

BACKGROUND NOTE

ZERO DISCRIMINATION IN HEALTH CARE SETTINGS

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For further reference, all case studies can be found online as a Conference Room Paper through the PCB website: [UNAIDS/PCB \(41\)/CRP1](https://www.unaids.org/en/resources/presscentre/featurestories/2014/04/20140414pcb41crp1).

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I. EXECUTIVE SUMMARY

1. The topic of the thematic segment of the 41st PCB meeting—“Zero discrimination in health-care settings” —reflects increasing acknowledgment of the need to address stigma and discrimination, including in health-care settings, as a fundamental requirement for achieving the Fast-Track targets set for 2020 and for realizing the promise of the 2030 Agenda for Sustainable Development to leave no one behind.

Discrimination in health-care settings

2. Discrimination in health-care settings violates many of the most fundamental human rights that are protected by international treaties and by national laws and constitutions. The discrimination is often driven by stigma—negative beliefs, feelings and attitudes towards people living with HIV or key and affected populations.
3. Discrimination in health-care settings is widespread across the world and takes many forms. It is often directed towards some of the most marginalized and stigmatized people in society, including people living with HIV and key populations, many of whom face intersecting forms of discrimination on the basis of their age, sex, race or ethnicity, physical or mental health status, disability, sexual orientation or gender identity, nationality, asylum or migration status, or criminal record. Women and girls are particularly likely to experience multiple forms of discrimination.
4. Discriminatory laws, policies and practices—including the criminalization of key populations or age-related consent laws for accessing health services—and a lack of protective laws and policies have pernicious effects on the environment in which health care is provided.
5. Discrimination in health-care settings seriously reduces the quality of life of individuals who experience it, and impedes the use of health services.
6. Discrimination can also affect health workers. Negative attitudes about and fears of HIV among health workers, compounded by inadequate training or protocols, may lead to inadequate caring for people living with or affected by HIV. A lack of respect for the rights of health workers also affects their ability to provide services, and may be harmful to their own health. Health workers may themselves be living with HIV or engaging in stigmatized behaviours, which could deter them from seeking the care they need. Those working with people living with HIV may be subject to HIV-related discrimination by proxy. Gender-based discrimination is also entrenched in the health workforce.

Moving towards solutions

7. Solving these challenges requires the implementation and scale-up of targeted, coordinated, time-bound, evidence-based, multisectoral actions to eliminate discrimination in health-care settings. This involves:
 - *Monitoring levels of discrimination in health-care settings*, including the experiences of health service users, as well as the attitudes and practices of service providers;
 - *Educating the health workforce*, including pre-service and in-service training to develop human rights and gender equality competencies, as well as an understanding of medical ethics and of the rights and responsibilities of health workers in addressing discrimination in health-care settings;

- *Reviewing and reforming laws, policies and institutional practices* to ensure that they provide a supportive environment for discrimination-free health care;
- *Protecting health workers* through the effective implementation of occupational health and safety standards and respecting the labour rights of health workers;
- *Strengthening the capacity of community health workers and building community interventions*, and ensuring appropriate linkages between communities and formal health systems;
- *Empowering health service users and increasing their access to justice* by making them aware of and able to claim their rights, including those to discrimination-free health care, through rights/legal literacy programmes and legal services;
- *Strengthening accountability* by guaranteeing access to effective redress mechanisms (for both users of health services and health-care providers) and by strengthening the reporting, monitoring and evaluation of discrimination; and
- *Ensuring the meaningful participation and involvement* of people living with HIV and key and affected populations, as well as of community-based organizations.

Implementing the Agenda for Zero Discrimination in Health-Care Settings

8. The Agenda for Zero Discrimination in Health-Care Settings, co-led by the UNAIDS Secretariat and the World Health Organization (WHO), brings together key stakeholders to achieve a world where everyone, everywhere, is able to receive the health care they need with no discrimination.
9. Eliminating discrimination in health-care settings requires time-bound targets and targeted funds, with resources allocated to programmes and actions that are proven to work. It also requires people and organizations to work together towards the same aim. Governments are ultimately accountable for ensuring non-discrimination in health care. However, networks of people living with HIV, key populations (and other affected populations), women and young people also have key roles to play in striving for zero discrimination in health-care settings and for providing discrimination-free services in the community. Global and national professional associations of health workers can help apply pressure to ensure that workplaces adhere to labour rights and standards.
10. In every region of the world, too, Fast-Track Cities are working together to achieve zero stigma and discrimination by 2020.
11. Social media and new mobile and internet technologies are valuable tools and can be particularly useful in supplementing traditional methods of monitoring the quality of health services and cases of discrimination, and for connecting individuals to relevant services.

The way forward

12. In order to Fast-Track the implementation of the Agenda for Zero Discrimination in Health-Care Settings, as well as to improve access to vital prevention, testing, treatment and care services for people living with HIV and key populations, a number of priority areas for action emerge:

- Discrimination in health-care settings is often directed towards the most marginalised members of society who may be discriminated against on many different grounds. It is therefore necessary for countries **to take multisectoral measures to address intersecting forms of discrimination**, including those related to age, sex, race or ethnicity, mental health conditions, sexual orientation, gender identity or nationality in health-care settings and to ensure that the same quality of care is provided to everyone, while taking into consideration the specific needs of each individual.
- There is a need to **consolidate and disseminate existing evidence** on effective programmatic and policy responses to eliminate discrimination in health-care settings to ensure that national AIDS programmes and Ministries of Health, in collaboration with other sectors, can establish and expand evidence-based programmes to reduce discrimination in the context of health.
- It is also important that countries **set Fast-Track zero discrimination targets**. These efforts could be aligned with the ongoing processes around the Global HIV Prevention Coalition and the HIV Prevention 2020 Roadmap. To be able to set time-bound targets, it is essential to **measure discrimination in health-care settings**. The levels of such discrimination should be measured both from the perspective of both service users and service providers, in collaboration with civil society and other partners, including through the use of the updated People Living with HIV Stigma Index. To increase accountability, information about progress in eliminating discrimination in health-care settings should be included in countries' reports to various human rights mechanisms, including in the context of the Universal Periodic Review, and when reporting on their progress towards the Sustainable Development Goals through voluntary national reviews, as well as to the Global AIDS Monitoring reports and the National Commitments and Policy Instrument. It is also important to undertake financial analyses of how much money is lost due to stigma and discrimination and its implications for health systems.
- In order to ensure that health workers have the necessary capacity to provide discrimination-free health-care, **issues related to human rights, non-discrimination, free and informed consent, confidentiality and privacy should be integrated into pre- and in-service training curricula for health workers**. Training on the right to non-discrimination should also be provided to police, law-enforcement officers, prison staff and other relevant professions. Best practices on such training and education programmes and materials should be shared.
- At the same time, people living with HIV, key populations and other groups in situations of vulnerability should be **empowered to know and demand their right to non-discrimination in the context of health care**, including through health and human rights literacy and through "Patient Charters" that encapsulate the principles and criteria for non-discriminatory, people-centred services at the health facility level.
- It is also important to ensure that **health workers have a supportive working environment and to reduce discrimination towards health-care workers**, including gender-based discrimination.
- There is also a need **to review and reform laws that reinforce stigma and discrimination**, including laws related to the age of consent, HIV non-disclosure, exposure and transmission, criminalization of key populations, travel restrictions and mandatory testing.

II. ACRONYMS

2030 Agenda	2030 Agenda for Sustainable Development
AIDS	acquired immune deficiency syndrome
ART	antiretroviral therapy
ARV	antiretroviral
CDC	U.S. Centers for Disease Control and Prevention
Global Fund	Global Fund to fight AIDS, Tuberculosis and Malaria
HIV	human immunodeficiency virus
ILO	International Labour Organization
PCB	Programme Coordinating Board
PEPFAR	U.S. President's Emergency Plan For AIDS Relief
SDG	Sustainable Development Goal
TB	tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
WHO	World Health Organization

III. INTRODUCTION

13. At its 39th meeting, the UNAIDS Programme Coordinating Board (PCB) decided that the topic of the thematic segment of the 41st PCB meeting would be “Zero discrimination in health-care settings”. This decision reflected increasing acknowledgment of the need to address stigma and discrimination, including in health-care settings, as a fundamental requirement for achieving the Fast-Track targets set for 2020 and for realizing the promises of the 2030 Agenda for Sustainable Development, including the target of ending AIDS.
14. The decision of the 39th PCB regarding this thematic segment follows and builds upon a series of previous Board discussions, decisions and recommendations that reaffirm the importance of ending discrimination in health care and that recognize it as a major barrier to the uptake and provision of HIV services (see UNAIDS/PCB (26) in 2010, UNAIDS/PCB (29) in 2011 UNAIDS/PCB (31) in 2012 and UNAIDS/PCB (35) in 2014).
15. The 2030 Agenda for Sustainable Development places respect for equality and non-discrimination at the centre of its mission. Its core principles are to ensure that no one is left behind, and to reach those who are furthest behind first. Ending discrimination in health-care settings is essential to these principles, and to achieving the Sustainable Development Goals (SDGs) of the 2030 Agenda, in particular SDG 3 (good health and wellbeing, including achieving universal health coverage and ending the AIDS and tuberculosis epidemics); SDG 4 (quality education); SDG 5 (gender equality); SDG 8 (decent work and economic growth); SDG 10 (reduced inequalities); and SDG 16 (peace, justice and strong institutions).
16. The 2016 Political Declaration on Ending AIDS recognizes the HIV epidemic as a human rights challenge.¹ It expresses grave concern that discrimination continues to be reported and that restrictive legal and policy frameworks continue to discourage and prevent people from accessing HIV services.² In the 2016 Political Declaration, States commit to:
 - Promote non-discriminatory access to health care, employment, education and social services;³
 - Eliminate HIV-related stigma and discrimination by 2020;⁴
 - Eliminate gender inequalities and end all forms of violence and discrimination against women and girls;⁵
 - Review and reform laws that reinforce stigma and discrimination, including on age of consent, HIV non-disclosure, exposure and transmission, travel restrictions and mandatory testing;⁶ and;
 - Empower people living with, at risk of or affected by HIV to know their rights and access justice and legal services.⁷
17. The UNAIDS Strategy 2016–2021 includes specific targets on eliminating HIV-related discrimination (with a particular focus on health care), eliminating gender inequality and gender-based violence, and improving access to health-care services for key populations. The WHO’s Global Strategy for human resources for health also prioritizes promoting and protecting human rights and ending discrimination in health-care settings, as does the WHO’s Global Health Sector Strategy for HIV 2016–2021. Meanwhile, the Global Fund Strategy for Investing to End Epidemics 2017–2022 commits the Global Fund to introduce and scale up programmes that remove human rights barriers to HIV, TB and malaria services, and thereby can help ensure that health services supported by the Global Fund reach and are utilized by all people who need them.

