2025 AIDS targets

Target-Setting, Impact and Resource Needs for the Global AIDS Response

Technical consultation on social enablers

19 – 21 June 2019

Montreux, Switzerland

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Summary

UNAIDS is leading a participatory process for the development of HIV programmatic targets for 2025 and impact and resource needs estimates for 2021–2030. The outputs from this process aim to serve as inputs to the next UNAIDS strategy, a possible future United Nations General Assembly High Level Meeting on the global HIV response, Global Fund replenishments, national target-setting and strategic planning and the decision-making of major global partners.

A multi-stakeholder Steering Group is guiding the process, and experts' technical inputs are being made within six consultative thematic groups on (1) testing and treatment, (2) primary prevention[1], (3) social enablers, (4) costs and resources, (5) integration and (6) longer-term technologies. The social enablers consultative group met on 19-21 June 2019 in Montreux, Switzerland. The group was urged to achieve the following over the course of the meeting:

- To examine and suggest operational definitions of the social enablers that modify the effectiveness of HIV programmes in the Sustainable Development Goal (SDG) era.
- To discuss and propose country or local programme activities to address social enablers to optimize the 2020-2030 response to HIV.
- To discuss and suggest 2025 targets specific to social enablers for the HIV response.
- To discuss and propose ways to estimate or model the direct and indirect effects of social enablers on the AIDS response.
- To delineate the elements of the proposed country programmes addressing social enablers to allow the costing of their implementation.

Consensus

Consensus was achieved on the following:

It was widely agreed that major progress had been made, and that the work conducted had significance far beyond target-setting. There were calls to use the work generated for advocacy purposes, research and scholarly work, with many potential uses by communities as well as political processes, including the next High-Level Meeting on HIV/AIDS.

- It is no longer possible to claim that there is not enough evidence to act: there is extensive evidence on the barriers to HIV prevention, treatment and care, as well as measurement tools for social enablers, and growing (but still insufficient) data on interventions that work

- In any case, lack of evidence is not lack of impact

- Social enablers, targets and measurements need to take into account and adapt to contexts (including increasingly hostile political environments, shrinking civil society space and increased violence and stigma and discrimination against key populations)

- Communities are social enablers

  o deliver HIV services ("respectful care is low cost and cost effective")

  o collect data and build the evidence base

  o build PLHIV/KP capacity and empowerment

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[1] Primary prevention does not include antiretroviral therapy nor the prevention of mother-to-child transmission.

- o KP-led and –staffed approaches create change from the inside

- o Hold others and themselves accountable

- o Community-led approaches need to respect the full diversity of communities

- o Community members *are* experts

- o Community-led approaches should coordinate between global/national/grassroots levels and between different communities to leverage all existing expertise and experience and avoid "divide and conquer"

- Leveraging development synergies can help achieve outcomes and increase resources for HIV and wider human rights and programmatic goals

- There is a need for further definition of the difference between social enablers (or the opposite of barriers) and strategies to promote or operationalize social enablers (or address barriers)

- *Decriminalization*

- o Decriminalization is a *process* along a *continuum,* with the possibility of interim successes

- o Decriminalization is a *long-term project* which requires an enabling environment

- o Decriminalization itself is not the end of the process

- *Gender, violence, equity*

- o Intersectional approach necessary – violence and negative outcomes are *compounded*

- o Certain issues remain invisible: lack of data and appropriate interventions for transgender women, violence against men; IPV in same-sex relationships; trans men; male HIV-related mortality…

- o Change in this area is *incremental* and targets need to reflect this

Recommendations for future research

- Formal request for a paper outlining a revised and clarified definition of social enablers

- Community-led key population Stigma Indexes (not just members of key populations living with HIV)

- Establish baseline for policing practices: harassment of key populations, arbitrary arrest etc.

- Rates of violence against criminalized populations

- Recent changes in laws and what has happened in broader uptake of services

- Need to look at evidence over time (e.g. successes of specific programmes), and need a control group for such studies

- The impact of stigma and discrimination-reduction interventions in health care settings on internalised stigma (as well as on health care providers)

- Measurement of changes in interactions between care providers and clients (i.e. the quality of care)

- How to capture compulsory/coercive treatment across all key populations.

Introduction and background

Over the past two decades the Joint United Nations Programme on HIV/AIDS (UNAIDS) has played a central role in the development of impact-level and programmatic targets for the global AIDS response, as well as estimates of the financial resources required to reach these targets. UNAIDS estimations of targets, resource needs and impact have informed multi-year strategies for the global response, Global Fund replenishments and three General Assembly high-level meetings. The Fast-Track target-setting and modelling, begun in 2014, focused on the development of 2020 targets that would establish the momentum necessary to achieve the goal of "ending AIDS as a public health threat", which is defined in the 2030 Agenda on Sustainable Development as a 90% reduction in new HIV infections and AIDS-related deaths and stigma and discrimination, compared to 2010 baseline estimates

This modelling analysis determined that a "Fast-Track" approach was needed: a front-loading of investments to rapidly accelerate programme coverage and reach a set of targets by 2020—including the 90–90–90 testing and treatment targets[2], 95% coverage of services to prevent mother-to-child transmission of HIV, and access to a package of HIV prevention services to at least 90% of key populations.[3] Annual financial resources needed for this Fast-Track response for all low- and middle income countries (LMICs) would peak in 2020 at US$26.2 billion—including US$7.4 billion in low-income countries, US$8.2 billion in lower middle-income countries and US$10.5 billion in upper-middle-income-countries—before declining approximately 9% by 2030. This resource needs estimate included savings of up to 35%; future efficiencies generated by economies of scale, price reductions and other technical and allocative efficiencies. The outputs of the model served as the basis for the UNAIDS 2016–2021 Strategy and the commitments within the United Nations General Assembly's 2016 Political Declaration on HIV/AIDS.[4]

New round of target-setting and resource needs estimation

From late 2018 to the middle of 2021, programmatic targets for 2025 and resource needs estimates for 2021–2030 will be developed by UNAIDS in close collaboration with its partners. As in past years, the outputs are timed to serve as inputs to the next UNAIDS strategy, possible future United Nations General Assembly High Level Meetings on the global HIV response, Global Fund replenishments, national target-setting and strategic planning and the decision-making of major global partners.

The multi-stakeholder Steering Committee guiding the process held its first face-to-face meeting on 10-12 October 2018 to define the scope of its work, to establish technical groups to inform the process, and to develop a plan for the dissemination of the outputs of the process. The Steering Committee's decisions on various operational and technical issues are contained in the report of its first meeting. Of note were decisions to focus the process on:

- Defining what is needed to reach the 2030 impact goals and guide countries to more efficiently and effectively achieve them.
- Setting programmatic targets to achieve high coverage of accessible and quality bundles of people-centred services.

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[2] 90% of people living with HIV know their status; 90% of people living with HIV who know their status are on treatment; and 90% of people on treatment are virally suppressed.

[3] Stover J, Bollinger L, Izazola JA, Loures L, DeLay P, Ghys PD et al. What Is required to end the AIDS epidemic as a public health threat by 2030? The cost and impact of the Fast-Track approach. PLoS ONE. 2016;11(5):e0154893. doi:10.1371/journal.pone.0154893.

[4] Fast-Track commitments to end AIDS by 2030. Geneva: Joint United Nations Programme on HIV/AIDS, 2016 (http://www.unaids.org/sites/default/files/media_asset/fast-track-commitments_en.pdf).

- Ensuring that the contribution of social enablers and their costs are included in the target-setting and resource needs estimation.
- Capturing synergies between the HIV response and other health and development efforts.
- Project the impact of the introduction of new technologies on new HIV infections and AIDS-related deaths.

Social enablers consultative group

Among the decisions was for pairs of Committee members to co-chair technical consultative groups on six thematic areas: (1) testing and treatment; (2) primary prevention; (3) social enablers; (4) integration; (5) costs and resources; and (6) longer-term technologies.

The main outputs of the technical groups may include, depending on the topic:

- An updated inventory of services with proven impact in the HIV response, including state-of-the-art interventions, innovative approaches that will be rolled out during the 2020–2030 period, and those that will become available during 2030-2050.
- Identification and incorporation of newer methods to assess the impact of non-biomedical interventions, including the role of advocacy, social media, human rights enforcement and community engagement in increasing meaningful access to critical services.
- Exploration of the increased use of combination/bundled approaches to prevention, testing, treatment and support.
- Link service provision and social enablers.
- Identify synergies between HIV service delivery and efforts to deliver other health and social services.
- Propose ambitious yet feasible targets for 2025.
- Calculate the impact of reaching these targets by determining the size of populations, coverage of services within these populations and the effectiveness (impact on incidence and mortality) of each service.
- Update unit costs for service delivery, including feasible allocative, technical and productive efficiencies.
- Estimate resource needs, based on the targets, populations sizes and unit costs.
- Develop peer-reviewed scientific papers on the above topics, as appropriate.

