIV transmission. Similarly, decriminalization of sex work can reduce violence, harassment and HIV risk. Sex workers should enjoy human rights protections guaranteed to all individuals, including the rights to non-discrimination, health, security and safety.”***

On the Fast-Track to End the AIDS epidemic
Report of the Secretary-General
1 April 2016

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[6] In addition, another 29 countries out of the 100 reported that they had no specific legislation criminalizing same-sex sexual activity, but they did not state that same-sex sexual activity was legal or decriminalized.

[7] Countries were also asked if they have laws criminalizing cross-dressing. Taken together, 23 out of 114 reporting countries stated that they criminalized or prosecuted transgender persons and/or criminalized cross-dressing.

In Cambodia, for instance, the first month of an antidrug crackdown that began in January 2017 led to a 46% reduction in the number of people who inject drugs participating in a needle–syringe programme and a 19% reduction in people accessing opioid substitution therapy *(48)*. The local nongovernmental organization providing these harm reduction services, the Khmer HIV/AIDS NGO Alliance (KHANA), suspected these clients dropped out "because they feared that police would follow them"—a belief that was confirmed in interviews with people who inject drugs *(48)*.

Criminalization creates specific barriers for women who use drugs. In some countries, including parts of the United States of America, drug use during pregnancy can lead to automatic criminal charges and incarceration for the duration of pregnancy and beyond *(28, 49)*. Women who are identified as dependent on illegal drugs can have their children removed from their care: in a number of countries in eastern Europe and central Asia, for example, seeking treatment for drug addiction requires being registered as a drug user, which can be automatic grounds for losing custody of a child *(28)*. In the Russian Federation and Ukraine, forced abortions and the termination of the parental rights of women who use drugs are legal *(28)*. Mothers interviewed as part of a study on opioid pharmacological treatment in Sydney, Australia, said they had been reported prenatally by a hospital *(28)*. These laws and practices also discourage women who use drugs from accessing health services.

Legislation that bans sexual intercourse between consenting adults of the same sex can derail efforts to prevent HIV among gay men and other men who have sex with men. A 2011 study investigated the impact on HIV prevention and treatment in Senegal following the arrest of nine male HIV prevention workers under that country's law concerning same-sex sexual relations. It found that the arrests and surrounding publicity had resulted in pervasive fear and hiding among men who have sex with men; service providers also had suspended HIV prevention work with these men out of fear for their own safety. This meant it was more difficult for men who have sex with men to access condoms and appropriate lubricants. Providers that continued their services, including physicians, noticed a sharp decline in participation in prevention efforts and medical visits among men who have sex with men in the month following the implementation of the law *(50)*.

In Nigeria, the 2014 Same-Sex Marriage Prohibition Act expanded existing laws criminalizing consensual same-sex sexual acts to prohibit same-sex marriage, cohabitation, public shows of affection and gay clubs, societies and organizations. A 2015 study assessed the immediate impact of the Act on stigma, discrimination and engagement in HIV prevention and treatment services among gay men and other men who have sex with men in the country *(51,52)*. It found that a higher proportion of gay men and other men who have sex with men reported being more fearful of seeking health care or of avoiding health care after the Act took effect. In addition, participants who had never been tested before the study's baseline were more likely to be lost to follow-up care in the period after the Act's implementation. The study also found an increase in reports of blackmailing and verbal harassment of gay men and other men who have sex with men and a decrease in safe spaces to socialize immediately after the law went into effect *(51)*.

Efforts to ban sex work can have a similar impact. In 2016, although sex work is not criminalized in Kyrgyzstan, local police announced they would “cleanse” the streets of sex workers and encouraged “community patrols” to photograph people they thought were sex workers and send the photos to the police *(53)*. A number of sex workers were arrested on the charge of petty hooliganism, which amounts to a de facto criminalization of sex workers. Soon after, there was an increase in the number of documented human rights abuses against sex workers, including police extortion, illegal detention, threats, blackmail, verbal humiliation and degrading treatment *(53)*. Sex work is highly stigmatized in Kyrgyzstan. Nongovernmental organizations have found that female sex workers in Kyrgystan face barriers in accessing health care, including sexual and reproductive health services, and that health-care providers discriminate against sex workers by denying them treatment or offering low-quality treatment and not respecting confidentiality *(54)*.

The criminalization of key populations not only affects the ability of individuals to seek HIV-related services; it can also have a more systemic impact on HIV-related programming. A 2017 study that compared population size estimates for men who have sex with men across 154 countries found that countries that criminalize same-sex sexual behaviour were more likely to report implausibly low numbers of gay men and men who have sex with men than were countries that do not criminalize such behaviour. Criminalization thus affects the ability of countries to know their epidemic and mount an appropriate response: low or absent size estimates “contribute to official denial of the existence of [men who have sex with men]; to failure to adequately address their needs; and to inflated HIV service coverage reports that paint a false picture of success” *(55)*.

Criminalization of HIV transmission

HIV-related stigma and discrimination, including the criminalization of HIV nondisclosure, exposure or transmission, further discourage individuals from taking steps to avoid HIV acquisition—or to prevent transmission of HIV to their children—for fear of prosecution, being deprived of their sexual and reproductive health rights, or losing custody of their children.

Laws criminalizing the nondisclosure, exposure and transmission of HIV remain widespread. Fifty-one of the 109 reporting countries reported having such laws, while another 25 countries indicated they do not have such laws, but that prosecutions do occur based on general criminal laws *(19)*.

The criminalization of vertical transmission of HIV—where mothers can be prosecuted for transmitting HIV to their fetus—can discourage pregnant women from being tested for HIV. In instances where women know they are living with HIV, criminalization can stop them from disclosing their status and accessing prenatal and postnatal care and services to prevent mother-to-child transmission *(60, 61)*. Four countries (Libya, Nauru, Saint Lucia and Tajikistan) have reported that they continue to criminalize vertical transmission *(19)*.

Migrants

Migrants often face conditions that hinder their access to HIV prevention, care and treatment services *(56)*. Their rights may be violated by compulsory testing, or they may be unable to access voluntary testing services, in part due to stigma and discrimination and fear of the consequences (including deportation) of a positive HIV test result. The attitudes of health-care workers, a lack of information about health services and rights among migrants, and barriers related to culture, language and religion also prevent access to services *(16)*.

Thirty-five countries still impose restrictions on entry, stay and residence for people living with HIV *(57)*. Although there is no evidence that such restrictions protect the public health or help prevent HIV transmission, they do constitute discrimination on the basis of HIV status and they violate the rights of the individuals affected (notably a migrant's right to free movement). Restrictions also limit the uptake of voluntary HIV testing and hinder adherence to antiretroviral therapy. For example, migrant mine workers in southern Africa—including miners living with HIV and multidrug-resistant tuberculosis—have been expelled from their destination country and left at the border of their home country without access to treatment or a referral to local health services *(56)*.

