
Technical Brief

HIV, Human Rights, and Gender Equality

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1. Introduction

The purpose of this Technical Brief is to assist Global Fund applicants in their efforts to include and expand concrete and effective programs to remove human rights-related barriers to HIV prevention, diagnosis and treatment services. This brief discusses the barriers to access and uptake of HIV services that these programs help to remove, the investment approach to these programs, the various forms the programs take, the need to cost and allocate budget for them, and how to implement them in effective ways and at appropriate scale. It also aims to help stakeholders ensure that, as they are rolled out, HIV health services and programs promote and protect human rights and gender equality more broadly.

Programs recognized as effective in removing human rights-related barriers to HIV services

- Stigma and discrimination reduction
- Training for health care providers on human rights and medical ethics
- Sensitization of law-makers and law enforcement agents
- Reducing discrimination against women in the context of HIV
- Legal literacy (“know your rights”)
- Legal services; and
- Monitoring and reforming laws, regulations and policies relating to HIV and TB.

1.1 Global commitments to end HIV

Years of experience and greater understanding of HIV prevention and treatment now enable the world to end the HIV epidemic as a public health problem. But the evidence shows that reaching this goal is possible only if there is much greater focus on addressing the vulnerabilities that lead to HIV infection, including targeting the populations at highest risk of infection or living with and most affected by HIV.

UNAIDS has underlined in 2019 that key populations and their sexual partners now account for more than half (54%) of new HIV infections globally. Further, HIV infections among young women aged 15-24 years are 60% higher globally than among young men of the same age.

Human rights violations, including gender inequality and gender-based violence, constitute major vulnerabilities to HIV infection, as well as major barriers to HIV and other health services.

To address these disparities, the Global Fund has committed to increase its support to programs for people who are most affected by the three diseases yet less likely to access services.

In addition, the Global Fund “Sustainability, Transition and Co-Financing Policy” outlines how all countries, regardless of income level, should include in their funding proposals programs that respond to key and vulnerable populations and to human rights-related barriers.

Programs to remove human rights-related barriers are an essential means to reach the global goal of ending the HIV epidemic by 2030 and to increase the effectiveness of Global Fund grants.

“One of the common lessons learned in a diversity of geographic, epidemic and cultural settings is that providing a comprehensive set of services tailored by and for the people in greatest need—and removing gender- and human rights-related barriers to service access—is a winning formula that alters HIV epidemics.” UNAIDS Global AIDS Update 2019, p. 9

To further support countries in their strategic commitments to scale-up programs to remove human rights-related barriers to services, the Global Fund launched in 2017 the initiative Breaking Down Barriers, an initiative targeted to 20 countries.

In 2018-2019, baseline assessments were completed in the 20 countries, describing the nature of the human rights-related barriers, the populations most affected by them, existing programs to remove such barriers, and a proposed comprehensive response to these barriers. Additional funding was also provided to the 20 countries on a matching funds basis. By mid-2019, there was a 7-fold increase in funding for such programs in the 20 countries, totaling 74.81 million USD (compared to approximately 10 million in the 2014-2016 allocation period). Further, there was a more than 4-fold increase in the amount of HIV funding made available overall for these programs in middle income countries. This was the first time that this level of funding has been made available for concrete human rights interventions in national HIV responses.

Based on the findings of the assessments and analyses by other partners, all 20 countries will hold multi-stakeholder meetings to outline multi-year plans that address, at a comprehensive level, human rights-related barriers to health services. These plans seek to align with and support national HIV strategies and engage a broad range of stakeholders, including government, civil society, affected populations and other donors. Follow-up assessments will measure the impact of the increased funding and programming.

In 2019, UNAIDS released its global AIDS update entitled UNAIDS Communities at the Centre, Defending Rights, Breaking Barriers, Reaching People with HIV Services. The report shows that less than 50% of key populations were reached with combination HIV prevention services in more than half of the countries that reported and that criminal laws, aggressive law enforcement, harassment and violence continue to push key populations to the margins of society and deny them access to basic health and social services. Discriminatory attitudes towards people living with HIV remain extremely high in far too many countries. Across 26 countries, more than half of respondents expressed discriminatory attitudes towards people living with HIV. (Taken from the UNAIDS press release of 16 July 2019).

2. Removing human rights-related barriers to HIV service

The response to HIV is predicated on reaching people with information on how to avoid HIV infection, prevent HIV transmission, and take up treatment if living with HIV and adhere to it. It requires support to behavior change so that people can act on this information, and be willing and able to interface with health care services and maintain prevention or treatment strategies that make sense in their lives. Calls for universal health coverage and health for all require States to overcome barriers that prevent individuals and population groups from accessing and remaining on necessary health care.

Human rights-related barriers undermine calls for universal health coverage and block uptake of and retention in HIV prevention and treatment services. In the following paragraphs, this brief describes existing barriers and concrete programs to overcome them.

2.1 Stigma and discrimination

There is greater acceptance of people living with HIV than ever before. However, high levels of stigma and discrimination against people living with HIV remain, along with high levels of internalized stigma. Within their own families and communities, people living with and affected by HIV face internalized stigma and isolation as a result of judgment and rejection. In addition, they may experience exclusion from places of worship and other community institutions. In household and community settings, HIV-related stigma and discrimination can also manifest through subtle gestures, such as refusing to share food or utensils with people living with or thought to be living with HIV, as well as more overt actions, such as rejecting or shunning a person living with HIV.

Due to fears of stigma and discrimination, people are afraid to use condoms or find out about their HIV status, get tested or inform partners of the results, and take up or continue treatment. They may deny that they are HIV positive, as stigma and discrimination threaten their marriages and families, their livelihoods and place in the community, their access to health care and justice, and possibly can also result in ostracism and violence.

