
A framework for understanding and addressing HIV-related inequalities

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Acronyms

CSE	comprehensive sexuality education
FAO	Food and Agriculture Organization
GAM	Global AIDS Monitoring
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
GNI	gross national income
IBBS	integrated biological and behavioural surveillance
IIGH	Institute on Inequalities in Global Health
ILO	International Labour Organization
IOM	International Organization for Migration
LGBTI	lesbian, gay, bisexual, transgender and intersex
MEL	monitoring, evaluation and learning plan
MoT	modes of transmission modelling
NCPI	National Commitments and Policy Instrument
OHCHR	United Nations Office of the High Commissioner for Human Rights
PEPFAR	United States President's Emergency Plan for AIDS Relief
PrEP	pre-exposure prophylaxis
SDGs	Sustainable Development Goals
STIs	sexually transmitted infections
TRIPS	Trade-related Aspects of Intellectual Property Rights
UBRAF	UNAIDS United Budget, Results and Accountability Framework
UN	United Nations
UN DESA	United Nations Department of Economic and Social Affairs
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
UNSDCF	United Nations Sustainable Development Cooperation Framework
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
WHO	World Health Organization

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Introduction

Persistent inequalities, including infringements of human rights, continue to undermine progress towards ending AIDS by 2030. As HIV continues to spread, worsening inequalities threaten to halt or even reverse the progress that has been made (1). Gender inequality remains one of the most pervasive forms of inequality globally, impacting the ability of women, girls and gender-diverse people to prevent HIV infection and mitigate the experience of living with HIV. For example, growing inequalities in opportunities and outcomes relating to education, food security, employment, housing, health services and economic resources are linked to years of discriminatory policies and social dynamics, including human rights violations and gender inequality, that have left people behind—even as biomedical advances offer opportunities for improved HIV prevention and treatment (2). While inequalities may manifest differently within different populations, the historically rooted structural factors that shape today’s inequalities have yet to be adequately addressed within and across populations. Many of these inequalities were exacerbated by the COVID-19 pandemic during 2020–2022, but the pandemic also brought inequalities to the forefront in national and global discussions on health and social protection (3). As the world considers how to “build back better” from COVID-19, addressing inequalities that disproportionately affect some people more than others will be critical—both to ending that pandemic and to ending AIDS (1).

In 2015, United Nations (UN) Member States collectively committed to addressing inequalities when they unanimously adopted the 2030 Agenda for Sustainable Development and its 17 Sustainable Development Goals (SDGs). Central to the 2030 Agenda is the promise to “leave no one behind and reach the furthest behind first” (2). Through the SDGs, UN Member States have committed to combatting inequalities and vulnerabilities that leave people behind, including eradicating poverty in all its forms and ending discrimination and exclusion. Specifically, SDG 10 calls on Member States to “reduce inequalities within and among countries.” Further commitments to address HIV-related inequalities are captured in SDG 5 (“Achieve gender equality and empower all women and girls”) and SDG 3 (“Ensure healthy lives and promote well-being for all at all ages”) (4). The momentum and determination reflected in the 2030 Agenda to “break the cycles of disadvantage and inequity that threaten to leave people irrevocably behind” is shared across UN agencies, and it helps guide the work and strategy of UNAIDS (2).

Attention to inequalities by the highest levels of the UN is evidenced by the 2016 adoption of the UN System Framework for Action on Equality to “establish a common understanding of the challenge of rising inequalities and pervasive discrimination” in support of the implementation of the SDGs (5). One of the actions put forward by the UN Secretary-General is to: “Continue our efforts to help design policies that support the most vulnerable and/or excluded groups, recognizing and responding to multiple and intersecting deprivations and sources of discrimination that limit opportunities and make it harder to escape poverty, live with dignity and enjoy human rights on a healthy planet” (6).

In line with the SDGs and the UN System Framework for Action on Equality, the *Global AIDS Strategy 2021–2026: End Inequalities, End AIDS* focuses on reducing the inequalities that drive the HIV epidemic in order to end AIDS. Inequality is defined in the *Global AIDS Strategy 2021–2026* as “an imbalance or lack of equity . . . [that] encompasses the many inequities . . . disparities and gaps in HIV vulnerability, service uptake and outcomes experienced in diverse

settings and among the many populations living with or affected by HIV” (1).¹ The Global AIDS Strategy 2021–2026 boldly and directly highlights the importance of addressing inequalities and prioritizing people who are vulnerable but not yet accessing HIV prevention, treatment, care and support services in order to help achieve the 2025 Fast-Track Targets.

The principles that underpin the work of the Joint Programme—including human rights, gender equality, and community engagement and leadership—are highlighted throughout the Global AIDS Strategy 2021–2026, and they serve as the grounding principles of this framework and toolkit.

The UNAIDS approach to addressing HIV-related inequalities is also guided by the 2021 UN Political Declaration on HIV and AIDS: Ending Inequalities and Getting on Track to End AIDS by 2030. Through the 2021 Political Declaration on AIDS, Member States committed to “urgent and transformative action to end the social, economic, racial and gender inequalities, restrictive and discriminatory laws, policies and practices, stigma and multiple and intersecting forms of discrimination, including based on HIV status, and human rights violations that perpetuate the global AIDS epidemic.” To support the achievement of the targets of the 2021 Political Declaration on AIDS and to translate the Global AIDS Strategy 2021–2026 into action, the UNAIDS Unified Budget, Results and Accountability Framework (UBRAF) 2022–2026 was approved in 2021. The UBRAF 2022–2026 is used by the Joint Programme to operationalize the UNAIDS Strategy and support countries and communities to address HIV-related inequalities and support achievement of the targets, as well as the long-term vision of zero new HIV infections, zero AIDS-related deaths and zero discrimination (1, 7). Current goals and targets also reflect the new focus of the HIV response on eliminating inequalities, particularly the shift in emphasis from improving overall access to prevention, testing, treatment and care to explicitly reducing inequalities for all across this whole continuum. Eliminating inequalities is the strategy to ensure that no one is left behind in the AIDS response.

It is well-recognized that insufficient attention to inequalities can result in harmful gaps in understanding and addressing HIV risk and vulnerability factors, including those that prevent access to prevention, testing and treatment (1). In order to end AIDS, the Global AIDS Strategy 2021–2026 and the UBRAF 2022–2026 have outlined targets across three pillars—systems, services and societal enablers—that are designed to help address both HIV-related inequalities and their drivers.² Alongside the biomedical advances that are essential to expanding choices, lowering transmission and reducing inequalities in HIV outcomes across the continuum from prevention to viral suppression, the societal enabler targets for 2025 aim to ensure that “less than 10% of people living with HIV and key populations experience stigma and discrimination; less than 10% of people living with HIV, women and girls and key populations experience gender-based inequalities and gender-based violence; and less than 10% of countries have punitive laws and policies” (8). With these 10–10–10 targets, UNAIDS contributes to SDG 10 by focusing on the inequalities most relevant to HIV and coordinates the relevant HIV-related actions of the Joint

¹ Equity is defined in the UN System Shared Framework for Action as fairness in the distribution of costs, benefits and opportunities among population groups defined socially, economically, demographically or geographically (2). With due attention to the importance of equity for health and well-being, this framework explicitly adopts the notion of equality, recognizing its foundational importance to international human rights law.

² Social and structural drivers of HIV-related inequalities are factors that are reflective of both macro- and community-level structures, processes and norms that influence HIV risk behaviours at the individual level and impact an individual or groups’ ability to access HIV services (12).

Programme Cosponsors. Furthermore, UNAIDS contributes to SDG 3 and SDG 5. Some of the most relevant targets for these three SDGs are outlined below (Box 1).

Box 1. Select Sustainable Development Goals and targets particularly relevant to HIV-related work on inequalities

SDG 3: Ensure healthy lives and promote well-being for all at all ages (9).

3.3: By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases.

3.8: Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

SDG 5: Achieve gender equality and empower all women and girls (10).

5.1: End all forms of discrimination against all women and girls everywhere.

5.5: Ensure women's full and effective participation and equal opportunities for leadership at all levels of decision-making in political, economic and public life.

SDG 10: Reduce inequalities within and among countries (11).

10.2: By 2030, empower and promote the social, economic and political inclusion of all, irrespective of age, sex, disability, race, ethnicity, origin, religion or economic or other status.

10.3: Ensure equal opportunity and reduce inequalities of outcome, including by eliminating discriminatory laws, policies and practices and promoting appropriate legislation, policies and action in this regard.

This framework and its accompanying toolkit are designed to help the Joint Programme support countries and communities in their efforts to identify HIV-related inequalities and their drivers and to address them according to the Joint Programme's comparative advantages and capacity—and, in doing so, support the full realization of human rights.

Collectively addressing disparities in the HIV response

In 2021, there were 38.4 [33.9–43.8] million people living with HIV worldwide (8). There is ample evidence that vulnerability to HIV infection, barriers to accessing HIV-related services and the risk of poor HIV-related outcomes are not evenly distributed globally, with certain groups of people disproportionately affected across the different dimensions of the HIV response. A central reason why inequalities in the HIV response remain so stark and persistent is that there has been insufficient action to understand and address them, including their intersectionality and the social, structural, systems and service drivers that fuel inequalities, increase HIV vulnerability and actively diminish people's abilities to access and effectively benefit from HIV-related services (1, 12). Left unaddressed, these intersecting inequalities have significant consequences for the ability of countries and communities to achieve the targets and goals stipulated in the Global AIDS Strategy 2021–2026. It is important to recognize that the Joint Programme is already

supporting countries and communities to address inequalities through the Secretariat's and Cosponsors' diverse programming, as per each organization's individual mandate. However, a shared framework to systematize the approach to HIV-related inequalities can help to capitalize on the respective strengths of different parts of the Joint Programme most effectively and to amplify their impact.

To identify actions to address inequalities across population groups, one must first determine across all of the Global AIDS Strategy's Result Areas not only who is being left behind, but also why they are being left behind (i.e., the factors driving specific inequalities relevant to HIV). Only once the factors that contribute to layered inequalities resulting in HIV vulnerability and unequal outcomes are identified can the actions to address them be prioritized and enacted through context-specific work, including workplans, results frameworks, and monitoring and evaluation plans.

This framework and its accompanying toolkit are designed for use by the Joint Programme with its partners. They rely on Joint Programme staff reaching out to affected communities and other partners to participate in the proposed processes to support identifying, addressing, monitoring and evaluating HIV-related inequalities and their reduction in every country.

Purpose of the HIV Inequalities Framework and Toolkit

The HIV Inequalities Framework and its accompanying Toolkit are intended to help guide Joint Programme staff in identifying and addressing the HIV-related inequalities that matter most for a country's HIV epidemic, and which the Joint Programme, given its resources and expertise, can most effectively seek to reduce or even eliminate through support to countries and communities.

These products are meant to do the following:

- To help the Joint Programme staff support countries and communities to operationalize the Global AIDS Strategy 2021–2026 and the 2021 Political Declaration on AIDS, and to implement the UBRAF 2022–2026 in order to “tackle inequalities to ensure equitable access to services in prevention, treatment and support” (7).
- To help the Joint Programme Secretariat and Cosponsors leverage their relative strengths in order to reduce inequalities that drive the HIV epidemic, including the mobilization and engagement of communities and civil society partners that are central to an effective response.

This framework is designed to help identify inequalities that are having a substantial impact on the HIV epidemic in a particular context, recognizing that there will be additional, relevant inequalities that may not be captured here. Prioritizing actions can be guided by identifying relevant groups and drivers of inequality that—if reached and/or addressed—would have substantial positive effects on reducing the epidemic and making progress towards broader development goals. Looking at the data, this requires asking:

- Which population groups are being most impacted by high HIV incidence or mortality?
- Why is this? What are the social, structural, systems and service drivers that create and perpetuate these disproportionate impacts?
- What actions can the Joint Programme most usefully take to help address these drivers?

The Framework and Toolkit are resources to help the Joint Programme, through both its structures and its staff, do the following:

- Use existing data, analysed differently, in order to better understand inequalities, their intersections and their social, structural, systems and service drivers.
- Select priority drivers from all those underlying the range of inequalities within a specific context in order to better address and eliminate them.
- Identify which contributing factors the Joint Programme is best placed to address and where data gaps may need to be filled.
- Determine which activities to start, scale up and stop in order to address HIV-related inequalities and serve as entry points for addressing wider inequalities that present barriers to achieving multiple Sustainable Development Goals (SDGs).

The Joint Programme and its partners can also use this framework and toolkit to ensure that efforts to address HIV-related inequalities are central to revisions of national HIV strategic plans, overall health strategies and funding proposals, and to national United Nations Sustainable Development Cooperation Framework (UNSDCF) planning. The inequalities lens presented here is meant to help the Joint Programme support countries and communities to go beyond aggregate measures of progress in prevention, treatment and care of HIV to explicitly and deliberately include eliminating HIV-related inequalities in these and related areas, thus contributing to new global goals and targets.

This document constitutes a framework for systematically seeking to understand who is being left behind and, critically, why and how to prioritize actions and indicators for addressing and monitoring the inequalities that impact the course of the epidemic. Central to an inequalities analysis is understanding why some groups have unequal access to information, services, technology and opportunity, and why some institutions deliver only for some populations, thus widening overall gaps in outcomes. In order to focus such an analysis, it is important to first understand which populations (and groups within them) are being left behind by the current response. This is the starting point for the inequalities analysis, which seeks to explore the factors driving these inequalities in depth, with a view to identifying how best to address them. Thus, the Framework is structured to first identify who is being left behind, then to analyse why that is the case, then to look at the existing response, and finally to prioritize interventions for addressing the most important HIV-related inequalities that were identified. The overall aim of the Framework is to help support countries and communities to reduce HIV-related inequalities within their HIV response, while the Toolkit serves to operationalize the Framework.

Approach

Building on past and present work of the Joint Programme and its partners to address inequalities and the 2030 Agenda, the Framework reflects the Global AIDS Strategy 2021–2026. It is “guided by human rights principles, norms and standards, commitments to achieve gender equality, and approaches that put communities at the centre of the global response” (1). Attention to human rights, gender equality, and community engagement and leadership are embedded throughout the Framework. It is designed to help UNAIDS focus on addressing inequalities in its advocacy, coordination, governance, research and technical support work with communities, governments, civil society, academia, the private sector and others in order to deliver effective HIV responses around the world. The Framework is informed by—and designed to complement and build on—the many existing relevant initiatives of partners and Cosponsors, including the Global Partnership for Action to Eliminate all Forms of HIV-related Stigma and Discrimination, the Breaking Down Barriers initiative of the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund), and the seven UNAIDS key programme areas to reduce stigma and discrimination

and increase access to justice in national HIV responses. A brief on the methodology used for designing the Framework is provided in Annex 1.

The Framework first draws attention to some of the populations most affected and commonly left behind in the HIV response, with due recognition that the specifics will vary between and within countries. Understanding and centring people's experiences of inequalities helps identify the drivers of these inequalities, and therefore where action can most usefully be taken. The Framework then explores some of the cross-cutting social and structural health systems and services drivers of relevant inequalities. Finally, it details a four-step process for identifying and addressing HIV-related inequalities in particular contexts, including prioritizing and monitoring relevant actions. The steps are designed to help users integrate this work into existing programme planning and processes, and they are meant to encourage collaborative, synergistic work across the Joint Programme by identifying key actions for the UNAIDS Secretariat and each Cosponsor to undertake with their respective partners and affected communities. Both the Framework and the Toolkit are meant to be adaptive tools that can be updated regularly based on the experiences of the Joint Programme.

The first part of the Framework covers the different components of building an HIV-specific inequalities lens, including the identification of priority populations and drivers of inequalities, as well as the intersectional nature of these groups and drivers.

Once this has been laid out, the Framework focuses on the practical application of this inequalities lens, elaborating on a four-step approach to identify and address HIV-related inequalities across the Result Areas of the Global AIDS Strategy 2021–2026, building on existing in-country efforts.

Scope

HIV-related inequalities are the focus of the Framework and Toolkit, bearing in mind that these are situated within broader layered and intersecting inequalities that may fall outside the direct mandate of the Joint Programme. While these broader inequalities will be referenced in this work only to the extent that they support the understanding of how HIV-related vulnerabilities and opportunities are shaped and might best be addressed, the implementation of the Framework and Toolkit are intended to help Cosponsors and other partners contribute to reducing and eliminating inequalities more broadly.

Audience

The Joint Programme and its staff, particularly at the country and regional levels, are the primary audience for the Framework and Toolkit. They are designed with consideration for the complementary mandates of the UNAIDS Secretariat and the different Cosponsors that provide the Joint Programme with the opportunity to act on a wide range of critical societal, structural and systems enablers within national HIV responses.

Key features

Using the inequalities lens and other elements of the Global AIDS Strategy 2021–2026 as a starting point, the Framework builds on the inequalities work already being operationalized by the Joint Programme and its other partners. The Framework focuses specifically on HIV-related inequalities, with a particular emphasis on how intersecting inequalities compound vulnerabilities in the context of HIV. Below are some of the key features of this framework that support identifying, understanding and acting on the inequalities that drive HIV.

Alignment with national structures and processes: The HIV Inequalities Framework and Toolkit are designed to be used as part of ongoing planning processes and to lead to outputs that are integrated within national strategies and workplans, results frameworks, and monitoring and evaluation plans. This will help to avoid the creation of parallel processes or duplicate efforts.

Building on existing foundations: The HIV Inequalities Framework and Toolkit are grounded in human rights, gender equality, and community engagement and leadership, and they are designed to build on local HIV responses that seek to address HIV-related inequalities. The Framework and Toolkit were created to help identify strengths and gaps in current responses from an inequalities perspective in order to bolster the response moving forward.

Participation: The HIV Inequalities Framework and Toolkit are designed to inform and guide the Joint Programme to effectively support community-led civil society partners, including key and affected communities, in leading multistakeholder processes to understand and address HIV-related inequalities.

Adaptability and flexibility: Recognizing that HIV-related inequalities manifest differently in different places, the HIV Inequalities Framework and Toolkit are designed to ask questions that can help create a response that is tailored to local realities.

Maximizing the use of available information: The HIV Inequalities Framework and Toolkit highlight widely available resources to help understand HIV-related inequalities—both those traditionally used in the HIV response and other resources that, when analysed alongside these data, might provide additional insights into inequalities and their drivers (see Annex 2). The need for and value of qualitative and experiential data are key to the process of understanding HIV-related inequalities and their drivers.

Building an HIV-specific inequalities lens

HIV-related inequalities include “the many inequities . . . disparities and gaps in HIV vulnerability, service uptake and outcomes experienced in diverse settings and among the many populations living with or affected by HIV” (1).

