

# **REPORT BY THE NGO REPRESENTATIVE**

## **Left Out: The HIV Community and Societal Enablers in the HIV response**

**Additional documents for this item:** *none*

**Action required at this meeting—the Programme Coordinating Board is invited to:**

See draft decision points in the paragraphs below:

115. *Recalls* the 45<sup>th</sup> Programme Coordinating Board decisions 4.1 to 4.4 under agenda item 1.4: Report by the NGO Representative on the essential need to address economic, social, structural, and regulatory barriers that prevent access to comprehensive HIV services and health-related programs
116. *Recalls* the commitments from the 2021 Political Declaration on HIV/AIDS to ensure that by 2025 community-led organisations deliver: 30% of testing and treatment services; 80% of HIV prevention services; and 60% of programmes to support the achievement of societal enablers and to expand investment in societal enablers – including protection of human rights, reduction of stigma and discrimination and law reform;
117. *Takes note* of the Report by the NGO Representative;
118. In order to reach the 10-10-10 societal enabler targets by 2025, *calls on* Member States to:
  - a. Increase investments in and scale up programmes related to societal enablers that have been proven to work, including programmes to reduce HIV-related stigma and discrimination and to increase access to justice; to train health care workers and law enforcement officials on HIV and access to services for key populations; and to eliminate gender based violence and empower women and girls in all their diversity;
  - b. Partner with civil society and community-led organizations to deliver programmes on societal enablers, and gradually increase the proportion of such programmes delivered by communities to reach the target of 60 percent of programmes to support the achievement of societal enablers are delivered by communities;
  - c. Ensure unimpeded access to education, employment and healthcare for people living with HIV, key populations and other vulnerable groups such as women and girls, adolescents and young people, and migrants who are disproportionately affected by HIV;
119. In order to reach the 10/10/10 targets by 2025, *calls on* the Joint Programme to:
  - a. Harmonize existing Joint Programme and Cosponsor policies and guidance to support scaling up of programmes on societal enablers;
  - b. Advocate for laws and policies that protect the rights and health of all;
  - c. Support countries to ensure that indicators for societal enablers are integrated into national M&E systems and routinely monitored, including through community-led monitoring; and
  - d. Support countries and communities to ensure that, by 2025, 60 percent of programmes to support the achievement of societal enablers are delivered by communities.

**Cost implications for the implementation of the decisions:** *none*

## Table of Contents

<b>ACRONYMS AND ABBREVIATIONS .....</b>	<b>4</b>
<b>EXECUTIVE SUMMARY .....</b>	<b>5</b>
<b>INTRODUCTION .....</b>	<b>6</b>
<b>DESCRIPTION OF METHODOLOGY .....</b>	<b>8</b>
<b>THE IMPORTANCE OF SOCIETAL ENABLERS IN THE GLOBAL HIV RESPONSE .....</b>	<b>8</b>
<b>The impact of societal enablers on education to prevent HIV .....</b>	<b>11</b>
<b>Societal enablers to eliminate employment-related stigma and discrimination .....</b>	<b>14</b>
<b>Societal enablers to improve healthcare access and outcomes.....</b>	<b>15</b>
<b>Changing laws and policies to accelerate progress towards ending AIDS.....</b>	<b>16</b>
<b>COMMUNITY-LED ACTION TO SCALE UP SOCIETAL ENABLERS .....</b>	<b>21</b>
<b>THE CRITICAL ROLE OF COMMUNITY-LED SERVICES.....</b>	<b>23</b>
<b>THE ROLE OF THE JOINT PROGRAMME IN SCALING UP SOCIETAL ENABLERS .....</b>	<b>26</b>
<b>CONCLUSIONS .....</b>	<b>28</b>
<b>RECOMMENDATIONS.....</b>	<b>29</b>
<b>PROPOSED DECISION POINTS FOR THE 49TH MEETING OF THE UNAIDS PCB .....</b>	<b>30</b>
<b>ANNEXES .....</b>	<b>31</b>

## ACRONYMS AND ABBREVIATIONS

**AIDS:** Acquired immunodeficiency syndrome  
**ART:** Antiretroviral therapy  
**CAYPLHIV:** Children, adolescents, and young people living with HIV  
**CSE:** Comprehensive sexuality education  
**ECOSOC:** United Nations Economic and Social Council  
**ESF:** World Bank Environmental and Social Framework  
**GIPA:** Greater Involvement of People Living with HIV  
**GBV:** Gender-based violence  
**Global Fund:** Global Fund to Fight AIDS, Tuberculosis and Malaria  
**Global Partnership:** Global Partnership for Action to Eliminate all Forms of HIV-Related Stigma and Discrimination  
**GNP+:** Global Network of People Living with HIV  
**HAV:** Hepatitis A virus  
**HBV:** Hepatitis B virus  
**HIV:** Human immunodeficiency virus  
**HPV:** Human papillomavirus  
**ILO:** International Labour Organization  
**INPUD:** International Network of People Who Use Drugs  
**LAC:** Latin America and the Caribbean  
**MSM:** Men who have sex with men  
**MTCT:** Mother-to-child transmission  
**NGO:** Nongovernmental organization  
**NSWP:** Global Network of Sex Work Projects  
**PEPFAR:** U.S. President's Emergency Plan for AIDS Relief  
**PCB:** Programme Coordinating Board  
**PLHIV:** People Living With HIV  
**PEP:** Post-exposure prophylaxis  
**PrEP:** Pre-exposure prophylaxis  
**SDGs:** UN Sustainable Development Goals  
**SRH:** Sexual and reproductive health  
**SRHR:** Sexual and reproductive health and rights  
**STI:** Sexually transmitted infections  
**UBRAF:** Unified Budget, Results and Accountability Framework  
**UN:** United Nations  
**UNAIDS:** Joint United Nations Programme on HIV and AIDS  
**UNDP:** United Nations Development Programme  
**UNESCO:** United Nations Educational, Scientific and Cultural Organization  
**UNFPA:** United Nations Population Fund  
**UNGA:** United Nations General Assembly  
**WHO:** World Health Organization  
**Y+:** Global Network of Young People Living with HIV

## EXECUTIVE SUMMARY

1. The Global AIDS Strategy recognizes that HIV services, while critical to hopes for ending AIDS as a public health threat, will on their own not be sufficient to reach the 2030 target without concerted efforts to address the social and structural factors that increase HIV vulnerability and diminish the ability of marginalized populations to access essential services. The Strategy's 10-10-10 targets, endorsed as well in the 2021 Political Declaration on HIV and AIDS: Ending Inequalities and Getting on Track to End AIDS by 2030, call for unprecedented action to eliminate punitive legal and policy frameworks, eliminate stigma and discrimination and ensure gender equality and lives free of violence.
2. The persistence of punitive laws, stigma and discrimination, gender inequalities and violence prevent HIV responses from leveraging proven strategies to reduce HIV vulnerability and increase equitable service access. For example, access to education, shown to contribute to HIV prevention and the empowerment of women and girls, is undermined by unequal gender norms, transphobia, homophobia, bullying and violence. Barriers to education prevent many young people from receiving comprehensive sexuality education, an essential pillar of combination HIV prevention.
3. Although stable employment buttresses HIV responses by reducing HIV vulnerability and improving health outcomes for people living with HIV, many people living with or affected by HIV are denied employment due to stigma and discrimination, with especially dire consequences for key populations. Intersectional forms of stigma, discrimination, marginalization and inequalities block healthcare access for many people living with or affected by HIV or deter individuals from seeking the health services they need. The COVID-19 pandemic has in many instances worsened inequalities and deepened the impact of social and structural barriers.
4. Laws and policies often impede effective HIV responses. These include punitive laws that criminalize drug use, same-sex sexual relations and sex work, as well as those that authorize criminal penalties for HIV exposure, non-disclosure or transmission. In many countries, laws restrict the ability of young people under age 18 years to access comprehensive sexual and reproductive health services. Where counterproductive laws and policies have been removed, evidence clearly shows that HIV responses have been strengthened.
5. Communities play a central, yet badly under-resourced, role in efforts to achieve the 10-10-10 targets for societal enablers. Countries advocate for policy change, take action to reduce stigma and discrimination, monitor and respond to human rights violations, promote community solidarity and resilience and undertake programmes to prevent violence and change harmful gender norms. Community-led service delivery also helps ensure service access for the key and vulnerable populations that are most heavily affected by societal barriers. Although the Global AIDS Strategy envisages that at least 60% of programmes to support achievement of the 10-10-10 targets will be delivered by community-led organizations, community-led efforts are

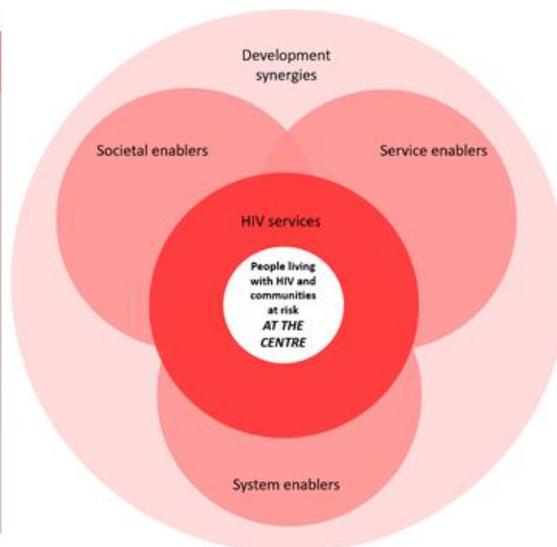
undermined by inadequate and inconsistent funding and by all-too-common political, cultural and religious resistance in their home countries.