18. In 2016, UNAIDS and the WHO Global Health Workforce Alliance launched the Agenda for Zero Discrimination in Health-Care Settings which aims to achieve the vision that everyone everywhere enjoys health services without discrimination, by bringing key stakeholders together to take joint action.
19. In June 2017, 12 UN entities joined forces to launch the Joint United Nations (UN) statement on ending discrimination in health-care settings, in which they call on all stakeholders to commit to taking targeted, coordinated, time-bound, multisectoral actions to end to discrimination in health-care settings.
20. In May 2017, a new UNAIDS guidance note on advancing human rights in efforts to accelerate the HIV response was launched (*Fast-Track and human rights*), which also explicitly links human rights barriers, including stigma and discrimination, to HIV vulnerability and limited access to HIV services.⁸
21. In 2012, the Global Commission on HIV and the Law (comprised of former Heads of State, and human rights, public health and legal experts) published a landmark report that urged governments to promote laws and policies grounded in evidence and human rights, and to overturn laws and policies that impede the HIV response.⁹ It emphasized that laws that stigmatize people living with and vulnerable to HIV perpetuate discrimination, block people from seeking health services and undermine public health goals.¹⁰ In July 2017, members of the Commission and other experts assessed progress in advancing the report's recommendations, examined the remaining barriers and discussed opportunities for further progress. They noted that despite efforts to advance the report's recommendations (documented in 88 countries), both persistent and new human rights challenges confronted the HIV epidemic and response, including discrimination in health-care settings. They called for an update report to reinvigorate progress in advancing human rights and ensuring that no one is left behind.¹¹
22. Against that backdrop, this paper and the thematic segment review the evidence of the impact of discrimination in health-care settings on efforts to Fast-Track the HIV response. They also highlight examples of good practice in reducing discrimination in health-care settings, and outline actions that can create enabling environments for ending such discrimination.
23. The paper and the thematic segment aim to stimulate multistakeholder action and commitment from Member States to eliminate discrimination in health-care settings. They provide Programme Coordination Board (PCB) members with an opportunity to:
 - Review the evidence of the impact of discrimination in health-care settings on universal health coverage and on efforts to reach the global HIV prevention and treatment targets;
 - Identify focused, coordinated, time-bound, multisectoral, evidence-informed programmatic actions to end discrimination in health-care settings;
 - Reflect on how to galvanize inclusive leadership and community capacities and leverage synergies to end discrimination in health-care settings;
 - Deliberate on strategies to accelerate the implementation of the Agenda for Zero Discrimination in Health-Care Settings; and
 - Suggest recommendations and propose a way forward.
24. In preparation for the thematic segment, UNAIDS issued a call for the submission of examples of interventions that have contributed to reducing discrimination in health-care settings (good practices). A total of 52 good practice submissions were received, showcasing the wide range of efforts made at all levels to end discrimination in health

care. The submissions have informed this paper, and some are specifically featured. The 52 submissions are available in the Conference Room Paper UNAIDS/PCB (41)/CRP1.

IV. THE PROBLEM OF DISCRIMINATION IN HEALTH-CARE SETTINGS

25. Discrimination in health-care settings may violate many of the most fundamental human rights protected by international treaties and by national laws and constitutions. These include:

- The *right to non-discrimination and equality before the law*. International human rights law guarantees the right to equal protection before the law and the right to non-discrimination on many grounds. The principle of non-discrimination also underpins the realization of all other human rights.
- The *right to the enjoyment of the highest attainable standard of physical and mental health*, which includes the core minimum obligation of states to ensure access to health facilities, goods and services on a non-discriminatory basis, as well as to ensure that these facilities, goods and services are equitably distributed; that they are available in sufficient quantity; that they are respectful of medical ethics, culturally appropriate (respectful of the culture of individuals, minorities, peoples and communities), sensitive to gender and life-cycle requirements, and designed to respect confidentiality and improve the health status of those concerned; and that they are scientifically and medically appropriate and of good quality.¹²
- The *right to privacy*, which encompasses the obligation to respect physical privacy (for example, the obligation to seek an individual's informed consent to any medical procedure), and the need to respect the confidentiality of personal information.
- The *right to liberty and security of the person*, which should not be arbitrarily limited on the basis of a person's HIV status or social or legal status. Compulsory HIV testing and the forced sterilization of women living with HIV, for example, constitute a deprivation of liberty and a violation of the right to security of the person.
- The *right to freedom of expression and information*, which provides for the right to seek, receive and impart information related to HIV prevention, treatment, care and support without any obstacles of access, as well as the freedom to hold opinions without interference.
- The *right to live free of arbitrary interference of [one's] privacy, family, home [and] correspondence [and of] attacks on [one's] honour or reputation*. This right and the right to freedom of expression and information underpin the right to express diverse sexual orientation or gender identity without reprisal.¹³

26. Both direct and indirect discrimination are prohibited under international human rights law. Direct discrimination occurs when an individual is treated less favourably than another person in a similar situation for a reason related to a prohibited ground (such as where health care is denied to a person living with HIV because of their HIV status). Indirect discrimination refers to laws, policies or practices that appear neutral at face value, but have a disproportionate impact on the exercise of human rights (for example, requiring a medical certificate of good health for employment may discriminate against people living with HIV who may be perfectly able to perform a job).¹⁴

27. International human rights law also distinguishes between formal discrimination and substantive discrimination. The former applies to situations in which a rule explicitly excludes certain individuals or groups, while the latter refers to unjustified disparate impacts of a measure. Substantive discrimination can be either direct or indirect. Implementing the principle of non-discrimination must include addressing both formal discrimination (such as by reviewing discriminatory laws or policies) and substantive discrimination (such as by adopting special measures to overcome attitudes or conditions that perpetuate discrimination in practice).¹⁵

Multiple drivers, forms and manifestations of discrimination

28. Discrimination in health-care settings is often driven by stigma—negative beliefs, feelings and attitudes towards people living with HIV or key and affected populations. It is important to note, however, that even if individuals hold stigmatizing beliefs they can decide not to act in a way that is unfair or discriminatory. Conversely, a person may discriminate against another without personally holding stigmatizing beliefs, such as where discrimination is mandated by law or policy, or when discriminatory practices that are not codified under law or policy (such as excessive standard precautions) become common practice in health-care establishments (their very commonness obfuscating their discriminatory nature).

29. Discrimination in health-care settings is widespread across the world and takes many forms. It may be manifested when an individual or group is denied access to health-care services that are otherwise available to others, or when care, treatment and/or medical procedures are refused or delayed on a discriminatory basis. It can also occur through the denial of services that are only needed by certain groups, such as women and girls (including those living with HIV) or people who use drugs.

30. Individuals or groups may also be subjected to judgmental, stigmatizing and/or partial treatment; physical and verbal abuse or violence; involuntary treatment; forced or pressurized testing; breaches of confidentiality; compulsory notification to justice departments or to the police; denial of autonomous decision-making, such as the requirement of consent to treatment by parents, spouses or guardians or the lack of free and informed consent to testing or other medical procedures;¹⁶ coerced sterilization and forced abortions; making care or treatment conditional on the use of certain forms of contraception; and the denial of delivery services for women living with HIV who are in labour, or the requirement for women living with HIV to have a caesarean, whether or not they have chosen the procedure or it is medically advised.¹⁷

31. Discrimination in health-care settings is often directed towards marginalized and stigmatized populations in society—the very people that States promised to prioritize through the 2030 Agenda, and who are frequently excluded or left behind. People living with HIV and key populations (including gay men and other men who have sex with men, people who use drugs, sex workers, transgender people and people in prisons and other closed settings) are particularly affected, as are indigenous populations, migrants, refugees, and women and girls, who also face gender-based discrimination fuelled by gender inequality.

32. Many such individuals and groups also experience intersecting or compounding forms of discrimination on the basis of their age, sex, race or ethnicity, physical or mental health status, disability or vulnerability to ill-health, sexual orientation or gender identity, nationality, asylum or migration status, or criminal record. For example, prisoners and detainees often suffer from substandard or non-existent health services (including harm-reduction and HIV services) during incarceration, but given that some populations are

over-represented in detention (such as members of indigenous populations and people who use drugs), this is doubly discriminatory.

33. Women and girls are particularly likely to experience multiple forms of discrimination, with structural gender inequalities intersecting with HIV status and/or gender identity and/or sexuality and/or behaviours, such as drug use or sex work, and/or being a member of an indigenous or minority population (among many other factors). Unequal power relations, harmful social norms, gender-based violence and stigma create barriers for women and girls in accessing health services, affect the quality of services they receive, and discourage positive health-seeking behaviours. Such barriers result in very high rates of new HIV infections among adolescent girls and young women in some parts of the world (especially in eastern and southern Africa).
34. A 2015 global review of key barriers to women's access to HIV treatment, involving more than 200 women living with HIV from 17 countries and guided by a global reference group of women living with HIV, identified several gender-related discriminations women face in accessing HIV treatment and care:
 - *Violations of rights to privacy, confidentiality and bodily integrity in health services*, including the disclosure of women's HIV status in front of family members, health workers and health service users; refusal of health care for themselves and their children; and human rights violations during and after labour, as well as forced and coerced sterilization.
 - *Stigma and discrimination* against women from marginalized groups in health-care settings and communities, impeding their access to treatment.
 - *Punitive laws* that exacerbate structural and community violence against women and impede access to treatment.¹⁸
35. In some cases harmful social and gendered norms can negatively affect men. There is evidence, for example, that HIV testing and antiretroviral coverage is lower for men than for women, and that men are more likely to die while on HIV treatment. Men also are more likely than women to present for health care with advanced disease and are more likely to be lost to follow-up.¹⁹
36. Physical and mental disabilities intersect with HIV. For example, persistent discrimination against and exclusion of people with disabilities increases their vulnerability to HIV, while HIV services are rarely designed to be accessible to people with disabilities.²⁰ People with disabilities are left behind in HIV policy planning, programme development, service delivery and data collection, while increased vulnerability and exclusion are linked to legal and economic inequalities, gender-based violence and human rights violations against people with disabilities, including the provision of health care.²¹ This exclusion is compounded by gender inequality, with women and girls with disabilities at particular risk.²²
37. HIV and mental health are also linked, with many people with HIV experiencing psychological difficulties that are related to their HIV diagnosis and to their experiences or fears of stigma and discrimination. Results from the People Living with HIV Stigma Index surveys indicate that people living with HIV experience high levels of self-stigma and social exclusion, particularly those who belong to a key population. These experiences are compounded in the context of discriminatory and stigmatizing health care.²³ People with pre-existing mental health issues already face barriers to accessing health care and other social services, which may also place them at higher risk of HIV and delay access to diagnosis, treatment and care.²⁴