Despite significant achievements in policy dialogue, advocacy, education and medical interventions over the past four decades, there were 1.5 [1.1–2.0] million new HIV infections and 650 000 [510 000–860 000] AIDS-related deaths in 2021 (8). These infections and deaths are not equally distributed.

The inequalities blocking progress towards ending AIDS reflect the ways in which HIV intersects with complex fault lines across epidemiological, economic, legal, social, cultural, political and health factors and systems. These fault lines—also known as “drivers of inequalities”—act at all levels, from the macro to the community to the individual, in order to influence patterns of vulnerability to HIV and the ability to access services. Furthermore, these drivers of inequalities affect the ability of HIV-affected communities to meaningfully and effectively engage in decision-making and the community-led responses needed to end AIDS. In order to address inequalities, one must first understand who is being most affected by HIV in a given context. It is then critical to recognize how these vulnerabilities are created and exacerbated at every step by social and structural drivers. These drivers of inequalities are the problems to be addressed: only in understanding them can an HIV response be designed to make the needed structural and systems changes.

To support the building of an HIV-specific inequalities lens, this framework brings together the theory and data on inequalities most relevant to the HIV epidemic. By having this information gathered in one place, the Framework—and its accompanying annexes—can serve as a resource to support the Joint Programme in thinking systematically about priority populations, their intersections, the different drivers of the HIV-related inequalities these populations experience, and how they might most effectively be addressed.

This section will first provide basic information on some of the populations that are often considered to be most vulnerable to HIV infection and related outcomes. The manifestations and impacts of the inequalities experienced by different population groups are not uniform, in part due to the intersecting and overlapping identities of individuals (as discussed in the “Intersectionality” section below). The main structural and social drivers of inequalities in HIV—as well as the drivers in health systems and services, and the compounding effect of these factors—are then covered. Understanding and addressing inequalities requires deep analysis of the entrenched structural inequalities—often perpetuated by institutions, policies and practices—that have created these inequalities and continue to exacerbate them. Finally, the available data on these drivers and priority populations are discussed, including their potential for disaggregation, as well as data needs, sources and gaps.

Who is being left behind in efforts to end AIDS?

This section provides an overview of some of the information known about groups that are generally understood to be most left behind in current HIV responses. People can belong to one, some or all of these groups at once, and this might change over time. The priority populations that are more likely to experience HIV-related vulnerabilities and unequal outcomes will also vary between and within countries based on a variety of factors, including the epidemiological, economic, legal, social, cultural, gender and political contexts. For all identified priority populations, it remains essential to consider the heterogeneous, dynamic nature of people, as individual identities are multifaceted and evolving. Even within each population grouping, there might be substantial differences in vulnerabilities, service coverage and outcomes based on personal circumstances. Understanding the complexity of layered identities and behaviours situated within unequal power dynamics, and how these change over time, can help pinpoint at a more granular level where targeted efforts are most needed. Some of the many factors that shape the HIV inequalities experienced by identified priority populations are discussed later in this framework.

Recognizing the interplay between these various factors and identified population groups, the following sections provide relevant information concerning some of the populations identified by the Joint Programme as generally being at higher risk of exposure to HIV and least likely to have access to comprehensive HIV prevention, treatment and care services. These include women and girls, key populations, and other groups within specific settings whose experiences may render them at higher HIV risk than the general population.³ More detailed information on other priority populations is provided in Annex 3.

Women and girls

Globally, over half of people living with HIV are women, and women accounted for more than half of new HIV infections in 2021. Adolescent girls and young women are particularly at risk, with 4900 globally acquiring HIV every week in 2021. In sub-Saharan Africa, women and girls accounted for 65% of new infections among adults (15 years and older) in 2021. Adolescent girls and young women (aged 15 to 24 years) in the region accounted for 31% of HIV infections in 2021, despite representing just 10% of the population. Adolescent and young mothers have lower rates of retention in HIV care and treatment, and higher rates of new infections during pregnancy and breastfeeding (14). Outside of sub-Saharan Africa, many women and adolescent girls assumed to be at elevated risk of HIV infection are recognized as belonging to one of the key population groups described below, including simply because they are the sexual partners of men who belong to key populations (15). Although there have been steady declines in new HIV infections among women globally, the number of infections among women rose in central and eastern Europe and the Middle East and North Africa, fuelled in large part by gender inequalities and violence against women (16). Further disaggregating the specific issues for adolescent girls and young women in each context is key to an inequalities analysis, highlighting the ways in which more granular attention is needed.

³ Key populations can be defined as populations who are at increased risk of HIV, irrespective of local epidemiology. The five key populations identified in the Global AIDS Strategy 2021–2026 are: people living with HIV; gay men and other men who have sex with men; transgender people; people who inject drugs; and sex workers and their clients (1).

Key populations

Key populations and their sexual partners accounted for an estimated 70% of new HIV infections globally in 2021, and 94% of new infections outside of sub-Saharan Africa. This highlights the need to understand where, how and which populations in each country are affected by HIV, which is recognized to be a central strategy to help direct an effective response. Key populations include women, men and gender-diverse individuals of all ages, as described below.

Compared with people who do not inject drugs, the risk of acquiring HIV is 35 times higher for people who inject drugs. Transgender women have a 14 times greater risk of acquiring HIV than adult women (aged 15–49 years). Female sex workers have a 30 times higher risk of acquiring HIV than other adult women (aged 15–49 years) in the general population. According to the most recent global data, gay men and other men who have sex with men have a 28 times greater risk of acquiring HIV than adult men (aged 15–49 years) in the general population. Of course, the risks are not the same for everyone within each identified key population, and they will be further determined by a range of additional factors, including the economic, legal, social, cultural and political environment within which people live (see Box 2 below). Even within identified key populations, there remain significant data gaps, such as for adolescent and young key populations, transgender men and male sex workers. This lack of data—alongside reluctance in some places to prioritize services for key populations, including the women and girls among these populations—can create blind spots in programming and thus contribute to the risk of those groups being left behind.

Box 2. Intersecting drivers of vulnerability: diversity among key populations

Recognizing the heterogeneity of key populations and the trends of HIV epidemics affecting them is key to addressing inequality. Certain people within an identified population may be at higher risk than others due to intersecting and overlapping factors. This can contribute, for instance, to different experiences of stigma and discrimination, to varying political, economic, social and environmental conditions, and to different availability, accessibility, acceptability and quality of HIV-related services.

An example of a highly heterogeneous key population is people who engage in sex work. This population may include women, men, transgender and other gender-diverse people over the age of 18 who exchange sexual services for money or goods (18). People engaged in sex work, for example, have diverse sexual orientations, and they may be young adults or older people, poor or rich, close or far away from services, married or unmarried or have disabilities (19). They also may be members of ethnic minorities (including displaced indigenous peoples), and they may have many other individual characteristics that affect their experience with HIV-related inequalities.

Often the data on key populations are gathered, analysed and/or presented in a manner that fails to capture this diversity. This, in turn, obscures inequalities in HIV-related risk and outcomes. Based on available data, people engaged in sex work across the gender spectrum (identified as including women, men, transgender and other gender-diverse people) accounted for approximately 8% of all new adult HIV infections globally in 2019 (20). Transgender women who sell sex often have higher HIV rates than cisgender female sex workers; in some countries, the reported rate has been more than 20 times higher (18).

While having these data is an important start, their availability can obscure the fact that, in many places, there are few data on other groups within a particular population—such as male sex workers—even though these other groups may experience additional challenges and vulnerabilities. That is why understanding who is being left behind requires the ability to disaggregate key population data in order to identify who within identified population groups is being reached, who is being excluded and who is “experiencing multiple and intersecting forms of discrimination and inequalities” that result in significant inequalities in HIV risk and outcomes (2).

Other priority populations

While ending AIDS by 2030 requires a continued focus on women and girls and the key populations mentioned above, other populations that bear a significant burden of HIV infections in some locations and are at risk of being left behind must also be considered. Across all regions, identifying priority populations and subpopulations is highly contextual and requires a close look at the people who fall within and across groups. People who may be at elevated risk of HIV include (among others): people in prisons and other closed settings; young people; children; men and boys; persons with disabilities; ethnic and racial minorities; people in humanitarian and conflict situations, including refugees and internally displaced persons; migrants; people in uniform; indigenous peoples; and people living in poverty (21). It is important to note that the above list lends itself to intersecting inequalities, as people may fall into one, some or even most of these categories simultaneously. Additionally, some people—including older persons living with HIV—may experience poorer outcomes after HIV infection because of particular challenges in accessing testing and/or treatment services and thus be at greater risk of comorbidities. Annex 3 serves as an expanded resource that brings together HIV-related information concerning the populations described above.

Intersectionality

“Evidence shows that the disparities in HIV service access, HIV incidence and AIDS-related mortality are the result of multiple, overlapping inequalities, and unequal access to education, employment and economic opportunities.” — Global AIDS Strategy 2021–2026 (1).

Despite significant attention to inequalities in the global HIV response, additional work is still needed to better understand and address intersectional inequalities. The indivisible and interconnected nature of human rights supports this attention to intersectionality, with attention to the multiple, overlapping inequalities that affect different populations differently.⁴

An individual's vulnerability in the context of HIV is generally the result not of one disadvantage or deprivation, but of many factors that reflect the multifaceted nature of their identity and the types of discrimination they encounter (2). For an individual, their HIV outcomes can be heavily influenced not only by HIV-related stigma and discrimination, but also by other forms of

⁴ Intersectionality can be understood as the ways in which social categorizations at the individual and group levels (such as race, class and gender) overlap to create interdependent systems of discrimination or disadvantage (19).

discrimination, including discrimination based on race, sex, age, socioeconomic status, ability/disability, sexual orientation, gender identity or national origin (22). It is this “convergence of multiple, concurrently existing identities” that shapes people’s experiences of stigma and discrimination, determines their vulnerability to HIV and influences their ability to access services (23). For example, the stigma and discrimination faced by a wealthy, white, well-educated man who has sex with men might be far less than that faced by a man who also has sex with men, but who is poor, Black, has little education and little or no access to pre-exposure prophylaxis (PrEP). Power and privilege can provide a buffer against some structural and social drivers of HIV, actually exacerbating inequalities within groups. Understanding the intersectional nature of HIV inequalities requires engaging with how overlapping forms of oppression, discrimination and marginalization are experienced by individuals (24).

“More than 40 years into the HIV epidemic, stigma and discrimination continue to ruin lives and undermine efforts to end AIDS. Overlapping forms of discrimination humiliate people, deter them from using health and other essential services, and harm their health.”— *The 2022 Global AIDS update: in danger* (8).

Given this complexity, it has long been recognized that HIV programming cannot take a “one-size-fits-all” approach. It cannot even be effectively tailored for key populations across all contexts due to the diversity within those populations. Individual experiences can also change over time as identities and behaviours change, as can cultural assumptions around age and capacities and the legal frameworks within which people live. These changes all have a profound impact on how best to address HIV risk and outcomes. For example, as a child living with HIV ages into adolescence, the HIV-related stigma they may experience can intersect more explicitly with racism, gender discrimination, homophobia, transphobia, discrimination towards migrants or other forms of discrimination (25). Similarly children and adolescents who are perceived to be gender-diverse are at higher risk of sexual violence and bullying in all parts of the world (26). Their experience is not of multiple, separate stigmatized identities, but rather how their respective identities intersect to produce an individualized experience of heightened stigma and discrimination. It is crucial to recognize this complexity and identify how it can best be addressed in the HIV response.

The following text box provides an example of intersectionality, looking at the context of HIV and how women and girls may simultaneously experience a range of inequalities.

Box 3. Highlighting gender inequalities: intersectional inequalities experienced by women and girls

While women and girls are at risk of experiencing various forms of oppression, this experience will be greatly influenced by the coexistence of other determinants, such as socioeconomic status, age, sexual orientation, geographic location, migration status, health, the legal and cultural environment, and many other factors (24). The following is just one example of how women and girls may experience intersectional inequalities that shape their HIV risk and outcomes.

Adolescent girls may have fewer opportunities to attend school than their male peers because of poverty and cultural norms that devalue the education of girls. Where school fees exist, adolescent girls may engage in transactional sex to cover the costs of school,

putting them at higher risk of unintended pregnancies, HIV and gender-based violence due to power imbalances between them and their sexual partners (22). The HIV risk that a girl faces in this setting is therefore at the intersection of her risk as: (a) a female; (b) a young person; (c) someone living in poverty; (d) someone living in a society that undervalues girls' education; and (e) someone engaging in transactional sex who may face difficulty negotiating the use of condoms. Additionally, where laws prevent access to sexual and reproductive health services—including HIV testing, information and related services without parental consent—the chance of a girl being able to protect herself from HIV risk and negative outcomes is greatly decreased. Understanding how all of these factors intersect to shape HIV-related vulnerabilities is the first step towards identifying priority actions to address them.

An intersectional approach is not only important when considering how best to address an individual's risk of acquiring HIV, but also in designing HIV programmes that can offer them needed prevention, treatment, care and support to deliver the benefits of scientific advances for all people, including those who experience intersecting inequalities (1). Vulnerability to HIV and unequal outcomes within any population group varies widely depending on the additional challenges and disadvantages that each person might face, requiring nuanced approaches to policies and programmes. It is well known that aggregates and averages may hide and leave behind the most disenfranchised individuals. Paying attention to this range of inequalities, as well as their drivers, is therefore key. These drivers will be explored in the next section.

Drivers of inequalities in HIV and compounding effects of different factors (Why are people being left behind?)

A key principle of the Global AIDS Strategy 2021–2026 is to “address intersecting structural and social inequalities and prioritize actions that may be difficult but are needed the most, rather than focus on easier actions that do not confront persistent inequalities” (1).

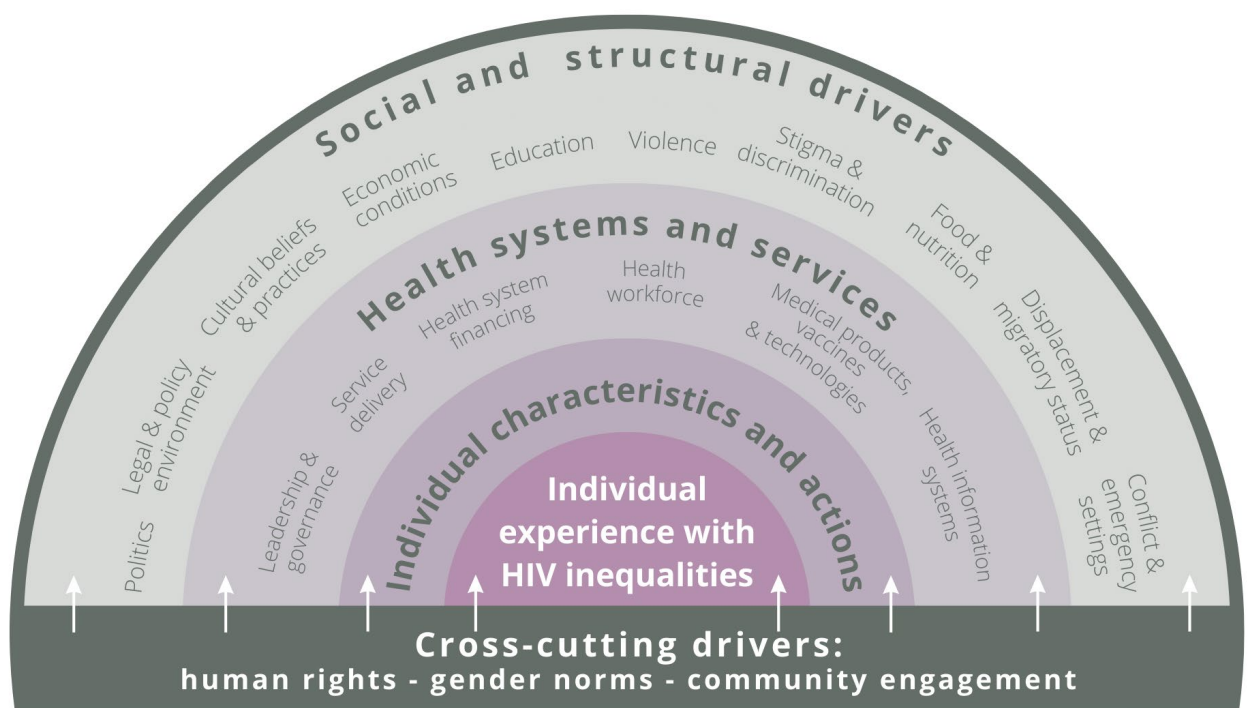
To tackle the persistent inequalities recognized in the Global AIDS Strategy 2021–2026, the immediate, underlying and root drivers of the deprivations, disadvantages or discriminations that cause people to be left behind must be identified and addressed. The intersection of these drivers can have cumulative, mutually reinforcing effects—both HIV-related effects and more general ones—that lead to systemic disadvantages and the perpetuation of discrimination, inequality and exclusion from generation to generation (27). Addressing inequalities therefore entails: (a) addressing social and structural barriers that over time frustrate the equal enjoyment of human rights and gender equality; (b) reversing unequal distributions of power, resources and opportunities; and (c) challenging discriminatory laws, policies, institutions, social norms (including gender norms) and stereotypes (28). Failure to apply an inequalities lens may inadvertently result in HIV programmes that inadvertently exacerbate inequalities.

Focusing on drivers of exclusion—including personal circumstances that leave some people within a population more vulnerable than others—rather than solely on identified populations is not only more effective, but it can also help to avoid creating or reinforcing stigma against specific groups or treating an entire subgroup as homogenous and equally served or unserved. It can also help to uncover the reality of intersectional disadvantages and their fluidity over time, and it can unpack context-specific drivers of inequalities to clarify why an identified group's experience

might vary from place to place. Finally, it can help identify drivers of exclusion and inequalities that affect multiple populations—that, if addressed, could positively impact both the HIV epidemic and the achievement of multiple SDGs.

This section sets out some of the main social and structural drivers of HIV-related inequalities, looking first at the cross-cutting drivers of human rights, gender norms and community engagement. These drivers each have a critical, direct impact on HIV inequalities, and they underpin other social and structural drivers. Next, the section highlights some of the main social and structural drivers of HIV inequalities, and how these drivers can become compounded. It then moves to an examination of how health systems can actually address or drive HIV-related inequalities. All of these drivers also may be manifestations of power imbalances, social norms and other cross-cutting, underlying dynamics of societies. When determining an appropriate strategy for addressing HIV-related inequalities, it will be important to identify any additional context-specific drivers that may not explicitly be included in the following section.

Figure 1. Identified drivers of HIV-related inequalities



Source: Figure based on: Dahlgren G, Whitehead M. Policies and strategies to promote social equity in health. Stockholm: Institute for Futures Studies; 1991.