The technical consultative group on social enablers was convened on 19-21 June 2019 in Montreux, Switzerland. The meeting was chaired by Ms Michaela Clayton from the AIDS and Rights Alliance for Southern Africa (ARASA) and Dr. George Ayala from Global Action for Gay Men's Health and Rights (MPact). Group members included experts from government programmes, civil society, research consortia and the Global Fund (see participants list).

The objectives of the meeting were:

- To examine and suggest operational definitions of the social enablers that modify the effectiveness of HIV programmes in the SDG era.
- To discuss and propose country or local programme activities to address social enablers to optimize the 2020-2030 response to HIV.
- To discuss and suggest 2025 targets specific to social enablers for the HIV response.
- To discuss and propose ways to estimate or model the direct and indirect effects of social enablers on the AIDS response.

- To delineate the elements of the proposed country programmes addressing social enablers to allow the costing of their implementation.

It was widely and repeatedly acknowledged achievement of HIV-related targets requires addressing the barriers that impede the response, and bolstering the social enablers to service access and utilization.

Reference was made to the previous technical meetings on testing and treatment and on prevention, in which social enablers permeated the discussions. The participants of these technical meetings agreed that community- and key population-led responses facilitate social enablers, and that there has not yet been enough investment in such responses. These meetings also called for an evolution in the way targets are articulated and defined, emphasizing packages of appropriate interventions for particular sub-populations (as a way to address the fact that key populations, for example, are not homogeneous) rather than standalone interventions and one-size-fits-all approaches.

I. Context

Progress to date

Globally, most aspects of the HIV response are short of their targets. Although many countries are on track to achieve the 90-90-90 testing and treatment targets, most are not. The latest available data show that global deaths had only declined by 34% and new infections by 18% between 2010 and 2017, while financial resources were not on track to meet the resource needs of the Fast-Track approach. A Fast-Track target of 6% of resources to be budgeted for social enablers[5] (rising to 8% of US$ 26.2 billion by 2020) is not on track for achievement – either as a percentage of total spending or in actual terms.

In sub-Saharan Africa, adolescent girls and young women are at particularly high risk of infection compared to adolescent boys and young men. Key populations are at higher risk of HIV infection in all regions. Achievements vary across regions, countries, genders, and age and population groups.

Similarly, while stigma has declined since 2000,[6] elimination is a long way off. Discrimination continues in many countries,[7] including in health care settings[8]. Members of key populations in particular continue to report avoiding health care services as a result of stigma and discrimination, which constitutes an infringement of the right to health.

Violence against women—particularly intimate partner violence and sexual violence—is a major public health problem and a violation of women's human rights. Evidence from locations with high HIV prevalence in sub-Saharan Africa suggest that intimate partner violence increases susceptibility to HIV, and is associated with lower treatment access, treatment adherence rates and rates of viral suppression among women and girls living with HIV. Members of key populations experience higher levels of physical and sexual violence (up to 50%) than the general population.

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[5] including advocacy, community and political mobilization, community monitoring, public communication, outreach programmes to increase access to rapid tests and diagnosis, as well as human rights programmes such as law and policy reform, and stigma and discrimination reduction.
[6] As measured by the percentage of people who would not buy vegetables from a shopkeeper living with HIV.
[7] As measured by the percentage of people who would not buy vegetables from a shopkeeper living with HIV or think children living with HIV should not be able to attend school with children who are not living with HIV.
[8] As measured by the percentage of people living with HIV who reported that a health care professional ever told other people about their HIV status without their consent, or that they were denied health services because of their HIV status at least once in the past 12 months.

Meanwhile, laws and policies across the world continue to criminalize same-sex sexual acts, sex work (or aspects of it), drug possession and/or use, and HIV transmission, exposure or non-disclosure of status. People living with HIV struggle to claim their rights, with a minority seeking legal redress where their rights are abused and even fewer whose efforts are rewarded.

Measuring social enablers

It was noted on a number of occasions that while discussion of social enablers is far from new, UNAIDS and others are still grappling with how to quantify and measure such enablers in order to address them more explicitly. While 2020 programmatic targets were established in the 2016 United Nations Political Declaration on Ending AIDS for prevention, testing and treatment, there are few numerical or precise targets for social enablers. While many of the targets for HIV testing, treatment, prevention interventions include language on addressing barriers to services, there are few precise targets for removing these obstacles.

Global AIDS Monitoring (GAM) is the UNAIDS framework and process for country reporting on progress towards the 2016 Political Declaration. GAM is structured around the 2020 targets, and the 2025 target-setting process offers an opportunity to address areas of the HIV response that are under-represented in the GAM. Although the GAM—and particularly its National Commitments and Policy Instrument (NCPI)—includes several measures related to social enablers (including laws, legal policies and practices; stigma reduction; gender-based violence) many are not fully reflected. These include political commitment and advocacy; community mobilization; local responses to change the risk environment; gender-based violence beyond IPV and in line with WHO recommendations; laws and policy implementation; and the existence/implementation of programmes related to social enablers. It was suggested that more efforts should be made to measure efforts to reach adolescent girls and young women and key populations.

Linking HIV and other health and development goals

The target-setting process for social enablers needs to ensure that it reflects both the move towards Universal Health Coverage (UHC) and its dangers. A key message from civil society at the UN Multi-Stakeholder Hearing on UHC in April 2019 was that expanded health coverage towards UHC demands meaningful access for the poor, stigmatized and marginalized, as well as social justice, efficiency and quality. However, social enablers have not been a large part of the UHC conversation and there is very little language on social enablers in the draft UHC declaration. Clear targets and rationale, and costing, for social enablers for the HIV response can be an influential model for UHC discussions.

There is also widespread recognition that the future of a sustainable HIV response will depend on finding opportunities for strategic integration of HIV services with other health services. However, any integrated model development is strongly contextually bound, making it difficult to replicate, and can possibly be successful only if it accounts for the unique needs and characteristics of the population it aims to serve. The focus should be on the integration of health-service delivery for diseases and conditions that are usually delivered separately but often affect the same populations (such as tuberculosis, malaria, viral hepatitis, non-communicable diseases such ashypertension and diabetes, HIV prevention and treatment services, sexual and reproductive healthcare (including sexually transmitted infections, family planning and maternal and child healthcare, human papilloma virus vaccination and cervical cancer treatment, drug dependency treatment and mental healthcare). Integration is controversial and difficult to pin down in a comprehensive way, and definitions also depend on the purpose of integration. It can be very difficult in certain contexts, and often does not

include interventions around stigma and discrimination. In addition, where integrated services are not delivered adequately, it means that those who are least served in one area are also least served in another.

Resources for social enablers: Co-financing

Much of the work to be done towards both setting targets and generating resources for social enablers lies in how to value them. Social enablers and related interventions are often undervalued because the value assigned to them is in most cases both specific and directly related to an outcome desired by a specific/single payer. This means their assigned value does not include the values of other payers who might be looking for different outcomes and paying for different interventions.

However, if a transition from a sector/target-specific approach to a cross-sectoral financing approach is done properly, it is possible to achieve the same or greater outcomes for the same or less capital investment. This will save governments money through the pooling public resources and more efficient allocation of public-sector funding to interventions that address multiple SDG targets, across different sectors, at once. Cross-sectoral financing may also help to address situations where governments are spending money to support people on the one hand but disinvesting on the other.

The process will require political leadership and changes in budgeting and governance systems. It will be important to identify the values and efficiency gains of enablers, as well as the mutually derived benefits from structural interventions of interest to another constituency, to help prioritise a social enablers list for HIV.

II. Defining social enablers

A major result of the meeting was the expansion of the definition of social enablers. This was achieved by assessing why social enablers have not gained as much traction as desired, particularly at the country level. For many in the group, the 2025 target-setting process provides a vital opportunity to rethink what the endpoint(s) should be, as well as how to ensure that social enablers promote access to services that are high quality, appropriate and acceptable, and to reframe language where necessary in order to accelerate progress.

The starting point was the definition of social enablers from the 2011 Investment Framework: *political commitment and advocacy; laws, legal policies and practices; community mobilization; stigma reduction; gender-based violence; and local responses to change the risk environment ("structural approaches").*

Figure 1. 2011 Investment Framework
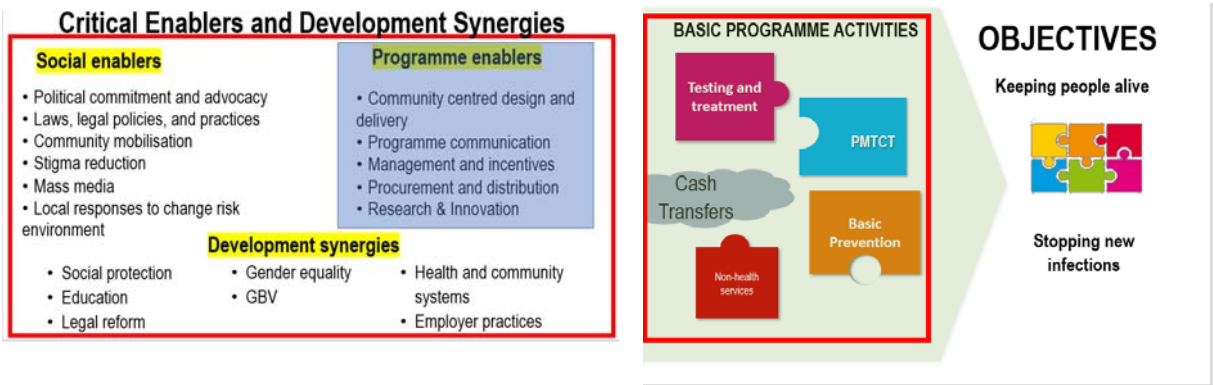
The Investment Framework is based on three components: basic programmes (prevention, testing and treatment and PMTCT); critical enablers (programme and social enablers); and development synergies. Development synergies can be activities wholly or partially supported by AIDS budgets that support broader development and/or health objectives, or activities supported by other budgets that provide a range of benefits, including HIV-related impacts.

