WORLD AIDS DAY REPORT 2024

TO END AIDS

UNAIDS

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TAKE THE *RIGHTS* PATH

TO END AIDS

UNAIDS

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Foreword by

WINNIE BYANYIMA

UNAIDS Executive Director and United Nations Under-Secretary-General

The world can end AIDS—if the human rights of people living with or affected by HIV are respected, protected and fulfilled, to ensure equitable, accessible and high-quality HIV services.

The HIV response has come so far that the end of AIDS as a public health threat is achievable, by 2030. The progress on HIV prevention and treatment services that has been made is linked to advances in protecting human rights, and has, in turn, galvanized broader progress in realizing the right to health.

But gaps in the realization of human rights for everyone are keeping the world from getting on the path that ends AIDS, and are hurting public health.

In 2023, 1.3 million people around the world newly acquired HIV—three times higher than the global target set for 2025 of no more than 370 000. To bring down the trajectory of the pandemic, it is imperative that lifesaving programmes can be reached without fear by all who need them.

When girls are denied education; when there is impunity for gender-based violence; when people can be arrested for who they are, or who they love; when a visit to health services is dangerous for people because of the community they are from—the result is that people are blocked from being able to access HIV services that are essential to save their lives and to end the AIDS pandemic. Laws, policies and practices that punish, discriminate against or stigmatize people obstruct access to HIV prevention, testing, treatment and care. So do laws, policies and practices that hinder the work of people providing vital HIV services for affected communities or advocating for reforms. Only rights can fix these wrongs. There is an urgent need to remove criminal and other laws that harm people's rights, and an urgent need to enact laws and approaches that uphold the rights of everyone impacted by HIV and AIDS. Acceptance, respect and care are vital enablers for HIV programmes to work.

This report shows what can be done. It shares examples from around the world of proven policies and programmes that are succeeding in protecting health and HIV services by protecting rights. It sets out how the HIV movement is building up momentum for action. It brings together the latest research, case studies, guest essays from global leaders, and recommendations for getting the world on track to end AIDS as a public health threat by 2030. It is a route map to guide the way.

The HIV response is at a crossroads. We can end AIDS, if we take the *rights* path. Let us walk it together.

ABBREVIATIONS

Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
LGBTQ+	lesbian, gay, bisexual, transgender, queer plus
PHIA	Population-based HIV Impact Assessments
PrEP	pre-exposure prophylaxis
SDGs	Sustainable Development Goals
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

INTRODUCTION

The world's decades-long response to HIV is at an inflection point. The 2024 Joint United Nations Programme on HIV/AIDS (UNAIDS) global report, The Urgency of Now: AIDS at a Crossroads, demonstrated that the world now has the means to end AIDS as a public health threat by 2030 *(1)*. Midway to the 2025 milestone set at the United Nations General Assembly in June 2021, the global HIV response has moved closer to the goal of ending AIDS as a public health threat by 2030, a commitment enshrined in the Sustainable Development Goals (SDGs). Fewer people acquired HIV in 2023 than at any point since the late 1980s. Almost 31 million people were receiving lifesaving antiretroviral therapy in 2023, a public health success that has reduced the numbers of AIDS-related deaths to their lowest level since the peak in 2004.

Despite these successes, the world is currently not on track to end AIDS as a public health threat by 2030. In 2023, 9.3 million [7.4 million–10.8 million] people living with HIV were still not receiving antiretroviral therapy and 1.3 million [1.0 million–1.7 million] people newly acquired HIV. In the regions where numbers of new HIV infections are growing the fastest, only very slow progress is being made in scaling up pre-exposure prophylaxis (PrEP). These regions also lag behind sub-Saharan Africa in progress towards meeting the 95–95–95 HIV testing and treatment targets.[1] Coverage of prevention services among the populations at greatest risk of HIV is far too low—typically at less than 50%. In at least 28 countries, the number of new HIV infections is on the rise, and a growing resource gap imperils the important progress made to date in the global HIV response.

At this historic crossroads, the path the world takes—towards ending AIDS, or towards a future of needless illness, death and unending costs—depends on political will.

The world now has the means to end AIDS as a public health threat by 2030.

1 95% of people living with HIV know their HIV status; 95% of people who know they are living with HIV receive antiretroviral therapy; and 95% of people receiving antiretroviral therapy have a suppressed viral load.

HIV services will reach people in need only if their human rights are upheld.

How to end AIDS as a public health threat is not in doubt. More than four decades since the HIV pandemic was first recognized, research and extensive hands-on experience in diverse settings have identified some of the key ingredients for success, including bold and sustained political leadership; ready access to affordable prevention and treatment tools; sustained action on human rights, including gender equality; community-led engagement across the breadth of the response; and robust and sustainable financing.

This report focuses on one of these essentials—the central role of human rights as it relates to ensuring access to HIV prevention and treatment services and addressing the structural determinants that increase vulnerability to HIV. To end AIDS as a public health threat, there is a need to respect, protect and fulfil the human rights of all people living with or affected by HIV, including people from key populations. An approach grounded in human rights is vital for the collective HIV response to be robust, person-centred and sustainable. HIV services will reach people in need only if their human rights are upheld; if discriminatory and harmful laws are removed; and if stigma, discrimination and violence are effectively tackled.

Since the earliest days of the HIV pandemic, the global response has—in large measure due to sustained community advocacy and systematic research and evaluation—recognized human rights at its centre. At the very outset of the response, the Global Programme on AIDS at the World Health Organization (WHO), under the leadership of the late Jonathan Mann, emphasized the inextricable links between human rights and health. In 1989, the very first resolution relating to discrimination and HIV was adopted at the then United Nations Human Rights Commission, along with a report on problems and causes of discrimination against people living with HIV *(2)*. The 2001 United Nations General Assembly Declaration of Commitment on HIV/AIDS, a landmark in the global response to HIV, declared "Realization of human rights and fundamental freedoms for all is essential to reduce vulnerability to HIV/AIDS" *(3)*.

The global HIV response has advanced and amplified efforts to achieve gender equality and shone a global spotlight on the human rights of all people, including people living with HIV and people from key populations—gay men and other men who have sex with men, sex workers, people who inject drugs, transgender people, and people in prisons and other closed settings. Experience in the global HIV response has shown that person-centred, human rights-based approaches are effective and sustainable in achieving public health aims.

The central role of human rights in the global HIV response

Many people consider the creation of UNAIDS in 1996 as marking a starting point for the modern global HIV response. Recognizing that efforts to address the HIV pandemic needed to extend well beyond the health sector, HIV stakeholders purposely established a multisectoral United Nations joint programme to galvanize actions at the global, regional and country levels to respond to HIV and AIDS, which at the time was increasing exponentially and erasing decades of development gains, but receiving only limited attention.

Community and civil society organizations led the way in demanding that the international community ground the response to HIV in human rights principles. Placing people and human rights at the centre of the global HIV response was, therefore, a defining principle of UNAIDS from its outset. As one of its very first steps, in 1996 UNAIDS joined with the Office of the United Nations High Commissioner for Human Rights to develop the International Guidelines on HIV/AIDS and Human Rights. Following consultations with international experts on health and human rights, the International Guidelines were amended in 2002 and consolidated in 2006 *(4)*.

At a time when many countries and stakeholders were uncertain as to how best to address a spiralling health challenge, the International Guidelines provided a roadmap for aligning national responses with human rights commitments. The International Guidelines advised: "Public health interests do not conflict with human rights. On the contrary, it has been recognized that when human rights are protected, fewer people [acquire HIV] and those living with HIV and their families can better cope with HIV and AIDS" *(4)*.

Human rights have continued to guide and inspire the global HIV response—from the global movement for universal access to affordable HIV treatment, to focused efforts to remove punitive laws targeting people living with HIV, women and girls, and people from key populations, to the 10–10–10 social enabler targets for 2025.

SOCIAL ENABLERS		
10–10–10 targets for removing social and legal impediments towards an enabling environment limiting access or utilization of HIV services		
Less than 10% of countries have punitive legal and policy environments that deny or limit access to services.	Less than 10% of people living with HIV and people from key populations experience stigma and discrimination.	Less than 10% of women, girls, people living with HIV and people from key populations experience gender inequality and violence.

Although crucial gains in the realization of rights have been made in the global HIV response, human rights violations continue to undermine national HIV responses and slow progress towards the 2030 goal of ending AIDS as a public health threat. Currently, only three countries report no prosecutions over the past 10 years for HIV nondisclosure, exposure or transmission, and have no laws in place criminalizing sex work, same-sex relations, possession of small amounts of drugs, transgender people, or HIV nondisclosure, exposure or transmission *(5)*.

Across 42 countries with recent survey data, nearly half of people (47%) harboured discriminatory attitudes towards people living with HIV *(6, 7)*, with surveys in 25 countries finding that nearly a quarter of people living with HIV experienced stigma when seeking non-HIV-related health services in the previous year *(8)*. Beyond health-care settings, and across the world, the people who are most vulnerable to HIV commonly experience violence, social exclusion and other human rights abuses. Women and people living in rural areas have more odds of experiencing HIV-related perceived stigma *(9)*.

Today, actions to ensure a human rights-based response to HIV confront major new challenges. Even as important progress has been made in removing punitive laws that undermine HIV responses, growing human rights violations are hampering vital services. The human rights environment is deteriorating in many countries, and the commitment to multilateral efforts to address global challenges is often fraying *(10)*. These trends are interconnected and threaten to undermine access to HIV prevention and treatment. Contexts that are experiencing democratic retrenchment are frequently those that are increasingly hostile to gender equality and the human rights of people from key populations *(10–14)*.

In 2023, the world celebrated the 75th anniversary of the Universal Declaration of Human Rights. The international human rights covenants and instruments the world has made set out the fundamental rights belonging to every person and the obligations of all countries to ensure their promotion, protection and fulfilment for people living with or affected by HIV. Even in the face of the anti-rights backlash, the world continues to celebrate and build on its human rights achievements. At its 68th session, the Commission on the Status of Women called for governments to fully respect and fulfil the human rights of women and girls, to eliminate violence and discrimination in all their forms, to promote the leadership and engagement of women, and to address health threats to women, including HIV *(15)*. In 2024, the Human Rights Council adopted a landmark resolution reaffirming that the "protection and fulfilment of human rights in the context of HIV" is "an essential element in achieving the full realization of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health and in ending AIDS" *(16)*.

ESSAY

This is a fight for equality and justice

Elton John
Musician and founder, Elton John AIDS Foundation

In 2024, we have seen more incredible scientific breakthroughs in the HIV response, with new long-acting prevention medicines offering real hope of ending HIV transmission and showing the very best of what humankind can achieve.

Just as these scientific advances demonstrate the best of humanity, however, we are witnessing and living through times where the worst of humanity is laid bare, where dehumanization and suffering are rife, and where one life is considered more important than another.

Approximately 9.3 million people living with HIV are not receiving treatment. Marginalized groups—the LGBTQ+ community, people who use drugs, women and girls—do not get the same access to health information, medicines and support, because their circumstances somehow make them undeserving. Shockingly, 44% of all new HIV infections worldwide are among women and girls. The risk of acquiring HIV is 23 times higher for gay men and other men who have sex with men than for people in the general population.

Inequality threatens our future. Stigma and discrimination, fear and neglect are pushing millions of people away from lifesaving health services and standing in the way of ending AIDS as a public health threat. This is heartbreaking to me, both personally and as the founder of the Elton John AIDS Foundation.

When I set up the Foundation in 1992, there were no gamechanging medicines, no government support—but there was plenty of gay-hate and far too much AIDS shame. Since then, we have seen huge leaps forward. Effective HIV testing, treatment, prevention and post-exposure medicines and the funds to dramatically expand their use, by initiatives such as the bipartisan United States President's Emergency Plan for AIDS Relief (PEPFAR) and the multilateral Global Fund to Fight AIDS, Tuberculosis and Malaria, have helped tens of millions of people access lifesaving care. But the shame—the idea that people

We need to strip away the labels of "us" and "them", of "undeserving" and "worthy".

affected by HIV do not deserve our help—agonizingly persists.

I know the feeling of shame and what it can do. I grew up in an era when being gay was seen as sin. Although I have never hidden my sexuality, one of the reasons why, even as a successful singer and songwriter, I became addicted to drugs was because I felt I was not loveable enough. If there had not been people who really saw me for me, rather than discounting me because of my gayness or my addiction, I would not be alive today.

Shame causes suffering and loss. The human costs it carries are momentous. We know that suicide, poor mental health, substance abuse and HIV risk are all exacerbated by fear, hate and marginalization. It is time we all understood the real price and loss of shame. When you consider the millions of people who have been dehumanized and disenfranchised by difference and indifference—scientists, artists, academics, writers, leaders of all kinds—whose labels defined and ultimately destroyed them and the gifts they had to offer—it feels like, as a world, we are sabotaging our future.

Indeed, an increasing number of "us", as we may be politically expedient to define, are becoming "them" to many of our leaders and some of their followers. In our world, and at a time when democracy itself can often seem to be teetering on the brink, democratic values of freedom, equality and respect for each other are being systematically challenged or cast aside.

We need to strip away the labels of "us" and "them", of "undeserving" and "worthy", across our societies—labels that drive disease underground, cause immeasurable suffering, and ultimately destroy much-needed and precious potential.

This is why the work of the Elton John AIDS Foundation focuses on the people who too often are being left behind. We work in some of the most challenging countries and contexts because ending AIDS as a public health threat depends on access for everyone, everywhere.

But we also need governments around the world to invest in the prevention, testing and care programmes that can keep people safe; to build health-care systems that do not discriminate; and to invest in and share the wealth of new technologies and treatments that can ultimately end AIDS as a public health threat. Above all, leaders must remove the laws that drive stigma and discrimination, so that as societies we can foster cultures that celebrate differences, not demonize them.

There is a chapel in my house in Windsor dedicated to the friends I've lost to AIDS; their memories are etched on my soul. And from all the people I have met over the last four decades, from a young mother in a South African township to a gay man in Kyiv, I have learnt that as long as HIV is seen as a disease for the "others", not so-called "decent people", AIDS will not be beaten.

Science, medicine and technology may be the "what" in ending AIDS, but inclusion, empathy and compassion are the "how". Demonizing other people, scapegoating them and scaring society about them comes with much drama and costume and lends itself to secrets and lies. Embracing people for their honest differences, recognizing that we all have a unique contribution to make in the world and are worth loving and saving, is more challenging in today's world, but ultimately more enriching and more noble. Surely we are up for that challenge?

Confronting violations of human rights that threaten access to lifesaving HIV services

Access to HIV prevention and treatment services is inextricably linked to upholding human rights of people living with or affected by HIV. To entrench human rights as the foundation for the HIV response, and to ensure this centring of human rights can be sustained, unified forces are more effective than isolated efforts.

In eastern and southern Africa, the ESA Network is helping to bring together people working to advance the health, well-being and human rights of LGBTQ+ people living with or affected by HIV.

With the support of MPact Global Action for Gay Men's Health and Rights, LGBTQ+ leaders from sub-Saharan Africa strategized at the 2022 International AIDS Conference about how best to address the surge in anti-LGBTQ+ sentiment and legislation across the region. After a face-to-face meeting in Marrakesh, Morocco, the activists decided it was time to form a network to champion advocacy and promote safer and thriving communities of gay men and other men who have sex with men. This new network aims to learn from previous efforts to sustain a regional network for LGBTQ+ people.

Alex Kofi Donfor, co-founder and executive director of LGBT+ Rights Ghana, is involved in efforts to get the new network off the ground. His organization has experienced first-hand how surges in homophobia and intolerance pose risks to LGBTQ+ people. After LGBT+ Rights Ghana created a safe space for the provision of health information and services to the LGBTQ+ community, the centre was forced to close after hostile media coverage, much of it stoked by far-right groups from the Global North.

"But we have been resilient," remarks Kofi, "and are looking for diverse ways to reinvent our work to create the safe space our community needs."

"What we are facing is not peculiar to one country," he says. "We have seen laws proposed across the region to target LGBTQ+ people or any form of sympathy for LGBTQ+ people. We needed to create a regional network to protect our community. If we can influence even one country, then that can help shape the approach of other countries as well."

"The LGBTQ+ community has been a scapegoat in so many of the sufferings we go through as Africans. It can be draining. On the one hand, you have some state institutions that are supposed to look at the interests of its own citizens but are perpetrating harms against its own citizens. We also have some media in the region that can be very shallow in their approach to discussing sensitive issues. We need a different narrative that can speak not only to issues in our own community but to the public at large. In particular, we need to find ways of showing how empowering LGBTQ+ people benefits everyone."

Fully aligning the HIV response at the global, regional and country levels with human rights is not only the right thing to do; it is also essential for ending AIDS as a public health threat. In recent years, a large body of evidence has emerged on the effects of human rights violations on progress in the HIV response. Although human rights violations persist in some countries that appear to be on track to achieve HIV epidemic control, a clear pattern emerges from available data. This new evidence finds that countries with policy frameworks that promote, protect and respect human rights tend to achieve markedly better HIV outcomes than countries with coercive and punitive approaches towards HIV and the populations most affected by HIV. In particular, human rights violations have a notably negative effect on outcomes along the 95–95–95 testing and treatment cascade.

This report focuses on the essential role that human rights must play if the world hopes to end AIDS as a public health threat. It begins with a review of the latest evidence on the role that human rights protections and violations play in progress and setbacks in the HIV response, including reaching the 2030 milestone of ending HIV as a public health threat. It then provides a status report on human rights in the context of HIV—identifying where the world is falling short, while highlighting opportunities to close human rights gaps in the response. The report ends with a call to action and a series of concrete recommendations to strengthen and mainstream human rights as a means to ensure accessible and sustainable HIV prevention and treatment outcomes, recognizing that failure to do so will cost countless lives and block the world's ability to end AIDS.

Boxes in the report highlight key human issues in the global HIV response and profile community-led efforts to resist the anti-rights and anti-gender backlash and advance the human rights of everyone affected by HIV. Guest essays by global leaders from different regions and walks of life explain why protecting and promoting human rights is fundamental to ending AIDS as a public health threat.

This report has a wide range of audiences. It is addressed to governments, which are the primary duty-bearers for protecting human rights and ensuring their citizens have access to HIV services, if needed. The recommendations in this report are not unorthodox, but rather urge governments to follow through on the commitments they have already made in national plans and strategies that align with the Global AIDS Strategy 2021–2026 *(17)* and the United Nations General Assembly 2021 Political Declaration on HIV and AIDS *(18)*.

The report offers lessons for all involved in the HIV response. Human rights cannot be understood as a siloed or distinct element of the response, but instead need to guide action across the breadth of the response. All HIV actors—clinicians, programme managers, service providers, researchers, policy-makers and communities—need to apply a human rights-based approach to HIV service delivery, advancing gender equality and the universal right to health, promoting equity and inclusion, and taking steps to address the social and structural factors that result from and give rise to human rights violations in the context of HIV.

The report also speaks to everyone engaged in health more broadly. The lessons of the HIV response can be applied to many other aspects of the health sector and government obligations with respect to the right to health.

International donors are another key audience for this report. Given that few national authorities invest in civil society advocacy that challenges their existing practices, laws and policies, international solidarity is vital to ensure the robust funding needed for policy reform advocacy and other human rights work to accelerate and sustain access to HIV services.

As countries develop roadmaps for long-term sustainability of the HIV response, a key message of this report for all stakeholders is that a sustainable response to HIV is possible only where the human rights of people living with or affected by HIV are respected, protected and fulfilled to ensure equitable, accessible and high-quality HIV services. Biomedical and behavioural interventions can achieve their desired impact only if the communities most affected by HIV have structural enablers in place to ensure access to and the ability to use them, without fear of stigma and discrimination.

1

THE WORLD CANNOT END AIDS WITHOUT A HUMAN RIGHTS-BASED APPROACH

A growing number of countries are making historic progress towards ending AIDS as a public health threat.

As of December 2023, four countries were on track to reduce numbers of new HIV infections by 90% by 2030, and an additional 18 countries were within reach of this target. Nine countries had reached the 95–95–95 targets, and a further 10 countries were close to these targets. Yet, although impressive advances in HIV treatment continue, the world is not close enough to reaching the HIV prevention and social enabler targets set out in the Global AIDS Strategy 2021–2026 *(17)* and the 2021 Political Declaration on HIV and AIDS *(18)*.

UNAIDS projects that at least 35 countries have the ability to achieve exceptionally high levels of HIV viral suppression by 2025 if they take necessary action to continue and accelerate current momentum *(19)*. In countries where national HIV responses are on track, these gains will be sustained only if disparities in service access and outcomes are closed and no one is left behind. In a number of countries that are closing in on HIV control, further efforts are needed to leave no one behind. For example, in Kenya, overall antiretroviral therapy coverage in 2023 was 96%, but coverage is below 50% among people from key populations, including sex workers, gay men and other men who have sex with men, people who inject drugs and transgender people *(20)*.

Unlike countries that are on track to reach their targets for ending AIDS as a public health threat, most countries are not presently where they need to be for ending AIDS as a public health threat. Globally, the 1.3 million [1.0 million–1.7 million] new HIV infections in 2023 were more than three times higher than the global target for 2025 (370 000). Outside sub-Saharan Africa, an estimated 80% of new HIV infections in 2023 were among people from key populations and their sex partners. And although decreasing, the incidence of HIV among adolescent girls and young women aged 15–24 years is extraordinarily high in parts of sub-Saharan Africa. To change the trajectory of the epidemic, it is essential to make major gains in accelerating HIV prevention services and to reach marginalized communities that are most vulnerable to HIV.

The AIDS pandemic continues to be driven in large part by underlying inequalities and inequities that increase vulnerabilities, diminish service access, and undermine the social solidarity needed to accelerate and sustain an effective HIV response. As this report shows, these inequalities in the HIV response are often the result of human rights violations, many of them systemic and sanctioned by law. Laws, policies and approaches that are stigmatizing, discriminatory,

ESSAY

The end of AIDS is within our grasp—if we uphold rights

Michael D. Higgins
President of Ireland

We are at a critical moment that will determine whether world leaders meet their commitment to end AIDS as a public health threat by 2030, in line with the United Nations 2030 Agenda. Whilst the end of AIDS is within our grasp, currently the world is off track to do so—as with so many of the Sustainable Development Goals, our collective blueprint for a flourishing future.

Globally, of the 39.9 million people living with HIV, almost a quarter (9.3 million) are not receiving lifesaving treatment. Consequently, a person dies from AIDS-related causes every minute.

It is 42 years since the first cases of HIV were diagnosed. It may be troubling to recall the moral and ethical atmosphere of society then, but it is necessary to give testimony to the people who lived through the HIV experiences of the time. The people who suffered the most in the 1980s were those exposed not only to a prejudice born of misunderstanding of HIV, but also other forms of social oppression, which were—and are—too often manifested in our society.

Challenging stigma, discrimination and inequality is key to ensuring public health.

Our multiple, concurrent global crises, including the return of extreme hunger and famine in the Horn of Africa, and the promulgation of wars in Ukraine and the Middle East, have the consequence of pushing the fight against AIDS further down the international agenda. It is essential that we keep the HIV response firmly and prominently on the agenda. Ending AIDS as a public health threat requires stepping up action to respect, promote and fulfil human rights.

As we reflect on the past four decades, it is clear that the institutional and societal responses in many countries

Fulfilling the pledge to end AIDS as a public health threat is a political and financial choice.

were anything but adequate in those early years of HIV. Great strides have been made thanks to the efforts of activists and campaigning organizations, often conducted in the face of ignorance and hostility.

I take this opportunity to acknowledge and pay tribute to those activists and the researchers working at the frontiers of science for their endeavours in this important area of public health policy.

There remain many parts of the world where HIV remains stigmatized, where a sense of shame is attached to living with HIV, and where access to treatment is poor.

It is an appalling statistic that over 40 million people have died from AIDS-related causes since the beginning of the epidemic—including 630 000 people in 2023. Although this represents a halving of fatalities—from 1.3 million in 2010, and a 69% decrease from the peak of 2.1 million in 2004—these 630 000 people suffered preventable deaths and their lives have tragically been cut short. Sub-Saharan Africa, home to two-thirds of all people living with HIV globally, remains the hardest hit region.