38. In many cases, people who are coinfecting with HIV and tuberculosis (TB) experience specific challenges related to “the stigmatizing social symbolism of their illness”, which worsen constraints related to health care access, and affect their health decisions around disclosure, adherence and retention in medical care.²⁵
39. Discrimination sometimes leads to the “invisibility” of certain populations, while simultaneously contributing to their further marginalization. As a result, health services are not adequately designed for, or accessible and culturally appropriate to these populations. For example, a study of the experiences of lesbian, bisexual and transgender women living with HIV in accessing HIV services in Toronto, Canada, revealed a trajectory of marginalization. While structural factors such as social exclusion and violence elevated their risk of HIV infection, that risk was exacerbated by inadequate HIV prevention information, and participants described multiple barriers to HIV care and support. The underrepresentation of lesbian, bisexual and transgender women in HIV research further contributed to their marginalization and exclusion.²⁶ Recent Global Fund assessments have confirmed that certain populations are underrepresented in health services, while in some locations, particularly rural areas, more extreme barriers exist and less is done to address them. In settings where key and affected populations are overrepresented (for example in prisons), they may be further marginalized and “invisible”.²⁷
40. There is incomplete information about the health status of and access to health services by indigenous populations. The data that do exist indicate alarming health disadvantages for indigenous peoples even in wealthy nations, with studies showing an association between self-reported racism and ill health (including negative mental health outcomes).²⁸ Historically, indigenous peoples have suffered the impact of colonization and assimilation policies, as well as the imposition of exogenous development models. They continue to suffer discrimination, which has a major impact on their lives and their health.²⁹ In New Zealand, for example, researchers have found that among people who self-identify as Māori, those who reported being “socially assigned” as “European-only” had a health advantage compared with those who were socially assigned as Māori and/or as any other non-European group.³⁰
41. Migrants and other people on the move also face specific forms of discrimination in health-care settings. Migrants rarely have the same entitlements as citizens to insurance schemes that make health care affordable. They may face restrictions in accessing public health care, along with significant challenges in accessing mechanisms of redress in relation to discrimination or abuse. In some instances, migrants may be subjected to compulsory HIV testing and migrants living with HIV may be detained or deported. Such treatment creates additional stigma and incurs financial costs. Lack of information about health services and rights among migrants, and barriers related to culture, language and religion might also affect their access to services.
42. Where migrants are undocumented, they may incur further risks due to substantially limited access to adequate health services, health insurance, social protection or justice. They also may experience social exclusion and insecure housing and employment conditions.³¹

Box 1. Good practice: National protocols and guidelines to improve access to health services for migrants in France

In France, nearly half (48%) of people living with HIV diagnosed in the past 10 years were born abroad, and nearly 9% of the country's population comprises migrants from a wide variety of countries and with a wide variety of mother tongues.

In January 2016, the French government passed an article of law (Article L1110-13) under the Public Health Code that explicitly lays out the requirement for health-related mediation and professional interpretation services to improve access to rights, prevention and care for people who may be marginalized from these services because their first language is not French.³² These individuals need language interpretation, particularly in the context of HIV testing or treatment, in order to ensure that their rights to privacy, confidentiality and consent to treatment are respected, along with their right to health.

As a result, a number of people whose mother tongue is not French now have telephone access to professional interpreters when receiving an HIV, TB or viral hepatitis test, accessing infectious disease services (prevention, testing, treatment and care) at a hospital, at TB treatment centres, or in specialized health centres for vulnerable migrants. The Ministry of Health partners with an association of interpreters who are available 24 hours a day, throughout the country, and can provide services in over 100 languages and dialects, who are familiar with medical and public health terminology, and who are bound by the rules of medical confidentiality. Over 5,000 such calls are made every year.

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43. In 2013, 1 in every 22 people living with HIV was affected by a humanitarian emergency, and an estimated 1.6 million of the world's 314 million people affected by humanitarian emergencies were living with HIV.³³ Refugees and people displaced within their countries by humanitarian emergencies often lack access to HIV-related services and HIV-related commodities.³⁴ Refugees often also encounter the false assumption that they increase HIV risk among their host communities (although refugee communities can have lower HIV prevalence than their hosts), and this can contribute to their stigmatization in host communities and to mandatory HIV testing.³⁵
44. Although HIV education, counselling and treatment are theoretically integral to the care provided to refugees, not all refugees can access such services. This is in part due to the inability of host communities to provide services to both residents and refugees, and in part due to unequal treatment linked to language barriers, fear and xenophobia.³⁶ It can also be due to the failure to include refugees (and internally displaced people) in HIV funding proposals, national HIV programming and service delivery planning, or to incorporate HIV services into humanitarian responses.³⁷
45. People in prisons and other closed settings also suffer disproportionately from unequal access to health services—despite the fact that HIV prevalence among incarcerated persons is frequently much higher than among the wider population.³⁸ Prisoners may also be particularly likely to experience unwarranted limitations on their right to privacy and medical confidentiality.³⁹

The legal environment

46. Some national laws, policies and practices may foster and perpetuate discrimination in health-care settings, both by reinforcing stigmatizing attitudes and discriminatory actions (including prohibiting certain groups of people from accessing health services) and by discouraging people such as sex workers, people who use drugs and people engaging in same-sex relations from seeking the broad range of health-care services they may need. Some laws run counter to established human rights standards and evidence that demonstrates their harmful public health impact.
47. For example, parental and spousal consent laws for health services disproportionately affect women, girls and adolescents, and prevent them from accessing vital sexual and reproductive health and other health services under their own volition. Such laws may also serve to perpetuate harmful gender norms and practices which further reduce the ability of women and adolescent girls to protect themselves against HIV. Of the 106 countries that provided data to UNAIDS on age of consent laws, 29% reported requiring parental consent for people younger than 18 years to access HIV testing, 25% require parental consent for HIV treatment and 28% require parental consent to access sexual and reproductive health services.⁴⁰
48. The criminalization of certain behaviours (particularly drug use, sex work and same-sex relationships or intercourse) or of entire populations (such as transgender people or those with a non-cisgender gender identity and/or non-heterosexual sexual orientation) also hinder access to health services. According to data submitted by countries to UNAIDS in 2017:
- 44 out of 100 countries have laws that specifically criminalize same-sex sexual activity;
 - 17 out of 116 countries criminalize or prosecute transgender people;
 - 84 out of 110 countries criminalize some aspect of sex work;
 - in 78 out of 90 countries drug use or possession of drugs for personal use is a criminal offence or grounds for compulsory detention;
 - 9 out of 107 countries impose the death penalty for drug-related offences; and
 - 51 out of 109 countries have laws criminalizing the non-disclosure, exposure and transmission of HIV, while another 25 countries indicated they do not have such laws, but that prosecutions do occur under general criminal laws.^{41,42}
49. Such laws foster (justified) fears of arrest, mistreatment, violence and incarceration, deterring people from seeking health-care and other protective services, such as harm reduction or sexual and reproductive health services, and making it difficult for service providers to support these individuals. Such laws and policies also have negative impacts on wider perceptions of people living with HIV and key and affected populations, fuelling discriminatory attitudes in their families and communities.
50. Where there is a lack of protective laws and policies for people living with HIV and key populations, people who experience discrimination in health-care settings may lack legal recourse to remedy the situation.

The impact of discrimination on health care

51. Discrimination in health-care settings seriously reduces the quality of life of individuals who experience it, and impedes the use of health services. It explicitly or by omission excludes or deters people from seeking health services for fear of stigma, discrimination, judgmental attitudes or lack of confidentiality. It acts as a barrier to reaching the 90–90–90 targets⁴³ and has negative impacts along the continuum of care that encompasses HIV prevention, testing, treatment and sustained viral load suppression.
52. For example, a study among street-based female sex workers in Saint Petersburg, Russian Federation, found that 30% had been refused medical care, and 58% said that they had not gone to a doctor when they needed to because they were worried that doctors would treat them poorly.⁴⁴ Similarly, female sex workers in Kenya who anticipated stigma from health workers were twice as likely to avoid non-HIV health services compared with those who were not apprehensive about stigma.⁴⁵
53. A study of women, men and transgender sex workers in Kenya, South Africa, Uganda and Zimbabwe found that they had numerous unmet health needs, including diagnosis and treatment for sexually transmitted infections and insufficient access to condoms and lubricant. Denial of treatment for injuries due to physical assault or rape was common, as was generalized hostility from public sector health-care providers.⁴⁶
54. More than 70% of the female sex workers surveyed by REDTRASEX (the Latin American and Caribbean Network of Sex Workers) in 2016 reported having been victims of institutional violence. Even when female sex workers reported violence, almost all cases went unpunished. This endemic violence is reflected also in abuses perpetrated by health-care providers against female sex workers, which creates further barriers to health care.⁴⁷
55. Transgender women in Argentina who had previously experienced discrimination in health-care settings (either from health workers or other health service users) were three times more likely to avoid health services than transgender women without those experiences. A total of 41% of respondents reported that they had avoided seeking health care because of their transgender identity.⁴⁸
56. In a number of countries, anti-drug policies are being enforced in an increasingly punitive manner, including extra-judicial killings of alleged drug dealers and users.⁴⁹ In countries such as Cambodia and the Philippines, such policies and practices badly limit the reach of harm reduction services for people who use drugs (for example, the first month of an antidrug crackdown in Cambodia in January 2017 saw a 46% drop in the number of people who inject drugs who participated in a needle-syringe programme, and a 19% drop in the number of people accessing opioid substitution therapy).⁵⁰ These practices run counter to successful and inclusive protection efforts for key populations in these countries—such as Cambodia’s regulations affirming the labour rights of entertainment workers, issued in 2014, or the implementation of the “Time Has Come” training package for health workers in the Philippines to reduce stigma and discrimination against gay and other men who have sex with men, and transgender people in health-care settings.⁵¹
57. Criminalization also creates specific barriers for women who use drugs. In some countries, drug use during pregnancy can lead to automatic criminal charges and incarceration for the duration of pregnancy and beyond. Women who are identified as dependent on illegal drugs can have their children removed from their care (as in a number of countries in eastern Europe and central Asia, where seeking treatment for drug addiction requires being registered as a drug user, which can be automatic grounds for losing custody of a child). In some countries, forced abortions and the termination of

the parental rights of women who use drugs are legal. These laws and practices discourage women who use drugs from accessing health services.⁵²

