GLOBAL PARTNERSHIP FOR ACTION TO ELIMINATE ALL FORMS OF HIV-RELATED STIGMA AND DISCRIMINATION

GUIDANCE BY THE GLOBAL PARTNERSHIP FOR ACTION TO ELIMINATE ALL FORMS OF HIV-RELATED STIGMA AND DISCRIMINATION

Monitoring and evaluating programmes to eliminate HIV-related stigma and discrimination in six settings

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CONTENTS

INTRODUCTION

In 2018, the Global Partnership for Action to Eliminate all Forms of HIV-related Stigma and Discrimination (Global Partnership) was launched to "harness the combined power of governments, civil society, bilateral and multilateral donors, academia and the United Nations to consign HIV-related stigma and discrimination to history" (1).

The partnership is currently co-convened by the United Nations Entity for Gender Equality and the Empowerment of Women (UN Women), the United Nations Development Programme, the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), the Global Network of People Living with HIV (GNP+), the Joint United Nations Programme on HIV/AIDS (UNAIDS), PCB NGO Delegation, the Centers for Disease Control and Prevention (CDC).

Leadership and technical support from the NGO Delegation to the UNAIDS Programme Coordinating Board was critical to creating the Global Partnership, which seeks to inspire countries to take action to remove critical barriers to HIV services.

In 2020, the Global Partnership launched a guidance document that reviewed the latest evidence on effective programmes to eliminate HIV-related stigma and discrimination in the six settings of the Global Partnership (2). The present guidance is a companion to the evidence guidance focused on monitoring and evaluation (M&E), with the goal of supporting programme planners, implementers and managers at government agencies and nongovernmental and community-based organizations to understand the outputs and outcomes of their programmes and inform programme improvement and scale-up.

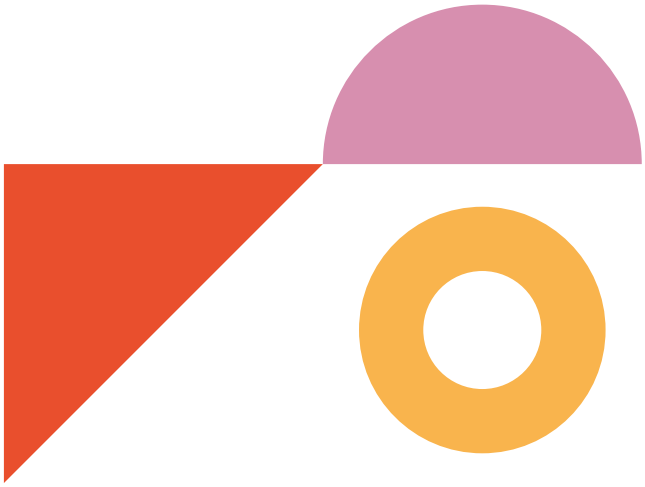
This M&E guidance was developed with alignment and harmonization in mind. For example, at the United Nations High-level Meeting on HIV and AIDS in June 2021, United Nations Member States adopted a new political declaration to guide the future direction of the HIV response. The declaration included a set of people-centred global targets for achievement by 2025. These targets included three 10–10–10 targets for achieving the societal enablers of HIV (3):

- Less than 10% of countries have legal and policy environments that impede access to HIV services.
- Less than 10% of women, girls and people from key populations[1] experience gender inequality and violence.
- Less than 10% of people living with HIV and people from key populations experience stigma and discrimination.

The programmes implemented by countries to eliminate HIV-related stigma and discrimination will support the achievement of the societal enabler targets. Implementing organizations will select their own output and outcome indicators to understand how their programmes are operating and how they could be improved.

Many of the indicators selected by implementing organizations for their own M&E efforts may also be useful for national and global reporting. For example, implementing organizations may report some of the data they collect on programme outcomes to the Global Fund, the United States President's Emergency Plan for AIDS Relief, or national-level authorities as part of the Global AIDS Monitoring process.

The conceptual framework on the stigmatization process and M&E methodologies recommended in this guidance are aligned with UNAIDS guidance on evidence-based programmes for reducing HIV and key population stigma and discrimination (2), guidance from Frontline AIDS and the Global Fund on implementing and scaling up programmes to remove human rights-related barriers to HIV services (4), and the latest guidance documents from UNAIDS on rights-based and community-led M&E (5, 6) (Figure 1). Taken together, these resources will enable countries to achieve the new HIV targets by 2025 and beyond.



1 Key populations as defined by UNAIDS include gay men and other men who have sex with men, sex workers, transgender people, people who inject drugs and people in prison.

Figure 1. Key resources for implementing monitoring and evaluating programmes to achieve societal enabler targets

GLOBAL AIDS STRATEGY TOP-LINE TARGETS FOR 2025

PEOPLE LIVING WITH HIV AND COMMUNITIES AT RISK AT THE CENTRE

95%

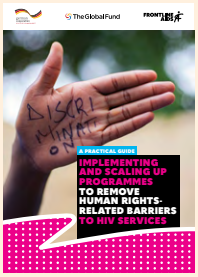
- of people use combination prevention
- of people living with HIV know their HIV status
- of people living with HIV who know their status initiate treatment
- of people living with HIV on treatment are virally suppressed
- coverage or services for eliminating vertical transmission
- of women access HIV and sexual and reproductive health services

90%

- of people living with HIV and people at risk are linked to people-centred and context-specific integrated services

Less than 10%

- of countries have punitive laws and policies
- of people living with HIV and key populations experience stigma and discrimination
- of women and girls, people living with HIV and key populations experience gender based inequalities and gender based violence



Key Resources:
HIV stigma and discrimination

Key Resources:
M&E tools and guidance

M&E FRAMEWORK

Before developing an M&E plan, it is important to understand some key terminology. Box 1 defines the key components of an M&E framework, as reported in the 2019 guidance on rights-based M&E of national HIV responses (5).

Box 1.

M&E FRAMEWORK: KEY COMPONENTS

WHAT IS AN M&E FRAMEWORK?

An M&E framework identifies and illustrates (7, 8):

- The logic flow from programme inputs, activities, outputs, outcomes and impacts.
- The indicators that will be used to measure the performance and results of the programme outputs, outcomes and impacts.
- How those indicators will be verified—that is, the source of information for these measurements.

A results framework or logframe is a management tool used in designing a programme or project that correlates key strategic elements (including objectives, inputs, outputs, outcomes and impacts) with indicators and the assumptions and risks that may affect the implementation of the programme or project. Logframes are useful for planning, executing and evaluating programmes and projects.

M&E TERMINOLOGY

- Activities—actions taken or work performed through which inputs such as funds, technical assistance and other resources are mobilized to produce specific outputs.
- Baseline—fixed point of reference for comparison purposes.
- Data—specific quantitative and qualitative information or facts that are collected and analysed.
- Data source—location from which the data being used originate.
- Evaluation—systematic collection of information about the activities, characteristics and outcomes of a specific programme to determine its merit or worth. Evaluation provides credible information for improving programmes, identifying lessons learnt, and informing decisions about future resource allocation. Evaluation aims to investigate the achievement of a programme's results. Evaluation is a rigorous and independent assessment of completed or ongoing activities. Evaluations are done independently to provide managers and staff with an objective assessment of whether they are on track.
- Impacts—cumulative effect of programmes on what they ultimately aim to change over a longer period of time. Often, this effect will be a population-level health outcome, such as a change in HIV infection, morbidity and mortality. Impacts are rarely, if ever, attributable to a single programme, but a programme may, with other programmes, contribute to impacts on a population.
- Indicator—quantitative or qualitative variable that provides a valid and reliable way to measure achievement, assess performance or reflect change connected to an activity, project or programme.
- Inputs—resources used in a programme, such as financial and human resources from a variety of sources. Resources can also include curricula, materials and other resources. Inputs can be outputs from other activities.
- Monitoring—routine tracking and reporting of high-priority information about a project or programme, such as its inputs, outputs, outcomes and impacts. Monitoring activities measures progress towards achieving programme objectives.

- Outcomes—intermediate changes that a programme effects on target audiences or populations, such as changes in knowledge, attitudes, beliefs, skills, behaviours, service access, policies or environmental conditions.
- Outputs—immediate results of programme activities. This relates to the direct products or deliverables of programme activities, such as the number of counselling sessions completed, the number of people reached or the number of materials distributed.
- Target—specific performance goal tied to an indicator against which actual performance will be compared.

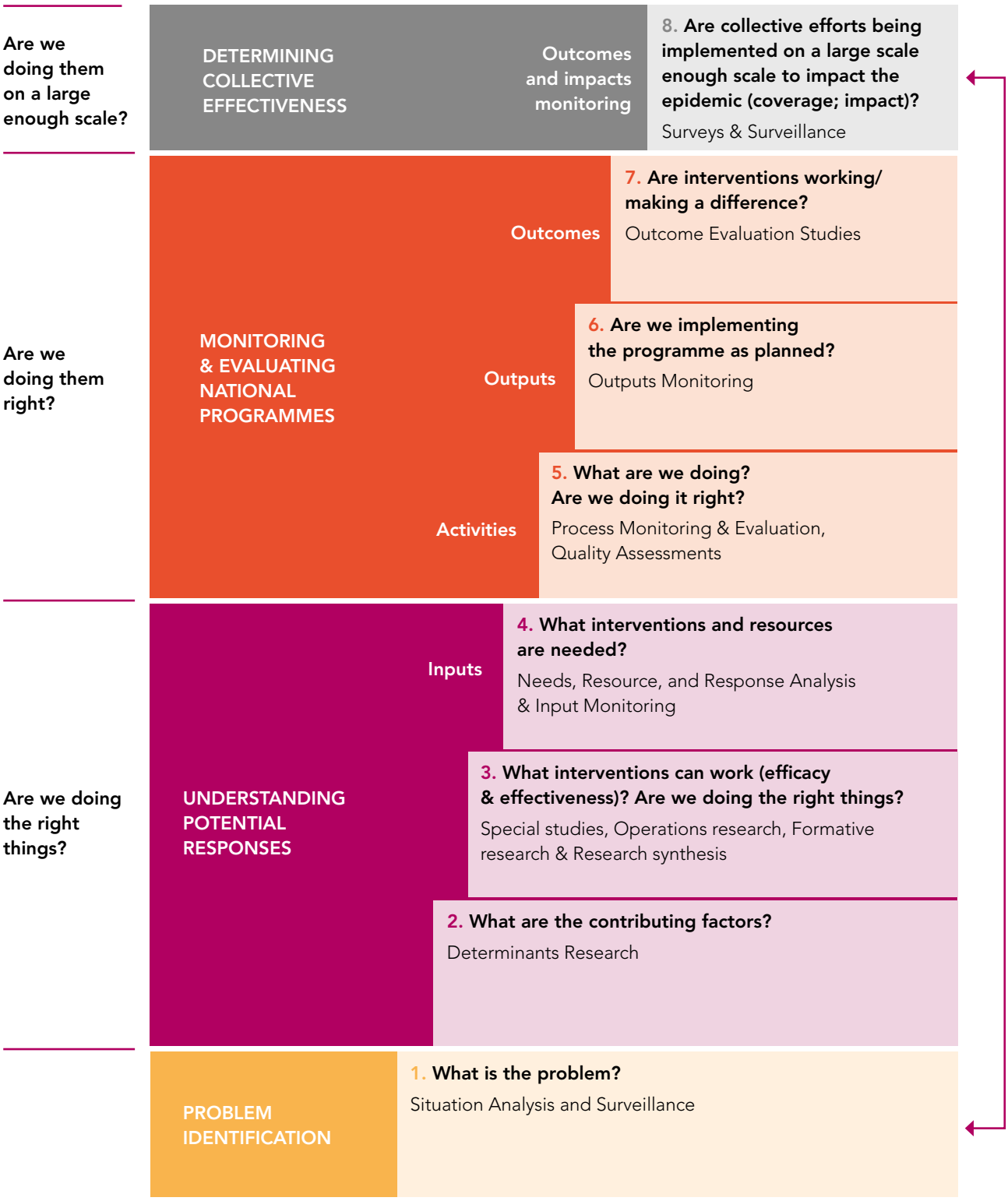
WHY DO WE NEED AN M&E FRAMEWORK FOR ELIMINATING HIV AND KEY POPULATION STIGMA AND DISCRIMINATION?

To reduce or eliminate HIV and key population stigma and discrimination, it is crucial that appropriate mechanisms are in place to:

- Guide the planning, coordination and implementation of the programme (i.e. a clear framework agreed among key stakeholders at the end of the planning stage that provides a plan for M&E) (9).
- Measure programme results at all levels (impact, outcome, output, process, input) and provide the basis for accountability and informed decision-making at both programme and policy level.
- Assess the effectiveness of the programme.
- Identify areas for programme improvement.
- Ensure accountability to the people whose lives the programmes aim to improve.

A public health questions approach can be useful to identify relevant questions that need to be addressed when planning a comprehensive national M&E system. These questions are presented in Figure 2, which also lists the main data collection

Figure 2. Public health questions approach to M&E



Sources: Organizing framework for a functional national HIV monitoring and evaluation system. Geneva: UNAIDS; 2008 (https://www.unaids.org/sites/default/files/sub_landing/files/20080430_JC1769_Organizing_Framework_Functional_v2_en.pdf); Rugg D, Carael M, Boerma T, Novak J. Global advances in monitoring and evaluation of HIV/AIDS: from AIDS case reporting to program improvement. New Directions for Evaluation. 2004; 103:33-48

methods that can be used to answer the questions (5). Table 1 provides an example of a generic logframe based on the public health questions approach to address HIV and key population stigma and discrimination.