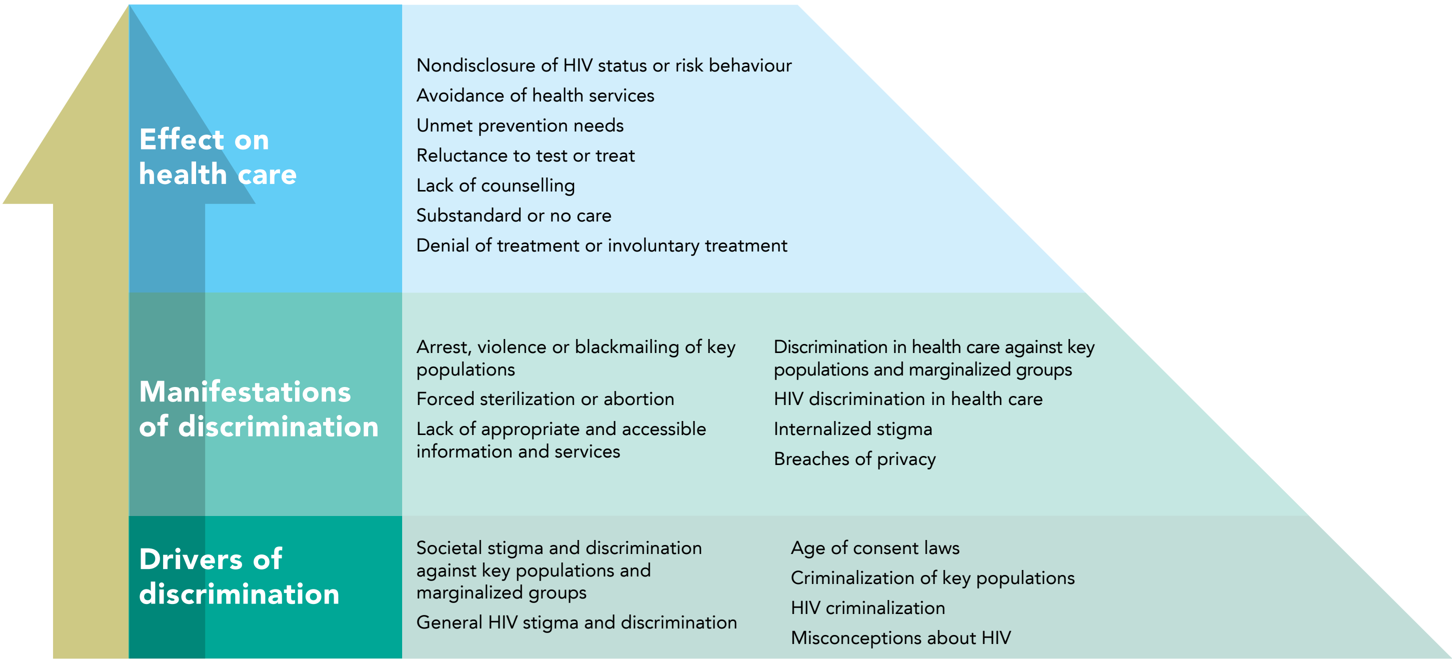
Migrants also rarely have the same entitlements as citizens to insurance schemes that make health care affordable and they may face restrictions in accessing universal health care or significant challenges in accessing mechanisms of redress in relation to discrimination or abuse *(56, 58)*. In some instances, migrants living with HIV may be treated as criminals, detained or deported, and this treatment creates additional stigma and financial consequences.

Where migrants are undocumented, they may incur further risks due to substantially limited access to adequate health-care services, health insurance, social protection or justice; they also may experience social exclusion and insecure housing and employment conditions. For migrants in Europe, although all countries in the European Union/European Economic Area have ratified a number of international and regional human rights instruments that enshrine access to health care as a human right that should be available to everyone without discrimination, a significant number do not provide antiretroviral therapy to undocumented migrants *(59)*.

Stigma and discrimination:

How they create barriers to accessing health-care services...

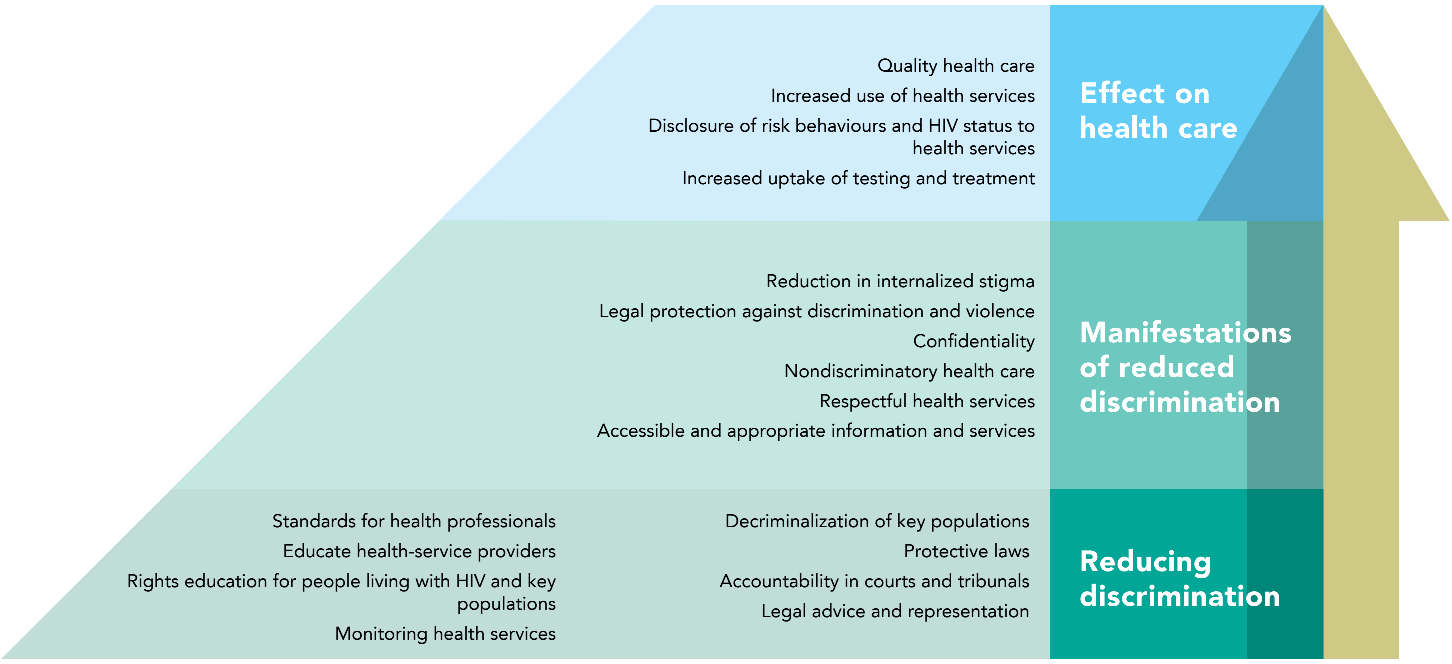
Figure 15. The effects of stigma and discrimination on health care access for prevention, testing and treatment



Criminal laws, community attitudes, misinformation, prejudice and fear are all drivers of stigma and actual manifestations of discrimination affecting access to health care by people living with HIV and key populations.