6. To end AIDS as a public health threat by 2030, urgent action is needed to fully leverage societal enablers, including intensified advocacy for the removal of harmful laws and policies and actions to ensure unimpeded access to education, employment and healthcare opportunities for people living with HIV, key populations and other vulnerable groups. Substantially stronger efforts are required to eliminate stigma and discrimination. The magnitude and consistency of funding for community-led efforts on societal enablers and service delivery must markedly increase, and data must be more rigorously and strategically used to guide scale-up of societal enablers. The Joint Programme is a pivotal actor in efforts to reach the 10-10-10 targets, underscoring the need for robust, predictable funding for UNAIDS and for the Joint Programme to fully leverage its core strengths and comparative advantages.

## INTRODUCTION

7. Every year, the NGO Delegation prepares a report to the UNAIDS Programme Coordinating Board (PCB) on issues that are of urgent concern to communities and civil society. This annual report of the NGO delegation, presented at the 49<sup>th</sup> PCB meeting, focuses on the imperative to scale up societal enablers to accelerate progress towards ending the AIDS epidemic as a public health threat by 2030, as pledged in the Sustainable Development Goals.
8. The Global AIDS Strategy, endorsed by the PCB at a special meeting in March 2021, as well as the 2021 Political Declaration on HIV and AIDS: Ending Inequalities and Getting on Track to End AIDS by 2030, adopted by the United Nations General Assembly in June 2021, include specific, ambitious targets on societal enablers. These targets provide that by 2025:
  - Less than 10% of countries have punitive legal and policy environments that deny or limit access to services;
  - Less than 10% of people living with HIV and key populations experience stigma and discrimination; and
  - Less than 10% of women, girls, people living with HIV and key populations experience gender inequality and violence.
9. The 10-10-10 targets recognize that HIV services, while essential, are unable on their own to bring an end to AIDS as a public health threat, so long as social and structural factors diminish the ability of people to access and remain engaged in services. Complementing biomedical interventions with a greater focus on societal enablers is critical to hopes for achieving the 2030 goal.
10. Furthermore, the 2021 Political Declaration on HIV/AIDS call for the expansion of investment in societal enablers – including protection of human rights, reduction of stigma and discrimination and law reform, where appropriate – in low and middle-income countries to 3.1 billion United States dollars by 2025.
11. The 2020 World AIDS (WAD) report provides useful examples on enablers in the AIDS response illustrated as follows:

<b>HIV services</b>	Services proven to prevent HIV infections or AIDS-related mortality.
<b>Enablers</b>	<p>A law, system or action that positively modifies the effectiveness of an HIV service.</p> <ul style="list-style-type: none"> <li>• <b>Societal enablers</b> include supportive laws and policies, and societies that respect gender equality and do not discriminate against PLHIV and key populations.</li> <li>• <b>Service enablers</b> include the linkage or integration of services, differentiated service delivery, community-led services and anti-stigma training for health workers and police.</li> <li>• <b>System enablers</b> include infrastructure, strategic planning, budgeting and management systems, monitoring and evaluation systems and communications systems.</li> </ul>
<b>Development synergies</b>	Broader efforts in different sectors that advance the results of the HIV response. Examples include efforts to end poverty and fulfil the right to health and other human rights.



12. Building on the examples on societal enablers presented in the 2020 WAD report and those in the Global AIDS Strategy 2021-2016 and the 2021 Political Declaration as well as during consultations led by civil society organisations on the topic, this report examines the different elements that can be considered as societal enablers based on real life experiences from people living with HIV, key populations and other vulnerable groups in countries across different regions of the world.
13. Societal enablers have a pivotal role to play in ending the HIV-related inequalities that continue to drive the epidemic, especially affected key and vulnerable populations. UNAIDS considers gay men and other men who have sex with men, sex workers, transgender people, people who use drugs, and prisoners and other incarcerated people as the five main key population groups that are particularly vulnerable to HIV and frequently lack adequate access to services.<sup>i</sup> People living with HIV and other vulnerable groups - such as women and girls, adolescents and young people, and migrants (including people in conflict zones and in humanitarian settings) - continue to face unique HIV-related barriers and challenges.
14. A core finding of this report is that communities know what they need and what HIV services are best for them. The HIV epidemic cannot be ended unless those who are most affected, namely key populations and other vulnerable groups, are fully included in every step of the epidemic response. Communities have a vital role to play not only in addressing societal enablers but also in delivering essential services to marginalized, stigmatized communities that are often not well served by mainstream service systems. This report highlights the voices of diverse communities affected by HIV.
15. After describing how the NGO delegation went about analyzing the critical role of societal enablers, the report focuses on how societal enablers can maximize the benefits of education, employment, healthcare and laws and policies in reducing HIV vulnerability and enhancing service access and outcomes. The report presents illustrative examples to highlight how community-led efforts on societal enablers, including those funded by national governments and by international donors, are critical to an effective HIV response. Steps by community-led responses to create tailored, people-centred services for populations that experience stigma, discrimination, gender inequality and violence are also highlighted. The report examines persistent impediments to community-led efforts to scale up societal enablers, including but not limited to insufficient funding. The examples used in this

report to highlight the importance of working on societal enablers in the HIV response are drawn from case studies, information collected during key informant interviews, and from an online survey in three languages.

## DESCRIPTION OF METHODOLOGY

16. The NGO Delegation produced the NGO Report 2021 by using a combination of methodologies:
  - 16.1. *Literature review*: The NGO Delegation reviewed a range of sources including UNAIDS and UN publications, resources produced by community-led groups, academic journal articles, reports, policy briefs, policy documents and other sources.
  - 16.2. *Key informant interviews*: Semi-structured interviews were conducted via Zoom with 15 individuals with experience and expertise working on societal enablers in the HIV response. The interviewees included eight community activists representing people living with HIV, key populations, and other vulnerable groups; six staff members from UNAIDS Cosponsors; and one staff member from another UN agency (see Annex I for the full list of interviewees, their country/region, and their affiliated organization). Several quotes throughout this report are taken from the key informant interviews.
  - 16.3. *Case studies*: Case studies - from both the Global South and developed countries - demonstrate how societal enablers have made the HIV response more effective and sustainable. The case studies examine how HIV-affected communities worked to bring about necessary changes that improved the quality of their lives.
  - 16.4. *Survey*: An online survey in English, Russian and Spanish was disseminated to community stakeholders with experience in HIV issues and familiarity with the NGO Delegation. A total of 131 responses were received and several quotes throughout this report are taken from the survey (see Annex 2 for a breakdown of the respondents by region).
  - 16.5. *Internal review process*: Multiple draft texts of the NGO Report 2021 were reviewed by serving members of the NGO Delegation, as well as experts on the topic from the UNAIDS Secretariat.

## THE IMPORTANCE OF SOCIETAL ENABLERS IN THE GLOBAL HIV RESPONSE

17. The new UNAIDS Global AIDS Strategy 2021–2026 (the Strategy) focuses on inequality as a primary driver of the epidemic, including in regions and countries where new HIV infections are increasing.<sup>ii</sup> The Strategy calls for an investment of US\$3.1 billion over five years towards societal enablers to combat inequality and to end HIV as a public health threat by 2030. It calls for these investments to be co-financed by the HIV response and non-health sectors and to be focused on creating favourable legislative and policy environments.
18. The 10-10-10 targets explicitly prioritize societal enablers as a central pillar of the HIV response. By endorsing the role of societal enablers in the HIV response, the Strategy acknowledges that HIV treatment and other biomedical interventions are critical but not sufficient on their own to achieve epidemic control. The interrelated HIV epidemic, trauma, incarceration and poverty interact with each other and with social, structural, and behavioural factors to contribute to an excess burden of disease among socially marginalized groups. Stigma, prejudice and discrimination

create a hostile and stressful social environment that operates as a profound disincentive to seek essential health services.<sup>iii</sup> Without societal enablers, the communities most affected by HIV - who are often also the communities that are the most stigmatized and marginalized - will remain invisible and unable to access the services they need. Such an outcome, in which the most affected populations cannot access services to reduce HIV risk and prevalence, would make ending AIDS as a public health threat by 2030 unachievable.

19. In the 2021 Political Declaration, the UN General Assembly welcomed efforts by countries to fully leverage societal enablers, including enabling laws and policies, public education campaigns, and anti-stigma training for healthcare providers and law enforcement officers. It also welcomed efforts to empower women and girls to engage in their sexual and reproductive health and rights to end the marginalization of people living with HIV and at higher risk of HIV infection.
20. The Strategy's explicit and unwavering commitment to ending inequalities in the HIV response through a focus on disparities, on societal enablers, and on key populations and other vulnerable groups is welcome news for communities that are disproportionately ravaged by the HIV epidemic. In 2020, key populations and their sexual partners accounted for 65% of all new HIV infections globally, including 93% of all new HIV infections outside of sub-Saharan Africa. In every region except eastern and southern Africa, key populations and their partners account for the majority of new HIV infections. The burden on key populations is stark: compared to the general population, the risk of acquiring HIV is 35 times higher among people who inject drugs, 34 times higher for transgender women, 26 times higher for female sex workers, and 25 times higher among MSM.<sup>iv</sup>
21. Societal enablers help address underlying causes of inequities in education, employment, social protection, healthcare and other areas. Many of these inequities - which lead to higher HIV risk for marginalized communities and undermine robust service access - have been exacerbated by the ongoing COVID-19 pandemic.<sup>v</sup>
22. Stigma and discrimination against marginalized and vulnerable communities can be a major barrier to service access. Societal enablers improve service access by empowering individuals and helping them overcome social mores and policies that restrict their livelihoods. This is especially important today as the ongoing COVID-19 pandemic has worsened socioeconomic disparities and imposed additional obstacles in the 40-year fight against HIV. Societal enablers strengthen the HIV response by tackling key cross-cutting issues, including human rights, the right to health, political will and commitment to social change and investments in communities.
23. Societal enablers enhance the HIV response in practical ways. For instance, anti-discrimination laws (that cover HIV status, drug use, sex work, gender identity, and sexual orientation) that allow people to enjoy their lives more fully and without fear (laws and policies). At this pivotal moment in the HIV response – when progress towards global targets has slowed and HIV funding has flattened, but also when a new Global AIDS Strategy outlines a roadmap for overcoming these challenges – societal enablers urgently need to be brought to scale in order to achieve optimal impact.
24. If we hope to scale-up societal enablers, communities must lead the way. Community-led services are central, now more than ever, to the global HIV response but communities are increasingly encountering restrictions from governments on their ability to work on human rights, organize and fundraise.<sup>vi</sup>