In addition to stigma and discrimination based on HIV, other social or legal status, as well as gender and age, are also major barriers to the uptake of health services. Other status include sex, sexual orientation, gender identity, sex work, drug use, disability or nationality. People who use drugs or sell sex are highly marginalized as well as criminalized. In many countries, LGBT people are also criminalized. Migrants and refugees may not have legal status and may face stigma and discrimination socially, as well as denial of health care. People living with disabilities are also often highly marginalized, experiencing high levels of stigma, violence and lack of access to health and social services. When they approach health care services, these populations fear stigma and discrimination based on their social and legal status. Gender-based discrimination can exacerbate and compound the exclusion and abuse faced by marginalized and criminalized communities. Thus, women and girls in these groups often face higher levels of stigma and discrimination, as described in a later section in this brief.

Stigma and discrimination is common in health care settings where health care workers may be under-trained or uninformed, fearful of infection and poorly supported to avoid infection, or if living with HIV, they may be afraid of revealing their own HIV status. Stigma and discrimination in health care settings takes many forms, including lack of respect for those vulnerable to or affected by HIV, judgmental or disparaging treatment, neglect, denial of or delays in providing care, or the provision of sub-standard care.

Discrimination in health-care settings excludes or deters people from seeking health services for fear of stigma, judgmental attitudes or breaches of confidentiality. It has negative impacts along the continuum of care, from HIV prevention and testing, to treatment and sustained viral load suppression. Stigma faced in healthcare settings by adolescents, young women and girls due to age discrimination or providers' negative attitudes or perceptions limits their access to or uptake of sexual reproductive health services. Survivors of sexual violence and other forms of gender-based violence often face stigma when seeking health services or services from the criminal justice system as a result of bias or blame from service providers and community members. These attitudes may delay the survivors' timely presentation to seek emergency care.

In educational settings, children and young people living with HIV may drop out of school or be excluded altogether or if they remain in school, their performance may be affected. Discriminatory acts against children and young people living with HIV include isolation in seating arrangements and rejection during play activities, name-calling and labelling which leads to low self-esteem, and physical abuse which impairs participation in learning activities. Teachers living with HIV are also subject to stigma and discrimination in education settings.

Quality comprehensive sexuality education provides young people with accurate knowledge about HIV transmission and emphasizes the importance of equal rights for people living with HIV and key populations. In contrast, lack of access to comprehensive sexuality education perpetuates HIV-related stigma and discrimination.

Stigma and discrimination in workplace settings remains high. People living with HIV have higher unemployment rates than the national average, and lack of access to work increases the vulnerability of people living with HIV and affected communities. In many countries, people living with HIV have had their job descriptions or the nature of their work changed or have been refused promotions because of their HIV status. Mandatory HIV testing as a prerequisite for work remains a key barrier to employment for people living with HIV. Confidentiality of HIV status, including loss of confidentiality as a result of mandatory testing, remains a central workplace issue. An HIV-positive status is often disclosed to employers or co-workers without the consent of people living with HIV. Countries still exclude people living with HIV from participating in certain types of employment, such as serving in the armed forces, law enforcement and the prison service.

War, climate change, food insecurity, poor governance and other challenges interrupt access to HIV prevention, treatment and support services and increase risky behaviors. Food insecurity during emergencies makes it harder to adhere to treatment. It can also result in transactional sex that puts individuals at higher risk of HIV. Refugees from key populations living with HIV can face triple stigma based on their status. In humanitarian situations where confidentiality is not maintained, people living with HIV can be reluctant to seek support.

Thus, whether based on HIV status, social or legal status, gender or age, or based on an intersection of these, high levels of stigma and discrimination, found in communities, the workplace, schools, and health care settings, continue to act as major disincentives to uptake of and retention in HIV prevention and treatment services.

2.2 Punitive laws, policies and practices

In many countries and communities, there are practices, policies and laws that drive people away from health care. Within health services, these may involve: (a) lack of informed consent and confidentiality, (b) mandatory testing, (c) demands for bribes or high fees, (d) policies allowing for discriminatory treatment of particular groups, or lack of enforcement of anti-discriminatory laws, and (e) laws requiring healthcare providers to report certain groups to law enforcement.

In 75 countries, HIV non-disclosure, exposure or transmission, including unintentional transmission is criminalized. Thirty countries outlaw sex work explicitly, and at least forty-seven other countries criminalize some aspect of sex work including penalizing the clients of sex workers or operators of brothels while not criminalizing sex work per se. Sixty-eight countries criminalize consensual same sex conduct, punishable by the death penalty in six of those countries. Most countries criminalize some aspect of drug use or possession for personal use and at least 35 countries maintain the death penalty for drug-related crimes.

In the community, police may engage in harsh policing and illegal practices against people who use drugs, sex workers and LGBT people. Illegal police practices involve harassment, extortion, arbitrary arrests and violence, including sexual violence. Harsh policing or illegal police practices may force sex workers and their clients, LGBT people and people who use drugs to go underground, avoid health services and/or engage in risky practices.

Other forms of punitive law enforcement directly undermine HIV prevention and treatment efforts. People who use drugs may be arrested by police as they try to enter harm reduction service sites; or harm reduction may be altogether denied due to criminalization of drug use. Sex workers may be arrested and condoms in their possession may be used as evidence against them. Overly-broad laws criminalizing transmission of HIV that make people fearful of getting tested or informing their sexual partners of their HIV status may exist. Those in police custody, prisons or other closed settings may be denied access to condoms, harm reduction measures and other forms of HIV and TB prevention and treatment. Often, they are held in crowded conditions that do not meet minimum standards for health and safety and increase risk of HIV infection or death from AIDS-related illness. Migrants and refugees may be denied access to HIV prevention and treatment that is available to citizens.