Figure 1 depicts the social, structural, systems and service drivers of HIV-related inequalities that are covered in this framework, including those that are cross-cutting. Many of these factors have the potential to influence inequalities positively or negatively. The bottom band depicts the cross-cutting drivers of human rights, gender norms and community engagement; these impact the dynamics of all the other bands, in that protection of human rights, gender equality and community engagement and leadership can be very beneficial, even as violations of human rights, gender inequality and lack of community leadership in the HIV response can individually

and collectively seriously worsen people's experiences of HIV inequalities and outcomes. Where beneficial, these cross-cutting drivers can be thought of as the societal enablers discussed in the Global AIDS Strategy 2021–2026.

The outer band in Figure 1 depicts the social and structural factors that can act as drivers of HIV inequalities, which affect an individual's risk of acquiring HIV and deliver poor HIV outcomes. These social and structural factors shape and interact with the different elements of health systems and services (depicted in the second outermost band), which can themselves be drivers of HIV-related inequalities. These social, structural, systems and service drivers further interact with individual characteristics and actions in various ways that mould an individual's experience with HIV-related inequalities. Interactions across drivers are recognized to be complex and multidirectional.

In addition to understanding intersections of different vulnerabilities experienced by the same person, it is equally important to analyse and address the multiple drivers operating across different levels that drive each type of inequality. Box 4 provides an illustrative example of some of the different drivers of HIV-related inequalities and how these may impact gay men and other men who have sex with men in certain settings.

Box 4. Highlighting the range of drivers of loss to follow-up from antiretroviral therapy services among gay men and other men who have sex with men: an illustrative example

In a setting where there is particularly high loss to follow-up from antiretroviral therapy services among gay men and other men who have sex with men, stigma and discrimination against them may exist within those services and discourage retention. This in turn may be driven by a lack of investment in training and sensitization for health workers to provide population-friendly services. This might be due to a simple lack of prioritization, but it may also be due to societal attitudes, such as the existence of a law that criminalizes same-sex sexual relations between men. Such a law might also fuel HIV-related discrimination in other settings, such as workplaces, which itself might discourage men from regular attendance at the antiretroviral therapy clinic because they may be seen, outed as living with HIV and perhaps lose their job.

These layers of interconnected drivers interact to shape the ability and willingness of gay men and other men who have sex with men to engage with treatment services, even where they are accessible and available. Understanding these interconnections can help identify multiple entry points for action to address relevant HIV-related inequalities and ensure that these men are not lost to follow-up.

The drivers described in this section bring together the work that the Joint Programme has produced on different dimensions of the HIV epidemic—and inequalities more generally—because they are particularly appropriate to addressing the intersections of HIV and relevant inequalities. This section is intended to serve as a resource for identifying and addressing the drivers of HIV-related inequalities.

In the remainder of this section, individual drivers of HIV-related inequalities are explored, starting with cross-cutting drivers, followed by social and structural drivers, and then health systems drivers. Finally, their compounding nature is further described.

The UNAIDS Reference Group on Human Rights has provided useful illustrations of the breadth of actions required to address the range of drivers of inequality. Drawing attention to the inextricable nature of social, structural, systems and service drivers of inequality in the context of HIV, they note: “Ending police abuses against key populations requires dislodging stigmatizing attitudes but also structural changes to end impunity for arbitrary detention and torture. Ending inequality in the health of prisoners requires not only access to care equivalent to that outside prison but an end to torture, overcrowding, inadequate nutrition and sanitation in places of detention . . . adequate, enforceable protections in health-care settings for privacy and requirements for informed consent for HIV testing are needed to protect against discriminatory disregard for bodily autonomy and confidentiality” (29).

Cross-cutting drivers of HIV-related inequalities

To achieve progress towards reducing HIV-related inequalities, it will be critical to make more concrete efforts to promote and protect human rights, implement gender-transformative interventions and support community leadership in the HIV response. As a first step, this will require understanding how human rights violations, unequal gender norms and a lack of meaningful community engagement and leadership are driving HIV-related inequalities in a given setting, with a view to informing appropriate interventions.

Human rights

“Recognizing the equal worth and dignity of every person is not only an ethical imperative and an obligation arising from international human rights instruments, it is central for ending AIDS . . . SDG 3 cannot be achieved if stigma, discrimination, criminalization of key populations, violence, social exclusion and other human rights violations in the context of HIV are allowed to continue and if HIV-related inequalities persist.” — The Global AIDS Strategy 2021–2026: end inequalities, end AIDS (1).

Human rights, rights principles and approaches have long been recognized as central to addressing inequalities in HIV vulnerability and outcomes (1). While the promotion and protection of human rights are key to improving HIV-related efforts, the neglect or violation of human rights can exacerbate HIV-related inequalities. Non-discrimination must be central to any effort to address HIV-related inequalities, and a range of rights are key—particularly the right to health. As guaranteed under the International Covenant on Economic, Social and Cultural Rights, the right to health is an inclusive right, extending not only to health care but also to the underlying determinants of health. This approach is further carried out in other human rights documents that guarantee the right to health, such as the Convention on the Elimination of All Forms of Discrimination Against Women and the Convention on the Rights of the Child. Under international human rights law, UN Member States are obligated to ensure the right to the highest attainable standard of health.

As key components of rights principles that are central to an effective HIV response, relevant standards and principles include: (a) the availability, accessibility (including affordability), acceptability and quality of the goods and services provided; (b) non-discrimination and equality; (c) privacy and confidentiality; (d) respect for personal dignity and autonomy; and (e) meaningful

participation and accountability (26). Human rights principles and approaches can effectively be used as a framework to inform and strengthen an HIV response so that it supports all people. This can strengthen the focus on inequalities during the planning and delivery of the HIV response and help identify both current strengths and shortcomings that might act as barriers to achieving HIV targets (30).

Human rights principles and approaches can be used positively at multiple levels to create an enabling environment for the HIV response. At the individual level, the respect, protection and fulfilment of human rights can support people to access and benefit from the HIV response and participate in fostering effective HIV programming. At the policy and programme level, this application of human rights principles can further the effectiveness of HIV services by: (a) improving their availability, accessibility, acceptability and quality; (b) ensuring privacy and confidentiality, as well as accountability for the ways that services are delivered; and (c) bringing attention to the most marginalized communities in the processes of design and implementation. At the societal level, concrete attention to human rights can create an enabling legal, political, social and economic environment that improves service access and uptake by ensuring the safety and quality of life of affected populations and empowering individuals to realize their right to quality services (26).

Where human rights violations occur, inequalities are exacerbated, with many specific implications for an HIV response. HIV-specific examples abound, such as coerced HIV testing of sex workers or coerced sterilization of women living with HIV, but even when human rights are neglected in other contexts, this can negatively impact an effective HIV response.

Intersectional approaches that draw on human rights principles in their application can increase the efficacy of HIV responses (30). Grounded in international law, human rights can also support the use of a framework for accountability for what is and should be done. With important implications for an HIV response, functional and accessible accountability mechanisms within each locality can help to guide course corrections and provide recourse to those whose rights are violated. Human rights are central to addressing HIV-related inequalities and, given their cross-cutting nature, they permeate throughout the Framework and form the backbone of this effort.

Gender norms

Gender encompasses a socially constructed set of norms, roles, behaviours, activities and attributes (31). Unequal power dynamics related to gender have long been understood to drive negative development and health outcomes, and they are a recognized driver of the HIV epidemic (15). Gender inequality contributes to increased HIV vulnerabilities and outcomes, and gender inequality is cross-cutting and must be addressed alongside other intersecting axes of inequality for an effective HIV response.

Women and girls

Unequal power dynamics grounded in patriarchal norms significantly drive the HIV epidemic (15). Gender inequality and discrimination have long denied women equal levels of access to education, economic opportunities and health care, including sexual and reproductive health-care information and services. Gender-based power imbalances may also result in women and girls being denied sexual autonomy, decision-making power, dignity and safety, and they may limit the ways in which women are able to access and use sexual and reproductive health services (8, 15). Autonomy in health-related decisions is thought to be lowest among married adolescent girls and young women, with clear repercussions for HIV vulnerabilities (15). In one of its most extreme

forms, gender inequality can manifest as sexual and gender-based violence, including intimate partner violence (8).

HIV-related laws can specifically be discriminatory against women, but even if they are seemingly gender-neutral, HIV-related laws can disproportionately and negatively affect women. Discriminatory laws—such as those criminalizing HIV transmission, exposure or non-disclosure—can render women particularly vulnerable to prosecution if they are the first person in a partnership to know their status, usually through HIV testing in antenatal care (15). Age of consent laws have been shown to be used predominantly against girls and young women, undermining the HIV response by denying adolescent girls information and services regarding their sexual and reproductive health and impeding their sexual autonomy.

A lack of legal protection against gender discrimination also impacts vulnerability to HIV among women and girls, such as through failure to criminalize or prosecute intimate partner violence or marital rape. Even where ostensibly protective legislation exists, actual implementation may be hampered by social norms and practices (15).

On average, men still earn approximately twice as much as women around the world (33). Gender norms that discriminate against women and girls play out in the contexts of both economic and educational opportunities, and the restricted income-earning and livelihood prospects that result from this may leave them exposed to risk-taking strategies. This type of discrimination undermines their agency and limits their decision-making power within relationships, families and societies, and it heightens their risks of acquiring HIV (15).

Around the world, many women have limited financial autonomy, are disproportionately represented in informal and unregulated sectors of the economy, shoulder the burdens of unpaid care and domestic work, and lack equal property and inheritance rights (15). Access to property and inheritance rights for women can be critical in preventing and responding to HIV by providing women with basic financial security, but this is still not a reality in most parts of the world. Women are also known to perform a disproportionate share of unpaid care work for family members living with HIV, and this—along with the related mental health and other costs to women—hinders their ability to do paid work in the labour market. The gendered care burden around HIV also deepens inequalities between women and men when it comes to education opportunities and other social activities (34).

Gender norms combine with other drivers of inequality in ways that can exacerbate vulnerabilities in certain populations. Box 5 provides an example of how gender and migration can intersect in a way that has a negative impact on HIV vulnerability.

Box 5. The intersection of HIV, gender and migration

Gender, HIV and mobility are deeply intertwined. The needs of mobile populations, including displaced and refugee populations, are not often included in national HIV policies, making HIV prevention and treatment difficult for them to access (15). Women and girls in particular are known to experience increased risk of HIV infection associated with migration processes; migration-associated livelihood insecurity often results in labour becoming further gender-segregated (15, 35). Nearly three quarters of women and girls within mobile populations are thought to work in the service sector, with many of the remainder holding temporary roles or work in the informal sector. All of these employment scenarios contribute to heightened vulnerability to exploitation and violence, including sexual and gender-based violence, which exacerbates HIV-related inequalities (35).

Men and boys

Men generally have lower uptake of HIV testing and poorer HIV-related outcomes than women. Men and boys may not be willing or able to seek HIV services as a result of traditional expectations around masculinity, and this is compounded by related fears of stigma and discrimination and by restricted opening hours for services that may impede attendance for people who work (35). Delayed HIV testing prevents timely initiation of treatment, and it also has implications for HIV prevention. Gendered expectations and norms around seeking services for HIV and sexual and reproductive health—including HIV testing—means that services are more often accessed by women (particularly women of reproductive age, who tend to access services more regularly because they emphasize reproductive health, such as antenatal and postpartum care). Despite some recent improvements, treatment coverage generally remains very low for men and boys (15).

Harmful concepts of masculinity—such as not using condoms and not seeking HIV- or other health-related services—also augment the risk of HIV transmission. For gay men and other men who have sex with men, this risk is further exacerbated when coupled with homophobia and/or discriminatory laws against same-sex sexual relations among men (36).

Transgender and other gender-diverse people

Transgender and other gender-diverse people face heightened risks of violence, criminalization and discrimination, all of which increase HIV vulnerability and unequal outcomes. People from within these communities may be at increased risk of experiencing sexual violence or exploitation. Both sexual and economic violence contribute to HIV vulnerabilities: for example, social stigma and employment discrimination may contribute to transgender persons engaging in sex work, where they are particularly vulnerable to different forms of violence and discrimination that can impact their HIV risk (19, 37). Transgender and gender-diverse people may also experience stigma from health-care providers and systems, and from peers, family members and the broader society, all of which negatively impact their access to HIV prevention, testing and treatment services and to other social protection services. Both institutional and social discriminatory practices can prevent transgender and gender-diverse people from accessing the HIV prevention and care services they seek (15).

Community engagement

A guiding principle of the global HIV response and of all UNAIDS work is the meaningful and measurable involvement of civil society, especially people living with HIV and populations most at risk of HIV infection (1). The Global Aids Strategy 2021–2026 emphasizes the essential role of community-led organizations in guiding its HIV response, and the involvement of community-led organizations is an underlying concept of this framework.⁵

Community-led organizations relevant to the HIV context include groups or networks by and for people living with HIV, key populations and other priority populations—including women and young people—that have priorities rooted in the lived experiences and perspectives of their members and constituencies (1, 38). Community-led responses are "specifically informed and implemented by and for communities themselves," ensuring that policies and services are responsive, including to diverse and changing needs, which results in improved HIV-related outcomes (38, 39).

Community-led organizations have always been well-placed to identify inequalities within their given contexts and suggest how they might be addressed. Explicit integration into the HIV response is critical. For example, community-led monitoring and data collection can provide sources of data that address official data gaps, identify who is truly being left behind and how, and inform more inclusive HIV responses with attention to relevant and intersecting drivers of inequality.

The efficacy and sustainability of the HIV response is dependent on ensuring that the needs of the most marginalized groups are met—and that community involvement increases the capacity of programmes and services to do so. For example, UNAIDS has highlighted meaningful youth participation as key to a sustainable HIV response. Engaging young people in all their diversity as beneficiaries, partners and leaders in HIV responses results in services that are better tailored to their needs and, thus, improved health outcomes, particularly among young, hard-to-reach groups.

Community-led organizations—including those reflecting and representing key populations, women, young people and other priority populations—already play a significant role in ongoing HIV responses. When successfully integrated into HIV response activities, community participation has been shown to improve health outcomes by mobilizing demand for services, providing services and access to previously hard-to-reach populations, strengthening health systems, garnering political support, shifting social norms and creating an enabling environment for access (40). Adequate integration of community leadership and participation within HIV-related efforts is central to ensuring that strategies do not continue to leave people behind or reinforce existing HIV-related inequalities.

Social and structural drivers of HIV-related inequalities

“A central reason why inequalities in the HIV response persist is that we have not successfully addressed the social and structural determinants that increase HIV vulnerability and diminish the

⁵ As defined by UNAIDS, community-led organizations, groups and networks are entities for which the majority of governance, leadership, staff, spokespeople, membership and volunteers reflect and represent the experiences, perspectives and voices of their constituencies, and who have transparent mechanisms of accountability to their constituencies. In the AIDS response, this includes organizations by and for people living with and affected by HIV (38).

ability of many people to access and effectively use HIV services.” — Global AIDS Strategy 2021–26 (1).

To help inform action, this section briefly describes some of the most significant factors that can shape an individual’s experience with HIV-related inequalities. The descriptions of the social and structural drivers of HIV-related inequalities are meant to help inform their interrogation in a given context, as described later in this framework.

Politics

Politics and ideology continue to influence the HIV response, even in the face of solid evidence demonstrating that this should not be the case. This often has the greatest effect on populations who are marginalized or whose behaviours are criminalized. A persistent backlash against women’s rights at the political level, particularly sexual rights and bodily autonomy, perpetuates and worsens gender inequalities that contribute to HIV inequalities. Resilience and even resistance may be required in some settings to ensure appropriate attention to inequalities in the HIV response, including ensuring a response for all affected populations and addressing relevant drivers of inequality. A nuanced understanding of the local political context—including election cycles and perspectives on HIV-related issues held by those in and running for office—is critical to ensuring that any actions taken will be effective and not result in backlash and potential negative impacts on affected communities. The political nature of what it means to address inequalities at every level, from global to local, including potential resistance, cannot be ignored. Opportunities must be identified to create positive political shifts, and these should be taken with utmost care and with communities at the centre.

Legal environment

Laws and policies can be powerful tools to protect the human rights of all people to non-discrimination and health, and to help ensure privacy and confidentiality, free and informed consent, autonomy in health care decision-making, and many other protections (40). In most countries today, however, the legal environment perpetuates stigma and discrimination that impacts HIV and populations that are vulnerable to HIV, thus affecting quality of life and the ability to prevent infection, as well as reducing service access and use (1).

Punitive and discriminatory laws against people living with HIV or at risk of HIV infection continue to affect HIV-related outcomes in myriad negative ways. These laws affect people living with and at risk of HIV infection, with the effects compounded for women and girls, children, young people and gender-diverse populations, all with devastating effects. Criminalizing a wide range of behaviours and aspects of health care not only perpetuates stigma and discrimination but is extremely harmful to the HIV response. This includes the criminalization of same-sex sexual behaviour, sex work, gender identity and expression, drug use or possession, and HIV exposure, non-disclosure and transmission (40). For example, many countries in 2022 still criminalized the use or possession of drugs, 153 countries criminalized some aspect of sex work, 67 countries criminalized consensual same-sex sexual acts, 20 countries criminalized transgender persons, and 134 countries criminalized or otherwise prosecuted HIV exposure, non-disclosure or transmission (8). Criminalization of HIV transmission remains a scourge to be addressed for an effective response.

The criminalization of people living with HIV and key populations is bad for public health, and it contributes to the inequalities that undermine HIV responses (1). Evidence has shown that laws and policies that criminalize the behaviours, actions or existence of key populations result in

reduced access to HIV services and increased HIV risk. Countries with punitive laws towards same-sex sexual relationships, sex work and drug use have significantly lower percentages of people living with HIV who know their HIV status and achieve viral suppression than countries that do not have such laws in place (8, 15, 30). For instance, evidence from sub-Saharan Africa shows that HIV prevalence is higher among female sex workers in countries with punitive and non-protective laws around sex work (41).

More than 11 million people inject drugs globally, among whom an estimated 1.4 million are living with HIV. Punitive drug law enforcement practices have had major negative public health implications: people who inject drugs are forced away from HIV prevention and treatment services, and the mass incarceration of non-violent drug offenders significantly increases their HIV risk (42). Furthermore, many countries continue to ignore evidence that drug dependence treatment is a key tool of the HIV response: less than 1% of people who inject drugs live in countries with high coverage of opioid substitution therapy and needle–syringe exchange programmes, which are key elements of comprehensive harm reduction services that are still often considered illegal (43).