Meeting participants agreed that the 2011 definitions, boundaries and scope of social and programme enablers and development synergies need updating, including by expanding the objective of "keeping people alive" to reflect that the aim is also to keep people healthy and maximize their wellbeing. Other aspects need to be included, such as the use of surveillance, monitoring and strategic information as a programme enabler, the integration of service delivery, and the appropriate framing of the HIV response around UHC and the SDGs. Allocating resources should be considered in light of what is HIV-exclusive and what is cross-sectional (in terms of development synergies). Social enablers in particular often imply larger structural investments, with impacts that are not necessarily just related to HIV.

An initial set of enablers was suggested, with discussions undertaken on the understanding that the broader goal was to target *structures* and that a larger question for consideration was how to understand what a social enabler is:

- Political will and commitment
- Laws, policies and practices
- Education (including upstream, comprehensive sexuality education, sensitization, changing public views/attitudes)
- Gender equality
- Protections against violence
- Community-led organizations and responses (including monitoring, advocacy, resources)
- Poverty reduction, housing stability and work

Further discussion was had on how to differentiate social enablers themselves from the strategies, interventions and programmes that promote them. A useful frame was established, with the suggestion that enablers can be identified by finding the opposite of barriers, following which it is possible to identify the programmes and strategies to address barriers and promote social enablers.

Input from the Global Network of Young People Living with HIV brought a supplementary perspective, defining social enablers primarily as individuals and communities who can make an impact on the HIV response. They help to ensure impartial access to HIV related services, encourage community involvement, ensure that initiatives are owned by those directly affected and that they are knowledgeable of such initiatives, and create a more sustainable response that is focused on local challenges and the priorities of those most affected. Their roles in HIV programming are to train, advocate, sensitize, encourage, give support, lobby, educate, build capacity, empower, and provide safe spaces. They influence their peers, state actors, doctors, policy makers, community members, and parents/guardians.

The list was altered and expanded during the discussion, with the finalized social enablers considerably expanded. Stigma and discrimination and access to justice were added. UNAIDS recommends seven programmes to reduce stigma and discrimination and increase access to justice in national responses

to HIV: stigma and discrimination reduction; HIV-related legal services; monitoring and reforming laws, regulations and policies related to HIV; legal literacy (know your rights); training for health-care workers on human rights and medical ethics in the context of HIV; sensitization of lawmakers and law enforcement officials; and reducing discrimination against women in the context of HIV.

A number of clarifications around stigma and discrimination and violence in particular were needed, with the group noting that addressing these needed to include support and access to justice for victims of violence and for people subjected to discrimination. In light of this, the wording was changed from "reducing" or "eliminating" to "addressing" stigma, discrimination and violence. It was decided to use the framing device of "economic justice, security and livelihoods" to cover the multiple barriers of poverty and unstable housing and work, as well as social capital. Similarly, it was agreed that education—broadly defined to include comprehensive sexuality education and sensitization—was part of the wider social enabler of changing public views and attitudes, which also covers knowledge, skills and training.

A number of cross-cutting issues were identified that should be considered as part and parcel of each individual social enabler (and/or strategies to promote them). These included the right to health and other human rights. The issue of promoting/respecting sexual rights and reproductive rights—as distinct both from the biomedical aspects of sexual and reproductive health, and each other—was added as a social enabler in and of itself. Investment in social enablers was also identified as a cross-cutting issue deserving of its own space. Political will and commitment were similarly agreed on as cross-cutting issues, as they serve to promote an enabling environment for the fostering of all social enablers. Considerable discussion was also held around how to include civic space and enabling environments, and how to define these, particularly in light of the community decision to define community-led organizations as social enablers in themselves (see more, below). The consensus was to use community system strengthening as a cross-cutting issue/strategy, to include accountability and monitoring, advocacy, addressing resourcing issues and harnessing the power of communities and elevating their voices.

It was also noted on a number of occasions that this process should aim to address current realities as well as the higher-level aims of eliminating all stigma and discrimination, inequities and so on. Social enablers, by their very nature build long-term, incremental structural changes. They do not only serve to achieve a certain programmatic or impact targets of the HIV response. Each step along this path should be celebrated for its own sake and to help engage country ownership.

Final agreed list of social enablers and cross-cutting issues

Cross-cutting issues

- Human rights, including the right to health
- Political will and commitment - investment
- Community system strengthening

Social enablers

1. Laws, policies, practices and enforcement
    - Including decriminalization

2. Access to justice

3. Community-led organizations

4. Addressing stigma and discrimination

5. Gender equity

6. Sexual rights and reproductive rights

7. Addressing violence (prevention and response)

8. Economic justice, security and livelihoods (poverty, housing stability, work, social capital)

9. Changing public views/attitudes

    o Education - upstream, CSE, sensitization

    o Knowledge skills and training

*** Note: This list is not prioritized but organized in the order of discussion and clustering for group work.*

III. Modelling social enablers

Modelling is used to determine the service coverage needed to achieve desired impacts. It is possible to model the impact of interventions across the spectrum of HIV disease dynamics, from susceptibility to HIV infection to AIDS-related death, for each population group. Social enablers affect both disease dynamics and the success of interventions to achieve targets, while various barriers affect risk behaviours and norms; increase HIV transmission/infection risks; block the use of prevention services; decrease the willingness to test; impede access to and uptake of treatment; and affect efforts to retain people living with HIV on treatment.

What is needed to include social enablers?

- What do we do? What specific activities should be implemented?
- Who (which populations) needs these services?
- What do they cost?
    o How do we make estimates (as with some biomedical interventions, can use data we have to estimate for variety of settings)?
- What effects are expected?
    o e.g. change in behaviours? Increase in demand or use of services?

Are there other sets of indicators that can be used, tracked, set targets for?

The impact of some social enablers and development synergies, such as those with a proven effect on the incidence of HIV infection, can be modelled. For others, there may be evidence of behaviour change, but not a change in HIV incidence or AIDS-related mortality. For yet others, there may be no direct proof of impact on either incidence or behaviours, but they were included in the 2011 Investment Framework and costed nevertheless because it is believed they are important. What it is not possible to do very well with modelling is to track whether the money goes to the "right" people and is being used correctly and achieving the desired effects; this is the purpose of monitoring.

Discussions of the modelling process included how to deal with the issue of evidence, and the importance of good data sets to ensure good models. The issue of scale (magnitude and coverage) for interventions was also raised, such as those on stigma and discrimination. A number of questions were raised: Should we introduce new indicators such as the numbers of people prosecuted under XYZ laws, or the level to which a particular policy is implemented, or how the legal and policy environment has been substantively impacted? Are interim indicators a good way to deal with the fact that the most ambitious targets—such as zero discrimination—remain a long way off? How to address the difficulties of modelling political change? How does modelling build these sorts of changes in? Is it possible to run models in low/medium/high political toxicity contexts to show how these might affect interventions? How do we monitor what doesn't (yet) exist?

There were also questions around defining numerical targets given contextual differences between countries, as well as how granular (or detailed) targets should be. Where granular targets are used, there are greater requirements in terms of monitoring and the need for a baseline. It is more helpful to have intervention-specific (and population-specific) targets, or very specific example interventions, which can be costed and used as a benchmark for costing similar interventions or building intervention packages.

IV. Evidence and investments

Stakeholders continue to ask for evidence that addressing human rights- and stigma and discrimination-related barriers will lead to greater impact. The evidence is there, but we still need to make the case, and find better ways to make the case. Equally, although there are a number of interventions that *work*, they need to be better and further communicated to counter questions about whether human rights interventions are actionable or merely "fluff and banners to wave". The 2025 target-setting process should counter the myth that human rights are "too hard to programme" and find ways to amplify the existing evidence, while continuing to build on it.

A UNAIDS-commissioned systematic review of studies (2003-2015) that assessed the effectiveness of human rights interventions on improving HIV-related outcomes found that most studies (83%) reported a positive influence of human rights interventions on HIV-related outcomes, but that investments in the implementation and evaluation of such programmes has been minimal.