Globally, there is much which needs to be done, and approached with urgency. Access to treatment remains the core challenge, because about a quarter of people living with HIV lack antiretroviral medicines. Universal health coverage and access to good-quality health care, including sexual and reproductive health services, are essential if we are to end AIDS as a public health threat by 2030.

Challenging stigma, discrimination and inequality is key to ensuring public health and delivery of successful HIV programmes. The importance of supporting civil society in securing progress in the realization of human rights, including those related to the achievement of public health initiatives such as HIV programmes, remains as important today as it ever was.

Upholding the rights of women and girls is vital because gender is an inextricable aspect of HIV. Young women are disproportionately vulnerable to HIV. Older women and young girls are disproportionately affected by the burden of caregiving in the wake of HIV. Gender inequality and poor respect for the human rights of women and girls are key factors in the HIV epidemic, from the point of view of effectiveness and from the perspective of social justice.

Ensuring that the fullness of human rights is achieved, that their interconnectedness is understood, and that their moral and practical necessity is realized is crucial if we are to rid the world of the scourge of AIDS.

Support for the rights of marginalized communities underpins Ireland's international HIV programmes and the approach to global health initiatives. It is a fundamental tenet that is essential to the success of HIV programmes given that HIV disproportionately impacts the most vulnerable people in society.

Now is the time to look forward to all that must still be achieved around the world to realize the possibility of an AIDS-free generation and to ensure people living with HIV can live their lives without stigma, fear or discrimination. We are also required to create the consciousness for more inclusive and just societies.

It is urgent that we come together in solidarity to deliver a response that eliminates inequalities based on gender, sexuality and race; that raises the dignity of all people and meets the demands of social justice; and that is truly capable of ending AIDS and ensuring people living with HIV can live free of stigma, prejudice and discrimination.

Fulfilling the pledge to end AIDS as a public health threat is a political and financial choice. The time to choose the correct path is long overdue.

coercive or punitive hinder the engagement and service access of the vulnerable people and communities most likely to be left behind. When authorities fail to reach the people who are most in need, the consequences include needless new HIV infections and AIDS-related deaths, worsening and prolonging epidemics. These harms can be put to an end through evidence- and human rights-based approaches.

Why human rights are essential to ending AIDS

When AIDS first emerged more than 40 years ago, it represented one of the world's foremost public health challenges. In the intervening years, epidemiological and biomedical research, innovations and programmes have delivered results, rapidly identifying how HIV is transmitted and prevented, and developing an extraordinarily potent array of prevention and treatment tools that have reached millions of people around the world—including the more than 30 million people who now have access to lifesaving HIV treatment.

Scientific advances on their own cannot ensure the world will end AIDS as a public health threat.

It has been demonstrated that scientific advances on their own cannot ensure the world will end AIDS as a public health threat *(21)*. Indeed, the protection and promotion of human rights has been central to the successes of the global HIV response. The multifaceted nature of the AIDS pandemic and the interrelated and interlinked nature of human rights mean that the global HIV response intersects with an expansive array of fundamental rights. A review of a sample of internationally recognized human rights shows how these rights intersect with biomedicine, often playing a determinative role in whether available prevention and treatment interventions are accessible and effective. The world's ability to leverage historic scientific advances to end AIDS depends in large measure on progress in upholding human rights for people living with or affected by HIV, including people from key populations.

The right to health

The Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, and the WHO Constitution recognize the right of all people under international law to the "highest attainable standard of physical and mental health" *(22)*, with the International Covenant legally binding on states. According to the Committee on Economic, Social and Cultural Rights, as part of this right governments are responsible for ensuring the availability, accessibility, acceptability and quality of health services and health promotion efforts and for addressing the underlying determinants of health *(23)*. In the context of HIV, this requires, among many other things, that all people living with or at risk of HIV have meaningful access to person-centred health services that meet their needs. States have an immediate obligation to ensure enjoyment of this right without discrimination. Without equitable service access, preventable new HIV infections persist and many people living with HIV do not have a suppressed viral load.

ESSAY

Public health depends on human rights

Adeeba Kamarulzaman
Professor of Medicine and Infectious Diseases and Pro Vice Chancellor and President of Monash University, Malaysia, and former President of the International AIDS Society

As a trained HIV physician, it has been inspiring to witness the steady development of ever-more effective treatments for HIV. The continual expansion of proven HIV prevention tools has resulted in lifesaving benefits for so many people.

But it has also been heartbreaking to witness the obstruction of scientifically proven methods from reaching their full potential.

When in 1997 I started my service in my home country, Malaysia, my HIV practice was overwhelmed with people who inject drugs. I was struck by the contrast with my experience where I received my medical education and training, in Australia—where although I had seen plenty of patients living with HIV, almost none of them had acquired HIV through injecting drugs.

The HIV response has demonstrated that, as health workers, we cannot leave the work of advocating for human rights to other people.

The reason became readily apparent. Australia was addressing drug use as a public health issue, and people who used drugs could access harm reduction services and protect themselves from HIV—but Malaysia was applying a punitive and highly stigmatizing approach to drug use, and people who used drugs could not access harm reduction services or protect themselves from HIV. Drug use was prevalent in Australia and Malaysia, but the very different human rights climates drove very different public health consequences.

This experience had a profound impact on my professional career and on me personally. The Hippocratic Oath taken by all physicians mandates that we

Societies are stronger when everyone is treated with respect, dignity and inclusion.

focus on helping people who are sick and that we do no harm by our actions or inactions. I came to understand that improving health outcomes for my clients needed more than just a biomedical approach. I also had to become a defender of their human rights.

Providing HIV prevention and treatment services to people who inject drugs, including people in prisons and other closed settings, led me to become deeply involved in the reform of drug policy, because it is clear that only by aligning drug policy with human rights principles will it be possible to advance public health.

Some critics said that enabling harm reduction would be impossible in a country like ours. But after years of overcoming resistance, we implemented it—and it worked. Since the introduction of the harm reduction programme, needle-sharing has stopped being the main channel for HIV transmission in Malaysia and prevented thousands of new infections.

Some critics said that harm reduction would be unaffordable, but it saved the country huge amounts of money.

The HIV response across the world has demonstrated that, as health workers, we cannot leave the work of advocating for human rights to other people.

Human rights violations are keeping our scientifically proven tools from working. Too many people are still being pushed away from lifesaving care because they are from communities whose rights are being violated. People who come to health centres only at a very late stage of HIV tell us that they delayed seeking treatment because they were afraid of being kicked out, losing their jobs or being treated badly. When we fail to tackle discrimination, HIV wins and humanity loses.

The evidence is clear. Without protecting everyone's human rights, we will not be able to end AIDS as a public health threat.

In recognition of this, the International AIDS Society–Lancet Commission on Health and Human Rights, which I co-chaired, issued a recommendation that "practitioners and stakeholders across the health field should ensure that all aspects of their work reflect and promote a commitment to human rights".

To help protect public health by protecting human rights, the Commission further recommended that people working in the health field should make common cause with other sectors and communities, including human rights organizations and scientists, and advocates addressing issues such as climate justice, women's rights, LGBTQ+ rights, and racial and migrant justice.

We are at a challenging moment, in which human rights are under attack worldwide. People seeking to take away human rights sometimes claim to be defending religious values—but these claims are false.

I know that working to protect everyone's health by protecting everyone's human rights is honouring Islamic teaching, fulfilling its commitment to compassion and its prioritization of the preservation of life. To uphold human rights is to recognize the value of the life of every individual and to see that our societies are stronger when everyone is treated with respect, dignity and inclusion. Likewise, protecting public health requires that we leave no one behind, understanding that none of us is safe and secure until all of us are. It is not for us to judge others but to take care of each other.

Human rights belong to everyone, and upholding them is essential to enable us all to be healthy and to flourish.

Affordable and accessible health technologies: essential to realizing the right to health

Achieving the highest attainable standard of physical and mental health necessitates, among other things, the ready accessibility of effective health technologies for everyone who needs them. Historically, the inaccessibility of essential medicines, diagnostics and preventives has been an important driver of global health disparities, because many low- and middle-income countries have waited years or even decades for the prices of breakthrough technologies—which are rapidly made available in high-income countries—to become affordable and available for widespread use.

The global HIV response broke this model for medicines access, in large part due to the demands of activists for universal treatment access. The emergence in 2001 of generic antiretroviral medicines manufactured in India led to marked declines in the prices of HIV medicines during the first decade of the 21st century, which in turn enabled worldwide access to antiretroviral therapy. Civil society advocates continue to work to improve affordability, most recently in Indonesia, where the Indonesia AIDS Coalition in 2022 and 2023 opposed the patent for bedaquiline, a component of first-line treatment for multidrug-resistant tuberculosis (TB) *(24)*. Following in the footsteps of earlier actions by such countries as Brazil, Ecuador, Malaysia and Thailand, the Government of Colombia in 2024 issued its first compulsory licence for dolutegravir, a component of the recommended first-line HIV treatment regimen. Unfortunately, efforts by countries to make full use of flexibilities afforded under the Agreement on Trade-related Aspects of Intellectual Property Rights (TRIPS) are frequently hindered by economic and political pressures from the pharmaceutical industry and the governments of high-income countries.

As a result of sustained advocacy by civil society, Unitaid moved in 2010 to establish the Medicines Patent Pool as a mechanism to accelerate market entry of patented products through voluntary licensing agreements. Many, but not all, pharmaceutical companies in the HIV space now often enter into voluntary licensing agreements, frequently through the Medicines Patent Pool. As of September 2024, the Medicines Patent Pool had executed voluntary licensing agreements with patent holders of 13 antiretroviral medicines and one HIV technology platform *(25)*. Although this approach is imperfect—whether to seek a voluntary licence is still up to each company, and licences typically exclude many middle-income countries with a heavy HIV burden—it has nevertheless saved tens of thousands of lives and shown the global health field the feasibility of achieving rapid global uptake of breakthrough health technologies *(26)*. Unitaid has played a valuable market-shaping role in the push for worldwide HIV treatment access, with especially transformative results in accelerating the affordability and uptake of paediatric antiretroviral medicines.

The fight to ensure HIV technologies are affordable and available for all is not finished. Long-acting antiretroviral formulations for HIV prevention and treatment are becoming available, with two large clinical trials in 2024 demonstrating the remarkable efficacy of twice-yearly injectable lenacapavir for PrEP *(27, 28)*. One group of scientific experts refers to the emergence of these compounds as "perhaps the greatest advance in HIV care in over a decade" and a potential gamechanger with respect to efforts to achieve global HIV targets *(29)*. To fully leverage the potential of these new technologies to accelerate progress towards ending AIDS as a public health threat, concerted efforts must focus on ensuring affordable access in all settings, overcoming regulatory hurdles, and building the capacity of health systems to quickly and effectively introduce these transformative tools *(29)*. Without this prioritized, coordinated push by HIV stakeholders, it is projected that meaningful access among the people who need these technologies the most could be delayed "until well into the 2030s" *(29)*. In 2024, the maker of lenacapavir announced non-exclusive voluntary licensing agreements with six generic manufacturers to produce the medicine for use in 120 resource-limited countries, pending regulatory approvals *(30)*.

Although this report focuses on HIV, it is concerning that the world has not sufficiently taken on board the lessons learned from HIV about enhancing the availability, affordability and accessibility of lifesaving health technologies. For example, much of the world lacks access to treatments for diseases such as cancer and diabetes that are readily available in high-income countries *(31, 32)*. During the COVID-19 pandemic, the most serious global health emergency in a century, the world watched while the "self-interested actions of a few pharmaceutical companies ... proved to be a crucial driver of global inequities in access to COVID-19 vaccines" *(10)*. The world can—and must—do better to realize the right to health for all people, regardless of where they live.

ESSAY

Access for everyone, everywhere

Othoman Mellouk
Access to Diagnostics and Medicines Lead, International Treatment Preparedness Coalition

The title of the Universal Declaration of Human Rights makes it clear. Our rights are universal. When it comes to these rights, no one is excluded.

Yet, when it comes to access to medicines and other essential health tools, the world has yet to recognize the universality of our rights. People are denied access to affordable, lifesaving health technologies based on where they live. This is a violation of human rights, and it holds back progress in ending AIDS as a public health threat.

I first became involved in the response to HIV in my home country of Morocco, motivated by a commitment to supporting the gay community and promoting principles of equality and nondiscrimination. Our work was an affirmation of the equal value of every life. There was no treatment then, and so we worked to raise awareness of HIV prevention among gay men and other men who have sex with men.

Then came an amazing medical breakthrough. At the International AIDS Conference in Vancouver in 1996, we learned that HIV need not be invariably fatal, and there were effective treatments that could prevent the progression of AIDS.

But now the people I worked with faced another violation of rights, another exclusion. This time, it was because of where they lived: HIV treatment was almost exclusively available in North America and western Europe.

Activists united to demand that the HIV response chart a new way forward on access to lifesaving medicines. The emergence of generic manufacturers for antiretroviral medicines meant there was a path to ensure worldwide access to affordable medicines.

The 2001 Doha Declaration on the World Trade Organization Agreement on Trade-related Aspects of Intellectual Property Rights (TRIPS) and public health emphatically stated that patents should not tie the hands of countries seeking to address public health threats.

Just as no one should be obstructed from access to lifesaving medicines because of their sexuality, no one should be excluded because of their nationality.

Afterwards, we saw countries issuing compulsory licences for HIV medicines, enabling the purchase of more affordable generic versions. The vision of universal access to HIV medicines, in which the fruits of technology would be available to all, wherever a person lived, at last seemed realizable.

Today, however, access to new HIV medicines, including long-acting medicine that requires only two shots a year, is being denied to people based on where they live. Large multinational pharmaceutical companies are determining which countries will have access to affordable HIV medicines and which will be denied them. They are denying access to many countries in the Global South, including countries with high HIV prevalence and countries in which numbers of new HIV infections are on the rise.

The justification for excluding these countries is that they are "middle-income", an arbitrary measure based on categorizations made by international finance institutions that were never developed to determine access to medicines. In fact, the people most affected by HIV in many of these countries are some of the most economically deprived and socially excluded people on the planet.

So now we have early access to HIV medicines in high-income countries because that is where the greatest profits are made and where governments can afford those prices; late and incomplete access in lower-income countries, through voluntary licences; and access denied in many middle-income countries, which are explicitly prevented from purchasing products from generic producers granted those voluntary licences.

The voluntary nature of the current approach to medicines access is an inherent and fatal flaw. People, regardless of where they live, should never have to depend on the determination of a business to obtain the medicines they need to survive. And exclusion of countries undermines the HIV response globally. AIDS cannot be ended unless it is ended everywhere.

Using the flexibilities in the World Trade Organization Agreement on Trade-related Aspects of Intellectual Property Rights (TRIPS), rather than depending on the whims of individual pharmaceutical companies, constitutes the path towards equitable access to medicines. Countries have the right to override patent protections through the use of compulsory licensing to ensure access to medicines and vaccines needed to address high-priority health problems. Claims by the pharmaceutical industry that compulsory licences represent an unwarranted theft of their intellectual property are false, because compulsory licences still include the payment of royalties to the patent-holder.

Just as no one should be obstructed from access to lifesaving medicines because of their sexuality, no one should be excluded because of their nationality. Ensuring access to affordable medicines for everyone, everywhere, is human rights work—and it is essential for the world to be able to end AIDS as a public health threat.

The right to equality and nondiscrimination

The right to be free from discrimination and to equal enjoyment of human rights is a fundamental principle underlying international human rights law, being central to all international human rights treaties and the Universal Declaration of Human Rights. Discrimination is defined as constituting "distinction, exclusion, restriction or preference or other differential treatment that is directly or indirectly based on prohibited grounds of discrimination and which has the intention or effect of nullifying or impairing the recognition, enjoyment or exercise, on an equal footing, of Covenant rights" *(33)*. Prohibited grounds include race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status, which has been held to include health status (including HIV), sexual orientation and gender identity, among others *(34, 35)*.

The International Covenant on Civil and Political Rights mandates that all people have the right to equal, nondiscriminatory enjoyment of all civil and political rights *(36)*. The international human rights framework prohibits "discrimination against Indigenous peoples, migrants, people with disabilities, discrimination against women, racial and religious discrimination, or discrimination based on sexual orientation and gender identity" *(37)*.

Discrimination in the context of HIV undermines the effectiveness of HIV prevention and treatment services. Surveys consistently show that previous experience of discrimination or unfair treatment in seeking health care markedly reduces the likelihood that a person will seek health-care services in the future *(38–40)*. Among people living with HIV surveyed in 2020–2023 who reported stopping HIV treatment at some point, 34.3% reported delays in restarting treatment due to fears that health-care workers would treat them badly or disclose their HIV status without their consent *(8)*.

Qualitative research by the International Community of Women Living with HIV and Johns Hopkins University found that coercion, mistreatment and abuse experienced in health services by women living with HIV, including women from key populations, have considerable immediate, medium-term and longer-term negative effects on women's well-being *(41)*.

The people most likely to experience discrimination in accessing health services are typically those most vulnerable to HIV and most in need of HIV services. Experience of HIV-related stigma and discrimination beyond the health-care setting can lead to social isolation and feelings of shame and deter people from discovering their HIV status *(42)*. Substantive equality requires affirmative efforts to address underlying determinants of inequalities and ensure everyone has equal enjoyment of their rights.

Discrimination undermines the effectiveness of HIV prevention and treatment services.

Stigma lies at the root of many human rights violations, causing neglect and exclusion in the enjoyment of human rights. Stigma and discrimination are closely entwined, reinforcing and legitimizing each other. It can lead to and be used to justify discrimination, particularly systemic discrimination in the equal enjoyment of human rights and thus a breach of state obligations, States are therefore obligated to address stigma, in its multiple and intersecting forms, as part of their obligations to protect human rights, including, but not limited to, the right to health *(43)*.

Intimate partner violence is linked with a heightened risk of HIV acquisition among women in high HIV prevalence settings.

The right to gender equality

Women's rights are human rights, and they apply to women in all their diversity. Ensuring gender equality is pivotal for achievement of the full array of Sustainable Development Goals (SDGs) *(44)*. The Convention on the Elimination of All Forms of Discrimination Against Women obligates Member States to take all appropriate measures to ensure adherence to and enforcement of the gender equality mandates in the international human rights framework *(45)*. Although the Universal Declaration of Human Rights prohibits discrimination on the basis of sex, gender inequalities remain a key driver of HIV. Among women and girls aged 15–49 years who are married or in a union, only 56% can make decisions about their sexual and reproductive health, with substantial disparities between countries and regions *(46)*.

In at least 22 countries in eastern and southern Africa, HIV incidence among adolescent girls and young women is more than three times that among adolescent boys and young men. Intimate partner violence is linked with a heightened risk of HIV acquisition among women *(47)*. Gender-based violence undermines HIV service outcomes: women who have experienced intimate partner violence in the previous year have been found to be 9% less likely to have a suppressed viral load compared with women who have not experienced violence *(48)*.

The obligation to protect children

The Convention on the Rights of the Child obligates all countries to act in the best interests of the child and to ensure "such protection and care as is necessary for his or her well-being" *(49)*. These obligations have special importance in the context of HIV. Children aged 0–14 years living with HIV are considerably less likely than adults to be diagnosed and receive antiretroviral therapy. About 43% of the global total of 1.4 million [1.1 million–1.7 million] children living with HIV were not receiving treatment in 2023, and children accounted for 12% of all AIDS-related deaths, even though they constitute only 3% of people living with HIV *(50)*.

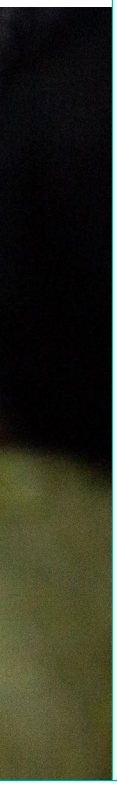
The right to privacy

Article 17 of the International Covenant on Civil and Political Rights recognizes the fundamental human right to be protected from arbitrary or unlawful interference with one's privacy *(36)*. Protecting the privacy and confidentiality of HIV-related information supports uptake of essential HIV services, because fears regarding confidentiality are commonly cited as reasons people avoid or delay seeking HIV care *(51–53)*. In Kazakhstan, for example, 23% of women living with HIV and 19% of men living with HIV reported in 2022 that they had been tested for HIV without their consent, and 5% of people living with HIV reported that a health-care worker had disclosed their HIV status without their consent *(54)*.

Freedom of expression

Although the right to freedom of expression is enshrined in the Universal Declaration of Human Rights and the International Covenant on Civil and Political Rights, laws in many countries infringe on this fundamental freedom. For example, laws that prohibit expression of transgender identities or bar the "promotion" of homosexuality contribute to a climate of fear and intolerance that effectively blocks efforts to engage LGBTQ+ communities in public health approaches. At a fundamental level, such laws communicate a clear message that transgender people, gay men and other men who have sex with men, and other LGBTQ+ people are not welcomed as full members of society, violating their human rights to equal participation in society and undermining efforts to reduce HIV-related illness and death in these communities.

Laws that inhibit communities from coming together prevent community-led responses from playing their essential role in the response to HIV.



Freedom of assembly and association

The International Covenant on Civil and Political Rights recognizes the "right of peaceful assembly" *(36)*. This right is of critical importance to the global HIV response, because there is overwhelming evidence that community-led responses are essential to ending AIDS as a public health threat *(55)*. Realizing the full potential of community-led responses demands that communities have the freedom and resources to unite for advocacy, mutual support, service delivery, participation in strategic planning and resource allocation, and monitoring of national responses and human rights violations. Laws that inhibit communities from coming together to address their needs—such as onerous registration requirements, laws that effectively criminalize entire communities, or abusive practices by law enforcement—prevent community-led responses from playing their essential role in the response to HIV.

The right to education

Under the Universal Declaration of Human Rights, Article 13 of the International Covenant on Economic, Social and Cultural Rights, and other international and regional instruments, everyone has the right to education. As in all other international human rights, Member States are obligated to respect, protect and fulfil the right to education *(56)*. Access to education has an important impact on efforts to end AIDS as a public health threat. Women and girls with poor school attendance *(57)* and lower educational attainment *(58–60)* are at increased risk of acquiring HIV. Comprehensive sexuality education has been found to increase use of HIV testing services among adolescent girls and young women *(61)*.

The right to an adequate standard of living

The International Covenant on Economic, Social and Cultural Rights entitles every person to an adequate standard of living. Women and girls are more likely than men and boys to live in poverty and experience unemployment or underemployment *(46)*. Member States are obligated to ensure "progressive realization" of this right and nondiscrimination in access to the essentials of life *(62)*. Although the relationship between HIV and poverty is multifaceted and complex, there is overwhelming evidence that food insecurity increases the odds that a person living with HIV will have an unsuppressed viral load *(63–65)*. There is evidence associating homelessness or housing instability with reduced knowledge of HIV status, lower HIV treatment use and adherence, and lower rates of HIV viral suppression *(66)*.

Other human rights

There are many other international human rights pertinent to the HIV response *(67)*. In addition to their universality, international human rights are indivisible and interdependent. Accountability is centred on the international human rights framework: countries are obligated to have rights-promoting laws and functional human rights institutions in place and to report regularly on adherence to international human rights mandates. The centrality of human rights to an effective response to HIV is the reason for the 1996 International Guidelines on HIV and Human Rights—issued at the outset of the global HIV response—insisting that the only effective approach to HIV is one grounded in human rights principles.

HIV and people with disabilities

One in six people worldwide—an estimated 1.3 billion people—have disabilities *(68)*, which the Convention on the Rights of Persons with Disabilities defines as "long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder [the] full and effective participation [of people with a disability] in society on an equal basis with others" *(69)*. People with disabilities experience numerous health inequities, including with respect to HIV.