Limiting the ability of certain population groups to effectively protect themselves from infection; or restricting their access to prevention, testing, treatment, care and support services, are serious human rights violations with significant negative public health consequences.

2.3 Gender inequality and gender-based violence

Inequality and discrimination based on sex, gender and gender identity and expression cause major vulnerability to HIV infection and increase the negative impact of living with HIV. The forms and effects of gender inequality and inequity are different for men and women, boys and girls, and gender non-conforming communities. Health and community systems that respond to the gender-specific needs of individuals in where and how they receive services are more effective. Furthermore, health programs should promote gender equality and gender equity, so that the different needs and vulnerabilities of women, girls, men, boys, trans-women and gender non-conforming individuals are identified and addressed.

Women's economic, political and social subordination is deeply entrenched in harmful cultural norms, attitudes, beliefs and practices, as well as in retrogressive laws. Depending on the locale, these gender-specific vulnerabilities for women and girls may comprise lack of autonomy, unequal access to educational and economic opportunities, forced or early marriage, third party authorization requirements limiting their access to health care, and various forms of violence in private or public spaces, including laws and policies that condone various forms of gender-based violence and harmful cultural practices.

In many communities, women fear to reveal their HIV status or seek treatment because they fear rejection, blame, loss of property and custody rights, and/or violence if their HIV status becomes known. Many women and girls cannot negotiate for safer sex with their intimate partners nor make decisions on use of contraceptives. In many settings, women do not have access to sexual health services, including comprehensive family planning and contraceptive choice. In addition, early or forced marriage constitutes a serious human rights violation posing risks of HIV infection and significant reproductive health problems.

In almost all contexts, women and girls face high rates of gender-based violence, and there is a proven link between gender-based violence and HIV. Such violence or fear of it can undermine their capacity to negotiate safer sex or leave an abusive relationship. Violence not only increases risk of infection, but also negatively influences adherence to treatment and access to other health services.

Criminalized communities, including sex workers, people who use drugs and LGBT people are at higher risk of violence. Sex workers and trans women also face higher risk of sexual violence, including rape, at the hands of clients, police and sometimes vigilantes and others in the community.

Boys and men also experience gender-related vulnerability to HIV, including violence. Gender norms and notions of masculinity may push men and boys into avoiding health seeking behavior, and engaging in behaviors that put them at risk of HIV infection, such as high alcohol and drug use and having multiple and concurrent sexual partners. Because of these gender-related vulnerabilities, a disproportionate number of men fall off treatment, and there is a disproportionately higher death rate of men from AIDS than women. While women and girls face higher rates of violence, there are communities of men, including those who use drugs and male sex workers, vulnerable to high levels of violence.

2.4 Programs to reduce human rights-related barriers to HIV services

Evidence has shown that human rights- related barriers to HIV services can be overcome by implementing concrete and evidence-based programs. Governments committed to implement these programs in the 2011 and 2016 Political Declarations on HIV and AIDS. In particular, in the 2016 Political Declaration where States agreed to fast track the AIDS response, they committed to implement:

“...national AIDS strategies that empower people living with, at risk of and affected by HIV to know their rights and to access justice and legal services to prevent and challenge violations of human rights, including strategies and programs aimed at sensitizing law enforcement officials and members of the legislature and judiciary, training health-care workers in non-discrimination, confidentiality and informed consent, and supporting national human rights learning campaigns, as well as monitoring the impact of the legal environment on HIV prevention, treatment, care and support.”

These programs are recognized as “critical enablers” by UNAIDS, WHO and other technical partners. They are “critical” because they improve access, uptake and retention of health services by those living with, affected by and most at risk of HIV infection. In particular, they help ensure that health services will reach those who are most vulnerable as well as those most marginalized. They also help build strong community and health systems by educating and empowering affected populations, health care workers and law enforcement about human and patients’ rights related to HIV.

Based on country experiences and best practices, UNAIDS recommends Seven Key Programs to Address Stigma and Discrimination and Increase Access to Justice as set out in the box above and described in detail in this section. These are programmatic outcome areas, within which a range of actions and interventions can be designed and implemented. Thus, these program areas and the interventions within them are flexible, can take many cost-effective forms, and can be tailored to different issues and contexts, as well as to different key and vulnerable populations.

In its HIV Information Note 2019, the Global Fund calls for an investment approach to HIV which involves four steps: understand, design, deliver and sustain. The programs to remove human rights-related barriers to services should be included in Global Fund proposals following this same approach. The first step involves understanding the human rights-related barriers and their impact: what are the barriers? whom do they affect? what are the gender dimensions of these barriers? how do they reduce access to services? what

programs will remove them? For many countries, there is information already available on the nature of the human rights-related barriers as these countries have benefited from various efforts by governments, the UN system and civil society to describe relevant barriers through such things as legal environment assessments (LEAs), gender assessments, measurements of stigma and discrimination in health care and communities, human rights reporting and community-based monitoring. In addition, there are the baseline assessments in the 20 countries described above that have drawn from and/or complimented these efforts by partners.

The second step is designing a mix of interventions that maximizes impact. Since these programs are meant to remove barriers to HIV prevention and treatment services, they should be designed in a way that follows and supports those services. Thus, designing the human rights programs involves taking what is known about the barriers and those experiencing them, and rolling out programs that will remove the barriers for those populations in the context of the national prevention and treatment strategies from which they benefit. Further, these programs should be designed to support key population programming and be gender-responsive, that is, designed in a way that also responds to the gendered dimensions of risk and access to services.