Table 1. Generic logframe showing example programme components that address HIV and key population stigma and discrimination and potential data sources from a public health questions perspective

Programmatic logic flow	Relationship clarifier questions	Components within logic flow	Data sources
Assessment and planning	What is the current situation? Which are the most affected or marginalized populations? What domains of stigma are acting as barriers (e.g. drivers, manifestations)? Where do we aim to be? What do we need to do?	Situation analysis Response analysis Stakeholder capacity Gaps and needs Resource analysis Collaboration plans	Programme development
Inputs (resources)	What resources do we need? Why do we need these inputs? So we can deliver the following activities ...	Staff Funds Materials Facilities Supplies	Programme-based data
Activities (interventions, services)	What do we need to do? Why do we need these activities? So we can deliver the following outputs ...	Training Services Education Documentation Interventions	
Outputs (immediate effects)	What will these activities yield? Why do we need these outputs? So we can deliver the following outcomes ...	Output indicators: ■ Number of duty bearers trained ■ Number of stigma reduction materials provided ■ Number of legal literacy materials provided ■ Number of clients served ■ Number of laws assessed ■ Number of institutional policies assessed	

Outcomes (intermediate effects)	What are the outcomes of the activities and outputs? Why do we need these outcomes? So we can have the following long-term impacts ...	Outcome indicators: ■ Duty bearer behaviour ■ Risk/resilience behaviour ■ Service use ■ Percentage of cases of human rights violations where redress has been sought or resolved ■ Clinical outcomes ■ Quality of life	Population-based biological, behavioural and social data
Impacts (long-term effects)		Impact indicators: ■ Social and legal norms ■ HIV incidence ■ Sexually transmitted infection incidence ■ AIDS-related mortality ■ Economic impact ■ Enjoyment of highest attainable standard of health	Population-based biological, behavioural and social data Modelling

Source: Rights-based monitoring and evaluation of national HIV responses. Geneva: Joint United Nations Programme on HIV/AIDS; 2019 (https://www.unaids.org/en/resources/documents/2019/rights-based-monitoring-evaluation-national-HIV-responses).

DEVELOPING AN M&E PLAN

Successful M&E requires the development of an M&E plan through a participatory process. Box 2 highlights the benefits and key components of M&E planning.

Box 2.

M&E PLANNING: BENEFITS AND COMPONENTS

M&E planning helps to (8, 10, 11):

- Ensure sufficient resources allocated to M&E activities (time, money, personnel) are built into the programme or project budget.
- Meet the ultimate purpose of M&E—to inform decision-making processes and improve programme performance.
- Educate programme managers about the value of M&E, such as increasing the efficiency and effectiveness of resource use throughout the life of the programme or intervention.
- Generate strong empirical proof about the demonstrable effects on the desired goals.

An M&E plan typically should include:

- Underlying assumptions regarding context, activities and goals.
- Anticipated relationships between activities, targets and outcomes.
- Well-defined indicators with information on how they will be measured and calculated. See the UNAIDS Indicator Registry for more information.
- Partnerships and collaborations required to achieve results and build ownership and buy-in of the development of national M&E plans.
- Specific attention to periodic evaluation and use of performance indicators, with resources allocated at least mid-term and at the end of the project.
- Detailed M&E workplan and budget.

For additional information on developing an M&E plan, see the UNAIDS documents Monitoring and Evaluation Modules (10) and Guidance on Capacity Building for HIV Monitoring and Evaluation (11).

GUIDANCE STRUCTURE

This guidance document is organized by the six settings of the Global Partnership (2):

Community—this encompasses people, households and institutions (e.g. workplaces, schools, health facilities) within a shared geographical area. Communities are common sources and facilitators of social norms and practices, including stigma and discrimination. For the Global Partnership, institutions are considered separately under the workplace, education and health-care settings.

Workplace—this comprises all settings in which people work, including formal and informal economies. Policies and norms within the workplace influence stigma and discrimination experienced by workers.

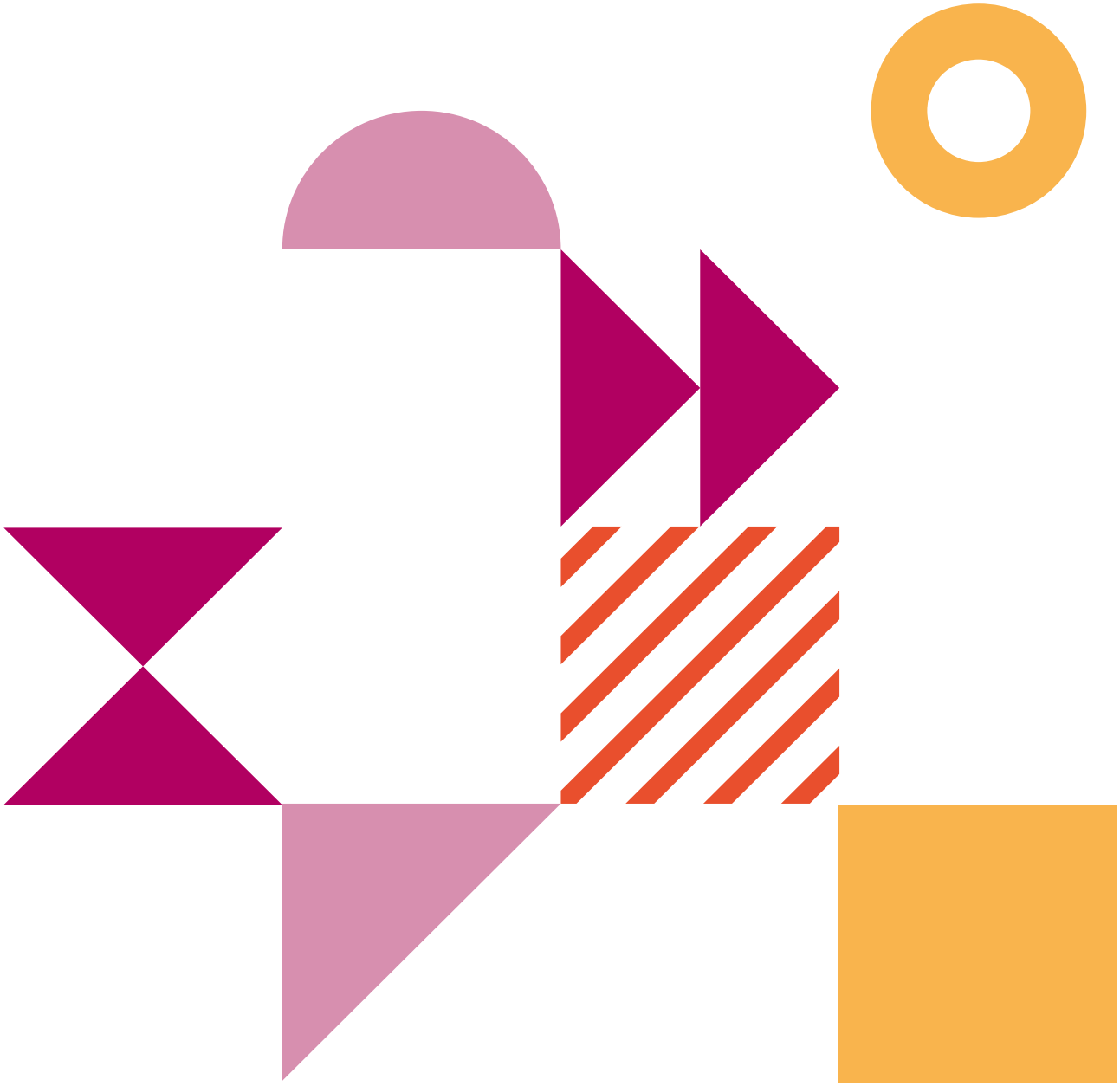
Education—stigma and discrimination can be influenced by factors such as school policies, teachers' attitudes, and the comprehensiveness of the sexuality education curriculum.

Health-care—this can be a source of stigma and discrimination through practices that obstruct access to appropriate health-care, including delays in treatment, differential care, conditional care, neglect and refusal of service.

Justice—stigma and discrimination can manifest as discriminatory laws, policies and practices regarding HIV, harassment and mistreatment on the part of law-enforcement agents, and wrongful arrest or imprisonment of people living with HIV and people from key populations.

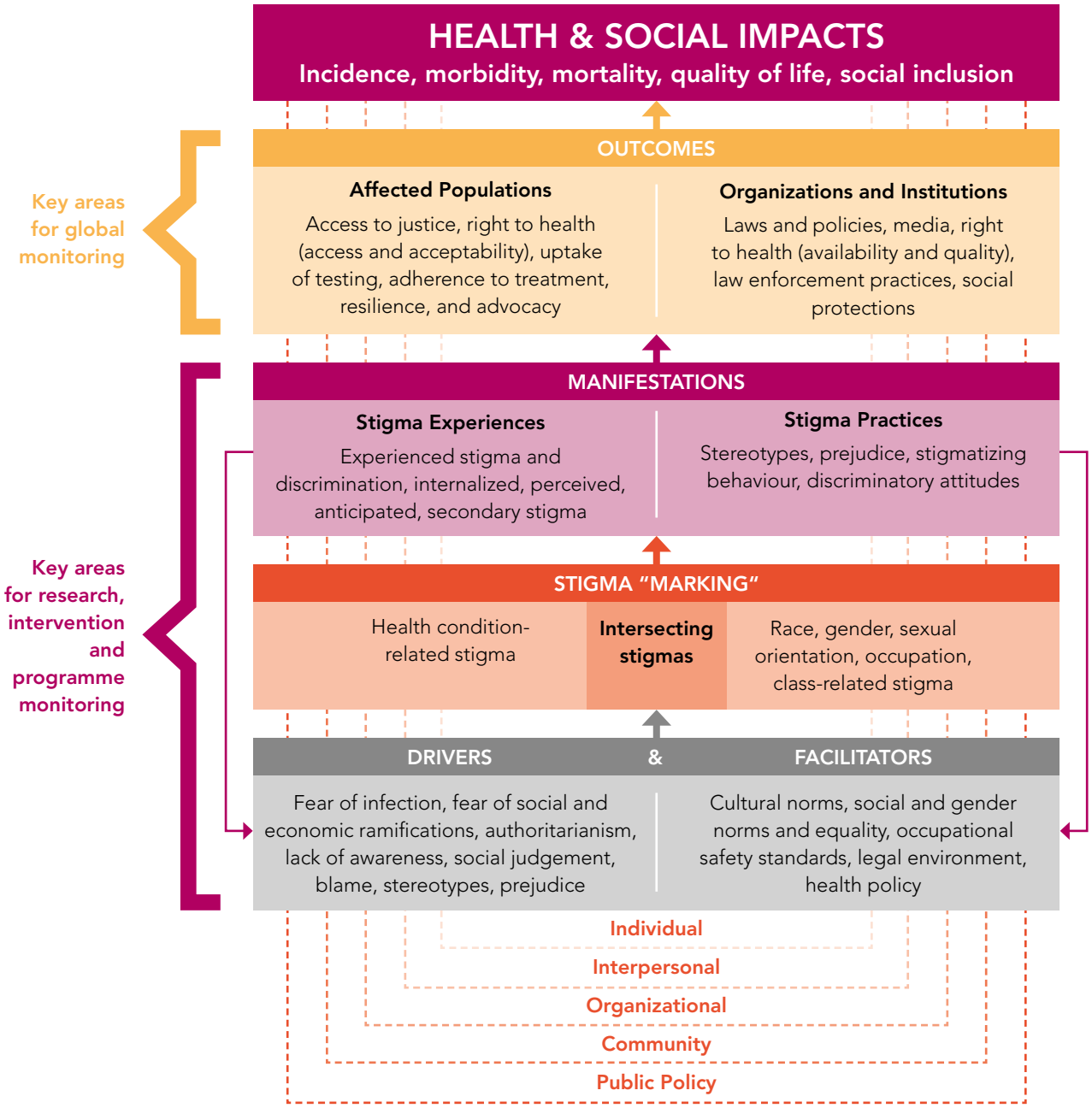
Emergency—stigma and discrimination can exacerbate the challenges already experienced by people living with HIV and people from key populations in the wake of conflicts and crises.

Like the 2020 evidence guidance, the M&E guidance recommends using the Health Stigma and Discrimination Framework (2, 12) to guide decision-making about developing an appropriate M&E plan for the mix of programmes being implemented in each country to reduce HIV-related stigma and discrimination (Figure 3). For a full explanation of how the stigmatization process works in the context of HIV and health more broadly, see the 2020 companion guidance document (2). The Health Stigma and Discrimination Framework can be used together with the seven human rights programmes[2] to guide the development of interventions and M&E plans.



2 The seven human rights programmes for reducing stigma and discrimination are; increasing access to HIV-related legal services; monitoring and reforming laws, policies and regulations; enhancing legal literacy; sensitizing lawmakers and law-enforcement agents; training health-care providers on human rights and medical ethics related to HIV; and reducing discrimination against women in the context of HIV.

Figure 3. Health Stigma and Discrimination[3] Framework



3 Source: Stangl A, Earnshaw V, Logie C, et al. The Health Stigma and Discrimination Framework: a global, cross-cutting framework to inform research, intervention development and policy on health-related stigmas. BMC Med. 2019

M&E BY SETTING

This section provides guidance on monitoring and evaluating stigma and discrimination reduction efforts in each of the six settings of the Global Partnership. It includes a brief overview of how stigma and discrimination manifest in the setting, followed by an example logframe and example indicators for assessing the outputs and outcomes of two of the activities in the logframe. For a more in-depth discussion of HIV-related stigma and discrimination in each setting, see the 2020 companion guidance document on the latest evidence to eliminate HIV and key population stigma and discrimination (2).

LINK BETWEEN EXAMPLE LOGFRAMES AND EXAMPLE INDICATORS

The example logframes included here cover a wide range of activities that could be implemented as part of a national strategy to reduce stigma and discrimination in each setting. The example activities included in each logframe would work in concert to achieve the example outcomes (e.g. improved attitudes and actions of community members and reduced experience of stigma and discrimination among people living with HIV and people from key populations in the community).

These outcomes would in turn influence coverage and uptake of key HIV and sexual and reproductive health and rights services in the medium term and, together with the outcomes of other HIV programmes, lead to reduced HIV incidence and AIDS-related mortality and increased quality of life among people living with HIV and people from key populations in the longer term.

Each activity would need to be monitored for programme improvement purposes. Some would need to be evaluated to see whether activities lead to expected outcomes. A logframe for each activity should be developed and used to inform the M&E efforts of implementing organizations. Programme managers need to decide the most appropriate output and outcome indicators to collect in their context. The example indicator tables provided for each setting link directly to some of the example activities presented in the logframes.