Various studies have found that people with disabilities may be at heightened risk of acquiring HIV. An early systematic review of studies in sub-Saharan Africa found that prevalence of HIV among people with disabilities was more than 30% higher compared with people without disabilities, with the disproportionate risk especially pronounced among women *(70)*. More recently, a survey among children and young people aged 13–24 years in Lesotho found that women with disabilities were almost twice as likely to be living with HIV as women without disabilities *(71)*. In Burundi, HIV prevalence is more than three times higher among women with disabilities compared with women without disabilities *(72)*.

People with disabilities who are living with HIV face barriers to health-care access. Clinical sites may be unprepared to enable access or to address the needs of people with disabilities. Inadequate capacity to address mental health needs is a barrier to many people with disabilities. People with disabilities and their households are more economically vulnerable, with diminished incomes and employment options and higher out-of-pocket costs for health services *(73–75)*.

Stigmatizing and discriminatory attitudes and practices within health-care service sites impede meaningful access to good-quality, person-centred care for people with disabilities *(76)*. Some health-care workers adopt infantilizing communication approaches, such as addressing the caregiver rather than the client or not acknowledging the client's

agency and autonomy. Girls and young women with disabilities often experience overwhelming barriers in accessing sexual and reproductive health and rights services, including disempowerment and forced sterilization, and discriminatory attitudes, norms and behaviours that render them invisible *(77)*.

Violence represents an important source of vulnerability for people with disabilities who are living with HIV. Numerous studies have found that women with disabilities are more likely than women without disabilities to experience intimate partner violence *(78)*. In Bujumbura, Burundi, women with disabilities had an almost three-fold greater risk of sexual violence compared with women without disabilities *(72)*. In South Africa, women with disabilities who are living with HIV are twice as likely to experience intimate partner violence as women without disabilities who are HIV-negative *(79)*.

Ending AIDS as a public health threat demands sustained action to eliminate human rights barriers facing people with disabilities. All countries and subnational jurisdictions must ensure adherence to the rights outlined in the Convention on the Rights of Persons with Disabilities. Additional research and rigorous data collection are needed to build the evidence base to guide efforts to address these disparities *(80)*, including studies that examine the intersectional issues and factors that contribute to barriers experienced by people with disabilities *(76)*.

Human rights-based approaches markedly improve HIV outcomes

A growing body of evidence documents the concrete contributions of human rights-based approaches to progress towards ending AIDS as a public health threat and the deadly consequences of human rights violations on the communities most heavily affected by HIV.

Human rights touch on the full spectrum of human activities. No single metric exists to neatly compare HIV outcomes in countries with human rights-based responses to outcomes in countries whose responses are not grounded in human rights. In recent years, researchers have focused on analysing countries' successes in responding to HIV based on the degree to which their public policies are aligned with human rights principles.

Studies have consistently found that HIV policies grounded in human rights achieve superior results over those that are not rights-based. A landmark study found that decriminalization of sex work would avert 33–46% of new HIV infections among sex workers over 10 years *(81)*. Among gay men and other men who have sex with men, HIV prevalence is five times higher in countries that criminalize same-sex

sexual acts than in those that do not *(82)*. Access to testing is improved by decriminalization: in sub-Saharan Africa, gay men and other men who have sex with men have double the odds of ever taking an HIV test in countries that have legalized same-sex relations compared with countries that have not legalized same-sex relations *(83)*.

These findings underscore the importance of grounding HIV responses in human rights principles. A 2021 comparison of HIV outcomes in countries that criminalize sex work, same-sex relations and drug use and countries that do not found that countries with such criminal laws in place had 18–24% lower levels of knowledge of HIV status and viral suppression among people living with HIV *(84)*.

For countries making steady progress on the HIV response, this 18-24% difference in HIV outcomes among countries with and without punitive policy frameworks may mean the difference between going the last mile and falling short of ending their national epidemics. For countries that are lagging behind—including those where numbers of new HIV infections continue to increase—failing to ground HIV laws and policies in human rights makes the journey more difficult and perilous, taking them further from the goal of ending AIDS as a public health threat.

Advancing human rights makes an enormous—in some cases, definitive—difference between success and failure in the response to HIV. The cost of failure is calculated in countless human lives lost and substantial future financial outlays for HIV services that could be avoided.

Leveraging visibility to reduce HIV-related stigma

Ibanomonde Ngema is a young university student in Johannesburg, South Africa, working towards certification in software development. She is full of hope and optimism for the future, although this was not always the case.

Nomonde was born with HIV. She learned she was HIV-positive at the age of seven, when her mother and grandmother disclosed her HIV status to her. "All I ever heard from my family was 'Do not tell anyone about your HIV status, and do not play with boys!'" she recalls. "When I was younger, I was so depressed. I had no one to turn to for a conversation about my fears. I was stigmatized even in primary school because I had HIV, and later in high school I was even stigmatized by my partner."

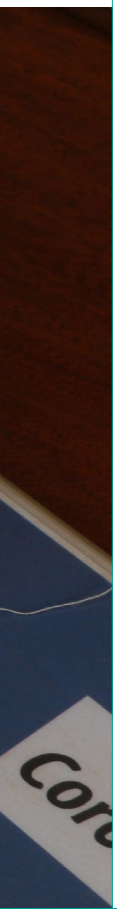
As Nomonde found, HIV-related stigma is often translated into discriminatory actions, a violation of human rights.

While getting her primary and secondary education, Nomonde found that school-based HIV education sometimes inadvertently reinforced the stigma about HIV. "Although we learn basic facts [through standard HIV education], very little in what is taught encourages compassion or helps everyone see people living with HIV as whole people."

Last year, Nomonde decided to publicly disclose her HIV status by making a TikTok video that reached more than a million people. "When I was younger, I was always searching online to find girls my age who were talking about living with HIV. I finally decided that I would be that person. It was a somewhat impulsive decision, but it has opened the door to purposeful living. Now I can be someone's safe space, the place people can turn to when they have no place else to go."

Since releasing her video, Nomonde has become deeply involved in efforts to eliminate HIV-related stigma. She became a youth ambassador for Her Voice Fund and was selected by Y+ to champion the rights of girls and young women living with HIV. She has addressed world leaders at the United Nations General Assembly in New York. Nomonde has written a book, Heart to Heart, which includes her poetry written from the perspective of a young woman living with HIV. She is exploring the creation of a YouTube channel and hopes to help digitalize an array of useful resources for young people living with HIV.

"I am working on turning my pain into purpose, victory over my challenges and being of service to others by using your vulnerability as your superpower. I have learned that there is nothing wrong with me. And I have also allowed myself to be loved for who I am. When there is truth and love, stigma cannot win."



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HIV AND HUMAN RIGHTS: A STATUS REPORT

The elevation of human rights and gender equality in the global HIV response has had a profound impact on the broader field of global health, demonstrating how inclusive, multisectoral action grounded in human rights principles can catalyse gains against the most complex and intractable health challenges *(85–87)*.

Placing human rights at the centre of the response has led to more equitable, effective and community-centred HIV strategies and policy frameworks.

Equality is a cornerstone of the international human rights framework. As it has become evident that approaches that work for some communities do not always work for others, particularly communities that are marginalized, the global HIV response has increasingly held substantive equality as the goal of the HIV response—focusing on equality of outcomes (often referred to as equity) for everyone, including people who need more tailored or different interventions. Recent analyses of data from Population-based HIV Impact Assessments (PHIA) in 15 low- and middle-income countries and from national health databases and surveillance reports from 182 countries found that service access and outcomes tend to be more equitable for HIV programmes than for national health systems overall *(88, 89)*.

The achievement of substantive equality within the HIV response and adherence to human rights principles and obligations remain imperfect and uneven. The growing anti-rights backlash threatens to roll back many of the human rights gains made to date in the global HIV response. Even in such uncertain times, however, diverse countries and communities across the world are displaying courage in addressing human rights violations that create barriers to ending AIDS as a public health threat, underscoring the importance of seizing opportunities for progress and at the same time uniting to prevent hard-won rights from being taken away.

This chapter provides a status report on the landscape of HIV and human rights. It shows where a human rights approach to HIV has yet to be implemented and where the gains of the HIV response appear most at risk. It also highlights the continuing progress on respecting, protecting and fulfilling human rights in many aspects of the response to HIV.

The right to equality and nondiscrimination: off-track to reach global targets

The emergence of AIDS more than four decades ago gave rise to a parallel epidemic of fear, stigma and discrimination. In 2024, stigma and discrimination may still represent the most important barrier impeding faster progress towards ending AIDS as a public health threat. Stigma itself is not a human rights violation, but it infringes on fundamental rights when it is translated into discriminatory actions or neglect.

Although changes in the methodology of the People Living with HIV Stigma Index make it difficult to identify trends over time, there are indications from more recent surveys that some gains have been made in certain settings in mitigating the stigma associated with HIV and in preventing discriminatory treatment of people living with or affected by HIV.

However, these scattered signs of progress are far short of what is needed to put the world on track to end AIDS as a public health threat. In several countries (Cambodia, Chad, Côte d'Ivoire, Cuba, Dominican Republic, Guyana, Kenya, Malawi, Mozambique, Sao Tome and Principe, Zimbabwe), discriminatory attitudes declined for a time but are now on the rise. In other countries (Central African Republic, Comoros, Ghana, India, Liberia, Madagascar, Mauritania, Nepal, Turkmenistan), multiple surveys have detected no decline in discriminatory attitudes over time *(1)*.

There are indications that the surge in anti-rights legislation and rhetoric across the world is exacerbating HIV-related stigma. The fourth round of public opinion surveys in four Central American countries (El Salvador, Guatemala, Honduras, Panama) found that stigmatizing opinions towards gay men and other men who have sex with men, transgender people and people living with HIV increased from 2016 to 2023 *(90)*.[2] Research regarding HIV service use among people from key populations in Senegal detected a "resurgence of stigmatization and discrimination in HIV service settings" *(91)*.

2 Increases in stigmatizing attitudes were documented with respect to the right of people living with HIV to access public space, the rights of women living with HIV to become pregnant, openness to having a gay friend living in one's home, and the rights of transgender women to have documents that align with their gender identity.

The impact of stigma and discrimination

Stigma and discrimination have profound emotional, physical, social and practical costs for the people who experience them *(92)*. Preliminary results of a global survey conducted in 2021 found that increased levels of homophobia among family members, communities and institutions (including legislation) are associated with reduced socioeconomic status of LGBTQ+ people, with the greatest losses experienced by those on low incomes *(93)*.

Stigma, discrimination and punitive laws give rise to substantial human rights violations and undermine the HIV response at every step. Punitive and discriminatory laws and policies can reduce people's ability to protect themselves from HIV acquisition. For example, laws criminalizing the possession of drug paraphernalia discourage people who inject drugs from accessing harm reduction services *(94)*.

Stigma and discrimination across six key settings (health, community, justice, workplace, education and humanitarian) reduce the effectiveness and public health impact of HIV treatment and access to prevention. Stigma, discrimination and other societal barriers represent perhaps the most significant of all impediments to achievement of the 95–95–95 testing and treatment targets *(95)*. Results from nationally representative surveys in 33 African countries found that increases in community-level stigmatizing attitudes towards people living with HIV of 50% were associated with people living with HIV being 17% less likely to be on antiretroviral therapy and 15% lower HIV viral suppression *(96)*. Fear of discriminatory treatment or unauthorized disclosure of HIV status is a key reason for many people not seeking HIV testing or interrupting care after starting antiretroviral therapy *(8, 92, 97, 98)* and for many women living with HIV disengaging from care postpartum *(99)*.

ESSAY

Our message as young people: our lives are on the line

Jerop Limo
Youth activist, Executive Director of the Ambassador for Youth and Adolescent Reproductive Health Programme (AYARHEP)

My health depends on my rights. That's not a theory—it's my life. As a 26-year-old who has lived with HIV from birth, I have witnessed first-hand how protecting the health and well-being of young people is inextricably bound with upholding our human rights.

I have learned too how upholding our rights begins with seeing us as people whose experiences count, recognizing that we are not merely beneficiaries—we are co-creators. I was lucky. At the paediatric clinic where I used to go for services, my clinician, understanding and valuing this talkative child, created opportunities for me to support other kids living with HIV. That began my life as an AIDS activist. I ventured out to become a peer educator and trained advocate. Today, I am the executive director of a youth-led nongovernmental organization, the Ambassador for Youth and Adolescent Reproductive Health Programme (AYARHEP) in Nairobi. My work now is to help lift up other young people living with or at risk of HIV.

Across the world, youth-led organizations are working to address societal stigma and promote rights.

At AYARHEP, we provide a safe space where young people can access comprehensive information about HIV, sexual and reproductive health, mental health, and any other issues that matter to them. We provide youth-friendly activities, such as educational events and sports tournaments, to engage young people living with HIV, and we advocate and partner for improvements in services for adolescents and young people.

Safe spaces are vital, because so many spaces simply are not safe for young people living with or at risk of HIV. Across the world, too many clinicians use discriminatory or stigmatizing language and approaches for young people, and too many take a casual approach to protecting the confidentiality of young people's HIV status. Young women living with HIV have been forced to take contraceptives to get antiretroviral medicine refills, and some young women living with HIV have even been forcibly sterilized. Queer young people often find they are unable to access essential services due to fear of being judged by health-care providers.

Young people have an inalienable human right to education, but in too many countries laws and policies block young people from accessing comprehensive sexuality education, with youth organizations often obstructed from providing frank and accurate sexuality education for their peers. Some schools and colleges provide almost no information about safer sex, even though young people, especially adolescent girls and young women, are at very high risk of acquiring HIV. Legal barriers often prevent young people from getting an HIV test. Requiring young people to get approval from their parents to get a test or treatment makes many young people too scared to get them.

Across the world, youth-led organizations are working to address societal stigma and promote rights by engaging faith-based leaders, teachers, parents and community members who all have vital roles to play in tackling prejudice and defending people's rights. We help people address internalized stigma, too, accompanying them through the journey to self-acceptance, helping them to love themselves so they have strengthened resilience to overcome hardships and get the support they need, and so they can be confident in insisting on their rights being upheld.

Every person living is equal in dignity. But people living with HIV are not recognized as equal by many providers and decision-makers. And although young people who acquired HIV at birth like me do sometimes get at least a little compassion from society, too often young people who acquired HIV later are met with judgement and blame. When a young person is struggling with adherence to antiretroviral therapy and receives criticism rather than support, it makes it harder for them to stay on treatment. If health-care providers are judgemental rather than empathetic, many young people will simply close the door on seeking health-care services.

Human rights violations have grave costs for people who experience them. When people's rights are not respected, it obstructs and discourages them from getting prevention, testing and treatment. Violations of human rights can break the very core of people's sense of self. All of us, regardless of our HIV status, just want to live a normal life. We want the opportunity to live, to love, to learn, to thrive, to give back to our communities, and to know that our communities are looking out for us. Feeling good about oneself is essential for a healthy and fulfilling life. It is there—inside ourselves—where stigma, discrimination and human rights abuses do the deepest damage.

As young people, our message is this: our lives are on the line. Policy-makers owe it to all young people to do what it takes to protect our health by protecting our rights.

Stigma and discrimination undermine a society's ability to mobilize to reach HIV targets. Ending national HIV epidemics requires a whole-of-society response that draws on the contributions, talents and insights of diverse sectors and communities *(100)*. Policies that criminalize, blame or incite violence against the marginalized communities most affected by HIV block the social solidarity needed for an effective, sustainable HIV response.

An urgent need to eliminate HIV-related stigma, discrimination and violence

The 2021 Political Declaration on HIV and AIDS provides a target that by 2025, less than 10% of people living with, at risk of or affected by HIV will experience stigma and discrimination *(18)*. The world is not on track to reach this target, however. Stigma Index surveys in 25 countries in 2020–2023 found that 37.6% of people living with HIV had experienced feelings of internalized stigma regarding their HIV status; nearly one in four (23.6%) had experienced stigma and discrimination in their communities. Among 8128 people living with HIV surveyed in eastern Europe and central Asia, more than half (50.4%) experienced stigma from external sources, such as in legal, workplace or health-care settings *(101)*. Between 2015 and 2022 in Brazil, actions by employers resulted in 569 convictions for HIV-related job discrimination *(102)*.

People from key populations are especially likely to experience the harmful effects of stigma and discrimination. Experiencing stigma and discrimination in the 12 months before participating in the Stigma Index 2.0 in 2020–2023 was highest for transgender people (49.4%), followed by gay men and other men who have sex with men (40.5%), people who use drugs (27.0%) and sex workers (25.7%) *(8)*. Among people who use drugs and sex workers, females were more likely than males to report having experienced stigma and discrimination in the previous 12 months. Over a 10-month period in 2023 in Mali, community-led monitoring identified reports of violence against 367 LGBTQ+ people, nearly half (49%) of whom were transgender *(103)*. The vulnerability of sex workers and people from sexual and gender minorities to violence and other forms of abuse is especially pronounced in fragile settings affected by conflict *(104, 105)*. Social protection programmes and policies can aid in reducing inequalities associated with stigma, discrimination, violence and punitive laws, but many people from key populations struggle to access social protection, especially in settings where key populations are criminalized *(106)*.

Stigma and discrimination undermine a society's ability to mobilize to reach HIV targets.

The social and legal climate faced by people from key populations and women can be lethal. In August 2024, Christopher Ikbu Terpha, chair of the Nigeria Key Populations Health and Rights Network, and one of his colleagues were brutally murdered *(107)*. From October 2022 to September 2023, at least 235 transgender and gender diverse people were murdered in Latin America, including 100 in Brazil *(108)*. The number of women and girls murdered worldwide in 2022 (almost 89 000) was the highest annual number in two decades *(109)*.

Women from key populations are especially vulnerable to human rights violations. In South Sudan, one in four female sex workers screened by an HIV programme over a 12-month period in 2022–2023 reported having experienced gender-based violence *(110)*, one of the more extreme forms of gender discrimination. Among women from key populations in eastern Europe and central Asia, female sex workers are significantly more likely to experience sexual violence than women from other key populations *(111)*.

Hostile social, economic and legal environments, including the enactment of laws that directly violate human rights, can create or exacerbate discrimination, which in turn has major negative effects on HIV responses. According to a mixed-methods study in 2023, passage of Uganda's Anti-homosexuality Law led to reduced availability of services for HIV, sexually transmitted infections and sexual health; contributed to the closure of organizations and drop-in centres for people from key populations; and increased stigma and discrimination, leading to job losses, housing evictions and assaults *(112)*. Since passage of the law, community data have documented a steady increase in human rights violations against sex workers and LGBTQ+ people *(113)*. Globally, structural and community-level discrimination is strongly associated with lower use of HIV testing among LGBTQ+ people, reducing HIV test-seeking by almost half compared with the global average *(114)*.

Nearly one in seven people living with HIV (13.0%) surveyed in 2020–2023 experienced stigma and discrimination from health facility staff when accessing HIV care and treatment services, and almost double (24.9%) experienced stigma and discrimination when trying to obtain non-HIV-related health services *(8)*. Women living with HIV and women from key populations experience high levels of stigma, discrimination and coercion in relation to accessing HIV and sexual and reproductive health services. Women living with HIV have reported experiencing a lack of confidentiality and consensual care; inappropriate medical interventions; stigmatizing comments and insults; and verbal, emotional, physical and sexual abuse *(41)*.

In a survey of more than 18 000 health-care workers from 54 European countries in 2023, more than half expressed worry about caring for a person living with HIV, with 8% indicating they would avoid physical contact with a person living with HIV and 12% expressing a desire to avoid caring for a person who injects drugs *(115)*. In a survey of health professionals in Bayelsa State, Nigeria, 9% said they refused to care for people living with HIV and two-thirds (66%) said they had seen others doing so *(116)*.

The Ritshidze community-led monitoring programme in South Africa found that transgender people across seven provinces reported poor quality of care, with transgender men more likely to report unfriendly or disrespectful experiences in their encounters with health-care facilities *(117)*. Real or perceived discrimination in health-care settings worsens outcomes across the 95–95–95 cascade, diminishing use of antiretroviral therapy *(118)*, treatment adherence *(119)* and retention in care *(120)*.

The stigma and discrimination experienced by people living with or at risk of HIV are multifaceted. The United Nations Independent Expert on Protection Against Violence and Discrimination Based on Sexual Orientation and Gender Identity has reported: "[P]eople's experience of discrimination and violence based on sexual orientation, gender identity or sex characteristics is also shaped and compounded by other factors such as race, class, age, disability and economic status" *(121)*. A global review of Indigenous people's experiences of HIV determined that "HIV in Indigenous populations continues to intersect with multiple forms of oppression, racism and discrimination, which are yet to be eliminated from laws, policies and practices" *(122)*.

Indigenous people, HIV and human rights

The United Nations Declaration on the Rights of Indigenous Peoples affirms the rights of all Indigenous people and communities to all internationally recognized human rights, grounded in part in the fundamental right to "self-determination of all peoples" *(123)*. The United Nations special rapporteur has documented that the human rights of Indigenous people often remain unrealized, however, due to national governments' lack of recognition of Indigenous peoples, failure of former colonial powers and other actors to ensure reconciliation and redress for historical violations, stigma and discrimination, and socioeconomic conditions that block Indigenous people's ability to exercise their human rights *(124)*.

In Canada and Latin America, studies have found that Indigenous women (specifically women living with HIV in Latin America) experience higher rates of violence and homicide than non-Indigenous women *(125, 126)*. These rights violations are exacerbated by an increase in threats towards, attacks on and criminalization of human rights defenders among Indigenous people *(127)*.

A review of HIV and human rights among global Indigenous people in 2023 concluded: "HIV in Indigenous populations continues to intersect with multiple forms of oppression, racism and discrimination, which are yet to be eliminated from laws, policies and practices. Eradicating white supremacy and Indigenous-specific racism across all health systems is a bare minimum requirement to uphold Indigenous rights within health care, and must be accompanied by support for Indigenous, self-determined, culturally tailored, and community-specific health and wellness services" *(122)*.

Disparities stemming from these human rights violations are apparent in the HIV pandemic. In Canada, the rate of new HIV infections among Indigenous people is nearly four times the rate for the country as a whole and driven in large measure by injecting drug use *(128)*. In the United States of America, Indigenous people living with HIV were notably less likely than white people living with HIV to have a suppressed viral load in 2022 (65% vs. 71%) *(129)*. Indigenous people are several times more likely to acquire HIV and to die of AIDS-related causes than non-Indigenous people in a number of Latin American countries *(130)*.

Racism and HIV

A special Lancet series found that "racism, xenophobia and discrimination are ubiquitous" *(131)*. The O'Neill–Lancet Commission on Racism, Structural Discrimination and Global Health describes racism as "one of the most consequential transnational phenomena to impact health and lives of afflicted communities globally *(132)*."

States have an obligation to ensure equal enjoyment of the right to health without discrimination on grounds of race or ethnicity. The realities of the HIV pandemic underscore the critical role of racism in global health inequities. In 2023, sub-Saharan Africa, home to 15% of the world's people *(133)*, accounted for nearly two-thirds (65%) of all people living with HIV (UNAIDS data, 2023). Racial disparities in HIV burden and outcomes are evident within many countries. In the United States, Black people are nearly eight times more likely than white people to acquire HIV *(134)*, and Black people living with HIV are less likely to have a suppressed viral load than white people living with HIV (61% vs. 71%) *(129)*. In England, the ratio of PrEP use to PrEP need/eligibility in 2021 was 278 times higher among white men than among Black women *(135)*.

Countering racism is key to ending AIDS as a public health threat and advancing sustainable health and development. Careful monitoring of HIV programmes is needed to identify racial or ethnic disparities in service access and outcomes, with interventions scaled up to address and eliminate these inequities. HIV activists must also be antiracist activists. As a form of reparations for the enduring legacy of colonialism, international donors should continue to provide low- and middle-income countries with essential funding to end their national HIV epidemics.