Restrictive laws relating to the agency that adolescents have over their health are consequential barriers to the ability of young people to access sexual and reproductive health services. For example, age of consent laws can require parental consent for an adolescent to access services such as contraception and HIV testing and treatment (1, 15, 44). Often gendered in their implementation, these laws disproportionately hurt girls and young women. There are also additional vulnerabilities to consider in countries where the legal age of consent in relation to sexual activity is lower than the age of consent at which health information and services can be accessed. Again, the impact is different—and disproportionately negative—for girls and young women. Prohibiting young peoples' access to sexual and reproductive health education and services leads to greater risk of HIV, other sexually transmitted infections (STIs) and unwanted pregnancy (15).

Many countries restrict entry, stay and residence for people living with HIV. Irregular migrants living with HIV face additional challenges, such as legal restrictions or fear of deportation, if they attempt to access essential services, such as health care (35).

For anyone whose behaviours are in conflict with the law, the ways in which the law is implemented can also negatively impact HIV-related vulnerabilities. Harsh enforcement of the law, rough treatment of those arrested and inadequate attention to due process have all been found to occur across a wide range of settings. This highlights the important roles played by the police and judiciary in the HIV response, and the impacts that these actions have on HIV-related inequalities. Furthermore, conflicts exist within the legal framework in many countries, creating confusion and fear about rights. For example, some municipal laws on mandatory HIV testing for sex workers are in opposition to federal non-discrimination laws, and in some settings, carrying syringes and needles outside of health-care settings is illegal, despite the existence of a government-mandated harm reduction programme that would presumably include the provision of safe injecting equipment (45).

Policy

Policy can be both a support and a barrier to reducing HIV risk and vulnerability: as a barrier to HIV-related services, policy generally occurs along lines of existing social inequalities. Policies tend to negatively impact populations that are already marginalized in some way: for example, a policy that is blind on gender or disability will negatively affect those groups who were not

considered in the design of the policy disproportionately. These measures undermine HIV responses by reinforcing stigma and discrimination and preventing individuals from accessing HIV services. For example, harmful policies can exacerbate HIV risks faced by members of key populations and incarcerated people, such as certain prison policies that do not permit the distribution of condoms, prison health systems that do not provide PrEP, and policies that require individuals to be housed according to their sex assigned at birth, placing transgender prisoners at heightened risk of sexual violence. Furthermore, attention must be paid not only to the design and presence of policies, but also to their implementation, as policies may not be enforced as intended.

Restrictive policies—with the stigma surrounding HIV and discriminatory attitudes or taboos around women and sex—have a disproportionate impact on women and girls, such as policies requiring women to have proof of their partner’s consent before accessing services (1, 15). According to the most recent available data, at least 40 countries do not address the specific needs of women and girls in their national HIV strategies, nor is it common for a country to allocate any budget for addressing these HIV-related specific needs (1).

Despite the potential role of policy as a driver of inequalities, it can also work to reduce inequalities if appropriately designed and employed. For example, countries can use HIV-sensitive social protection systems to promote health equity and reduce the financial burden of health services for people living with or affected by HIV (46). Social protections include formal and informal initiatives that provide social assistance, social services, social insurance and social equity for marginalized groups. These initiatives can focus on people living in poverty or those sensitive to livelihood shocks, groups who cannot access services, and groups at increased risk of experiencing stigma or discrimination due to any number of intersecting inequalities. Policies that acknowledge the relationship between health and other social protections are able to address the multidimensional aspects of poverty, and their correlation to HIV vulnerability, risk and outcomes (46). By engaging populations that are socioeconomically disadvantaged, HIV-sensitive social protections can promote equity, alleviate conditions that increase HIV risk, and broaden availability and access to HIV-related services and support (46).

Economic conditions

Social and economic exclusion or marginalization are also known to affect people’s ability to protect themselves from HIV (1). Even as wealth inequalities between countries have declined in recent decades, wealth inequalities within countries have significantly increased (33). Even prior to the COVID-19 pandemic, based on 2015–2020 data from 80 countries, as income inequality is more pronounced, countries tend to have higher HIV incidence (statistically significant based on p -value < 0.001) (27).

Poverty is not simply an individual-level characteristic: it is created and perpetuated by exclusionary policies and systems. Policies limiting inheritance rights, justice systems with high imprisonment rates, methods of market regulation, rules of trade and financial systems, limitations in access to natural resources, foreign occupation and exploitation, and apartheid and racist governments are just some examples of underlying, fundamental drivers of economic inequality that are known to lead to intergenerational cycles of poverty and marginalization and the inequitable distribution of wealth (2).

In most places, poverty is linked to increased vulnerability to HIV and poorer HIV outcomes through multiple pathways. Situations of poverty may, for example, lead people to migrant labour practices, which can erode social cohesion and disrupt family structures, create food insecurity,

and lead to reduced access to HIV-related information and services, including condoms or power to negotiate condom use (27). Women's lower access to financing, financial literacy and financial instruments can also increase their risk of acquiring HIV and lower their ability to mitigate living with HIV. HIV may in turn contribute to poverty, as families affected by HIV may experience job loss and/or rely on financial coping strategies that reduce the economic capacity of the household, such as selling productive assets, using household savings, obtaining loans or removing children from school (27). Economic inequalities within societies include intergenerational disparities and persistent wealth gaps, and intergenerational cycles of disadvantage contribute to persistent health disparities related to socioeconomic status (47). In certain contexts, poverty and HIV can have an inverse relationship to what is described above. In parts of sub-Saharan Africa, wealthier countries and individuals have higher HIV prevalence than their poorer counterparts (48). This highlights that the relationship between economic conditions and HIV is not static and that it can continue to change over time.

Education

The completion of secondary education has been shown to protect adolescents and youth, particularly girls, from acquiring HIV infection (8, 15, 27). Furthermore, women with higher educational levels are generally recognized to have stronger decision-making power about their sexual relationships and health-care access. Educational levels are influenced by the strength and reach of the education system; as such, education system strengthening may be an important intervention to help reduce HIV-related inequalities.

In addition, quality comprehensive sexuality education (CSE) can help to reduce sexual risk behaviours among young people and reduce HIV-associated stigma (15, 27). It can also contribute to positive health and development outcomes, including poverty reduction and gender equality, thus addressing other drivers of HIV-related inequalities (15). However, it still remains taboo in some cultural contexts to discuss HIV, and there are concerted and organized efforts in every region of the world to dismantle CSE (49). All of this hinders educational opportunities for young people to learn about modes of transmission, prevention, risk and options for treatment and care services, particularly among young people who have limited access to the Internet or other sources of health information (27).

Violence

Gender-based violence is an extreme manifestation of gender inequality that includes violence against women and girls, as well as violence perpetrated on people within or believed to be within lesbian, gay, bisexual, transgender and intersex populations (LGBTI) (8, 15, 27). These and other various forms of violence are bidirectional in their linkage to HIV, meaning violence can be a factor in increased HIV vulnerability and that living with HIV is a risk factor for violence (24).

Prevailing social and cultural norms related to patriarchal taboos and shame around female sexuality contribute to a lack of female autonomy, agency and choice; favour male power in sexual relationships; and in so doing contribute to gender-based violence. Socially constructed, harmful ideals of masculinity promote dominant, aggressive behaviours and heterosexism among men and boys, heightening the risk of them engaging in acts of violence against women and girls and people perceived to be in LGBTI communities (50). Nearly one in three women have experienced physical and/or sexual violence in their lifetime, a statistic that increases during displacement and times of crisis (51). This increases risk of acquiring HIV for women and girls, and it can lead to reduced access and adherence to treatment among women living with HIV. Students from within LGBTI communities are reported to be between three and five times more

likely to experience school-related violence than their peers, leading to a higher likelihood of them missing or not returning to school, thus increasing their vulnerability to HIV (52).

Women who experience intimate partner violence in high-prevalence HIV settings are more than 50% more likely to be living with HIV compared to women who have not experienced partner violence (1). In all parts of the world, women, girls and gender-diverse people who learn of and disclose their HIV status are at increased risk of experiencing various forms of violence. Between 68% and 95% of women living with HIV experience intimate partner violence in their lifetime: it heightens HIV risk through potential transmission and can also prevent the ability to access to HIV and other health services (24, 53).

There are many other forms of violence that significantly contribute to HIV-related inequalities for women and girls, key populations and other priority populations. Non-partner sexual violence heightens HIV risk through direct transmission, and it often coincides with other axes of inequality, such as living with a disability, being engaged in sex work, being incarcerated, or living in conflict and humanitarian settings. Psychological and emotional violence is heightened against individuals living with HIV; it can present as stigma or discrimination and can include verbal abuse, all of which can contribute to preventing individuals from accessing HIV services. Economic or financial violence can manifest in various ways; it is often gendered and can include an intimate partner maintaining control over the other partner's access to economic resources or preventing the other partner from seeking health care or opportunities, such as employment or education. Economic injustice on a wider scale relates to various intersecting inequalities that contribute to the lack of sustainable livelihoods experienced by many people living with HIV. Structural and institutional violence heightens the inequalities in HIV vulnerability and outcomes by further entrenching other drivers of inequality through discriminatory laws and policies and lack of protections for vulnerable populations (24). Examples of structural and institutional violence include racism in all its forms, homophobia, income inequality, sexism, ableism and many other means of social exclusion—all of which lead to HIV-related vulnerabilities, such as incarceration, poverty and lack of access to health and social protection services.

Stigma and discrimination

Stigma and discrimination violate the rights and dignity of people living with or affected by HIV, which often results in denying them access to HIV prevention, testing and treatment services. Among the societal enabler targets in the Global AIDS Strategy 2021–2026 are that by 2025, less than 10% of people living with or affected by HIV experience stigma and discrimination, and that less than 10% of countries have punitive laws and policies or barriers in place to accessing justice. These experiences of stigma and discrimination and lack of access to justice are well known to exacerbate HIV-related inequalities, particularly when they conspire to affect the same people all at once.

HIV-related stigma is evident in irrational or fear-driven negative attitudes, behaviours and judgments towards people living with HIV, their partners, families and communities. HIV-related discrimination results in unfair and unjust treatment of a person or group of people based on their real or perceived HIV status. HIV-related discrimination also includes the unfair treatment of key populations, women and girls, and other groups, including people with disabilities, older people, indigenous populations, mobile and migrant populations, and prisoners and other incarcerated people. People who fall into more than one of these categories are particularly impacted. Discrimination on the basis of HIV status, sexual orientation, sex and gender identity and expression, health status (including drug dependency) or sex work can constitute human rights violations (40).

A systematic review and meta-analysis of studies conducted between 2002 and 2016 found that people living with HIV who perceive high levels of HIV-related stigma are 2.4 times more likely to delay enrolment in care until they are very ill (54). Across countries with available data in 2020, up to 21% of people living with HIV reported being denied health care in the past 12 months (40). Stigma and discrimination increase the risk of HIV acquisition and progression to AIDS, violence and marginalization, and they can affect access to social support. At the same time, they can also reduce access to health care, education, employment and justice. For example, the perceived stigma associated with an HIV-positive status has been found to be a significant deterrent to women reporting or pursuing property and inheritance rights violations, which are known to affect women disproportionately and to impact their vulnerability to HIV and HIV-related outcomes (22).

Both HIV-related stigma and discrimination can be compounded by other forms of discrimination. Stigma and discrimination based on the perception of HIV status or on behaviours, activities, sex, age, race, class, ability/disability, socioeconomic status, national origin and other categories of difference underlie many other drivers of HIV-related inequalities. Even in countries and regions that show strong progress towards ending their AIDS epidemics, stigma and discrimination continue to impede equitable progress, affecting not only uptake of HIV services but also quality of life for many people. Particularly in the context of addressing inequalities, decisions about how and where to scale up any elements of the HIV response should be evidence-informed and seek to support the most marginalized within a society. Where this does not occur—and where responses are instead based on prejudicial assumptions or a discriminatory refusal to acknowledge which people are most affected and in need of services—inequalities are fuelled (26).

HIV-related inequalities are worsened by stigma and discrimination across many dimensions of people's lives, including in the law, in health-care settings, in educational settings, in the workplace and in humanitarian settings. Through different pathways, this can worsen poverty, create additional vulnerabilities to HIV and other health concerns, and reduce access to HIV and health services. These impacts can also be intergenerationally felt, exacerbating a negative spiral.

Food and nutrition security

Adequate food and nutrition are critical to good HIV outcomes. Food insecurity and poor nutrition undermine the effectiveness of HIV treatment and adherence to it, which negatively impacts individual outcomes and increases the potential for onward HIV transmission. HIV impairs the body's ability to ingest and absorb nutrients; inadequate dietary intake exacerbates an individual's vulnerability to undernutrition, compounding the existing immune impairment. This causes increased susceptibility to opportunistic infections, and increased morbidity and mortality (55). Food and nutrition insecurity augment the socioeconomic impacts of HIV, including by reducing work capacity, compromising an individual's livelihood and ability to maintain nutritional support (46).

Cultural beliefs and practices

As with many drivers, cultural beliefs and practices have the potential to either reduce or exacerbate HIV-related inequalities. For example, protective associations have been identified in some circumstances between religion, faith and spirituality, and certain primary HIV prevention activities, such as condom use and HIV testing (56). In this way, community and faith leaders have played an essential role in promoting practices that reduce HIV risk and offer support to affected communities. Community and faith leaders can also negatively contribute to cultural

beliefs about key populations, such as promoting negative attitudes about women, people living with HIV and LGBTI communities.

Meanwhile, harmful cultural practices such as female genital cutting can significantly increase HIV transmission risk for women and girls, and cultural barriers can hinder access to HIV services and other health services (57). For example, cultural beliefs that encourage pregnant women to see traditional birth attendants exclusively and not to seek antenatal care at health facilities may result in reduced access to HIV testing and treatment services for women and their children, including services to prevent mother-to-child HIV transmission (58). In some societies, myths around HIV may still persist, including false beliefs about transmission and treatment, while cultural practices such as polygamy, widow inheritance and early marriage also make women especially vulnerable to HIV infection (59, 60). Taboos around women's sexuality are a further example of how cultural expectations can impact women's access to prevention services, such as when women who carry or purchase condoms may be assumed to be engaged in sex work (59).

Displacement and migratory status

Displacement and migration are pressing humanitarian challenges for the 21st century; between the years 2000 and 2020, the rate of international migration grew 2.4% annually. In 2020, there were 281 million international migrants, including 29.9 million refugees. The end of 2020, the last year for which figures are available, also marked a record number of internally displaced persons (55 million) (61).

In and of itself, migration does not drive HIV vulnerability or unequal outcomes, but the significant diversity within mobile populations and the services on offer to them means that there are certain groups that experience heightened risk due to migration (35). Displacement and migration have direct and indirect repercussions for HIV vulnerabilities and outcomes, which vary during different phases of migration.

At its most basic level, access to HIV treatment and prevention services becomes challenging during migrant travel and transition to a host country. This can lead to late diagnosis of HIV and increased treatment interruption. Irregular migrants are also likely to experience limited access to HIV-related services for prolonged periods of time. This is due in part to legal restrictions in many places on the provision of services to individuals who move and are not recognized as citizens, and in part to the fear of deportation that may prevent individuals from seeking out essential services (35). Groups that are especially vulnerable to exclusion and its myriad impacts include refugees and stateless persons, and this experience can be particularly compounded for women, girls and boys (2). Mobile populations also experience a number of issues with health-related ramifications, such as poor nutrition, lack of services related to opportunistic infections (like tuberculosis), and challenges related to water, sanitation and hygiene—all of which increase HIV-related vulnerability. Furthermore, existing vulnerabilities among key populations are significantly pronounced in situations of migration-related insecurity when compared to their non-mobile counterparts (35).

Inequalities in HIV vulnerabilities and outcomes associated with mobile populations remain largely unaddressed. Ministries of health often lack experience in issues experienced by mobile populations. Funding is an additional challenge, as a large portion of HIV donor institutions inadequately address mobile populations in their work (35).

Conflict and emergency settings

The disruption of health-care delivery in conflict and emergency settings limits access to services relevant to HIV prevention (such as information, PrEP, voluntary medical male circumcision, condoms and opioid substitution therapy), as well as continued treatment for people living with HIV. Though relevant only in certain circumstances, conflict and humanitarian emergencies can result in the breakdown of social cohesion, limitations in access to resources such as food or income, displacement or limitations on mobility, and the disruption of infrastructure, including education, communication and health-care delivery systems (55). Emergencies also exacerbate other drivers of inequalities, such as economic conditions and food and nutrition insecurity, and can they cause increased levels of sexual violence and stigma and discrimination. Inequalities in HIV risk and outcomes are increased during conflict and in emergency settings by compounding existing vulnerabilities in key populations (55).

People living with HIV and their households may already have only limited access to essential services, medicines and other commodities at the onset of an emergency, which is a time when services are often disrupted. Furthermore, access to HIV prevention, care and treatment services in protracted humanitarian situations can remain limited, while vulnerability to HIV may increase for some groups (55).

Women and children living in conflict and emergency settings may experience a disproportionate increase in HIV risk and vulnerabilities due to such factors as lack of rights protections, poverty and food insecurity. The co-existing challenges of livelihood insecurity and the breakdown of social structures during conflict or emergencies can lead to emergency-related coping mechanisms, such as transactional sex. People who engage in the sale and exchange of sex in humanitarian settings are diverse, but the entirety of this group faces health risks, including increased vulnerability to HIV and violence (19).

HIV risk and vulnerability during conflict and within emergency settings are dynamic and extremely contextual—and the responses to them should reflect that. Effective HIV-related humanitarian responses account for each context's baseline HIV prevalence among different populations and geographies as a basis for prioritizing and targeting interventions (55).

Health systems drivers of HIV-related inequalities

Health systems operate within an environment shaped by the social and structural drivers of HIV-related inequalities described above. Yet they also warrant additional exploration given their centrality to any HIV response. Gaps in systems, including services, exist in every country, but the specificity of the gaps varies. Annex 4 and the “Universal health care: exploring the synergies” section describe the importance of health systems to both reducing HIV-related inequalities and promoting universal health coverage—two intertwined strategic goals for most countries.

The health system model of the World Health Organization (WHO) is comprised of six interconnected building blocks that are critical to the overall system's effectiveness. It is important to assess each of these so-called building blocks of the health system in order to understand why the system may not be meeting the ever-evolving needs of current and potential users. Long-term organizational change may be required to support large-scale redistribution of resources across the health system to address HIV-related inequalities (62). The relevance to HIV of each building block is briefly examined below.