25. Community members representing people living with HIV, key populations and other vulnerable groups who were interviewed for this report or who responded to the online survey overwhelmingly agreed that societal enablers should be a central part of the global HIV response. When asked to rank the four main societal enablers covered in this report in terms of importance, access to healthcare and supportive laws and policies were considered the most important by a majority of respondents, followed by access to education and employment opportunities.
26. The Joint Programme has recognized the importance of societal enablers in supporting people living with HIV and key populations and other vulnerable communities to survive and thrive. For example, the World Bank takes into account gender equality and ending gender-based violence by using an Environmental and Social Framework (ESF) as part of safeguard procedures during its lending process. The ESF includes a gender marker to ensure that women, girls, and sexual and gender minorities are not excluded from programs funded by the Bank. Additionally, contractors engaging in gender-based violence or in sexual exploitation, abuse and harassment are identified and not hired for future Bank projects.
27. This report will next examine the impact of societal enablers in facilitating access to and fully leveraging education, employment, healthcare, and supportive laws and policies. By scaling up societal enablers, we can ensure that people living with HIV, key populations and other vulnerable groups access the means and tools of HIV prevention and treatment, as well as other services they need to ensure their survival, health and well-being.

*"HIV epidemic control will not be achieved without involving key populations and other vulnerable groups in every facet of the HIV response." - Justin Chidozie Chukwukere, Executive Director, Center for Health Education and Vulnerable Support, Nigeria*

*"Societal enablers help key populations and other vulnerable groups gain autonomy and make better decisions. It allows these marginalized groups to get more protection from violence and stigma." - Cecilia Chung, Director of Evaluation and Strategic Initiatives, Transgender Law Center, U.S.A.*

*"Human rights and access to health are intertwined, and the causal relationship between human rights violations and vulnerability to HIV are well evidenced. Social determinants of health such as stigma, poverty, criminalisation, legal oppression and gender inequality, negatively impact on sex workers' health, including increased vulnerability to HIV. Criminalisation of sex work, including the criminalisation of clients and third parties, fuels and fosters human rights violations and discrimination, reducing sex workers' access to HIV prevention, treatment and care."  
- Ruth Morgan Thomas, Global Coordinator, NSWP*

*"My country lacks non-discrimination legislation, it criminalizes same-sex intimacy, sex work, and abortion, does not have a human rights institution, and does not fully implement comprehensive sexuality education in schools. These gaps have a detrimental effect on the HIV response. For example, due to stigma and discrimination, people living with HIV must travel from one location to another to receive their treatment for fear of being exposed in their communities. This imposes increased transportation costs, creates stress, and leads to high risk of loss to follow-up and adherence." - Anonymous, Latin America and the Caribbean*

*"Around the world, LGBTI people must confront discrimination and violence because of the lack of social protections. Government investment in the lives of LGBTI people benefits everyone and is a demonstration of a commitment to fundamental human rights." - Alex Garner, Director of Community Engagement, MPact Global Action for Gay Men's Health and Rights*

*“Societal enablers are essential for key populations and other vulnerable groups to be able to live full and productive lives.” - Tim Sladden, Technical Advisor, United Nations Population Fund*

### **The impact of societal enablers on education to prevent HIV**

28. Multiple studies have demonstrated that education is one of the best ways to prevent new HIV infections. Adolescents and young people with higher levels of education have greater knowledge about HIV prevention methods and risk factors. A study in a country in southern Africa showed that just an additional year of education reduced the chances of acquiring HIV by 7%.<sup>vii</sup>
29. Higher levels of education have also been directly linked to declining HIV rates. A study in a country in East Africa found that a sharp rise in secondary school enrollment of girls led to a significant decline in the number of new HIV diagnoses. The increase in schooling among young women came about because of an affirmative action policy in 1990 that prioritized women for university admissions. The subsequent reduction in HIV cases in the country was rapid as prevalence fell from about 15% of the population in 1990 to just 5% by 2007.<sup>viii</sup>
30. HIV-related stigma has been shown to restrict access to education and subsequent employment, fueling disparities caused by poverty.<sup>ix</sup> Homophobia<sup>x</sup> and transphobia<sup>xi</sup> have long undermined the educational potential and attainment of sexual and gender minority adolescents and young people. Bullying and violence targeting sexual and gender minority adolescents and young people are associated with increased suicidality<sup>xii</sup> and increased vulnerability to HIV.<sup>xiii</sup> Stigma associated with HIV places young people living with HIV at a disadvantage in terms of educational outcomes, enrollment, attendance, performance, and completing their education.<sup>xiv</sup> Ensuring equitable and violence- and bullying-free educational environments is critical to ensuring that learners with HIV or at risk of HIV are not denied education which is crucial to future economic and social opportunities.
31. Unequal gender norms also block many girls and young women from obtaining education. Worldwide, 129 million girls are not in school.<sup>xv</sup> Only 42% of countries have attained gender parity in lower secondary education, and only 24% report gender parity in upper secondary education. Overlapping factors explain these gender disparities in educational attainment, including early marriage and/or pregnancy, gender-based violence and the fact that women and girls account for a disproportionate share of caregiving.
32. Broader efforts to eliminate stigma, discrimination and gender inequalities are needed to establish an environment that promotes school attendance for adolescent and young people. In addition, focused initiatives play a role in addressing the needs of adolescent and young school students who are living with or affected by HIV. For example, the Global Network of Young People Living with HIV (Y+) and the Global Network of People Living with HIV (GNP+) have teamed up with the United Nations Educational, Scientific and Cultural Organization (UNESCO) to support people living with HIV in schools.
33. UNESCO has also helped member states establish anti-gender-based-violence and anti-bullying programmes in schools. UNESCO and the United Nations Population Fund (UNFPA) launched a programme for comprehensive sexuality education in dozens of countries in sub-Saharan Africa to reduce stigma and discrimination and

address the needs of adolescents and young people from key populations and other vulnerable groups.

34. Creative methods to increase participation of adolescents and young people in formal and informal education should be explored. In a country in southern Africa, cash transfers linked to girls' school attendance resulted in an approximately 61% reduction in HIV risk and a 62% increase in school attendance.<sup>xvi</sup> These programmes provide cash to meet basic needs, reducing the need to turn to transactional sex and decreasing financial dependence on male sex partners. Young women involved in the personal financial education and business development aspects of cash transfer programmes may also feel empowered and financially secure enough to turn down sex partners, thus reducing their potential HIV risk.<sup>xvii</sup> Economic empowerment programs for adolescent girls and young women in sub-Saharan Africa are gaining traction as an effective strategy to reduce HIV risk and vulnerabilities.<sup>xviii</sup>

### **Comprehensive sexuality education and HIV prevention**

An important, independent reason to maximize school attendance is to increase the exposure of adolescents and young people to comprehensive sexuality education, a curriculum-based approach that addresses the broader sociocultural and gender influences on sexual and reproductive health and rights, with a specific focus on building life skills. Although schools are not the sole source of comprehensive sexuality education – and youth clubs, peer programmes and other community-based sites need to be optimized – schools play a key role in equipping adolescents and young people with the knowledge, attitudes and skills to support their health and wellbeing, regardless of gender, socioeconomic status, sexual orientation, or gender identity.

Comprehensive sexuality education (both within and outside school settings) is an essential component of combination HIV prevention. Indeed, a growing number of countries, including many in sub-Saharan Africa, have endorsed regional and international frameworks to address the sexual and reproductive health needs of adolescents and young people, including through the provision of comprehensive sexuality education.

However, many countries have not adopted all elements of comprehensive sexuality education. A study that reviewed the UNESCO and UNFPA-supported comprehensive sexuality education curriculum in 10 countries in eastern and southern Africa found that six had curricula with minor to moderate concerns while four had moderate to serious gaps. In the Asia-Pacific region, where more than 80 000 adolescents and young people are newly infected with HIV each year, implementation of comprehensive sexuality education has been uneven and inconsistent, with some countries allowing decentralised decisions on education by states and/or provinces, undermining the consistency and quality of comprehensive sexuality education delivery. Sociocultural norms can lead to resistance to implementation of comprehensive sexuality education, such as in one country in eastern Africa, which in 2016 banned comprehensive sexuality education programmes on the grounds that they encourage sexual immorality and weaken national and moral values. Some programmes that ostensibly aim to provide comprehensive sexuality education are of poor or uneven quality, omitting education on condoms or prioritizing abstinence, an approach that has been rejected as ineffective by medical and public health professionals.

Where countries have committed to implementation of robust, evidence-based comprehensive sexuality education, important benefits for the health and well-being of adolescents and young people have been achieved. In response to new HIV infections among adolescents and young people, high rates of teenage pregnancy and substantial stigma and discrimination against people living with HIV, Namibia incorporated comprehensive sexuality education in its life skills education curriculum, which is taught as a mandatory standalone subject. In Namibia, comprehensive sexuality education is also included in extracurricular activities such as the Galz and Goals project that engages girls in sports activities and uses football to empower girls aged 10-14 through education on life skills, HIV and health.

In response to concerns regarding the tendency of many young people to obtain erroneous information on sexual and reproductive health from the internet or traditional and family sources, Zambia committed in 2013 to include good-quality comprehensive sexuality education and youth-friendly sexual and reproductive health services for adolescent and young people. Zambia took a multisectoral approach involving the ministries of education, health, gender, youth, culture, sports, as well as NGOs and local and international partners to develop its comprehensive sexuality education programming. Policymakers, parents, adolescents and young people and other key groups were engaged in development of the curriculum, contributing to broader buy-in. The government's political will and commitment were crucial for successful integration and institutionalization of comprehensive sexuality education into the national education system.