A substantial and growing body of evidence documents effective measures to mitigate HIV-related stigma. Evidence-based strategies exist to address stigma in each of the six settings prioritized by the Global Partnership for Action to Eliminate All Forms of HIV-related Stigma and Discrimination (community, workplace, education, health care, justice and emergency) *(136)*. Measures proven to reduce HIV-related stigma and discrimination in health-care settings include integration of paralegals in health facilities; peer support and psychosocial assistance for people receiving health services; human rights and stigma reduction pre-service and in-service training for health facility staff; written guidelines and accountability mechanisms for nondiscrimination; and adherence to universal infection control precautions to reduce providers' fears around occupational exposure to HIV *(40, 136, 137)*. Although effective, these measures have yet to be brought to scale. A growing number of countries are committing to the Global Partnership, but even countries that are making steady progress in the HIV response need to do additional work to address HIV-related stigma and discrimination.

Aligning laws and policies with human rights commitments

Laws and judicial systems represent key avenues for protecting and promoting human rights, offering "immense potential to better the lives of HIV-positive people" *(138)*. The United Nations Special Rapporteur on the Right to Health observed in 2024, however, that "Law and policy can themselves become a conduit to harm by either enhancing or generating it" *(139)*. In particular, criminal law must be consistent with international human rights law and cannot discriminate, either directly or indirectly, on prohibited grounds, including in relation to health status, sexual orientation or gender identity *(140)*.

In the 2021 Political Declaration on HIV and AIDS, countries committed to ensure that by 2025, less than 10% of countries will have restrictive legal and policy frameworks that lead to the denial or limitation of access by services. The world is far off reaching this target. In 2024, 169 countries criminalized sex work, 152 countries criminalized the possession of small amounts of drugs, 63 countries criminalized same-sex sexual behaviour, and 156 countries allowed criminal penalties for HIV transmission, exposure or nondisclosure.

In 2024, the Human Rights Council expressed concern that "restrictive, punitive and discriminatory legal and policy frameworks and practices that target those persons [all people living with, presumed to be living with, at risk of or affected by HIV, including girls, adolescent girls and young women, people with disabilities and people from key populations] can hinder access to HIV services and increase risks of infection with HIV, perpetuating the global AIDS epidemic" *(141)*.

ESSAY

Removing harmful laws is a victory for human rights and public health

Douglas Mendes
Former Belize appeal court judge and Trinidad and Tobago Law Association president

As an attorney and a citizen, I have always been motivated by a deep commitment to equality and human dignity for every person.

Human rights frame every aspect of life. Our fundamental rights and freedoms, as outlined in the international human rights framework, are the essential foundation for democracy, for peace and for a healthy society. This is true for all regions of the world.

My work across the Caribbean has been shaped by an appreciation that upholding human rights law is vital for tackling the abuse of power by those who wield it, and who need to be restrained from having excessive influence over public decisions regarding a fair distribution of society's resources, so that the less powerful are protected. That recognition drove my earliest focus as an attorney, acting on behalf of trade unions in my home country of Trinidad and Tobago.

Our rights do not depend on how popular we are. We all have them. A fundamental purpose of human rights law is to protect individuals from the tyranny of the majority. States have a responsibility to protect the rights and freedoms of individuals to live their lives as they wish, so long as they do not do harm to others. There is a need for active intervention to protect the rights of individuals and communities, especially those who belong to an unpopular or disfavoured minority, so that politicians and officials cannot exert unreasonable control over people's personal lives.

I have seen for myself how the protection of human rights is essential for public health. In the case of HIV, an example is the need to tackle gender-based violence. Gender-based violence increases HIV risk and obstructs access to HIV treatment. In Trinidad and Tobago, we have seen important strides—for example, towards enacting legal

measures strengthening the ability of survivors of domestic violence to obtain protection orders. These laws, however, are sometimes administered by officials and adjudicated by judges whose attitudes still need to change. We may have passed a good law, but to protect rights we need to educate the people who will administer it.

Another example is that laws criminalizing same-sex sexual relations obstruct efforts to respond effectively to the AIDS pandemic. Such laws cost lives. Over the last several years, I and other lawyers in the Caribbean region, under the guiding hand of colleagues at the University of the West Indies, have brought together two key points: that such laws often block people from accessing HIV prevention, testing and treatment services; and that such laws violate the inalienable rights and freedoms that belong to each person. When it comes to consenting adults, the state has no business in someone's bedroom, and its being there is harmful. These legal challenges have secured important progress. Over the past decade, a number of Caribbean countries—including Antigua and Barbuda, Barbados, Belize, Dominica, Saint Kitts and Nevis, and Trinidad and Tobago—have struck down the criminalization of same-sex relations. The removal of these laws represents a victory for human rights and for public health. We still have work to do. Laws criminalizing same-sex relations are still in place in over 60 countries around the world. And although homophobia in countries that have removed criminal laws is not as virulent as it once was, it is still alive and kicking. Removing harmful laws is necessary but not sufficient for the protection of rights.

Our fundamental rights are the essential foundation for a democracy, for peace, and for a healthy society.

I am hopeful that we will continue to advance progress in the protection of human rights. When any of us has our rights undermined, we are all harmed. When we protect the human rights of another person, we are made freer and safer.

Criminalization of key populations as a violation of multiple human rights

Equality and nondiscrimination in the enjoyment of human rights is only one of a number of state obligations at issue when governments criminalize the behaviours of people from key populations.

Criminalization of same-sex relations, for example, has been found to violate the rights to privacy, family, health, freedom from violence and protection against arbitrary detention, among others. In the 12 jurisdictions that authorize the death penalty for violations, criminalization of same-sex relations also violates the right to life. The rights of transgender people to equality, privacy, freedom of expression, equality before the law and freedom from arbitrary arrest are violated by laws prohibiting same-sex relations and by laws in a number of countries that focus on gender identity or expression *(142)*.

Laws criminalizing the possession of drugs for personal use interfere with enjoyment of the right to health *(143, 144)*. Incarceration for such offences is a form of prohibited arbitrary detention *(145)*. In countries that authorize the death penalty for drug violations or where authorities enact, enable or condone extrajudicial killings of people found to possess drugs, these practices violate the right to life *(146)*.

The criminalization of sex work has been repeatedly shown to negatively affect sex workers' safety and health, including reducing access to and use of condoms and increasing the rate of violence. Criminalization of sex work thus contributes to other rights violations, including denial of the rights to life, housing, security, privacy and access to health services *(147, 148)*.

Laws criminalizing HIV exposure or nondisclosure, including for acts such as spitting or biting that cannot result in HIV transmission, "promote fear and stigma about HIV, can adversely affect relationships between patients and health care providers, and can discourage people from seeking HIV testing and treatment" *(149)*.

Recent years have seen a wave of anti-LGBTQ+ legislation and a rise in harsh rhetoric towards the LGBTQ+ community. In 2024, the Parliament of Ghana passed the Human Sexual Rights and Ghanian Family Values Bill, criminalizing same-sex relations and supporters of rights for LGBTQ+ people. This law has yet to go into effect because the President has not signed the legislation, awaiting the results of a legal challenge before the Supreme Court. Anti-gay legislation has been introduced recently to parliaments in a number of countries, including Kenya, Niger, Uganda and the United Republic of Tanzania *(150, 151)*.

After Uganda enacted the Anti-homosexuality Act in March 2023, which authorized the death penalty for acts of "aggravated homosexuality", the number of PrEP initiations dropped sharply *(152)*. The effects of the law are similar to those seen in Nigeria, where passage in 2014 of a law that made more punitive the country's prohibition of same-sex relations was followed immediately by documented increases in stigma and avoidance of health services among gay men and other men who have sex with men *(153)*. Across eastern Europe and central Asia, people living with HIV in countries with the highest rates of conviction for HIV exposure, nondisclosure or transmission were nearly five times more likely than people living with HIV generally to experience stigma enacted by the legal system and more than twice as likely to experience stigma in the workplace *(101)*. In the United States, where several states have enacted anti-LGBTQ+ laws, passage of these laws was associated with 5–10% lower PrEP uptake among young people from sexual and gender minorities compared with states without such laws *(154)*.

The surge in harmful legislation extends worldwide. In 2024, the Parliament of Iraq passed legislation authorizing 10–15 years' imprisonment for people who have same-sex relations and up to three years' imprisonment for transgender people who express their gender or receive gender-affirming care. LGBTQ+ people have come under attack in countries in Asia and the Pacific, the Caribbean, central Asia, Europe and North America *(1)*.

Drug policy, human rights and HIV

It is estimated that 292 million people use drugs every year, with only a small proportion developing a drug dependency. People use drugs in every region of the world. Men are more likely than women to use drugs, but women who use drugs are less likely to have access to treatment services for substance use *(155)*.

Data from 58 countries indicate that women who inject drugs are 20% more likely than men who inject drugs to be living with HIV *(156)*.

The most humane, effective and sustainable way to mitigate the harms associated with drug use is through a public health and human rights-based approach rather than through coercion and incarceration. The International Guidelines on Human Rights and Drug Policy emphasize that all aspects of drug policy must conform with human rights and fundamental freedoms, as recognized by the United Nations General Assembly *(143)*. Punitive and coercive approaches to drug use and possession for personal use have implications for states in meeting their obligations in relation to the rights to health, privacy, freedom of thought, conscience, religion and life.

The Working Group on Arbitrary Detention and the Special Rapporteur on the Right to Health have both held that the criminalization of drug use violates the right to freedom from arbitrary detention and the right to health *(139, 145)*. The Office of the United Nations High Commissioner for Human Rights has called for a shift away from punitive drug control models, including prioritization of alternatives to criminalization and "zero tolerance" approaches *(5, 157)*.

Despite international calls for an approach to drug control policy grounded in human rights, and an abundance of evidence regarding the harms caused by coercive approaches, most countries continue to wage a "war on drugs". At least 152 countries criminalize possession of small amounts of drugs for personal use, including 35 countries that retain the death penalty for drug-related convictions *(157)*.

There are practical reasons and human rights obligations for rejecting the war on drugs in favour of an approach that is based more on evidence, public health and human rights. Punitive drug control laws, policies and law enforcement practices have been shown to be among the greatest obstacles to health care in many countries, along with financing and political will *(158, 159)*. Police harassment of people in possession of small amounts of drugs or paraphernalia, including at harm reduction service sites, makes many people unwilling to seek prevention services *(160, 161)*. These punitive approaches drive many people underground, away from services, and lead to unsafe practices *(138, 162)*. Even where countries have decriminalized drug use, administrative penalties such as heavy fines can have a similar punitive effect to criminalization and a concomitant negative impact on HIV outcomes.

Punitive drug policies have disproportionate effects on certain populations, including young people, people of African descent and Indigenous people *(157)*. These disparities, which affect populations that are already vulnerable, contravene the international human right to be free of discrimination and the mandate of the SDGs to address the needs of the most vulnerable people first.

A punitive approach to drugs results in profound human suffering. Millions of people worldwide lose years of their lives due to drug-related incarceration. In the United States alone, 360 000 people are currently incarcerated for drug-related offences *(163)*. Punitive drug laws contribute to overincarceration and prison overcrowding, which can contribute to transmission of infectious diseases.

The irony in the counterproductive approach to drugs adopted across much of the world is that punitive laws represent the costliest option. For less than 3% of the US$ 100 billion spent each year on punitive drug control measures, the world could achieve all harm reduction targets *(164)*. In central Asia and central and eastern Europe, the costs of incarceration of people who use drugs are 1.2–15 times greater than the costs required to provide access to harm reduction and social services for people who use drugs *(165)*.

Although rights-related threats to the global HIV response are on the rise, there are also hopeful signs that many countries are rejecting discriminatory and harmful laws and policy frameworks. In 2024, the High Court of Namibia struck down as unconstitutional a law that had criminalized same-sex relations (although this decision is now being appealed); the Supreme Court of Mauritius struck down the country's law criminalizing same-sex relations; and Dominica became the sixth Caribbean country to remove laws criminalizing same-sex relations. Other countries that have removed anti-LGBTQ+ laws in recent years include Angola, Botswana, Gabon, Lesotho, Mozambique, Seychelles, and São Tomé and Principe. After the constitutional court in Zimbabwe prohibited law enforcement officers from arresting women on charges of loitering for the purposes of sex work, reports indicate that police have largely stopped harassing sex workers, which has encouraged them to seek health services.

Deconstructing a human rights victory in Namibia

In June 2024, the High Court of Namibia found the apartheid-era national common law offences criminalizing consensual same-sex relations to be unconstitutional and invalid. In a powerful decision, the High Court held that any interest the Government might have in regulating sexual intercourse between consenting males is vastly outweighed by the "harmful and prejudicial impact" these laws have on gay men and other men who have sex with men. The High Court further held that "the enforcement of the private moral views of a section of the community (even if they form the majority of that community), which are based to a large extent on nothing more than prejudice, cannot quality as ... a legitimate governmental purpose" *(166)*.

In Namibia, this human rights victory built on the collaboration of Positive Vibes, an African queer human rights organization, and the Human Dignity Trust, which works to remove laws criminalizing LGBTQ+ people. The lead applicant, Friedel Dausab, was a gay man who had been diagnosed with HIV more than 25 years ago.

"The law [criminalizing same-sex sexual relations] was emboldening homophobes, transphobes and other bigots in our society to keep on oppressing and violating the rights of LGBTQ+ people," Friedel says. "It is important to understand that while this law specifically proscribes anal sex between two adult males in private, it was generally interpreted to say that homosexuality is illegal and that homosexual and transgender people are unwelcome in Namibia."

As a long-time LGBTQ+ activist in Namibia, Friedel worked with Positive Vibes on a multicomponent strategy to change social norms and attitudes about homosexuality. Beginning in 2019, Positive Vibes

worked to encourage legislative repeal of Namibia's law criminalizing same-sex relations. A law to repeal the criminalization measure was introduced in Parliament in 2021 but subsequently stalled.

It was only following the failure of this legislative push that the coalition began exploring litigation. As a legal challenge required a lead applicant who had been personally affected by the law, the coalition searched for a suitable person willing to be the face of the litigation.

"I was helping look for a candidate and came around to the fact that maybe I am ready, after so many years as an advocate and activist, to do this," Friedel says. "It was personally really important for me to get rid of that law because it was something I had realized very early in my activism was one of the huge impediments to the provision of services."

Friedel turned out to be the perfect lead applicant for the challenge, says Flavian Rhode, Executive Director of Positive Vibes. "It had to do with the combination of Friedel's life, his journey, and the fact that he has come to a real place of reflection and peace within himself. Our strategy [to be positive and avoid criticizing the government in public] very much suited who he is."

Although the removal of this criminal offence represents a large step towards realization of the human rights of LGBTQ+ people, Friedel and his partners at Positive Vibes recognize that the fight for dignity and equality in Namibia is not over. They worry about the possibility of a political backlash, but they have been cheered by expressions of support from a number of leading political figures. The coalition is hopeful about the passage of a civil registration bill and expansion of the country's domestic violence law to explicitly include same-sex couples. In collaboration with the United Nations Development Programme (UNDP), the coalition is active on social media, working to encourage more respectful and welcoming social norms towards LGBTQ+ people.

A global movement to address the harmful effects of criminalization of sex work

A substantial body of data demonstrates that laws criminalizing sex work increase the HIV vulnerability of sex workers and impede their ability to access essential HIV services *(81, 167)*. The Global Network of Sex Work Projects has demonstrated that laws criminalizing sex work cause harm to sex workers, exposing them to arrest, harassment, violence and social exclusion *(168)*. Some jurisdictions have technically legalized sex work but imposed such onerous regulations that a criminalizing context remains in place. The Special Rapporteur on the Right to Health found in 2024 that such criminal laws completely fail in their ostensible goal to eradicate or diminish the sex industry and negatively affect the health and well-being of sex workers *(139)*.

In recent years, sex workers across the world have mobilized to demand decriminalization of sex work. In 2024, the Human Rights Council Working Group on Discrimination Against Women and Girls concluded "there is now sufficient evidence of the harms of any form of criminalization of sex work" and recommended "full decriminalization of adult voluntary sex work from a human rights perspective, as it holds the greatest promise to address systemic discrimination and violence and impunity for violations of sex workers' rights" *(147)*.

In 2022, Belgium decriminalized sex work *(169)*, joining New Zealand *(170)* and New South Wales *(170)*, the Northern Territory *(171)* and Victoria *(172)* in Australia. A major push is now under way to decriminalize sex work in Thailand, with community-led activists collecting signatures for a petition urging final action on draft legislation *(173)*.

Sex workers are also advocating for recognition that they are entitled to the application of the protections of labour law and access to social protection, which often excludes coverage of sex workers *(174)*. Following extensive advocacy by sex workers, in 2024 Belgium approved a law allowing sex workers to enter into employment contracts and receive social protection benefits *(175)*. Years of advocacy by Asociación La Sala, with support from the regional network RedTraSex, led Costa Rica to recognize sex workers' rights in employment *(176)*.

Laws criminalizing sex work impede sex workers' ability to access essential HIV services.

In the midst of a frightening global anti-rights backlash, it is heartening that some national leaders are issuing ringing reaffirmation of human rights principles. For example, there is a small but clear trend globally towards the removal of laws criminalizing HIV exposure, nondisclosure or transmission, although HIV-related prosecutions were reported in 18 countries in 2023 *(177)*. In 2022, after the emergence of a powerful coalition involving parliamentarians, the National AIDS Council, civil society and international development agencies, Zimbabwe repealed its law criminalizing HIV transmission *(178)*.

How human rights violations against migrants undermine efforts to end AIDS as a public health threat

More people than ever before are migrating. There were 281 million international migrants worldwide in 2024 *(179)*, including a record 117 million people forcibly displaced as a result of persecution, conflict, violence, human rights violations or events seriously disturbing public order *(180)*. Migration itself is not a vulnerability for HIV acquisition, but it can place people in situations that increase their HIV vulnerability, including sexual and gender-based violence and lack of access to services. A systematic review found that HIV prevalence is higher among international migrants than among their native-born counterparts *(181)*. Population displacement has especially notable effects on HIV outcomes *(182)*. A modelling study in Malaysia associated migration with an increase in HIV incidence of 12 percentage points *(183)*. Another study linked an increase in HIV diagnoses in Europe in 2022 to the refugee crisis resulting from the war in Ukraine *(184)*. These studies do not show that migrants cause increases in HIV incidence in their countries of destination, but rather that the hardships associated with migration or the factors that prompt people to leave their home countries can increase migrants' risk of HIV acquisition. Indeed, available data point to substantial post-migration acquisition of HIV *(185, 186)*. Many factors contribute to HIV vulnerability among migrants, including disruption of social networks, linguistic and cultural difficulties in obtaining essential health information, and increased risk behaviours *(186)*.

Among the many factors that can increase HIV vulnerability among migrants, human rights violations appear to play a central role. Populist xenophobic appeals by political figures have worsened stigma and hostility towards people born outside the country where they currently live *(8)*. Antimigrant stigma leads to increased stress and mental health disorders among migrants *(187)*, which are linked to poorer HIV service outcomes *(188)*.

Structural discrimination can lead to significant violations of human rights for migrants living with or at risk of HIV. In 2024, 44 countries and territories restricted the entry, stay and residence of people living with HIV, including several countries in the Middle East that attract substantial numbers of migrant workers. Even many countries that formally aspire to universal health coverage exclude migrants from equitable health-care access *(189)*. National HIV strategies frequently fail to address the needs of migrant workers living with HIV *(190)*. Barriers to access to health-care are especially pronounced for people whose immigrant status is undocumented.

In addition to violating the human rights of migrants, these restrictions on access to health-care are contrary to public health, because infectious diseases do not recognize national boundaries or individual

immigration status. A review of scientific literature from 2010 to 2023 found that restrictive national legal and policy environments are associated with increased vulnerability of migrants to HIV (in part due to increased risk behaviours and limited engagement with HIV prevention interventions), reduced access to health care, and precarious legal circumstances *(191)*.

Migrant gay men and other men who have sex with men represent one of the many groups of migrants who confront heightened vulnerability to HIV *(192)*. Especially given the rise in anti-LGBTQ+ hatred in many parts of the world, gay men and other men who have sex with men often flee persecution, violence, stigma and other forms of abuse in their home communities. Migrant gay men and other men who have sex with men are at high risk of acquiring HIV after arriving in their destination country, with the odds of HIV acquisition strongly associated with social disadvantage *(193)*. Due to widespread HIV stigma and homophobia in their countries of origin, many gay men and other men who have sex with men migrate with little knowledge of HIV before their post-migration diagnosis *(194)*. This lack of HIV prevention knowledge, combined with structural stigma towards immigrants and gay men and other men who have sex with men, is associated with an increase in sexual risk behaviours of migrant gay men and other men who have sex with men and suboptimal HIV service coverage *(195)*.

People have a fundamental, internationally recognized human right to be treated with respect due to their inherent dignity and value as human beings.

People in prisons and other closed settings and HIV: a neglected priority

Like all other people, people in prisons and other closed settings have a fundamental, internationally recognized human right to be treated with respect due to their inherent dignity and value as human beings *(196)*. National governments have a duty under international law to provide people in prisons and other closed settings with the same standard of health-care services available in the community *(197)*. Although incarceration by definition involves the loss of a degree of liberty, people in prisons and other closed settings "retain the human rights and fundamental freedoms set out in the Universal Declaration of Human Rights" *(196)*.

Globally, median HIV prevalence among people in prisons and other closed settings in 2023 (1.3% in 70 countries reporting data) was nearly double the estimated prevalence (0.7% [0.6–0.8%]) of the global population of adults aged 15–49 years. The United Nations Office on Drugs and Crime (UNODC) reports that the number of people who transition between the community and prison is three times greater than the 11.5 million people who are living in a prison setting on any given day *(198)*. A sound human rights-based approach to HIV in prisons and other closed settings is important for the health and well-being of the more than 4% of people in prisons and other closed settings globally who are living with HIV *(199)*.

Given the heavy burden of HIV among people in prisons and other closed settings, universal access to voluntary and confidential HIV testing, antiretroviral therapy and combination HIV prevention in these settings is imperative. Only 37 of 192 countries provide antiretroviral therapy in prison settings, only 30 countries make condoms available in at least some prisons (and only 14 countries have national prison condom access), and only 59 countries provide opioid agonist maintenance therapy in at least one prison *(200)*. Only nine countries have prison-based needle–syringe programmes *(201)*. Many women in prisons and other closed settings have experienced domestic or sexual violence and need psychosocial support and comprehensive sexual and reproductive health services *(202)*. Peer support to enable people to navigate legal services is also valuable in prisons and other closed settings.

One in three people in prisons and other closed settings globally are in pretrial detention. Many pretrial detention facilities have even less capacity to ensure adherence to human rights, including the right to health. Common human rights violations experienced by people in prisons and other closed settings include mandatory HIV testing and unauthorized disclosure of HIV status to other people.

The conditions in which people live in prisons and other closed settings frequently violate governments' obligations to ensure

access to proper food and nutrition, hygiene and cleanliness, sanitation, temperature, lighting and ventilation *(197)*. Globally, the prison population in 120 countries exceeds national prison capacity, with the number of people in such settings exceeding capacity by at least 250% in 15 countries *(198)*. Overcrowded conditions significantly increase people's vulnerability to acquisition of TB *(203)* and COVID-19 *(204)* and to sexual violence *(205)*.

Access to justice: notable gains but still persistent gaps

Human rights are not meaningfully realized if the people who experience rights violations are unable to obtain protection from and redress for these violations. The fundamental principles of legality and accountability that rest at the core of the international human rights framework demand that all people have access to justice to enforce the rights to which they are entitled. Access to justice enables people experiencing human rights violations to obtain remedies under the law. Enforcing the rights of people living with HIV deters others from committing such violations.

To advance access to justice, fundamental rights and protections against discrimination should be clearly spelled out in national constitutions and articulated in laws. Courts and other redress mechanisms should be easily accessible. Communities should be educated about their rights and have ready access to legal services. An independent judiciary and well-trained judges with the courage and capacity to enforce human rights law are essential.