58. Legislation that prohibits consensual sexual activity between adults of the same sex has been shown to decrease the use of services by gay and other men who have sex with men. A 2015 study in Nigeria found that gay and other men who have sex with men reported being more fearful of accessing health services after the 2014 Same-Sex Marriage Prohibition Act came into force.⁵³ A study in Swaziland found that 62% of surveyed gay and other men who have sex were afraid to seek health care. The fear appeared linked to legal discrimination and the men's experiences of stigma in health-care settings.⁵⁴
59. Where people cannot or will not access health services, they are less likely to be tested for HIV at all, let alone in a timely manner to ensure that they benefit from the early initiation of treatment. Discrimination and the fear of stigma particularly affect testing. In 7 of 31 countries with available data, about 20% of people living with HIV reported that a health worker had disclosed their HIV status without their consent.⁵⁵
60. Although people at high ongoing risk of HIV infection should retest at least every 12 months, many avoid doing so. More than 10% of female sex workers surveyed in Brazil and 60% of those in Fiji reported avoiding HIV testing due to fear of stigma from health-care providers, as did more than 30% of gay and other men who have sex with men, also in Fiji. A study among people who inject drugs in Thailand found that respondents were almost seven times as likely to avoid HIV testing if they had previously been refused treatment or services by health workers.⁵⁶
61. A review of ten studies from low- and middle-income countries found a significant association between stigma and late presentation for HIV care. People living with HIV who perceived high HIV-related stigma were 2.4 times more likely to present late for HIV care.⁵⁷
62. Where people living with HIV do initiate treatment, discrimination can lead to them being lost to follow-up and less likely to adhere to antiretroviral therapy. They may also be unable to benefit from other care and support services.⁵⁸ People living with HIV and key and affected populations who experience discrimination in health-care settings may also be reluctant to access other support services, or may not be referred to such services by health-care staff.

Lack of empowerment combined with discrimination in the workplace affects health workers

63. Discrimination not only affects the users of health services, it also affects health workers. Health workers are subject to the same drivers of discrimination as other people, including negative attitudes towards people living with HIV, key populations, and women and girls.
64. Health-care provider surveys in Thailand show that attitudes about HIV among health facility staff may prevent them from adequately caring for people living with or affected by HIV. The attitudes include notions that HIV is "punishment" for immoral behaviour, that most people living with HIV do not care if they infect other people, and that it can be appropriate to sterilize a woman living with HIV, even without her consent. In some cases, health-care providers explicitly state that they would prefer not to provide services to members of key populations.⁵⁹

65. Discrimination often thrives in resource-constrained settings, where difficult working conditions and a lack of standard precautions and support services affect the ability of health workers to deliver quality health services.
66. A lack of respect for the rights of health workers also affects their ability to provide quality services, and can harm their own health. Indeed, health workers may themselves be living with HIV, while those working with people living with HIV may be subject to HIV-related discrimination by proxy.
67. Health workers living with HIV may also experience intersecting forms of discrimination. Health workers who are registered with professional colleges often feel unsafe disclosing their health needs for fear that they may be penalized or have their license revoked. Some health workers have lost their employment as a result. Inadequate training, awareness and protocols may render health workers fearful of HIV and therefore more likely to discriminate.
68. Discrimination also takes the form of entrenched gender-based discrimination in those cadres of the health workforce that are female-dominated, as seen in physical and sexual violence, wage gaps, irregular salaries, lack of formal employment, and exclusion from leadership and decision-making.
69. In many contexts, ethnic and racial minorities (some of whom are migrants) are also overrepresented in the health workforce, particularly at the sub-professional levels, and they may also be subject to racial discrimination in the workplace (those who are women, often experience multiple or intersectional discrimination).
70. For these and other reasons, health workers and the rights of health workers must be included in efforts to end discrimination in health care, ensuring that their labour rights and working conditions are tied to addressing discrimination in their workplaces. We must move beyond the single narrative—in which health workers are “perpetrators” of discrimination—and recognize the importance of supporting health workers not only to fulfil their roles and responsibilities, but also to claim their right work in conditions that are supportive, enabling and free of discrimination.

V. FROM CHALLENGES TO SOLUTIONS

71. Solving these challenges and eliminating discrimination in health-care settings requires the implementation and scale-up of focused, coordinated, time-bound, evidence-based, multisectoral actions.
72. There is a growing body of evidence showing which kinds of programmatic approaches work to reduce discrimination in health care. The United States Centers for Disease Control and Prevention (CDC) and the International Center for AIDS Care and Treatment Programs at the Columbia University’s Mailman School of Public Health have conducted a systematic review of the evidence relating to programmes, legal and policy standards, accountability mechanisms and best practices that are most successful at reducing stigma and discrimination in health-care settings.⁶⁰ Several such interventions are described below.

Monitoring discrimination in health-care settings

73. Programmes and other measures to eliminate discrimination in health-care settings must be based on the evidence. Discrimination must therefore be monitored, measured and tracked. In particular, it is important to gauge both the experiences of service users and the attitudes and practices of service providers, as well as to monitor the existence and implementation of national-, local- and facility-level non-discrimination policies.
74. A number of resources for monitoring levels of discrimination are available and can be accessed through “ZeroHIVDiscrimination”, an online repository of tools related to eliminating HIV-related stigma and discrimination in health-care settings, with an inbuilt tool finder.⁶¹ Good examples of tools to measure stigma and discrimination include the one created by the Health Policy Project.⁶² Based on experiences in Thailand (see Box 2), it should be easy to adapt this tool to other country contexts.

Box 2. Good practice: Monitoring stigma and discrimination in health-care settings in Thailand

Thailand is systematically monitoring stigma and discrimination among health facility staff, using an adapted version of a global standardized tool.

The tool covers issues pertinent to the development of effective stigma reduction programmes, including: concerns about HIV transmission when caring for people living with HIV; attitudes towards people living with HIV; self-reported stigmatizing avoidance behaviours; observed stigma; and the elements conducive to a supportive environment for stigma-free services.⁶³

Two questionnaires were adapted: one for health facility staff and one for people living with HIV. This allows for the triangulation of data by comparing experienced and observed stigma, and it offers an opportunity for dialogue between health facility staff and people living with HIV.⁶⁴ Key stakeholders helped ensure that the questionnaires would be acceptable and useful.

Following a pilot in two provinces, the tool was incorporated as a routine monitoring instrument and rolled out in 22 provinces. The data collected are being used for baseline national estimates and fed into to the design of a national intervention approach.

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75. The People Living with HIV Stigma Index (Stigma Index) was launched by a consortium of people living with HIV in 2008 to provide evidence for advocacy and programme design, and to contribute to upholding the GIPA principle (Greater Involvement of People Living with AIDS). Since 2008, more than 90 countries have reported data that have been used for evidence-based programming (see Box 3). Meanwhile, however, the HIV epidemics and response have evolved, and more evidence is available about how stigma affects different populations, especially in relation to early initiation of treatment and the 90–90–90 targets. The Stigma Index tool is therefore being updated.⁶⁵
76. Following a review and consultation, including with key informants from networks of people living with HIV, the tool was revised and it is currently being pilot tested in Cameroon, Senegal and Uganda. The revised Stigma Index is shorter, and the section exploring experiences in health-care settings has been strengthened. The tool also better captures the experiences of key populations, who often experience multiple stigmas, and also measures the resilience of people living with HIV.⁶⁶

77. The Stigma Index is a good example of meaningful engagement of people living and affected by HIV. It serves both as a data-collection tool and an empowering intervention because it is implemented *by* people living with HIV (as interviewers and study managers), *for* people living with HIV. It is essential for affected communities to be involved integrally in the design, implementation monitoring and evaluation of efforts to eliminate stigma and discrimination from health-care settings.
78. UNAIDS, the Global Network of People Living with HIV (GNP+), researchers and academics are currently working on developing an indicator on stigma and discrimination in health care for inclusion in Global AIDS Monitoring from 2018, derived from seven elements of the Stigma Index.

Box 3. Good practice: Using Stigma Index findings to reduce HIV-related discrimination in dental care in Germany

The Stigma Index study in Germany showed high levels of stigma and discrimination towards people living with HIV in dental services. Based on these findings, the Federal Chamber of Dentists and Deutsche AIDS-Hilfe (including people living with HIV) took steps to address this situation and ensure that people living with HIV receive discrimination-free dental care.

Information material on HIV and Hepatitis B and C was produced and distributed to all dental clinics, with more than 30 000 dental care services and 70 000 dentists receiving the information. The programme has resulted in positive changes in behaviour towards people living with HIV in dental care and a change in working styles in some health centres. Decreased fear by the dental staff is reported and people living with HIV have improved access to dental care.

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79. Populations that have historically been “invisible” in statistics or “under-monitored” —in terms of HIV prevalence, vulnerability to HIV, and specific needs—need to be included in monitoring exercises. Such populations include indigenous populations, trans women and men, people in prisons and other closed settings, people with disabilities and people with mental health challenges. Many of these people already experience disproportionate stigma and discrimination as well as significant health disparities, whether or not they are living with HIV. In many cases, adolescents and young people are “under-monitored”, while perceptions of older people as being at low risk of HIV infection may result in lower rates of testing and other interventions.⁶⁷ Health workers should be aware of the needs of such populations.

Box 4. Good practice: Engaging community networks to measure stigma and discrimination in Viet Nam

In Ho Chi Minh City, Viet Nam—a Fast-Track city—partners developed and piloted a training initiative to reduce HIV-related stigma and discrimination in health-care settings. Survey tools, trainers' guides and practical experience from other countries in the region (including Thailand) were adapted to Viet Nam's context.

UNAIDS and the Vietnam Administration for HIV/AIDS control supported the Ho Chi Minh City Provincial AIDS Center and the Viet Nam Network of People Living with HIV to adapt the survey tools and use these to assess HIV-related stigma and discrimination in selected health-care settings in late 2016. The survey results were then used to develop training manuals, which were used to pilot training for health workers in selected health-care facilities.

The involvement of the Viet Nam Network of People Living with HIV in the process was vital to the success of the pilot, and provided members with valuable opportunities to develop their capacity for data collection and analysis, interviewing and training.