*“Comprehensive sexuality education using a rights-based approach should be included in school curriculums so that people adopt a healthier attitude towards people living with HIV. Comprehensive sexuality education can also reduce infections and help curb the epidemic.” - Efraín Soria, Director, Fundación Ecuatoriana Equidad (Ecuadorian Equity Foundation),*

*“Political advocacy should be undertaken to include comprehensive sexuality education for all schools to reduce stigma and discrimination related to HIV and key populations.” - Fernando Cisneros Dávila, Development and Program Quality Coordinator, Save the Children, Peru*

*“Investing in the education of adolescents and youth, including young girls, yielded stunning results in reducing HIV cases.” - Kathy Ward, UNAIDS Focal Point, The World Bank*

### **Societal enablers to eliminate employment-related stigma and discrimination**

35. Unemployment is associated with increased risk behavior.<sup>xix</sup> Stable and rewarding employment reduces HIV vulnerability and contributes to HIV prevention by increasing access to material resources, reducing chronic stress, and increasing political power, thus helping improve health outcomes, social standing and health equity.<sup>xx</sup>
36. Employment also has clear benefits for people living with HIV. Unemployment is associated with delayed testing or diagnosis,<sup>xxi</sup> as well as reduced access to and engagement in care.<sup>xxii</sup> By contrast, employment is associated with better HIV medication adherence, while employment loss, on the other hand, is associated with persistent elevated viral load.<sup>xxiii</sup> Having stable employment also helps mitigate the epidemic’s impact, improving quality of life for people living with HIV and yielding physical and mental health benefits.<sup>xxiv</sup>
37. While broader economic and labour market conditions affect access to meaningful and sustained employment, punitive laws, stigma, discrimination and gender inequality also diminish employment opportunities for people living with HIV and key and vulnerable populations.<sup>xxv</sup> In the Dominican Republic, for example, 13% of people living with HIV report having been denied employment due to their HIV status.<sup>xxvi</sup> Compared to people who are not living with HIV, people living with HIV are less likely to have full-time jobs.<sup>xxvii</sup> HIV-related employment discrimination can come in multiple forms. As an example, asking for an employee’s HIV status or mandating HIV testing can dissuade a person living with HIV from applying for a job or from being able to secure a job, which in turn can contribute to impoverishment and health problems.
38. Key populations and other vulnerable groups who are at high risk from HIV may also face challenges in getting their work recognized as legitimate. For instance, sex workers in many countries are not recognized as legitimate employees who are entitled to government services (see case study from Kolkata, India later on in this report). During the COVID-19 pandemic, many sex workers were denied access to government financial aid available to other workers as they were not considered to be employed. Sex workers in many countries are also criminalized under the law and forced to work in the shadows, making them vulnerable to abuse and violence and placing them at greater risk for HIV transmission.
39. Due to stigma and discrimination, transgender people are often unable to find jobs that are stable and pay well. In the absence of other employment options, many transgender people are forced into survival sex work, putting them at higher risk of HIV transmission and violence. The absence of employment nondiscrimination laws and policies in most countries continues to harm transgender people and restrict their livelihood options.

40. A study in a country in the Latin America and Caribbean region showed that intersecting stigma related to HIV status, sexual orientation and gender identity can reduce the ability to find and maintain stable and adequately compensated work. The study noted that well-paying job opportunities are particularly scarce for transgender women due to discrimination related to gender identity. Among gay men and other men who have sex with men, discrimination related to HIV status is the most significant barrier to employment.<sup>xxviii</sup> These patterns illustrate how power structures operate when a person has multiple marginalized identities, such as being transgender *and* a sex worker *and* a person living with HIV.<sup>xxix</sup>
41. International normative guidance prioritizes actions to eliminate the many forms of employment discrimination that can affect people living with or at risk of HIV. Consistent with the human rights underpinnings of the 1958 ILO Discrimination Convention on Employment and Occupation, ILO Recommendation 200 calls for protections for workers who have HIV, confidentiality regarding employees' HIV status and recognition of the severe impact of HIV on vulnerable groups. Additionally, the ILO's Violence and Harassment Convention of 2019 is the first international treaty to recognize the right of everyone - including members of key populations and other vulnerable groups - to work in environments free from gender-based violence and harassment.<sup>xxx</sup> The ILO engages with networks of people living with HIV on programme planning and runs an economic empowerment program in a country in Southeast Asia and in a country in Latin America and the Caribbean to teach business skills to key populations.

*"The majority of the key population live below the poverty line. This is because most of them cannot get quality work or meaningful employment as a result of poor academic opportunities, their sexual/social behaviour, or sexual orientation." - Anonymous, Community activist, Africa*

*"Governments should mandate policies that protect people living with HIV in workplaces and impose stiffer penalties for persons who break them. These policies should cover the private and public sectors." - Lorraine Graham, Western Region Redress Field Officer, Jamaican Network of Seropositives*

*"Discriminatory employment practices such as asking for an employee's HIV status can dissuade people living with HIV from applying for jobs or from getting them, leading to a spiral of poverty." - Diddie Schaaf, Technical Officer, International Labour Organization*

### **Societal enablers to improve healthcare access and outcomes**

42. The Global AIDS Strategy underscores the centrality of high-quality, accessible healthcare services to efforts to end the AIDS epidemic as a public health threat. The 95-95-95 targets call for intensified efforts to scale up and ensure equitable access and outcomes among all populations and in all settings for HIV testing, treatment, combination prevention and sexual and reproductive health and rights.
43. Intersectional, overlapping forms of marginalization and stigma impede people living with HIV, key populations and other vulnerable populations from accessing and remaining engaged in healthcare services. Many people living with HIV and key populations experience real or perceived stigma and discrimination in healthcare facilities, especially in socially conservative settings.<sup>xxxii</sup> Such stigma can undermine diagnosis, treatment quality and health outcomes. Removing stigma is critical to delivering high-quality healthcare and achieving optimal health outcomes.<sup>xxxii</sup>

44. Community members who have experienced stigma and discrimination are often deterred from seeking health services. Moreover, individuals with stigmatizing experiences also share their unfavourable impressions with others, who may also avoid health services.
45. In many countries, efforts to make healthcare settings as welcoming, equitable and people-centred as possible are being spearheaded by community organizations. For example, in one country in Latin America and the Caribbean, community members launched an initiative to sensitize and train healthcare workers on issues affecting people living with HIV, key populations and other vulnerable groups. Community members reported improved access to healthcare services and better engagement with providers where training was consistent.
46. In two West African countries, a sex workers organization launched an initiative to integrate sexual and reproductive health services into existing HIV services, offering safe spaces and opportunities for community members to connect through social media or WhatsApp groups. The programme built community solidarity and enhanced mutual support, as community members posed questions regarding their health, body, and even work.
47. At a time when there are more mobile people than ever before, migrants frequently experience hostility, social exclusion and diminished access to healthcare services. The International Organization for Migration, a UN agency, has advocated for people-centered healthcare that is readily accessible for migrants and mobile populations. This necessitates concerted efforts to remove stigma and discrimination as barriers to healthcare access for migrant communities, as well as focused initiatives to ensure universal health coverage that is migrant-inclusive.

*“Due to the COVID-19 pandemic, many people living with HIV who belong to key population groups were unable to get refills for antiretroviral therapy. Focusing on societal enablers such as better access to healthcare could have prevented this situation. Now we run the risk of viral load increases for people living with HIV in the absence of adherence to treatment.” - **Tonny Muzira, Foundation for Male Engagement, Uganda***

*“Sensitization and awareness raising of healthcare providers by sex workers has yielded great results as we have been treated better at healthcare facilities.” - **Elena Eva Reynaga, Network of Women Sex Workers of Latin America and the Caribbean, Argentina***

*“Provision of free antiretroviral therapy and proper counseling has helped people living with HIV a lot in maintaining adherence and also reduced stigma to a great extent. Still, people living with HIV from various communities like LGBTQ people, drug users, and sex workers face double stigma. This needs to be reduced.” - **Pritha, Community activist, India***

### **Changing laws and policies to accelerate progress towards ending AIDS**

48. Punitive laws and policies reflect and reinforce stigma, discrimination, gender and other inequalities and social exclusion. Laws such as these represent human rights abuses, as key populations, other vulnerable groups and people living with HIV should be able to live their lives free of criminalization, stigma, discrimination and violence.
49. Punitive laws also undermine the fight against HIV. Criminalization of drug use, same-sex sexual acts and sex work have been shown to lead to worse health outcomes and lower viral suppression rates among people living with HIV.<sup>xxxiii</sup> For

instance, in countries where same-sex sexual relations between consenting adults are criminalized, the proportion of people living with HIV who knew their HIV status was 11% lower and viral suppression levels 8% lower. Sex work criminalization was associated with 10% lower knowledge of HIV status and 6% lower viral suppression. Drug use criminalization was associated with 14% lower levels of both. Criminalizing all three was associated with approximately 18%–24% worse outcomes.