Leadership and governance: Leadership is responsible for decisions about resource allocations and oversight of their implementation. However, leadership may choose to prioritize so-called

quick wins and/or shy away from what it sees as more sensitive services, such as HIV services designed to support key populations. Furthermore, participatory decision-making and oversight are key but often overlooked principles that underlie people-centred health services. Leadership of women, young people and key populations is often under-prioritized. Effective governance, which requires mechanisms to ensure transparency and accountability, is key to support investment in and maintenance of a sustainable HIV response within the overall health system. In order to achieve HIV-related targets, decisions must be made at the highest level (and indeed at every level) to prioritize attention to inequalities—to identifying those being left behind, making every effort to reach them and providing them with the best services possible. These decisions affect each one of the other building blocks.

Service delivery: Where community engagement is lacking, health workers may not give sufficient attention to quality of care, including “friendly” and gender-responsive service provision, non-discrimination or client preferences. Such preferences might include, for example, differentiated service delivery and/or—conversely—integrated services. For instance, although tuberculosis is the leading cause of death among people living with HIV, less than half of the estimated incident tuberculosis cases among people living with HIV are diagnosed and treated appropriately, and there is poor uptake of treatment regimens for latent tuberculosis infection. Similarly, prevalence of and mortality from cervical cancer are disproportionately high among women living with HIV, even when receiving antiretroviral therapy. Services for prevention, screening and treatment of tuberculosis and cervical cancer are often insufficiently integrated with HIV services and often not available at scale. Other services that are generally insufficiently integrated into HIV services include mental health, STIs, treatment services for drug and substance use, and services for the prevention and treatment of hepatitis C (1). When sufficiently funded, community-led organizations can play a key role in HIV-related service delivery; community engagement in government service delivery is also needed (63).

The right to health—encompassing the standards of availability, accessibility, acceptability and quality—provides useful guidance for ensuring rights-based HIV-related service delivery (see Box 6, below).

Box 6: the right to health: availability, accessibility, acceptability and quality

Availability means that “[f]unctioning public health and health-care facilities, goods and services, as well as programmes, have to be available in sufficient quantity” (64).

Accessibility means that “goods and services have to be accessible to everyone without discrimination,” and that includes physical and geographical accessibility as well as economic or financial accessibility (i.e., affordability) (64).

Acceptability means that all “health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e., respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned” (64).

Quality requirements include that “as well as being culturally acceptable, health facilities, goods and services must also be scientifically and medically appropriate and of good quality” (64).

Applying an inequalities lens to these standards means considering them for all affected populations within service delivery and determining how each of these can most usefully support the HIV-related services on offer.

Health system financing: In almost all countries, government allocations to health and HIV services could usefully be increased; depending on the context, promising avenues for raising the additional funds to do this include pooled funding mechanisms, such as progressive taxation policies. Ensuring that HIV-related financing for facility-based service delivery—including human resources, laboratory infrastructure, information systems and supply chains—is channelled through the health system rather than used to set up parallel systems can maximize in-country efficiencies. Sufficient funding for community-level services, such as social contracting, has also been found to be crucial.

Out-of-pocket expenditures still account for a large share of health-care expenditure in many countries, with particular impacts in low-income countries and for people with limited financial resources. Out-of-pocket expenditures are considered a regressive source of financing, meaning that lower-income groups contribute a disproportionately higher share of their income compared with higher income groups (65, 66). This creates challenges for people of low socioeconomic status, adding a layer of disincentive for many people to access health services.

Health system financing for HIV should be situated within broader funding strategies and include explicit attention to addressing HIV-related inequalities.

Health workforce: The deficit of human resources for health, including for the provision of HIV services and other services needed by people living with HIV, is well-recognized. The health workforce is often concentrated in urban areas, leaving some parts of a country particularly underserved. Shortcomings in health-worker training have been noted, particularly when it comes to the provision of non-discriminatory care to key populations, including people living with HIV. Limited numbers of specialist health workers—including those trained to reach and work in a non-discriminatory way with key and other marginalized populations—also curtail service availability

and quality in many places. Community health workers, often working alongside community support groups, are a key part of the health workforce; as such, they should be recognized and fairly paid. While women constitute the majority of the health workforce, including in service provision and the staffing of community-based organizations, they often are not included in decision-making around the HIV response. The health workforce shapes people's experience of health services, and its overall quantity, quality, distribution and engagement are crucial determinants of sustained quality of care.

Medical products, vaccines and technologies: Frequent stock-outs of drugs, equipment and supplies negatively impact quality of care and can contribute to reduced adherence to antiretroviral therapy and other services. This includes drop-out from care, particularly for people who already face challenges accessing services. At a more macro level, many intellectual property regulations exacerbate inequalities in access to medications and health technologies. Flexibilities in the Trade-related Aspects of Intellectual Property Rights (TRIPS) agreement are relevant to addressing inequalities between countries: while TRIPS was designed to increase access to medicines, including HIV medicines and technologies, reluctance to use these flexibilities continues to impede access in many low- and middle-income countries.

Health information systems: There is already a heavy reporting burden when it comes to HIV-related data, but this is not always carried out with a view to understanding HIV-related inequalities. Data that may be collected through health information systems to address HIV inequalities include not only outcomes, but also information on individual characteristics and available health systems and services. Further detail on these and other types of data to understand HIV-related inequalities can be found in Table 1 in the "Available data and gaps" section (below). In many countries, data reporting is incomplete and data can be of low quality. Many health management and information systems do not capture data disaggregated by the many factors that underlie inequalities. Understanding data gaps and how best to fill them is a key step to an effective response. Of equal importance, however, is ensuring that data are actually used to inform decision-making. Additional data considerations are addressed in "Available data and gaps" (below).

Compounding and intersecting drivers

A better understanding of why and how different kinds of deprivations cluster can allow policies and programmes to be more responsive to lived experiences and make a greater difference in people's lives. This requires "a recognition of the systems of oppression and discrimination" that make certain populations more susceptible to these forms of deprivation and exclusion (2). By considering the intersecting structural, system and service failures that enhance individual HIV risk and vulnerability, programmes can better address the root causes of HIV-related inequalities. Rather than treating the manifestations of these inequalities within siloed, vertical responses, HIV responses are best designed with explicit attention to each of these different levels and to the relations among them—and for what this means for individual experience.

Available data and gaps

Disaggregated data are a critical requirement for understanding HIV-related inequalities and informing responses to them. Despite this, there are a number of challenges to accessing these data, and there is a recognized urgent need to improve disaggregation by sex, age and other stratifiers. This has to some degree been recognized in SDG 17.

SDG 17.18: Enhance capacity-building support to developing countries, including for least developed countries and small island developing States, to increase significantly the availability of high-quality, timely and reliable data disaggregated by income, gender, age, race, ethnicity, migratory status, disability, geographic location and other characteristics relevant in national contexts.

Data on HIV-related inequalities and their drivers exist across a multitude of sources that may not have traditionally been analysed together. A plethora of data collection tools exist for collecting HIV-related data, but they may not explicitly capture inequalities. Similarly, some excellent tools exist to measure inequalities (e.g., the Multidimensional Inequality Framework) but they are not focused on HIV (67). Where such tools are used, this can provide useful data to inform and complement implementation of the HIV-related Inequalities Toolkit.

Significant data gaps nonetheless persist across the world, and these should be identified so that additional information can be sought to inform appropriate HIV-related interventions in the short-term and data collection processes can be improved to minimize gaps in the longer term. The use of so-called non-traditional data sources—such as reports of lived experience and programmatic achievements—will be particularly beneficial. In some places, data gaps may reflect a lack of political will based on sociocultural or religious beliefs to acknowledge the existence of certain behaviours. Absence of data does not constitute evidence of absence of a particular population or behaviour, and it should not be used to justify inaction in specific areas of the HIV response; data gaps may in fact highlight populations that have been intentionally excluded from the response to date. This framework provides an overview of data needs, some illustrative data sources that are useful for understanding HIV-related inequalities, and some suggestions for identifying and addressing data gaps.

Data needs

For each population that is identified as experiencing HIV-related inequalities in a particular context, it is important to assess what data are available and what are missing. This will help understand the level and nature of inequalities that people within the identified population may be experiencing.

Table 1 highlights some of the different types of generally available data that may be useful for understanding HIV-related inequalities and their drivers. It might also help identify which of these types of data are not available and thus creating potential blind spots. Column One includes some of the common HIV outcome data available in most countries. Column Two includes some of the individual characteristics and actions explored above that affect HIV-related inequalities; it is useful to consider how much of the data in Column One can be disaggregated by the characteristics in Column Two (including disaggregation by more than one characteristic at the same time). Columns Three and Four are types of data relevant to the drivers of inequalities based on the social, structural and health system and service factors explored above. Using data

to understand the drivers of the identified inequalities can help inform interventions and advocacy to address them.

Table 1. Useful data for understanding HIV-related inequalities

HIV outcome data (includes 95–95–95)	Individual characteristics and actions	Social and structural factors (includes 10–10–10)	Health systems and services
Incidence Modes of transmission Prevalence Percentage of people living with HIV who know their status Percentage on treatment Viral load suppression Mortality Population size estimates (e.g., key populations, migrants or prisoners)	Sex Sexual orientation Gender identity Age Wealth Education Geography Ability Caste Class Race/ethnicity Incarceration status/history Religion Key populations HIV-related knowledge HIV-related behaviours	Protective laws Criminal and other punitive laws Policies Stigma and discrimination Food security Gender norms Human rights Violence Migration Conflict/emergency Community engagement	Discrimination in services Costs of services/affordability Coverage and distribution of services Distribution of health workforce Quality of services Stock-outs

Analysing datasets from these columns in combination with one another might provide useful insights. For example, if HIV-related outcomes appear particularly poor in a certain region within a country, it would be important to review the distribution of HIV service providers in the region. To better understand the drivers of inequalities in that particular region, it will also be useful to consider additional factors relating to: (a) the health system; (b) the legal and policy environment; (c) human rights and gender equality dimensions; (d) education; (e) socioeconomic status; and (f) stigma and discrimination. Doing so would make it possible to begin creating a more comprehensive picture of relevant HIV-related inequalities and what is needed to address them.

Despite the importance of these sorts of data, it is always important to take into account relevant human rights and ethical considerations when collecting, accessing or using data. These are introduced in Box 7.

Box 7. Human rights and ethical considerations relating to data

While it is important to invest in and expand the availability of disaggregated data, people's safety must remain paramount. This means that the potential risks to individuals and groups must always be prioritized during data collection, analysis, review and dissemination. This can help ensure that no one is inappropriately exposed, categorized and/or potentially put in harm's way.

A set of principles—*A human rights-based approach to data for leaving no one behind*, published in 2018 by the Office of the High Commissioner for Human Rights (OHCHR)—provides normative and practical guidance for data collection, disaggregation and analysis, including for participation, self-identification, transparency, privacy and accountability (2, 83).

Data on these outcomes, inequalities and drivers are likely to be dispersed, even within a very local setting. A range of potential sources is explored below, but these should be augmented each time with context-specific sources, such as national databases, civil society assessments and other research studies.

Data sources

Understanding HIV-related inequalities requires systematic analysis of available data—quantitative (disaggregated, as appropriate and available), qualitative, and legal and policy data. It is important to begin by identifying the range of datasets that are available in any given context. Conversation with the relevant stakeholders can help identify different data sources that might be analysed jointly, including data sources relevant to inequalities that might not have traditionally been considered in the HIV response. Importantly, this should include data from national human rights institutions, organizations working with marginalized communities, and data from local advocates and communities—all of which might help shed light on inequalities that remain invisible in official sources. As data are increasingly georeferenced, spatial disaggregation to the extent available can also be useful (2).

Box 8. Using data from the UNAIDS Country Configurations spreadsheet

The UNAIDS Country Configurations spreadsheet is an internal document that is a useful place to find an overview of data already being collected as part of a particular national HIV epidemic and response, including some potential social and structural drivers of inequalities. Where data are missing, it can be useful to interrogate these gaps to determine the extent to which this is causing blind spots in the response or preventing certain individuals or groups from benefitting from the response.

The spreadsheet includes a list of data sources on which the summary data are based. For example, under the “Societal enablers” heading, a score is provided on “criminalization policies,” which is measured on a scale of 1 to 5, with a higher score indicating a worse situation. This score is based on data from the National Commitments and Policies Instrument (NCPI), so turning to the original data will help identify what types of criminalization policies exist; this, in turn, can help clarify who is most affected by them.

It will also be important to learn the extent to which subnationally disaggregated data are available. For example, the spreadsheet includes national-level data on HIV prevalence among different identified groups, but further analysis can show the differences and variations by geographical area within the country. Attention to geographical differences is key for all aspects of an effective response, such as helping the health sector determine relevant differences in health worker density.

Data on a country's human rights commitments—as well as any relevant concluding observations and recommendations from the human rights treaty monitoring bodies and other Special Procedures and reporting mechanisms—can help shed light on some structural factors, including human rights violations, that are influencing the national HIV epidemic.

When reviewing and analysing data sources, it will be particularly crucial to centre the perspectives and experiences of key and vulnerable populations. Additional context-specific data sources should also be used, including research studies, official data, and qualitative and anecdotal data; this will help improve understanding of the experiences of populations and the strengths and weaknesses of programmatic responses to HIV-related inequalities. Community-led monitoring and research are critical sources of context-specific data.

Annex 2 provides a table of data sources that might be useful to review in order to understand HIV-related inequalities in the national context, including many of the data sources used to create the UNAIDS Country Configuration spreadsheet.

Common data gaps

After reviewing all available data, it is vital to identify and prioritize the gaps in data that limit understanding of HIV-related inequalities and their underlying drivers. A key question is: where is information lacking with regard to understanding HIV-related inequalities among different populations (and groups within each population) and the underlying drivers of these inequalities? Data will help to identify next steps to address inequalities only to the degree that they are inclusive and disaggregated (2).

All countries face data gaps relevant to trying to understand HIV-related inequalities, and context-specific data gaps need to be considered each time. While these gaps vary by country, it is already well known that there is a dearth of data in most places. For example, many settings lack data for prisoners, migrants and other mobile populations, people with disabilities, people who are unhoused, people who use drugs and transgender populations. When considering intersectional inequalities, it is important to remember that data gaps around young women in key populations, transgender men and male sex workers are particularly common.

Accurate population size estimates are an important tool to help guide effective programming decisions. Even where population size estimates exist, or where behaviours are criminalized or highly stigmatized, it is worth recalling that these are likely to be underestimates (68).

Another important factor in assessing the utility of existing data is understanding when the data were most recently collected and how often these types of data are collected. For example, where data are used from surveys that are only conducted every five years, it will be impossible to use them to track changes on an annual basis. It will be important to determine the most useful

frequency for collecting different types of data in order to help guide efforts to address HIV-related inequalities more systematically.

Filling data gaps

Populations who are missing from the data or whose stories are not explained by the data should be recognized and additional efforts should be put in place to determine the relevant HIV-related inequalities to address. It will then be important to identify what interventions might help reach these populations and how data systems might be strengthened to better capture the information needed to appropriately shape local HIV responses.

As noted above, it is important to engage affected communities and community-led organizations to provide additional programmatic and primary data (such as through key informant interviews or focus group discussions) that can complement available data. Where possible, additional investment in more and better quantitative data alongside qualitative data collection might make it easier to understand and address HIV-related inequalities.

Disaggregating data by more than one dimension simultaneously can be a challenge. In some cases—such as disaggregation by both sex and location—it is highly feasible. In other cases, however, it might simply not be possible to disaggregate sufficiently, such as understanding HIV incidence among ethnic minority adolescent girls who live in urban informal settings. Sometimes sample sizes are too small to allow such disaggregation; sometimes data on all of these potential factors of inequality are not collected. There are always trade-offs between sample size, periodicity of data collection and the detail of data collected. It may be useful to reconsider these questions and what is prioritized from an inequalities perspective, because the trade-offs may shift to enable additional disaggregation.

Working with limited data is a challenge, but it is not impossible. The experiences of communities and implementers, including anecdotal evidence, can help guide interventions in the absence of a more formal evidence base. Quantitative, qualitative and policy data are all important and, in many cases, where one of these types of data is missing, the other two can still help give some clarity on the situation if they are jointly analysed. Once all of the relevant data have been amassed, it will be useful for a multistakeholder group to jointly reflect on them and bring their respective experiences to the table to assess data quality, gaps and priorities moving forward. Ultimately, additional data collection may be necessary, but it is important to make the most of the different types of data available to ensure that populations are not left behind just because good data do not exist.

From analysis to planning

The above analysis of data related to HIV-related inequalities is designed to inform action. Investment in structural, rights-based and gender-transformative interventions is crucial to tackle institutionalized discrimination at all levels and across all spaces, and to shift harmful social norms towards equitable norms and practices. Once it is clear what data exist that address the factors that are driving these inequalities and hampering the HIV response, needs can be matched to priority actions in the Global AIDS Strategy 2021–2026 and UBRAF 2022–2026. For example, if a review of both policy data and HIV outcome data indicates that laws criminalizing same-sex sexual relations between men exist, then these can be understood to be a driver of new infections in this population. Programming might then be prioritized to address the impacts of the law, as well as legal advocacy to work towards a change in the law that is in keeping with a country's international human rights obligations. If budget allocation to community-led services is

very low, advocacy might be needed to increase the budget. Finally, a lead Cosponsor can be identified for each priority action based on mandate, capacity and existing portfolio that can design specific activities that serve the dual purpose of contributing to their individual organizational mandate and the UNAIDS goal of reducing HIV-related inequalities. The approach to doing this is explored in the next section.

How to apply an inequalities lens: practical application of the theory

This section bridges the Framework content above and the Toolkit by introducing readers to the practical application of an inequalities lens in HIV responses. This integration is intended to help HIV programmes better deliver the benefits of scientific advances by attending to the complex needs and realities of people who experience multiple and often intersecting inequalities, in order to “know your epidemic, know your response.”