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80. Monitoring systems should enshrine the values of human rights and the principle of non-discrimination. For example, the WHO guidelines on validating the elimination of mother-to-child transmission⁶⁸ go beyond a focus on clinical benchmarks and include a set of minimum standards for community engagement, human rights and gender equality. The guidelines were developed in consultation with the International Community of Women Living with HIV and GNP+. The tool measures whether countries seeking validation have met a baseline of human rights standards and have integrated community engagement in their efforts. The framework marks the first time these dimensions have been included in global or national disease monitoring.⁶⁹ To date, Anguilla, Antigua and Barbuda, Armenia (HIV only), Belarus, Bermuda, Cayman Islands, Cuba, the Republic of Moldova (syphilis only), Montserrat, St. Christopher and Nevis, and Thailand have been validated, and have met these strict human rights and engagement standards.⁷⁰

Training of health workers

81. As part of a comprehensive strategy to eliminate discrimination in health-care settings, countries should provide pre- and in-service education to the health workforce. This allows health workers develop human rights and gender equality competencies, as well as strengthen understandings of medical ethics and workers' rights, roles and responsibilities in relation to discrimination in health-care settings.

82. Areas of focus include sensitization regarding specific populations, including children and young people; indigenous populations; women and girls; and key and affected populations, as well as the need to provide targeted, respectful and inclusive services. Education should include HIV-specific training, as well as training in communication methods, and should reach all cadres of health facility staff (not only doctors, but also nurses, physiotherapists psychologists, pharmacists, non-medical staff etc.). It should also emphasize the issues of consent and privacy. Education and training for health workers also provides an opportunity to address intersectionality and relations of power in health-care settings, which can fuel discrimination and stigma, as well as affect health workers themselves.

Box 5. Good practice: Information campaigns for health workers in Sweden

According to national surveys, general knowledge about HIV and people living with HIV in Sweden is relatively low, and people living with HIV are afraid to talk openly about their status because they fear negative reactions. People living with HIV are more likely to experience mental health challenges than other members of the population due to HIV-related stigma.

To combat these issues, the Swedish Public Health Agency, together with civil society organizations, developed a national information campaign about HIV in Sweden, targeted at the general public and health workers, that ran between from November 2015 to January 2016. The central message was that HIV is no longer a fatal disease but a chronic, treatable infection and that people who receive well-managed HIV treatment, and who have undetectable viral load, have a minimal risk of transmitting HIV to others. The activities also included dissemination of training materials to health workers.

By the end of the campaign, 44% of the population aged 18–79 years was aware of the campaign, of whom 70% said that it had left a positive impression, 52% said it had improved their knowledge and 33% said that it led them to actively update their knowledge.

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83. Finally, including health workers themselves in the design of training and education curricula and materials on human rights and discrimination can improve workers' own understanding, internalization and use of the concepts, and help make the materials and curricula more relevant and engaging.
84. The Office of the High Commissioner for Human Rights has published a reflection guide on the provision of human rights-based sexual and reproductive health services.⁷¹ However, further formal and informal training programmes for health workers are needed, with anti-discrimination modules built into all pre-service health worker training courses and curricula. Such training should emphasize the role of health-workers as human right defenders and their responsibility to counter all forms of discrimination. In contexts where key populations (or their behaviours) are criminalized, health workers must be particularly aware of their responsibility and duty before the law to protect patients' health.

Box 6. Good practice: CapacityPlus: Working towards gender equality in the health workforce

The CapacityPlus, a USAID-funded programme, developed learning and advocacy tools to address gender-based discrimination in the health workforce and the health professional education systems, and to promote gender-transformative principles in advocacy, policy-making and programme implementation.

The project has supported the use of the tools for advocacy, policy-making, and the implementation of gender-transformative interventions to promote equal opportunity and non-discrimination in the workplace, health professional education systems, and clinical care. It has also trained health workers to better recognize, treat, and refer clients who have experienced gender-based violence.⁷² This approach increased the wellbeing and awareness of health workers, and contributed significantly to reducing discrimination across health services.⁷³

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85. Global competency frameworks exist for use by countries to standardize the training and competencies of health workers and to ensure they are properly equipped to fulfil their roles.⁷⁴ WHO is developing a global evaluation toolkit for health workforce education,⁷⁵ and has called on the International Labour Organization (ILO) to revise the International Standard Classification of Occupations for greater clarity on the delineation of health workers and health professions.⁷⁶
86. In some cases it may be appropriate to consider providing compensation/incentives for health workers to attend training sessions and other forms of education (e.g. where some health workers, such as working mothers, may not otherwise be able to attend). Other incentives could include a civil society-run awards programme for health workers who have provided appropriate services that are non-discriminatory, which could motivate other health practitioners to provide stigma-free services.

Creating an enabling legal and policy environment

87. Generally, simply educating health workers to challenge HIV-based or other prejudices will be less successful if the education is not accompanied by legal and policy shifts, changes in institutional practice and other structural adjustments that make it easier to avoid discriminatory behaviour and report discrimination. This requires leadership, political commitment and funding.
88. Countries should review and strengthen laws to prohibit discrimination in the provision and distribution of health services and to provide access to remedies for individuals whose rights have been violated, as well as penalties for the perpetrators. Such laws must be harmonized with other non-discriminatory laws, such as those relating to labour and education and those addressing gender inequality and gender-based violence. Non-voluntary and non-consensual medical procedures should be made illegal.
89. Countries should also review and repeal laws that have been shown to have negative health outcomes and that run counter to established public health evidence (including the criminalization of drug use, sex work and same-sex relationships or intercourse), as well as discriminatory laws that particularly affect women and girls' abilities to access health services, including spousal and parental consent laws.

90. Steps also should be taken to ensure that legal and policy reforms (both the removal of punitive legislation and the enactment of supportive and protective laws and policies) are effectively applied and implemented. Unless victims have access to redress mechanisms and perpetrators of discrimination are brought to justice, there will be little change in discriminatory behaviours against people living with and affected by HIV.

Box 7. Good practice: Decriminalizing consensual sexual relations among adolescents in Peru

A 2006 Peruvian law criminalizing sex, whether consensual or not, with an adolescent aged between 14 and 18 years was found to impede adolescents' access to sexual and reproductive health. Adolescents feared approaching health facilities for information about contraception and prevention of sexually transmitted infections, and those who were pregnant were afraid to attend prenatal care. The law put adolescents at greater risk of HIV and other sexually transmitted infections and of getting pregnant; indeed, pregnancy rates among adolescent girls have risen.

The UN Population Fund (UNFPA) in Peru promoted youth participation in advocacy to overcome this legal obstacle. It publicized evidence of the impact of the law on adolescent's sexual and reproductive health, and advocated with policy-makers. Youth groups presented the Constitutional Court with a petition calling for the removal of the law. This was accompanied by an *amicus curiae* submitted by the UN. As a result, the Court in 2013 decriminalized consensual sex among adolescents and recognized their right to sexual health, as well as to privacy and information on issues related to sexual freedom.

Following the decision, information booklets were published, training workshops about the change were held for almost 1,000 prosecutors and service providers, and a social network dissemination strategy was implemented to ensure that both adolescents, lawmakers and policy-makers were aware of the judgment and its implications.

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Strengthening other protective measures

91. Eliminating formal discrimination rooted in laws and policies is one part of the solution. States must also put in place measures that protect people living with HIV and members of key populations in and beyond health-care settings.
92. In addition to laws that prohibit discrimination, countries should have specific policies, regulations and standards that ensure access to non-stigmatizing services for marginalized groups. These can include developing and implementing protocols, norms, guidelines and other legal tools or mechanisms that guarantee effective and non-discriminatory access to health services for key populations and marginalized groups.
93. For example, the UN (in partnership with key population networks) has developed a series of implementation tools to guide HIV programming with sex workers, gay and other men who have sex with men, transgender people and people who inject drugs.^{77 78}
^{79 80} The tools summarize best practice for rights-based programmes that place people at the heart of HIV responses and ensure non-discriminatory approaches for reducing HIV risk and impact. The tools focus on priorities for key populations, including addressing violence and other human rights abuses and ensuring that supportive and non-judgmental service providers deliver quality, holistic services. Community empowerment and support for community-led services lie at the heart of this guidance.

Box 8. Good practice: Access to health care for lesbian, gay, bisexual, transgender and intersex persons in Mexico

Mexico's 2017 National Discrimination Survey revealed that lesbian, gay, bisexual, transgender and intersex people are less likely to be able to exercise their right to health, and that discrimination is a major barrier. This confirmed the need to develop health service delivery protocols that are non-discriminatory and protect human rights.

The Ministry of Health is now disseminating a national-level protocol and associated guidelines to increase access to health care for lesbian, gay, bisexual, transsexual, transvestite, transgender and intersexual persons. Community representatives participated in the development of the protocol, along with representatives from academia, Government and the private sector.

The protocol and guidelines apply across the national health system in all public, social and private health-care establishments. They provide general compliance mechanisms and specify criteria for the care of lesbian, gay, bisexual, transsexual, transvestite, transgender and intersexual populations. They also provide guidance for health service managers on the kinds of policies that are needed to ensure non-discrimination.

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94. The 2016 WHO framework on integrated people-centred health services was developed to support progress towards universal health coverage by increasing access to safe, high-quality, effective, people-centred and integrated services.⁸¹ The framework is based on the principle that truly universal health care requires a shift from health systems that are designed around *diseases* and *health institutions* towards ones designed for *people*.
95. People-centred care is structured around the perspectives of individuals, carers, families and communities as participants in and beneficiaries of health systems that are organized around the needs of people.⁸² It is rooted in primary care services and it requires that people have the necessary education and support to participate in decisions about their own health care. Integrated health services are managed and delivered in ways that ensure people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease management, rehabilitation and palliative care services according to their needs and throughout their lives.⁸³
96. There are currently no universally accepted indicators to measure progress in establishing integrated people-centred health services.⁸⁴ However, criteria have been identified that can help ensure that services focus on people (see Box 9).

Box 9. Criteria for people-centred health services

- Discreet but accessible settings/locations.
- Clear, attractive signage.
- Friendly service staff who provide:
 - A welcome greeting,
 - A caring atmosphere and attitude,
 - Non-judgmental, non-moralizing, respectful and accepting attitudes,
 - Time to hear input, and clearly explain issues in a friendly manner.
- “Charter of Service”/“Patients’ Charter” is clearly displayed.
- Choice of service providers including:
 - Both male and female staff for gender-sensitive care,
 - Medical/nursing staff, counsellors, health educators, social workers, peer educators.
- Professional service providers who are knowledgeable about the health needs of people living with HIV and members of key populations:
 - Competency-based service provision,
 - Experienced providers who are able to gain trust.
- Flexible opening hours (such as during evenings/weekends).
- No appointments and/or short waiting times and/or adequate clinic staff to ensure quick service.
- Free services—including clinics, counselling, training/workshops.
- Confidential services:
 - Private counselling and clinic examination rooms,
 - Providers/staff are only informed if they are directly involved in client care,
 - Parents/guardians are not informed of young client attendance unless requested by the client,
 - Locked storage of all client notes/records.
- Voluntary and informed consent, with clear explanation of procedures and clients involved in decision-making.
- Peer involvement, for example:
 - In reception to encourage uptake by peers,
 - During clinic exams to act as chaperones, on client request.
- Both fixed-site and outreach/mobile services—mobile care providers and peer educators.
- “One-stop-shop” services catering for all health needs that are fully equipped with equipment and reliable supplies of commodities and able to provide:
 - A range of services: sexual and reproductive health, HIV and other sexually transmitted infections, drugs and alcohol, psycho-social care and support,
 - Point-of-care testing or quick referrals for fast results,
 - Counselling on all issues of concern,
 - Healthy lifestyle promotion (diet, nutrition, exercise),
 - Referrals for further specialist care (if required and with client consent).
- Information and education communication materials (such as brochures, fact cards, posters, DVDs, group presentations) on health issues.