...and how confronting stigma and discrimination can overcome those barriers

Figure 16. Removing stigma and discrimination improves health care access for prevention, testing and treatment



By addressing these drivers, through the removal of harmful laws, introduction of protective laws, education of rights holders and service providers and legal empowerment of communities to defend their rights, the gap between those who can access services and those who cannot can be closed, leading to better health for all.

Eliminating stigma and discrimination and ensuring access to the cascade of services

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“People-centred health care builds trust between health-care workers and beneficiaries, improves experiences and health outcomes for beneficiaries, and increases the confidence and job satisfaction of health professionals. People get the right care, at the right time and in the right place.”

International, national, community and individual actors around the world are proving that improving access to health-care services by reducing HIV-related stigma and discrimination is both possible and essential to achieving the targets within the 2016 United Nations Political Declaration on Ending AIDS. A variety of interventions have been shown to be effective, including the following:

- Empowering individuals and communities to address and respond to discrimination.
- Training and supporting health workers to overcome personal and institutional discriminatory attitudes and actions.
- Eliminating discriminatory laws and policies.
- Strengthening the legal and policy framework to address discrimination.
- Ensuring that all actors are accountable for their actions and take responsibility for the elimination of discrimination.

Since then, networks and organizations of people living with HIV have worked with local, national and international partners to strengthen their capacity and coordination, empower people living with HIV, sensitize health workers and contribute to the development of enabling laws, policies and programmes that reduce discrimination and increase access to key services *(62)*.

Putting people at the centre of health services

People-centred services

People-centred services aim to put people and communities rather than diseases at the centre of health systems. People-centred health care builds trust between health-care workers and beneficiaries, improves experiences and health outcomes for beneficiaries, and increases the confidence and job satisfaction of health professionals. It also can increase access to health services. Essentially, people-centred services mean that people get the right care, at the right time and in the right place *(63)*.

In the context of the HIV response, the concept of people-centred care means that prevention, testing and treatment services are provided in a manner that is acceptable, accessible, of good quality and suited to the needs of the individuals receiving them. It means looking at the particular needs and circumstances of key populations and other marginalized groups—such as migrants, people who inject drugs or sex workers—who may not be able to access general health services on an equal basis with others, and designing health services to suit their needs and improve coverage across the entire cascade of services.

Ways of ensuring people-centred health care for people living with HIV and key populations can include:

- Adapting service opening hours to suit clients (such as providing late or night hours for sex workers).
- Introducing youth-friendly health services to counterbalance their exclusion from other services.
- Integrating HIV and sexual and reproductive health services to avoid the disclosure of confidential information.

Addressing discrimination and building trust between stakeholders is a key aspect of people-centred care. Consultation with beneficiaries will ensure that their needs are understood and actually met, and it will improve their overall engagement with health services.

> ***"In one clinic in Namibia, a people-centred approach has led to a 20% reduction in deaths among patients living with HIV."***

Namibia provides an example of people-centred health services in action. In 2016, HIV prevalence among adults (aged 15–49 years) in Namibia was estimated at 13.8% [12.1–15.1%]. In 2015, the country had an estimated infant mortality of 33 deaths per 1000 live births and a maternal mortality rate of 265 per 100 000 live births; in 2014, approximately 17% of pregnant women attending antenatal clinics were living with HIV *(64, 65)*. To address this, a new model was piloted at seven health facilities. Integrating HIV and sexual and reproductive health services to improve HIV service uptake, the model also sought to reduce other sexually transmitted infections and unintended pregnancies, and to maximize opportunities to address the sexual and reproductive health needs of people living with HIV. Each participating clinic used a model of "one nurse, one patient, one room." This was a change from the previous practice of reserving specific rooms for people living with HIV, which compromised confidentiality and discouraged many people from accessing the services they needed.

An operational research study looking at the Namibia model in one particular clinic found that integrated services improve accessibility and quality of antenatal care services by improving provider–patient communication and by reducing the length of time that patients stay in the clinic, their wait times for services and their expectations of how long services will take. The integrated model also improves nurse productivity and reduces stigma without compromising the uptake of services for tuberculosis, HIV, outpatient or antenatal care or those for first visit family planning. For example, the average number of patients collecting timely routine refills of antiretroviral medicines increased 16.3% under the model, the average number of patients who stopped antiretroviral therapy decreased 7.2%, and the average number of patients with HIV who died each month decreased by 20% *(66)*.

Argentina has established a policy on what it calls "key population-friendly health services" in order to reduce stigma and discrimination towards gay men and other men who have sex with men, transgender people and sex workers, and to increase their access to (and uptake of) HIV-related and other health services. Civil society organizations and networks are involved in outreach activities and the design and implementation of services. Twenty-one key population-friendly health centres have been established within the public health system, with interdisciplinary teams of health and social workers providing a variety of health and social services (and in some cases, legal or referral services) that are tailored to the needs of lesbian, gay, bisexual, transgender and intersex (LGBTI) populations and sex workers. For example, services are open in the afternoon and evening to make it easier for the key populations to access them *(67)*.

Multilayered interventions

Combining discrimination reduction with other HIV-related interventions that cater to the specific needs of individuals can have cumulative positive impacts. In Peru, community popular opinion leaders were identified, recruited and trained in 10 neighbourhoods to provide support to marginalized populations, reduce sexual risk behaviours and increase HIV testing. Nearly 3050 men who self-identify as heterosexual, men who self-identify as homosexual and socially marginalized women were reached by these popular opinion leaders, resulting in lower levels of stigmatizing attitudes among both groups of men (although no significant differences were found among the women) *(68)*.

Pooled data from two trials addressing both treatment adherence and the influence of stigma indicate that the integration of human rights-based interventions resulted in significant improvements in adherence *(69–71)*. In Zambia, participants received group or individual interventions to increase social support and patient–provider communication, and to decrease concerns about HIV medication. The trial findings indicated that people who experienced decreased experiences of stigma, increased social support and increased patient–provider communication were more likely to visit clinics than those who did not *(70)*.