Addressing HIV-related inequalities through programming and advocacy

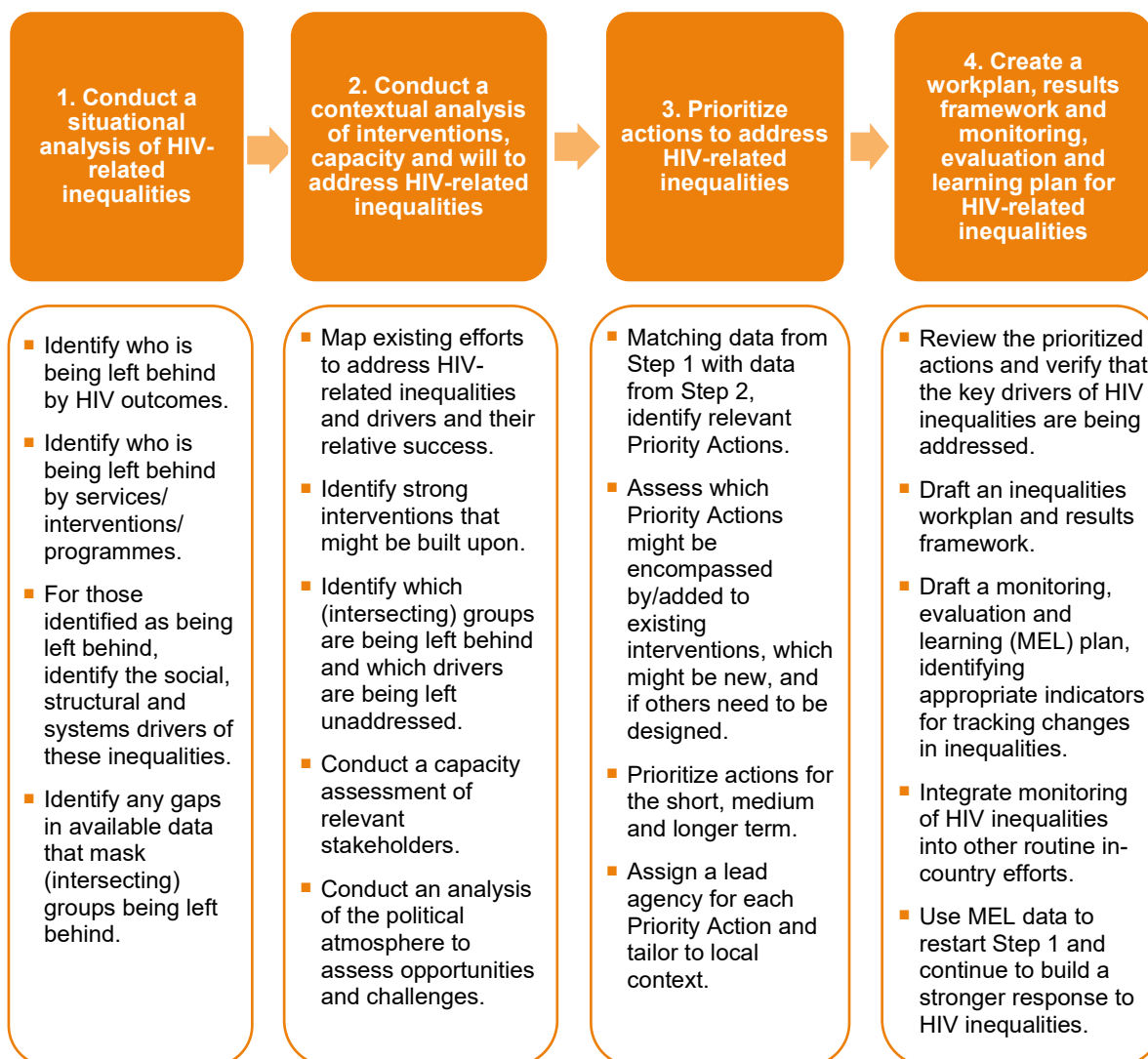
The Global AIDS Strategy 2021–2026 and UBRAF 2022–2026 emphasize the importance of understanding and addressing inequalities as a core component of the UNAIDS mandate. This framework and its accompanying toolkit are designed to build on and strengthen existing efforts of the Joint Programme to fulfil this mandate and strengthen country and community efforts to reach all populations, with particular attention to addressing the inequalities that result in some populations being left behind.

This section provides a stepwise process for the application of an inequalities lens to the Global AIDS Strategy 2021–2026 Priority Actions and activities in the UBRAF 2022–2026, ensuring that this perspective becomes central to UNAIDS workplans, targets, indicators and allocation of resources. This process has been designed to layer onto other, ongoing planning processes, bringing an inequalities lens to the fore.

A step-by-step process for identifying, prioritizing and addressing HIV-related inequalities is introduced in Figure 2. These steps are meant to help the Joint Programme identify and address the inequalities that stand in the way of reaching those furthest behind and achieving its targets across all of the Strategic Priorities and Result Areas in the Global AIDS Strategy 2021–2026. They are meant to help national responses focus on reducing inequalities, not just improving overall HIV indicators. Further elaboration and practical application of these steps is provided in the accompanying toolkit.

There is no quick fix to address HIV-related inequalities. This is an ambitious, long-term goal and a critical one; progressive realization will be required to address identified inequalities and ensure the full realization of human rights for all. The HIV Inequalities Framework and Toolkit are grounded in human-rights norms and standards. They are designed to help create pathways towards the elimination of HIV-related inequalities, recognizing that these pathways will by necessity be long and not straight. Every step forward along the pathway is progress; if this can be measured and courses corrected as lessons are learned, the ultimate goal of addressing HIV-related inequalities and ending AIDS can be achieved.

Figure 2. Steps to identify and address HIV-related inequalities



Steps to identify and address HIV-related inequalities

Preparation

It is assumed that this HIV inequalities four-step process will not be a standalone one, but that it will be incorporated into existing strategic planning processes such as a national HIV strategic plan update, a UNSDCF planning cycle, implementation of the Leaving No One Behind toolkit, a Global Fund proposal or a United States President’s Emergency Plan for AIDS Relief (PEPFAR) Country Operational Plan development process. It will be important to identify forthcoming processes to which this inequalities assessment might be usefully attached. The Framework and Toolkit are designed to help ensure systematic attention to HIV-related inequalities throughout these processes, from ensuring the range of people who understand inequalities are in the planning group to including appropriate attention to disaggregation of data in proposed monitoring and evaluation efforts. Embedding this inequalities analysis within other ongoing processes will minimize the additional resource needs and help ensure that this lens is applied to the national response as a whole—and that it does not form a separate and disconnected exercise.

Within any broader process, it is important to identify, assess and garner political will and support from affected communities, civil society, government and others to tackle both seen and unseen inequalities related to HIV. It is important to consider who—beyond the “usual” team brought together for the process—should be included to help ensure appropriate attention to the range of identified HIV-related inequalities that are relevant to this assessment. Any team should be multisectoral and encompass not just health, but also other relevant sectors, including education, social protection, justice, youth, gender and more. Community and civil society leadership should play key roles, both in advancing this work and in monitoring and accountability efforts around it.

Before embarking upon the HIV inequalities four-step process, some useful preparatory work can be done. This initial work might include:

- Bringing together information currently in use in the current HIV response.
- Identifying key stakeholders who are addressing HIV, inequalities or both.
- Collating easily accessible data that can help illustrate why addressing HIV-related inequalities will be critical to the national response.
- Identifying key stakeholders addressing HIV, inequalities or both.
- Strategizing among Cosponsors and other partners on how to set up the assessment process.

This preparatory work may result in a concept note that highlights the relevance of the HIV-related inequalities assessment and why these issues need to be addressed. Once the Joint Programme has completed this initial work, the real work can begin: this includes engaging other stakeholders and working through to the creation of an evidence-informed workplan, results framework, and monitoring and evaluation framework for addressing HIV-related inequalities, all of which can be incorporated into national plans and workflows.

Step 1: Conduct a situational analysis of HIV-related inequalities

Once key decision-makers and stakeholders are identified and have committed to participating in all steps of this process, the next set of actions are intended to help deepen understanding of context-specific HIV-related inequalities in preparation for determining and prioritizing action steps. This starts with looking at who is not being reached in the current HIV response, including understanding differences in HIV-related risks and outcomes among populations, and with respect to uptake of services, programmes and interventions. What are the greatest inequalities in HIV risk and outcomes? These will vary by country, and existing data and in-country expertise will be key to identifying what populations (and groups within those populations) in each setting are currently being left behind. Disaggregated data are key to this process and should be used where available.

This process should also include an assessment of data availability, quality and gaps that might need to be further explored. This work can build on other relevant assessments, such as Know Your Epidemic or the Multidimensional Inequality Framework, in order to ensure that efforts to understand inequalities most relevant to HIV are central (67). Understanding these greatest inequalities draws attention to where immediate action needs to be taken, which starts with investigating why these inequalities exist.

The next analysis is an examination of the drivers that may be contributing to these inequalities in HIV risk and outcomes. This can be done with a causality or problem tree analysis that starts with identification of a core problem (such as disproportionately low HIV treatment adherence among

women who use drugs) and asks why this is happening. Once the immediate causes have been identified, the next step is to ask why those causes are happening; this is then repeated, each time digging deeper towards the underlying (or “root”) causes that contribute to the core problem. The more immediate causes are likely experienced at the individual level (e.g., HIV-related knowledge and behaviours), which are all influenced by deeper causes relating to services (e.g., quality of care, gender-related biases and barriers to services), systems (e.g., distribution of health workers and access to decision-making in the HIV response for women and girls from key populations), societies (e.g., widespread societal discrimination against people who use drugs) and structural factors (e.g., laws and policies criminalizing drug use and/or HIV transmission). At each step of the analysis, it may be useful to take a step back and doublecheck that all appropriate stakeholders are involved, since this analysis may lead to unexpected areas where additional expertise is needed.

It also may be useful to create multiple problem trees to explore the drivers of different HIV-related inequalities being experienced. Looking across problem trees can help identify factors that are driving multiple inequalities simultaneously, which could yield benefits across more than one population if they are addressed.

Step 2: Conduct a contextual analysis of interventions, capacity and will to address HIV-related inequalities

After Step 1, a contextual analysis of current interventions, capacity and will to address HIV-related inequalities is necessary to assess the feasibility of addressing the inequalities identified in a given context. This includes mapping current efforts—formal and informal, with particular attention to the community and grass-roots levels—and available funding sources across sectors to address any inequalities and drivers, and then identifying through this step which groups are being left behind and which drivers are left unaddressed. It may be useful to map not only HIV-focused interventions but also interventions in other areas that touch on the work of Cosponsors and other partners that might provide additional entry points for action and financial resources to address inequalities.

The mapping should also include identifying capacity strengths and shortcomings across government, civil society, affected communities and Cosponsors, as well as areas where additional technical assistance might be needed. Key to this will be identifying what the Joint Programme can most usefully support across the pillars of leadership, advocacy, partnerships, strategic information, coordination and governance where it normally works, considering the UN system call for action on addressing inequalities and the respective mandates, strengths and country presence of Cosponsors. Where recent programmatic mapping has been done, this can provide a good starting point, but additional efforts will likely be needed to ensure appropriate focus on interventions to address inequalities in the context of HIV and to encompass Cosponsor efforts. The Joint Programme’s HIV and Social Protection Assessment Tool might also be useful to support work in this area (69).

Community-led efforts should be central throughout this process, including the work of community-led organizations, networks of people living with HIV, community-led services and direct engagement with Joint Programme efforts or other aspects of HIV response leadership. The current and potential efforts of youth also must be prioritized. Feasibility should include an analysis of the political atmosphere—including election cycles that might affect government willingness to engage in issues that might be seen as controversial—opportunities for synergies with other government initiatives and civil society space. Other important factors to analyse include: (a) relationships between the Joint Programme and the government, and with religious,

faith-based and community leaders; (b) public opinion; (c) the role of the media; and (d) the role of social media. Also essential is an overall willingness to collaborate over time among all relevant partners to implement changes that could help redress the identified inequalities and their drivers.

Step 3: Prioritize actions to address HIV-related inequalities

This is where all of the earlier analyses come together to inform action. Once the capacity mapping has taken place, the next step is to apply the contextual insights gathered through the previous steps to the “Priority Actions” under the Results Areas of the Global AIDS Strategy 2021–2026. Keeping in mind the identified HIV inequalities and drivers—and the feasibility of addressing those drivers—the next step is to identify which of the Priority Actions from the Global AIDS Strategy 2021–2026 Results Areas are most relevant and could be appropriately tailored to the local context. They should then be prioritized and the feasibility of putting in place specific interventions should be determined. In all cases, immediate actions should be planned to address the biggest inequalities, even as longer-term plans may also be needed to address additional structural drivers. Even structural drivers can be broken down to smaller, more immediate steps: for example, instead of trying to tackle “unequal gender norms,” interventions might focus specifically on a single aspect of this, such as ensuring that young women have access to relevant information and services, or tackling harmful norms of masculinity.

Looking across what was learned from Steps 1 and 2 can help guide the selection of which drivers should be prioritized, which can then inform actions. Key information to consider from Steps 1 and 2 includes the following:

1. Which groups (and groups within them) are being left behind in the HIV response?
2. What are the key drivers of inequalities affecting these groups individually and collectively?
Are they the same?
3. What impact would it have on the course of the HIV epidemic if these social, structural, systems and service drivers could be addressed?
4. What foundation of funded work exists to address these identified drivers?
 - How might this foundational work be built upon and strengthened to better tackle relevant drivers?
 - Which interventions may no longer be needed?
 - In cases where there is no foundation of funded work, what brand new efforts might be needed to address current gaps and blind spots?
5. Where does in-country capacity exist to address these newly identified drivers?
 - Is support needed to address these drivers, or to build capacity to address them?
6. What types of political support exists to address these identified drivers? Where will it be most needed?

Questions to consider to help with prioritization include the following:

1. Which of the interventions that have been identified as priorities might be encompassed by (or added to) existing interventions, and which might be totally new?
2. Within these Priority Actions, which interventions might—or have already been proven to—lead to the biggest reductions in HIV-related inequalities?
3. Which new interventions identified through this exercise seem most feasible at this moment to impact HIV-related inequalities if implemented?
4. How might interventions be grouped together to create synergistic benefits across various forms of inequalities?

5. Are there inequalities and drivers of importance to the local HIV epidemic that are not sufficiently addressed by any of the identified Priority Actions?
6. Is there a need to select additional Priority Actions or design new interventions not included in the Global AIDS Strategy 2021–2026 to ensure key drivers are addressed?
7. How do the prioritized interventions aim to better realize human rights, transform harmful gender norms and promote community engagement and leadership?
8. Considering the most relevant Priority Actions in light of all of the identified inequalities and drivers—and based on feasibility, including potential for change—which activities should be prioritized for the short, medium and longer term?

The appropriate lead agency or agencies can then be identified for each activity, with attention to the Joint Programme division of labour and as indicated in the UBRAF 2022–2026. This may vary by country. The identified lead agencies for each activity can lead the process of prioritizing actions and activities in line with the Global AIDS Strategy 2021–2026 and UBRAF 2022–2026, and developing corresponding, locally tailored activities and appropriately disaggregated indicators. Additional indicators will be needed to capture related impacts. All of these indicators will help capture the effectiveness of these interventions at reducing HIV-related inequalities and feed into reporting on the UBRAF 2022–2026 indicators, both on the Result Areas and the Secretariat functions.

Step 4: Create a workplan, results framework and monitoring, evaluation and learning plan for HIV-related inequalities

Once the suggested actions for the UNAIDS Secretariat and Cosponsors are identified and prioritized, each identified action can then be reviewed and approached using the findings from the application of the inequalities lens (see the preceding steps). The partners that are best positioned to address identified inequalities should also be engaged, with attention to the participation and leadership of community-led organizations in the processes described below.

Whenever possible, the workplan, results framework and monitoring, evaluation and accountability plan resulting from this assessment should be integrated into existing processes and plans—such as national HIV plans, UNSDCF planning, national funding applications and so forth—to mainstream an inequalities focus across all new and existing objectives, activities, indicators and monitoring efforts.

Choosing appropriate indicators is critical to being able to assess the effectiveness of efforts to address HIV-related inequalities. The data sources consulted in the situational analysis might be useful starting points for identifying the types of indicators that might be most appropriate and how they might best be disaggregated. (Also see Annex 2 for a list of potential sources to consult for different types of data.) Where data gaps and needs have been identified, activities might be included in the workplan to advocate for such data collection or to provide technical support for appropriate stakeholders to collect it. Community engagement should be central to all of these plans and processes to help ensure that the voices, leadership and decision-making of people living with and affected by HIV permeate the national response. This is particularly the case with respect to selecting critical indicators and designing data collection processes, since community knowledge can help fill gaps in “official” data. In addition, it will be important to consider how this work contributes to the Secretariat indicators for the UBRAF 2022–2026.

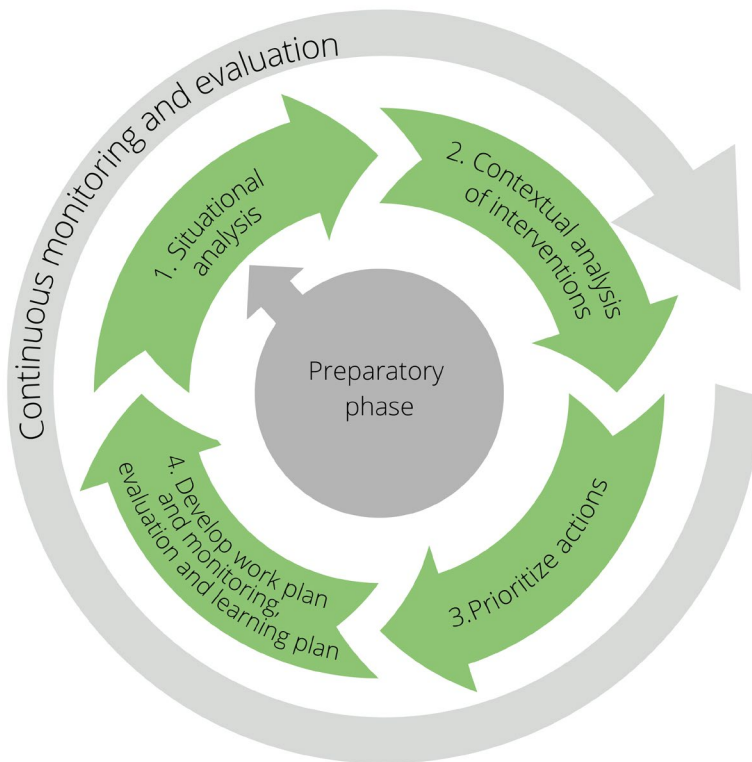
It is critical that ongoing monitoring and evaluation of efforts to address HIV-related inequalities takes place, that data be used to course correct, that lessons be shared and that progress towards benchmarks and targets is regularly checked. No parallel system is needed to monitor

progress in addressing HIV-related inequalities. With attention to broader questions of human rights, gender and inequality, this should be done as part of routine in-country efforts, in coordination with the government, civil society and other relevant partners. Strong systems for accountability should be used (or, if necessary, put in place) to help track progress around addressing HIV-related inequalities and to provide avenues for follow-up and redress where progress is insufficient.

Follow-up to this four-step process

Figure 3 illustrates the ongoing nature of this work. Once this initial planning exercise is complete, continuous monitoring and evaluation is required. In the short and long term, this will lead to revisiting the original problems and implemented solutions to assess their success and the challenges encountered. This will help to inform an even stronger response to HIV-related inequalities.