97. Although all health services should be free from discrimination of any kind, in some cases it may be necessary to establish specific services that are tailored to the needs of specific populations.

Box 10: Good practice: Focusing on key populations in Jamaica

In Jamaica, lesbian, gay, bisexual and transgender persons experience high levels of violence, as well as discrimination in health care (including seemingly unnecessary medical or psychological testing, inappropriate “curiosity” and unequal treatment). Many people decline treatment or change health care providers for fear of discrimination.

J-FLAG (now the Equity for All Foundation Jamaica), in partnership with the Ministry of Health, implemented a project titled “Mitigating risks and enabling safe public health spaces for LGBT Jamaicans”. It was aimed at fostering an enabling environment that promotes lesbian, gay, bisexual and transgender people’s right to health, and that makes it possible to seek HIV services and support free of stigma and discrimination.

The project conducted training and sensitization about human rights and dignity as they relate to sexual orientation, human rights and HIV, and about transgender people and their health needs. Training on stigma and discrimination and the rights of lesbian, gay, bisexual and transgender people was held for health workers and other health facility staff.

Government ministers, parliamentarians, business leaders, technocrats, policy-makers and civil society partners received “policy-maker education”. Outreach sessions were held with civil society, health-care providers and service users to promote the Ministry of Health client complaint mechanism, which is intended to increase monitoring and improve responses to human rights violations against lesbian, gay, bisexual and transgender persons. The project developed or revised policies, protocols and guidelines for lesbian, gay, bisexual and transgender-friendly public health facilities and programmes. It also conducted situation analyses in health facilities and civil society organizations to evaluate access to and quality of services for lesbian, gay, bisexual and transgender persons.

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Box 11. Ecuador: Moving towards accessible health care

Comprehensive health services not only help realize the right to health, they help eliminate historical inequities and improve life conditions for groups that have suffered discrimination on the basis of ethnicity, indigenous or cultural status, gender, sexual orientation, disability, and/or economic status.

Ecuador is working towards providing inclusive health services at the primary care level, starting with legal steps. In order to address systemic discrimination and human rights abuses against lesbian, gay, bisexual and transgender persons, over 45 “dehomosexualization centres” have been closed, six judicial processes have been launched, and instructions on the referral of such cases are being prepared.

The Government developed a *National plan of sexual and reproductive health 2017–2021*, which recognizes sexual and reproductive rights as human rights under national legislation and guarantees permanent and timely access to health programmes (including health promotion and HIV prevention) and to comprehensive sexual and reproductive health services, without discrimination. Manuals on health care for lesbian, gay, bisexual and transgender people, and for sex workers have been developed, and training in good practices is being provided to more than 33 000 health professionals. A number of lesbian, gay, bisexual and transgender people are being trained as primary health-care technicians as part of a drive to improve their inclusion in health services. A virtual course on human rights and good practices in HIV health-care procedures has been rolled out to all health sector personnel, including army and police and private-sector health staff. The Ministry of Public Health is also developing a national training programme on sexually transmitted infections that will include HIV, human rights and key and affected populations.

The *2017 Handbook for sexual and reproductive comprehensive care for people with disabilities* marks another important step away from historical discrimination against this population. The handbook addresses the need for health professionals to understand and recognize the sexual and reproductive rights, needs and expectations of people with disabilities, and it places special emphasis on eliminating gender-based violence.

Protecting health workers

98. The labour rights and standards of health workers, including around occupational safety and health, must be fully respected, protected and fulfilled, and health workers must be free from discrimination and violence in the workplace. A number of interventions and practices can help achieve those aims.
99. For example, national laws and regulations in the areas of employment/labour law and health must cover labour rights and standards for health workers, including steps for implementation and penalties for violations. Such laws and regulations should also include measures to address gender disparities in health workforces, such as working hours, remuneration, training, fixed contracts and more.
100. Minimum standards for health workplaces should be set and enforced. These should also address gender disparities and should provide for recourse if the standards are not upheld.

Box 12: Recognizing midwives, reducing deaths in Cambodia

Cambodia was one of nine countries to achieve the Millennium Development Goal of reducing maternal death by at least 75% by 2015. This remarkable progress was brought about by officially recognizing midwives as key to the reduction of maternal and newborn mortality, and by integrating them into the formal health system. The Government improved the curriculum for midwives, expanded their training, provided monetary incentives for deliveries in hospitals or health centres and created scholarships for midwives to apply for higher qualification and pay scales.⁸⁵

Midwives work with traditional birth attendants and are deployed to areas where mortality rates are highest. They deliver babies and advance the rights of women and girls, offer support to survivors of gender-based violence and provide reproductive health counselling to adolescents. They help ensure that women from all communities—including marginalized and poorer communities, ethnic minorities, geographically isolated women and the urban poor—can access quality services.⁸⁶

101. Other proactive protective measures for health workers include:

- Initiatives of “caring for the carers”, which can address difficult working conditions (such as long hours, heavy workloads and poor pay, gender inequities in the workplace, as well as the psychological impact of working in emotionally demanding conditions) and provide periodic counselling and support;
- Introducing strong non-discriminatory workplace policies at health facilities, addressing HIV, gender and sexuality issues, and ensuring management support for their implementation;
- Providing occupational health and safety programmes (such as the WHO/ILO HEALTHWISE tool; see Box 13), which has been implemented in Africa and Asia to address stigma and discrimination in health-care settings within the context of occupational health and safety, and to help eliminate/minimize workplace injuries; and
- Establishing “charters” at the health-facility level to clearly delineate the rights and responsibilities of health workers.⁸⁷ Such charters, publicly displayed at health workplaces, can help health workers claim their rights and empower them to fulfill their responsibilities.

Box 13. Good practice: Using the ILO/WHO HealthWISE tool in China

The ILO, the China Centre of Disease Control, the China Labour Institute of MOHRSS, the China HIV and STD Prevention and Control Association and civil society organizations have used the joint ILO/WHO HealthWISE toolkit for a combined HIV and occupational safety and health programme covering 20 hospitals and reaching 31 000 health-care workers.

HealthWISE provides a practical, participatory methodology for improving the quality of health facilities, and has been used to strengthen the capacities of health workers and institutions, and to empower people living with HIV. Guidelines on the management of occupational exposure to blood-borne pathogens were developed and implemented, and a high-level workshop was held to remove a discriminatory clause in the Medical Standard of Recruitment of Civil Servants in China. Civil society organizations were assisted in expanding the provision of legal services to people living with HIV.

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Strengthening community health workers and building community interventions

102. States should promote and strengthen the role of community health workers in the provision of HIV, sexual and reproductive health, and broader health services. These workers should be provided with the training and other support (including funding) they need to deal with discrimination. In many cases, community health workers and community-based organizations that provide health services are the only or prime source of information and health services for key populations and/or people living in poorly serviced areas.
103. Involving civil society organizations (including through social contracting) should be an integral part of national HIV programming. These organizations should be recognized as capable service providers and implementing partners. Their participation not only increases access to hard-to-reach communities, but also helps ensure a rights-based approach is used. Community-led interventions can include drop-in centres; peer outreach and mobile services; providing referrals to known, trusted providers; providing rapid response teams for immediate legal support; and providing in-service peer supporters to help service users navigate processes at health facilities.⁸⁸ Appropriate links should be established between community-led programmes and formal health services.

Empowering health service users

104. Countries should also implement programmes that empower and engage individual users of health services to make them aware of and able to claim their rights, including those to discrimination- and violence-free health-care, through rights/legal literacy programmes.
105. Although national situations vary, some common approaches can be adapted to different circumstances to empower service users and promote patients' rights. These may include medical and other professional codes, patients' charters and similar instruments which are drafted on the basis of agreed, common understandings between health service users, health professionals and policy-makers, and which are revised periodically in response to changing circumstances.⁸⁹

106. Patients' charters, prominently displayed, enable users of health facilities to understand and claim their rights to non-discriminatory and quality treatment and care, and remind health workers of their responsibilities to provide such care. They should be accompanied by guidance on how to seek redress if any element of the charter is violated.
107. Opportunities must exist for health-care users (and health workers) to report perceived discriminatory practices either directly or anonymously, allowing health-care facilities (and patient support/advocacy networks) to track the incidence of such cases and take appropriate action. Accessible and confidential systems are needed to encourage reporting, and to ensure no reprisals are taken. New technologies as well as traditional reporting methods can be used. For example, in Ghana, Viet Nam and several countries in Latin America people can use web-based apps to comment on the quality of health services, report discrimination, and to connect to relevant services (See Box 14).

Box 14. Good practice: VAMOS—helping adolescents access sexual and reproductive health services in Latin America and the Caribbean

In many countries in Latin America and the Caribbean, access to health services for adolescents and young people (aged 10–24 years) continues to be inadequate. Yet 1 in 20 young people in the region have a sexually transmitted disease, and HIV-related complications are among the five most common causes of death in that age group. In the Caribbean, approximately 1.6% of people aged 15–24 years are living with HIV. High-quality, youth-friendly health services are urgently needed.

In 2017, the *Fundación Huésped* and partners (including the youth organization *Colectivo de Juventudes por los Derechos Sexuales y Reproductivos*) developed the VAMOS website and app to help young people access sexual and reproductive health services. VAMOS was launched in October 2017 across the region with support from the International Planned Parenthood Federation's Western Hemisphere Region.

An open source platform, VAMOS works on any device with an Internet connection and can be used anonymously and safely. Users can find service providers near their location using their device GPS. VAMOS also enables young people to monitor and report on discrimination at health facilities, and it gathers users' anonymous feedback on the quality of services. The data collected can be used to advocate for improvements in service access and quality.