The Global Fund's new 2017-22 strategy includes intensive support provided to 20 countries[9] ranging across different geographical, epidemic and income contexts, beginning with baseline assessments of human rights-related barriers and existing services in each country; what evidence there is of the effectiveness of these services; what would be required to comprehensively address the barriers; and what it would cost to do so, over five years. The assessments have provided additional evidence that human rights-related barriers do exist, and persist across countries and contexts, affecting the ability of key and vulnerable populations to access services. Among the most pervasive of these are stigma and discrimination, particularly in healthcare settings, police harassment and abuse, limited legal literacy and access to justice, and legal and policy barriers. The assessments also provided evidence of funding gaps for human rights in the countries. Evidence from 20 countries has shown, too, that catalytic funding works as an incentive. It was suggested by participants that UNAIDS establish a target

[9] Honduras, Jamaica, Benin, Senegal, Sierra Leone, Cameroon, Cote d'Ivoire, Ghana, Democratic Republic of Congo, Botswana, South Africa, Mozambique, Kenya, Uganda, Tunisia, Ukraine, Kyrgyzstan, Nepal, Philippines and Indonesia.

to leverage the opportunity provided by the Global Fund's 2017-22 strategy, convening community organizations to prepare inputs for Global Fund funding requests, and helping to mobilize key populations involved in the process.

According to the Global Fund, current evidence also shows that human rights and social enabler-related programmes work, and future interventions will produce more evidence. Such programmes have proven public health outcomes: modelled effect on incidence; positive effects on the percentage of people living with HIV who know their status; increases in coverage of prevention, treatment and care; and improved adherence. They have proven human rights outcomes, including stigma and discrimination reduction and increased legal literacy and access to justice. The evidence also shows that such programmes work best if they are implemented consistently, at scale, through institutionalization and integrated approaches.

Evidence and data from the South African investment case were presented. The model showed both that it is possible to model enablers as long as there is evidence of an enabler having an HIV impact (endpoint), and that costing is a cheap activity so modelling can be undertaken even where there is no cost available. However, the model also found that in this context, social enablers (and development synergies) were not able to compete with other interventions on the basis of HIV endpoints, even when limiting the cost share borne by the HIV budget. If these are to be scaled up further, they should therefore be funded by non-HIV budgets.

The investment case prompted considerable discussion, particularly around the idea that social enablers need to be cost-effective, or that they are not "competitive". A number of cautionary points were raised, including around definitions of 'quality' evidence, the need to go beyond the restrictions imposed by the modelling process to accurately reflect the full picture, and the need to include (and indeed privilege) community as well as academic and programmatic evidence. The costs of inaction – of *not* using social enablers – should also be taken into account. When social enablers are absent, investments in prevention, treatment and other programmes are undermined. The point was also forcefully made that social enablers help to reach the most vulnerable, bridging the gap between the coverage achievable simply through service expansion (say, 85%) and leaving no-one behind. This may well increase cost but is inherently worthwhile. The investment case included technical efficiency factors to try to address this point.

It was emphasized that no evidence of effectiveness does not necessarily mean that interventions are not effective, but could mean that we need to be better at gathering the evidence. Building the capacity of community organizations to participate in data collection, monitoring and evaluation is vital.

V.   "We are the experts of our own lives": Defining and supporting community-led responses

Community mobilization, peer-driven programmes and meaningful participation are critical driving factors for key populations and people living with HIV the world over. A one and a half-day meeting immediately prior to the target-setting working workshop aimed to define community-led responses. Although there was extensive discussion around the idea that "community-led organizations are social enablers for the HIV response", the definitions were established and a task force set up to further solidify them.

1. **Community-led organizations, groups, and networks***, irrespective of their legal status, are entities for which the majority of governance, leadership, staff, spokespeople, membership and volunteers**, **reflect and represent the experiences, perspectives, and voices of their constituencies** and who have transparent mechanisms of accountability to their constituencies. Community-led organizations, groups, and networks are self-determining and autonomous, and not influenced by government, commercial, or donor agendas. Not all community-based organizations are community led.

   Community-led organizations, including key population-led organizations, are social enablers for the HIV response.

   *Including collectives, coalitions, and other ways that people self organize.

   **These entities may structure themselves differently and may not have all of these actors.

2. **Key population-led organizations and networks** are led by people living with HIV, female, male and transgender sex workers, gay men and other men who have sex with men, people who use drugs, and transgender people. Key populations share experiences of stigma, discrimination, criminalization, and violence and shoulder disproportionate HIV disease burden in all parts of the world. Key population-led organizations and networks are entities whose governance, leadership, staff, spokespeople, members and volunteers reflect and represent the experiences, perspectives, and voices of their constituencies. Key population-led organizations and networks and their expertise are anchored in their lived experiences, which determine their priorities. They speak for themselves and are an intrinsic part of the global HIV response. This definition of key populations is not meant to preclude the ways that people describe themselves, including related to sexual orientation, gender, and gender identity.

3. **Community-led responses** are actions and strategies that seek to improve the health and human rights of their constituencies, that are specifically informed and implemented by and for communities themselves and the organizations, groups, and networks that represent them. Community-led responses are determined by and respond to the needs and aspirations of their constituents. Community-led responses include advocacy, campaigning and holding decision-makers to account; monitoring of policies, practices, and service delivery; participatory research; education and information sharing; service delivery; capacity building, and funding of community-led organizations, groups, and networks. Community-led responses can take place at global, regional, national, subnational, and grassroots levels, and can be implemented virtually or in person. Not all responses that take place in communities are community led.

   Community-led responses are social enablers for the HIV response, shaping the social, economic, political and environmental factors that affect the performance of HIV and AIDS programs and influence the outcomes.

4. **Key population-led responses.** Key populations are primary actors in, and intrinsic to, the global HIV response. Their responses are transformational, based on their priorities, needs and rights. Key populations should be included, on their own terms and with consideration to varying social and structural determinants, at all levels of the global HIV response. Key

population responses aim to strengthen the capacities of their communities and are committed to action, irrespective of resource availability. Key population communities are overlapping and thus their responses strive to be intersectional. Key populations choose their own representative and how they engage in HIV-, gender-, human rights-, and development-related processes.

A request was made that UNAIDS adopt these definitions as soon as possible. Discussion around the definitions raised the point that such organizations and responses are predicated on lived experience, which changes with new members of communities and key population, including young people. Using an intersectional approach will help to ensure that organizations remain dynamic and leave nobody behind. Equally, including their dynamic and changing constituencies is linked to the need for organizations to be accountable and commit to meaningful communication. It is hoped that the language can be used in other contexts, including TB, UHC and non-communicable diseases (and where necessary be adapted e.g. for specifically women-led responses, for example in consultation with UN Women and their community constituents).

VI.   Social enablers and targets

Participants called for the process of target-setting to challenge past neglect and harness upcoming opportunities. Criteria to prioritize enablers should include those that have value for different sectors. It will be necessary and useful to identify ways and opportunities to amplify the rationale for addressing human rights barriers, focusing on proven strategies, and identifying specific entry points (see, for example, the Global Fund catalytic investments and the Global Partnership to end HIV-related discrimination) to galvanize action and eliminate the gaps between commitments and action.

Inputs to the discussion included presentations covering a wide range of social enablers and barriers, as well as existing tools, interventions and evidence to measure and monitor their impact on HIV responses. Discussions expanded on these inputs, with the aim of making progress towards setting real, tangible goals that are ambitious but reachable, with numerical and costed targets that address the roots of problems and promote social enablers. Below is a summary of the social enablers and related targets and measurement tools required to reach all those in need, achieve zero discrimination, and end AIDS as a public health threat.

What is needed to support communities as social enablers?

- Greater articulated work: more coordination between global, national and local organizations - global targets should be aligned with local needs – equal and two-way partnerships between global and grassroots levels and within the local level (avoid competition)

- Common cause and collaboration between communities and allies, including across "key population divides" (e.g. sex work and drug use); those outside the HIV response (eg the women's movement, the labour movement, faith leaders etc.)

- Budgeting for advocacy, including placing a financial value on different ways of doing advocacy. The role of advocacy can be defined as using social and programmatic enablers to change the HIV response in a sustainable way, based on a human rights framework. It should be based in evidence of real needs, address the causes of stigma and discrimination, and

create structural change to make existing behavioural strategies sustainable while providing legal protection to the most vulnerable.

- The meaningful participation of people living with HIV and members of key populations; their meaningful representation in community organizations (e.g. criteria for membership, leadership, decision-making, speaking for the community, employment conditions, etc); and greater ownership by those communities and organizations that do not currently feel reflected in advocacy.

- The adequate and meaningful representation of difference and diversity within communities (across gender, sex, cis/trans, sexuality, ability, age, migration status, drug use, indigenous status…)

- Increased skills and capacity across all community-led activities and organizations

- Community-centered design and delivery: "by us, for us" – services provided by members of key populations, peer support and outreach, volunteerism (which contributes to advocacy and increases engagement in care and the use of services, and can lead to health careers for volunteers), links with wider policy and structural improvements including legal change

    o It should be noted that where services are low-cost because they are provided by volunteers, there is a need to capture these in costing and account for variations in cost of services. When it comes to scaling up service provision, the use of volunteers also becomes more problematic (although they may be crucial to the success of the original programme, which may not then be able to be replicated).