In Viet Nam, a multilevel behavioural intervention undertaken in one province among men who inject drugs increased survival rates among those living with HIV. Participants benefited from one of four interventions: a community standard of care intervention, a community stigma reduction intervention, an individual enhanced counselling intervention, or both community and individual interventions. This fourth category resulted in the greatest impact: 87% of participants were still alive at 24 months, 84% of those with a CD4 cell count <200 cells/mm3 and not on antiretroviral therapy at baseline were still alive at 24 months, and participants had the greatest increase in the uptake of antiretroviral therapy *(72)*.

Engaging health-care workers

Strengthening skills, sharing tools

Strengthening the capacities of health-care workers through training and information is an effective way of reducing stigma, discrimination and exclusion in health-care settings. In Chile, for example, training for health-care providers on HIV-related legislation and the identification and documentation of rights violations increased knowledge of the law relating to HIV fivefold *(73)*.

"In South Africa, first-year medical students who received student-led peer training were 1.5 times more likely to report empathetic attitudes towards people living with HIV three to six months following their training than peers who had received no training."

There is evidence that discrimination-related training also leads to a reduction in stigma and discrimination. A 2017 review of data from four randomized control trials of training for health-care students in India, Lithuania, Puerto Rico and the United States showed that following the training, there was an improvement in the attitudes of the students towards people living with HIV and a reduction in stigma *(74–79)*.[8] In South Africa, first-year medical students who received student-led peer training were 1.5 times more likely to report empathetic attitudes towards people living with HIV three to six months following their training than peers who had received no training *(80)*. In China, a training programme on universal precautions, fighting HIV-related stigma and improving patient care was implemented in hospitals for doctors, nurses and laboratory technicians. Those who received training showed a significantly greater reduction in prejudicial attitudes towards people living with HIV and reductions in avoidance intent (not wanting to care for patients living with HIV) than those who did not receive the training *(81)*.

Harnessing global tools

There are an increasing number of ready-made tools and mechanisms that can be used to reduce stigma and discrimination. For example, an online repository of tools on discrimination in health care—available at www.zeroHIVdiscrimination.com—provides practical resources for those working to eliminate discrimination. HealthWISE is a tool developed jointly by the International Labour Organization and WHO to guide health-care institutions in improving occupational health and safety conditions for health workers and the quality of health services *(82)*. The tool has a dedicated module on discrimination issues, including discrimination and staff–patient and staff–staff violence *(82)*. Pilot projects applying the tool in Senegal, Thailand and the United Republic of Tanzania resulted in better information and practices on working conditions, and they increased sensitization of hospital health workers about HIV and safer work practices *(83)*.

Tools also have been developed to tackle discrimination faced by specific groups. The Time Has Come training package, developed jointly by the United Nations Development Programme and WHO, was designed to reduce stigma and discrimination against gay men and other men who have sex with men and transgender people in health-care settings in Asia and the Pacific. The package enables participants to gain a deeper understanding of data and evidence relating to HIV prevention and care among gay men and other men who have sex with men and transgender people, and to use that data effectively. The Time Has Come has been adopted into national HIV training programmes for health providers in Bhutan, India, Indonesia, Nepal, the Philippines and Timor-Leste *(84)*.

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[8] A statistically significant standardized mean difference of 0.34 (95%, CI: 0.19; 0.48), indicating an improvement in attitudes towards people living with HIV and a reduction in stigma following training.

Empowering community-based health workers

Community health workers are health workers who perform functions related to health-care delivery and who have been trained in some way in the context of the intervention. While the definitions vary, generally they have received no formal professional, paraprofessional or tertiary education. They are members of the communities where they work and accountable to them for their activities, and they should be selected by the communities they serve and be supported by the health-care system *(85)*. For instance, they might use new health technologies, support systems, rapid HIV test kits and simplified treatment protocols to improve the coverage of interventions across the HIV prevention, testing and treatment cascades as they engage in broader health promotion and primary care *(85)*.

Integrating community health workers into the health-care system has the potential to expand coverage and reduce inequities in access to essential health services, particularly in underserved areas or for excluded and vulnerable populations *(86)*. In India, the Asha-Life intervention demonstrated that the involvement of a lay health worker known as an "Asha" (a village woman trained in HIV or an accredited social health activist) increased the impact of HIV-related training for rural women living with HIV. The training included coping and stigma-reduction mechanisms, and some women received weekly support training from an Asha when the training was complete. The Asha helped to monitor barriers to antiretroviral therapy adherence and provided assistance to mitigate any barriers the participants faced in accessing health care or the prescribed treatment. This included accompanying the women to the district hospital or psychologist, or counselling them about coping strategies to deal with rights violations (such as discrimination). Six months after enrolment in the training sessions, the women who had been allocated an Asha reported significantly greater reductions in internalized stigma and avoidance that those who had not; they also showed significant improvements in adherence, CD4 levels and other health parameters, as well as a reduction in depressive symptoms *(87)*.

"Kenya's sex workers know what is best for Kenya's sex worker movement": intersectional support for intersectional problems

In Kenya, the Bar Hostess Empowerment and Support Programme (BHESP) began as a group of sex workers and bar hostesses working together against HIV, violence and exploitation. The civil society organization grew to provide a wide range of services that both protect and empower sex workers.

BHESP is rooted in the community of sex workers, and it engages with the wider community, enlisting sex workers themselves to protect, care for and advocate for their peers. Some of the ways BHESP does this includes the following:

- Establishing 42 sex worker groups, training group leaders as peer educators and helping participants to access health services on their own.
- Setting up drop-in centres and placing peer educators in hospitals to facilitate referrals.
- Running a home-based care programme for people with AIDS-related illnesses.
- Engaging with clinic directors and health officials on behalf of sex workers.
- Providing sensitization training for health-care providers.
- Establishing two wellness centres that provide free services to sex workers, including testing and treatment for sexually transmitted infections, cervical cancer screening and family planning.

Through these various health interventions, BHESP reaches approximately 8000 sex workers in Nairobi and an additional 2000 in areas surrounding the capital.

BHESP also provides a number of other services for Kenya's sex workers that complement their health interventions and address the systemic barriers that impact on their health and safety, including discrimination, violence, arbitrary arrest and legal issues. These services include the following:

- Monitoring medical research to ensure the rights of sex workers are not violated and that they are not exposed to risk.
- Participating in research that documents violence against sex workers.
- Providing a legal aid programme that features sex worker peer educators who are trained as paralegals to provide 24-hour support, counselling, advice and bail payment.
- Establishing quarterly legal aid clinics where sex workers can receive advice from lawyers.
- Using the law to hold police accountable for misconduct, and helping sex workers contest charges and pursue cases against police.
- Building bridges with law enforcement to prevent violence and harassment, and organizing forums that bring police and sex workers together to foster mutual understanding and identify ways to reduce abuse.
- Helping sex workers use the courts to take action against those who violate their rights (such as when they have children removed from their care or when they are physically abused or subjected to extortion).
- Advocating for national policies and programmes related to sex work, including the prioritization of programmes for sex workers within the national AIDS response.
- Working with the media to raise awareness of sex workers' rights and reduce discrimination, and organizing demonstrations on issues such as police inaction on violence against sex workers *(88)*.