According to data reported to UNAIDS, 118 countries have mechanisms to access legal support, but only 92 countries have mechanisms to record and address HIV-related discrimination. According to reports by community and civil society representatives from 117 countries, awareness of these options remains limited. Barriers still exist that impede access. Affordability constraints were reported in about a third of countries, and the mechanisms were reportedly not functioning in 47 countries *(5)*.

Among people living with HIV who reported human rights abuses in the previous 12 months, 73% sought redress, including through filing a formal complaint or seeking the assistance of a community organization or network *(8)*. The training and integration in HIV services of paralegals, peer educators and case managers has occurred in a number of countries, including the Democratic Republic of the Congo, Indonesia, Jamaica, Kyrgyzstan and the Philippines, to support people from key populations to challenge human rights violations, including discrimination and gender-based violence *(206)*.

Participatory rights: the rights to full participation, assembly, association and expression

As documented in the 2023 World AIDS Day report, Let Communities Lead, community-led organizations and responses play an essential role in the global HIV response and are pivotal to ending AIDS as a public health threat *(55)*. Community-led responses are uniquely effective advocates for legal and policy reform, monitor national responses, and ensure strategic planning is informed by the needs and perspectives of the communities most heavily affected by the AIDS pandemic. Prevention and treatment services delivered by community-led groups reach people unable to access public facility-based services as a result of stigma, discrimination or other human rights barriers. The pivotal contribution of community-led responses is why the global HIV response has embraced the 30–80–60 targets.[3]

Key population- and community-led organizations are especially suited to identify and address human rights violations in the context of HIV. A UNDP review of experiences in the HIV response in 2018–2022 identified 14 tactics, strategies and approaches used by key population-led organizations to reform or mitigate the impact of punitive and discriminatory laws and policies *(207)*. These findings led to development of a toolkit to guide and support key population-led law and policy reform efforts *(208)*.

Communities are pivotal actors in defending human rights and aligning HIV responses with human rights principles. Civil society advocacy has catalysed HIV-related legal and policy reform in recent years in Argentina, Belize and Colombia *(209)*. In the Philippines, TLF Share, a recipient of funding from the UNDP-led SCALE initiative,[4] contributed to passage of a comprehensive rights-based ordinance in the municipality of Sumilao on prevention and control of sexually transmitted infections and HIV. In Indonesia, community-led monitoring, response and redress actions aided 897 transgender people to obtain identity cards, linked more than 300 people who experienced HIV-related discrimination to redress mechanisms, and sensitized more than 400 health-care workers on human rights and gender issues *(210)*.

Community responses led by women and girls living with HIV and people from key populations play a key role in providing leadership in the HIV response, addressing gender discrimination and gender-based violence, advocating for women's rights and women-friendly technologies and accessible and nondiscriminatory services, and ensuring research and HIV clinical trials include women and respond to their priorities *(211, 212)*.

3 These targets for 2025 provide that community-led organizations deliver 30% of HIV testing and treatment services, 80% of HIV prevention services for people from key populations and women, and 60% of programmes to support societal enablers.

4 SCALE initiative partners include the Global Fund, UNAIDS, UNDP, the United States President's Emergency Plan for AIDS Relief, and others.

Leveraging the singular benefits of community-led HIV responses requires that communities have the freedom to come together, strategize, advocate for change, and plan and deliver the services that often only they can provide. All these activities are protected under fundamental human rights, including the rights to full participation in public life, freedom of assembly, association and freedom of expression.

Community-led responses are, however, increasingly constrained by governmental actions that restrict civic space in violation of international and national law. In 2023, CIVICUS monitoring found that 28 countries or territories were completely closed to civil society, 50 repressed civic space, and 40 substantially obstructed the ability of civil society organizations to operate. More than 85% of the world's people live in societies that completely foreclose, repress or obstruct civil society activities *(213)*. In many countries, harassment or closure of civil society groups is common *(214)*.

The worldwide proliferation of national laws requiring civil society organizations to register as "foreign agents" if they receive international funding is further squeezing the space of community-led responses in many parts of the world. Although a broad range of countries have laws mandating registration by individuals or entities acting on behalf of another state, some of the more recently enacted foreign agent laws appear specifically designed to restrict the freedom of civil society to advocate for law and policy changes *(215–217)*. In 2024, Georgia became the most recent country to implement a foreign agent registration system that critics contend places onerous and unreasonable restrictions on civil society organizations *(218)*. In addition to undermining the ability of communities to lead efforts to end AIDS and prevent human rights violations, the most restrictive of such laws also violate international human rights, including the rights to expression, privacy and freedom of assembly *(215, 217)*.

The ability of LGBTQ+-led organizations to contribute to ending AIDS is impeded in a growing number of countries by laws prohibiting so-called "gay propaganda". In 2022, the Russian Federation extended its previous gay propaganda law by formally banning the public depiction of "non-traditional relations" *(219)*. Laws emulating the Russian Federation's anti-gay legislation have been enacted or introduced in a number of countries *(220)*, including in 2024 in Georgia, where the Parliament gave initial approval to legislation banning "LGBTQ+ propaganda" regarding same-sex relations and gender reassignment surgery *(221)*. These laws, and laws that criminalize the promotion of drug use or the promotion of sexual and reproductive health and rights violate freedom of expression and can lead to violations of the right to health and other human rights.

Restrictions on the ability of civil society organizations to engage in the HIV response are contributing to preventable new HIV infections and worsening HIV outcomes. According to a study involving more than 8000 gay men and other men who have sex with men in 10 sub-Saharan African countries (Burkina Faso, Cameroon, Côte d'Ivoire, Eswatini, Gambia, Guinea-Bissau, Nigeria, Rwanda, Senegal, Togo), HIV prevalence among gay men and other men who have sex with men is nearly 10 times greater in countries that prevent registration or participation of civil society organizations serving this population than in countries that do not impose such restrictions *(82)*.

Although the declining space for civil society in many parts of the world is alarming, there are places where space for civil society is expanding. In 2023, civic space opened up in more than 30 countries, including through judicial decisions, the release or acquittal of human rights defenders, or civil society policy victories. Tajikistan adopted a national human rights strategy and action plan in 2024, in close collaboration with civil society organizations, and the Republic of Moldova approved a platform for dialogue and civic participation in parliamentary decision-making processes. Kenya's Supreme Court held that it was unconstitutional and discriminatory to deny the ability of the National Gay and Lesbian Human Rights Commission to formally register as a nongovernmental organization *(213)*.

HIV and the right to an adequate standard of living

Every person has the right under international law to an adequate standard of living. Each day, however, this right is routinely violated across the world in countries of all income levels. More than 700 million people are living in extreme poverty and more than 2.3 billion people experience moderate to severe food insecurity *(222)*. The COVID-19 pandemic and the partial and uneven recovery from it have set back progress across a broad range of SDGs.

People living with HIV are at increased risk of food insecurity and malnutrition, especially in sub-Saharan Africa *(223–226)*. Studies have found exceptionally high levels of food insecurity, often severe, among people living with HIV in broadly diverse settings, including Ethiopia *(225)*, Kenya *(227)*, New York state in the United States *(228)* and Senegal *(229)*. Food insecurity is associated with poorer HIV outcomes *(228–230)*. A study of women living with HIV found that women with food insecurity had more than double the viral load of their sufficiently nourished counterparts *(63)*. Integration of food and nutrition support in HIV services can improve both nutritional status and HIV outcomes *(231, 232)*.

Safe and adequate housing is recognized as a human right under the International Covenant on Economic, Social and Cultural Rights. An estimated 1.6 billion people worldwide lacked adequate housing in 2023, and this number could nearly double by 2030 *(233)*. A review in 2024 found that housing shortages are increasing the HIV-related vulnerability of sex workers, including transgender and gender diverse sex workers, with these vulnerabilities exacerbated by criminal laws, punitive policing and discriminatory housing laws *(234)*. Homelessness and housing instability are linked with lower rates of HIV testing, use of antiretroviral therapy and viral suppression *(66)*.

The human rights of women and girls: far from being realized

Gender equality is "at the heart of human rights" *(235)*. The rights outlined in international human rights instruments apply to women in all their diversity, including cisgender, transgender, gender diverse and intersex women.

More than 3 billion women and girls live in countries marked by "poor" or "very poor" levels of gender equality. No country in the world has achieved its gender equality commitments under the SDGs, and 30% of countries have either made no progress at all or backtracked on gender equality in recent years *(236)*. Twenty-eight countries do not grant women equal rights to enter marriage or initiate divorce proceedings, 67 countries have no laws prohibiting discrimination against women, and 53 countries do not require equal pay for work of equal value *(237)*.

Gender inequality increases the HIV vulnerability of women and girls in many ways, undermining progress in the global HIV response. Women are more likely than men to experience food insecurity, with more than half of all women in sub-Saharan Africa (54.8%) experiencing moderate or severe food insecurity in 2023. One in 10 women worldwide is living in extreme poverty. By 2030, sub-Saharan Africa is projected to account for nearly two-thirds (64.5%) of the 342 million women who will be living in extreme poverty *(237)*.

Twelve million girls each year are married during childhood, and it is estimated that more than 100 million additional girls will marry before their eighteenth birthday by 2030 *(238)*. Since 2016, the number of women and girls who have experienced female genital mutilation (230 million as of 2024) has increased by 15% globally. Such practices violate numerous rights of women and girls, including the rights to bodily autonomy, health, life and freedom from violence *(239)*.

In 2023, 53% of all people living with HIV were women and girls. In 2023, women and girls accounted for 44% of new HIV infections worldwide but 62% of all new HIV infections in sub-Saharan Africa *(240)*. Across sub-Saharan Africa, adolescent girls and young women are three times more likely to acquire HIV than adolescent boys and young men. As of 2023, an analysis of legal and policy frameworks found that sub-Saharan Africa was far from meeting its SDG-related policy commitments on gender equality *(237)*.

The surge in anti-rights sentiment and policies is having profoundly harmful effects on women and girls. In surveys of women living with HIV in 23 countries, nearly 20% of women living with HIV reported having experienced "reproductive coercion, mistreatment and abuse" *(41)*. Across the African continent, as many as one in three women living with HIV report having experienced "at least one form of discrimination related to their sexual and reproductive health and reproductive rights in a health care setting" in the previous 12 months *(241)*. Laws criminalizing drug use during pregnancy deter pregnant women from seeking sexual and reproductive care and may result in abusive antenatal treatment, such as forced terminations and nonconsensual examinations *(242, 243)*. A family judge in Argentina issued an injunction against breastfeeding by a new mother living with HIV, threatening the woman and the child's father with criminal prosecution—an outcome that was averted only through litigation supported by the International Community of Women Living with HIV Argentina *(244)*. These patterns underscore the degree to which HIV-related stigma and discrimination and gender inequality intersect to increase women's vulnerability to human rights violations.

Sixty-two per cent of all new HIV infections in sub-Saharan Africa are among women and girls.

ESSAY

A mother's fight for health and rights

Jeanne Gapiya-Niyonzima
Founder of ANSS, and the first person in Burundi to publicly announce that they were living with HIV

My heartbreak as a mother, and my anger at the violations of the rights of people living with HIV, gave rise to my lifetime of involvement in the HIV response. I tell people—please do not feel broken when you learn my story, please be moved instead to take action so that no one else goes through the deprivations of rights that I and many others have gone through. I share my story to explain why, as a person living with HIV, I work for human rights, and why this work must continue until we have protected the human rights of all communities affected by HIV.

Throughout my journey—and in sharing this journey with my brothers and sisters living with HIV—I have witnessed cruelty and brutality towards people living with HIV.

Please do not feel broken when you learn my story, please be moved instead to take action.

It began for me the day my baby tested positive for HIV and a doctor abruptly announced that I, my baby and my husband were all going to die. Later, the doctor told me to take my baby out of the hospital to die at home so that his hospital bed could be freed up for someone who could be saved.

When I told my doctor I was pregnant with a second child, he insisted I terminate the pregnancy. During the procedure, the doctor, without my consent, removed my uterus to ensure I could never have another child. I was shellshocked. I no longer felt like a woman. It took me 10 years to finally come to terms with what had been done to me. A cruel irony is that I remarried aged 36 and have remained asymptomatic. I could have had more children, but a doctor robbed me of my autonomy and made this most personal of decisions for me.

It is recognized now that women living with HIV can, with support, have babies who are free of HIV. It is recognized that forced

A human rights violation against anyone is an attack on the rights and health of all of humanity.

sterilization of women living with HIV is a violation of their human rights. It is also recognized now that such violations of the rights of women living with HIV push them away from health care and undermine programmes working to end AIDS. This recognition did not come automatically: all this only came because we mothers fought.

Know this: no one fights like mothers. I am a practising Catholic. I went to a World AIDS Day mass in 1994, seeking solace after years of loss and heartbreak. In the previous few years, AIDS had robbed me of my husband, my 18-month-old child, my sister and my brother. By attending the mass, I hoped to memorialize the untimely loss of so many people in my life. Instead, what I heard from the priest that day was bigotry and condemnation. The priest said all people who died from AIDS-related causes were sinners. I knew that I, my husband and my siblings, while not angels, were good people. But my late baby boy was a different matter. He, I knew, was indeed an angel.

As a mother who had been insulted and disrespected, that triggered a revolt in me. I stood in front of the church and announced I was living with HIV. I said that no one should insult my angel baby. I added that no one should insult people living with HIV or people who have died from AIDS-related causes. I was, I declared, no more sinful than anyone else attending the mass. After the conclusion of the service, several people approached me, asking for my help to deal with the stigma and discrimination they were experiencing.

Shortly after the fateful World AIDS Day service, I co-founded l'Association Nationale de Soutien aux Séropositifs et Malades du Sida (ANSS), which evolved to become ANSS Santé Plus. For over 30 years, ANSS has worked to increase HIV-related knowledge and awareness, to combat stigma and discrimination, and to help people living with HIV realize their rights.

We have made major advances for rights and for the effectiveness of the HIV response. Before we campaigned, HIV test results were openly shared. This violated people's right to privacy and scared people away from getting tested. My colleagues and I have successfully advocated for policies that protect the confidentiality of HIV test results, providing the assurance that encourages more people to get tested.

We have secured access to medicines to treat HIV-related opportunistic infections.

We have secured progress that helps uphold the right of children living with HIV to education.

As so many widows are abused by their in-laws or rejected by their own families, we have challenged their mistreatment, including in the courts, to secure recognition of their rights.

We were the first association in Burundi to integrate the gay community into our work. Protecting rights means protecting rights for everyone. As a heterosexual woman who has become a public figure, I accept to take risks to protect others, and I have a responsibility to do so. As someone whose human rights have repeatedly been violated, I understand that a human rights violation against anyone is an attack on the rights and health of all of humanity.

In the end, the challenges I went through, and the movement I have been part of, leave me hopeful. We know the pathway to building a society in which we all thrive. If the world wants to end AIDS as a public health threat, it needs to protect the rights of every person.

The Office of the United Nations High Commissioner for Human Rights has documented that transgender, gender diverse and intersex people experience shocking violations of human rights, including violence, targeted killings, failure to respect the gender identity of people in prisons and other closed settings, surgery on intersex children and adults, and forced sterilization of transgender people *(142)*.

The ability to identify and respond effectively to violations of the right to health of women and girls living with HIV is undermined by a shortage of strategic information. Few data are available regarding outcomes along the 95–95–95 cascade for adolescent girls and young women and women from key populations. Most data available on women living with HIV are captured during pregnancy and early motherhood, which does not reveal the true picture at other stages of women's lives. As global attention increasingly focuses on addressing the health needs of older people living with HIV, it is notable that very little information is available on the experiences of older women living with HIV.

Women-led networks have a unique ability to drive positive change towards gender equality *(245)*. In Kazakhstan, women living with HIV support and mentor other women living with or affected by HIV, providing psychosocial support and helping women register for HIV and social support services *(246)*. UNAIDS has supported ATHENA, a global network advancing gender equity and human rights through the HIV response, to elevate the voices and leadership of adolescent girls and young women at key international and regional fora. Women-led networks are instrumental in addressing gender-based violence, linking peers to psychosocial support, aiding women who have experienced gender-based violence to navigate referral pathways and addressing women's mistreatment in HIV and sexual and reproductive health services.

Women-led networks have a unique ability to drive positive change.

Responding to the global pandemic of gender-based violence

Gender-based violence persists as one of the most appalling violations of multiple human rights. It has substantial consequences for efforts to end AIDS as a public health threat. A regional study in seven countries in Latin America and the Caribbean found that 64% of women living with HIV reported a history of emotional violence at home, 55% had experienced physical or sexual violence at some point, and 18.5% had experienced such violence over the past year *(126)*. Research supported by UNAIDS concluded in 2024 that "gender-based violence is pervasive in conflict, fragile and humanitarian settings, exacerbating HIV risk and threatening the health and well-being of those already severely affected by conflict and crises, including people living with HIV" *(247)*.

Gender-based violence increases vulnerability to HIV acquisition and reduces uptake of essential HIV services. A 2024 analysis of nationally representative data from six countries found that gender inequality and gender-based violence are significantly linked with poor HIV service outcomes *(89)*. An analysis of nationally representative surveys from 30 countries in sub-Saharan Africa found that women who had experienced sexual or physical intimate partner violence in the previous year were more than three times as likely to have recently acquired HIV than women who had not experienced violence *(48)*. A review of studies from 17 countries found that women who experience gender-based violence have lower uptake of HIV testing, care and treatment services *(248)*. In a study in the metropolitan area of Kampala, Uganda, experience of violence was associated with reduced use of HIV prevention, care and treatment services and lower rates of HIV treatment adherence among transgender women *(249)*.

The world has not achieved its collective commitment in the 2021 Political Declaration on HIV and AIDS to ensure that less than 10% of women and girls have experienced physical or sexual violence from a male intimate partner in the previous 12 months. Globally, one in eight women and girls experience sexual violence before the age of 18 years *(250)*. In 2018, the latest year for which data are available, an estimated 13% [10–16%] of women and girls had experienced such violence in the previous year. More than half (82 of 156) of countries with available data reported rates of physical or sexual violence below 10%—a sign of progress but still an intolerably high level *(1)*. In nine of 18 countries in sub-Saharan Africa with pertinent household survey data between 2019 and 2023, at least one in three people surveyed said it was "acceptable" under certain circumstances (e.g. going out without telling the husband, arguing with the husband, refusing to have sex) for a husband to beat his wife *(251)*. Among adolescent girls aged 10–14 years in Zimbabwe enrolled in the DREAMS programme, girls who reported already having had sex were more than twice as likely to have experienced violence than girls who had not had sex *(252)*. More than half of countries (54%) do not have laws in place that base the legal definition of rape on the lack of freely given consent *(46)*.

Women and girls in all their diversity, including women from key populations, are affected by gender-based violence. Female sex workers are particularly vulnerable, with 28.1% of more than 6000 sex workers surveyed in Ethiopia reporting having experienced gender-based violence in the previous 12 months *(253)*. In Nigeria, recent studies found that women and girls living with HIV who are on the move reported 14 percentage points more gender-based violence (39.2%) than their peers who were not on the move (25.5%) *(254)*. During the COVID-19 pandemic, transgender women in Nigeria had 2.6 times higher odds of experiencing gender-based violence, 3.8 times higher odds of reporting disruption in accessing HIV services, and 2.3 times higher odds of reporting severe symptoms of anxiety and depression compared with vulnerable cisgender women *(255)*.

In the face of persistent gender inequalities, there is compelling evidence that progress is possible. UN Women reports that countries with national legislation on domestic violence report notably lower rates of intimate partner violence (9.6% in the previous year) compared

with countries without such legislation (16.1%) *(237)*. Nearly all countries (97%) have closed their gender economic gap by at least 60% since 2006, although at this pace it will require 134 years to reach full gender parity *(256)*. In January 2024, a new law in Jamaica came into effect that expands the spectrum of people allowed to apply for a protection order against gender-based violence. In Guatemala, civil society advocacy led to adoption of a new legal framework for HIV and sexually transmitted infections that mandates governmental action to address the link between HIV and gender-based violence, requires sexual education in schools from a gender perspective, and enshrines the state's obligation to provide post-exposure HIV prophylaxis in cases of sexual violence.

The right to education: an urgent need to invest in girls' education in sub-Saharan Africa

The legally binding International Covenant on Economic and Social Rights, the Universal Declaration on Human Rights, and the Convention on the Rights of the Child recognize education as a basic human right. SDG 4 pledges to ensure all girls and boys complete free, equitable, good-quality primary and secondary education by 2030. A large body of evidence demonstrates that girls' education is among the best of all health and development investments, improving health outcomes, advancing gender equality, and enhancing food and economic security *(257)*. The United Nations Educational, Scientific and Cultural Organization has issued guidance and tools to aid countries in fully realizing and leveraging the right to education for the health and well-being of young people and societies at large *(258)*. The Education Plus initiative unites 15 African governments, the African Union, civil society organizations, networks of girls and young women, donors, UNAIDS Joint Programme partners and other stakeholders to promote free secondary education for all, sexuality education, sexual and reproductive health and rights, effective school-to-work transitions and other strategies to leverage the potential of education to improve HIV outcomes and the health and well-being of girls, their male partners, communities and countries.

Globally, important progress has been made in closing gender gaps in educational attainment. Worldwide, as of 2022, 70% of males and 69% of females had completed lower secondary education, and 46% of males and 44% of females had completed upper secondary education *(259)*.

Girls' education is among the best of all health and development investments.

In sub-Saharan Africa, however, where females account for three of four new HIV infections among people aged 15–24 years, much larger educational disparities persist by gender, especially at the upper secondary school level. Alarmingly, although more girls are in school today than ever before, less than half of adolescent girls in sub-Saharan Africa complete secondary education (42%) and there has been no progress at all in closing this gap in the past 20 years. Educational deficits are especially pronounced for young people living in rural areas in sub-Saharan Africa, only 15% of whom have completed upper secondary education (compared with 44% in urban areas) *(259)*. The number of girls out of school has declined globally, but the number of girls in sub-Saharan Africa who are not in school is increasing and higher than ever before as the population of the region increases *(260)*. Being out of school has direct health consequences, with out-of-school youth missing annual immunization days and health interventions.

Failure to invest in girls' education represents a missed opportunity for girls and women and for society at large. Lack of educational and economic opportunities for girls and women costs the African region US$ 60 billion annually *(261)*.

Due to gender and other societal inequalities, many adolescent girls and young women, especially those with low education levels and incomes, struggle to make their own informed decisions about their sexual lives. In 10 of the 16 countries with available data, less than half of married adolescent girls and young women said they could make their own decisions regarding sexual relations, contraceptive use and health care, creating vulnerabilities to HIV *(6)*.

Targeted cash transfers and education grants have proven effective in boosting girls' educational attainment *(262)*, and cash transfers that incentivize girls' school attendance show promise for preventing HIV acquisition among adolescent girls and young women *(263)*—but these approaches have yet to be brought to scale.

Protecting children: leaving many children behind in efforts to end the HIV pandemic

Children, just like adults, possess fundamental human rights, as recognized in Article 3 of the Convention of the Rights of the Child.