- Strengthening of and resources for community-led structures and processes that enable accountability and monitoring of global, regional and national commitments (including those in the 2016 Political Declaration), policies and laws.

- Community-led research and tools and respect for and inclusion of community knowledge production and expertise

What social enablers (and targets) are needed to support gender-transformative programming?

Attention should be paid in gender-transformative programming to:

- Addressing inequities (ability to access AND use of resources)

    o Economic resources

    o Decision-making power (individual/interpersonal and social) and agency

    o Constraints of care burdens (paid and unpaid)

- The role of gender norms, power dynamics in interpersonal relationships and interactions with HIV and other services (especially health care)

- The most marginalized – intersectionalities (HIV, age, membership of key population, trans/cis, migration status, ability) particularly around stigma

- Gender-based violence (physical, sexual, emotional, institutional), including:

- o Intersectionalities with HIV, mental health, SRHR, pregnancy and motherhood, stigma, drug and alcohol use and punitive policies, sex work

- o Institutional violence (such as forced sterilization, abortion or circumcision), homicide; financial violence; arrest and detention; police extortion; discrimination from health care providers; and domestic violence.

- o Male controlling behaviour

- o Lack of data, especially for transgender women, transgender men, lesbians, bisexuals and other women who have sex with women

- o Lack of sustained funding and investment

- Specific areas where more research is needed:

  - o Adolescent girls and young women (including transactional sex)

  - o Intimate partner violence in same sex relationships and sexual violence against men,

  - o Health-seeking behaviour among men (especially adolescent boys and young men)

  - o Men's access to and engagement in SRHR programmes

  - o Transgender men

- Men as agents of change

- Measuring gender, agency and power relations

  - o Existing tools to measure/investigate gender-related dynamics (cf. for example, Tsima Treatment as Prevention; STRIVE briefs to measure different structural drivers, including alcohol-related HIV risk, IPV, stigma and discrimination, and transactional sex; updated People Living with HIV Stigma Index, the Actions Linking Initiatives on HIV and VAW (ALIV[H]E) Framework,)

  - o Consistent measurements

- Investing in community-led processes and responses (including community monitoring and community documentation) and women's leadership, including in research and community expertise

- Using combination approaches to bring about changes in gendered power structures across all levels (from the individual to society, and across formal and informal spheres).

- Institutional change: organizations with typically patriarchal structures (including government, for-profit and non-governmental) may not be able to lead social norms change programmes.

What social enablers (and targets) are needed to address stigma and discrimination?

Necessary responses to stigma and discrimination include setting targets and indicators; increasing resources for community-led programmes and interventions; monitoring and reporting on implementation; and holding governments to account to address issues raised during GAM reporting.

- Review discriminatory laws, policies and practices
- Prevent, address, monitor and report violence against people from key populations and people living with HIV
- Build and communicate the evidence base, including on:
  - Self-stigma and the cascade of care, including the impact of interventions in health care settings (in the HP+ project in Ghana and Tanzania, health care providers themselves often raised the need for an intervention to help with self-stigma).
- Remove coercion (such as coerced and/or forced sterilization of women living with HIV) or behavioural requirements (such as using certain contraceptive methods) as a prerequisite for accessing services.
- Provide comprehensive training packages and intervention tools for health care workers and law enforcement – these already exist and can be tailored for different audiences and timeframes
  - Total facility approaches can improve conditions for both clients and health workers by providing stigma-reduction training for all staff, from gardeners to receptionists to medical staff.
  - Training needs to be part of wider stigma-reduction interventions rather than implemented alone
- Enhance community empowerment, strengthen the capacity of community health workers, build community interventions, use participatory approaches and engage stakeholders from key populations
- Empower health service users and increase their access to justice.
- Protect the health of health care workers (occupational health and safety standards) and respect their labour rights
- Avoid stigmatizing people who have been engaging in stigmatizing behaviours.
- Support the sustainability of programmes, including support for clinics and health care workers to expand interventions and conduct community outreach

It was noted that standardized and validated measurement tools do exist, and stigma and discrimination indicators should be integrated into national HIV M&E frameworks as part of making stigma and discrimination reduction a key goal in national strategies. Specific targets for measuring stigma and discrimination could include:

- Number of countries repealing criminalization laws
- Number of countries lifting travel ban and HIV-related restrictions
- Number of countries providing care and treatment services irrespective of residence or migration status
- Reports of countries removing employment restrictions based on HIV status
- Number of employers penalized, taken to court for discriminatory practices

- Number of country NSPs and programmes adopting human rights, gender equity and community engagement frameworks

- Percentage reduction in reported negative attitudes from health care workers towards people living with HIV.

- Proxy measure of underinvestment in marginalized communities, or political discrimination (e.g. percentage of recommended investment in harm reduction or other interventions achieved)

Intervention and programmatic tools are also available, so reducing stigma and discrimination across stigmatized groups can be incorporated into all HIV programmes and made an explicit component of delivering high-quality health services. These include:

- The Health Policy Project measurement tool for stigma and discrimination, with indicators covering institutional policies; fear of HIV infection; attitudes and opinions; observed enacted stigma; unnecessary precautions and measures; and staff needs and support.

- The new UNAIDS/WHO/FHI360 BBS guidance (blue book)

- The expanded section on health facility stigma in the revised People Living with HIV Stigma Index surveys (2.0)

- Thailand's national model to routinely monitor and reduce stigma and discrimination

What social enablers (and targets) are needed to support key populations?

Targets for social enablers for key populations to access services should address:

- Intersectionalities between behaviours (unsafe sex work, drug use, same-sex sexual activity) and between memberships of different key populations and with other factors (gender, violence, criminalization etc.)

- Community empowerment, organizing and meaningful participation.

- Community-led services, including peer outreach.

- Bolstering and monitoring advocacy efforts aimed at improving the socio-economic, political and cultural determinants for transgender people.

- Tracking financial investments in programmes that respond to the [high] HIV burden in the transgender community.

- Developing and tracking the impact of complementary programmes that respond to violence against key key population.

- Developing and measuring stigma and discrimination-reduction efforts that contribute to an enabling environment for transgender communities

- Measuring transgender-led programmes implemented to respond to the HIV burden.

- Eliminating laws and policies that criminalize transgender people around the world

- Implementing service provision that incorporates both HIV care and gender-affirming care.

- Addressing stigma and discrimination (including homophobia, transphobia and internalised stigma) and their impacts on physical violence, social and economic isolation, mental health, self-care and the access to and use of services (including confidentiality concerns)

- Addressing stigma, food insecurity and residential instability as products of criminalization and punitive policies (for sex workers and others)

- Addressing the impacts of migration and mobility that confer HIV risks.

- Addressing workplace factors for sex workers (intersecting social, physical, policy and economic features of places within which sex workers operate and work, including venues, street and public spaces, online and other off-street self-advertising spaces)

- Addressing poverty, debt and economic pressures (including client financial incentives and police bribes for sex workers).

What social enablers (and targets) are needed to support decriminalization?

- Decriminalization efforts need to remove (among others):
  - HIV-related travel restrictions (on entry, travel and stay)
  - All related punitive laws for sex workers, their clients and other parties
  - Punitive laws related to drug use, possession and cultivation
  - Laws and policies that criminalize homosexuality/same-sex sexual activity
  - Laws and policies that criminalize transgender people specifically (not just those aimed at criminalizing homosexuality)

- Decriminalization efforts also need to address all discriminatory laws and policies that impact on people living with HIV, key populations and HIV responses, including:
  - Laws that restrict or constrain civil society space.
  - The unjust application of criminal and similar laws to people living with HIV based on HIV-positive status, either via HIV-specific criminal statutes or through general criminal or similar laws, including intended transmission (HIV-specific and infectious diseases) laws; sexual assault laws; anti-homosexuality laws; and anti-pornography laws.
  - Alternatives to punishment or to prison, such as mandatory treatment, administrative detention and other sanctions, prison-based treatment, probation, fines or disciplinary work, that do not qualify as either decriminalization or non-punitive, nor be preferred by key populations (such as people who use drugs, who may not be able or want to pay a fine and would rather go to prison).
  - Mandatory testing policies
  - Employment policies (including restrictions on enlisting in the army or those imposed by international companies such as Chinese companies working in Africa)
  - Policies that provide unequal access to services (such as PMTCT or ART) for migrants

- o Other ways used by governments (and others) to criminalize communities in the absence of explicit laws targeting members of key populations/people living with HIV
  - o This might include "trial by media" as in the case of the Kenyan nurse criminalized for not disclosing her status.
- Ensuring that the outcomes of decriminalization are not *de facto* criminalization, such as by putting in place exorbitant fines for possession and requiring people who use drugs to pay for their rehabilitation.
- Identifying and funding the right implementers to undertake interventions of high quality that are appropriately targeted.