In the United States, community health workers led interactive group-based educational sessions in English and Spanish for underserved Hispanics in three south-western communities *(89)*. The community health workers were themselves living with HIV or otherwise affected by HIV, and the sessions emphasized positive cultural values and community assets as part of efforts to decrease stigma and motivate behavioural and attitudinal change. The results were positive: scores assessing HIV-related stigma among participants decreased significantly, and HIV-related knowledge, willingness to discuss HIV with sexual partners and HIV risk perception increased *(89)*.

A joint programme between government and eight nongovernmental organizations in Thailand for migrants from Cambodia and Myanmar has trained migrants to act as health assistants for their peers. These assistants distribute information, educational and communication materials, and condoms within migrant communities and workplaces. The participation of these volunteers has helped to address some of the barriers to accessing health services among migrant workers, and it has helped them become aware of their rights. The programme also has established migrant-friendly health services within government health facilities that provide diagnosis and treatment of sexually transmitted infections and voluntary HIV counselling and testing *(90)*.

Creating an enabling legal environment for people to access health care

Reforming or removing discriminatory and punitive laws and implementing protective legal norms empowers individuals and communities, providing an environment where people feel they can access health services safely, with dignity and on an equal basis with others. It also strengthens mechanisms and institutions, increasing access to HIV services, health care and other social services.

Decriminalizing sex work

In 2015, a model to measure the impact of decriminalization of sex work found that decriminalization could avert 33–46% of HIV infections in the next decade through "combined effects on violence, police harassment, safer work environments and HIV transmission pathways" *(91)*. A recent study among 27 European countries concluded that countries that had legalized some aspects of sex work saw significantly lower HIV prevalence among sex workers than those that criminalized all aspects of sex work *(92)*.

In 2003, New Zealand decriminalized sex work and established a legal framework that aimed to safeguard the human rights of sex workers, protect them from exploitation, promote their welfare and occupational health and safety, and contribute to public health. At the same time, the framework did not endorse or morally sanction sex work, and it prohibited the involvement of people under the age of 18 years in sex work *(93)*. A 2008 review by the New Zealand Government found that sex workers had greater access to health information than they did before decriminalization, and that they were more comfortable insisting on safer sex. HIV rates were negligible prior to decriminalization and remained so, and the number of sex workers in the country did not increase *(93)*.

Decriminalizing same-sex sexual activity

When same-sex sexual behaviour and relationships are not punishable by law, gay men and other men who have sex with men and transgender people are better enabled to seek out the health care and other services they need. There is evidence of this as far back as 1985, when a study in Australia that compared homosexual men in different jurisdictions found that those who lived where same-sex sexual practices were decriminalized reported improvements in psychological adjustment and reduced incidence of sexually transmitted infection *(94)*.

In 2009, the Delhi High Court overturned laws criminalizing same-sex sexual behaviour on the basis that these laws violated the Indian Constitution, which provides for the equality of all Indian citizens and the right to live with dignity *(95–97)*.[9] A 2013 study found that the ruling had resulted in increased self-acceptance and self-confidence among gay men, other men who have sex with men, hijras, kothis and outreach workers *(95)*.[10] It had also contributed to reduced harassment by state actors and increased societal and familial acceptance.

Decriminalizing drug use

In countries that have implemented full or partial decriminalization of drug use, there have been tangible impacts on addiction, drug-related deaths and HIV transmission. Czechia, for example, features one of the lowest rates of HIV among people who inject drugs, and this has been credited to the decriminalization of the possession and use of small quantities of drugs, combined with robust harm reduction efforts *(98)*.

In Portugal, the combination of a significant relaxation of antidrug legislation in 2000 and harm reduction scale-up was followed by declines in the rate of crime related to drug consumption, problematic drug use and drug-related harms *(99, 100)*. It was also marked by a subsequent increase in the number of people enrolled in drug dependence treatment *(99, 100)*. Following these changes, annual new cases of HIV infection among people who use drugs fell from 1575 in 2000 to 78 in 2013, and the number of new AIDS cases among people who use drugs fell from 626 to 74 during the same period, indicating an improvement in both the prevention and testing and treatment cascades *(101)*. Portugal has not seen a rise in regular drug use since the legal change, and drug use among some populations has actually decreased *(102, 103)*.

Removing or adapting parental consent laws

There is broad consensus that parental consent laws restrict access to sexual and reproductive health and HIV services among adolescents and young people, and that removing such laws will serve to improve their access. In one study from the United States, a substantial increase in the uptake of HIV testing and counselling services was

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[9] This decision was reversed by the Supreme Court in 2013. In 2015, the Court agreed to review the decision again *(96)*.

[10] Hijras are "physically male or intersex persons who are considered a member of 'the third sex'." Kothis are "males who show obvious feminine mannerisms and who participate mainly, if not only, in receptive anal/receptive oral intercourse with men" *(95)*.

observed after New Jersey state law was changed to remove requirements for parental consent to HIV testing *(104)*. Lesotho, South Africa and Uganda have similarly all reduced the age of consent for HIV testing and counselling to 12 years *(105*). Further research is required to investigate the effect of these actions on the uptake of testing and counselling services.

Introducing protective legislation

The elimination or absence of laws and policies that overtly discriminate against people living with HIV and people at risk of HIV infection is not enough to end stigma and discrimination. Actively protecting the rights of marginalized populations is essential to the mitigation of societal stigma and discrimination. This includes laws that do the following:

- Prohibit discrimination on the basis of HIV status, sexual orientation and gender identity in health-care settings and elsewhere.
- Create systems for handling and investigating complaints of discrimination.
- Protect confidentiality of personal information and the right to consent to treatment.

Such measures contribute to creating an enabling environment where people living with HIV and members of key populations are genuinely able—and feel enabled—to access the services and support they need.

"A study on the introduction of protective laws for transgender people in Argentina found that reports of discrimination in health care based on gender identity halved after the law came into effect."

The 2012 Argentinian Gender Identity Law, for example, has had a positive impact on quality of life for transgender people in Argentina, including increasing their access to education, work and health services *(106, 107)*. The law allows people to change their name and gender on their identity documents through a simple administrative procedure; it also guarantees access to comprehensive health care, including hormonal and surgical treatment, based solely on the informed consent of the person (without any other judicial, medical or administrative requirements). A 2014 study showed that the law enabled better and earlier access to health services among transgender people, including HIV testing and treatment. It also resulted in a significant reduction in stigma and discrimination in health-care settings: only three out of 10 study participants reported discrimination based on their gender identity after the enactment of the law (compared to eight out of 10 before it). Respondents noted that passage of the law generated a collective and individual empowerment that counteracts discrimination *(106, 107)*.