HOW TO USE THIS INFORMATION

Figure 4 depicts the relationships between planning, M&E and reporting. The information provided in this guidance can be used by M&E programme planners at national and organizational levels to inform this cycle.

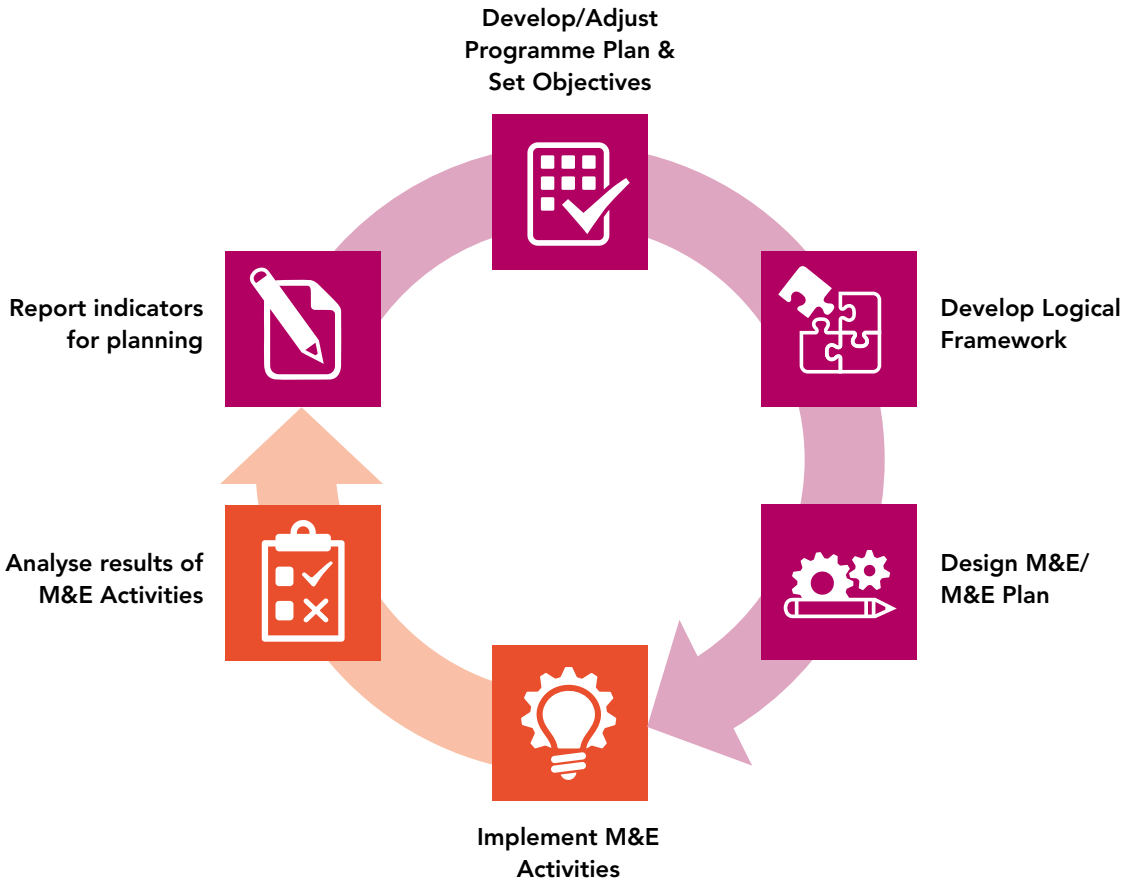
First, using existing data on HIV-related stigma and discrimination (e.g., from the people living with HIV Stigma Index 2.0, community-led monitoring, integrated bio-behavioural surveys, demographic and health survey or other relevant data sources) and the information on how stigma operates from the Health Stigma and Discrimination Framework, M&E specialists and program implementers can develop objectives for reducing or eliminating stigma and discrimination in the settings relevant for them and then select programmes to achieve these objectives. For example, organizations or national governments can use the Health Stigma and Discrimination Framework alongside existing baseline data and inputs from the community of people living with or affected by HIV and people from key populations to decide where to focus their efforts.

IT IS IMPORTANT TO NOTE THAT HIV-RELATED STIGMA OFTEN CO-OCCURS WITH OTHER, INTERSECTING STIGMAS, SUCH AS THOSE RELATED TO SEXUAL ORIENTATION, GENDER, RACE, OCCUPATION, AGE, DISABILITY AND POVERTY. CONSIDERING INTERSECTIONAL STIGMA IS NECESSARY WHEN PLANNING HOW TO ADDRESS HIV-RELATED STIGMA AND DISCRIMINATION, AS STIGMA MANIFESTATIONS AND HEALTH OUTCOMES MAY BE INFLUENCED BY A RANGE OF STIGMATIZING CIRCUMSTANCES THAT MUST BE CONSIDERED TO UNDERSTAND THE FULL IMPACT OF STIGMA. FOR MORE INFORMATION ON INTERSECTIONAL STIGMA AND HOW TO ADDRESS IT, PLEASE SEE THE 2020 UNAIDS EVIDENCE GUIDANCE ON PROGRAMMES TO ELIMINATE HIV-RELATED STIGMA AND DISCRIMINATION.

Second, the information on the key elements of a logframe and the examples provided for each setting can be used to develop a logframe linked with the selected objectives and programmes.

Third, the information on designing an M&E plan, selecting output and outcome indicators, and the example indicators provided can guide the design of the M&E needed to determine whether selected objectives are met, including the development of the M&E plan and to whom indicators should be reported and for what purpose (e.g. programme planners for programme improvement, national government for national and global reporting purposes).

Figure 4. Relationship between planning, M&E and reporting



The example logframes should be used as templates and must be adapted and contextualized for each country. Adaptation includes defining a timeframe for implementation of the strategy (e.g. 24 months); noting when it will be revised or updated to account for progress made (e.g. every 12 months); and quantifying the inputs (e.g. resources such as staff, funds and materials), activities (e.g. number or frequency of training sessions) and resources required.

WHILE WE HAVE PRESENTED HYPOTHETICAL NATIONAL-LEVEL RESPONSES TO HIV-RELATED STIGMA AND DISCRIMINATION IN EACH OF THE SIX SETTINGS OF THE GLOBAL PARTERNSHIP, SUCH LOGFRAMES MAY BE DEVELOPED AT DISTRICT-, PROVINCE- OR STATE-LEVEL, OR FOR SPECIFIC PROGRAMMES OR PROJECTS, AS NEEDED. THE EXAMPLE LOGFRAMES ARE SETTING SPECIFIC TO SHOW THE RANGE OF ACTIVITIES THAT COULD BE CONSIDERED IN EACH SETTING, HOWEVER, RESPONSES SHOULD BE COMPREHENSIVE AND CONSIDER ACTIVITIES ACROSS RELEVANT SETTINGS IN EACH COUNTRY. WE DO NOT RECOMMEND SILOED PROGRAMMING BY SETTINGS. HOWEVER, SETTING-SPECIFIC LOGFRAMES CAN BE USEFUL TO FACILITATE PLANNING AND M&E (SEE THAILAND COUNTRY CASE STUDY).

It is important to determine a baseline value for the outcome indicators selected to understand the full impact of a programme on these outcomes. Programme implementers are encouraged to use existing baseline data where possible, such as from Global Fund baseline assessments conducted as part of the Breaking Down Barriers initiative or recent Demographic and Health Survey data. Where not available, baseline assessments should be conducted before programme implementation begins.

In addition, baseline data on key outcomes can guide programming decisions. For example, if preservice training curricula on HIV-related stigma and discrimination already exist in a country, then resources can be focused on scaling up training based on the curricula and monitoring improvements in knowledge and attitudes among health providers in training. As another example, if anticipated stigma during a health facility visit is high among people who use drugs but low among sex workers in a given country, then resources can be focused accordingly.

The outputs and outcomes listed in the example logframes link directly with the output and outcome indicators used in the example indicator tables for each setting. The indicators selected by a given country must be updated based on the actual activities implemented. Once defined, the output and outcome indicators must be collected (e.g., by community-led organizations, implementing organizations, health facility managers, school administrators or employers) to monitor efforts and inform programme improvement. Some of these indicators will likely be reported to the national government, including for calculation of the global indicators reported to UNAIDS through the Global AIDS Monitoring process.

Note that although the information in this guidance is presented by setting, the intention is not to encourage siloed programming to reduce HIV-related stigma and discrimination by setting. Indeed, the settings may overlap, and programme planners will likely determine that it is necessary to implement programming across settings to achieve a stated goal. For example, if the goal of a programme is to decrease experienced stigma and discrimination among people who inject drugs, the programme would likely need to include programme components with the police in legal settings, people who inject drugs and their family members in community settings, and employers in workplace settings. Programming will also need to take into consideration intersecting discrimination faced by communities.

COMMUNITY SETTING

Shared environments are common sources and facilitators of social norms and practices, including HIV-related stigma and discrimination. The social judgement of household and community members can result in internalized stigma among people living with HIV or anticipated stigma among people who think they may be living with HIV. Such experiences may prompt self-isolation and deter disclosure and engagement with HIV testing, care and treatment services (13–16).

Table 2. Example logframe for national strategy to reduce HIV and key population stigma and discrimination in community settings

Objective: to reduce HIV and key population stigma and discrimination in community settings (i.e. among people and households within a shared geographical area), the government and partners from community-led, faith-based, and nongovernmental organizations will support a variety of interventions and structural changes in communities throughout the country, including educational and awareness events and campaigns, community-led monitoring, and provision of stigma mitigation and resilience-building services. This strategy is expected to reduce internalized, anticipated and experienced stigma and discrimination, and increase coping and resilience, among people living with HIV and people from key and vulnerable populations. In addition, the strategy is expected to reduce harmful community and gender norms that fuel stigma and gender inequalities to accelerate the reduction of stigmatizing attitudes and discriminatory actions of community members towards people living with HIV and people from key and vulnerable populations. Ultimately, this strategy will contribute to reducing HIV incidence among people from key and vulnerable populations, reducing AIDS-related mortality and improving quality of life.

Inputs	
Community engagement in planning and monitoring	Staff Funds Materials Facilities Supplies

Activities	Outputs
Implementers: community-led, faith-based,and nongovernmental organizations, with support from ministry of health Provide mental health services (e.g. in-person, virtual or m-health support groups, individual cognitive behavioural therapy) for people living with HIV and people from key populations Provide support services (e.g. resilience building, job training, nutrition) for people living with HIV and people from key populations	Increased number of mental health services available for people living with HIV and people from key populations in the community Increased number of support services available for people living with HIV and people from key populations in the community Increased number of people living with HIV and people from key populations who access mental health services Increased number of people living with HIV and people from key populations who access support services
Implementers: community-led, faith-based, and nongovernmental organizations with support from ministry of health Provide family support services to raise awareness and knowledge among families of adults and young people living with HIV about how HIV is and is not transmitted and about non-stigmatizing ways to support family members living with HIV (e.g. adherence support strategies, supported disclosure to trusted family members and peers) Implement programmes to strengthen parent and caregiver relationships with adolescents Implementers: community-led organizations Implement community-led monitoring in health facilities to assess availability, accessibility, acceptability and quality of HIV and other health services for people living with HIV and people from key and vulnerable populations	Increased number of family support services available for people living with HIV and their families Increased number of people living with HIV and their families who access family support services Increased knowledge of HIV among family members Increased awareness of stigma and its harmful consequences among family members Increased parent and caregiver caring Increased parent and caregiver support Increased community-led monitoring activities in health facilities Increased advocacy efforts based on data gathered through community-led monitoring
Implementers: community-led and nongovernmental organizations with support from ministry of health Implement stigma and discrimination reduction programmes that use cultural and religious mediums delivered through large public events, combined with advocacy and engagement led by people living with HIV and people from key populations	Increased campaigns to reduce HIV stigma and discrimination about HIV stigma (e.g. poster campaigns, U = U awareness campaigns, contact strategies, community events, dramas) Increased awareness campaigns about stigma related to gender, sexuality and use of drugs (e.g. poster campaigns, contact strategies, TV/ radio shows, community events, dramas) Increased exposure to HIV stigma reduction campaigns among public Increased exposure to stigma reduction campaigns about stigma related to gender, sexuality and use of drugs among public

Outcomes

Experiences of people living with HIV and people from key and vulnerable populations in the community, measured by:

- Reduction in internalized stigma
- Reduction in anticipated stigma
- Reduction in experienced stigma and discrimination
- Increase in acceptability of services received
- Increase in quality of care
- Increase in resilience

Attitudes and actions of community members towards people living with HIV and people from key and vulnerable populations, measured by:

- Reduction in fear of HIV infection from nontransmissible contact
- Reduction in shame and blame of people living with HIV and people from key populations
- Reduction in stigmatizing attitudes towards people living with HIV
- Reduction in inequitable gender norms

Impacts

MEDIUM TERM:

Improved HIV service use (coverage) among people living with HIV and people from key and vulnerable populations, measured by:

- Increase in uptake of prevention services (e.g. PrEP, VMMC, condoms, harm reduction)
- Increase in uptake of care and treatment services (e.g. engagement in care, treatment initiation)
- Increase in treatment adherence and continuation (e.g. antiretroviral therapy and PrEP)

LONG TERM:

HIV incidence among people from key and vulnerable populations

AIDS-related mortality

Quality of life

PrEP, pre-exposure prophylaxis; U = U, undetectable = untransmissible; VMMC, voluntary medical male circumcision.

Table 3 provides examples of the types of indicators that could be used to monitor and evaluate two of the activities included in the logframe in Table 2.