The third step is delivering high quality and efficient programs for effective scale up. In this regard, programs to remove human rights-related barriers to services should be, where possible, integrated into prevention, treatment, retention and key population services, or otherwise linked to them, so that they benefit the same targeted populations. This way the human rights programs will maximize the impact of the prevention and treatment programs. For example, community health care workers providing HIV prevention and treatment information and services can also be trained to provide human rights literacy, or if trained as peer paralegals, they can provide legal services. Trainings of healthcare workers to provide HIV services can include training on medical ethics and patient rights related to HIV to result in respectful, more effective HIV services.

Furthermore, the Global Fund is supporting comprehensive programs to remove human rights-related barriers to services. Small-scale ad hoc programs are not considered to be effective. The Global Fund Technical Working Group on Human Rights Monitoring and Evaluation defined “comprehensive” programs as programs that: (a) comprise a set of activities that are internationally recognized as effective in reducing human rights-related barriers to health; (b) are accessible or serve the majority of the estimated numbers of key and vulnerable populations affected by such barriers; and (c) are adequately resourced to move from non-existence or one-off/small-scale activities to a level of implementation likely to significantly reduce human rights-related barriers to services (a sustained, mutually-reinforcing, broadly protective package at scale).

Being comprehensive also entails combining programs strategically so they support each other and maximize results. For example, when stigma and discrimination are high in health care settings, four interventions could be put in place that would mutually reinforce each other: (a) train health care workers on human rights, gender equality and equity, and medical ethics related to HIV and enhance their accountability; (b) provide gender-responsive patients’ rights and human rights literacy to affected populations so that they know how they should be treated in the clinic and can deal with any discrimination they face; (c) support community based organizations to monitor the quality of health care that is being provided and give feedback; and (d) provide community and peer-based legal services and support to those discriminated against so that they are supported to continue accessing and staying on health care.

The programs to reduce human rights-related barriers to services singly or in combination often contribute to the achievement of more than one objective that will positively affect uptake of and retention in health care services. For example,

programs aimed at building ethical and human rights competence among health-care providers or supporting rights-based policing also contribute towards reducing HIV-related stigma and discrimination.

Finally, in the investment approach, it is important to build sustainability into these programs, avoiding such things as one-off trainings or production of written materials. Rather, activities should be ongoing among key stakeholders, including members of key and vulnerable populations, health care workers, police and judges, so as to create cadres of expertise and sufficient outreach involving peer human rights educators, peer paralegals, and community-based monitoring and support. These interventions will serve in the short and long-term to support and strengthen both community systems and health systems. For more information, the Global Fund HIV Information Note, 2019.

In 2017, UNAIDS released guidance entitled Fast-Track and human rights Advancing human rights in efforts to accelerate the response to HIV, which explains that States will only achieve their commitments to fast-track the HIV response and end the HIV epidemic by 2030 if they address human rights and gender-related barriers in all national responses to HIV. The UNAIDS guidance complements this brief and should be read together with it. The guidance provides applicants and implementers with practical approaches to integrating and expanding human rights principles and programs to reduce barriers to health care, maximize uptake and adherence, and ensure that no-one is left behind.

The following sections describes each program area and summarizes elements of its effective implementation.

3. Programs to reduce HIV-related stigma and discrimination

There are broadly two types of interventions regarding stigma and discrimination – those that measure stigma and discrimination and those that reduce them.

Measurement and monitoring of stigma and discrimination is critical to inform evidence-based programs to reduce these and other human rights-related barriers to access to health services, and to improve the quality of those services. A number of tools have been developed to measure HIV-related stigma and discrimination in communities, in health care settings, and as experienced by people living with HIV and other key and vulnerable populations (see box below). Many countries have carried out such measurements, and the results may be available to inform design and implementation of programs to reduce stigma and discrimination. Countries should put in place a system to generate the necessary data to appropriately monitor stigma and discrimination experienced by people living with HIV and other key and vulnerable populations, as well as the impact of these on HIV service access and uptake. This data should be sex and age disaggregated to better understand and respond to the gender and age dimensions of stigma and discrimination.

Tools by which to measure HIV-related stigma and discrimination

- The people living with HIV stigma index implemented by and for people living with HIV
- Questions in general population surveys used to construct indicators on discriminatory attitudes, stigma manifestations and fear as driver of stigma
- A survey tool to measure HIV stigma in health care settings by the Stigma Action Network
- The PLHV-friendly Achievement Checklist for health care settings by the Population Council, and the
- IBBS module on S&D experienced by key populations.

The 2019 GAM framework includes six indicators related to stigma and discrimination:

- Indicator 4.1. Discriminatory attitudes towards people living with HIV
- Indicators 4.2A-D Avoidance of health care among key populations because of stigma and discrimination (four sub-indicators, one each for sex workers, men who have sex with men, people who inject drugs and transgender people) and
- Indicator 4.4 - experience of HIV-related discrimination in health-care settings.

The UNAIDS National Composite Policy Index (NCPI) includes multiple questions on policies and strategies related to stigma and discrimination reduction.

Programs to reduce stigma and discrimination should:

- Address the drivers, facilitators and manifestations of stigma and discrimination based on evidence
- Involve those affected in the design, delivery and evaluation of programs
- Be gender-responsive, and
- Be taken to necessary scale to make a difference.

The reduction of stigma and discrimination can be aimed at the following levels: structural, institutional, community or individual. In most cases, interventions to address each level will be required.

At the structural level, the adoption and implementation of policies and laws that protect against HIV-related discrimination support the changing of harmful behaviors and provide redress to those affected. Strong accountability mechanisms are also important. To remove discriminatory policies and laws, see section below on programs to reform policies, regulations and laws.