Other jurisdictions have instituted similar measures. New Zealand's decriminalization of sex work in 2003 provided employment, health, safety and human rights protections to sex workers *(93)*. Similarly, the Cambodian Ministry of Labour and Vocational Training issued regulations in 2014 on the labour rights of entertainment workers, many of whom are employed informally and expected by their employers and clients to provide sexual services *(108)*. Their labour rights now include access to health information and services, rights to sick leave and protection from violence and harassment *(109)*. Labour inspectors received training in occupational safety, labour rights, HIV prevention and the reduction of stigma and discrimination against entertainment workers living with HIV *(110)*.

Numerous countries have enacted legislation that specifically protects the rights of people living with HIV *(111)*. In 2017, the Indian parliament passed the HIV and AIDS (Prevention and Control) Bill, which explicitly calls for people living with or affected by HIV to have equal access to education, housing and employment. It also protects property rights and requires informed consent for HIV testing, treatment and status disclosure. The legislation includes a national process for handling HIV-related complaints, with an ombudsman in each state having the power to issue orders related to such complaints and the provision of health services, and to levy penalties such as fines and/or imprisonment *(112, 113)*. This follows a 2016 Supreme Court of India ruling that transgender people have the right to self-identify as male, female or third gender, and that the Indian Government had an obligation to ensure their fundamental rights without discrimination *(96)*.

Strengthening accountability for discrimination-free health care

All health-care providers have a duty of care to patients; they also have a legal and moral obligation to adhere to a standard of reasonable care when performing acts that could foreseeably cause harm to others. The fundamental ethical principles at the heart of clinical care are those of nonmaleficence (do no harm), beneficence (do good) and trust. Health practitioners should also seek to ensure that patients are given adequate information regarding their health condition and potential courses of action, and voluntarily consent to treatments and procedures, and that they have the capacity to understand the potential benefits and risks of the care they receive *(114)*. This duty is owed to all persons without discrimination.

Ideally, this duty of care is strengthened by national laws, policies and professional standards. Some countries adopt specific legislation, while others have policies or statements drafted by national and or international professional bodies. Still others have standards or precedents developed by the courts over time. Such standards should require health professionals to provide the same level of care and treatment to all persons without discrimination, therefore providing a guaranteed level of protection and treatment to patients. Sanctions for violations must be in place, and violators must be held accountable.

In Viet Nam, the 2013 Decree on Penalties for Administrative Violations against Medical Laws built upon the previous 2006 Law on HIV/AIDS Prevention and Control that prohibited many forms of HIV-related discrimination. The Decree stipulates a range of fines and remedies for acts of HIV-related discrimination that include (but are not limited to) the following:

- Disclosing HIV status or other personal details without consent.
- Disseminating pictures of people living with HIV or their families.
- Failing to disseminate HIV-related information or provide testing and counselling.
- Obstructing the right to access HIV services.
- Performing forced HIV testing.
- Failing to provide treatment to those eligible *(115)*.

In 2014, the Supreme Court of Namibia found that the Government of Namibia had breached its duty of care to three women living with HIV who had been forcibly sterilized in a public hospital. According to the court, the duty of care included a duty to ensure all medical treatment was undertaken with the informed consent of the patient *(116)*. In the case of the three women, this consent had not been obtained. The court's decision meant the government was obligated to take steps to eliminate the practice of forced sterilization in the country *(116)*.

The right to health: the global mechanisms

The right to health, like all international human rights commitments, requires multisectoral monitoring in order to ensure accountability and compliance. At the global level, there is a rigorous structure in place to do just that, consisting of expert country reviews through treaty bodies, special procedures such as working groups and rapporteurs, peer review through the Human Rights Council and the Universal Periodic Review (UPR), and individual complaints mechanisms. Organizations and individuals have used these mechanisms in a variety of ways to report evidence that a country is failing to meet its obligations under the right to health and to obtain recommendations from experts and other states to rectify such failures, including in relation to discrimination, health care and HIV. Although such recommendations are not enforceable, they can be used to ensure political accountability, contribute to legislative reform, influence policy and guide professional standards (including for health care).

In 2016, the Human Rights Committee reviewed Costa Rica's implementation of its obligations under the International Covenant on Civil and Political Rights, commending the country's efforts to combat discrimination against people living with HIV but also noting concerns that certain key and vulnerable populations (people deprived of their liberty, LGBTI persons and migrants in irregular situations) "are discriminated against and face problems finding employment and accessing health services and medical treatment" *(117)*. The Human Rights Committee recommended that Costa Rica adopt specific measures to raise awareness of HIV in order to combat prejudice and stereotypes and to ensure that people with HIV enjoy equal access to health care and medical treatment.

Human rights treaty bodies can also receive individual complaints from people who claim to be victims of human rights violations. The respective treaty body will then issue findings and recommendations to the state party concerned.[11] In 1994, the Human Rights Committee held that a law criminalizing homosexuality in Tasmania, Australia, was a breach of privacy that amounted to discrimination on the basis of sexual orientation under the International Covenant on Civil and Political Rights. The case led to a repeal of Tasmania's laws against homosexuality in 1997 *(121)*.

“In 2014, a review found that 48% of UPR recommendations had been either fully or partially implemented within 2.5 years of the initial review.”

The Universal Periodic Review: a human rights peer review process

The UPR was created in 2006. It is a unique process where each country’s human rights record is reviewed by the Human Rights Council and any other interested United Nations Member States. Among other human rights issues, it also encourages countries to uphold the rights of people living with HIV and those at risk of infection *(118)*. For example, Romania accepted a recommendation to “provide effective sanctions for discrimination against people living with HIV, to ban mandatory HIV testing as a condition of employment and to ensure that persons living with HIV are not arbitrarily prevented from working or attending vocational schools” *(119)*.

Similarly, Malawi accepted a recommendation to “guarantee that people of the lesbian, gay, bisexual, transgender and intersex communities have effective access to health services, including treatment for HIV/AIDS” *(119)*.

In 2014, a review found that 48% of UPR recommendations had been either fully or partially implemented within 2.5 years of the initial review *(120)*. This indicates that the UPR process is a powerful tool for ensuring compliance with the right to health.