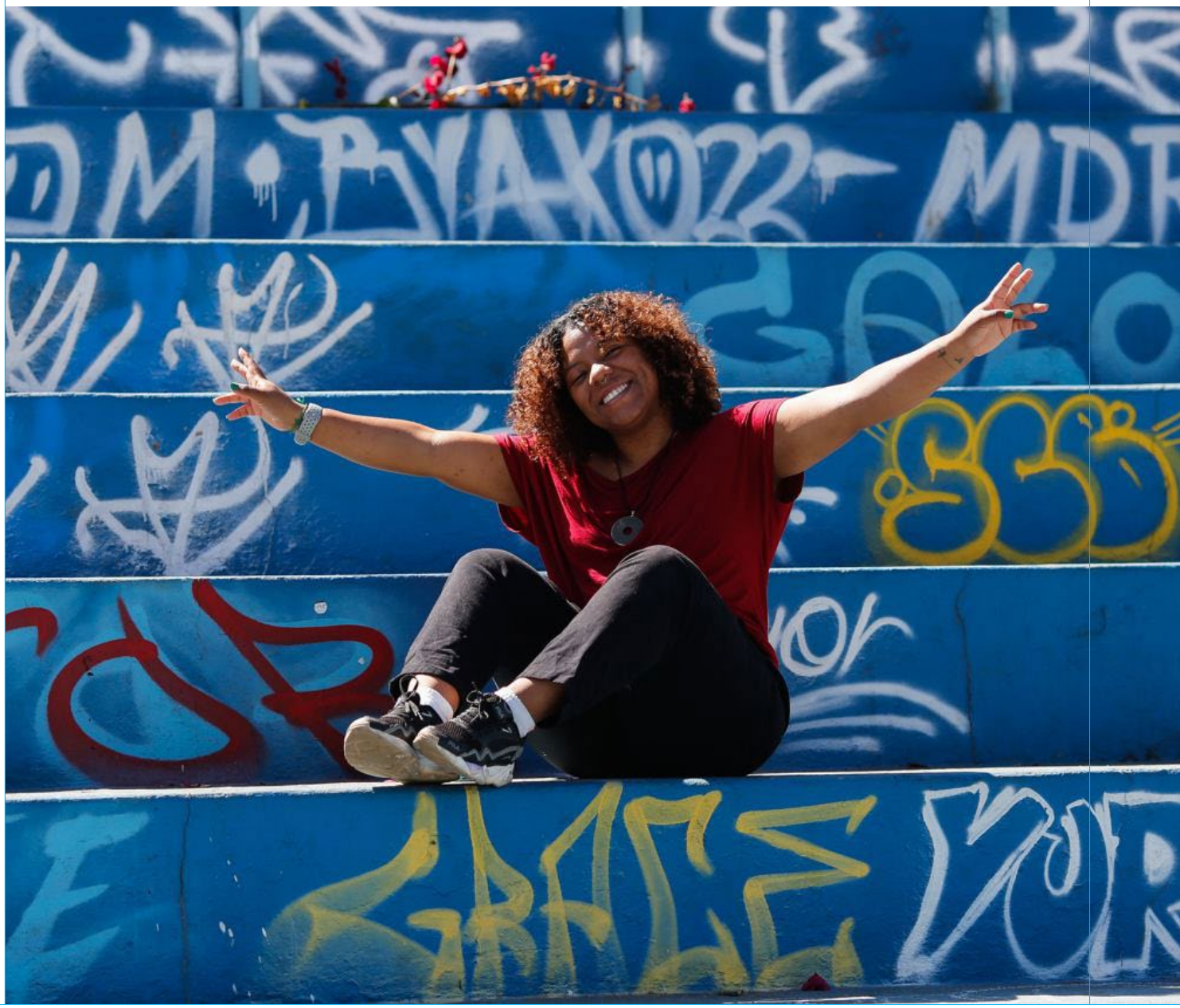
Children aged 0–14 years experienced pronounced declines in numbers of new HIV infections (38%) and AIDS-related deaths (43%) between 2015 and 2023 *(50)*. These gains stem from the worldwide scale-up of programmes to prevent vertical HIV transmission.

However, given that the means exist to achieve the 2030 milestone of ending AIDS as a public health threat, including for children, the world is not keeping its commitments to protect the health and well-being of children living with or affected by HIV. One in three children exposed to HIV do not receive HIV testing within the first two months of life; provision of lifelong antiretroviral therapy to pregnant and breastfeeding women living with HIV has not increased over the past decade (84% [72–>98%] in 2023); and HIV treatment coverage is markedly lower for children (57% [41–75%]) than for adults (77% [62–90%]) *(50)*.

The world is not keeping its commitments to protect the health and well-being of children living with or affected by HIV.

Continued vertical transmission stems in large measure from a failure to provide essential support to pregnant and breastfeeding women living with HIV. Globally, 48% of cases of vertical transmission can be traced to women's lack of access to antiretroviral therapy during pregnancy or breastfeeding, with another 19% attributable to discontinuation of HIV treatment during pregnancy or breastfeeding *(50)*.

Substantial gaps are evident with respect to the response to HIV among adolescents aged 15–19 years, with 140 000 [39 000–240 000] newly acquiring HIV in 2023; of these, 70% were adolescent girls. Among adolescents aged 10–19 years, HIV treatment coverage (65% in 2023) *(264)* is markedly lower than among adults (77%) *(240)* and well off pace for achieving the 95–95–95 targets. It is especially concerning that only modest increases have been made in HIV treatment coverage among adolescents over the past five years.



Stagnation is not inevitable in efforts to realize the human rights protection mandate for children and adolescents living with or at risk of HIV. The Global Alliance to End AIDS in Children has outlined a blueprint for success and focused intensified support for 12 high-burden countries that together account for two-thirds of new HIV infections among children. Three Global Alliance countries (South Africa, Uganda, United Republic of Tanzania) have achieved coverage of antiretroviral therapy among pregnant and breastfeeding women above 95%, and four Global Alliance countries (Kenya, South Africa, Uganda, Zimbabwe) in 2023 provided HIV testing within the first two months of life to at least 80% of infants exposed to HIV *(50)*.

Advancing the rights to health and education by delivering comprehensive sexuality education

Comprehensive sexuality education is a pillar of a sound education and a critical element of combination HIV prevention. The United Nations Human Rights Council recognized in its 2024 resolution on gender discrimination that access to comprehensive sexuality education respects, protects and fulfils the right of all women and girls to education *(265)*. The Committee on the Rights of the Child provides that "Age-appropriate, comprehensive and inclusive sexual and reproductive health education, based on scientific evidence and human rights standards and developed with adolescents, should be part of the mandatory school curriculum and reach out-of-school adolescents" *(266)*. Comprehensive sexuality education advances gender equality by engaging young people regarding gender and power dynamics, helping to transform gender roles and increasing the ability of young people to serve as agents of change *(267)*. In its 2024 resolution on human rights in the context of HIV and AIDS, the Human Rights Council called to states to scale up "scientifically accurate, age-appropriate comprehensive education on sexual and reproductive health, relevant to cultural contexts" to empower young people to make healthy and informed decisions to protect themselves from HIV *(268)*. According to the National Commitments and Policy instrument results from 2017 to 2024, 87 of 141 countries have education policies on life skills-based HIV and sexuality education in primary schools, with 117 of 141 countries reporting having such policies in secondary schools.

These gains are put at risk by steps proposed to curtail comprehensive sexuality education *(269)*.

Ensuring access to lifesaving health services for children and adolescents

The Convention on the Rights of the Child provides that children and adolescents aged up to 18 years have the right to the highest attainable standard of health and to treatment and rehabilitation services *(49)*. Given the substantial risk of adolescent girls acquiring HIV, especially in sub-Saharan Africa, ready access to HIV testing, treatment and prevention services is critical to realization of girls' right to health *(270)*. Ensuring access for adolescents to HIV services advances the core principles that animate the Convention on the Rights of the Child, including the rights to survival, development and the freedom to express views and preferences in accordance with each child's age and maturity *(271)*.

The Committee on the Rights of the Child states that "children should have access to confidential counselling and advice without parental or legal guardian consent, where this is assessed by the professionals working with the child to be in the child's best interest" *(272)*. Among 147 countries with available data, 104 have laws requiring that adolescents obtain parental consent before being tested for HIV—including more than 50 of 147 with laws requiring parental consent for people aged under 18 years *(5)*. These age-of-access laws, especially those with high age requirements to access testing services, have been shown to block access to HIV testing for many young people, with HIV testing coverage 11 percentage points higher in countries where the legal age of consent is below 16 years compared with countries with higher age requirements *(273)*.

Age-of-access laws also restrict access to other essential health services. For example, laws that permit access to HIV testing without parental consent do not ensure that an adolescent girl who tests positive for HIV will obtain treatment services, because 51 countries require parental consent for people aged under 18 years to access HIV treatment. At least 33 countries require adolescents to have parental consent before obtaining PrEP *(5)*.

Adolescents' right to participation

The Convention on the Rights of the Child recognizes children's rights to participation, highlighting the need for adults to take seriously children's input and the right of children to "share freely with others what they learn, think and feel" *(49)*. United Nations Children's Fund guidelines for realizing adolescents' "right to be heard in matters affecting them" stress the benefits of adolescents' meaningful, rights-based civic participation, including making programmes, services and policies more relevant to young people *(274)*. Consistent with the cross-cutting emphasis on youth engagement across the SDGs, the collective United Nations system has united around the goal of ensuring young people's involvement in decision-making and policy processes that affect their lives *(275)*.

In the HIV response, young people are often excluded from decision-making regarding interventions that affect them and denied essential resources to design, implement and monitor such interventions *(276)*. Historically, HIV programme and policy planning has regarded young people as "beneficiaries" rather than as "equal and valuable partners in projects that are led, co-led, and centred around young people" *(277)*. Ending AIDS as a public health threat demands that much greater attention is paid to engaging young people, especially young people from key populations, in decision-making processes and programmes that affect their lives.

The right to the highest attainable standard of physical and mental health

Although real, the equity gains in the HIV response are insufficient. Many of the disparities that undermine progress towards ending AIDS as a public health threat are the direct result of violations of fundamental human rights, which generate inequalities that prevent realization for many millions of people of the right to the highest attainable standard of physical and mental health.

Towards the aim of ensuring no one is left behind in the push to end AIDS as a public health threat, the Global AIDS Strategy 2021–2026 calls for application of a substantive equality lens across all aspects of the global HIV response *(17)*. A 2024 review of the available data concluded "specific programming addressing equity in the HIV response is still nascent and there is limited analytical work in this area" *(278)*.

The obligation to ensure the availability of accessible, acceptable and good-quality HIV testing and treatment without discrimination

The global expansion of HIV treatment access remains one of the most important and inspiring achievements in global health history. In 2023, 30.7 million [27–31.9 million] people received antiretroviral therapy—accounting for 77% [61–89%] of all people living with HIV. The historic scale-up of antiretroviral therapy has helped prevent AIDS-related deaths, which have fallen by 69% since their peak in 2004, and contributed to a 39% reduction in numbers of new HIV infections since 2010. WHO has included an array of antiretroviral compounds in the List of Essential Medicines *(279)*, which obligates countries under international law to provide them *(280)*.

Access to HIV treatment varies markedly within and between countries and regions, underscoring that the right to health remains unfulfilled for many people. Although 73% [66–81%] of adults living with HIV had a suppressed viral load in 2023, only 48% [39–60%] of children living with HIV had a suppressed viral load. HIV treatment coverage is notably lower in eastern Europe and central Asia and the Middle East and North Africa compared with other regions. People living with HIV from key populations have lower treatment coverage and poorer treatment outcomes than people living with HIV overall—for example, a systematic review found that only one in three people living with HIV who inject drugs have a suppressed viral load *(281)*.

Substantial inequalities within countries in access to HIV treatment are apparent. In the 15 countries where PHIA studies have been conducted, people living in the lowest income quintiles have worse treatment access and outcomes than those in the highest quintile. People living with HIV in rural areas have worse treatment outcomes than people in urban areas; people aged under 25 years do worse than older adults; and men are less likely to obtain HIV treatment and have a suppressed viral load than women *(88)*.

PHIA studies show that progress in minimizing substantive inequalities is feasible. In the six countries where multiple PHIA studies have been conducted (with four to five years between each study round), gains in HIV outcomes have been made and equity gaps reduced. For example, women living with HIV were nine percentage points more likely than men living with HIV to have a suppressed viral load in the first PHIA round (62% vs. 53%), but outcomes by the second round improved for women and men and the viral suppression gap declined (81% vs. 75%) *(88)*.

Addressing financial barriers associated with use of health services is essential for realization of the right to health. In addition to direct out-of-pocket costs for health service use, people who access HIV services may incur additional costs, such as transport or time lost from work or other productive activities *(282)*. Direct and indirect costs can deter people, especially those on low incomes, from obtaining the health services they need. For example, increases in out-of-pocket costs are strongly associated with increased rates of abandonment of PrEP *(283)*. Optimizing health and well-being of people living with, at risk of or affected by HIV requires action to minimize financial burdens on the users of health services.

ESSAY

For all to thrive

Dr Tlaleng Mofokeng
United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health

For millions of people worldwide, the full enjoyment of the right to the highest attainable standard of physical and mental health remains a distant goal. In my work as a medical doctor treating people living with HIV, as an expert on public health, and as United Nations Special Rapporteur, I know that upholding human rights is how the world will end AIDS as a public health threat.

The right to health provides us with freedoms and entitlements, protecting the social, economic and cultural rights of people. Human rights cannot be abstract principles but must be the core of the sustainable development agenda and must be expressed in all future plans for the world.

The right to health is interdependent and interconnected with the realization of other rights such as to life, education and employment. When, for example, people are denied their right to education, their right to an adequate standard living, or their right to nondiscrimination, they are in consequence denied their right to health. The obstacles people face, and the solutions to overcome them, are intersectional.

When people are denied their right to education, or their right to an adequate standard of living, they are in consequence denied their right to health.

The right to health is about more than the ability to access clinics or hospitals. It encompasses the right to underlying determinants such as safe potable water, nutritious food and a healthy environment. Sexual and reproductive health are integral elements of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health; yet for women and girls and people from gender and sexual minorities, many obstacles stand in the way of their enjoyment to sexual and reproductive health. These obstacles are interrelated and entrenched, operating at different levels—in clinical care, at the health systems level, and in the underlying determinants of health.

Access to health-related education and information, including on sexual and

The power of people will always keep us true as we demand an inclusive world where all people can thrive.

reproductive health, is especially liberating for women and girls and people from gender and sexual minorities, because their freedom is enabled through comprehensive sexuality and gender education about their rights to bodily autonomy, integrity, and protection from nonconsensual medical treatment and experimentation.

For LGBTQ+ people, structural violence in the form of punitive laws, policies and practices impedes, excludes and sometimes bars them from accessing information, health goods and services that are critical to HIV prevention and care. Protecting their right to health requires decriminalization and the ending of so-called "conversion therapy" methods.

For intersex people, protecting their health requires an end to unnecessary medical interventions. For sex workers, protecting their right to health requires an end to arbitrary arrest, confiscation of condoms and criminalization. For people who use drugs, protecting their health requires decriminalization and a massive expansion of harm reduction policy approach and services. For people in prisons and other closed settings, protecting their health requires ensuring they have access to high-quality goods, services and information.

The effective design of health programmes and policies depends on ensuring meaningful participation and engagement of rights-holders in decision-making, particularly those who have faced the greatest barriers. This requires prioritizing and listening to their lived experiences and concerns to ensure they have consequential impact on policies, budgeting and accountability.

The right to health prioritizes the right to a system of health protection—that is, health care and the underlying social determinants of health that provide equality of opportunity for people to enjoy the highest attainable standard of health.

Global solidarity is a key component of a multilateral world. Countries need to work with each other, in the spirit of mutual respect, to ensure sharing of the resources and scientific knowledge that are crucial to the upholding of human rights and to ending AIDS.

The comprehensive approach needed for health is sometimes dismissed with the excuse that it is too ambitious to be achieved. But I am glad to say that I have met legions of people, including community organizers, medical professionals and government officials, who are already making the changes we need.

The HIV response, led by the people for the people, has so much to teach. It has been exemplary in advancing people's rights to health, dignity and autonomy. For decades, HIV activists and advocates have kept on winning victories to secure access to the best that science has to offer, involvement in service delivery, and removal of harmful laws. Their example shows that the realization of human rights and health depends on maintaining the fires of determination. It is possible, anchored by the right to health framework, to galvanize governments to meet their obligations to ensure nondiscriminatory, affordable and acceptable access to quality health-care services, goods and facilities.

The right to health is a powerful tool to advance justice and equity in health. The power of people will always keep us true as we demand gender equality, peace, justice, and an inclusive world where all people can thrive.

Availability of accessible, acceptable and good-quality HIV prevention services

The right to the highest attainable standard of physical and mental health can be realized only if people at high risk of acquiring HIV have meaningful access to acceptable and evidence-based HIV prevention tools and services. The International Covenant on Economic, Social and Cultural Rights explicitly recognizes "prevention, treatment and control of epidemic, endemic, occupational and other diseases" as a human right *(284)*. As the array of biomedical prevention tools has expanded, people at risk of acquiring HIV should have the ability to choose between options according to their specific situations and preferences, giving them the ability to tailor prevention approaches in ways that meet their needs at each stage of the lifecycle *(285)*.

Many people who need HIV prevention services cannot access them due to a lack of availability, contravening their right to the highest attainable standard of physical and mental health. Although PrEP has the potential, in combination with other prevention methods, to help drive down HIV incidence *(286)*, only 15% of people who need PrEP were receiving it in 2023. It is not only for newer prevention methods where access deficits are apparent—for example, the total number of condoms distributed through social marketing fell by almost half between 2011 (3.5 billion condoms) and 2022 (1.8 billion condoms). In Europe, condom use at last intercourse declined between 2014 and 2022 from 70% to 61% among boys and from 63% to 57% among girls *(287)*. Failure to prioritize HIV prevention in resource allocations contributes to prevention access gaps, with only about 12% of HIV resources allocated to HIV prevention activities in 2023 in 82 low- and middle-income countries that reported data.

The refusal of many countries to permit or upscale harm reduction represents a violation of the right to the highest attainable standard of health. Evidence has long shown that it is possible to markedly reduce HIV transmission via injecting drug use by scaling up harm reduction services *(288)*. Under right to health obligations, states are required to "[e]nsure the availability and accessibility of harm reduction services as recommended by UN technical agencies such as the World Health Organization, UNAIDS, and UNODC, meaning that such services should be adequately funded, appropriate for the needs of particular vulnerable or marginalised groups, compliant with fundamental rights (such as privacy, bodily integrity, due process, and freedom from arbitrary detention), and respectful of human dignity" *(143, 289)*. Although the number of countries with at least one needle–syringe programme or at least one programme for opioid agonist maintenance therapy has increased (to 93 countries and 94 countries, respectively), harm reduction coverage remains low throughout much of the world *(290)*. Even if countries have at least one harm reduction programme in operation, such programmes are frequently inaccessible for people living in other cities or in rural areas.

For HIV prevention and treatment, access to sexual and reproductive health and rights services is essential for realization of the right to the highest attainable standard of health. This has been recognized by the United Nations Human Rights Council resolution on human rights in the context of HIV *(16)*. Although the twenty-first century has witnessed important gains in sexual and reproductive health and rights, including decreases in unintended pregnancy and maternal mortality, the latest data suggest these advances have stalled *(290)*. In sub-Saharan Africa, the proportion of women with an unmet need for family planning satisfied by modern methods rose from 52% in 2015 to 58% in 2022 *(291)*.

Failure to ensure equal access to acceptable, good-quality prevention services undermines the impact of efforts to reduce the number of new HIV infections. In 12 of 15 sub-Saharan African countries reporting pertinent data, coverage of comprehensive multisectoral prevention packages for adolescent girls and young women was below 40% in 2023 *(292)*. The median percentage of people from key populations who received two or more prevention services in the previous 12 months remains low in countries reporting relevant data: 40% among gay men and other men who have sex with men, 50% among sex workers, 39% among people who inject drugs, and 39% among transgender people. UNAIDS recommends that about a fifth of HIV resources in low- and middle-income countries should support prevention activities for people from key populations, but only about 2.6% of HIV spending is currently focused on prevention programmes for people from key populations.

Just as the global HIV response was beginning to ramp up, countries unanimously affirmed in the 2001 Declaration of Commitment on HIV/AIDS that "prevention must be the mainstay of the response" *(3)*. More than 20 years later, HIV prevention remains more important than ever, but efforts to end AIDS as a public health threat and to realize the right to health for millions of people continue to be weakened by inadequate prioritization of HIV prevention.

Efforts to end AIDS as a public health threat are weakened by inadequate prioritization of HIV prevention.

3

PUTTING HUMAN RIGHTS AT THE CENTRE OF EFFORTS TO END AIDS AS A PUBLIC HEALTH THREAT: A ROADMAP FOR ACTION

The anti-rights backlash threatens to undo much of the progress made to date in the global HIV response and to slow advances in countries that are already off-track for reaching global HIV targets.

As countries work to put in place sustainability roadmaps for their HIV responses, it is imperative that all decision-makers and HIV stakeholders recognize that there can be no sustainable response without human rights *(293)*.

Failure to fully align HIV responses with human rights commitments is a major reason for the world being off-track to end AIDS as a public health threat. Without a human rights-based approach, avoidable new HIV infections will lead to preventable human suffering and drive up even further the long-term costs of responding to the pandemic. If the current level of progress on HIV continues, UNAIDS projects that 46 million people will be living with HIV in 2050, each of them requiring lifelong treatment and care for HIV and comorbidities.

The actions to get the response on track to end AIDS as a public health threat are clear. A pivotal step is to align each element of the HIV response with the human rights commitments all countries have made. In recent years, a growing number of countries have further protected and fulfilled rather than restricted human rights in the context of HIV. Lessons learned from these countries now need to be applied more broadly.

The deteriorating human rights climate in many parts of the world has encouraged human rights defenders and HIV advocates to adopt an increasingly defensive posture. But the reality is the HIV response has a positive, proactive narrative for opposing and overcoming these trends and creating resilient societies. We can elevate the human rights of all people living with or affected by HIV and end AIDS as a public health threat—or we can scapegoat, ostracize and punish the most marginalized people and watch the long-term human and financial costs of responding to HIV increase ever further.

There are steps all of us can take to get the HIV response on track.

ESSAY

To protect everyone's health, protect everyone's human rights

Volker Türk
United Nations High Commissioner for Human Rights

Human rights are the bedrock of just, equitable and resilient societies. They are vital to ensure everyone, everywhere, can live in dignity, safety and freedom. And they are the crucial underpinning of public health.

HIV is treatable and entirely preventable. Nobody should die of AIDS-related causes. Nobody living with HIV should go without antiretroviral medicines. Nobody should lack access to HIV prevention tools. People can live long and full lives with HIV, and we can end AIDS as a public health threat by 2030—if treatment, testing and prevention services are accessible and available to everyone without distinction.

But despite this progress and potential, the world is currently off track when it comes to ending AIDS. Although three-quarters of people living with HIV are on treatment, one-quarter—more than 9 million people—are not.

Discrimination and stigma are obstructing progress and risking a resurgence of infections. But we have the power and the responsibility to change this. Put simply, to end AIDS, we need to uphold our universal rights.

When human rights are promoted, health is protected. Sadly, the opposite is also true. Every policy that discriminates against people from marginalized communities or in vulnerable situations makes it harder for them to access prevention, testing and treatment. Every crackdown on civil society organizations makes it harder for people living with HIV to get the support they need. Segments of society that are at greatest risk suffer the most.

Every week, 4000 adolescent girls and young women worldwide acquire HIV, three-quarters of them in sub-Saharan Africa. Human rights violations, including gender-based violence, sexual violence as a weapon of war, and trafficking, exacerbate women's risk of HIV. So too does the denial of the

right to education, including on sexual and reproductive health and rights.

HIV prevalence is several times higher among gay men and other men who have sex with men, sex workers, people who inject drugs, transgender people and people in prisons and other closed settings because of stigmatization, marginalization and scapegoating. Criminalization generates fear among people seeking treatment and frontline health workers. These laws cost lives. A study in sub-Saharan Africa showed that HIV prevalence among men who have sex with men was five times higher in countries that criminalized same-sex relationships.

We must consign such laws to history. Thanks to courageous campaigning by civil society, a growing number of countries are doing just that. There is a global shift away from criminalization of LGBTQ+ people—but there is also a highly organized backlash, leaving no room for complacency.

We know how to end AIDS as a public health threat. Countries must remove punitive and discriminatory criminal laws, actively work to eradicate HIV-related stigma and discrimination, and protect women and girls and people from key populations from violence, harassment and abuse—as set out in the 10–10–10 targets.

We need political leadership. Governments have a legal obligation to meet their human rights obligations to all their population. Ending AIDS as a public health threat requires them to root out inequalities, to ensure availability and accessibility of good quality health services for all, to stand up to the global anti-rights movement, and to make sure community-led organizations can work in a free and open space.