At the institutional level, programs to reduce HIV-related stigma and discrimination can be put in place in workplaces, health care settings, justice and law enforcement settings, and in schools. They can involve the development of institutional policies against stigma and discrimination, training of personnel, and complaints and redress procedures.

At the community level, relevant programs might involve public engagement of people living with HIV, members of other key populations, religious leaders, popular public figures and celebrities; community dialogues; media, advertisement, education designed to reduce stigma; and mobilization, self-help and empowerment, and peer outreach of people living with HIV and other key populations.

People living with HIV, sex workers, people who use drugs, LGBT people, migrants and people with disabilities have been underutilized as a major resource for stigma reduction. Their engagement in efforts goes a long way to change attitudes.

The Global Partnership for Action to Eliminate all forms of HIV related Stigma and Discrimination was launched on Human Rights Day in 2018 by UNAIDS, UNDP, UN WOMEN and GNP+. It aims to catalyze and accelerate implementation of commitments made to end HIV-related stigma and discrimination by Member States, UN agencies, bilateral and international donors, NGOs and communities as essential for ending HIV as part of achieving the Sustainable Development Goals by 2030. Based on the recommendations provided by civil society organizations, global networks of people living with HIV and key populations, the partnership focuses on healthcare, education, workplace, legal and justice, family and community and emergency and humanitarian settings.

4. Programs to train health care workers on human rights and medical ethics related to HIV

Health care settings should be places of exemplary welcome, acceptance, care and support for those at-risk of and affected by HIV. They should be free from any form of discrimination and bias based on health and social status, gender or other forms of identity. However, health care workers often do not have the training, awareness or support to provide such care and acceptance. In order to reduce stigma and discrimination in health care settings, research has shown that three “actionable” causes of stigma should be addressed: (1) “lack of awareness of what stigma looks like and why it is damaging; (2) fear of casual contact stemming from incomplete knowledge about HIV transmission; and (3) value judgments linking people with HIV to improper or immoral behavior”.

Programs to train and support health care workers on human rights and medical ethics can first help them better understand and secure their own needs and rights. These include access to appropriate levels of understanding and knowledge about HIV transmission; universal precautions; protection against discrimination when they are HIV-positive themselves or are perceived to be HIV positive; and access to workers’ compensation for job-related injuries or illness.

Secondly, such programs can help to increase access and uptake by those in need of HIV prevention and treatment when health care workers understand their duty to treat in a non-discriminatory fashion, drop stigmatizing attitudes and behaviors, and understand and implement informed consent and confidentiality. It is important that training addresses both stigma and discrimination based on HIV status as well as that based on belonging to a key or vulnerable population. Furthermore, access and uptake are increased when clients understand that health care providers are being held accountable, including through monitoring of compliance with non-discrimination and providing redress mechanisms when discrimination occurs.

Programs should be aimed at staff, administrators and health care regulators who should lead or support activities to put in place and enforce policies that reinforce the training and ensure respectful and effective health care delivery, including appropriate quality assurance and client satisfaction.

Research has shown that programs are more effective where care is taken to recruit trainers who are well respected by the health care workers. Program impact may also be enhanced when people living with HIV and members of other key and vulnerable populations are meaningfully involved as trainers. Consideration should be given to when and how often

such training should be provided, as well as gender balance and other gender considerations. These programs also significantly strengthen health care systems.

Research conducted at four hospitals in Vietnam assessed efforts to reduce HIV-related stigma and discrimination among hospital workers. A broad range of staff were trained, a hospital policy against stigma and discrimination was developed and needed supplies were provided. There was focus on both efforts to overcome “fear-based” stigma (based on lack of knowledge of how HIV is or is not transmitted) and stigma based on moral judgments. At baseline, almost half of hospital staff evidenced both fear and moral judgements. By the end of the interventions, there was a significant reduction in stigma and discrimination.

5. Programs to sensitize lawmakers and law enforcement agents

Law-making and law enforcement are key to support access to HIV services and to protect those vulnerable to infection or living with HIV from discrimination and violence. However, lawmakers, judges, prosecutors and police may not understand how HIV is transmitted or the many forms that vulnerability to HIV may take. They themselves may be sources of stigma, discrimination and hostile action. Further, these professions are usually heavily male-dominated, and there might be little understanding of the particular issues faced by women, leading to abuse or unfair treatment of women. This is particularly the case where women or girls have suffered intimate partner or sexual violence.

Programs to address these issues should:

- Aim to provide information on basic HIV epidemiology
- Show how law and law enforcement can support or undermine the HIV response
- Show how the judicial system and law enforcement can protect the rights of women and girls and address violence against them which among other things increases vulnerability to HIV
- Show how those in these professions can reduce stigma, discrimination and illegal police practices aimed at key populations.

These programs can take the forms of:

- Sensitization on HIV, the role of law and the enforcement of protective laws in the context of the HIV response
- Development of HIV workplace policies and practices to protect law-makers and police from HIV infection
- Facilitated community dialogues or joint activities with people living with HIV and members of other key and vulnerable populations, including on law enforcement that undermines the HIV response
- Sensitizing police and judges on gender issues and how best to respond to and protect women, girls and others suffering sexual violence; and
- Efforts to improve prison policies and practices regarding access to HIV prevention, treatment and harm reduction in prison.

Programs can be aimed at parliamentarians, personnel of Ministries of Justice and Interior, judges, prosecutors, religious and traditional leaders, police, and prison personnel.

In 2013, UNDP issued *Effective Laws to End HIV and AIDS, Next Steps for Parliamentarians* which details how parliamentarians can work to ensure laws that will support both the HIV response as well as the human rights of those vulnerable to HIV, and provides case studies of effective parliamentary action.