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108. Youth-friendly services are particularly important, since adolescents and young people can face particular barriers at facilities that are structured primarily for children or adults. Youth need services that “speak their language”. It is equally important for adolescents and young people to be aware of their rights to non-discriminatory health services (See Box 15).

Box 15. Good practice: Engaging adolescents and young people in their own health care in sub-Saharan Africa

In sub-Saharan Africa, adolescents and young people are a particularly affected population in the HIV epidemic, with HIV-related illnesses among the leading causes of death among 15–24 year-olds. Paediatric-Adolescent Treatment Africa is implementing a “Peers to Zero” programme in several countries to support adolescents and young people living with HIV to advocate for their rights and for youth-friendly health-care environments. Health-care providers are being sensitized and adolescents and young people living with HIV are involved as peer supporters in designing, delivering and monitoring services. The programme is being implemented across 60 health facilities in Kenya, Mozambique, Swaziland, Uganda, the United Republic of Tanzania, Zambia and Zimbabwe, and involves seven national networks of youth living with HIV. Peer supporters have assisted youth with disclosure, defaulter tracing and adherence counselling, while support groups, dedicated spaces and teen camps and clubs have been provided as well.

Over 12 months, the paediatric and adolescent patient base at participating facilities increased by 34%. Ninety-five percent of facilities included peer supporters in staff meetings, a practice that led to important programmatic improvements.

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Increasing access to justice

109. Legal and policy reform, programmes to train health workers and programmes to empower service users need to be accompanied by measures to increase access to justice in cases of discrimination in health care. Clear mechanisms are needed for reporting cases of discrimination in health-care settings. Access to free legal services should also be ensured to enable people who have experienced discrimination to seek legal advice and redress (Boxes 16 and 17).

Box 16. Increasing access to justice in Mozambique

Baseline assessments carried out by the Global Fund in the context of its strategic effort to expand programmes to remove human rights barriers to health services showed that some efforts to address discrimination in health-care settings exist. In Mozambique, for example, the legal empowerment cooperative Namati has developed a network of grassroots advocates to monitor the provision of health services in communities. The advocates are trained in the country’s health-related laws and policies and in additional skills such as mediation, adult education, and advocacy. They support individuals in raising problems regarding community health services, and facilitate problem-solving dialogue and other remedial actions.

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Box 17. Good practice: Strengthening legal advice in Egypt

In Egypt, the International Development Law Organization ran a programme to strengthen HIV-related legal services to address discrimination faced by people living with HIV and key populations.

The programme “twinned” human/legal rights organizations with health advocacy groups, so that each could learn from the other. The rights organizations learned about HIV-related issues while the health advocacy groups learned about options for legal action to enforce health rights. As a result, since 2015, more than 500 people living with HIV and key populations were provided with direct HIV-related legal information; more than 500 legal consultations were provided to people living with HIV and key populations; and more than 150 court cases were filed in the Egyptian judicial system. Many of the cases related to the health sector. Approximately 60 cases of alleged failure to provide satisfactory health services to people living with HIV were reported to the National AIDS Programme during 2014–2016. The programme resolved all but one of the cases to the satisfaction of the complainant (the other resulted in court action). A hotline and a Facebook page were also set up to disseminate HIV-related legal information.

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Strengthening accountability

110. States should ensure accountability for non-discrimination in health-care settings by guaranteeing access to effective redress mechanisms (for both users of health services and health workers) and by strengthening mechanisms for the reporting, monitoring and evaluation of discrimination.
111. Judicial systems have a role in ensuring that protective laws and policies are implemented, and in monitoring (through registries of complaints) the extent of discrimination that occurs. National human rights institution may, depending on their mandate, carry out investigations of human rights abuses and handle complaints. They can also maintain a case registry that contributes to the monitoring of discrimination.
112. Other government agencies, particularly Ministries of Health, should collect and analyse discrimination-related data to identify systemic gaps and to inform programming and policy development to address discrimination in health-care settings (and elsewhere).

Box 18. Good practice: Resolving complaints from health service users in Argentina

The Directorate of HIV and Sexually Transmitted Diseases under the Ministry of Health in Argentina has established a system to receive and respond to complaints related to discrimination towards people living with HIV, as well as problems in access to treatment or social services, such as pensions.

The system allows people to contact the Directorate via a free 0800-number, online form or by email—and receive a reply within 48 hours. Complaints are resolved through administrative means or are referred to other State or civil society entities that provide free legal services. An important part of the process is the empowerment of people living with HIV through the dissemination of “know your rights” materials, and the strengthening of capacity in provincial AIDS programmes to respond to HIV-related discrimination and other human rights violations, including through liaising with entities that provide legal services.

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113. International and regional human rights mechanisms should also be used to monitor the progress by States in ensuring non-discrimination in health-care settings, including for people living with HIV, key populations and other affected groups. Countries should report on the measures taken to that effect during the universal periodic review process. Similarly, measures taken to reduce discrimination in health-care settings should be included in the voluntary national reviews of progress towards achieving the Sustainable Development Goals.
114. At the regional level, institutions such as the European Court of Human Rights, the African Commission on Human and Peoples’ Rights as well as the Inter-American Commission and Court of Human Rights also have a role to play.

VI. IMPLEMENTING THE AGENDA FOR ZERO DISCRIMINATION IN HEALTH-CARE SETTINGS

115. The vision of achieving zero discrimination is a key part of the 2016 Political Declaration on Ending AIDS, with eliminating discrimination in health-care settings by 2020 one of the three Fast-Track commitments to end AIDS by 2030. The zero discrimination target goes hand in hand with the commitments to eliminate gender inequalities and end all forms of violence and discrimination against women and girls, people living with HIV and key populations, and with commitments to review and reform laws that reinforce stigma and discrimination, including on age of consent, HIV non-disclosure, exposure and transmission, travel restrictions and mandatory testing.
116. In an effort to Fast-Track the elimination of discrimination in health-care settings, UNAIDS and WHO in 2016 launched the Agenda for Zero Discrimination in Health-Care Settings. The Agenda also outlines the minimum requirements for discrimination-free healthcare. The action plan underpinning the Agenda aims to increase commitment, collaboration and accountability among countries, the UN and development partners, civil society, professional health-care associations, academics and other key stakeholders. The priorities of the action plan are to:

- Remove legal and policy barriers that promote discrimination in health care;
- Set the standards for discrimination-free health care;
- Build and share the evidence base and best practices to eliminate discrimination in health-care settings;
- Empower clients and civil society to demand discrimination-free health care;
- Increase funding support for a discrimination-free health workforce;
- Secure the leadership of professional health-care associations in actions to shape a discrimination-free health workforce; and
- Strengthen mechanisms and frameworks for monitoring, evaluation and accountability for discrimination-free health care.

Box 19. Discrimination-free health-care settings should, at a minimum:

- Provide timely and quality health care regardless of gender, nationality, age, disability, ethnic origin, sexual orientation, religion, language, socioeconomic status, or HIV or other health status, or because of selling sex, using drugs and/or living in prison;
- Prohibit mandatory testing or treatment, or coercive practices;
- Respect patient privacy and confidentiality;
- Link marginalized and most affected populations to additional service providers, peer-support networks or community-based organizations, or legal services when necessary;
- Employ clinical providers who ask health questions or perform health intakes to actively inform people of their rights and provide quality non-judgemental care;
- Put in place grievance mechanisms and mechanisms of redress and accountability for discrimination and violation of the rights of clients; and
- Ensure participation of affected communities in the development of policies and programmes promoting equality and non-discrimination in health care.

117. To further spur action at country level, 12 UN entities in June 2017 issued a Joint UN statement on ending discrimination in health-care settings, calling on all stakeholders to join the UN in committing to targeted, coordinated, and time-bound, multisectoral actions to support States. Such support would enable States to put in place:

- Guarantees against discrimination in law, policies, and regulations;
- Measures to empower health workers and users of health services through attention to and realization of their rights, roles and responsibilities;
- Measures to ensure accountability and compliance with the principle of non-discrimination in health-care settings; and
- Measures to implement the United Nations Shared Framework for Action on Combating Inequalities and Discrimination.⁹⁰

118. A year after the launch of the Agenda for Zero Discrimination in Health-Care Settings, there is increasing support for cohesive actions, as well as an understanding that more needs to be done, better and more effectively to achieve discrimination-free health care for all. Action must be accelerated to end discrimination in health-care settings. This will require targeted funds, leadership at many levels along with new ways of doing things.

Financing for zero discrimination in health-care settings

119. Global political commitment on the elimination of discrimination in health-care settings has been achieved. Now resources must be allocated to programmes and actions that have been shown to work. Some good practices already exist.
120. The Global Fund has embarked on a major strategic effort to expand programmes to remove human rights-related barriers to health services in national responses to HIV, TB and malaria, and thus increase the effectiveness of Global Fund grants. It has identified 20 countries that are eligible to receive intensive support for scaling up programmes that reduce stigma and discrimination and increase access to justice.⁹¹
121. As part of this effort, the Global Fund has established a catalytic fund of US\$ 45 million. In order to be eligible for those funds, countries have to meet certain requirements, including allocating an increased share of the grant to programmes aimed at removing human rights-related barriers (compared to their current grant), and matching the amount they are eligible for under the catalytic fund. Robust monitoring and evaluation efforts are planned in the 20 countries, including baseline, mid-term and end-term assessments to inform strategic planning and assess the results of programme scale-up. The Global Fund's goal is to move from small-scale, *ad hoc* investments to comprehensive programmes that deliver effective interventions, in the right places, for the right people, at the right scale. UNAIDS can play a key role in supporting this effort by convening the upcoming multistakeholder meetings in each of the 20 countries, and by providing technical assistance and support for the implementation of programmes to remove human rights-related barriers to services.

Box 20. Good practice example: the LGBT Fund: community-based approaches to reducing discrimination

PEPFAR's programmes support the creation of non-stigmatizing environments that protect human rights and enable all persons receiving services to have consistently safe access to quality clinical and community-based care and support.

PEPFAR is working to ensure non-discriminatory access to HIV services for all individuals in need, including through a partnership with the Elton John AIDS Foundation. The partners are providing a total of US\$ 10 million in grants to organizations working to meet the HIV-related needs of lesbian, gay, bisexual and transgender people.