Beyond laws, we need to build a culture of rights. Political leaders must tackle discriminatory attitudes and policies towards people living with, at risk of or affected by HIV. A practical first step is for governments to invest in human rights education and training to sensitize health workers, the police, law enforcement officers, prison staff and other relevant professions. They should also ensure the meaningful involvement of people living with HIV and people from key populations in the development, implementation and monitoring of HIV strategies and programmes.

At the global level, the international community needs to ensure universal and equitable access to HIV-related medicines and other tools and prevent them from being monopolized for private profit. We have a responsibility to strengthen development financing and to tackle the dangerous levels of debt that are obstructing low- and middle-income countries from investing in health.

Placing human rights at the centre of the HIV response is the only way we will end the pandemic once and for all. To protect everyone's health, we need to protect everyone's human rights.

Human rights are the crucial underpinning of public health.

Take a systematic, evidence-driven and community-led approach to human rights and HIV

The successful push to scale up antiretroviral therapy has been guided at each step by robust monitoring of service gaps and treatment outcomes, enabling rapid intervention to address bottlenecks and inequities. Increasingly, HIV prevention efforts are adopting a similar approach, using national roadmaps and regular reporting to drive accountability for results and improve prevention outcomes, including under the umbrellas of the Global HIV Prevention Coalition *(294)* and the Global Alliance to End AIDS in Children *(50)*.

A similarly systematic, carefully monitored and long-term approach is needed to address human rights barriers to progress towards ending AIDS as a public health threat. This is the approach recommended by the Global Partnership for Action to Eliminate All Forms of HIV-related Stigma and Discrimination, an alliance of 40 countries working collectively to identify human rights barriers, develop and implement comprehensive action roadmaps, and regularly monitor and report results, using the seven key human rights programmes to reduce stigma and discrimination *(295)*:

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

Global Partnership for Action to Eliminate All Forms of HIV-related Stigma and Discrimination

Launched in 2018, the Global Partnership for Action to Eliminate All Forms of HIV-related Stigma and Discrimination works to mobilize countries to take evidence-based, results-driven action on stigma and discrimination. To date, 40 countries have joined the Global Partnership, which is jointly convened by the Global Fund, the Global Network of People Living with HIV, the nongovernmental organization delegation of the UNAIDS Programme Coordinating Board, UNAIDS, UNDP, the United States Centers for Disease Control and Prevention, and UN Women.

Guided by a technical working group composed of United Nations agencies, international organizations, and civil society and community partners, the Global Partnership deploys regional and country coordinators to provide technical support to strengthen national action on HIV-related stigma and discrimination. To support country-level progress, the Global Partnership has identified proven interventions to reduce stigma and discrimination across six settings—health-care, workplace, education, humanitarian, justice and community *(136)*. The Global Partnership has generated guidance on best practices, innovations and practical steps that country-level partners can take to reduce stigma and discrimination *(137)* and normative guidance on monitoring and evaluating anti-stigma and anti-discrimination initiatives *(296)*. Regular newsletters highlight gains in addressing stigma and discrimination, enabling broad dissemination of innovations.

Under the Global Partnership umbrella, 25 countries have developed national roadmaps for action to eliminate HIV-related stigma and discrimination. Diverse multisectoral partnerships have been forged in countries to coordinate, drive and monitor progress to reduce HIV-related stigma and discrimination. The Global Partnership has aided partners in mobilizing and allocating resources to implement innovative stigma and discrimination initiatives. Global Partnership members monitor progress in reducing stigma and discrimination in the focus settings and report back annually.

The Global Partnership has catalysed concrete advances in reducing stigma and discrimination, such as the following:

- Initiatives to address stigma and discrimination among young people, including the HI-FIVE for HIV project in Ghana, Kenya and South Africa, which has empowered health-care students to advocate for stigma-free care; the *A l'assaut du sida* HIV education quiz in Côte d'Ivoire, which has engaged 188 000 young people, increasing their awareness on HIV, sexual health and human rights; and the Youth4HIVAction project in Jamaica, which has trained 64 young advocates.

- Health-care worker training and sensitization, including an online HIV learning platform for primary health-care physicians in Ukraine.

- Country-level normative guidance to prevent stigma and discrimination, including development of a manual in Uganda to prevent workplace stigma and discrimination, drawing on the contributions of the Federation of Ugandan Employers, the International Labour Organization, the National Forum of People Living with HIV/AIDS Networks in Uganda, and the Uganda AIDS Commission, and following extensive consultation with national ministries, labour unions, employer and employee representatives from the private sector, and the Global Network of People Living with HIV.

- Innovative initiatives to reduce internalized stigma, including a series of anti-stigma dialogues focused on women and girls in Senegal, a 10-day social media campaign encouraging everyone to "say no to stigma" in Ghana, and the pioneering Wakakosha initiative in multiple countries to reduce internalized stigma among young people.

- Legal and policy reform, such as parliamentary passage of a same-sex marriage bill in Thailand; revision of the national HIV law in the Central African Republic to decriminalize HIV transmission and strengthen human rights protections for people living with HIV; passage of a human rights-based, comprehensive HIV law in Argentina; implementation of business standards in Thailand to prohibit discrimination based on a person's HIV status; incorporation of anti-stigma and anti-discrimination interventions in the national HIV strategic plan in the Islamic Republic of Iran; and steps to embed HIV-inclusive policies in national frameworks and promote undetectable = untransmissible (U=U) awareness across health-care, workplace and community settings in Thailand.

- Support for communities and community-led responses, including creation of an emergency fund for sex workers facing imminent danger in Peru, and creation of a community-led initiative in Kazakhstan to provide shelter and mentorship support to women living with HIV.

- High-level advocacy to eliminate stigma and discrimination, including a major event hosted by the Spanish Ministry of Health focused on ending stigma and discrimination in Europe and beyond, resulting in Germany and Spain following Luxembourg in joining the Global Partnership; a skills-building initiative to strengthen transgender rights advocacy in Kazakhstan, Kyrgyzstan and Tajikistan; and multiple global advocacy campaigns, including the #More Than campaign celebrating the diversity of people living with HIV and the #NotACriminal campaign focusing on the removal of punitive laws that criminalize people living with or affected by HIV.

- Expanding learning and sharing on reducing stigma and discrimination, including through a collaborative exchange meeting among Global Partnership country focal points in Bangkok, Thailand in September 2024.

Systematic approaches help to identify concrete actions to address specific human rights barriers. For example, a review of the politicization of and growing opposition to comprehensive sexuality education indicates that pushing back against this well-funded opposition requires additional evidence regarding the effectiveness of comprehensive sexuality education, ongoing monitoring of opponents' strategies, mapping of allies, civil society mobilization, media engagement, and better understanding of optimal language and framing for debates *(269)*.

Align laws and policies with human rights commitments

Evidence-informed and human rights-based laws can play a transformative, positive role with respect to public health. The Global Commission on HIV and the Law states: "Good laws, fully resourced and rigorously enforced, can widen access to prevention and health care services, improve the quality of treatment, enhance social support for people affected by the epidemic, protect human rights that are vital to survival, and save the public money" *(138)*.

As this report shows, however, progress is held back by laws which undermine HIV responses by dividing societies, further marginalizing the most vulnerable people, and opting for coercion and punishment over tolerance and evidence-based public health approaches. As the primary duty-bearers in international and constitutional human rights frameworks, national governments are ultimately responsible for ensuring laws and policies adhere to the human rights commitments that countries have made. In polarized societies or where populist actors actively work to promote division and scapegoating, stepping forward as a leader to advocate for an inclusive approach aligned with human rights takes both courage and the difficult work of cultivating and persuading allies.

National governments have committed, under General Assembly and Human Rights Council instruments, to remove discriminatory and restrictive laws and policies that block service access and undermine the HIV response. This includes removing laws that specifically or over-broadly criminalize HIV exposure, nondisclosure and transmission, sex work, drug use, gender identity and expression, and same-sex sexual activity, because such laws violate human rights and are antithetical to a sustainable HIV response.

Governments have committed to remove discriminatory and restrictive laws and policies that block service access and undermine the HIV response.

The same is true for laws that discriminate against women and girls and affect their enjoyment of human rights. These laws also undermine the ability of national responses to reduce the HIV vulnerability of women and girls and address their HIV-related needs. To facilitate realization of the right to health for adolescent girls and young women, countries should remove onerous parental consent requirements for HIV testing, treatment and prevention services, with a particular focus on legal reform in countries with high age thresholds for service access without prior parental authorisation.

All countries should undertake a comprehensive review of their drug control laws, with consideration of reforming laws in a manner that promotes respect for human rights and alternatives to incarceration, as recommended by the United Nations Human Rights Council.

As a growing number of countries have moved in recent years to expand human rights by repealing outmoded, counterproductive laws and policies, there are opportunities for leader-to-leader learning about the benefits of a human rights-based approach. For example, in regions such as sub-Saharan Africa *(297)* and the Caribbean *(298)*, several countries have rolled back laws criminalizing same-sex relations, offering leaders from these countries an opportunity to share their experiences with leaders from other countries about the benefits flowing from legal and policy frameworks that welcome everyone into the national community and strengthen the national HIV response.

Aligning laws and policies with human rights commitments is a critical step in the HIV response.

Regional bodies have a potentially valuable role to play in building and strengthening regional consensus on important human rights issues. The Eastern and Central European and Central Asian Commission on Drug Policy, led by the former President of Poland and composed of senior opinion leaders from the region, has helped generate high-level support for reforms to drug laws, including the approval by the Committee on Law of the Kyrgyzstan Parliament to approve a draft law to prohibit compulsory treatment for people who use drugs *(299)*. In 2023, a committee of the African Commission on Human and Peoples' Rights recommended that African Union Member States "put an end to discrimination and stigma that people living with HIV and those affected by, vulnerable to and at risk of HIV face by implementing protection laws, rules and appropriates safeguards for civil spaces" *(300)*. The Southern African Development Community Strategy for Sexual and Reproductive Health and Rights recognizes the need for gender-transformative and human rights-based approaches to the delivery of sexual and reproductive health services, with periodic review of scorecards promoting accountability for these commitments *(301)*.

Aligning laws and policies with human rights commitments is a critical step in centring human rights across the HIV response, but reformed laws and policies must then be translated into meaningful action and policies. For example, although HIV and gender-based violence in humanitarian contexts have been incorporated into policy, mandates and operations of United Nations peace support operations, a review found that action on gender-based violence is often given insufficient priority on the ground, resulting in inadequate and fragmented responses that leave many women in fragile settings vulnerable to human rights abuses *(247)*.

In some settings and on certain key issues, removing punitive, discriminatory laws may require more years of hard work—building coalitions, marshalling evidence, cultivating allies and champions, and in some cases pursuing years-long strategic litigation. Even as this work continues, there may be ways to minimize human rights abuses in the context of imperfect legal and policy frameworks. For example, community-led dialogues with law enforcement agencies have proven to reduce the incidence of police-instigated violence and harassment of key population-led organizations and programmes *(302, 303)*. A modelling study found that a police education programme in Tijuana, Mexico would, based on its two years of operation, prevent 4.1% of new HIV infections and 18.5% of overdoses among people who inject drugs over 10 years, by reducing incarceration rates and prioritizing non-incarceration alternatives *(8)*.

Community-led work to repeal laws criminalizing drug use in Nigeria

In Nigeria, 10.9% of the estimated 446 000 people who inject drugs are living with HIV *(304)*. Like many countries, Nigeria has punitive laws in place criminalizing possession of drugs for personal use. A substantial and growing body of evidence shows that criminalization of drug use worsens HIV prevention and treatment outcomes *(305)* and invites a host of additional human rights violations *(145)*.

Across Nigeria, community advocates are working to repeal or mitigate the criminalization of drug use, pursuing multiple strategies that combine long-term and shorter-term approaches. Helping lead this fight is the Drug Harm Reduction Advocacy Network, a coalition of 20 organizations from 18 states.

"Most people who use drugs do not have money to start with," says Aniedi Akpan, chair of the Network. "They do not have jobs. They do not have education. When you arrest people, it puts more pressure on their drug use habits. People who use drugs are socially dislocated and excluded from the benefits of their local community."

The Network is undertaking a two-year advocacy campaign to encourage decriminalization of drug possession for personal use. As a stopgap measure towards full decriminalization, the Network is urging the Government of Nigeria to identify a clear threshold below which the possession of small amounts of drugs would not lead to arrest and incarceration. Members of the Network are working with legislators at the national and subnational levels and hosting meetings with law enforcement to increase awareness and reduce stigma.

According to Aniedi, the Network's use of social media has markedly increased public awareness of the need for decriminalization of possession of drugs for personal use.

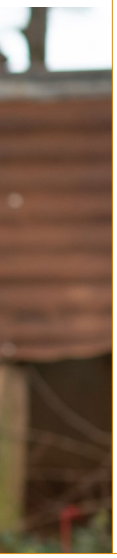
Fund human rights defenders and advocates

To fully align the HIV response with human rights standards and principles, defenders and advocates for human rights must receive sufficient, sustained support. Ideally, this funding would be embedded in national systems, structures and budgetary frameworks, to ensure sustainability. To date, the global community has largely failed this test. Although important funding initiatives have emerged to support human rights activities in the context of HIV, funding for societal enabler programmes[5] in 2023 (US$ 0.9 billion) was less than a third of the amount needed in 2025 (US$ 3.0 billion). When funded, many activities tend to be short-term or piecemeal.

Focused funding for human rights activities: the Global Fund Breaking Down Barriers initiative

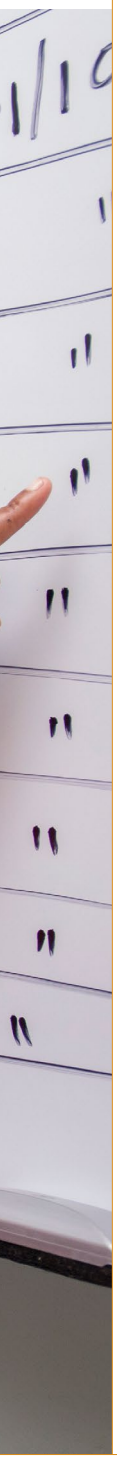
Launched in 2017, the Breaking Down Barriers initiative has channelled funding for HIV-, TB- and malaria-related human rights activities in 24 countries. Global Fund support for human rights activities has risen from US$ 10.6 million before the launch of the initiative to US$ 135 million in the 2020–2022 funding cycle. Scale-up of the human rights activities funded by the initiative has continued, with notable progress in implementation since a 2022 mid-term review *(91)*.

Through Breaking Down Barriers, the Global Fund has supported activities to reduce stigma and discrimination, human rights training for health-care workers, legal and policy reform efforts, legal literacy programmes to help people living with or affected by HIV know their rights, legal services, and initiatives to reduce violence against women. Funded programmes include the Look In, Look Out community dialogues in Côte d'Ivoire, Jamaica, the Philippines and Senegal, involving health-care providers, law enforcement personnel, faith-based groups, people living with HIV, and people from key and vulnerable populations. The Global Fund has supported paralegals and peer workers to facilitate access to justice for people affected by HIV-related human rights violations in the Democratic Republic of the Congo and Kyrgyzstan. With Global Fund support, community-led partners in South Africa sensitized police and health-care personnel to reduce stigma and discrimination towards people who use drugs.



5 Societal enabler programmes focus on reducing stigma and discrimination, advancing gender equality and removing punitive laws and policies, in line with the 10–10–10 targets.

Experience shows that international and national funding for human rights interventions generates results in the HIV response. International funding proved critical to successful advocacy efforts by the transgender-led Tangerine Clinic and other partners to persuade the Government of Thailand to include gender-affirming care in its universal health coverage scheme in 2024 *(306)*. Over the past decade, regional judges' fora have built knowledge and awareness among judicial officers on HIV-related human rights issues, contributing to a growing body of jurisprudence rejecting punitive laws and policies.



Investing in building allies in the judicial space

Effectively pushing back against the anti-rights movement requires strategic allies who can enable actions to protect, promote and uphold human rights for all. Following the initial 2012 report of the Global Commission on HIV and the Law, a group of senior judges worked with UNDP to establish the African Regional Judges Forum in 2014.

Since then, UNDP has continued to convene and expand annual regional judges' fora to improve knowledge and judicial ethics and ensure compliance with international legal standards, especially regarding cases related to LGBTQ+ people, HIV and the law. Meetings have included a convening in Chisinau, Republic of Moldova; the fifth Caribbean Judges' Forum on HIV, Human Rights and the Law in Trinidad and Tobago; and separate meetings for English-, Portuguese- and French-speaking judges in Africa in 2022 and 2023.

"We thought that judges as members of an independent arm of the state—the judiciary—have a role to play in ensuring that the marginalized and the vulnerable are accorded the rights that are promised to them in our constitutions: the right to human dignity, the right against discrimination and the right to life," says Honourable Justice Key Dingake, Botswana, a founding member of the African Regional Judges Forum. "We have been able to break down the walls of prejudice in many respects and promote a culture of inclusivity, of tolerance, of honouring human dignity."

In June 2024, 46 senior judges from 18 countries gathered in Johannesburg, South Africa to celebrate the 10-year anniversary of the African Regional Judges Forum, marking a decade of progress in advancing rights in the region through high-impact judicial engagement. The event was organized by the UNDP #WeBelongAfrica programme and the Southern Africa Litigation Centre, with support from Women's Link Worldwide. In July 2024, UNDP and the Supreme Court of Judicature of Guyana, in collaboration with the Judicial Education Institute of Guyana and the Judicial Education Institute of Trinidad and Tobago, hosted the National Judges' Forum on HIV, Human Rights and the Law in Guyana. More than 50 judicial officers attended, with discussions on the current situation of HIV in the Caribbean and Guyana, and the trend of decriminalization of same-sex relations across the region.

These judicial fora support the development of enabling legal and policy environments, underpinned by progressive laws, robust enforcement and equitable justice systems.

Take action to ensure the long-term sustainability of HIV financing

Adequate, reliable financing is essential to realize the right to health and its determinants for people living with, affected by or at risk of HIV. In 2023, US$ 19.8 billion was available for HIV programmes in low- and middle-income countries—nearly US$ 10 billion shy of the 2025 HIV funding target for 2025 and a 7.9% decline since 2020. Funding shortfalls have a concrete impact on people's right to health, keeping HIV services from reaching the people who need them and discouraging investment needed in underprioritized aspects of the HIV response, such as structural drivers and HIV prevention. In addition to boosting financing specifically for human rights interventions in the context of HIV, the world must redouble efforts to mobilize the financing required to end AIDS as a public health threat and to sustain these gains over time, with a specific focus on better leveraging potential funding sources that have been insufficiently tapped. Under international human rights law, states have an obligation to provide international assistance and cooperation, especially economic and technical support with a view to achieving the full realization of rights *(36)*.

Ending AIDS as a public health threat would generate a net return on investment of US$ 7.9 [US$ 5.4–11.6] per capita for each dollar invested between now and 2030 and US$ 10.6 [US$ 7.3–15.6] per capita for each dollar invested between now and 2050. By contrast, failing to meet global HIV targets will lead to huge economic, human and societal costs. The economic cost of inaction to achieve global HIV targets represents US$ 1.75 trillion by 2030 and US$ 7 trillion by 2050. By 2050, inaction could result in nearly 35 million more people acquiring HIV and 17.7 million additional AIDS-related deaths compared with a business-as-usual scenario *(307, 308)*.

Across sub-Saharan Africa, most countries remain heavily dependent on external assistance, including eight countries in western and central Africa that depend on donors for more than 90% of HIV programme costs *(309)*. Donor funding for HIV (US$ 7.86 billion in 2023) is markedly lower than it was in 2014 (US$ 8.6 billion), and it continues to decline *(310)*. Preserving and building on international HIV assistance will be critical for ending AIDS as a public health threat, especially in low- and lower-middle-income countries and among people from key and vulnerable populations, whose needs are not always addressed well by national governments.

Adequate, reliable financing is essential to realize the right to health.

Boosting and sustaining domestic financing is essential to end AIDS as a public health threat, but low- and middle-income countries confront considerable challenges in mobilizing domestic resources for the HIV response. Tax revenues are projected to remain stagnant in at least eight high HIV burden countries in eastern and southern Africa and to decline in Angola and Mozambique *(311)*. Tax revenues have fallen across western and central Africa and remain below pre-COVID-19 levels *(310)*.

At the same time, at least 60% of low-income countries are either experiencing or at high risk of debt distress. Across sub-Saharan Africa, debt service is consuming an increasing proportion of national gross domestic product, crowding out other people-focused investments. In 2023, debt service payments in eastern and southern Africa were 2.7 times higher than budget expenditure on health *(311)*. Debt service in sub-Saharan Africa is projected to rise faster than tax revenues in the coming years. Debt-related costs are rising, and the array of health and development challenges facing many countries is expanding, including but not limited to the urgent need for adaptation and mitigation measures in response to climate change.

Preserving and building on international HIV assistance will be critical for ending AIDS as a public health threat.

To realize the right to health for all people living with or affected by HIV, business as usual will not suffice, underscoring the immediate need for innovation to generate essential financing. Such innovations could include better integration of HIV services with other health services. A systematic review and meta-analysis found that HIV and health service integration tend to improve health and health system outcomes in addition to contributing to ending AIDS as a public health threat *(312)*. Costs of basic HIV and non-HIV services tend to be lower in integrated programmes, and all studies included in the systematic review showed positive cost-effectiveness of integration. In addition, HIV integration is associated with equity gains across all 95–95–95 HIV targets. The future path for integrating HIV with other services, such as sexual and reproductive health and rights, TB and viral hepatitis, should include human rights protections to remove service barriers experienced by people from key and marginalized populations and to ensure an enabling environment for optimal, equitable health outcomes *(89)*.

Improving the efficiency and effectiveness of tax collection and implementing more equitable tax policies could benefit the HIV response and other sustainable development goals. Relief from current levels of debt is essential, and donors should expand concessional financing for HIV and other health investments.

Ensure community-led responses and human rights defenders have sufficient civic space to lead efforts to centre human rights in the HIV response

Healthy societies have healthy civil societies, which promote accountability, citizen engagement, democratic governance and justice for all *(313)*. Civil society has played a pivotal role in the global HIV response—in articulating its underlying principles, advocating for approaches that respect human rights and leave no one behind, delivering services, and holding the HIV response to account. The Open Government Partnership recognizes key actions to protect and enhance civic space, including measures to protect freedom of expression, tackle disinformation, enable citizens and civil society to operate without undue burden, and ensure space is created for women, girls and people from marginalized populations to have their voices heard *(314)*. Although growing restrictions on civic space in many countries are alarming, it is also important to build on and learn from recent judicial decisions that have countered this trend by expanding civic space.

In the case of HIV, enabling official registration of organizations and networks of key and vulnerable populations is critically important. A critical aspect of ensuring sufficient civic space for human rights defenders is addressing security issues, because individuals and organizations that lead on human rights and HIV organizations are often vulnerable to harassment and violence, as documented in a review of security risks of civil society actors in Belize, the Dominican Republic and Guatemala *(315)*.

Impact of official registration of key population-led organizations: the case of LEGABIBO

In the late 1990s, community activists in Botswana came together to form LEGABIBO to work for the realization of human rights for LGBTQ+ people. As an unregistered organization, LEGABIBO initially had limited ability to advocate for legal and policy changes needed by the LGBTQ+ community. Aiming to formalize its status and elevate its ability to move a change agenda, LEGABIBO went to court and in 2016 won an appellate case confirming its legal right to register as a civil society organization.

Official registration of LEGABIBO helped usher in a sea change in national policy towards LGBTQ+ people. The Government of Botswana now funds LEGABIBO and other LGBTQ+-serving organizations to deliver HIV prevention and treatment services to community members. The Government has provided LEGABIBO with a mandate for coordination and oversight of organizations serving people from key populations, such as Captive Eye (for people who use drugs), Men for Health (for men who have sex with men), Nkaikela (for sex workers), Silence Kills (for sex workers), Sisonke (for sex workers) and Success Capital (for LGBTQ+ people). LGBTQ+ representatives now sit on policy-making bodies, including the National AIDS and Health Promotion Council and the Country Coordinating Mechanism of the Global Fund.