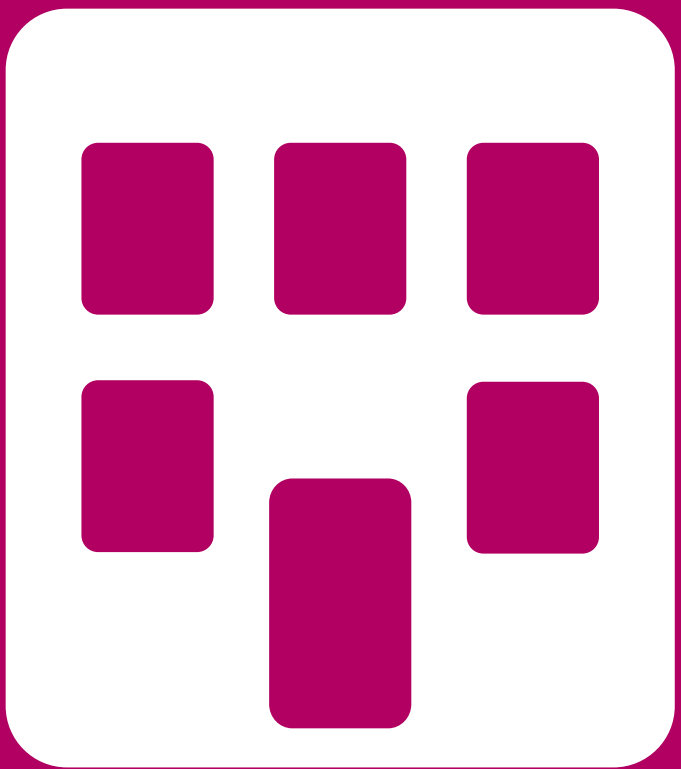
Table 3. Example indicators to monitor and evaluate interpersonal-level activities to reduce HIV stigma among young people living with HIV and their families

Interpersonal-level activity: provide support services to families of young people living with HIV to increase knowledge about how HIV is and is not transmitted; offer non-stigmatizing ways to support family members living with HIV (e.g. adherence support strategies, supported disclosure to trusted family members and peers); and strengthen parent and caregiver relationships with adolescents.

Indicator level	Indicator	Data source
Output	Percentage of HIV service provision organizations (e.g. health facilities, community-led, faith-based and nongovernmental organizations) that provided family support services to people living with HIV and their families in past 12 months	Programme monitoring data
Output	Number of young people living with HIV who received family support services in past 12 months	Programme monitoring data
Outcome	Percentage of family members of young people living with HIV who fear HIV is transmissible through contact with saliva of person living with HIV	Programme evaluation data
Outcome	Percentage of young people living with HIV who report internalized stigma	Programme evaluation data
Outcome	Percentage of young people living with HIV who report strong caregiver support	Programme evaluation data
Coverage (medium-term impact)	Percentage of young people living with HIV taking antiretroviral therapy who are virally suppressed	Programme monitoring data

Community-level activity: implement stigma and discrimination reduction programmes that use cultural and religious mediums delivered through large public events, combined with advocacy and engagement led by people living with HIV and people from key populations.

Indicator level	Indicator	Data source
Output	Number of stigma and discrimination reduction campaigns implemented in community in past 12 months (e.g. poster campaigns, U = U awareness campaigns, contact strategies, community events, dramas) Campaigns could address stigma related to one or more of HIV, sexuality, gender identity, race and use of drugs	Programme monitoring data
Output	Percentage of people exposed to at least one stigma and discrimination reduction campaign in past 12 months	Programme monitoring data
Outcome	Percentage of people living with HIV and people from key and vulnerable populations who reported resilience (i.e. ability to bounce back from stressful events) in past 12 months	Programme evaluation data
Outcome	Percentage of people living with HIV who experienced stigma and discrimination in community settings in past 12 months	Programme evaluation data
Coverage (medium-term impact)	Number of people living with HIV and people from key populations reached with HIV prevention, care and treatment services in past 12 months	Programme monitoring data



WORKPLACE SETTING

Workplace stigma and discrimination include refusing to hire a person living with HIV, harassment, bullying, forced HIV testing or disclosure, denial of work opportunities or promotion, pressure to resign, and wrongful termination of employment (17–19). Barriers to access to the workplace and experience of stigma in the workplace have immeasurable implications for the livelihood and well-being of people living with or thought to be living with HIV, their families and their communities. HIV and key population stigma and discrimination in formal workplace settings may negatively affect the health of employees living with HIV through discouraging testing, linkages with care, treatment adherence and routine health-care visits (17–25).

Table 4. Example logframe for national strategy to reduce HIV and key population stigma and discrimination in workplace settings

Objective: to reduce HIV and key population stigma and discrimination in workplace settings, the ministries of health and labour and community-led and nongovernmental organizations will support a variety of interventions and policy changes at the workplace level throughout the country, including the revision or implementation of workplace policies to reduce HIV stigma and discrimination, apprising workers of their rights, and educating the extended workplace community (e.g. families and communities of workers) on HIV. This strategy is expected to:

1) reduce the experience and anticipation of stigma and discrimination among people living with HIV and people from key and vulnerable populations within the workplace,

2) reduce the stigmatizing attitudes and discriminatory actions among workers towards people living with HIV and people from key and vulnerable populations, and

3) increase awareness of rights as an opportunity for redressal among people living with HIV and people from key populations in the workplace.

Ultimately, this strategy will contribute to reducing HIV incidence among people from key and vulnerable populations, reducing AIDS-related mortality and improving quality of life.

Inputs	
Community engagement in planning and monitoring	Staff Funds Materials Facilities Supplies

Activities	Outputs
Implementers: workplaces throughout country in partnership with ministries of health and labour and community-led and nongovernmental organizations Implement HIV workplace policies and practices based on principles of non-discrimination, gender equality, healthy work environment, social dialogue, non-screening for purpose of employment, confidentiality, continuing employment relationship, prevention, care and support	Increased number of policies that include principles of non-discrimination, gender equality, healthy work environment, social dialogue, non-screening for purpose of employment, confidentiality, continuing employment relationship, prevention, care and support
Implementers: workplaces throughout country in partnership with ministries of health and labour and community-led and nongovernmental organizations Implement programmes to make workers aware of opportunities to claim their rights	Increased knowledge of workers' rights among employees
Implementers: workplaces throughout country in partnership with ministries of health and labour and community-led and nongovernmental organizations Implement programmes to disseminate information on existing HIV workplace policies and provisions to all staff members so they understand their rights and ways to address any policy violations	Increased number of mechanisms or events (e.g. peer educators, training) implemented to disseminate information regarding HIV workplace policies Increased knowledge of HIV workplace policies among employees
Implementers: workplaces throughout country in partnership with ministries of health and labour and community-led and nongovernmental organizations Provide education, training and outreach to workers, their families and members of surrounding communities with accurate, up-to-date, relevant, evidence-informed information on HIV, comorbidities and legal literacy	Increased number of education, training and outreach events on HIV Increased knowledge of HIV among workers, their families and members of surrounding communities Increased knowledge of HIV comorbidities among workers, their families and members of surrounding communities Increased legal literacy among workers, their families and members of surrounding communities

Outcomes

Experiences of people living with HIV and people from key and vulnerable populations in workplace, measured by:

- Reduction in internalized stigma
- Reduction in anticipated stigma
- Reduction in experienced stigma and discrimination
- Increase in acceptability of services received
- Increase in quality of care

Attitudes and actions of employees towards people living with HIV and people from key and vulnerable populations, measured by:

- Reduction in fear of HIV infection from nontransmissible contacts
- Reduction in shame and blame of people living with HIV and people from key populations
- Reduction in stigmatizing attitudes towards people living with HIV
- Reduction in inequitable gender norms (e.g. acceptance of partner violence in some circumstances, harmful views towards men or women based on societal messages or norms)

Impacts

MEDIUM TERM:

Improved HIV service use (coverage) among people living with HIV and people from key and vulnerable populations, measured by:

- Increase in uptake of prevention services (e.g. PrEP, VMMC, condoms, harm reduction)
- Increase in uptake of care and treatment services (e.g. engagement in care, treatment initiation)
- Increase in treatment adherence and continuation (e.g. antiretroviral therapy, PrEP)

LONG TERM:

HIV incidence among people from key populations

AIDS-related mortality

Quality of life

Table 5 provides examples of the types of indicators that could be used to monitor and evaluate two of the activities included in the logframe in Table 4.

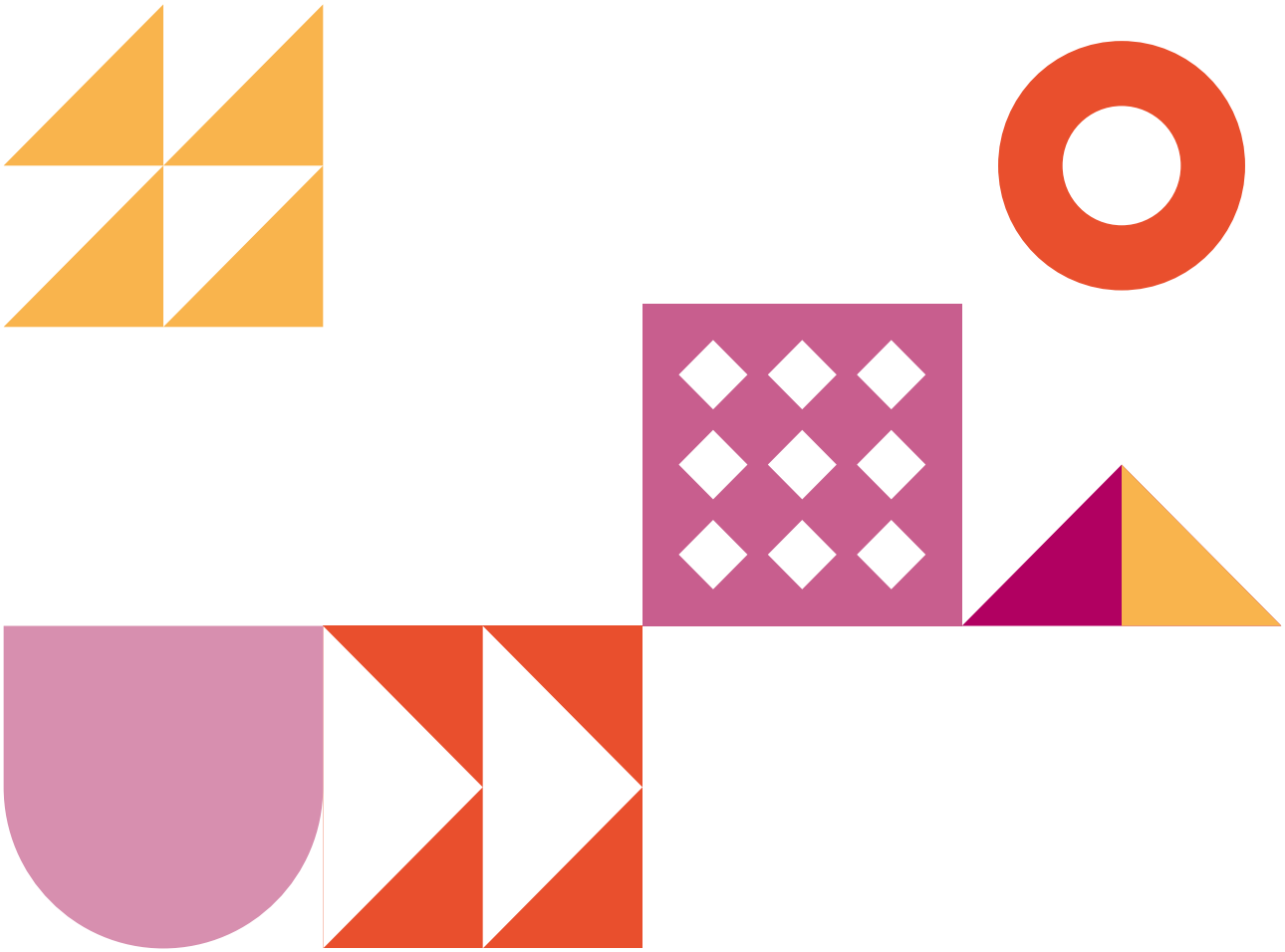
Table 5. Example indicators to monitor and evaluate organizational-level activities to reduce HIV stigma among employees and employers towards co-workers living with HIV

Organizational-level activity: implement HIV workplace policies (e.g. nondiscrimination policies, confidential discrimination reporting mechanisms) and practices (e.g. health fairs with HIV testing services available, sensitization workshops) based on the principles of nondiscrimination, gender equality, healthy work environment, social dialogue, non-screening for the purpose of employment, confidentiality, continuing employment relationship, prevention, care and support.

Indicator level	Indicator	Data source
Output	Number of sensitization workshops held with employees to review HIV workplace policies and practices in past 12 months	Programme monitoring data
Output	Number of employees who attended sensitization workshops to review HIV workplace policies and practices in past 12 months	Programme monitoring data
Output	Percentage of employees who report their facility has written guidelines to protect workers living with HIV from discrimination	Programme evaluation data: organizational-level staff survey
Outcome	Percentage of employees who have observed unjust treatment of co-workers living with HIV in their workplace	Programme evaluation data: organizational-level staff survey
Outcome	Percentage of employees who would be ashamed if someone in their family was: ▪ living with HIV ▪ a man who has sex with men ▪ a sex worker ▪ a young woman who got pregnant before marriage ▪ a person who injects drugs	Programme evaluation data: organizational-level staff survey
Coverage (medium-term impact)	Number of employees reached with HIV testing services in past 12 months	Programme monitoring data

Organizational- and community-level activity: provide education, training and outreach to workers, their families and members of surrounding communities with accurate, up-to-date, relevant, evidence-informed information on HIV, comorbidities and legal literacy.

Indicator level	Indicator	Data source
Output	Number of education, training and outreach events on HIV held in past 12 months	Programme monitoring data
Outcome	Percentage of workers, family members and community members with accurate knowledge of HIV	Programme evaluation data
Outcome	Percentage of workers, family members and community members who are aware of their rights to health-care under the law	Programme evaluation data
Outcome	Percentage of workers, family members and community members who are aware of their legal rights if discriminated against	Programme evaluation data



EDUCATION SETTING

In education settings, HIV-related stigma and discrimination are influenced by factors including school policies, teachers' attitudes, and the comprehensiveness of the sexuality education curriculum. Students and educators living with HIV may anticipate or experience HIV stigma and discrimination in schools, including bullying and violence; neglect, avoidance and isolation; breaches in confidentiality; and denial of enrolment of students or loss of employment for educators (26–31).