Research has shown that it is difficult, but important, to counter, with sensitization, the strong forces at work that influence the attitudes and behaviors of these professional groups. For example, police often deal with low pay, lack of informed leadership, and pressure from communities and superiors that could undermine the effectiveness of training if it is offered “one-off” or in isolation. Thus, it is important to provide such training in combination with other efforts that will reinforce changes in attitudes and practices. These efforts might involve collective advocacy and ongoing engagement with the police by key and vulnerable populations. Sensitization and training offered by police peers and involving oversight and leadership from high-level officials are also important predictors of success and positive change.

Furthermore, police appear to be more responsive to the training if it also deals with occupational safety issues involving risks of HIV infection during police work. Other promising programs involve study trips between countries to see successful harm reduction programs, joint activities with key populations to address police violence against them including sexual violence, and joint activities to monitor abuses and find redress for key populations.

In 2009, drug laws changed in Mexico with possession for personal use being decriminalized and diversion of habitual users into treatment becoming mandatory. In order to educate police about these changes and improve policing around them, a police education program was implemented in Tijuana, Mexico, using an occupational safety framework and addressing the new law, its enforcement, public health considerations and occupational knowledge of HIV. After the training and through follow-up studies, results indicated that police understood better the law, harm reduction and diversion; were less likely to arrest users and confiscate clean syringes; and were more likely to divert them into treatment. They also appeared better able to reduce risky occupational practices that exposed themselves to HIV infection.

6. Programs to provide legal literacy (“know your rights”)

Programs on human rights and legal literacy enable people to know their rights and the relevant policies and laws related to HIV and draw these down into concrete HIV-related demands. Being aware of their rights to health, non-discrimination, freedom from violence, privacy, gender equality, sexual and reproductive health, people can then mobilize around these and advocate for such things as nondiscriminatory health care; protective versus punitive policing; a dependable supply chain as well as reasonable prices for drugs; equality in child custody and property rights; protection against gender-based violence; and integration of services.

Programs can also promote patients' rights, integrating them into HIV prevention and treatment literacy efforts. These programs enable patients to know, expect and advocate for informed consent, confidentiality, nondiscrimination and supportive attitudes in health care settings.

Legal and rights literacy enable key and vulnerable populations to engage in community-based monitoring of aspects of the HIV response that are critical to them. Based on this monitoring, they can advocate with authorities on the basis of rights that are protected by local laws and policies. Legal and rights literacy is also a significant component of increasing access to justice, social accountability and community system-strengthening. Such programs can take the form of training, community mobilization, community paralegal support, community monitoring, peer human rights education, support and outreach, media campaigns, and hotlines. It is critical that resources are made available to build the organizational and technical capacity of communities to implement and promote human rights approaches, such as legal literacy and community-based monitoring, as these are important parts of community system-strengthening.

Evaluations have shown that greater results are reached by combining these programs with community mobilization, legal services and support, and HIV prevention and treatment information.

The Sex Workers Education and Advocacy Taskforce (SWEAT) of South Africa, in partnership with the Women's Legal Centre (WLC) of Cape Town, created a cadre of over 500 peer educators to strengthen the rights literacy of sex workers. The material had an HIV focus but also dealt with the daily security risks faced by sex workers at the hands of police (arbitrary arrest, extortion) and clients (violence), as well as discrimination in the community. The initial cadre of peer educators trained more educators. Their support to their sex worker colleagues focused not only on rights but also on access to HIV testing and treatment. Evaluation showed that the sex workers' working environment improved, they had better relations with the police, and they were able to better access HIV services.

7. Programs to provide HIV-related legal services

Legal services in the context of the HIV response can assist people to address a number of justice issues that affect their health, their health-seeking behavior, and their general wellbeing. These issues comprise discrimination in health services, employment, housing and property and custody rights; illegal police behavior involving harassment, arbitrary arrest and violence against key populations; overly broad prosecution for HIV transmission, drug use and sex work; prosecution based on sexual orientation; denial of services in prison and pretrial detention; and violence against women, including intimate partner violence and rape.

Legal services can also help people get access to social services and help them plan for the future, for example, estate planning and writing wills.

Legal services can take many cost-effective forms: community and/or peer paralegals, sensitized traditional and religious leaders, alternative forms of community dispute mechanisms, internet-based provision of advice, legal hotlines, attorney representation through pro bono clinics, and strategic litigation.

The lawyers of the Uganda Network on Law, Ethics and HIV/AIDS (UGANET) have trained over 100 paralegals chosen from a diverse array of people who are already respected in their communities as teachers, health care workers, traditional leaders and people living with HIV. These community-paralegals travel on bicycles provided by UGANET to far-flung communities where they provide advice on HIV-related rights, better access to health services, mediating disputes including over property grabbing and child support, working with the police, and writing wills. On complicated cases, they get support from the five legal aid clinics of UGANET. They also disseminate legal advice through call-in radio shows. They not only support individuals, but also support community activism around critical HIV issues.

Strategic litigation, legal defense and advocacy efforts are vital tools to counter the criminalization of HIV and advance a human rights and evidence-based public health approach. Strategic litigation has proved to be a useful tool to facilitate access to health services for key populations who are often overlooked in policy processes. UNDP's continued support of the Southern Africa Litigation Centre (SALC) and its partners through the Global Fund "Africa Regional HIV Grant on Removing Legal Barriers" has shown the success of the use of strategic litigation in challenging and removing legal barriers to access health services.