It was noted that eliminating "bad" laws and instituting "good" laws is not the whole or the end of the journey. It is possible, in the absence of good laws, to work with law enforcers to avoid enforcing "bad" laws. A comprehensive response should therefore not only include campaigns to change laws but also strategic litigation and access to justice while waiting for change. Education and training are needed for the judiciary, law enforcement and other law- and policymakers and those responsible for implementing current punitive laws as well as changes in policy and practice following decriminalization. Such programming should be funded in parallel with (and not after) advocating for law and policy change.

Education and training should be spread widely in the justice system, and not merely focus on lawmakers, the judiciary and law enforcement, but also those who support them in their roles. Consideration should be given to the relative success of "add-on" and "examinable" or integrated training. Global Fund baseline assessments have indicated that training on HIV, TB and human rights for legal and health care staff should be integrated into their professional education rather than provided as a one-off, and the feasibility of doing should be investigated. Consideration should also be given to how to balance the impacts of personal-level elements of interventions with a "show and tell" mentality that might prove tokenistic or even serve to increase negative impacts on members of key populations.

Sustainability in the face of political change: political enablers

Throughout the workshop, concerns were expressed regarding the impact of political contexts and changes on the use and efficacy of social enabler interventions. Human rights advances and progressive changes in law – already limited in many cases – have often been rolled back as governments change and/or become politically extreme or polarised or decreasingly secular, or where less-than-ideal alternatives implemented. This is the case, for example, in Mexico and Brazil, where changes in government have resulted in the reversal of progress achieved in implementing non-criminalizing approaches. It is also the case with the current wave of end-demand approaches to sex work that criminalize clients and have a number of negative impacts on sex workers themselves. In Kenya, the recent decision not to overturn the Penal Code provisions criminalizing homosexuality was particularly discouraging because the initial bench had been through training by UNAIDS and others and had previously made positive decisions - however, a new (religious) judge formed a new bench. Another issue is that of the culture of justice systems: where bribery and corruption are rife, it may be easier for those criminalized to bribe a judge than seek real justice.

Long-term and sustainable solutions are therefore vital, and attention needs to be paid in setting targets and programming for social enablers that these are not endangered by hostile political and social contexts. Part of this will be to ensure country ownership and persuade governments that it is better to do things differently. In this context, political targets can helpful (see the success of Universal Access, 3 by 5, and EMTCT (as well as the UHC process)), particularly where social enablers do not yet have any targets. Dedicated national fora can also contribute, as in India, where political and legal achievements have been enabled by the parliamentary forum on HIV/AIDS, which negotiated change within the political system.

Resources are particularly necessary to combat the shrinking of civil society and community space and maintain pressure on governments to implement programmes and achieve targets and objectives. As country contexts may change rapidly, such resources need to be flexible. Resource for social enablers should flow through both government and nongovernment channels, and they must be directed towards community and other civil society organizations.

Group work

A set of social enablers was established through group discussion (see above, *Defining social enablers*), and clustered for more efficient group work. Participants joined groups according to interest and expertise.

Cross-cutting:

- Human rights, including the right to health
- Political will and commitment - investment
- Community system strengthening

Group 1

- Laws, policies, practices and enforcement
    - Decriminalization
- Access to justice

Group 2

- Community-led organizations

Group 3

- Addressing stigma and discrimination

Group 4

- Gender equity
- Sexual rights and reproductive rights
- Violence

Group 5

- Economic justice, security and livelihoods (poverty, housing stability, work, social capital)
- Changing public views/attitudes
    - Education - upstream, CSE, sensitization
    - Knowledge skills and training

The group work was guided by a set of questions, with the moderators emphasizing again that the process would have a huge impact on policy and the need to bear in mind evidence of impact and effectiveness. They were also reminded of the fact that evidence and data do exist, and that there were many resources to draw on.

Groups were also reminded of the importance of distinguishing between social enablers and the programmes and strategies that promote them.

Guiding questions for group work

For each social enabler:

1. List appropriate actions, programmes and strategies

2. Define what the targets should be

3. Define what evidence we can identify

- including new data/examples to draw from

4. Where evidence is lacking, define the specific assumptions to be made

5. Note/flag where development synergies (and synergies between the social enablers) exist.

Results of group work

Laws, policies, practices and enforcement		
Populations	Strategies, programmes, actions ("buckets" or packages of services)	Upper limits/targets
	HIV-related legal services: • Training of community paralegals and lawyers • Paying for paralegals' and lawyers' fees • Funding the court cases: filing fees, expert witness fees • Participant protection • Protection of human rights defenders: mapping community risks, training on safety, provision and protection of information, immediate response • Community monitoring of legal aid services and access to justice: community capacity building, tools	*** NOTE these are umbrella targets covering both laws, policies, practices and enforcement AND access to justice, and the baseline is not known* *** CROSSCUTTING: community engagement and capacity building to engage in all these processes* *** Punitive laws are defined broadly, to include not only specific criminalization or public health laws but others that can be used to criminalize populations* *** Discussions focused on formal justice system but need also to consider role of community approaches eg to access to justice (cf. Global Commission on HIV and the Law report)*

		No new punitive laws are passed
		50% of punitive laws are repealed*
		Zero prosecutions/administrative sanctions under punitive laws
		X countries have adopted legal protections to prevent discrimination against people living with HIV and other key populations (general discrimination covering health, employment, education etc.)*
		How to capture implementation of protective laws??
		10% national HIV expenditure allocated to legal and policy interventions, including access to justice
		At least 90% of resources go to community- and KP-led organizations
		* disaggregated by population/law as appropriate at national levels
PLHIV, KP, other affected populations	*Legal literacy:* • Know your rights campaigns: material development, translation costs, printing, air time (radio, TV etc.), including where and how to access justice	

	• Community-level training: development of curricula and training toolkits, translation costs, training costs	
	Monitoring and reforming laws, regulations and policies relating to HIV: • Support for strategic litigation • Documentation of violation across KPs etc. • Reporting through ombudsmen • Shadow reports to international bodies • Apps/technology to promote reporting and follow-up (also relevant to other areas) • Support to civil society and community participation in international, national and sub-national laws, policies and regulations – funding, political support • Support mechanisms for regular multi-sectoral interface and technical discussion between government and civil society – funding, political support • Development of position papers, technical briefs, advocacy briefs • Support to regional and global networks for cross-country learning • Technical assistance for the creation, amendment and/or appeal of sub-national, national and regional laws, regulations and policies • Review and reform relevant national laws to conform with international standards • Legal environment assessments – participatory process (government, civil society and community), multi-stakeholder dialogue, follow-up mechanisms and accountability	

Parliamentarians, judiciary, lawyers, police	*Sensitization of law-makers and law enforcement agents:* • Pre-service: curriculum development, materials, translation, training, KP participation as trainers • In-service: curriculum development, materials, translation, training, refresher training, KP participation as trainers • Parliamentary fora/technical working groups… that include civil society and community participation	
All health facility staff (health workers, receptionists, guards, pharmacists…)	*Training for health care workers on human rights and medical ethics related to HIV:* • Pre-service: curriculum development, translation, training, KP participation as trainers • In-service: curriculum development, translation, training, refresher training, KP participation as trainers • Health facility-level monitoring of rights violations	

Access to justice		
Populations	*Strategies, programmes, actions*	*Upper limits/targets*
	Safe and functional mechanisms for reporting and redress that are accessible to people living with or affected by HIV • Office of the ombudsman – training, staffing • Human rights commission – training, staffing • Gender commission – training, staffing • Reporting mechanisms e.g. online reporting, health facility complaints mechanisms linked to the above mechanisms for action	x% increase in timely, positive outcomes of legal redress efforts (disaggregated by population?) x people who sought legal redress (disaggregated by population?) – should go up then come down

	Support for community monitoring of reporting and redress mechanisms *Also included under laws, policies, practice and enforcement (see above):* • HIV-related legal services • Legal empowerment of communities • Training programmes on HIV, human rights, gender equality and violence prevention and response for judiciary	

**The following apply across laws, policies, practices and enforcement AND access to justice

Topics that require further attention:

- Proactive multisectoral partnership to include respect, protection and fulfilment of human rights across sectors
- Violence protection
- Property/inheritance rights
- Travel restrictions
- Gender identity
- Policing practices
- Extrajudicial killings
- Intellectual property – drug pricing
- Prisoners
- Migrants
- Adolescents

Research agenda

- Establish baseline for policing practices: harassment of key populations, arbitrary arrest etc.
- Rates of violence against criminalized populations

Assumptions for modeling

1. Law & Policy interventions can be costed (Work to be done here).
2. We need overlapping interventions—training judges is not enough alone, we need strategic litigation, community mobilization, etc. This whole package can be costed.
3. When we reach sufficient capacity then _____% of the time will improve the policy environment by X%. (*policy lab project*)
4. Data to demonstrate the magnitude impact of improved law/policy environment:
   - Data on fear of entering care.
   - HIV stigma → 2.4 times more likely to present late for HIV care

- GAM indicator 4.4 on avoidance of health services to inform assumptions to compare countries with better laws.
- Stigma index 1.0 --> 70 reports, we can pool the analysis on denial of health services.
- Research agenda looking at recent changes in laws and what has happened in broader uptake of services.