These manifestations of stigma and discrimination can have serious repercussions on the health and well-being of students and educators living with HIV, including on their mental health, treatment adherence, and academic and professional success.

Table 6. Example logframe for national strategy to reduce HIV and key population stigma and discrimination in the education setting

Objective: to reduce HIV and key population stigma and discrimination in education settings, the education sector, together with the ministries of health and education, youth-led organizations and community-led organizations, will support a variety of interventions and policy changes at the education level throughout the country, including the implementation of school-based policies and programmes to reduce HIV stigma and discrimination and engaging the extended school community (e.g. families and communities of students and educators) on HIV. This strategy is expected to reduce the experience and anticipation of stigma and discrimination, and internalized stigma, among young people and educators living with HIV and young members of key populations within education settings. The strategy is also expected to reduce stigmatizing attitudes and discriminatory action among young people, educators, staff and the extended school community towards people living with HIV and people from key populations. Ultimately, this strategy will contribute to reducing HIV incidence among people from key and vulnerable populations, reducing AIDS-related mortality and improving quality of life.

Inputs	
Community engagement in planning and monitoring	Staff Funds Materials Facilities Supplies

Activities	Outputs
Implementers: community-led organizations and youth-led organizations in partnership with ministries of health and education Implement support programmes (e.g. peer mentor programmes, support groups, adherence clubs) outside school settings for young people and educators living with HIV (e.g. at community or youth centres) to provide skills and confidence necessary to manage living with HIV and reduce internalized stigma Advertise external support programmes widely in schools and community	Increased number of support programmes available to young people living with HIV outside school settings Increased number of support programmes for educators living with HIV outside school settings Increased awareness of available support services outside school settings among young people and educators living with HIV Increased use of support programmes among young people and educators living with HIV
Implementers: community-led organizations and health-care facilities in partnership with ministry of health Provide adolescents with access to youth-friendly HIV and sexual and reproductive health and rights services that ensure confidentiality and an environment free from stigma and discrimination	Increased number of youth-friendly HIV services available Increased use of youth-friendly HIV services
Implementers: ministries of education and health in partnership with community-led and youth-led organizations Implement pre-service and in-service teacher training to enable educators to deliver comprehensive sexuality education, including training educators to be confident and empowered in their communication with young people about HIV testing, treatment, care and prevention; the rights of people living with HIV; and preventing all forms of violence, bullying, stigma and discrimination based on HIV or health status, gender or conformity to gender norms	Increased number of teachers trained to provide comprehensive sexuality education in schools Increased number of schools providing comprehensive sexuality education to students in past 12 months
Implementers: school administrators with support from ministries of education and health Develop and implement policies to promote inclusion of learners in all their diversity, including young people living with HIV, and to prevent and address all forms of violence, bullying, stigma and discrimination Remove any policies or practices that require sharing information about HIV status for access to education, and establish a robust confidentiality policy and secure systems to protect young people's private health information	Updated existing policies Establishes safe reporting mechanisms for instances of stigma, discrimination, bullying and violence Increased awareness of nondiscriminatory policies and safe reporting mechanisms among educators and staff

Activities	Outputs
Implementers: community-led and youth-led organizations in partnership with local schools Engage parents and broader community (e.g. community meetings, contact strategies, sensitization through cultural mediums) to increase understanding of importance of comprehensive sexuality education and sexual health services for young people	Increased number of events to reach parents with information about importance of comprehensive sexuality education and sexual health services for young people Increased number of parents and community members who support comprehensive sexuality education in schools
Implementers: youth-led organizations Develop and implement innovative communications strategies (e.g. using social media platforms popular with youth, social or sports events) to reach young people with current and detailed information about HIV and encourage HIV testing, prevention and entry into care for young people living with HIV using a sex-positive approach to provide comprehensive sexuality education	Increased youth-led communication strategies to reach young people with information about HIV and sexualit

Outcomes
Experiences of people living with HIV and people from key and vulnerable populations, measured by: ■ Reduction in internalized stigma ■ Reduction in anticipated stigma ■ Reduction in experienced stigma and discrimination ■ Increase in resilience ■ Increase in hope for the future ■ Increase in support networks Attitudes and actions of students, faculty and staff towards people living with HIV and people from key and vulnerable populations, measured by: ■ Reduction in fear of HIV infection from nontransmissible contact ■ Reduction in shame and blame of people living with HIV and people from key populations ■ Reduction in stigmatizing attitudes towards people living with HIV ■ Reduction in inequitable gender norms

Impacts

MEDIUM TERM

Improved HIV service use among young people living with HIV, young members of key populations, and educators living with HIV, measured by:

- Increase in uptake of prevention services (e.g. PrEP, condoms, screening for sexually transmitted infections and cervical cancer, engagement in sexual and reproductive health and rights services)
- Increase in uptake of care and treatment services (e.g. engagement in care, treatment initiation)
- Increase in treatment adherence and continuation (e.g. antiretroviral therapy, PrEP)

LONG TERM

- Reduction in HIV incidence among people from key populations
- Reduction in AIDS-related mortality
- Increase in quality of life

PrEP, pre-exposure prophylaxis.

Table 7 provides examples of the types of indicators that could be used to monitor and evaluate two of the activities included in the logframe in Table 6.

Table 7. Example indicators to monitor and evaluate individual- and public policy-level activities to reduce HIV and key population stigma experienced by young people living with HIV in educational settings

Individual-level activity: implement gender-responsive support services (e.g. in-person support groups, virtual peer mentor programmes, one-to-one counselling sessions) outside school settings for young people living with HIV (e.g. at community or youth centres) to provide skills and confidence necessary to manage living with HIV, reduce internalized stigma and build resilience.

Indicator level	Indicator	Data source
Output	Number of schools that have established linkages with external support services for young people living with HIV	Programme monitoring data
Output	Number of schools advertising available external support services for young people living with HIV	Programme monitoring data
Outcome	Percentage of young people living with HIV who reported internalized stigma in past 12 months	Programme evaluation data
Outcome	Percentage of young people living with HIV who report resilience in the past 12 months	Programme evaluation & monitoring data,
Outcome	Percentage of young people living with HIV who reported the external support services they received met their needs	Community-led monitoring, program monitoring data

Policy-level activity: adapt, adopt or implement laws to ensure adolescents have legal access to HIV testing, treatment and care services, and screening for sexually transmitted infections, which exacerbate HIV risk, by removing age restrictions and punitive laws.

Indicator level	Indicator	Data source
Output	Existence of law to ensure adolescents have legal access to HIV testing and services by removing age restrictions	Programme monitoring data
Coverage (medium-term impacts)	Number of young people reached with HIV prevention, care and treatment services in past 12 months	Programme monitoring data

HEALTH-CARE SETTING

HIV and key population stigma and discrimination in health-care settings can negatively impact the health, well-being and quality of life of people living with HIV and people from key and vulnerable populations and hamper efforts to halt HIV transmission (32–34). Anticipation of experiencing discrimination or low-quality care, use of judgemental language and breaches of confidentiality can inhibit engagement in HIV prevention, testing and treatment. They may also prompt breaks in care or poor treatment adherence, increasing the likelihood of resistance to medicines and making it harder to manage the epidemic (35, 36).

Table 9. Example logframe for national strategy to reduce HIV and key population stigma and discrimination in health-care settings

Objective: to reduce HIV and key population stigma and discrimination in health-care settings, the government and partners will support a variety of interventions and structural changes at district, regional and national health facilities throughout the country, will enhance the pre-service instruction received by health-care professionals in training, and will support training of community members to implement routine community-led monitoring in all health facilities. This strategy is expected to improve the quality of care at all health facilities and reduce the experience and anticipation of stigma and discrimination among people living with HIV and people from key populations seeking care at health facilities. Ultimately, this strategy will contribute to increasing use of HIV prevention, care and treatment services, which will in turn lead to reductions in HIV incidence and AIDS-related mortality and improve quality of life.

Inputs	
Community engagement in planning and monitoring	Staff Funds Materials Facilities Supplies

Activities	Outputs
Implementers: ministries of health and education, universities, training institutions Integrate HIV sensitization, reduction of stigma and discrimination, and human rights approaches into curricula of health provider training schools (e.g. medical and nursing schools)	New or updated curricula developed for nursing and medical schools Increased implementation of training on HIV sensitization, reduction of stigma and discrimination, and human rights approaches in health provider training schools (e.g. universities, colleges)
Implementers: universities, training institutions Provide preservice training sessions on HIV, human rights, key populations, stigma reduction, non-discrimination, gender sensitization and medical ethics for health professionals in training	Increased number of nursing and medical students trained on medical ethics, gender equality, and legal and human rights of people living with HIV and people from key populations, and on reducing stigma, discrimination, and violence, in past 12 months Increased knowledge of gender equality and the impact of violence on HIV and health outcomes among health professionals in training
Implementers: administrators of district, regional and national health facilities in partnership with ministry of health Provide routine in-service training sessions at all district, regional and national health facilities on HIV, human rights, key populations, stigma reduction, non-discrimination, gender sensitization and medical ethics for all health facility staff, including non-health-care staff such as receptionists and data clerks	Increased number of health facility staff trained on medical ethics, gender equality, and legal and human rights of people living with HIV and people from key populations, and on reducing stigma, discrimination, and violence in past 12 months Increased knowledge of gender equality and the impact of violence on HIV and health outcomes among health professionals in training
Implementers: administrators of district, regional and national health facilities in partnership with ministry of health Review and update health facility policies to ensure non-discrimination	New or updated policies on non-discrimination developed Awareness of new or updated policies among health facility staff
Implementers: administrators of district, regional and national health facilities in partnership with ministry of health and community-led organizations Provide paralegal services on site to increase awareness of rights among people living with HIV and people from key populations and support people who have been discriminated against to seek redress	Increased number of health facilities with onsite paralegal services for people living with HIV and people from key populations
Implementers: administrators of district, regional and national health facilities in partnership with ministry of health Ensure universal precaution supplies and post-exposure prophylaxis are always stocked	Reduced supply stockouts (e.g. gloves, gowns, masks) Increased number of sharps kit available Decreased number of needle-stick injuries Increased adherence to medical waste removal practices

Activities	Outputs
Implementers: ministry of health in partnership with community-led organizations Train community members to conduct routine monitoring of accessibility and quality of health services Support community-led monitoring of services in all health facilities	Increased number of community members trained in community-led monitoring Increased number of health facilities where services are monitored routinely by community (e.g. annually, biannually) Increased number of meetings held to discuss community-led monitoring reports with health facility staff and administrators Increased number of joint and separate actions planned in response to community-led monitoring data
Implementers: administrators of local, regional and national health facilities in partnership with ministry of health Implement routine data collection with clients to assess satisfaction with health services provided in all health facilities (e.g. e-surveys, focus group discussions, anonymous paper surveys) Share regular client satisfaction reports among personnel and define (and document) actions to improve services at each facility Engage with community representatives to share client feedback and compare experiences Discuss joint and separate actions to improve experience at each facility	Increased number of meetings held to discuss client satisfaction data with health facility staff and administrators Increased number of actions planned by health facility administrators to improve services in response to client satisfaction data Increased number of joint actions planned with community-led organizations in response to client satisfaction data

Outcomes
Attitudes and actions of health-care providers, measured by: ■ Reductions in negative attitudes towards people living with HIV and people from key populations ■ Reduction in fear and worry of HIV transmission in occupational situations with no risk of transmission ■ Reduction in stigmatizing actions towards people living with HIV or people from key populations (e.g. double gloving, extended waiting times, verbal abuse, scolding) ■ Reduction in preference not to treat people living with HIV and people from key populations Experiences of people living with HIV and people from key and vulnerable populations seeking care at health facilities, measured by: ■ Reduction in experience of stigma and discrimination at health facilities ■ Reduction in anticipated stigma related to seeking health services ■ Increase in acceptability of services received ■ Increase in quality of care ■ Increase in resilience

Impacts

MEDIUM TERM

Improved HIV service use among people living with HIV and key and people from vulnerable populations, measured by:

- Increase in uptake of prevention services (e.g. PrEP, VMMC, condoms, harm reduction)
- Increase in uptake of care and treatment services (e.g. engagement in care, treatment initiation)
- Increase in treatment adherence and continuation (e.g. antiretroviral therapy, PrEP)

LONG TERM

- Reduction in HIV incidence among people from key and vulnerable populations
- Reduction in AIDS-related mortality
- Increase in quality of life

PrEP, pre-exposure prophylaxis; VMMC, voluntary medical male circumcision.

Table 10 provides examples of the types of indicators that could be used to monitor and evaluate two of the activities included in the logframe in Table 9.

Table 10. Example indicators to monitor and evaluate organizational-level activities to reduce HIV and key population stigma and discrimination in health-care settings

Organizational-level activity: implement in-service training on HIV sensitization, reduction of stigma and discrimination, gender-equitable norms and human rights approaches with all staff in health facilities.

Indicator level	Indicator	Data source
Output	Percentage of health facility staff trained in HIV sensitization, reduction of stigma and discrimination, gender-equitable norms and human rights approaches	Programme monitoring data
Outcome	Percentage of health facility staff who worry about being infected with HIV when providing care or services to people living with HIV	Programme evaluation data
Outcome	Percentage of health facility staff who use unnecessary precautions when providing care or services to people living with HIV	Programme evaluation data
Outcome	Percentage of people living with HIV who report experiences of HIV-related discrimination in health-care settings	Community-led monitoring, program evaluation data
Coverage (medium-term impact)	Number of people living with HIV and people from key populations reached with HIV prevention, care and treatment services in past 12 months	Programme monitoring data

Organizational-level activity: train community members to conduct routine monitoring of the accessibility and quality of health services and support community-led monitoring of services in all health facilities.