EL v the State (Malawi)

In this case, a woman living with HIV appealed against her conviction for a crime under section 192 of the Penal Code for breastfeeding a child. She had been sentenced to nine months in prison with hard labor. A positive judgement against criminalization of HIV transmission through breastfeeding was obtained in January 2017. The case was supported by SALC, and the community mobilization and advocacy around the case was supported by the AIDS and Rights Alliance for Southern Africa (ARASA), both partners under the Global Fund regional grant. The judge who issued the ruling is a member of the Africa Regional Judges Forum, a group of senior judges from across Africa that meet annually in a collegiate environment to discuss human rights and HIV/TB issues and share experiences and are also supported under the grant. This judgment and the follow-up engagements led to successful advocacy for the removal of the criminalization clause in the Malawian HIV Bill and resulted in the human rights-sensitive Malawi HIV/AIDS Act 2018. This shows the effectiveness of the theory of change that sensitization of key stakeholders on human rights and HIV/TB at regional level leads to strengthening of the legal and policy environment for the HIV response at national and subnational levels.

X v Brink and Others (Nigeria)

In this case in Nigeria, an employee of a private security firm sued on the basis of discrimination against him when his employer required that he undergo an HIV test and then fired him when he tested HIV-positive. This occurred even though the 2014 HIV and AIDS Anti-Discrimination Act prohibits such actions. Finding that the employee was discriminated against, the Court awarded over five years' salary to him as compensation. The lawyers from Lawyers Alert who represented the employee had previously taken part in a number of capacity-strengthening workshops on strategic litigation and human rights over the past three years under the "Africa Regional HIV Grant on Removing Legal Barriers". To bolster the case, Lawyers Alert reached out to SALC for technical assistance, and to Enda Santé for advocacy support. The court ruling sets a precedent and should deter such discrimination at the hands of other employers. Lawyers Alert also

conducts country level workshops in Nigeria to build capacity of local legal professionals, resulting in 40 lawyers having been trained.

8. Programs to monitor and reform laws, regulations and policies relating to HIV

There have been significant efforts, with some great successes over the years of the HIV response, to put in place policies and laws that protect people from discrimination and support their access to HIV prevention and treatment. Unfortunately, as detailed above, there remain many policies and laws that impede access, undermine proven HIV health strategies and discriminate against key populations (e.g. laws criminalizing same-sex sexual conduct or expression of gender identity; possession of small amounts of drugs or injection equipment for personal use; buying or selling sex; laws that provide for the overly broad criminalization of HIV; laws that fail to protect the equality of women in the public and private sphere, as well as protect them from violence). Some countries currently have regulations and policies involving mandatory testing, disclosure and treatment; registration of people who use drugs; user-fees; failure to take into account flexibilities in intellectual property law; and sterilization of HIV positive women.

When contemplating programs to monitor or reform policies, regulations and laws, it is important to determine whether a review of existing HIV-related policy frameworks has already been done or needs to be done. Such a review may be useful in determining which policies, regulations or laws should be subject to reform as a priority. Programs to monitor or reform laws look at the impact of policies, laws and regulations in terms of uptake and retention on HIV services; assessing the degree to which key populations have access to justice and advocating for improvements; advocacy for policy or law reform; and working with parliamentarians and Ministries of Health, Justice, Gender and Interior. Though national and sub-national laws send a powerful signal regarding the social and legal acceptance or rejection of key populations, reform of laws can be a difficult and a long process. Reform of regulations and policies may be quicker and may have more immediate impact on the lives of those vulnerable to and living with HIV.

9. Programs to reduce discrimination against women and girls in the context of HIV

The Global Fund supports programs that are gender responsive and take into account the specific gender-related risks and vulnerabilities. Gender-responsive programming is critical and relevant for everyone affected by HIV. As such, all the interventions described above should be gender responsive and should be implemented to reduce human rights-related barriers experienced by women, girls, men, boys and those of non-conforming genders. However, because women and girls are still disproportionately affected by new HIV infections compared to men and boys and face disproportionate gender-related stigma and

discrimination that keeps them out of HIV services, this program area places particular emphasis on addressing discrimination against women and girls.

All six programs outlined in this brief should be implemented for and by women and girls. The implementation of such programs would help to reduce the age-based and gender discrimination, gender inequality and violence that make women and girls highly vulnerable to HIV infection and to the impact of infection in many societies.

These programs can be tailored to the particular needs of women and girls, such as:

- Rights literacy on women's rights through peer educators
- Legal services through peer paralegals for women in the context of HIV
- Reform of policies and laws relating to gender inequality and violence that impact HIV vulnerability for women and girls (e.g. policies and laws on early marriage, sex work, age of consent, girls' education, property and custody rights, marital rape, intimate partner violence, female genital mutilation, protection from forced sterilization)
- Training of health care workers on informed consent, confidentiality and nondiscrimination in sexual and child health, including those working to reduce vertical transmission and providing treatment to women and girls, and
- Sensitizing law makers and police on protective laws and protective policing, including for women who use drugs, women engaged in sex work, adolescents, bisexual and transgender women, and women and girls suffering gender-based violence, including how to strengthen the evidentiary base in such cases.

Other programs that are critical to reduce human rights and gender inequality-related barriers to HIV services include those that challenge and address harmful gender norms and that seek to eliminate violence against women. These are programs for women, men and young people that address harmful gender practices that may also put women, girls and men at risk of HIV, including cross-generational sex, concurrent partnerships, wife inheritance, early or forced marriage, intimate partner violence, disproportionate burden of care, harmful dowry practices, female genital mutilation, and homo- and trans-phobia. They can be delivered as stand-alone programs focusing on HIV-related vulnerabilities; or the vulnerabilities specific to HIV can be integrated into general programs to promote gender equality and an end to violence against women, as well as into life skills and sexuality education programs for young people.