The grants will help grassroots organizations, community leaders, civil society, and service providers to create non-stigmatizing environments and improve access for lesbian, gay, bisexual and transgender people.⁹²

The inaugural recipients in 2016 were the International HIV/AIDS Alliance and the Global Forum on MSM & HIV, who will administer small grants and provide key technical expertise addressing stigma and discrimination through innovative and community-led approaches in sub-Saharan Africa and the Caribbean.⁹³

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Setting national and regional zero discrimination targets

122. Countries and regions have already started to adapt the global zero discrimination targets to their own contexts. This involves setting specific targets tailored to regional and national epidemics, their respective vulnerable groups and key populations, and adapting them to national health systems, capacities, and civil society capacity.
123. In 2015, the Second Latin American and Caribbean Forum on the Continuum of HIV Care agreed on a set of prevention and zero discrimination targets for 2020 which reflect the characteristics of the epidemic and responses in each of the sub-regions, while being aligned to the global zero discrimination target. Forum participants recognized the need to increase interventions to reduce prejudice, violence, stigma and discrimination against people living with HIV and key and other vulnerable populations. Such interventions may include eliminating legal and political barriers, reducing discrimination in health-care settings, addressing the specific needs of women and girls, reducing violence and guaranteeing access to justice.
124. In Asia and the Pacific, a regional meeting in Bangkok in 2016 discussed opportunities to increase the impact of efforts to achieve zero discrimination in health-care settings in the region. A regional support strategy was developed to encourage greater coordination and bolster the impact of activities through the consistent application of a human rights- and gender equality-based approach, and the principle of leaving no one behind. Support includes technical assistance, strengthening of engagement by governments and professional bodies to expand implementation and increase sustainability, and to improve integration.
125. The HIV Prevention 2020 Road Map, launched by the Global HIV Prevention Coalition, represents a tool that might be usefully considered in the context of domesticating the zero discrimination targets in line with the commitments of the 2016 Political Declaration on Ending AIDS. The road map contains a 10-point action plan that outlines immediate, steps countries can take to accelerate progress, including: conducting up-to-date analysis; developing guidance to identify gaps and actions for rapid scale-up; training; and addressing legal and policy barriers. It encourages countries to develop a 100-day plan for immediate actions, including setting national targets, reviewing the progress made against the plan after 100 days, reassessing their programmes and taking immediate remedial action. It also outlines actions for civil society, development partners, philanthropic institutions and the business community.

Leadership, partnerships, innovation: working together to achieve the Agenda for Zero Discrimination

126. The Agenda for Zero Discrimination requires people and organizations to work together in innovative ways—harnessing new technologies and global social networks, and using the resources of communities to monitor, report on and eliminate discrimination.

Professional and student associations

127. Global and national professional associations of health workers can apply pressure to ensure that workplaces uphold labour rights and eliminate discrimination towards both health service users and health workers. Associations can also contribute to the development of laws, regulations, policies, competency frameworks, licensing requirements and education/training.⁹⁴

128. For example, the International Federation of Medical Students' Associations has published a Declaration of Commitment endorsing the Agenda for Zero Discrimination in Health-care Settings and committing to "strengthening our individual and collective efforts in response to this Agenda, to eliminate discrimination in health care, and to advocate for the protection and fulfilment of all human rights, for everyone, everywhere."⁹⁵
129. The World Medical Association intends to establish and promote the highest possible standards of ethical behaviour and care by physicians,⁹⁶ as well as promote health-related human rights for all people worldwide.⁹⁷ In addition, since physicians can also be victims of human rights abuses, the Association intervenes to support them and denounce such violations.
130. The International AIDS Society is the world's largest association of HIV professionals, with members from more than 180 countries working on all fronts of the global HIV response. Positive Action Challenges and the International AIDS Society are supporting and scaling up good practices aimed at ensuring that every person is treated with dignity and respect, regardless of profession, gender or sexual identity. The aim is to scale up proven actions that are replicable and sustainable, and to encourage new "proof of concept" innovations that can lead to meaningful change.⁹⁸ The 2018 International AIDS Conference in Amsterdam will provide an additional platform for reporting and engaging around innovations for eliminating stigma and discrimination in health-care settings.
131. The International Federation of Gynecology and Obstetrics, which brings together professional societies of obstetricians and gynecologists, has published a publication on ethical issues that includes articles on HIV. Addressed in the publication are ethical aspects of HIV and reproduction, HIV and fertility treatment, and pregnancy and women living with HIV. The publication links the importance of non-discriminatory medical care to wider issues of human rights and social and economic discrimination, particularly gender-based discrimination, and includes HIV-related discrimination. It also refers to the duty of physicians to help protect patients from discrimination and unfair and punitive actions, including through public advocacy.⁹⁹ The Federation has also published a bioethics training programme that is available for free.¹⁰⁰

Civil society organizations

132. Networks of people living with HIV, key populations (and other affected populations), women and young people all have important roles in advocating for zero discrimination in health-care settings, as well as for providing discrimination-free services.

Fast-Track cities

133. On World AIDS Day 2014, mayors and other municipal leaders joined with civil society representatives to launch the Paris Declaration on Fast-Track Cities. They continue to work towards achieving zero stigma and discrimination by 2020 by fulfilling the pledge to provide services that are innovative, safe, accessible, equitable, free of stigma and discrimination, and responsive to local needs.
134. For example, in Kyiv, Ukraine, where stigma and discrimination prevent people living with HIV and key populations from accessing services, the RESPECT anti-stigma pilot project has shown excellent results in the six pilot clinics. A total of 720 health workers were trained in providing stigma-free services. As a result, confidentiality breaches reduced (down to 25% of health workers from 47% before the programme), knowledge levels about HIV transmission among health workers increased (by 15 percentage points), and the indicator for stigma, induced by the fear of acquiring HIV, reduced by a

factor of 2.5. After the health workers received further training in provider-initiated testing and provision of services, 85% of people newly diagnosed with HIV in the RESPECT facilities were linked to care (compared with 35% on average in the city as a whole).¹⁰¹

135. In Cape Town, South Africa, the non-profit Women's Legal Centre works closely with the Sex Workers Education and Advocacy Taskforce and Sisonke, South Africa's national sex worker movement, to support and advance the rights of sex workers, including those who are subjected to police harassment. It has moved from running weekly workshops for sex workers on human rights and laws related to sex work, to training sex workers as community-based paralegals who provide peer-based legal assistance. These paralegals now accompany Taskforce teams on outreach visits to sex work "hotspots" in Cape Town, providing sex workers of all genders with information and advice, escorting them to medical clinics or to court, and helping with bail applications and filing complaints about police abuse. The Women's Legal Centre has also produced pamphlets and an information card for sex workers that explains their rights if arrested or detained. Each year, it handles about 120 cases related to sex work, and it has noticed marked improvements in the behaviour and attitudes of police toward sex workers. By linking conventional services with outreach and support, the Centre manages to base its legal assistance around sex workers themselves, affording them the means to challenge violations of their rights in a direct manner.^{102 103}

Harnessing social media and mobile technologies

136. Social media and new mobile and Internet technologies are already being harnessed to the cause of increasing access and eliminating discrimination. They can be used for engaging communities of people living with HIV and key and affected populations, especially where access to health services is difficult due to a person's physical location or fears of discrimination. Such technologies can be particularly useful to supplement traditional methods of reporting on and monitoring the quality of health services and cases of discrimination, and to connect individuals to relevant services.

Box 21. LINKAGES: Using mobile technology to track stigma and discrimination

LINKAGES, a PEPFAR/USAID initiative dedicated to key populations, includes a number of interventions to address stigma and discrimination against key populations in health facilities and to improve service quality.

These include health worker training, peer navigation, and peer education and outreach with members of key populations. SMS-based systems have been used successfully as part of social and behaviour change communication messaging campaigns.

In Burundi, Côte d'Ivoire, the Democratic Republic of Congo, Malawi and other countries, LINKAGES uses SMS2, an SMS-based quality assurance and quality improvement activity that can be used by health services to monitor and track stigma and discrimination experienced by members of key populations in health-care settings. SMS2 is administered through existing community outreach activities, with trained outreach workers administering simple SMS assessments of facilities which individuals have visited. The information is shared with health workers, members of key populations, outreach workers, and LINKAGES staff via SMS.¹⁰⁴

VII. THE WAY FORWARD

137. In order to Fast-Track the implementation of the Agenda for Zero Discrimination in Health-Care Settings, as well as to improve access to vital prevention, testing, treatment and care services for people living with HIV and key populations, a number of priority areas for action emerge:

- Discrimination in health-care settings is often directed against the most marginalized members of society, who may be discriminated against on many different grounds. It is therefore necessary for countries **to take multisectoral measures to address intersecting forms of discrimination**, including those related to age, sex, race or ethnicity, mental health conditions, sexual orientation, gender identity or nationality in health-care settings and to ensure that the same quality of care is provided to everyone, while taking into consideration the specific needs of each individual.
- There is a need to **consolidate and disseminate existing evidence** on effective programmatic and policy responses to eliminate discrimination in health-care settings to ensure that national AIDS programmes and Ministries of Health, in collaboration with other sectors, can establish and expand evidence-based programmes to reduce discrimination in the context of health.
- It is also important that countries **set Fast-Track zero discrimination targets**. These efforts could be aligned with the ongoing processes around the Global HIV Prevention Coalition and the HIV Prevention 2020 Roadmap. To be able to set time-bound targets, it is essential to **measure discrimination in health-care settings**. The levels of such discrimination should be measured both from the perspectives of service users and service providers, in collaboration with civil society and other partners, including through the use of the updated People Living with HIV Stigma Index. To increase accountability, information about progress in eliminating discrimination in health-care settings should be included in countries' reports to various human rights mechanisms, including in the context of the Universal Periodic Review, and when reporting on their progress towards the Sustainable Development Goals through voluntary national reviews, as well as to the Global AIDS Monitoring reports and the National Commitments and Policy Instrument. It is also important to undertake financial analyses of how much money is lost due to stigma and discrimination and its implications for health systems.
- In order to ensure that health workers have the necessary capacity to provide discrimination-free health-care, **issues related to human rights, non-discrimination, free and informed consent, confidentiality and privacy should be integrated into pre- and in-service training curricula for health workers**. Training on the right to non-discrimination should also be provided to police, law enforcement officers, prison staff and other relevant professions. Best practices on such training and education programmes and materials should be shared.
- At the same time, people living with HIV, key populations and other groups in situations of vulnerability should be **empowered to know and demand their right to non-discrimination in the context of health care**, including through health and human rights literacy and through "Patient Charters" that encapsulate the principles and criteria for non-discriminatory, people-centred services at the health facility level.
- It is also important to ensure that **health workers have a supportive working environment and to reduce discrimination towards health-care workers**, including gender-based discrimination.

- There is also a need **to review and reform laws that reinforce stigma and discrimination**, including laws related to the age of consent, HIV non-disclosure, exposure and transmission, criminalization of key populations, travel restrictions and mandatory testing.

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