Human rights mechanisms also exist at the regional level. In 2006, the European Court of Human Rights ruled in favour of a man living with HIV who had been arrested in Moscow on charges of drug trafficking. The defendant was suffering from mental illness and several chronic diseases at the time of his arrest. He claimed that he had not received adequate medical treatment in the remand prison, and that the conditions of his detention had been inhumane and degrading. The Court ruled that the failure to provide timely medical assistance to the prisoner—and the refusal to allow him an independent medical examination—amounted to degrading treatment. The European Court of Human Rights awarded the applicant €12 000 for damages and Rub 105 000 (approximately €3133 at the time) for costs and expenses *(122)*. Unlike the UN treaty bodies, the European Court of Human Rights decisions have the advantage of being enforceable at the country level. More recently, the Court found breaches of the rights to privacy and nondiscrimination where medical staff have disclosed a patient’s HIV status to national newspapers, where migrants were subject to mandatory testing and where visas and residence permits were refused for persons living with HIV *(123 –125)*.

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[11] The treaty bodies with the power to consider individual complaints are the UN Human Rights Committee, the UN Committee against Torture, the UN Committee on the Elimination of Racial Discrimination, the UN Committee on the Elimination of Discrimination against Women, the UN Committee on Migrant Workers, the UN Committee on the Rights of Persons with Disabilities, the UN Committee on the Rights of the Child, the UN Committee on Economic, Social and Cultural Rights and the UN Committee on Enforced Disappearances.

"In 2006, the South African High Court ruled that the Government had failed to take sufficient measures to ensure access to antiretroviral therapy for prisoners living with HIV and ordered the provision of treatment with immediate effect."

Outside the international human rights system, the UNAIDS Global AIDS Monitoring system measures progress against international commitments and targets made within United Nations General Assembly declarations on the global AIDS response. United Nations Member States report against a standard set of indicators that measure the state of the epidemic, the coverage of services, the levels of stigma and discrimination, the scope of antidiscrimination efforts, the extent of public participation in the national AIDS response, and the availability of accountability mechanisms and barriers to accessing them *(126)*.

Judicial and administrative accountability

Where protective laws and policies are in place, groups and individuals can use the judicial system to ensure that their legal rights are respected, implemented and enforced. Depending on the laws or legal framework, courts and tribunals can be used to challenge the decisions and actions of public bodies and organizations—including the police, hospitals, schools or health boards—or of individuals.

For example, the Treatment Action Campaign (TAC)—a coalition of South African nongovernmental organizations campaigning for equitable and affordable access to HIV treatment—brought a rights-based legal challenge against the South African Ministry of Health in 2001. The challenge sought to overturn the government's unwillingness to extend the provision of nevirapine, a medicine proven to be effective in preventing mother-to-child transmission of HIV. At the time, women living with HIV in South Africa could not receive nevirapine unless they were able to afford private health care or access the restricted number of sites at which it was available *(127)*. The Constitutional Court of South Africa ruled in favour of TAC, holding that the government had not met its constitutional obligations and that its policy discriminated against disadvantaged people who could not afford to pay for health services. The government was required to expand nevirapine access, which it did; it also devised a national rights-based policy on the prevention of mother-to-child transmission *(128)*. In 2006, the South African High Court also ruled that the South African Government and others had failed to take sufficient measures to ensure access to antiretroviral therapy for prisoners living with HIV, and it ordered them to provide treatment with immediate effect to all prisoners who met the National Department of Health's criteria for treatment need *(129)*.

Governments can also be held accountable in court for failing to prevent rights violations, such as denial of health care by health-service providers or abuse or discrimination in health care. In Kenya, the Center for Reproductive Rights claimed in court that the Kenya Ministry of Health was responsible for discrimination and abuse experienced by women in public maternity hospitals. In 2015, the High Court of Kenya ordered the Ministry of Health to end such discrimination and to provide financial compensation to two women who were unlawfully detained and subjected to physical, mental and verbal abuse at a maternity hospital because they could not pay their hospital fees. The High Court noted that the women experienced numerous human rights violations, including the right to liberty and dignity, and that they were discriminated against on the basis of socioeconomic status and gender *(130)*.

The role of national human rights institutions

National human rights institutions—independent domestic bodies or mechanisms that promote and protect human rights—can advise governments on the implementation of international human rights obligations, recommend law reform, carry out investigations into human rights abuses, handle complaints and educate the public on their human rights.

In Argentina, the National Institute against Discrimination, Racism and Xenophobia (INADI) collects data on experiences of discrimination on the basis of HIV status, sexual orientation, gender identity, socioeconomic status, skin colour and other characteristics *(131)*. INADI then produces a discrimination map that inform efforts to eliminate discrimination *(131)*.

In Ghana, the Commission on Human Rights and Administrative Justice uses a multiplatform reporting mechanism. Individuals can report violations of their human rights, including discrimination, through text message, a dedicated website or in person, all while remaining anonymous *(132)*. Reports are followed up through a process of mediation, investigation and adjudication with the support of human rights organizations and legal representatives, often on a pro bono basis *(133)*.

Similar oversight and investigatory powers may be held by other national positions or organizations, such as ombudsmen, commissions and commissioners. In Peru, the Office of the Public Defender of Peru (Ombudsman) published a report in 2016 on violations of the rights of LGBTI people that called for a number of legislative changes, particularly regarding HIV and discrimination *(134)*.

Ensuring justice is accessible and enforceable

There are often significant barriers to accessing judicial and human rights systems. Court cases can be expensive, time-consuming and inaccessible, not to mention public, which may deter those who fear the stigma and discrimination that can result from disclosure of HIV-positive status or a risk behaviour, such as engaging in sex work. The law also can be complex at both the local and international levels, judges and enforcement personnel may themselves hold prejudicial views, individuals may not know their rights, and legal representation is often unavailable or unaffordable *(135)*. For people living with HIV and their advocates, there are a number of key concerns relating to access to justice and effective adjudication. These include include court procedures that do not maintain confidentiality, a judiciary that has limited knowledge of HIV and legal issues around HIV, and the court's lack of sensitivity to people living with HIV *(135)*.

Such concerns prompted Kenya to establish the world's only HIV-specific statutory body: the HIV and AIDS Tribunal. Established under Section 25 of Kenya's HIV Prevention and Control Act of 2006, the Tribunal has a mandate to adjudicate cases relating to violations of HIV-related human rights. Although limited research has been conducted to assess its effectiveness, there is evidence that the Tribunal is now achieving this mandate by addressing barriers to access to justice and ensuring swift rulings and the purposeful application of the law *(135)*.

In several countries, community advisory boards have given people greater opportunity to communicate grievances and seek legal redress. In Swaziland, people can report human rights violations related to health access through a toll-free line and suggestion boxes placed at facilities; the reports are submitted to the Ministry of Health to help improve access to health *(136)*. In Kazakhstan and Ukraine, people affected by discrimination are able to meet with health authorities and participate meaningfully through community advisory boards *(137)*.