The progressive decision of the Botswana Appellate Court in 2016 regarding the right of LEGABIBO to register as a nongovernmental organization set the stage for the unanimous ruling of the Court of Appeal in November 2021 decriminalizing same-sex relations.

Civil society organizations, especially those operating in fragile or difficult environments, require the ongoing support of international partners. When human rights crises arise, the need for a rapid and optimally coordinated response of United Nations partners can be critical. In 2024, UNAIDS and UNDP issued guidance for the United Nations system on responding effectively to HIV-related human rights crises, emphasizing the importance of anticipating and preparing for human rights crises before they arise, undertaking a rapid assessment to guide action, supporting the coordination of actions of diverse United Nations and non-United Nations partners, and promoting sustainable, long-term initiatives to prevent future human rights crises *(316)*.

Healthy societies have healthy civil societies.

Mainstream human rights commitments and expertise and apply an equity lens across the breadth of the HIV response

Human rights are not a subcomponent of the global HIV response—they are fundamental to every HIV-related activity and programme. Every actor in the HIV response—researchers, clinicians, prevention workers, epidemiologists, advocates, community educators and mobilizers—must take action to protect and promote human rights.

The recommendations of the International AIDS Society–Lancet Commission on Health and Human Rights are instructive. People involved in the HIV response, regardless of their role, should speak out against human rights violations and "critically examine how they can contribute to centring human rights in their work" *(8)*. Across all aspects of the response, HIV practitioners should be adept at identifying and addressing human rights concerns. HIV practitioners should actively correct misinformation or disinformation in their interactions with clients and colleagues, and identify, prevent and address stigma and discrimination and ensure services are accessible and acceptable to all without discrimination. Human rights training should be mainstreamed across medical and public health education and in HIV-related technical support projects in a manner that is sustainable. Broader sectors, such as education, workplace, justice and law enforcement settings, need to embed human rights and HIV expertise within their structures, and ensure regular training and sensitization on issues relating to HIV and key populations.

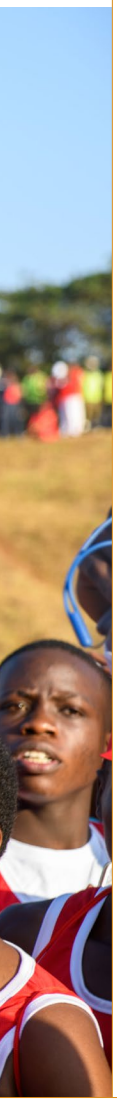
Recent history underscores how people whose jobs within the HIV response are not usually understood to focus on human rights issues can nevertheless become important catalysts for change on human rights issues. For example, leading researchers and HIV scientific experts, who normally focus on clinical measures, epidemiology and programme implementation, have catalysed important gains in HIV-related human rights issues. The 2018 Expert Consensus Statement on the Science of HIV in the Context of Criminal Law *(317)* supported acquittals of people living with HIV for alleged violations of HIV criminalization laws and successful court challenges to discriminatory HIV-related laws in at least six countries *(318)*. The conclusions of 20 leading scientific experts that laws criminalizing HIV exposure, nondisclosure or transmission are both discriminatory and scientifically groundless have been further buttressed by the WHO finding that it is almost impossible for a person with an undetectable viral load to transmit HIV to a sexual partner *(319)*. An increasing number of researchers are examining the impact of discrimination, stigma and criminalization on HIV outcomes.

Equity, or substantive equality, must be a cornerstone of the HIV response, and all programmes should be monitored carefully to identify and address disparities as they emerge. Although monitoring indicates that many HIV-related disparities have declined over time *(88)*, much work remains to be done to ensure equity in the HIV response. Where indicated, HIV service delivery sites and systems should be redesigned or new service channels created to address the needs of the people being left behind. Implementation research should prioritize identifying optimal strategies in diverse settings to close equity gaps in the HIV response and remove stigma, discrimination and criminalization to ensure equal access to services.

A key step to enhancing equity in the HIV response is to allocate resources where they are most needed and where gaps need to be closed. Reporting from 56 countries indicates that only 2.6% of HIV spending supported interventions specifically designed to address the needs of people from key populations for testing, treatment and care. As people from key populations and their sex partners account for the majority of new HIV infections worldwide, and for the very large majority of new infections outside sub-Saharan Africa, it is clear that additional funding that is specifically focused on these populations is required to end the HIV pandemic.

Balancing the potential benefits and risks of the digital revolution

The communications revolution over the past 35 years has buttressed the HIV response in many ways, expanding access to essential health information, providing spaces for key and vulnerable populations to build communities, and enhancing the ability of health-care providers to deliver holistic, coordinated care *(8)*. The International AIDS Society–Lancet Commission on Health and Human Rights advises that digital tools have proven important for human rights defenders, enabling them to record, document and broadly disseminate information about human rights violations in real time *(320)* and bolstering investigative journalism that can expose human rights abuses *(321)*. Effectively leveraging digital tools to improve health and well-being and advance human rights necessitates concerted efforts to close the "digital divide" by ensuring equitable digital access, paying particular attention to low- and middle-income countries and people in rural settings.



Increased use of digital tools, however, poses potential human rights risks in the context of HIV. For example, the growing use of digital identification in health-care systems across sub-Saharan Africa is associated with an increased hesitancy of people from key populations to access health services, especially in countries with weak data protection laws *(322)*. Towards the goal of ending AIDS as a public health threat, investments are needed in initiatives to educate young people regarding the benefits and risks of digital technologies and how best to navigate a world that is increasingly online *(323)*.

The freedom the internet gives to anyone, anywhere to say things virtually and anonymously, regardless of its truth, poses profound challenges for HIV efforts by offering avenues for the publication and broad dissemination of misinformation and disinformation. The emergence of various forms of artificial intelligence threatens to magnify these challenges and further undermine people's ability to distinguish truth from falsehoods *(8)*.

Disinformation has long harmed efforts to respond effectively to HIV, including during the pre-digital era. As South Africa confronted the world's most severe national HIV epidemic at the start of the twenty-first century, senior leaders embraced the disproven assertion that AIDS is not caused by HIV, blocking essential research and the provision of antiretroviral therapy for the prevention of vertical HIV transmission *(324)*. As a result of AIDS denialism, more than 330 000 lives—about 2.2 million person-years—were lost in South Africa between 2000 and 2005 *(325)*.

In the intervening years, South Africa has become a leader in the global effort to end AIDS as a public health threat *(326)*, but disinformation continues to imperil HIV prevention and treatment efforts. The digital world has amplified the reach and impact of false or misleading information about HIV. News stories and social media entries—in countries of all income levels—have disseminated damaging and stigmatizing falsehoods, including the unfounded claim that biting, spitting or kissing can transmit HIV *(327)*. As the world endeavours to scale up PrEP as a key strategy to accelerate progress towards ending AIDS as a public health threat, it is especially concerning that popular social media and news sites have disseminated false claims regarding the efficacy and safety of PrEP, including the groundless assertion that taking PrEP can "cause" HIV *(328)*.

Addressing HIV-related misinformation and disinformation is complex, in part due to the need to balance the right to health with the right to free speech. Social media companies should do a much better job of monitoring content to prevent the dissemination of demonstrably false claims that undermine public health or encourage human rights violations. HIV stakeholders should redouble efforts to correct misinformation through timely fact-checking, which has been shown to be effective in countering health-related misinformation and disinformation *(329, 330)*. In their encounters with the people they serve, HIV service providers should work proactively to counter HIV-related misinformation and disinformation.

Community action to protect young key populations from acquiring HIV in Indonesia

Indonesia continues to work towards controlling the HIV epidemic. But the Stigma Index 2.0 shows that stigma and discrimination remain a major barrier for people living with HIV and people from key populations to accessing HIV-related services.

Echoing the result of this study, Bella Aubree, the national coordinator for Inti Muda Indonesia, a network of young key populations working in the HIV response, spoke of her experiences of stigma and discrimination as a transgender woman living with HIV.

Nearly one in four transgender people (23%) in Indonesia are living with HIV. Violence against transgender people remains a major challenge, hindering their access to public services, including for health and HIV.

Bella was eight years old when she was kicked out of her home. As a teenager, she helped her aunt sell snacks on the street, but often she did not have enough money to pay her school fees. Many days she barely had enough to eat, leading her into vulnerable situations to meet her basic needs. "I did not know about the risks of HIV. I was just focused on paying for my tuition and food," she says.

One day, Bella took a bus from her village to the city for a health checkup, and she tested positive for HIV. Fortunately, the clinic moved swiftly to initiate antiretroviral therapy and to connect Bella with Inti Muda. "This was the first time in my life when I realized I was not alone," she recalls.

Bella, now 22, rose to leadership at Inti Muda, with a focus on protecting young key populations from acquiring HIV and improving the well-being of young people from key populations living with HIV. A challenge to her work is the tendency of many older people to discount the input of young people. "I emphasize to peers that if we are invited somewhere, we young people must be given the microphone to speak," she says.

UNAIDS Community Support Adviser, Elis Widen, affirms Bella's call to action: "We are seeing an increase in new HIV infections among people from key populations in the younger age group. It is vital to ensure young key populations know about HIV risks, are aware of how to protect themselves from HIV, and have the information they need on how to access the services they need," she says.

Back in Jakarta, Bella debriefs with her colleagues after her meetings with government officials. She has set her eyes on two major goals for Inti Muda: educating young people on sexual and reproductive health and rights to reduce their risk of getting HIV, and introduction of the twice-yearly injectable HIV prevention medicine lenacapavir. Reflecting on her life, she urges people: "Find your community, you are not alone! Keep dreaming, you deserve to live."

Landmark ruling exposes the human rights violation of forced sterilization of women living with HIV

In a momentous legal development, on 21 September 2022, Honorable Justice Mrima in Kenya ruled that the forced sterilization of four women living with HIV constituted a violation of their fundamental rights, including dignity, freedom from discrimination, the right to the highest attainable standard of health, and the right to establish a family *(331)*.

The Court's judgment firmly establishes that women living with HIV possess the inherent right to make informed choices regarding their reproductive decisions. Furthermore, it mandates that all medical facilities must uphold the paramount importance of obtaining informed consent from people who seek medical treatment on their premises.

Translate commitments on gender equality and HIV into reality

Given the HIV burden among women and girls in sub-Saharan Africa (64% of people living with HIV in the region) and the role of gender inequalities in slowing progress towards ending AIDS as a public health threat, implementing gender-transformative HIV responses is an urgent priority, especially in sub-Saharan Africa. Investment in women-led networks and movements is needed, along with meaningful engagement and leadership of women, girls and gender diverse people in all aspects of decision-making regarding HIV, sexual and reproductive health and rights, and gender-based violence.

National responses should address women and girls in all their diversity, taking account of the multiplicity of intersecting needs that affect HIV and other health outcomes. Good-quality, consensual, nondiscriminatory and rights-based services should be available to all women and girls to address their full array of HIV-related needs, with a specific focus on leaving no one behind, including women from key populations.

Country-owned, inclusive leadership is essential to promote implementation and scale-up of community-led interventions to transform unequal gender norms, attitudes, behaviours and harmful norms regarding masculinity and to promote respectful relationships that reduce sexual and gender-based violence and advance HIV prevention. Specific attention is needed to engage men and boys in efforts to make progress towards gender equality.

Further work is needed to strengthen gender equality expertise and high-level and multisectoral commitment to develop, implement and monitor gender-transformative HIV responses. These commitments should be backed up by robust budgets and investments, which in turn requires the ongoing tracking of pertinent expenditures and the identification and leveraging of opportunities to strengthen investments on gender equality in the HIV response. Gender-transformative responses must be multifaceted and multisectoral, addressing economic empowerment, decision-making, education and other essential building blocks towards gender equality and building robust cross-sectoral partnerships and collaborations to address the gender dimensions of the HIV pandemic.

Translate commitments into reality.

Unite with allies within and beyond the health sector

All HIV actors must champion and promote human rights, but the HIV response alone cannot resolve every human rights barrier to ending AIDS as a public health threat. Many of the systemic human rights abuses that undermine the HIV response require action that extends well beyond the health sector, including issues touching on the rights of women and girls, key populations, education, social protection, racial and migrant justice, labour, disability rights, international trade and the judicial system. If the HIV response is to help catalyse the removal of the broad array of HIV-related human rights barriers, it must make "common cause" with diverse sectors and communities to drive change *(8)*.

Multisectoral action to address social and structural factors that increase vulnerability has been shown to advance equity in the HIV response. In Kenya, a banking project in 36 villages implemented by the Western Organization for People Living with HIV has supported financial stability for 4570 people living with HIV, including 3000 women, reducing household- and community-level economic gender disparities by 80% between 2014 and 2024 *(332)*. In New York city, where one in three people diagnosed with HIV were receiving housing assistance at the end of 2023, 88% of people living with HIV had a suppressed viral load *(333)*. The International Labour Organization and UNDP have developed a checklist to aid countries in ensuring social protection programmes address the needs of people living with HIV and people from key populations *(106)*.

In many parts of the world, faith-based organizations are playing an important role in reducing stigma and discrimination towards people living with HIV and people from key populations. After a survey of church members in four regions found high levels of HIV-related misinformation and stigmatizing attitudes, the Jamaica Council of Churches held dozens of educational and sensitization sessions to challenge myths and misinformation about HIV and is now working towards developing a formal HIV policy that recommends acceptance by all Council churches of the full diversity of people living with HIV *(90)*.

Make "common cause" with diverse sectors and communities to drive change.

Ensure accountability for adherence to HIV-related human rights commitments and end impunity for human rights violations

Accountability demands transparent tracking and reporting of HIV-related human rights violations, and accessible, independent, impartial and effective mechanisms for holding perpetrators to account and providing redress to people who have experienced violations.

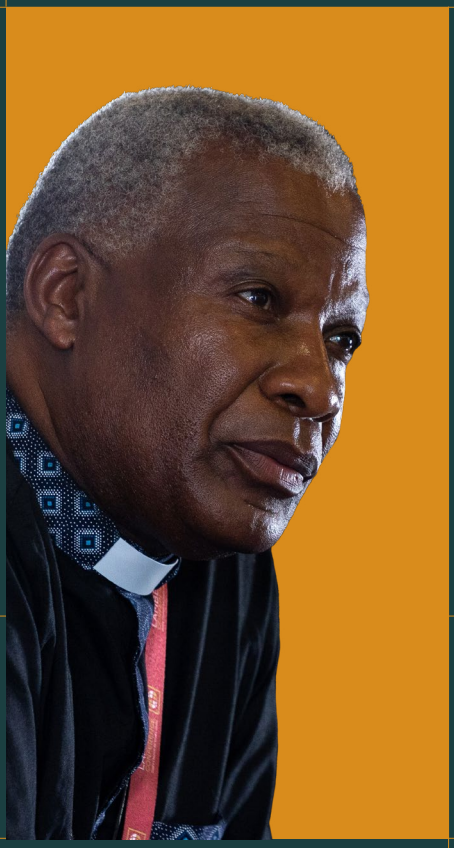
Community-led responses help enable accountability for human rights violations and redress for people who experience abuses. In the Democratic Republic of the Congo, the community-led feminist organization Repro Justice Congo deployed trained paralegals, elected from the communities of people who use drugs and transgender people, to document and address human rights violations, leading over a three-year period to successful prosecutions against eight health-care providers for discrimination against people from key populations and compensation to community members who experienced discrimination *(334)*.

Community-led responses help enable accountability for human rights violations and redress for people who experience abuses.

Trained paralegals engage in community awareness-raising regarding human rights and help resolve human rights violations in countries including Indonesia, Kyrgyzstan, Thailand and Ukraine *(335, 336)*. In eastern Europe and central Asia, a community-based and key population-led partnership has established a task force to drive accountability for achievement of the 10–10–10-targets, with support from UNAIDS and UNDP. In June 2024, coinciding with Pride Month in India, UNAIDS and UNDP partnered with the Humsafar Trust, the Integrated Network of Sexual Minorities, and the National Network of Transgender Persons to convene a national dialogue on HIV and human rights, with the aim of informing the development of a clear roadmap of inclusive rights in the context of HIV and health.

ESSAY

Our moral obligation to protect everyone's human rights



The Most Revd Dr Thabo Makgoba
Archbishop of Cape Town

I first witnessed the impact of the AIDS crisis in the late 1990s as an ordinary parish priest. It was a frightening time. Seeing the death and devastation wrought in my own and other communities across countries burned into my heart and soul.

Faith teaches us not only that God loves each one of us, but that every person is created in the image of the creator. As such, when in some parts of the world we genuflect to one another, we are saying "The God in me greets the God in you." In the isiZulu language, when we greet people, we say "Sawubona," meaning "We see you"—we see you for who you are and we feel your longing.

Every person is infinitely precious, and so we are called to respect and honour everyone.

As my predecessor Desmond Tutu said, we are God-carriers. To treat any one of God's children as less than this is not only unjust. It is not only painful for the one so treated. It is blasphemous—"like spitting in the face of God". Every person is infinitely precious, and so we are called to respect and honour everyone.

My public ministry over the years has centred on carrying out walks of witness. These entail literally walking together with my fellow pastors through places where people live in squalor, excluded, on the periphery. We do so to affirm that every person belongs in society, and that all human rights belong to every person. As the Universal Declaration of Human Rights sets out so powerfully, "All human beings are born free and equal in dignity and rights" and "Everyone is entitled to all rights ... without distinction of any kind, such as race, colour, sex, language, religion, political or

other opinion, national or social origin, property, birth or other status."

Choosing love means rejecting hateful laws against marginalized communities. Punitive discriminatory laws, such as those criminalizing LGBTQ+ people, push people away from lifesaving health care, and thus they kill.

But it is not only hateful laws that harm. We need to triumph over hateful hearts too. We need to champion the human rights of every person, not only in our legal statutes but in our everyday engagement with each other too. In this call to action, I include churches. We in the faith community have too often pushed people away with judgement and meanness. For this hard-heartedness we need to repent, and commit to always stand up for all people, especially the most marginalized. As our faith calls us, we need to love all of our neighbours.

Protecting everyone's human rights is crucial for success in our response to HIV. When we do not adhere to the commitments made in the Universal Declaration of Human Rights, our efforts to end AIDS falter. When we undermine the rights of people to be treated with dignity and without discrimination, we push people away from the health system. When we deny people the right to association, we prevent communities from being able to hold service-providers to account to improve service delivery.

Just as pandemics know no borders, neither should solidarity. As UNAIDS data show, we cannot end AIDS in some places or for some people. We can end AIDS as a public health threat only by upholding across international public policy the rights of everyone, everywhere. For example, new long-acting HIV prevention medicines that need to be taken only twice a year will be vital for enabling people currently missing out to be served. But companies are not moving fast enough or boldly enough to share the technology. This is undermining the advances that worldwide access to these medicines could secure.

The international policy frameworks that maintain this global apartheid in access to medicines are jeopardizing the health security of everyone, not only in the Global South but also in the Global North. So too is our failure to tackle the debt crisis. By choking developing countries resources, the debt crisis is preventing investments in health that would ensure health security worldwide. Because we are interdependent, when we exclude anyone, everyone loses—and when we include everyone, everyone wins.

The path to victory in the HIV response is well marked. That path is marked "human rights"—respect for the dignity of all and celebration of our differences. With love in our hearts, let us walk that path together.

It is not only hateful laws that harm. We need to triumph over hateful hearts too.

Strengthening community-led action to address human rights violations in Ukraine

Since it began operating in 2001, 100% Life, the largest community-led organization of people living with HIV in Ukraine, has played a pivotal role in the country's HIV response. A key element of the work of 100% Life is promoting the human rights of all people living with HIV and people from the key populations most heavily affected by HIV. Over the past four years, 100% Life has developed and implemented a digitized system that has improved the documentation of HIV-related human rights violations, hastened action to address human rights abuses, and enhanced the power of community-led advocacy for needed legal and policy change.

For years, 100% Life used a paper-based records system for recording and tracking human rights abuses, but this approach invited fragmentation and made it more difficult to identify patterns in HIV-related human rights violations. In line with the framework of the Global Partnership for Action to Eliminate All Forms of HIV-related Stigma and Discrimination, and with funding from the Global Fund, 100% Life in 2021 piloted a fully electronic system for recording, addressing and tracking human rights violations reported by people living with HIV and people from key populations. It planned to take the system live nationally in 2022, but the war in Ukraine has forced postponement of the nationwide rollout. In developing the digitized system, 100% Life incorporated features to ensure the security of information stored in the cloud. The Global Network of People Living with HIV has conducted an audit of the system to verify its security.

100% Life has trained a nationwide network of more than 200 paralegals responsible for addressing reported human rights violations. When a complaint is received, an algorithm assigns a paralegal, who follows up with the person making the complaint. Where a paralegal is unable to resolve the issue, the case is elevated to an attorney for a more formal response.

In its first full year of operating in 2023, the new system received 4564 reports of human rights violations. Of these, 77% were resolved, and an additional 21% are in the process of being addressed. Women accounted for 886 of the 1135 appeals by people living with HIV. Among people from key populations, the largest numbers of reported human rights violations occurred among people who inject drugs (662), sex workers (571), and people formerly in prisons or other closed settings (461). More than half of reports concerned human rights violations by medical institutions, ranging from denial of care to poor-quality care and disrespectful treatment.

An important benefit of the new system is that it aids community-led efforts to build the case for action to address structural and systemic causes of human rights violations. "The number of human rights violations is huge," says Valeria Rachynska, Director of Human Rights,

Gender and Community Development for 100% Life. "For us, it is super important to have these data to show to Government when there are systemic problems." Experience from 2023 has underscored the need for enhanced health-care worker training and for changes to laws and policies to strengthen human rights protections.

100% Life is now prioritizing community outreach and education to build awareness of human rights and to increase demand for the reporting of human rights violations. 100% Life expects to see a marked increase in numbers of reports of violations as people become more aware of these community-led resources for responding.

National human rights institutions can aid in developing reporting mechanisms for HIV-related stigma and discrimination, facilitate access to justice, and increase awareness of issues pertaining to HIV and sexual and reproductive health and rights *(337, 338)*. Regional bodies can help promote human rights norms and accountability through regular reporting, by convening high-level sessions and processes focused on human rights in the context of HIV, and by providing platforms for countries to learn from the successful experiences of other countries in protecting and expanding human rights.

Parliaments in countries play important roles, ensuring an enabling environment and monitoring government actions to ensure progressive realization of the right to health and guarding from retrogressive actions and measures.

CONCLUSION

At this turning point in the global HIV response, the world will either take the path to end AIDS as a public health threat or allow the pandemic to continue and risk a dangerous HIV resurgence.

This report has demonstrated that human rights are essential to a robust, person-centred, sustainable HIV response. Human rights violations are perpetuating critical inequalities in the HIV response and vulnerabilities to HIV. By contrast, the evidence is clear that approaches grounded in human rights achieve superior HIV prevention and treatment service outcomes, reduce inequalities in service access, and accelerate progress towards ending AIDS.

As duty-bearers for human rights, national governments should fulfil the commitments they have made to protect fundamental rights and freedoms in the context of HIV. Doing so will avert human suffering, promote sound development, and save substantial financial resources in the long term. Steps are needed to mainstream human rights across the HIV response and to make common cause with diverse sectors to address the factors that diminish HIV prevention and treatment service uptake and worsen service outcomes.

For domestic and international donors, closing resource gaps in the HIV response is essential to realizing the right to the highest attainable standard of physical and mental health. Particular action is needed to allocate new resources to aspects of the response that remain underprioritized, including human rights interventions, HIV prevention services, and responses for people from key and vulnerable populations. If we are to ensure a sustainable HIV response, funding for human rights must be a priority.

Taking the path to end AIDS as a public health threat requires political courage, but it will yield long-term benefits for individuals, communities and entire societies and catalyse progress towards the global vision of sustainable health and development for all.

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