Community-led organizations

Area	Strategies, programmes, actions	Upper limits/targets
Funding	**Increasing eligibility of community-led organisation in the procurement process for national, bilateral or multilateral donor funding**	**100% eligibility across all funders**
	Disaggregated reporting on funding for community-led and KP-led organizations globally	100% countries reporting
	Meeting resource needs for service delivery and advocacy by KP (requires agencies to work with global networks to perform total resource needs)	
		50% of resources needs to be met for each KP group by 2025
	Meaningful representation of KPs within country coordinating mechanism	
		100% of translation of national Global Fund documents, summarized in language that is accessible to communities; minimum review time of 30 days; 50% community representation on the CCMs with no conflicts of interest with government

Policy	**Meaningful representation of community within national HIV strategic planning committees**	**50% representation by civil society, of which 80% are from KPs (minimum one rep from each of the 5 key pop group)**
		50% of countries globally and regionally
	Ensure that there is a meaningful process that is owned and set by the community for HIV planning	
		100% of countries
	Broader national health strategies should include HIV	
	National health strategy planning process to include community	10% representation from communities, of whom 50% will be from KP and who will bring awareness of the broader health agenda
Service implementation	**Ensuring community- and KP-led organizations are delivering prevention/testing, medical care, and non-medical care support**	**Community-led services shall be the delivery mechanism for: 90% of prevention/testing services; 20% of medical care; and 90% of non-medical support services. 50% of these community-led services shall be implemented by KP-led organisations**
		100% key population involvement
	Meaningful involvement of key population in the design and development of services that intended for key populations but are not delivered by community-led organisations	

Accountability and monitoring	Increasing transparency for funding and service targets for civil socciety, national governments, regional organizations, multi lateral organizations and global organizations	100% transparency of budgeting process, expenditures, target setting, and progress towards goals at all levels
	Disaggregated data reporting on KP, age and migration status	100% for all countries
	Establishing systems of accountability for service delivery	**70% of countries will have community-led monitoring of quantity and quality of services**
Advocacy	**Advocacy actions are to be conducted and delivered by KP led organizations**	**100% of KP related issues developed and delivered by KP led organizations in meaningful partnerships**
Capacity building for community institution strengthening	**Community system strengthening: Ensuring technical capacity by KP-led organisations to manage and deliver services and conduct advocacy; and ensuring the institutional strength of KP-led organisations**	**100% of funding needed for technical capacity building will be available to peer-led organisations to provide to KP-led organisations. 100% of KP-led organisation shall report that their institutional strength is sustainable and accountable in a self-defined way**
Remove stigma and discrimination as a barrier to the HIV response		
Populations	*Strategies, programmes, actions*	*Upper limits/targets*
PLHIV	• Psychosocial social support interventions to address internalized and anticipated stigma. • Social justice capacity building and Acceptance, Commitment therapy training (ACT) (CHAMPS study – A. Li et al). • Community empowerment	**Target: Reduce internalized stigma by 50% by 2025** Or Reduce internalized stigma among PLHIV to less than 10%

		Indicator: % of PLHIV reporting internalized stigma in the past 12 months
		Target: Less than 10% of PLHIV reporting anticipated stigma in the health facility
		Or
		Reduce anticipated stigma in the health facility by 50% by 2025
		Indicator: Reduce % of PLHIV reporting anticipated stigma in the health facility
		(Anticipated stigma - did any of the following make you delay or hesitate getting care?)
		Target: No experienced stigma or discrimination reported by PLHIV in health facilities

Synergies with:

- Community-led enablers
- Access to justice

Group 3: PLHIV Targets – assumptions and evidence base

Target	Data sources	Evidence	Assumptions
Reduce internalized stigma	PLHIV Stigma Index and DHS new questions on PLHIV stigma	**PLHIV Stigma Index 2.0:** Cameroon – 36 – 55% Senegal – 13-32% Uganda –22 – 53% **PopART:** South Africa – Zambia – Use shame question asked in both as basis for expected range: 20 – 55% (5 countries in Africa)	Many PLHIV not comfortable disclosing their status, therefore, these ranges are likely to be underestimates, so need to be adjusted upwards?
Reduce anticipated stigma in health settings	PLHIV Stigma Index; WHO IBBS	**PLHIV Stigma Index 2.0** Delayed entry into care from anticipated stigma Cameroon, Senegal, Uganda: 21-28%	Need to look at data from other regions to make sure the targets are realistic.
Reduce experienced stigma and discrimination	PLHIV Stigma Index and DHS new questions on PLHIV stigma	**PLHIV Stigma Index 2.0 (3 countries)** 4-26% agreed with any of 4 items	We need to combine exp. stigma and discrimination as reporting of discriminatory acts is often quite low.

Key and vulnerable populations	Psychosocial social support to address internalized and anticipated stigma Interventions to improve coping skills Note: would be tailored for specific key and vulnerable populations	**Target: By 2025, Reduce the percentage of key and vulnerable populations who report avoiding healthcare services because of their key population status by 50%** **Target: Reduce internalized key population stigma by 50% by 2025** **Target: Reduce experienced stigma or discrimination reported by key populations by 50%**

Synergies with:

- Enablers on laws and policies
- Violence
- Gender equity

Target	Data sources	Evidence	Assumptions
Reduce report of avoidance of healthcare services because of their key population	PLHIV Stigma Index; WHO IBBS (new key pop stigma questions)	**PLHIV Index 2.0** Avoided seeking health services: 14 – 42% for MSM 8%-22% for sex workers No data on drug users *Ask MPact*	From KPs living with HIV
Reduce internalized key population stigma	PLHIV Stigma Index	**PLHIV Index 2.0**	From KPs living with HIV
Reduce experienced key population stigma and discrimination	PLHIV Stigma Index; WHO IBBS	? Need to double check.	Don't have this data specific to health facility settings, so are suggesting to keep it broader. We could think of adding a question about this in WHO IBBS

2030 | Ending the AIDS epidemic

UNAIDS

| Community members | Working with key opinion leaders (who is influencing the community?)

• Faith leaders
• Political leaders
• Youth leaders
• Others

Social and mass media campaigns (include new messages: U=U, plus the basics around how HIV is transmitted and not transmitted, stereotypes, norms, etc.)

Using cultural mediums to reach various populations (i.e theater, concerts, sports, etc.) ideally led my the community of PLHIV and key pops | **Target: No fear of contracting HIV from non-transmissible contact among community member by 2025**

Target: 50% reduction in people reporting shame if a family member were living with HIV by 2025

Target: 50% reduction in community members reporting any perceived stigma in the community by 2025 |

Synergy with:

- Individual, family, community (from global partnership work)
- Enabler on laws, policies and practices
- Enabler on education
- Enabler around violence
- Enabler on sexual rights and reproductive rights

Group 3: Community members – assumptions and evidence base

Target	Data sources	Evidence	Assumptions
No fear of contracting HIV from non-transmissible contact	DHS PopART		
Reduction in people reporting shame if a family members were living with HIV	PopART DHS		
Reduction in community members reporting any perceived stigma	Visser PopART DHS		

Health workers	Stigma-reduction intervention in health facilities (HP+ total facility approach; RTI)	**Aspirational Target: No HWs reporting fear of contracting HIV while providing routine care to PLHIV by 2025**
	Introduce comprehensive stigma, discrimination and human rights training as core component in training programs for health professionals (i.e. doctors, nurses, midwives, etc.) * Link with enabler on education (e.g. attitudes and practices)	**Intermediate Target: Less than 20% of HWs reporting fear of contracting HIV while providing routine care to PLHIV by 2025** **Zero % HW reporting unwillingness to care for [key population group] by 2025**
	Introduce monitoring system in health facilities to capture the level of stigma (include inputs from PLHIV and key	**Target: 50% reduction in HWs reporting use of protective**

	pop in the system – i.e. CSO/networks could survey their communities, etc.)	**behaviors during routine care provision with PLHIV** **Target: Zero % HWs reporting agreement that women living with HIV should be forcibly sterilized**

Synergy with:

- Workplace setting (from global partnership work)
- Enabler on laws, Policies and practices
- Enabler on violence (forced sterilization)
- Enabler on reproductive rights

Target	Data sources	Evidence	Assumptions
No HWs reporting fear of contracting HIV while providing routine care to PLHIV	**HP+ HW survey (4 items)**	**Fear composite of 4 items** (taking temp, BP or pulse, dressing wounds, drawing blood and touching) Ghana: 56.3% to 28.5%	
Reduction in HWs reporting unwillingness to care for KPs	**HP+ HW survey**	**HW survey Ghana: (if I had choice, would prefer not to provide care to.)** MSM: from 28.6% to 13.9% SWs: from 18.7% to 9.6% Sexually active adolescents: 12.5% to 7.5%	
Reduction in HWs reporting use of protective behaviors during routine care provision with PLHIV	**HP+ HW survey**	**Protective behaviors** Ghana: 69.2 to 45.5 85.9% to 35.5%	
Zero % HWs reporting agreement that women living with HIV should be forcibly sterilize	**HP+ HW survey**	**HW survey in Tanzania, Ghana, Caribbean, etc.** Question: It can be appropriate to sterilize a woman living with HIV even if it's not her choice. TZ: 45.6 % to 4.3 % Ghana:	

Police and teachers	Similar to HW interventions Note: we are assuming that the groups 1 and 5 are incorporating these interventions into their social enablers. Introduce monitoring system in police and schools to capture the level of	

	stigma (include inputs from PLHIV and key pop in the system – i.e. CSO/networks could survey their communities, etc.)	