In Nepal, a toolkit to empower women affected by HIV to protect their rights in sexual and reproductive health-care settings has been developed for use by networks, community-based organizations, nongovernmental organizations and international organizations working with women affected by HIV. The toolkit provides information on individual rights, ways of accessing justice if rights are violated and methods of mobilizing communities to engage with health-care service providers and improve transparency and accountability *(138)*.

National and regional human rights organizations also are involved in rights education. The National Human Rights Commission in Mexico has produced educational material related to HIV, human rights and discrimination *(139)*. In South Asia, a coalition of community-based organizations, United Nations partners and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) recently issued an advocacy brief for activists and LGBTI communities. The brief provides instructions on how to report human rights violations faced by LGBTI people to national human rights institutions in the region *(140)*.

Accessible and affordable legal representation is critical to accessing judicial systems. Legal access programmes that combine health services and legal aid have proven particularly effective. In Kenya, several nongovernmental organizations have integrated legal services into health care. Some examples of this include placing a paralegal or other legal service provider in a health clinic or training health-care providers to identify rights violations, give clients information on the law and provide referrals for legal assistance and other services alongside their health-care duties. An evaluation of these programmes found that trained health workers could assist their patients with legal documents and accessing appropriate legal services, including alternative dispute resolution; this, in turn, resulted in redress and a sense of justice *(141)*. The evaluation also found that health worker referrals improved client access to government authorities, additional health services and assistance for dealing with other problems underlying poor health. Finally, clients of health clinics with integrated legal services showed an increase in practical knowledge on how to access other legal aid *(141)*.

“iMonitor+ enables users to receive or send health-care information on things such as stock-outs, HIV treatment complications or positive and negative experiences at health facilities.”

In Indonesia, a community legal aid institute and networks of sex workers and people who use drugs have worked together to pilot or expand legal aid services for the populations that they serve. The institute supplies peer-led legal education and assistance to overcome stigma; it also provides paralegal support and support to lawyers who represent people who use drugs *(133, 142)*. 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 *(143)*.

Digital and Internet technology can provide valuable support for increasing access to justice. A Ugandan legal aid start-up, Barefoot Law, provides legal consultations via social media; meanwhile, in Ukraine, community legal centres are using online platforms to provide virtual advice to clients *(144, 145)*.

Social accountability: the power of communities

Community-based organizations play an essential role in efforts to document rights violations and the nonenforcement of protective laws. At the same time, community-based organizations help build a stronger and more resilient civil society that can better advocate for the rights of marginalized groups.

Community efforts to monitor the delivery of health care, such as the use of community scorecards, have been shown to improve health clinic utilization and health outcomes in India and Uganda *(146)*. Using mobile and Internet technology and social media provides an opportunity to reach a large number of people for monitoring, accountability, advocacy and outreach. One example is iMonitor+, which is based on an app for smartphones. iMonitor+ enables users to receive or send health-care information on things such as stock-outs, HIV treatment complications or positive and negative experiences at health facilities. Users also receive information on where to access services, and they are linked to other support mechanisms. iMonitor+ was developed in collaboration with civil society organizations, and it has been used in Botswana, Kenya, Indonesia, the Philippines, South Africa and Thailand *(147)*.

Similarly, the National Association of People Living with HIV and AIDS in Malawi has initiated, with UNAIDS support, a programme to enable people living with HIV to send free text messages to report discrimination, drug stock-outs and difficulties accessing services *(148)*. In Burundi, Côte d’Ivoire, Haiti and Malawi, text messaging is also being used to monitor the quality of health services. Peer outreach workers send messages to members of key populations asking questions about care they have recently received (including experiences of stigma and discrimination based on HIV status), while health-care workers can complete short SMS surveys on a regular basis to assess their personal performance and that of their facility *(149)*.

It is time to end discrimination in health

There is growing recognition that gaps across the cascade of HIV prevention, testing and treatment services are fuelled by stigma and discrimination faced by people living with HIV and people at high risk of HIV infection. Among the 36.7 million [30.8 million–42.9 million] people living with HIV globally at the end of 2016, an estimated 11.2 million were unaware of their HIV-positive status, another 6.0 million who knew of their infection were not accessing antiretroviral therapy, and another 3.6 million on treatment were not virally suppressed *(150)*. Meanwhile, new HIV infections among adolescents and adults have been declining far too slowly: more than 1.8 million new infections still occur every year worldwide *(151)*.

The evidence compiled in this report shows that equal access to health services can be achieved through the establishment of people-centred service delivery models, supportive legal and policy frameworks, monitoring and enforcement mechanisms, and sensitization training of health-care workers and other duty bearers.

The time to expand and build on these approaches is now. The science and the tools are available, and international treaties and the Agenda for Sustainable Development provide an international framework for addressing intersectional discrimination. Individuals, communities and governments will need to work together and invest time, money and other resources across sectors. Above all, people living with HIV and members of key populations must be engaged in discrimination reduction and the planning and implementation of health services, and they must be able to contribute to all aspects of the process.

The 2030 Agenda for Sustainable Development has been reinforced by numerous commitments and initiatives by the international community, from the 2016 United Nations Political Declaration on Ending AIDS, which includes a call for countries to eliminate HIV-related stigma and discrimination, to UNAIDS and WHO's Agenda for Zero Discrimination in Health-care Settings. UNAIDS developed its 2016–2017 strategy with a clear commitment to eliminate discrimination in health care, and WHO launched a campaign in the Middle East and North Africa to end discrimination and stigma in health care for people living with HIV *(152–155)*. In 2017, the Global Fund committed funds specifically to remove human rights barriers to HIV services and invest in reducing health inequalities *(156)*. Also in 2017, the United Nations released a joint statement from 12 agencies calling for law reform to remove punitive laws proven to have negative health outcomes, to strengthen legal protections against discrimination, to end discrimination in health care and education of health workers and those using health services on rights and to honour responsibilities in relation to discrimination in health care *(157)*.

The evidence shows what needs to be done to meet those commitments and eliminate discrimination: strong laws and policies must be in place, complemented by the rule of law and health-care workers, police and judges who are educated and aware of people's rights. People and governments must be held to account by empowered and supported communities through the use of the courts, administrative bodies and the United Nations. Engaged and empowered communities can monitor health services, improve service delivery and help to address complaints. When national and local governments put these measures in place, the global pledge of leaving no one behind can be realized, removing significant barriers to achieving the global target of ending AIDS as a public health threat.

> ***"Closing gaps in service coverage requires the empowerment of populations that are often left behind: women and girls, young people, key populations and people living with HIV. All national AIDS programmes require a strong community empowerment element and specific efforts to address legal and policy barriers."***

Reinvigorating the AIDS response to catalyse sustainable development and United Nations reform
Report of the Secretary-General
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