50. Criminalization is the biggest structural barrier to the ability of people living with HIV, key populations and other vulnerable groups to access key benefits, such as employment, education, healthcare and other services. Conversely, laws and policies that protect the human rights of people living with HIV, key populations and other vulnerable groups are societal enablers that can transform the HIV response in positive and powerful ways.
51. The Global Commission on HIV and the Law - an independent commission convened by the United Nations Development Programme (UNDP) on behalf of UNAIDS - found that punitive laws and discrimination against vulnerable and marginalized communities have hampered the global fight against HIV.<sup>xxxiv</sup> The Commission called for urgent action from governments to ensure rights-based responses to HIV and its co-infections such as TB and hepatitis. These actions include repealing laws that harm communities and stymie progress in fighting HIV.
52. Repealing criminalization laws, while critically important to an effective response, may not be sufficient on its own to capture the full benefits of societal enablers. Even in countries that do not criminalize people living with HIV, key populations or other vulnerable groups, stigma and discrimination often persist due to the country's failure to enact laws and policies that actively promote the health and human rights of these communities.<sup>xxxv</sup> In countries with laws expressly prohibiting discrimination and gender-based violence, rates of knowledge of HIV status and viral suppression are higher among people living with HIV.<sup>xxxvi</sup>
53. Discriminatory and misguided criminalization laws do not prevent new HIV infections among women or reduce their vulnerability to HIV. On the contrary, criminalization laws have been found to be harmful to women and have been found to have a negative impact on public health and human rights.<sup>xxxvii</sup>
54. Eighteen countries in the Asia-Pacific region criminalize consensual same-sex relations between adults, posing a massive obstacle to the ability of gay men and other men who have sex with men to access healthcare and other services. In a region where the HIV epidemic is already concentrated among key populations - who along with their partners account for an estimated 98% of new HIV infections each year<sup>xxxviii</sup> - criminalization laws make it harder to stop the worrying trajectory of the epidemic in many countries.
55. Decriminalization is associated with improved outcomes. When a South Asian country decriminalized consensual same-sex sexual relations between adults in 2018, community activists felt more empowered to advocate openly for their rights and for equitable access to societal enablers such as education and healthcare as they were deemed legitimate and felt their voices would be counted. Criminalization, on the other hand, can have a chilling effect not just on advocacy and community organizing, but also on the provision of essential healthcare services. In a country in West Africa, it has been difficult to get clinics to provide HIV services to key populations because of fear of prosecution following an incident in 2008 when health workers were arrested and imprisoned merely for carrying condoms.

56. A study in a country in North America showed that laws criminalizing exposure to or transmission of HIV are ineffective in reducing HIV incidence and may, in fact, undermine prevention efforts (there is more information about this topic later on in this report in the case study on The Netherlands).<sup>xxxix</sup> A long-time community activist in the same country noted that local laws criminalizing HIV transmission are particularly pernicious as they can lead to people being placed on a sex offenders registry and consequently being denied housing and employment opportunities.<sup>xi</sup>
57. A study in a West African country found that the criminalization of sex workers and gay men and other men who have sex with men amplified the HIV risk and vulnerability not just of these groups, but also of the general population. The government's official response to the HIV epidemic inadequately addressed the rights and needs of key populations and included no advocacy for decriminalization or harm reduction approaches for key populations. As a result, key populations' access to HIV prevention and treatment services was severely limited. This kept their HIV prevalence rates high, which in turn contributed to high national HIV prevalence.<sup>xii</sup> Criminalization of same-sex sexual relations also distorts the strategic data needed to plan optimally effective responses for key populations. In countries where consensual same-sex conduct is criminalized, it is difficult to conduct surveys to obtain reliable population size estimates. The invisibility of key populations in countries with criminalization laws also encourages official denial about the existence of these populations and enables a false sense of success in the fight against HIV.<sup>xlii</sup>
58. In addition to repealing criminalization laws and enacting protective laws, an effective response to HIV among people living with HIV, key populations, other vulnerable groups should also address the impact of bullying, abuse and violence that so often blight the lives of the most vulnerable around the world, including of many adolescents and young people. A study in a country in East Africa found that people who use drugs and sex workers were frequently subjected to violence. The violence put these key populations at elevated risk of HIV transmission and other health problems and also served as a barrier to access and uptake of HIV services. To be effective, HIV programs for key populations need to prevent and respond to violence against them.<sup>xliii</sup>
59. Laws or policies that require parental or guardian consent for adolescents and young people under the age of 18 to access sexual and reproductive health services and HIV testing and treatment can also be a barrier to access. Such laws and policies violate the privacy and confidentiality of young recipients of care, subject them to shame and judgement, and undermine the timely delivery of HIV prevention and treatment to adolescents and young people.
60. The UNAIDS Secretariat and Cosponsors play a crucial role in promoting the protection of the human rights and health of people living with HIV, key populations, and other vulnerable groups. For example, ILO and UNDP have partnered at the global and regional levels<sup>xliv</sup> on a human rights initiative to advocate for the scrapping of punitive laws that harm key populations. In 2021, the two agencies organized multilingual discussion events on people living with HIV, key populations and social protection.<sup>xlv</sup> The events focused on barriers for social protection during the COVID-19 pandemic, best practices and lessons learnt from social protection programs, and issues of funding and finance. Events like these can catalyze evidence-informed, rights-based, equitable, and impactful investments in HIV-sensitive social enablers for communities.

*Case study: Criminalization law reform in the Netherlands<sup>xlvi</sup>*

61. Criminalization law reform gradually occurred in the Netherlands between 1989 and 2007, demonstrating how legal reform served as a societal enabler that improved the quality of life for people living with HIV. During this period, 15 people living with HIV were prosecuted by the government using homicide and assault laws, including an assault law from 1881 on attempted/grievous bodily harm. The defendants were accused of exposing their sexual partners to HIV. Only one case involved potential transmission of HIV. Of the 15 trials, 14 led to convictions.
62. An increasing number of HIV, legal, and social activists and healthcare providers came to believe that the prosecutions were unwarranted and counterproductive, undermining the prevention message that everyone had personal responsibility for safer sex. The prosecutions also deterred people with HIV from getting tested and accessing services. To stop prosecutions for non-intentional transmission and for perceived exposure, activists set out to create guidance restricting the use of the 1881 law<sup>xlvii</sup> rather than to seek full repeal.
63. There was some reluctance from HIV groups and providers to engage with the criminal law and the government was initially unwilling to engage on the issue until confronted with a wide sectoral alliance of respected organisations. The first case challenging the scope of the 1881 assault law was filed in 1989 but real change began in 2000 when a legal clerk at the Crown Prosecution Service, Peter Smit, took up the issue as a volunteer with the HIV Association following his diagnosis with HIV. Smit began to challenge the prosecutions in court. In 2002, an alliance was formed between the HIV Association, Aidsfonds, Schorer Stichting, and the STI Foundation. These organizations jointly challenged the prosecutions for exposure or unintentional transmission until they were stopped by the government.
64. Several factors led to the successful efforts to get the government to stop prosecuting exposure or unintentional transmission of HIV. The involvement of a former employee of the state prosecution service, assistance from human rights lawyers who were also criminal law attorneys, the publication of articles in legal magazines, and the involvement of key community HIV organizations all played a role. Smit also enlisted HIV specialists to act as expert defense witnesses in criminal proceedings.
65. The HIV organizations produced a consensus expert report in 2004, "Detention Or Prevention,"<sup>xlviii</sup> that was crucial in persuading the government not to introduce a new HIV-specific law when the old one was found to be inappropriate. The report was generated by a heavyweight committee chaired by the legal advisor to the Dutch Medical Association with members including people living with HIV, healthcare providers, public health experts and lawyers. The document marshaled the scientific facts and concluded that the prosecutions did more harm than good. It recommended prosecution only where there was coercion or deceit, combined with genuine risk of HIV transmission.
66. The campaign to restrict the use of the 1881 assault law used both public health arguments and scientific evidence on genuine risk levels and on HIV treatment as prevention. Policy and legal experts worked together to challenge individual prosecutions while also building the case against prosecutions in general. These efforts culminated in two Supreme Court rulings in 2005 and 2007 confirming that the existing law was inappropriate. The government subsequently declined to create a

new law to cover the issue. As a result of the Supreme Court decisions and legislative awareness, today there is less discrimination against people living with HIV in the Netherlands. Because of this change in the country's legal framework, people living with HIV are able to live their lives without the specter of criminal prosecution hanging over them.

*Case study: Decriminalisation of drug use in Portugal<sup>lix</sup>*

67. Portugal became the first country to remove criminal penalties for the use of all drugs and the possession of small quantities of drugs in 2001 through Law 30/2000. Since decriminalisation, Portugal has seen dramatic declines in new cases of HIV, hepatitis C infections, overdose deaths, drug-related crime and incarceration rates. HIV rates plummeted from an all-time high of 104.2 new cases per million in 2000 to 4.2 cases per million in 2015.<sup>i</sup> Drug-related deaths have dropped from around 80 in 2001 to 16 in 2012.<sup>ii</sup>
68. Portugal's decriminalisation of all drugs demonstrates that progressive drug policies and legal reforms can act as a highly effective societal enabler in reducing HIV prevalence. Decriminalization of drugs made it easier to fund and resource a broad range of health, employment, and housing services across Portugal. These services, in turn, more effectively served the unmet needs of key populations and other vulnerable communities. The use of language also shifted in line with social and political changes. Pejorative terminology such as 'junkies' or 'addicts' was replaced with humanising language such as 'people who use drugs' and 'people who inject drugs'.
69. However, recent critiques of the Portuguese model reveal some limitations. People who use drugs remain subject to administrative penalties. Those caught with a personal supply of drugs are not arrested but they are given a warning and fined. They are also summoned before the Commission for the Dissuasion of Drug Addiction - composed of doctors, lawyers, and social workers - which compels people who use drugs to enter drug treatment services and 'social integration' programmes that continue to surveil the community. Thus, it may be argued that Law 30/2000, while prohibiting the worst aspects of the prior criminalization scheme, still embodies a moralistic approach to drug use and has not necessarily led to broader social acceptance of people who use drugs.
70. Overall, the Portugal decriminalisation model only partially decriminalised people who use drugs (even though all drugs were decriminalised). Carrying larger amounts of drugs is still criminalised, which means that people who use drugs continue to be stopped, searched, and harassed by police, and still subject to criminal penalties. The drugs that people buy and use are still produced in a black market context, which means that people still use drugs that can be excessively strong and/or may contain toxic contaminants. Since drug production and sales are not regulated, this means that when people buy drugs they must travel into risky environments to do so, jeopardizing their health and safety.
71. The Portuguese model of partial decriminalisation is an important and commendable first step, but it is not the end point. The new Global AIDS Strategy's 10-10-10 social enabler targets<sup>lii</sup> can provide new impetus for meeting the long-overdue need for progressive drug reforms, nationally and globally. Full decriminalisation, legalisation, and regulation of drugs need to be accompanied by an end to stigmatisation, discrimination, and social exclusion to which people who use drugs globally are subjected to, including in Portugal.