Figure 3. HIV-related inequalities assessment and response



Illustrative example

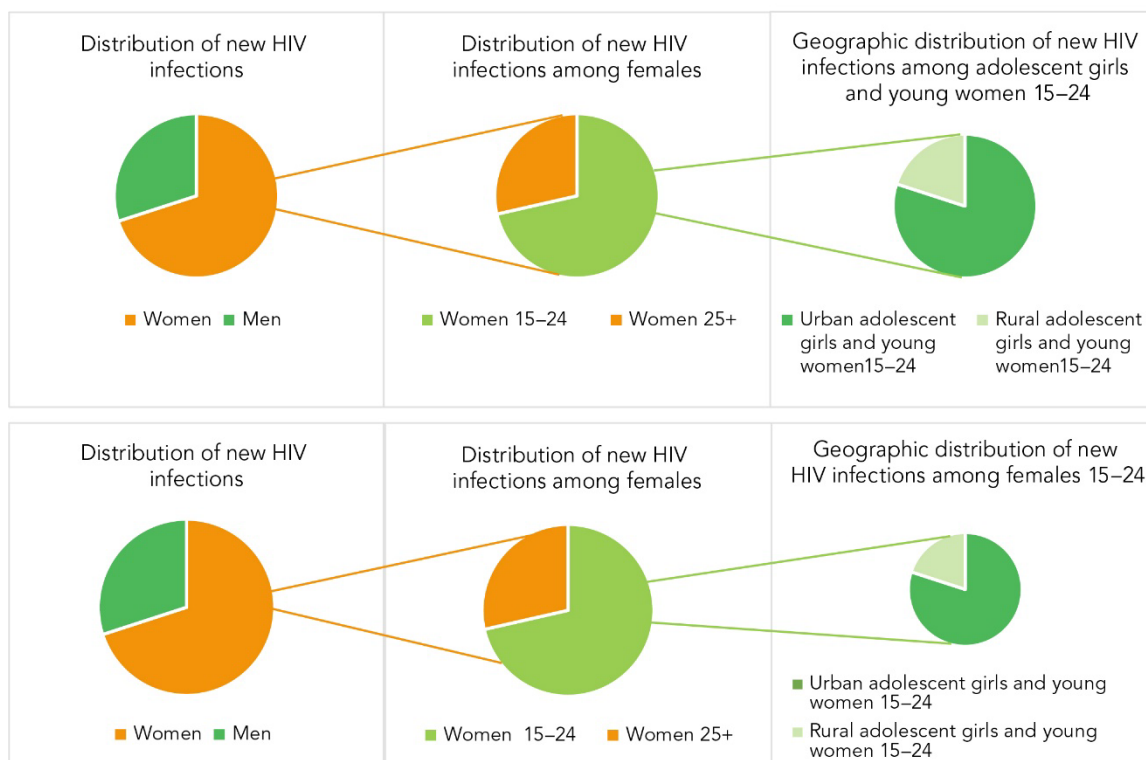
To make the above process more concrete, an illustrative example of how it is likely to work is provided below. This is just one hypothetical example looking at HIV prevention in a particular context. Similar analyses could be done around the whole care cascade, AIDS-related mortality or other indicators, and across different populations and drivers. The example starts at Step 1 of the process, assuming that the Joint Programme has already garnered commitment to the process from all relevant stakeholders.

Step 1: Situational analysis of HIV-related inequalities

Who is being left behind in HIV prevention?

What is the population breakdown of new infections (modelled or reported) in a given country? As an illustrative example, if it is known that a significant majority of these new infections are among women, it is then clear that providing focused HIV prevention services for women should be a priority. However, are all women equally affected in that country? In this example, adolescent girls and young women (aged 15 to 24 years) have even higher incidence rates than other women and, even within this group, adolescent girls and young women who live in urban areas are most affected. Using existing, though limited, data to understand this basic breakdown of new HIV infections helps further narrow down how HIV prevention efforts might usefully be focused. This is illustrated in Figure 4. These differences can only be teased out through analysis along equity lines—which in this example would include age and place of residence.

Figure 4. Analysing the distribution of new HIV infections: an illustrative example



Depending on data availability, this analysis might be taken further. For example, it would be useful to identify differences by wealth: are data available to disaggregate new HIV infections among urban adolescent girls and young women aged 15 to 24 years by wealth quintile or some other factors? Unfortunately, these data are not available in this example.

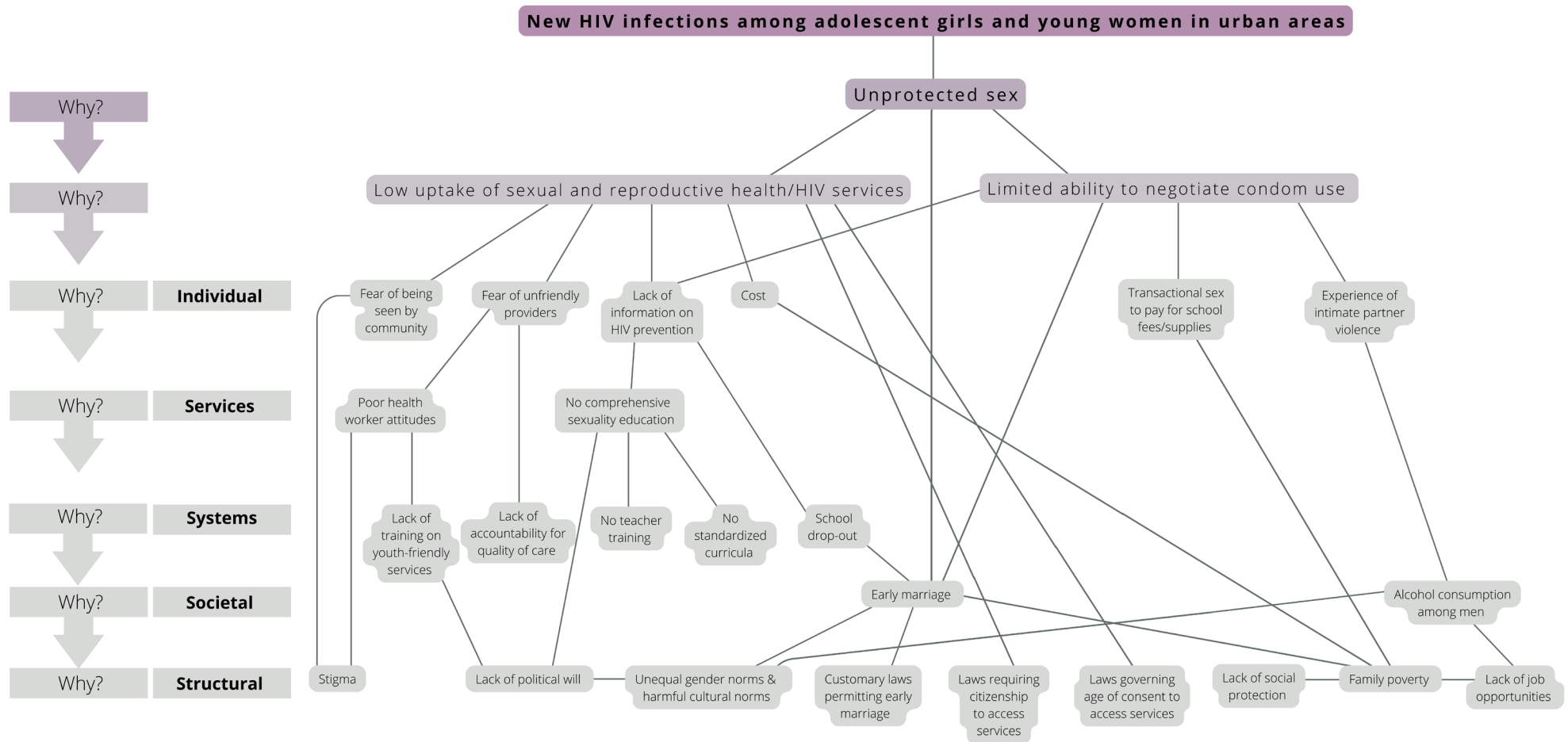
In reality, there will be more than one group contributing substantially to new HIV infections. Even with a focus on adolescent and young women, it might be important to look at each group separately. This could be done both in the above steps of drilling down into the detail of who is most affected, and in all subsequent sections of this example: diverse HIV-related inequalities might have different drivers and thus require different actions. It also may be important to

consider other population groups such as migrant workers, displaced people and key populations, and who within these groups might also be left behind.

Why are they being left behind?

After who is being left behind in terms of HIV prevention has been identified, examining the drivers of these inequalities in HIV risk and outcomes means asking why urban women aged 15 to 24 years are experiencing disproportionately high HIV incidence. This can be answered by conducting a traditional problem tree analysis. At the top of the “tree” is the core problem: by asking why this is a problem, one can identify its immediate causes. By asking why these immediate causes are problems, the underlying causes can then be explored. Through this exercise, the different drivers of the core problem—and their inter-relationships—can be drawn out. This exercise can be based on empirical data that are available, and on the expertise and experience of the group carrying out the analysis. Figure 5 shows a problem tree for this hypothetical example that is focused on urban adolescent girls and young women.

Figure 5. Problem tree analysis: an illustrative example



The grey boxes illustrate some of the factors that, in this hypothetical situation, are driving high HIV incidence among urban adolescent girls and young women. They include a mix of the different types of drivers explored in this framework—including social, structural, health system and services—along with individual characteristics and actions. It is important to recognize that experiences will be different, even within this population, and that each of the above factors offers an opportunity for intervention. It is also likely that even if some interventions already exist that intervention across multiple levels will be needed. It is useful to consider the relationships between the different boxes in the diagram to understand what different points of intervention might constitute a synergistic set of factors to reduce HIV-related inequalities that are relevant to adolescent girls and young women.

It is important to note where inequalities intersect in this diagram. For example, anything linked to “family poverty” will disproportionately impact adolescent girls and young women of lower economic status. Although there were no data available relating to disparities by wealth, this problem tree analysis in the original analysis of available data (see Figure 4) identified poverty as a driver of HIV incidence among urban adolescent girls and young women. The legal environment is also a challenge, including antiquated age of consent laws. Furthermore, girls involved in early marriage face challenges around the uptake of HIV and sexual and reproductive health services and with negotiating condom use. Thus, even without quantitative data that are specific to these subgroups within the overall population of interest, resources can be targeted to reach them based on this analysis.

Step 2: Contextual analysis of interventions, capacity and will to address HIV-related inequalities

In this example, several relevant interventions are already underway including:

- Efforts of the United Nations Development Programme (UNDP) to address HIV-related legal barriers, including age of consent laws.
- A recent assessment on quality of care carried out by WHO, the United Nations Population Fund (UNFPA) and the United Nations Entity for Gender Equality and the Empowerment of Women (UN Women).
- PEPFAR’s DREAMS programme.

It is important to identify the scope and geographical coverage of each of these interventions and the key stakeholders involved. Knowing that these programmes already exist can help identify how they might be strengthened to address some of the identified drivers of HIV-related inequalities that are relevant to this population. With a strong base intervention already in place, it might be useful to prioritize the drivers addressed by these programmes because expertise and experience already exist.

With regard to in-country capacity, some important observations in this example include:

- UNFPA and the United Nations Children’s Fund (UNICEF) have strong in-country presence and close collaborations with youth-led sexual and reproductive health organizations.
- HIV-related civil society is strong and cohesive.

Understanding that this capacity already exists might also help to identify the drivers that could most feasibly be addressed through new interventions.

With regard to political will, there have been a few important developments in this example setting:

- With a recent change in government, the Ministry of Education is now interested in instituting CSE.
- UNAIDS has a strong relationship with key members of the new government.
- Given the recent change in government, there will be no elections for five years, which suggests that there will be some stability among the key actors who will be involved in this effort.

With a new government in place, some opportunities for engagement are clear and the knowledge that there will not be elections provides a sense of stability that allows engagement in longer term activities, including those that might be perceived to be politically sensitive.

Step 3: Prioritize actions to address HIV-related inequalities

Having identified factors at all levels of this conceptual framework that are driving high HIV incidence among adolescent girls and young women in urban areas and the interventions currently in place to address them, we can now use the Global AIDS Strategy 2021–2026 and the UBRAF 2022–2026 to help identify relevant Priority Actions that can inform interventions to address these factors and the indicators to track progress. All of the grey boxes in Figure 5 can be seen as opportunities to intervene to decrease new infections that recognize the diversity of this population, which will ultimately reduce this HIV-related inequality. Reflecting the different types of drivers, interventions can be carried out at different levels, including the social, structural, systems, service and individual levels.

This is where all of the earlier analyses can come together to inform action. The questions below can help organize the findings from the earlier steps in this process. These questions will usually have multiple answers; a simplified version is shown in this illustrative example.

1. Which groups (and groups within them) are being left behind in the HIV response?

Urban adolescent girls and young women.

2. What are the key drivers of inequalities affecting these groups?

Anything from the grey boxes of the problem tree above might be included, such as:

- Stigma.
- Lack of youth-friendly services.
- Lack of CSE.
- Poverty/lack of job opportunities.
- Legal barriers to adolescent service access.
- Laws that allow child marriage.
- Gender and cultural norms.

3. What impact would it have on the course of the HIV epidemic if these drivers could be addressed?

In addition to reducing new infections in urban adolescent girls and young women, the following impacts are likely to occur:

- Addressing stigma would reduce new infections among other populations currently experiencing HIV-related stigma.
- Keeping girls in school would improve overall levels of education.

- Providing CSE would improve adolescent sexual and reproductive knowledge overall, including HIV prevention.
- Providing youth-friendly HIV-related services would expand access to and increase retention in HIV care and treatment services for adolescents.
- Removing legal barriers to accessing services for adolescents would improve adolescent sexual and reproductive health overall, including HIV prevention, testing, treatment and care.

4. What foundation of funded work exists to address these identified drivers?

a. How might this be built upon and strengthened to better tackle relevant drivers?

- UNDP has ongoing work to address HIV-related legal barriers; additional emphasis could be placed on legal barriers to accessing services for adolescents and improving laws relating to child marriage.
- WHO has recently led an assessment of quality of care in health services that highlighted the need for youth-friendly services; follow-on work is currently being discussed.
- PEPFAR's DREAMS programme is being implemented in some regions.

b. Which interventions may no longer be needed?

- The government has been investing in scaling up HIV testing for adolescents in antenatal care and ensuring that they know testing is available. Coverage is now very high, and access to HIV testing is now well understood by this population.

c. Where is there no foundation of funded work, and where might brand new efforts be needed to address current gaps and blind spots?

- There has been no recent work on CSE.
- There has been no attention to tailoring social protection to the needs of adolescents and young girls living with or affected by HIV.

5. What in-country capacity exists to address these identified drivers?

- UNFPA and UNICEF have strong in-country presence and close collaborations with youth-led sexual and reproductive health organizations.
- HIV-related civil society is strong and cohesive.

6. What types of political support exists to address these identified drivers?

- With a recent change in government, the Ministry of Education is now interested in instituting CSE.
- To date, the Ministry of Health has been reluctant to allocate budget specifically to youth-friendly services.
- UNAIDS has a strong relationship with key members of the new government.
- Given the recent changes in government, there will be no elections for five years, which suggests some stability among the key actors who will be involved in this period.
- The government has committed to participating in the Education Plus initiative to support adolescent girls' secondary education.

The answers to these questions can help guide the selection of which drivers should be prioritized. These data show some clear opportunities for action, such as the new Ministry of Education's willingness to engage on CSE, the strong in-country capacity of UNFPA and UNICEF, and the strategic partnerships and networks fostered by the Education Plus initiative.

The existing UNDP work to address HIV-related legal barriers coupled with there being no elections on the horizon might offer other, related opportunities.

Table 2 illustrates a process for identifying activities to address the drivers of HIV-related inequalities that are identified in the illustrative example. The table is not comprehensive—not all of the relevant drivers identified above are included—but it is designed to demonstrate the process that can guide the identification of relevant activities following the development of a problem tree.

Given all of the above information, which are the specific drivers that seem most important and feasible to address in the short term? Starting with these specific drivers, illustrative Priority Actions from the Global AIDS Strategy 2021–2026 are selected in Table 2 as the potentially most relevant. Using the UBRAF 2022–2026, the appropriate lead agency/agencies can be identified, noting that this may vary by country. The UBRAF 2022–2026 then serves as a useful resource for identifying interventions that are relevant to the drivers and Priority Actions. These Priority Actions can then be tailored to the identified drivers and the specific context, such as a specific geography or population. In this example, their aim should always be to reduce HIV incidence among urban adolescent girls and young women in order to reduce the intersecting inequalities they may face relating to HIV incidence. Finally, relevant indicators can be selected (which will be further discussed in the Toolkit). Three different sets of drivers are used as examples in Table 2 to illustrate some of the breadth of actions that might be taken.

Table 2. Using identified drivers of the disproportionately high HIV incidence among urban adolescent girls and young women to design activities and select indicators: an illustrative example

Identified drivers of HIV-related inequality from Step 2	Select relevant Priority Actions, as identified in the Global AIDS Strategy 2021–2026	Lead agency or agencies	Select relevant activities, as identified in the UBRAF 2022–2026	Interventions tailored to identified drivers	Select relevant indicators
<p>No political will to implement CSE; lack of standardized CSE curriculum; lack of teacher training in CSE</p>	<ul style="list-style-type: none"> ▪ Strengthen access to good-quality, gender-responsive, age-appropriate CSE services, both in and out of school, that address the realities of adolescents and young people in all their diversity, in line with international guidance, national laws, policies and context. ▪ Strengthen access to high-quality, gender-responsive, age-appropriate CSE programmes, both in school and out of school, particularly for adolescent girls and young women and young key populations in settings with high HIV incidence. 	<p>United Nations Educational, Scientific and Cultural Organization (UNESCO), UNFPA, UNICEF, UN Women</p>	<ul style="list-style-type: none"> ▪ Increase country capacities to enable all young people to receive a quality education through the secondary level, including access to CSE as defined in the Global AIDS Strategy 2021–2026. ▪ Build partnerships and collaborations to catalyse actions across sectors to address the gender dimensions of the AIDS epidemic. 	<ul style="list-style-type: none"> ▪ Provide technical support to Ministries of Education and Health to collaborate on the production of a CSE curriculum. ▪ Provide technical support to the Ministry of Education to develop teacher training on CSE. ▪ Convene meetings with youth-led civil society to provide input into the curriculum. 	<ul style="list-style-type: none"> ▪ Percentage of women and men aged 15 to 24 years who correctly identify both the ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission. ▪ Percentage schools that teach the CSE curriculum (with potential subindicators on the percentage of schools that teach specific topics within the curriculum). ▪ Number of teachers trained to deliver the CSE curriculum. ▪ Number of youth-led organizations that participate in CSE curriculum development.