In South Africa, research conducted in partnership with an NGO, People Opposing Women Abuse (POWA), offered women survivors of intimate partner violence education on human rights, HIV prevention and gender dynamics at drop-in centers and shelters for these women. Results included better understanding of risks associated with HIV and the right to insist on condoms, as well as greater willingness to tell family members about the interpersonal violence they had experienced. Also of interest was that the sessions appeared to allow the women to have increased knowledge of HIV prevention and to develop prevention strategies that they could use safely while they were in violent relationships. They also received support to leave such relationships if they decided to do so.

10. Ensuring implementation at scale of programs to address human rights-related barriers to HIV services

A lesson learnt from the last Global Fund funding cycle was that, whereas applicants referred to human rights-related barriers to HIV services in the introductions or analysis of their applications, few programs were identified to address these barriers, and those that were identified were seldom costed, budgeted or implemented. The very few that were implemented were at small scale with little capacity to make the necessary difference and almost no evaluation. Therefore, applicants should make concerted efforts to ensure that these programs are included in funding proposals, budgeted for, costed, implemented, have sufficient monitoring and evaluation built in, and are taken to comprehensive levels.

Participants in the design and development of an application to the Global Fund, as well as those developing investment cases, Fast Track strategies and national strategic plans, should consider the steps below when implementing and scaling-up programs to reduce human rights-related barriers to HIV services. This can be done during country dialogues and other opportunities, in consultation with members of affected populations, government counterparts, relevant civil society, technical partners and advocates working on human rights and gender equality in the context of HIV.

While this document and the resources listed below seek to elucidate the programmatic elements of these programs, costing them can be assisted by use of the UNAIDS Human Rights Costing Tool and its accompanying User Guide. UNAIDS is in the process of developing methodologies for costing interventions, including human rights-related interventions, for achieving 2025 targets.

Steps to be taken in full and meaningful consultation with people living with HIV and other key and vulnerable populations include:

1. Identify key and vulnerable populations who are at increased risk of infection and/or low access to HIV prevention and treatment services.
2. Based on consultations with key and vulnerable populations and evidence such as the results of LEAs, PLHIV Stigma index surveys, gender assessment sand others, identify the main human rights-related issues that are acting as barriers to access, uptake and retention of HIV prevention and treatment– taking gender into consideration.
3. Identify the populations, communities, health care services most affected by these barriers.
4. For each barrier, identify the relevant programs described above and the combinations of these programs, actors and scale that would result in effectively eliminating or minimizing the impact of such barriers.
5. Design and ensure ways that these programs are integrated into or closely linked to national health policies; prevention, treatment, key population and gender strategies; and monitoring and evaluation plans to ensure that they support prevention and treatment and build sustainability.
6. Estimate program costs.
7. Allocate budget.
8. Identify principal recipients and implementing partners sufficiently skilled and knowledgeable about human rights programming, as well as participatory implementation modalities, and technical capacity gaps that need to be addressed, to ensure effective implementation; and

9. Devise and budget for monitoring and evaluation of results.

11. A rights-based and gender-responsive approach to HIV programs

There is more to rights-based and gender-responsive health services than specific programs to address barriers. There are five human rights standards that Global Fund implementers should follow:

1. Grant non-discriminatory access to services for all, including people in detention.
2. Employ only scientifically sound and approved medicines or medical practices.
3. Do not employ methods that constitute torture or cruel, inhumane or degrading treatment.
4. Respect and protect informed consent, confidentiality and the right to privacy concerning medical testing, treatment or health services rendered, and
5. Avoid medical detention and involuntary isolation, which, consistent with WHO guidance, are to be used only as a last resort.

Further, a human rights-based and gender-responsive approach to addressing HIV and other health problems means integrating human rights and gender equality/equity norms and principles - non-discrimination, transparency, participation, fairness and accountability - into the design, implementation, monitoring, and evaluation of HIV and health programs.

It also means empowering vulnerable and key populations, putting in place necessary programs tailored to address their particular vulnerabilities and needs, ensuring their participation in decision-making processes which concern them, and ensuring that there are mechanisms for monitoring, making complaints and getting redress when rights are violated.

Human rights-based services should be informed by a thorough assessment and analysis of where human rights barriers and gender inequality/inequity exist, whom they affect and how. In some cases, improved targeting of existing programs to ensure inclusion of marginalized persons can be important human rights measures.

The planning, implementation and evaluation of Global Fund-supported HIV programs are also opportunities to contribute to rights-based, gender-responsive national HIV responses. They can help ensure that users of health services and those most affected by HIV are brought together in meaningful and non-threatening consultation with government, service providers, community leaders and others in civil society. The perspectives and voices of those affected by the disease are irreplaceable, including in determining priorities for reducing human rights-related barriers.

Where there are established national human rights bodies or ombudspersons, those institutions may also play an important role in ensuring the respect, protection and fulfillment of the rights of people needing and using HIV services. It is useful to leverage partners, movements, platforms and mechanisms that promote human rights and the right to health and non-discrimination, in particular, during the design and implementation of plans.

A rights-based and gender-responsive approach is also necessary for the monitoring and evaluation of national HIV programs. As elaborated in the UNAIDS guidance on Rights-based monitoring and evaluation of national HIV responses, national M&E frameworks ought to include indicators informed by a range of data sources, to track progress towards removing human rights-related barriers and effectiveness of the key program areas to reduce stigma and discrimination and increase access to justice. It is important to ensure

monitoring and evaluation systems themselves do no harm, and that they are applying human rights principles to data collection, analysis, disaggregation, protection and use.

Resources

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