Synergy with:

- Workplace setting (from global partnership work)
- Enabler on laws, Policies and practices
- Enabler on violence (forced sterilization)
- Enabler on education and sensitization, etc.

Evidence:

Many interventions have been tested (although more among PLHIV than among KP), including strategies that address internalized and anticipated stigma (e.g. psychosocial support). The next step is to list these and cost them.

Addressing violence (prevention and responses)

Populations	Strategies, programmes, actions	Upper limits/targets
Decision makers	(SDG 5.c) Developing/strengthening and implementing sound policies and enforceable legislation for elimination of harmful practices and gender-based violence. This should be reflected in national HIV policies, strategies, and plans, budgets and accountability frameworks. Decriminalization/reforming punitive laws and policies[10]	100% of NSPs on HIV and AIDS integrate HIV-violence linkages
Women and girls in all their diversity (including transgender, intersex and people with non-conforming gender identities), key populations, and all	NSPs on HIV/AIDS should include programming on these areas: – Addressing violence in HIV risk-reducing counseling – Addressing violence in HIV testing and counseling, vertical transmission services, treatment and care services; -- Provision of PrEP for people at higher risk of intimate partner	These strategies are applicable to concentrated and general epidemics

[10] Red = we assume covered by another group but want to check!

people living with HIV	violence or non-partner sexual violence	
	– Comprehensive post-violence care, including PEP, psycho-social support, access to emergency contraception and safe abortion, PrEP	
	– Addressing HIV in services for survivors of violence	
	-- To include access to safe, nutritious and sufficient food for people who need it into AIDS-related treatment delivery services and prevention programmes (2.1)	
	-- Peer-led safety strategies, such as safe houses, trusted peers and counsellors, safe spaces, drop-in centres, hotlines, etc.	
	-- Community-led advocacy actions, including campaigns, for gender-equitable norms and practices; promotion of rights literacy, etc.[11]	
	-- Sensitization of police, judiciary, health care workers, religious groups, educators, workplaces on violence-HIV linkages (all populations)	
	-- Addressing intersection of violence, harmful alcohol use and HIV risk	
	Stigma-reduction strategies including self/internalized stigma	
	Community-led documentation of human rights violations and response (eg REAct, Violence barometer)	minimum of 1 of each key population-led organization to be sufficiently funded/resourced to implement community-led documentation and response
Gender equity		
Populations	*Strategies, programmes, actions*	*Upper limits/targets*

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[11] Blue = cross cutting, should also be repeated in the other areas of gender equity and sexual rights and reproductive rights

Decision makers	Increase the quantity, quality and focus of investments to guarantee universal access to sexual rights and reproductive rights and scaled-up investments for gender equality and elimination of gender based violence – both by domestic sources and international development assistance when needed – ensuring that the respective financial commitments are effectively implemented and sustained	
Men and boys General population Teachers, school staff, students Women and girls in their diversity, including transgender, intersex and gender non-conforming people	Transforming gender norms • Working with men and boys to transform gender inequitable attitudes and behaviors • Changing unequal and harmful norms through community advocacy and mobilization. • Promoting gender equitable norms and practices in educational settings (challenging practices of patriarchy)	100% coverage in geographic locations and communities with high HIV prevalence
Women and girls in their diversity, including transgender, intersex and gender non-conforming people;	Build social assets/social capital for women and girls in their diversity, including transgender, intersex and gender non-conforming people; • e.g. peer networks, life skills, etc. Ensure meaningful engagement, participation, voice and leadership of	(UN Women target?)

	women in all of their diversity (including transgender, intersex and gender non-conforming persons and other members of LGBTI communities) (SDG5.5)	
Young women including young women living with HIV	Support young women's leadership in areas with high prevalence among adolescent girls and young women	All countries with high HIV prevalence among adolescent girls and young women
Young LGBTI individuals	Support young LGBTI leadership in areas with high prevalence among adolescent girls and young women	All countries with high HIV prevalence among adolescent girls and young women
Decisionmakers (NAC, MoH, UN agencies, etc)	Legal and policy frameworks to support equitable access to HIV-related services and resources (removal of barriers by age, ethnicity, race, gender, SOGIE, sex work, drug use) • provide legal gender recognition that is self-determining	X% (to be calculated) X% of countries (ref SDG 16.9)
Decisionmakers (NAC, MoH, UN agencies, etc)	Promote women's equal rights to economic resources and gender empowerment in national AIDS responses (ref SDG targets 5.a and 10.2) Community-led responses integrating strategies to promote women's and girls' economic empowerment • e.g. training for women living with HIV to improve livelihood • cash transfers, • micro credit, savings groups, etc. Adopt intersectional approaches	100% of national AIDS programmes and plans and gender policies include actions towards this % of community-led responses fully funded and capacitated
Sexual rights and reproductive rights		

Populations	Strategies, programmes, actions	Upper limits/targets
Adolescents and young people in their diversity General population	Implement comprehensive sexuality education programs within and outside schools • Male and female condom education and negotiation skills • Negotiation skills for PrEP and other emerging prevention technologies • Skills for negotiating with service providers	100% of schools implementing CSE # community-led organizations funded and capacitated to implement CSE outside schools (see UNESCO target?)
Women and girls in all their diversity (including transgender, intersex and people with non-conforming gender identities) Key populations, All people living with HIV	Tailored, integrated sexual rights and reproductive rights programmes and services for women in their diversity, adolescents and young people and key populations Strengthen/create strategies for promoting integration between harm reduction services for people who use drugs with SR/RR programmes and services Access to a comprehensive range of quality sexual and reproductive health services free from judgemental attitudes, coercion and violence	X% of national AIDS programmes, gender programmes, and adolescent health programmes 100% of harm-reduction programmes funded and capacitated • elimination of coerced / forced abortion or sterilization among women living with HIV, women who use drugs and transgender persons • 100% access to safe abortion • Elimination of coercive medical procedures including anal examinations for men who have sex with men • Elimination of genital mutilation among intersex people (gender assignment surgery)

	Hormone treatment and gender reassignment surgery as non-elective treatments	
	PEP for non-healthcare injuries and outside of the post-violence care package	
	Community monitoring of quality, appropriateness, accessibility and acceptability of support services including SRHR services	

Goals

- Poverty is an underlying issue – increased vulnerability
- Addressing this issue will allow more choices and opportunities, in particular: access

Populations

- Key populations, including members of key populations living with HIV

Actions/programmes/strategies

A. Access to financial services (microcredit, mortgage, bank services, loans, health insurance)

    Upper limit targets

- 30% of countries to remove discriminatory laws
- 90% of countries implementing studies on the impact on improvement of economic status and livelihoods among key population

B. Protective laws (workplace, anti-discrimination, trafficking,)

Upper limit targets

- 30% of countries incorporate anti-discriminatory language across all legal frameworks

C. Alternative housing and schools

Upper limit targets

- Percentage of countries investing in developing a system that provides alternatives to housing and education

D. Community-led monitoring
Mapping and documenting policies and practices and the impact of the laws including towards people's lives (community-led monitoring)

Upper limit targets

- 70% of countries investing in community-led monitoring systems on laws and practices
- All regional and global networks of KP have community-led monitoring system on laws and practices in place

E. Removal of administrative barriers to social services

Upper limit targets

- Percentage of countries that remove administrative barriers to social services, including:
  o User fees
  o Out of pocket expenditures

F. Data

Upper limit targets

- 100% of countries that disaggregate data by key populations, including transgender population [across different development sectors]

Changing public views and attitudes

Goals

- Political etc systems change all the time; in order to ensure long term impact, there should be investment in changing public views/attitude
- Entry point: right to health
- Changing attitudes and public views to create a sustained enabling environment
  - shift from project to systematic programming

Populations

- "Gatekeepers" to broader society and audience, including but not limited to:
Law enforcement, judges, parliaments, media, networks of communities, private sector, religious leaders, indigenous leaders, community leaders, teachers' associations, educational systems, medical schools [countries may add based on who is contextually strategic]

Actions/programmes/strategies

- Building Knowledge Package (includes training, sessions, workshops, hearings, public dialogues, public discourse….

Upper limit targets

- Minimum of 2 building knowledge packages implemented in country per year
- % of building knowledge packages integrated into academic/vocational base/core training

Evidence/assumptions

- Political and social interests
- Assumption of impact: enabling environment and policies

Development synergies and integration

- Across all other social enabler areas
- Global partnership to end HIV-related stigma and discrimination