72. Decriminalisation of drug use and possession have been shown to have a positive impact on HIV incidence and prevalence. A 2017 systematic review on HIV and criminalisation of drug use found that 80% of studies that were reviewed identified a beneficial impact of drug criminalisation on HIV prevention and treatment efforts.<sup>liii</sup> The International Network of People who Use Drugs (INPUD) has long advocated for full decriminalisation of drug use and possession and has welcomed the Global AIDS Strategy's 10-10-10 societal enabler targets that commit member states to work towards the removal of punitive laws and policies currently impeding the HIV response. Shaping future policy and legal reforms requires learning from past efforts of drug policy reform and its impact on people who use drugs.

*"Fifteen countries in the Asia-Pacific region criminalize same-sex relations and this is a massive obstacle for men who have sex with men to access healthcare and other services. The HIV epidemic in Asia is already concentrated among MSM and transgender people and these criminalization laws make it harder to stop the epidemic."* - **Midnight Poonkasetwattana, Executive Director, APCOM Foundation, Thailand**

*"Criminalization of HIV non-disclosure has made testing harder, has increased stigma, has eroded trust with healthcare providers, has made the lives of people living with HIV more difficult, lonely, and exposed them to increased violence."* - **Sandra Wesley, President, TOMS, Canada**

*"Condoms are one of the most effective ways of preventing HIV. Sadly, in Indonesia, condoms are seen as proof of indecency (namely sex before marriage). Despite condoms being recognised in government regulations in responding to HIV, sociocultural beliefs remain the main barrier. Additionally, condoms are often used as evidence to prosecute sexual minority groups. For example, there have been numerous times that a group of gay men have been arrested by law enforcement from private spaces for possessing condoms, although there is no single law that criminalises same-sex activities, the presence of condoms is often used as evidence to further prosecute them and charge them with indecency, pornography, and other laws."* - **Aditia Taslim Lim, Rumah Cemara, Indonesia**

*"Criminalizing some populations increases HIV risk for all."* - **Dr. Carlos Van Der Laet, Migrants Health Assistance Program Coordinator, International Organization for Migration**

## COMMUNITY-LED ACTION TO SCALE UP SOCIETAL ENABLERS

73. The 2021 Political Declaration calls for 60% of programmes to support the achievement of societal enablers to be delivered by community-led organizations. Endorsement of this ambitious target recognizes the centrality of community-led action to strengthen national responses by combatting punitive laws, stigma, discrimination, gender inequality and violence.
74. Communities are the most effective and compelling advocates for societal enablers. After the LGBT organization LEGABIBO intervened in litigation in Botswana, the country's High Court invalidated the criminalization of same-sex relations. Likewise, in India, community activists initiated the legal petition that led the country's Supreme Court to overturn the criminalization of consensual same-sex conduct. Sex workers, including Aboriginal and migrant sex workers, played a key role in the decision by Australia's Northern Territory to decriminalize sex work. Grassroots campaigning, including leadership by the Asociación de Lucha por Identidad Travesti-transsexual, led to passage of legislation in Argentina removing barriers to the ability of people to change their gender identities. The HIV Justice Network is supporting community efforts across the world to fight laws criminalizing HIV exposure, transmission or non-disclosure.

75. Communities are ideal implementers of anti-stigma programmes. In every region, networks of people living with HIV and key populations are strengthening community solidarity and resilience, increasing visibility and social inclusion and forging strategic partnerships to reduce the prevalence and impact of stigma and discrimination. Namati, a legal empowerment NGO in Mozambique, has contributed to concrete improvements in empowering, non-discriminatory services as health clinics and pharmacies by deploying health advocates who collect, investigate and follow up on complaints by service recipients. In Cameroon, the global key population organization MPact: Global Action for Gay Health & Rights led a multi-year effort with local NGOs to work on structural issues affecting healthcare access for gay, bi and transgender people. Working with the health district director, MPact and local organizations conducted affirming gender and sexual identity sensitization training with prison staffs, leading to changes in experiences of gay, bi and transgender people in that setting. Unfortunately, efforts like these must be institutionalized in practice and repeated in order for the environment to continue.<sup>liv</sup>
76. Community-led monitoring is also documenting and helping address human rights abuses. At least a dozen countries have completed, and at least 35 additional countries have begun implementing, the updated People Living with HIV Stigma Index (Stigma Index 2.0), enabling communities to document the incidence and impact of stigma and discrimination. The community monitoring approach developed by REAct, the first-ever system to monitor, record and assist in responses to human rights issues faced by key populations, has been used by community-based organizations in more than 22 countries in Asia and the Pacific, sub-Saharan Africa and the Middle East and North Africa. AVAC, the ATHENA Network, and Salamander Trust have documented gender-related barriers and facilitators for women's access to treatment and adherence, using guidance from a global reference group of women living with HIV from 11 countries.
77. However, effective community-led action on societal enablers is undermined by myriad factors. Many community leaders have identified the lack of adequate and/or consistent funding as a major barrier to their ability to work on societal enablers.<sup>lv</sup> Donor support is often the only funding available to work and is subject to policies and variables that are out of the control of beneficiary communities. For instance, donor funding can excessively focus on measurable outputs and outcomes, failing to prioritize longer-term work on societal enablers, which may not generate quick results.
78. Declines since 2018 in donor support for work on HIV and societal enablers – including but not limited to an 90% cut in international funding by the United Kingdom this year<sup>lvi</sup> -- has intensified financial pressures confronted by community organizations working on societal enablers. The Joint programme and several of its cosponsor agencies have recently seen funding reductions in HIV programmes, which has led to reductions in programming and elimination of HIV-focused staff positions. The reduction in dedicated HIV resources has led to fewer events of the kind that have traditionally provided a platform for coordination and dialogue between communities and UN agencies, thus making it harder to keep the focus on societal enablers and key populations.
79. Even as community-led responses and the UNAIDS Joint Programme provide critical leadership on HIV-related societal enablers, their work may not always bear fruit due to resistance in countries. In many countries, religious, cultural, and political attitudes pose considerable barriers to working on societal enablers that can benefit key

populations and other vulnerable groups, including women and girls. Similarly, when a major HIV funder like the PEPFAR bans advocacy for the rights of sex workers, it limits the ability to engage on societal enablers that affect this vulnerable key population. ILO conventions and recommendations call for an end to harassment and violence, but the lack of monitoring and enforcement mechanisms undermines broad-based adherence to these international norms.

## THE CRITICAL ROLE OF COMMUNITY-LED SERVICES

80. The Global AIDS Strategy envisages that by 2025, 30% of HIV testing and treatment services will be delivered by community-led organizations. The Strategy also provides that 80% of service delivery for HIV prevention programmes for key populations and women will be delivered by community-led organizations.
81. Communities are key sources of services for HIV prevention, treatment, care and support. Indeed, the COVID-19 pandemic highlighted the essential role of community-led services, as innovation by communities proved essential in preserving and expanding access to services during COVID-19-related lockdowns.<sup>lvii lviii</sup>
82. Communities are also providers of key social services. These include economic empowerment initiatives, as highlighted below in the case study from India.
83. As in the case of community-led work on societal enablers, the reach, impact and sustainability of community-led services are undermined by an acute and worsening lack of resources. Fully resourcing and supporting community-led services is a non-negotiable priority if we hope to end the AIDS epidemic as a public health threat by 2030.

### Spotlight:

In a country in Southeast Asia, an organization led by gay men and other men who have sex with men provided preventive packs with condoms, lubricants, and informational and educational materials to young gay engaging in chemsex. The organization was able to identify and assist gay adolescents and young people who could benefit from HIV prevention interventions because it was linked to the communities it was serving.

In a country in West Africa, a youth-led and key populations-focused community group used peer educator (peer counselor) cohorts to find and provide healthcare and HIV services to hitherto unreached and unserved community members. The use of peer counselors allowed other community members to feel comfortable and more likely to access services.

In the mid-1990's, the local government of a major city in North America opened a transgender health clinic, recognizing the barriers to healthcare access posed by stigma and discrimination commonly experienced by transgender service recipients. In addition to clinical services, the facility served as a venue for community members to congregate, helping strengthen community linkages, solidarity, information sharing, and peer networking and contributing to declines in new HIV cases. The transgender centre also provided creative programming and nurtured leaders from HIV-affected communities. Because of the success of the first centre, several transgender-specific health clinics have since been opened in the city, expanding access to gender affirming healthcare and have contributing to HIV prevention as well as the reduction of stigma.