Indicator level	Indicator	Data source
Output	Percentage of community-led organizations working on HIV or key population issues trained in community-led monitoring	Programme monitoring data
Output	Percentage of health facilities where quality of HIV services was assessed through community-led monitoring in past 12 months	Programme monitoring data
Output	Number of meetings held to discuss monitoring reports in quality of HIV services with community representatives in past 12 months	Programme monitoring data
Output	Number of joint actions planned in response to community monitoring data in past 12 months	Programme monitoring data
Outcome	Percentage of people living with HIV who reported the HIV services they received in the past year were of good quality	Community-led monitoring Programme evaluation data

JUSTICE SETTING

People living with HIV and people from key populations often face several challenges in accessing justice due to HIV and key population stigma and discrimination. This can manifest as discriminatory laws, policies and practices regarding HIV, harassment and mistreatment on the part of law-enforcement agents, and wrongful arrest and imprisonment of people living with HIV and people from key populations (37–41). Such discriminatory practices are not only harmful but also an infringement of human rights, a tacit validation of HIV and key population stigma and discrimination in other spheres, and counterproductive to efforts to reduce HIV incidence (42).

Table 11. Example logframe for a national strategy to reduce HIV and key population stigma and discrimination in justice settings

Objective: to reduce HIV and key population stigma and discrimination in justice settings, the government, in partnership with community-led and nongovernmental organizations throughout the country, will support a variety of interventions and policy changes at the legal level, including the revision or implementation of laws and policies to reduce HIV stigma and discrimination, ensuring access to redress mechanisms, apprising individuals of their rights, and training duty bearers on HIV and harm reduction. This strategy is expected to reduce the experience of stigma and discrimination during engagement with law enforcement, the justice system and human rights institutions among people living with HIV and people from key and vulnerable populations; reduce stigmatizing attitudes and discriminatory actions of duty bearers and the broader community towards people living with HIV and people from key and vulnerable populations; and create an enabling legal environment (i.e. development of more positive laws and policies) and expand access to justice (i.e. access to remedies or redress including through courts). Ultimately, this strategy will contribute to increasing access and use of HIV services and reducing HIV incidence among people from key and vulnerable populations, reducing AIDS-related mortality and improving quality of life.

Inputs	
Community engagement in planning and monitoring	Staff Funds Materials Facilities Supplies

Activities	Outputs
Implementers: community-led and nongovernmental organizations with support from ministries of health and justice Implement legal literacy programmes, such as awareness-raising campaigns that provide information about rights and laws related to HIV through media (e.g. TV, radio, print, internet), community mobilization and education, peer outreach and telephone hotlines among people living with HIV and people from key populations	Increased number of legal literacy programmes available for people living with HIV and people from key populations Increased number of people living with HIV and people from key populations who access legal literacy programmes
Implementers: ministries of justice, labour and health, with community-led and nongovernmental organizations Implement formal (e.g. mitigation services, access to court, including legal aid, availability of government reporting mechanisms) and informal reporting and redress mechanisms (e.g. community-led mediation services, anonymous reporting hotlines) for people living with HIV and people from key populations	Increased number of formal redress mechanisms available for people living with HIV and people from key populations Increased number of informal redress mechanisms available for people living with HIV and people from key populations Increased cases of redress sought following discrimination through formal and informal mechanisms
Implementers: community-led and nongovernmental organizations with support from ministries of health and justice Implement affordable legal support services (e.g. paralegals integrated into health facilities, community paralegals, pro bono legal services) for people living with HIV and people from key populations	Increased number of legal support services available for people living with HIV and people from key populations Increased number of people living with HIV and people from key populations who use legal support services
Implementers: community-led and nongovernmental organizations with support from ministries of health and justice Implement activities to sensitize law enforcement agencies and agents on harm reduction related to HIV prevention, laws protecting people living with HIV and people from key and vulnerable populations from discrimination, and harms associated with stigma and discrimination	Increased number of sensitization activities implemented with law enforcement Increased awareness among law enforcement agents of laws protecting people living with HIV and people from key and vulnerable populations against discrimination
Implementers: community-led organizations Advocate for removal of laws that criminalize use or possession of drugs for personal use, all aspects of sex work, sexual orientation, gender identity, and HIV exposure, nondisclosure and transmission	Increased advocacy efforts pushing for removal of laws that criminalize use or possession of drugs for personal use, all aspects of sex work, sexual orientation, gender identity, and HIV exposure, nondisclosure and transmission

Activities	Outputs
Implementers: parliamentarians Remove laws that criminalize use or possession of drugs for personal use, all aspects of sex work, sexual orientation, gender identity, and HIV exposure, nondisclosure and transmission	Increased efforts to remove or amend harmful laws or introduce protective laws by government (e.g. parliament, congress)
Implementers: nongovernmental organizations Bring forward strategic litigation cases to expand jurisprudence around discrimination related to HIV status, sexual orientation and gender identity	Increased number of strategic litigation cases pursued Increased number of strategic litigation cases decided
Implementers: parliamentarians Adapt, adopt or implement laws to ensure adolescents have legal access to HIV testing, treatment and care services, and screening for sexually transmitted infections, which exacerbate HIV risk, by removing age restrictions and punitive laws	Increased access to HIV testing and prevention services without parental consent for students below the age of majority

Outcomes

Experiences of people living with HIV and people from key and vulnerable populations with legal and law enforcement systems, measured by:

- Reduction in experiences of mistreatment (mental or physical) of people from key populations by law enforcement
- Increase in remedies received following discrimination
- Increase in knowledge of rights and laws related to HIV

Attitudes and actions of duty bearers in justice settings towards people living with HIV and people from key populations, measured by:

- Reduction in fear of HIV infection from nontransmissible contact
- Reduction in shame and blame of people living with HIV and people from key populations
- Reduction in stigmatizing attitudes towards people living with HIV and people from key populations
- Reduction in inequitable gender norms (e.g. acceptance of partner violence in some circumstances, harmful views towards men or women based on societal messages or norms)
- Enabling societal environment, measured by:
- Removal of laws that criminalize use or possession of drugs for personal use, all aspects of sex work, sexual orientation, gender identity, and HIV exposure, nondisclosure and transmission
- Development or passage of supportive laws and policies that prevent discrimination of people from key populations and ensure access to good-quality health-care services
- Reduction in negative attitudes towards people from key populations among law enforcement officers

Impacts

MEDIUM TERM

Improved HIV service use (coverage) among people living with HIV and people from key and vulnerable populations, measured by:

- Increase in uptake of prevention services (e.g. PrEP, VMMC, condoms, harm reduction)
- Increase in uptake of care and treatment services (e.g. engagement in care, treatment initiation)
- Increase in treatment adherence and continuation (e.g. antiretroviral therapy, PrEP)

LONG TERM

HIV incidence among people from key and vulnerable populations

AIDS-related mortality

Quality of life

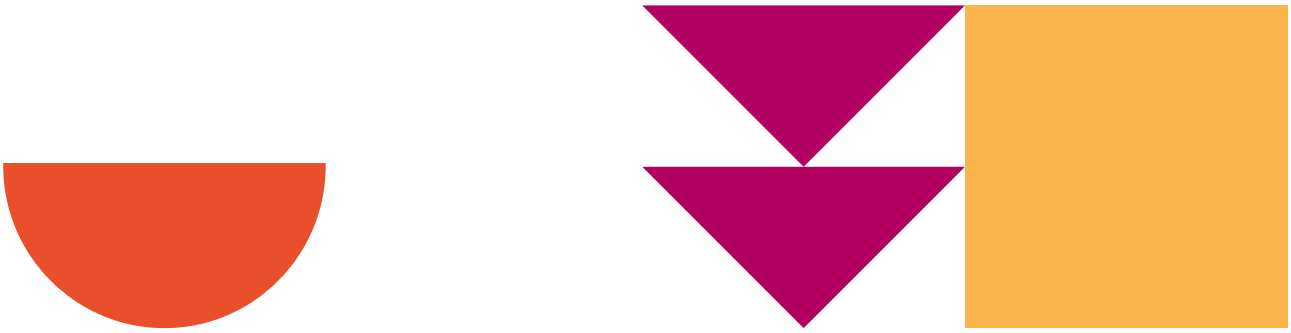


Table 12 provides examples of the types of indicators that could be used to monitor and evaluate two of the activities included in the logframe in Table 11.

Table 12. Example indicators to monitor and evaluate public policy and community-level activities to reduce HIV and key population stigma and discrimination in justice settings

Public policy and community-level activities: implement formal (e.g. mitigation services, access to court including legal aid, availability of government reporting mechanisms) and informal reporting and redress mechanisms (e.g. community-led mediation services, anonymous reporting hotlines) for people living with HIV and people from key populations.

Indicator level	Indicator	Data source
Output	Number of informal redress mechanisms available for people living with HIV and people from key populations to report abuse and discrimination	Programme monitoring data
Output	Number of formal redress mechanisms available for people living with HIV and people from key populations	Programme monitoring data
Outcome	Proportion of people living with HIV who have experienced rights abuses in past 12 months and have sought redress	Programme evaluation data
Outcome	Percentage of people from key populations who reported mistreatment by law enforcement	Community-led monitoring, program evaluation data
Coverage (medium-term impact)	Number of people living with HIV and people from key populations reached with HIV prevention, care and treatment services in past 12 months	Programme monitoring data

Organizational-level activity: implement activities to sensitize law enforcement agencies and agents on harm reduction related to HIV prevention, and laws protecting people living with HIV and people from key and vulnerable populations from discrimination and the harms associated with stigma and discrimination.

Indicator level	Indicator	Data source
Output	Number of activities implemented to sensitive law enforcement agencies and agents in past 12 months	Programme monitoring data
Output	Percentage of law enforcement agencies that received sensitization on harm reduction related to HIV prevention, laws protecting people living with HIV and people from key and vulnerable populations from discrimination, and harms associated with stigma and discrimination in past 12 months	Programme monitoring data
Outcome	Percentage of police officers who hold stigmatizing attitudes towards people from key populations	Programme evaluation data
Coverage (medium-term impact)	Number of people living with HIV and people from key populations reached with HIV prevention, care and treatment services in past 12 months	Programme monitoring data

EMERGENCY SETTING

The health of people living with HIV can be compromised in emergency and humanitarian settings. Conflicts and crises often cause interruptions in HIV prevention, care and treatment, specifically disrupting health systems and medical supply chains. HIV criminalization laws or travel restrictions may exacerbate access to HIV care and treatment services, as refugees living with HIV may fear expulsion from the host country or prosecution if they disclose their HIV status.

Table 13. Example logframe for strategy to reduce HIV and key population stigma and discrimination in emergency settings

Objective: to reduce HIV and key population stigma and discrimination in emergency settings, the government, in partnership with humanitarian, community-led and nongovernmental organizations throughout the country, will support a variety of interventions and policy changes within emergency settings, including the implementation of programmes to meet the needs of people living with HIV and people from key populations and training and preparing humanitarian actors and organizations to address HIV stigma and discrimination. This strategy is expected to increase access to and use of HIV services in emergency settings and reduce stigma among people living with HIV and people from key populations. Ultimately, this strategy will contribute to reducing HIV incidence among people from key populations, reducing AIDS-related mortality and improving quality of life.

Inputs	
Community engagement in planning and monitoring	Staff Funds Materials Facilities Supplies

Activities	Outputs
Implementers: ministry of health and humanitarian, community-led, faith-based, and nongovernmental organizations throughout country Provide people living with HIV and people from key populations in conflict and crisis safe access to HIV and sexual and reproductive health and rights services, including prevention, care and treatment	Increased number of programmes and services providing HIV and sexual and reproductive health and rights care and treatment Increased number of people living with HIV and people from key populations who access HIV and sexual and reproductive health and rights services during conflict and crisis
Implementers: ministry of health and humanitarian, community-led and nongovernmental organizations throughout country Ensure appropriate linkages between community health workers and formal health systems in emergency settings	Increased number of connections formed between community health workers and formal health systems in emergency settings
Implementers: ministry of health and humanitarian organizations in partnership with community-led organizations Educate humanitarian actors, including office for the coordination of humanitarian affairs, cluster leads and cluster partners, in addressing HIV and key population stigma and discrimination in emergency settings	Increased number of education events and trainings for humanitarian actors Increased knowledge of HIV-related stigma and discrimination among humanitarian actors
Implementers: humanitarian organizations throughout country, in partnership with community-led organizations and ministry of health Integrate stigma and discrimination reduction training into existing workforce capacity development and service performance monitoring for employees involved in emergency service delivery and planning	Increased stigma and discrimination reduction training in workplaces related to emergency service delivery and planning Increased service performance monitoring in workplaces related to emergency service delivery and planning
Implementers: ministry of health and humanitarian, community-led, faith-based, and nongovernmental organizations throughout country Implement programmes to prevent, address, monitor and report violence against people living with HIV and people from key populations in emergency settings	Increased number of programmes and mechanisms to prevent, address, monitor and report violence against people living with HIV and people from key populations

Activities	Outputs
Implementers: ministry of health and humanitarian organizations Implement provisions for people living with HIV and people from key populations in national emergency plans, including procedures to protect women and girls from gender-based and intimate partner violence	Increased number of provisions for people living with HIV, people from key populations and women and girls in national emergency plans

Outcomes

Experiences of people living with HIV and people from key and vulnerable populations in emergency settings, measured by:

- Reduction in internalized stigma
- Reduction in anticipated stigma
- Reduction in experienced stigma and discrimination
- Reduction in violence
- Increase in acceptability of services received
- Increase in quality of care

Attitudes and actions of workers and duty bearers in emergency settings towards people living with HIV and people from key populations, measured by:

- Reduction in fear of HIV infection from nontransmissible contact
- Reduction in shame and blame of people living with HIV and people from key populations
- Reduction in stigmatizing attitudes towards people living with HIV and people from key populations
- Reduction in inequitable gender norms

Impacts

MEDIUM TERM

Improved HIV service use (coverage) among people living with HIV and people from key populations, measured by:

- Increase in uptake of prevention services (e.g. PrEP, VMMC, condoms, harm reduction)
- Increase in uptake of care and treatment services (e.g. engagement in care, treatment initiation)
- Increase in treatment adherence and continuation (e.g. antiretroviral therapy, PrEP)

LONG TERM

HIV incidence among people from key populations

AIDS-related mortality

Quality of life

PrEP, pre-exposure prophylaxis; VMMC, voluntary medical male circumcision.