*“Trained and mentored peer counsellors known as Community Adolescent Treatment Supporters (CATS) have been adopted by Zimbabwe’s Ministry of Health and Child Care and embedded in 568 health facilities and their surrounding communities as a key cadre in the HIV response for children, adolescents, and young people living with HIV (CAYPLHIV). Symptoms of common mental disorders were reduced from 62% to 2% among adolescents counselled by CATS. The CATS intervention has been adopted in eight countries in the region where 1,745 CATS are supporting 55,833 CAYPLHIV. At the end of 2020, 98% of CATS, 97% of young mothers, and >90% of CAYPLHIV were virally suppressed.” - Nicola Willis, Founder and Executive Director, **Zuendzi Zimbabwe***

*Case study: Sex workers economic empowerment in India<sup>lix</sup>*

84. This case study highlights how a sex worker-led financial cooperative in India has strengthened the economic position of sex workers by providing low interest loans, savings programs and self-employment schemes for sex workers. Employment and economic empowerment have helped sex workers improve their health outcomes, including lowering HIV risk.
85. Usha Multipurpose Cooperative Society Limited (Usha) is the first and largest ever sex worker-led financial institution in South Asia, exclusively run by and for sex workers. It was formed in 1995 in response to the economic and social challenges faced by sex workers in Sonagachi, the red-light area of Kolkata, a city of 15 million in the state of West Bengal. Prior to the creation of Usha, sex workers in Kolkata could not open bank accounts without legal identification and proof of residence - documents that their “illegal” occupation did not allow them to possess. Laws in India make it illegal to run a brothel and also criminalise the earnings from sex work.<sup>lx</sup> Sex workers also faced stigma and discrimination as banks refused to offer them services upon learning their profession.
86. Due to their inability to open bank accounts, many sex workers kept their earnings with their brothel owners, pimps or even clients, leaving workers vulnerable to fraud. They were also often robbed of money by criminal gangs or extorted by the police. As a result, most sex workers chose not to save or were unable to save. In the absence of savings, they were forced to borrow money during emergencies from local moneylenders at exorbitant interest rates. Consequently, sex workers found themselves trapped in poverty and debt and were compelled to engage in potentially higher paying unsafe work, which further exposed them to severe exploitation and health risks, including HIV transmission.
87. To change this state of affairs, sex workers tried to start their own financial institution. However, a ‘morality clause’ in the West Bengal Cooperative Societies Act of 1983 was used to deny their application to form a Cooperative, on the grounds that sex work was not considered a legitimate or legal profession. In response, sex workers began organising and demanding that sex work be recognized as a legitimate form of work. A decade-long struggle finally led to the amendment of the Act in 2006 allowing sex workers to form a Cooperative by recording their profession as sex work.<sup>lxi</sup>
88. Since then, Usha has enabled sex workers to save for crises, such as the ongoing COVID-19 pandemic. Usha has helped free sex workers from dependence on unscrupulous money lenders and loan sharks and reduced indebtedness and economic insecurity. Financial security has led to a higher bargaining power with clients, putting sex workers at less risk of violence and HIV transmission.
89. Usha provides higher savings interest rates than commercial banks, thus incentivizing savings. The paperwork for investing and saving money have been simplified. Loans are offered at low interest rates along with easy and flexible loan

repayment schemes that are sensitive to sex workers' social and financial circumstances. Usha also undertakes a range of commercial activities that help supplement income for sex workers and create alternative jobs for out-of-work and elderly sex workers. These economic empowerment initiatives allow sex workers to move to other types of work if they wish. In response to the COVID-19 pandemic, Usha has offered small loans to sex workers who wish to start a new business since sex work has come to a halt.

90. Usha today serves 30 000 sex worker clients each year and has an annual budget of \$4 million. As a result of financial empowerment, sex workers are better able to meet their basic needs, access healthcare, and HIV services. Usha has additionally helped sex workers gain political leverage by pooling resources. Other Indian cities like Mumbai (with a population of 22 million and Asia's second biggest red light district) and Mysore have also followed Kolkata's lead and established their own community-led financial institutions to serve sex workers.

*Case study: Providing transgender-specific health services in Thailand<sup>xii</sup>*

91. Transgender women in Thailand have extremely high prevalence and incidence of HIV and STIs, but are often unable to access healthcare services that are tailored to their unique needs. It is estimated that over half of new HIV infections in the country each year are among transgender women and gay and other men who have sex with men. A recent study found high rates of rectal gonorrhea and rectal chlamydia among transgender women.
92. Many healthcare providers in Thailand have limited understanding and clinical skills to provide appropriate and friendly services to transgender people. A recent survey conducted by the Ministry of Public Health indicated that 15% of healthcare workers believe that transgender women living with HIV should be ashamed of their gender identity and/or their serostatus. Almost 50% of transgender women have reported negative experiences with providers.<sup>lxiii</sup> Concerns about hormone-antiretroviral cross-reaction is a key reason many transgender women living with HIV do not access treatment. Very few transgender women report having received counseling or advice from providers on gender-affirming hormone treatment.
93. Thailand's transgender community members clearly need tailored, accessible, friendly, and comprehensive health services, including hormone and sexual health services and appropriate training for providers. Recognizing these unmet needs, in 2015 the Thai Red Cross collaborated with the community to open the Tangerine Community Health Center with funding support from the United States President's Emergency Plan for AIDS Relief (PEPFAR). Located in the heart of Thailand's bustling capital, Bangkok, Tangerine is the first transgender-specific sexual health and wellbeing clinic in the country.
94. Tangerine offers comprehensive, fee-based health services including gender-affirmative hormone treatment; HIV testing, counseling, PrEP, post-exposure prophylaxis, and antiretroviral therapy; management of STIs; and vaccinations for viral hepatitis A, viral hepatitis B and human papillomavirus. In addition to gender-sensitive nurses and physicians, Tangerine also employs transgender staff, including staff living with HIV. The clinic maintains close contact with the community it serves in order to ensure that the services are accessible, sensitive, and of high quality.
95. Tangerine has worked with popular transgender social media influencers to reach clients who are vulnerable and at risk of HIV infection, including AYP and those getting tested for HIV for the first time. The Health Center has exceeded annual

targets for clients served, in large part due to engagement with transgender influencers as part of an online-to-offline social media strategy to better reach transgender communities.

96. As a result of Tangerine's community-led efforts, ART uptake has significantly improved among transgender women. The integration of hormone and HIV services made it likelier that clients were more likely to return to the clinic for follow-up visits. The Tangerine model that integrates gender-affirmative hormone services and sexual health services has proven to be feasible and effective in increasing access to and retention in HIV testing, PrEP, and ART services.

## THE ROLE OF THE JOINT PROGRAMME IN SCALING UP SOCIETAL ENABLERS

97. The UNAIDS Secretariat and the 11 Cosponsors have a central role to play in the global effort to avert tens of millions of infections and deaths and end the HIV epidemic by 2030, as envisioned by the Sustainable Development Goals.<sup>lxiv</sup> A central plank of these efforts is ending inequality, which can only be achieved by working on societal enablers to support people living with HIV, key populations and other vulnerable groups that are disproportionately harmed by HIV.
98. The Global Partnership for Action to Eliminate all Forms of HIV-related Stigma and Discrimination provides useful guidance for the Joint Programme on undertaking a multisectoral response - that includes communities, governments, bilateral and multilateral donors, academia, and the UN - to address HIV-related stigma and discrimination.<sup>lxv</sup>
99. The Global Partnership, which is a direct by-product of the NGO Delegation's advocacy at the PCB, recognizes that HIV-related stigma (irrational or negative attitudes, behaviours and judgments driven by fear) and HIV-related discrimination (unfair treatment, laws and policies) are widespread and are persistent barriers to access to HIV prevention, testing, and treatment services for those most at risk. The settings where stigma and discrimination occur include healthcare institutions, educational institutions, workplaces, the justice system, families and communities, and emergency and humanitarian settings. Despite decades of scientific advances in prevention and treatment, irrational fears of HIV infection and negative attitudes towards people living with HIV continue to undermine efforts to end the AIDS epidemic as a public health threat.
100. At the global level, the NGO Delegation recommends that the Secretariat lead efforts to create rights-based norms and standards on societal enablers, in order to avoid having work on societal enablers sidetracked by the lack of agreed UN terminology. There are dozens of existing standards, conventions, recommendations and policies produced by the Joint Programme that are supportive of engagement on societal enablers, including with marginalized groups. These documents should be harmonized and harnessed to establish explicitly rights-based norms and standards that support work on societal enablers and HIV. The NGO Delegation also recommends that efforts be made to simplify UNAIDS resources on societal enablers and to make them as user-friendly as possible.
101. Where there are gaps in knowledge and evidence, the Joint Programme should support and facilitate funding for research efforts that generate relevant information on the unique needs of key populations and other vulnerable groups. When conducting research, the safety, privacy and bodily autonomy of research

participants should be ensured by obtaining full informed consent. Safety, including data security, is important because many research participants may live in environments where they are criminalized and/or stigmatized. The knowledge generated from research should be provided back to communities to support their advocacy and organizing efforts.

102. UN agencies have global legitimacy and convening power. They are uniquely positioned to successfully lead collaborative processes to systematically, independently and rigorously gather data, for instance on punitive laws targeting key populations and how these undermine the HIV response.<sup>lxvi</sup> Identifying harmful laws and pointing out how they are incompatible with global standards and national commitments can provide a powerful impetus to governments to change or scrap the harmful laws.
103. At the regional and country levels, the Joint Programme should fully leverage its reputation as a source of accurate data, information and best practices on HIV prevention and treatment. Country and regional offices should identify the needs of HIV-affected communities in countries where they work and use this needs assessment to provide tailored, appropriate support for the national response, including direct support for community-led efforts.
104. Engaging directly with activists and community-led organizations representing people living with HIV, key populations and other vulnerable groups must be a top priority for the Joint Programme's country and regional offices. Such engagement can provide invaluable perspectives of the lived realities of groups affected by HIV. Communities should be involved in every stage of UN joint programming, from programme design to rollout and implementation. By regularly listening to the concerns of communities affected by HIV, the Joint Programme and Joint UN Teams will be able to design programmes that meet demonstrated needs and that can have a real impact in halting and reversing HIV prevalence rates.
105. The Joint Programme and members of Joint UN Teams should partner with national human rights organizations to document discrimination and violations faced by people living with HIV, key populations and other vulnerable groups. The evidence collected from such efforts can provide the rationale to advocate for change. The NGO Delegation recommends that the Joint programme leverage evidence and data to identify and call out countries that have inadequate HIV responses in order to galvanize needed action. UN country offices should also learn from successful past interventions in creating and adapting programming.