Table 14 provides examples of the types of indicators that could be used to monitor and evaluate two of the activities included in the logframe in Table 13.

Table 14. Example indicators to monitor and evaluate public policy and organizational-level activities to reduce HIV and key population stigma and discrimination in emergency settings

Public policy and organizational-level activities: implement provisions for people living with HIV and people from key populations in national emergency plans, including procedures to protect women and girls from gender-based and intimate partner violence, and train staff of humanitarian organizations to implement programmes and services in emergency settings.

Indicator level	Indicator	Data source
Output	Number of staff at humanitarian organizations trained in procedures to protect women and girls in emergency settings and services that should be available to help people living with HIV and people from key populations in conflict and crisis in past 12 months	Programme monitoring data
Outcome	Percentage of women and girls who reported having experienced physical or sexual violence in emergency settings in past 12 months	Programme evaluation data
Outcome	Percentage of people from key populations who report having experienced physical or sexual violence in emergency settings in past 12 months	Programme evaluation data
Outcome	Percentage of people living with HIV in emergency settings who report experienced stigma and discrimination in past 12 months	Programme evaluation data

Organizational-level activity: provide people living with HIV and people from key populations in conflict and crisis safe access to HIV and sexual and reproductive health and rights services, including prevention, care and treatment, and ensure appropriate linkages between community health workers and formal health systems in emergency settings.

Indicator level	Indicator	Data source
Output	Number of linkages formed between community health workers and formal health systems in emergency settings	Programme monitoring data
Output	Percentage of HIV service provision organizations (e.g. health facilities, community-led, faith-based and nongovernmental organizations) that provided safe access to care and treatment to people living with HIV and people from key populations in conflict and crisis in past 12 months	Programme monitoring data
Coverage (medium-term impact)	Number of people living with HIV and people from key populations reached with HIV services in emergency settings in past 12 months	Programme monitoring data

SELECTION OF INDICATORS FOR HIV AND KEY POPULATION STIGMA AND DISCRIMINATION

Many validated indicators are available to assess HIV and key population stigma and discrimination. UNAIDS recommends that, where possible, countries select and use existing indicators that have been validated to monitor and evaluate the activities being implemented to reduce HIV and key population stigma and discrimination. UNAIDS recommends the use of relevant validated indicators for the country where available, or to cross-culturally adapt existing validated indicators from other settings using a process such as that described for adapting measurement scales to new contexts (43).

At a minimum, survey items used to construct an indicator should be pretested with members of the populations to be assessed to determine whether the measures consistently and accurately capture what they intend to measure.

For new measures that have not been used before in a specific country , cognitive interviewing, which entails discussing the measures with members of the populations of interest to assess how the meaning and purpose of the items are interpreted and ensuring cultural relevance, is recommended (44).

SOURCES OF SURVEY ITEMS AND INDICATORS

There are several sources of validated survey items or scales to capture aspects of HIV and key population stigma and discrimination, and key outcomes of stigma and discrimination reduction programmes:

- UNAIDS Indicator Registry, including Global AIDS Monitoring indicators.
- Standardized population-based surveys, such as Demographic and Health Surveys and the United Nations Children's Fund Multiple Indicator Cluster Surveys.
- Standardized surveys for people living with HIV, such as the People Living with HIV Stigma Index 2.0.
- Standardized surveys for key populations, such as the World Health Organization integrated biobehavioural survey.
- Indicators and survey items validated in research studies (e.g. academic research and programme evaluations) conducted in the country or region.
- Programme data, including clinic and programme records (e.g. number of clients seen, number of support groups offered).
- Surveillance data.

MEASUREMENT ISSUES

Potential measurement issues to consider when developing an M&E plan for assessing the outcomes of HIV and key population stigma and discrimination reduction efforts are shown in Table 15.

Table 15. Potential measurement issues and workable solutions across the six Global Partnership settings

Measurement issue	Applicable settings	Workable solutions
In some countries, it may not be possible to disaggregate data by key population if some behaviours, occupations or identities are illegal	All	Implement integrated biobehavioural surveys with people from key populations or People Living with HIV Stigma Index surveys to estimate prevalence of stigma and discrimination among people from key populations Use respondent-driven sampling methodologies to reach hard-to-reach populations Whenever possible, disaggregate data by population and gender
It may be difficult to survey all staff in a busy health facility, school or workplace	Health-care Education Workplace	Use random sampling techniques to estimate prevalence of attitudes and behaviours (e.g. select a sample of health-care workers or teachers across all health facilities or schools in a specific region or country) Design brief survey instruments that can be implemented on electronic data capture devices (e.g. tablets, phones) Be flexible with timing of data collection to accommodate busy schedules (e.g. use nights and weekends, shift changes, breaks) Triangulate assessment findings with community-led monitoring of quality of care in health facilities
It may not be possible to capture all the nuances of HIV and key population stigma and discrimination with survey data	All	Quantitative data should be enriched with qualitative data (e.g. in-depth interviews, focus group discussions) whenever possible to provide a more nuanced understanding of changes in stigma and discrimination

Measurement issue	Applicable settings	Workable solutions
Discomfort responding to in-person interviewers about sensitive topics (e.g. experienced stigma, discriminatory attitudes)	All	Consider using self-administered paper or electronic surveys that can be completed anonymously Implement community-led data collection efforts, such as the People Living with HIV Stigma Index 2.0 Implement plan to protect respondents' privacy and confidentiality
It may be logistically difficult or dangerous to collect data in some settings (e.g. refugee camps, conflict settings)	Emergency	Use range of data sources (e.g. case reports of humanitarian workers, rapid assessments) to enhance understanding of the situation regarding HIV and key population stigma in the setting Work with local community organizations to understand impact of humanitarian crises on stigma and discrimination experiences of people living with HIV and people from key populations, and access to HIV services
Duty bearer resistance to being interviewed about stigma and discrimination	All	If it is not possible to conduct survey to assess attitudes of duty bearers towards people living with HIV and people from key populations, consider seeking information from affected communities on their experiences engaging with duty bearers Use qualitative assessments (e.g. in-depth interviews, focus groups discussions)

COUNTRY EXAMPLES

This section presents examples from two countries, Thailand and Jamaica, that have developed plans at the national level to reduce and mitigate HIV-related stigma and discrimination in the Global Partnership settings most relevant to their country context. Thailand and Jamaica have also developed M&E strategies for assessing progress towards achieving their established national and global goals. These examples highlight how the six settings of the Global Partnership can inform comprehensive and collaborative responses across government sectors, such that addressing HIV-related stigma and discrimination becomes a common interest and shared responsibility, rather than an agenda managed only by the Ministry of Health. With full input from community-led and civil society organizations (CSOs), as well as other key stakeholders, countries should select the settings most relevant to their HIV epidemic and country context, create a National Action Plan and/or Operational Plan to address HIV-related stigma and discrimination across the selected setting(s), and then develop an M&E plan and system to monitor progress and ensure accountability across all stakeholders. While these plans will vary across countries, in terms of settings of focus, goals and targets selected, and M&E systems developed, the examples from Thailand and Jamaica summarized should be informative for countries considering or beginning this process.

DEVELOPING A NATIONAL ACTION PLAN TO ELIMINATE ALL FORMS OF HIV-RELATED STIGMA AND DISCRIMINATION IN THAILAND

In 2022, Thailand launched a 5-year National Action Plan to eliminate all forms of HIV-related stigma and discrimination.

THAILAND PARTNERSHIP FOR ZERO DISCRIMINATION IN ACTION: 2022 – 2026 In Six Settings

HEALTH-CARE

Rapid scale-up of stigma and discrimination interventions to reach:

- **80% of health facilities**
- **80% of medical and nursing schools**
- **35% of prisons**

Scale-up package of stigma and discrimination reduction interventions for health facilities and community staff

- The 3x4 participatory training
- Continuous Quality Improvement (CQI) and integrated in DSC
- Basic E-learning modules
- Advanced E-learning modules for medical and nursing students and health care staff
- Develop self-stigma reduction interventions for health care staff

HUMANITARIAN AND EMERGENCIES

Fully functioning CRS

Community-led monitoring and data system established

Provincial goverment agencies, CSOs and private sector collaborate on COVID-19 response

- Provide gender-based violence protection and post-GBV care
- Report and respond immediately to human rights violations
- Build community-led responses and monitoring
- Enhance collaboration between goverment, CSOs, CBOs and private sector to respond to COVID-19

JUSTICE

50 provinces establish fully functioning Crisis Response System (CRS)

90% of human rights violation of cases receive assistance

5 punitive laws and/or policies removed or redressed

- Scale up CRS and provincial multi-disciplinary teams including paralegals
- Train law enforcement officers
- Engage parliament and law enforcement to improve laws and regulations
- Advocate for new non-discriminatory bill

WORKPLACE

8 177 public and private organizations implement stigma- and discrimination-free HIV policies and mesures and promote gender equality

- Implement national guidelines on the managements of AIDS in worplaces: removing HIV testing for jobs applicants/ employees without consent
- Revise guidelines on providing social welfare for people living with HIV
- Train labour inspectors on HIV-related stigma and discrimination and human rights
- Promote AIDS Standard Organisation and zero discrimination policies and practices through employer/ employee confederations and private sector associations

COMMUNITY

90% of community health workers (CHWs) trained on zero discrimination, self-stigma, human rights and gender

80% of CSOs/CBOs integrate zero discrimination, rights and gender into community-led services

20% of general population given information on stigma and discrimination, human rights and gender

- Enhance training on stigma and discrimination / human rights for CHW
- Integrate stigma and discrimination reduction interventions into the HIV service cascade
- Advise on how to reduce self-stigma
- Integrate CRS into community systems
- Raise awareness on U=U, stigma, discrimination and human rights
- Implement community-led monitoring and Stigma index
- Ensure communications are based on latest science

EDUCATION

17 609 schools implement stigma- and discrimination-free HIV policies and measures and promote gender equality

- Develop guidelines to protect children's rights
- Training on use of tools and guidelines for non-discrimination polices
- Ensure good quality, non-stigmatizing, comprehensive sexuality education is provided to children and young people and address needs of young people living with HIV
- Develop systems to report rights violations and to support students who experience violence due to their gender or HIV status
- Support youth leaders working to achieve zero discrimination in schools

FRAMEWORK FOR ACTION

To Achieve Zero Hiv-Related Discrimination: 2022–2026

STRATEGIC OBJECTIVE 1

People better understand HIV, human rights and gender diversity and have non discriminatory attitudes towards people living with and affected by HIV.

- Raising awareness on HIV-related rights among the general public
- Creating a non-stigmatizing environment around people living with and affected by HIV and key populations
- Fostering supportive families and communities around people who use and inject drugs

STRATEGIC OBJECTIVE 2

Public and private health, education and social services are based on policies, measures and interventions that are gender-sensitive and free from bias, social stigma, exclusion and discrimination.

- Promoting HIV-related rights and reducing stigma and discrimination in health care settings
- Promoting HIV-related rights and reducing stigma and discrimination in education settings
- Promoting HIV-related rights and reducing stigma and discrimination in workplace settings

APPLYING AN INEQUALITY LENS AND PUTTING PEOPLE LIVING WITH HIV AND COMMUNITIES AT RISK AT THE CENTER

STRATEGIC OBJECTIVE 3

People living with and affected by HIV realise their self-worth and can deal with problems appropriatcly, including accessing support and protection when their rights are violated because of their HIV status and/or gender.

- Promoting human rights and gender equality and a reduction in stigma and discrimination in community/key population led health services
- Providing assistance for those facing human rights violation in crisis or non-crisis situations and review discriminatory practices such as termination of employment
- Strengthening evidence-based interventions

STRATEGIC OBJECTIVE 4

Laws, regulations and policy mechanisms to protect the rights and respond to the problems of people living with and affected by HIV and key affected populations.

- Removing punitive laws and strengthening legal regulations and policy environment to remove discrimination against people living with and affected by HIV and key affected populations and to promote gender equality
- Scaling up the Crisis Response System to protect rights violations, building the capacity of multidisciplinary team at all levels, organisations, and provinces

CROSS-CUTTING ISSUES

HIV in humanitarian and emergency settings, promotion of gender equality and monitoring and evaluation

The plan was developed under the responsibility of the National sub-Committee on AIDS Rights, Protection, and Promotion, with support from UNAIDS Thailand. A multisectoral approach was used to develop the plan, based on the Global Partnership framework and following the 4th strategy of the National Strategic Plan to End AIDS (2017-2030), which is the stigma and discrimination reduction strategy.

Members of the sub-National Committee represented 7-8 key ministries allied with CSOs (i.e., NGO and people living with HIV network representatives). While the National Action Plan was developed by setting and may appear siloed on paper, implementation of the plan is collaborative, with coordination among ministries and CSOs across settings who work together on major interventions and activities. Indeed, using the six settings to guide planning was an effective way to drive multisectoral collaboration, as all players could see what needs to be done in their area/setting of expertise and understand how important their contribution is towards the collective goal of achieving the 10-10-10 societal enabler targets. As community is critical to eliminating stigma and discrimination at the country level, Thailand is also committed to achieving the 30-60-80 community-led targets (i.e., 30% of testing and treatment services to be delivered by community-led organizations; 60% of the programmes to support the achievement of societal enablers to be delivered by community-led organizations; 80% of service delivery for HIV prevention programmes for key populations and women to be delivered by community, key population and women-led organizations). In particular, Thailand plans to ensure that 60% of societal enabler programmes are delivered by community-led organizations, and that 80% of CSOs in 18 provinces will accelerate the integration of stigma and discrimination and self-stigma reduction, fundamental rights, and gender as part of their approach. Thailand has also set an ambitious goal to provide intensive training to 90% of community health workers from CSOs in 18 provinces on HIV-related stigma and discrimination, including self-stigma reduction, understanding human rights, gender, drug abuse and other sensitive issues, under national training curricula and as a requirement of the national community health worker certification system.

To achieve these ambitious goals, Thailand will need to strengthen common technical aspects, such as addressing key drivers of stigma and discrimination and human rights, across settings. For example, key drivers of stigma and discrimination in the healthcare and workplace settings are similar but not the same. Therefore, interventions and tools designed for the healthcare settings will need to be tailored for the other settings.

TARGETS

Thailand Partnership for Zero Discrimination: 2022–2026

Less than
10%

- Less than 10% of people living with HIV experience HIV-related discrimination
- Less than 10% of women and men age 15-49 years old have stigmatizing attitudes towards people living with HIV
- Zero pregnant women living with HIV get advice from health care providers to terminate pregnancy
- Less than 10% of people living with HIV and key populations avoided or delayed access to health services due to fear of HIV-stigma and discrimination
- Less than 10% of people living with HIV have their HIV testing or status disclosed without their consent
- Less than 10% of woman age 15-49 years old have experienced sexual violence in the past 12 months

PEOPLE LIVING WITH HIV AND AFFECTED COMMUNITIES AT THE CENTRE
By 2025 Reduce Inequality

26 593
discrimination-free workplaces

- At least 20% of general population is exposed to information on stigma and discrimination and rights related to HIV, gender and drug use
- 807 health facilities, 17 609 schools and 8 177 workplaces are free from stigma and discrimination and have gender sensitive measures in place
- At least 60% of people living with HIV and key affected populations have access to self-stigma reduction programmes, basic rights and gender equality information, and community crisis response support to protect their rights.
- 50 provinces have crisis response mechanisms in place for HIV-related rights protection and gender equality

To monitor progress towards achieving the targets Thailand has set, the National sub-Committee supplies a platform to support and monitor progress across settings through regular meetings and via the technical working group, which was established after the National AIDS Committee endorsed the National Action Plan in June of 2022. A National M&E framework was developed to go with the National Action Plan and forms the basis for routine monitoring efforts.

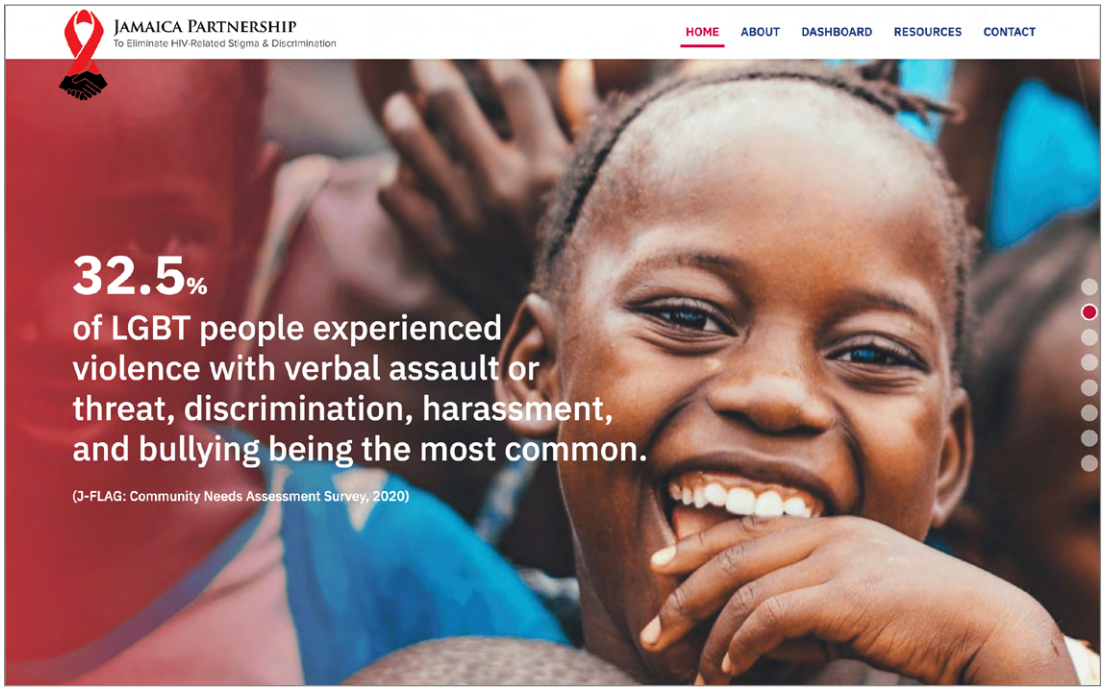
Table 16. National framework to measure HIV-related stigma and discrimination

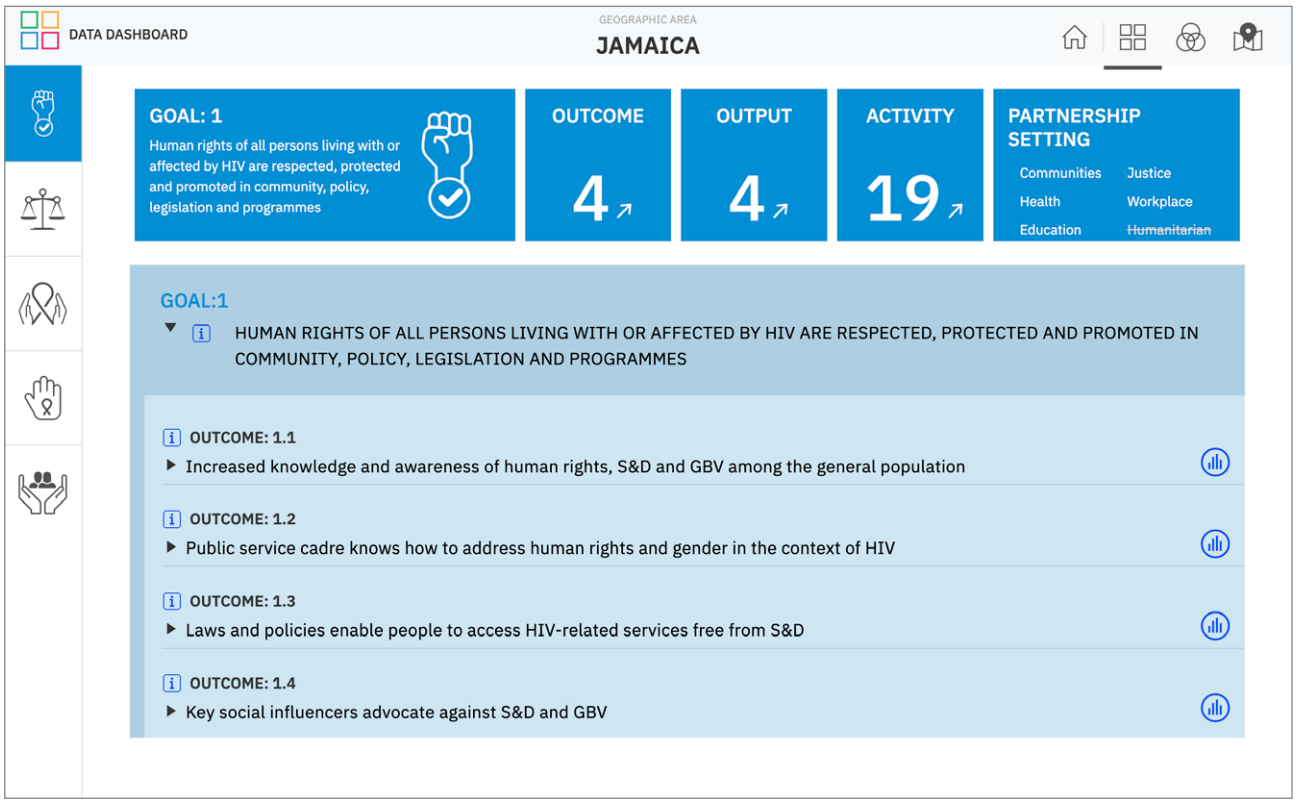
Target	Frequency	Key Issues	Measurement
General population	3-5 years	Attitudes towards people living with HIV	Household surveys - Health Examination Survey - Multiple Indicators Cluster Survey
Key Populations (MSM, SW, TG, PWID and Migrant Workers)	2 years	Experienced and internal stigma	Bio-Behavioural Survey
Health care providers	2 years	Concerns about contracting HIV, attitudes and judgments about people living with HIV, stigma avoidance behaviour and observed stigma and discrimination towards people living with HIV and key populations	Survey in health care setting
Clients living with HIV in health facilities	2 years	Experienced stigma and discrimination	The people living with HIV survey in health care settings
People living with HIV	2 years	Experienced stigma and discrimination across sectors, internalized stigma.	The Stigma Index survey
Reporting system on HIV-related human rights violations	Real-time	Events or complaints related to violence, abuse and human rights violations towards key populations and people living with or affected by HIV	Community-led Crisis Response System and mobile and web-based reporting and response tool.

MONITORING, EVALUATION AND LEARNING IN ACTION: THE JAMAICA PARTNERSHIP STORY

The *Jamaica Partnership to Eliminate All Forms of HIV-Related Stigma and Discrimination* focuses on ensuring coordination, coherence, and accountability among stakeholders implementing human rights interventions to bolster efforts to end HIV-related stigma and discrimination.

In Jamaica, significant work has been done around monitoring, evaluation, and learning for the Enabling Environment and Human Rights (EEHR) with and through multiple stakeholders and technical partners. Firstly, an Operational Plan for Enabling Environment and Human Rights was developed, informed by the National Strategic Plan for HIV, the Global Fund Human Rights Baseline Assessment Report, The Global Partnership Guidance, The Stigma Index 2.0 and other key evidence generated locally. Next, a monitoring and evaluation framework and online reporting dashboard were developed based on the Operational Plan, in partnership with the National Family Planning Board (NFPB) and UNDP/UNAIDS, to streamline collection and reporting of data regarding human rights programming. Lastly, civil society and government stakeholders implementing interventions to remove human rights barriers were trained on monitoring, evaluation, and learning for EEHR, including how to use the dashboard, to better enable stakeholders to populate the platform and track their progress. To view the dashboard visit: www.eehr.org.




DATA DASHBOARD
GEOGRAPHIC AREA
JAMAICA
GOAL: 1
Human rights of all persons living with or affected by HIV are respected, protected and promoted in community, policy, legislation and programmes
OUTCOME
4
OUTPUT
4
ACTIVITY
19
PARTNERSHIP SETTING
Communities
Justice
Health
Workplace
Education
Humanitarian
GOAL:1
HUMAN RIGHTS OF ALL PERSONS LIVING WITH OR AFFECTED BY HIV ARE RESPECTED, PROTECTED AND PROMOTED IN COMMUNITY, POLICY, LEGISLATION AND PROGRAMMES
OUTCOME: 1.1
Increased knowledge and awareness of human rights, S&D and GBV among the general population
OUTCOME: 1.2
Public service cadre knows how to address human rights and gender in the context of HIV
OUTCOME: 1.3
Laws and policies enable people to access HIV-related services free from S&D
OUTCOME: 1.4
Key social influencers advocate against S&D and GBV

Since 2021, The Partnership has produced an Annual Report on EEHR to showcase the achievements by stakeholders working to end inequalities and reduce stigma, discrimination, and violence. Two Human Rights Scorecards have been produced as well. These resources have strengthened knowledge management systems for EEHR and stimulate continuous learning and sharing.

Table 17. Enabling Environment & Human Rights Operational Plan Scorecard Six-Month Review

Performance Summary			Measurement		
	No	%		No	%
Total Number of Activities Planned	234		**Total Number of Persons Reached**		
Total Number of Activities Initiated	125	53%	**Total Number of Gay, Bisexual and other MSM**	262	9%
Total Number of Activities Completed	78	33%	**Total Number of people living with HIV**	100	3%
Total Number of Ad Hoc Activities	22	9%	**Total Number of Sex Workers**	158	5%
Total Number of Activities	256		**Total Number of Adolescents & Youth**	52	2%
Implementation Rate	57%		**Total Number of Transgender Persons**	127	4%
Completion Rate			**Total Number of Other Key & Vulnerable Populations**	679	23%
Total Number of Activities Not Initiated	104	41%	**Total Number of General Population**	949	32%
Total Number of Activities Moved to July-Dec	109	43%	**Total Number of Policy & Decision-makers**	6	0%
			Total Number of Healthcare Workers	155	5%

Based on the operational plan, the interventions and activities planned by stakeholders are reviewed and mapped to show alignment and cross referenced with the societal enabler indicators in the Global AIDS Strategy 2022-2026 and The Global Fund for HIV/TB/Malaria grant Baseline Assessment Programme Areas. From this, mid-year and end-of-year assessments are undertaken to ensure activities are being implemented and monitor the settings in which they are being implemented and the total number of persons reached. The assessments are done jointly with partners using simple forms that only require partners to input data they already have. The output of these assessments has been shared with partners so everyone can see how well they are doing and identify programmatic gaps.

CONCLUSION

Eliminating HIV and key population stigma and discrimination is critical to achieving the global HIV goals of zero new infections and zero AIDS-related deaths. Stigma and discrimination impede HIV prevention, care and treatment services. Despite effective biomedical prevention and treatment options, we cannot reach all people in need of these services without significant investment in evidence-based programmes that greatly reduce HIV and key population stigma and discrimination and support people living with HIV and people from key populations to overcome the stigma and discrimination they already face.

The Political Declaration on HIV and AIDS: Ending Inequalities and Getting on Track to End AIDS by 2030 approved at the United Nations High-level Meeting on HIV and AIDS in 2021, which includes specific targets for reducing HIV and key population stigma and fostering supportive legal environments, should, for the first time, galvanize the resources and the political will needed to address stigma and discrimination at the level required to see real impact. Having a robust M&E strategy in place is critical to ensure rapid and appropriate allocation of resources to address stigma and discrimination. In addition, it will allow programme implementers to course-correct and improve the programmes being implemented to ensure maximum effectiveness and national governments to assess the impact of their investments in stigma and discrimination reduction on key HIV outcomes.

This M&E guidance document, combined with the companion evidence guidance on programmes to eliminate HIV and key population stigma and discrimination released in 2020 (45), is intended to support countries to develop M&E frameworks for each setting of the Global Partnership, select evidence-based programmes, and implement rigorous M&E efforts using validated indicators.

We have evidence-based programmes that we know work. We have validated measures of HIV and key population stigma. We have new global targets to achieve. The time to act is now.

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