*“UNAIDS should mobilize funds to support community-led advocacy to get governments to institute, implement, and integrate societal enablers as an integral part of the national HIV response.” - Mara Quesada, Executive Director, Action for Health Initiatives Inc, The Philippines*

*“UNAIDS should create ongoing mechanisms for listening to key population communities. It should create funding mechanisms so that social enablers are included in the development of programme strategies.” - Leonardo Moura, Advocate and community mobilizer, Brazil*

*UNAIDS should fund community-led HIV prevention activities, youth friendly centers, income generating activities, safe houses for adolescents and youth, key populations and other vulnerable groups. - Maryam Sani Haske, Program Officer, National Agency for the Control of AIDS, Nigeria*

*“UNAIDS should engage with departments beyond HIV control programmes at the country level and invest in communities most affected by HIV and train them in advocacy and negotiation skills.” - Sonal Mehta, Regional Director for South Asia, International Planned Parenthood Federation*

*“Do not continue to cut UNAIDS staff. The current alignment process is extremely concerning and raises questions on whether the organization is being steered in the right direction. Keep supporting and funding the roll out of the Partnership to Eliminate All Forms of HIV-related Stigma and Discrimination.” - **Anonymous, Community activist, Latin America and the Caribbean***

*“UNAIDS needs to start talking more about the social determinants of HIV and health. Talk more about mental health, talk more about economic disparities, talk more about gender inequalities, talk more about human rights, talk more about education, talk more about employment, talk more about justice. Because these will eventually lead us to achieving the testing and treatment targets.” - **Anonymous, Community activist, unspecified region***

## CONCLUSIONS

106. This report, drawing on the best available evidence and from examples from around the world, conclusively demonstrates the critical role of societal enablers making the HIV response more effective and sustainable. It has demonstrated that people living with HIV, key populations and other vulnerable groups stand to benefit greatly from scaled-up societal enablers, especially when services are provided by community-led organizations. Investments in societal enablers are crucial at a time when reduced funding, punitive legal environments and shrinking space for civil societies are compounded by the challenges of the ongoing COVID-19 pandemic.<sup>lxvii</sup>
107. Engagement on societal enablers as part of the HIV response is explicitly endorsed by the Global AIDS Strategy and by the 2021 Political Declaration.
108. The Global AIDS Strategy focuses on inequality as a primary driver of new HIV infections round the world and calls for the removal of punitive laws and policies that block an effective HIV response, including those related to HIV transmission, same-sex sexual relations, sex work and drug use. It explicitly endorses the role of societal enablers as a pillar of the HIV response, commits to supporting community-led programmes with the necessary resources, and acknowledges that HIV treatment is central - but not enough by itself - to achieve epidemic control by 2030 as envisioned by the UN Sustainable Development Goals.
109. The Political Declaration welcomed efforts by countries to work on societal enablers and called for an end to the marginalization of people living with HIV and of communities at higher risk of HIV infection. The Declaration endorsed specific targets on societal enablers and for programmes to be delivered by community-led organizations and encouraged investment in efforts to protect human rights, reduce stigma and discrimination and enact legal reforms in low- and middle-income countries.
110. Stigma, prejudice, discrimination and violence create a hostile social environment for people living with HIV, key populations and other vulnerable groups. Communities and the Joint Programme should collaborate to end stigma and discrimination and to augment biomedical interventions with programming on societal enablers. Societal enablers play a key role in expanding access to societal enablers such as education, employment and healthcare, which in turn reduce underlying inequalities and empower individuals and communities to demand access to the services they need. Rapid scale-up of societal enablers is essential.

111. Further marshaling the evidence on how investments in societal enablers can lower HIV prevalence and reduce transmission risk will be crucial to getting broader buy-in from member states and other stakeholders to increase financing for societal enablers. The Joint Programme should map out clear pathways on how investments in societal enablers result in gains for HIV-affected communities. Harmonizing existing UN standards and policies on societal enablers and HIV can help establish explicitly rights-based norms and standards that support increased work on societal enablers and HIV.
112. The HIV epidemic is currently *not* on track to end by 2030. Existing HIV tools and strategies have proven to be insufficient. While improving upon existing prevention and treatment strategies will yield significant gains, the HIV pandemic will remain a major global challenge for the foreseeable future. HIV services should therefore engage the most affected communities and include an ironclad commitment to human rights, gender equality, and equitable access to societal enablers.<sup>lxviii</sup> As this report makes clear, the HIV epidemic cannot be ended unless those who are most affected - namely people living with HIV, key populations and other vulnerable groups - are an integral part of the global response.

## RECOMMENDATIONS

113. Based on the findings and conclusions of the NGO Report 2021, it is recommended that to enhance the existing global HIV response to end the AIDS epidemic as a public health threat by 2030, relevant stakeholders should:
- a. Fully leverage societal enablers to ensure unimpeded access to education, employment and healthcare opportunities for people living with HIV, key populations and other vulnerable groups such as women and girls, adolescents and young people, and migrants who are disproportionately harmed by HIV;
  - b. Scale up efforts to increase access to justice and to eliminate punitive laws and policies that criminalize people living with HIV, sex workers, people who use drugs, transgender people and gay men and other men who have sex with men;
  - c. Advocate for laws and policies that protect the rights and health of all;
  - d. Eliminate stigma, prejudice, discrimination, abuse and violence against people living with HIV, key populations, and other vulnerable groups to ensure that everyone can access HIV prevention, testing and treatment services;
  - e. Scale up HIV and societal enabler-related interventions that have been proven to work;
  - f. Scale- up existing biomedical HIV interventions and treatments with a greater focus on societal enablers;
  - g. Design and implement evidence- and community-informed and rights-based HIV services;
  - h. Harmonize existing Joint Programme and Cosponsor policies and guidance to support increased work on societal enablers;
  - i. Use data, science and evidence to advocate for the importance of working on societal enablers as part of a comprehensive HIV response.
  - j. Support community-led efforts on HIV and societal enablers.
  - k. Promote the importance of investments in societal enablers and document how these result in gains for HIV-affected communities;

## PROPOSED DECISION POINTS FOR THE 49TH MEETING OF THE UNAIDS PCB

114. Based on the findings and conclusions of the NGO Report 2021, the following Decision Points are recommended to the 49th PCB meeting:
115. *Recalls* the 45<sup>th</sup> Programme Coordinating Board decisions 4.1 to 4.4 under agenda item 1.4: Report by the NGO Representative on the essential need to address economic, social, structural, and regulatory barriers that prevent access to comprehensive HIV services and health-related programs;
116. *Recalls* the commitments from the 2021 Political Declaration on HIV/AIDS to ensure that by 2025 community-led organisations deliver: 30% of testing and treatment services; 80% of HIV prevention services; and 60% of programmes to support the achievement of societal enablers and to expand investment in societal enablers – including protection of human rights, reduction of stigma and discrimination and law reform;
117. *Takes note* of the Report by the NGO Representative;
118. In order to reach the 10-10-10 societal enabler targets by 2025, *calls on* Member States to:
- a. Increase investments in and scale up programmes related to societal enablers that have been proven to work, including programmes to reduce HIV-related stigma and discrimination and to increase access to justice; to train health care workers and law enforcement officials on HIV and access to services for key populations; and to eliminate gender based violence and empower women and girls in all their diversity;
  - b. Partner with civil society and community-led organizations to deliver programmes on societal enablers, and gradually increase the proportion of such programmes delivered by communities to reach the target of 60 percent of programmes to support the achievement of societal enablers are delivered by communities;
  - c. Ensure unimpeded access to education, employment and healthcare for people living with HIV, key populations and other vulnerable groups such as women and girls, adolescents and young people, and migrants who are disproportionately affected by HIV;
119. In order to reach the 10/10/10 targets by 2025, *calls on* the Joint Programme to:
- a. Harmonize existing Joint Programme and Cosponsor policies and guidance to support scaling up of programmes on societal enablers;
  - b. Advocate for laws and policies that protect the rights and health of all;
  - c. Support countries to ensure that indicators for societal enablers are integrated into national M&E systems and routinely monitored, including through community-led monitoring; and
  - d. Support countries and communities to ensure that, by 2025, 60 per cent of programmes to support the achievement of societal enablers are delivered by communities.

[Annexes follow]

**ANNEXES**

*Annex I: List of key informant interviews*

	<b>Name</b>	<b>Country/Region</b>	<b>Organization</b>
<i>Community activists and leaders</i>			
1	Ivan Cruickshank	Jamaica/LAC	Caribbean Vulnerable Communities Coalition
2	Maguette Niang	Senegal/Africa	University of Dakar Center for HIV prevention & MPact
3	Ronald Brands	The Netherlands/Europe	HIV Vereniging
4	Cecilia Chang	United States/North America	Transgender Law Center
5	Tobi Elizabeth	Ghana/Africa	Health Train Media
6	Tonny Muzira	Uganda/Africa	Foundation for Male Engagement
7	Justin Chidozie Chukwukere	Nigeria/Africa	Center for Health Education and Vulnerable Support
8	Midnight Poonakastwana	Thailand/Asia Pacific	APCOM Foundation
<i>Joint Programme Cosponsors</i>			
9	Tim Sladden	Global & Asia-Pacific	UNFPA
10	Kathy Ward	Global & East and Southern Africa	World Bank
11	Diddie Schaaf	Global	ILO
12	Kofi Amekudzi	Global	ILO
13	Ariana Stahmer	Global	UNESCO
14	Christopher Castle	Global	UNESCO
<i>Other UN agencies</i>			
15	Carlos van der Laet	Global	IOM

*Annex II: Number of online survey respondents by region and language*

	<b>Africa</b>	<b>Asia</b>	<b>Europe</b>	<b>Latin</b>	<b>North</b>	<b>Total</b>
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		<b>Pacific</b>		<b>America and Caribbean</b>	<b>America</b>	
<b>English</b>	16	7	4	9	6	44
<b>Spanish</b>	0	0	1	75	3	81
<b>Russian</b>	0	3	3	0	0	6
<b>Total number of respondents</b>						131

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