<p>Age of consent laws; early marriage</p>	<ul style="list-style-type: none"> ■ Address the structural and age-related legal barriers faced by adolescents and young key populations. ■ Repeal discriminatory laws and policies that increase women and girls' vulnerability to HIV and address violations of their sexual and reproductive health and rights. ■ Remove legal and policy barriers, including age-of-consent laws and policies, for adolescents and youth to access HIV services, and ensure access to other health and social services. This includes sexual and reproductive health services, PrEP, condoms and other contraceptives, and commodities and wider health and social services relating to young people's well-being. 	<p>UNDP, UNFPA</p>	<ul style="list-style-type: none"> ■ Leverage partnerships (such as the Global Partnership for Action to Eliminate all Forms of HIV-related Stigma and Discrimination) and other platforms (such as the Global Commission on HIV and the Law) to promote access to justice and the creation of enabling legal and policy environments, including by removing punitive and discriminatory laws and policies and reducing stigma and discrimination. 	<ul style="list-style-type: none"> ■ Support civil society advocacy to repeal laws that might contribute to high HIV incidence among adolescent girls and young women. ■ Work with government and communities to sensitize parliamentarians on the impact of these laws on health. ■ Convene discussions where all stakeholders can safely discuss legal barriers affecting HIV among adolescent girls and young women. 	<ul style="list-style-type: none"> ■ Number of organizations supported in activities to remove or amend punitive and discriminatory laws and policies, and/or develop protective ones affecting the HIV response. ■ Number of protective laws introduced. ■ Number of legal barriers removed. ■ UNAIDS convening role is used to provide advice and support on HIV-related human rights issues, crises and gender-based violence.
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<p>Discrimination in health services and lack of youth-friendly health services</p>	<ul style="list-style-type: none"> ■ Mobilize funding for sustainable community-led responses, ensuring financial support and equitable pay for community-led work and funding for activities led by networks of people living with HIV and key populations, including those led by women and young people. 	<p>WHO, UNFPA, UNICEF, UNDP, United Nations Office on Drugs and Crime (UNODC)</p>	<ul style="list-style-type: none"> ■ Support and guide health system strengthening to reduce inequalities; eliminate stigma and discrimination; implement integrated and differentiated services; improve health information systems; support and integrate community-led responses; and strengthen consolidated procurement, supply management and multipurpose laboratory systems. 	<ul style="list-style-type: none"> ■ Advocacy for allocation of domestic resources to support networks of adolescent girls and young women living with HIV. ■ Technical support to the government to institutionalize health worker training on adolescent sexual and reproductive health and rights. 	<ul style="list-style-type: none"> ■ Percentage of adolescent girls and young women living with HIV who report experiences of HIV-related discrimination in health-care settings. ■ Percentage of health workers trained in adolescent sexual and reproductive health and rights.
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Looking across this set of interventions, is anyone still being left behind? For example, if CSE is only an in-school program, how will out-of-school young women and girls be reached with HIV-related information and skills building? If user fees, social protection and lack of job opportunities are not addressed, how will young women and girls of low economic status be reached with needed services? It may be an iterative process of selecting and designing interventions to ensure that they are appropriately focused to leave no one behind and have a meaningful impact on the HIV epidemic.

Step 4: Create a workplan, results framework and monitoring, evaluation and learning plan for HIV-related inequalities

The workplan should include all identified interventions, as well as who is responsible for implementation and a timeline. This does not need to be a standalone document that is specific to addressing HIV-related inequalities; instead, it should be incorporated into national workplans to promote an integrated and sustainable response.

For each set of interventions, outcome and process indicators can be taken from Table 2 above. The source of these data, any technical support needed, the frequency of data collection and the levels of disaggregation should all be determined at this stage. Table 3 provides an example based on the provision of CSE.

Table 3. Data sources, collection and disaggregation: an illustrative example

Type of indicator	Indicator	Source	Provision of technical support	Frequency of data collection	Disaggregation
Outcome	Percentage of women and men aged 15 to 24 years who correctly identify both the ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission	Global AIDS Monitoring	UNAIDS	Annual	Age, sex
	Percentage of schools that teach the CSE curriculum (with potential subindicators on the percentage of schools that teach specific topics within the curriculum)	Ministry of Education	UNESCO, UNFPA, UNICEF, UNAIDS	Annual	District; type of school
Process	Number of teachers trained to deliver the CSE curriculum in a youth-centred, non-judgmental fashion	Ministry of Education	UNESCO, UNFPA	Annual	District; type of school
	Number of youth-led organizations that participate in CSE curriculum development and implementation	UNFPA	N/A	Annual	District

A review of UBRAF indicators shows the following indicator to be most relevant in this context: “Number of countries supported to scale up multisectoral interventions that align with ministerial commitments to increase access to youth-friendly sexual and reproductive health (SRH) services, including comprehensive sexuality education (CSE), to improve young people’s well-being” (7). Data on this indicator will be collected annually. This will constitute observations, assessments, reports and reviews that will be reported through the Joint Programme Monitoring System.

As good practice suggests, when progress is not being made as expected with regard to reducing HIV-related inequalities in this population and more broadly, an investigation will be needed to identify why this is the case and if activities need to be tweaked to improve effectiveness. This will be an inclusive process—also based on good practice—with affected communities, and data will be publicly available to allow for transparency and promote accountability.

Introduction to using the Toolkit

The HIV Inequalities Framework is intended to be used alongside the accompanying Toolkit to help Joint Programme staff better understand and address inequalities relevant to HIV. This, in turn, will help strengthen national and local responses to achieve the targets and commitments set out in the Global AIDS Strategy 2021–2026, the High-Level Political Declaration and other global and regional commitments. Taken together, these products can help the Joint Programme not only improve understanding of the types of inequalities and the contexts within which they occur based on existing data, but also consider data gaps that, for example, may exclude sufficient attention to key populations and those most at risk.

As introduced in the steps outlined in the Framework, the Toolkit can further help programmes identify blind spots in the approach taken and identify new opportunities and areas that require additional effort. Following use of the Toolkit, Joint Programme staff can prioritize evidence-informed interventions to address the intersecting issues of inequality around HIV and design monitoring systems, including indicators and metrics to be tracked, in order to measure progress towards addressing these inequalities. In the current context of growing needs and limited resources, understanding societal enablers, social protections and other factors related to HIV-related inequalities may help prioritize the most pressing issues within the mandate of the Joint Programme.

Conclusion

There is no quick fix to address HIV-related inequalities. This is an ambitious, long-term goal and a critical one; progressive realization will be required to address identified inequalities and ensure the full realization of human rights for all. The HIV Inequalities Framework and Toolkit are grounded in human-rights norms and standards. They are designed to help create pathways towards the elimination of HIV-related inequalities, recognizing that these pathways will by necessity be long and not straight. Every step forward along the pathway is progress; if this can be measured and courses corrected as lessons are learned, the ultimate goal of addressing HIV-related inequalities and ending AIDS can be achieved.

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Annex 1. Methodology

Methodology overview

To develop an inequalities framework that complements and supports the new Global AIDS Strategy 2021–2026, a mix of methods was used, in close consultation and collaboration with UNAIDS. This work is grounded in existing United Nations (UN) frameworks, guidance, strategy documents and monitoring efforts. The aim was to produce materials that are synergistic with existing efforts in ways that can support UNAIDS and its partners to better understand and address the inequalities that drive the HIV epidemic.

Desk review

A comprehensive desk review of all documentation provided by the UNAIDS Inequalities Task Team and Cosponsors was conducted, alongside a review of relevant literature from other agreed upon sources. This included:

- The Global AIDS Strategy 2021–2026.
- Inequalities frameworks.
- Toolkits.
- The UNAIDS United Budget, Results and Accountability Framework (UBRAF) 2022–2026.
- Annual reports.
- Peer-reviewed and grey literature.
- Technical reports related to inequalities.
- Data sources available on inequalities and HIV-related inequalities.
- Other tools, guidelines and relevant documents, as identified by the Joint Programme.

A limited number of other documents—found through targeted online searches and a review of references in source documents listed above—were also reviewed.

After an initial review of select background documents, a standardized data extraction tool was developed and tested, which was then used to systematically abstract relevant information, allowing for cohesive thematic analysis across project documents. Given the diversity of documents received, detailed notes on documents for which the standardized tool was less relevant were also included in the analysis.

Consultations: regular consultations with the Inequalities Task Team and other staff from the Joint Programme

Throughout the review and drafting process, meetings with different teams from the UNAIDS Secretariat and the Cosponsors took place in order to get their ideas and feedback. In addition to weekly meetings with the three co-chairs of the Inequalities Task Team and regular meetings with the full UNAIDS Inequalities Task Team and other Secretariat staff, meetings with regional and national staff members on different teams and the Human Rights Reference Group took place to better inform this work.

Pilot testing of the Framework and accompanying Toolkit will be a future step that is coordinated by the UNAIDS Secretariat.

Annex 2. Useful data sources

The table below includes some traditional sources of HIV data that might be used to help understand the national and regional context, as well as some additional sources of data that, given the focus on inequalities, might also be useful to review when carrying out this exercise. Data disaggregation varies across these data sources as they currently exist and, in most cases, no single data source will be sufficient to understand relevant inequalities fully. Even where data are only provided in aggregate form, they may nonetheless still provide useful insights into how HIV affects a specific population group; they also might usefully be analysed alongside data from other sources included in Table 4 to create a more complete understanding of HIV-related inequalities. For example, the national inequality indices provide insight into inequalities beyond just those related to HIV, which is useful contextual information for addressing HIV-related inequalities. Furthermore, successfully reducing HIV-related inequalities should also have a positive impact on these broader measures of inequalities. For example, in contexts where national food insecurity is high, it will be important to further investigate which populations are being most affected and how different groups of people living with or vulnerable to HIV are affected. Similarly, if there is a large population of migrants, it will be critical to understand their HIV-related needs and any specific challenges they may face when it comes to accessing services across the continuum of care.

Although the availability of organizations that engage in community-led monitoring varies by country, it still will provide important complementary data sources alongside all of those noted in the table. Countries also may have access to data that are further disaggregated than what is reported globally, which will be useful information. Table 4 is designed to be illustrative rather than exhaustive, and it should be supplemented by stakeholder knowledge of additional sources of data. Data in italics are included in the Country Configuration spreadsheet.

Table 4. Illustrative data sources for accessing data to understand HIV-related inequalities

Data	Potential data source(s)	Website	Dataset/indicator description	Types of disaggregation
HIV outcome data (includes 95–95–95)				
Incidence Modes of transmission Prevalence 95–95–95 Mortality <i>Population size estimates</i> (key populations, migrants, prisoners etc.)	UNAIDS estimates Population-based HIV Impact Assessment Integrated HIV Biological and Behavioural Surveillance (IBBS) (for key populations) Modes of Transmission (MoT) modelling Investment cases	https://aidsinfo.unaids.org https://www.cdc.gov/globalhiv/tb/what-we-do/phia/phia.html https://www.aidsdatahub.org/taxonomy/term/268 https://www.unaids.org/en/dataanalysis/datatools/incidencebymodesoftransmission https://www.unaids.org/sites/default/files/media_asset/JC2359_investing-for-results_en_1.pdf	Data on HIV incidence, prevalence, coverage of services and mortality. Nationally representative household survey to assess the current status and effectiveness of national programmes in reaching HIV epidemic control. The IBBS is a population-based survey capturing information on sociodemographic characteristics, type of sex partners and sexual risk behaviours. The MoT spreadsheet helps to calculate the expected number of new infections per year on the basis of a description of the current distribution of infections and patterns of risk within a population. The people-centred investment tool is designed to help guide investment priorities that are cost-effective, efficient and produce maximum impact.	Sex, age, key populations. Sex, age, key populations, wealth, urban/rural, race/ethnicity. Sex, gender, age, citizenship, education, religion, income, ethnicity, marital status. Varies by country. Varies by country.
Knowledge and actions				
Knowledge (e.g., percentage of women and men aged 15–24 years who correctly identify both ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission; do you think that a healthy looking person can be	Global AIDS Monitoring (GAM) IBBS	https://aidsinfo.unaids.org https://www.aidsdatahub.org/taxonomy/term/268	Data for monitoring progress towards the 2021 Political Declaration on AIDS, including HIV-related outcomes, behaviours and experiences of discrimination.	Sex, age, key populations. Varies, but may include data from different key populations. Can also include geographical location, age, literacy, marital status, occupation.

Data	Potential data source(s)	Website	Dataset/indicator description	Types of disaggregation
infected with HIV, the virus that causes AIDS? Actions (e.g., condom use at last sex)				
Health systems and services				
Experiences of discrimination in services	National Commitments and Policy Instrument (NCPI) People living with HIV Stigma Index IBBS	https://lawsandpolicies.unaids.org/ https://www.stigmaindex.org/ https://www.aidsdatahub.org/taxonomy/term/268	Legal and policy indicators; availability of key population-related services (e.g., harm reduction, services within prisons). Developed to be used by and for people living with HIV, this is a standardized tool to gather evidence on how stigma and discrimination impacts the lives of people living with HIV. Country reports include quantitative data across different dimensions of stigma and discrimination.	N/A. Varies but can include: sex, gender, age, relationship status, education, ability to meet basic needs, work status, indigeneity, disability, ethnicity, refugee status, internally displaced persons, incarceration. Sex is also combined with each of the other variables. Varies, but may include data from different key populations. Can also include geographical location, age, literacy, marital status, occupation.
Doctors per 10 000 population	World Health Organization (WHO)	https://www.who.int/data/gho/data/indicators/indicator-details/GHO/medical-doctors-(per-10-000-population)	Includes generalists, specialist medical practitioners and medical doctors not further defined in the given national and/or subnational area.	Cannot be disaggregated
Nurses per 10 000 population	WHO	https://www.who.int/data/gho/data/indicators/indicator-details/GHO/nursing-and-midwifery-personnel-(per-10-000-population)	Number of nursing and midwifery personnel. Includes nursing personnel and midwifery personnel in the given national and/or subnational area.	Cannot be disaggregated

Data	Potential data source(s)	Website	Dataset/indicator description	Types of disaggregation
Expenditure	UNAIDS	https://hivfinancial.unaids.org/hivfinancialdashboards.html	The HIV Financial dashboard brings together more than 85 different indicators on HIV financial resources into a single platform. The indicators included in the dashboard are an extension of the data reported through the GAM.	Cannot be disaggregated
Out-of-pocket expenditure (health) Donor dependency for health	WHO	https://apps.who.int/nha/database/Select/Indicators/en	Includes 275 indicators on global health expenditure, including domestic private expenditure on HIV and AIDS and sexually transmitted infections (STIs), and share of current health expenditures funded from external sources.	Cannot be disaggregated
Service availability and readiness	WHO	https://www.who.int/data/data-collection-tools/service-availability-and-readiness-assessment-(sara)?ua=1	Systematic survey to generate a set of tracer indicators of health service availability and readiness. Service availability refers to the physical presence of the delivery of services, encompassing health infrastructure, core health personnel and service utilization.	Health facility-level data
Social protection	International Labour Organization (ILO)	https://ilostat.ilo.org/topics/social-protection/	Share of population covered by at least one social protection benefit.	Cannot be disaggregated by HIV status
Community services can be provided by civil society organizations	NCPI	https://lawsandpolicies.unaids.org/	These data include a group of indicators to assess community-led services provision for HIV.	N/A
Social and structural factors (includes 10–10–10)				
Protective laws Criminalization laws Policies	NCPI People living with HIV Stigma Index HIV policy lab	https://lawsandpolicies.unaids.org/ https://www.stigmaindex.org/		

Data	Potential data source(s)	Website	Dataset/indicator description	Types of disaggregation
	Legal environment assessments Gender assessments	https://oneill.law.georgetown.edu/projects/hiv-policy-lab/		
Stigma and discrimination	NCPI People living with HIV Stigma Index GAM	https://lawsandpolicies.unaids.org/ https://www.stigmaindex.org/ https://aidsinfo.unaids.org		
Women experiencing intimate partner violence	GAM	https://aidsinfo.unaids.org	Proportion of ever-married or partnered women aged 15 to 49 years who experienced physical or sexual violence from a male intimate partner in the past 12 months.	Age, HIV status (if available)
Food security and nutrition	Food and Agriculture Organization (FAO)	https://www.fao.org/faostat/en/#data/FS	Suite of national-level indicators relating to food security.	Cannot be disaggregated
Migration–displacement tracking matrix	International Organization for Migration (IOM)	https://dtm.iom.int	This is an information management system that regularly collects, analyses and disseminates critical information on mobility, needs and vulnerabilities of displaced and mobile populations.	N/A
Conflict/emergency—fragile states index	The Fund for Peace	https://fragilestatesindex.org/	The Fragile States Index includes 12 conflict risk indicators relating to cohesion, economics, politics and social and cross-cutting issues to measure the condition of a state at any given moment.	N/A
National inequalities				
Inequality adjusted Human Development Index (IHDI)	United Nations Development Programme (UNDP)	http://hdr.undp.org/en/content/inequality-adjusted-human-development-index-ihdi	This index calculates the human development costs of inequality by country.	Cannot be disaggregated

Data	Potential data source(s)	Website	Dataset/indicator description	Types of disaggregation
Gini index	World Bank	https://data.worldbank.org/indicator/SI.POV.GINI	Gini index measures the extent to which distribution of income (or, in some cases, consumption expenditure) among individuals or households within an economy deviates from a perfectly equal distribution. A Gini index of 0 represents perfect equality, while an index of 100 implies perfect inequality.	Cannot be disaggregated
Gender Inequality Index	UNDP	http://hdr.undp.org/en/content/gender-inequality-index-gii	Built on the same framework as the IHDI, the Gender Inequality Index measures gender inequalities in three important aspects of human development: reproductive health, empowerment and economic status.	Cannot be disaggregated
Multidimensional Inequality Framework	London School of Economics	https://sticerd.lse.ac.uk/inequality/get-started/default.asp	The Multidimensional Inequality Framework is organized around seven key life domains that have been identified as those that are critical to enjoying a good quality of life: life and health; physical and legal security; education and learning; financial security and dignified work; comfortable, independent and secure living conditions; participation, influence and voice; and individual, family and social life.	Varies
Compendium of Gender Equality and HIV Indicators	MEASURE Evaluation	https://www.measureevaluation.org/resources/publications/ms-13-82.html	The indicators in the Compendium are either part of existing indicators used in studies or by countries, or those that have been adapted from existing indicators to address the intersection of gender and HIV. The intended purpose is to provide programme managers, organizations and policy-makers with a menu of indicators to better “know their HIV epidemic/know their response” from a gender perspective.	Varies

Data	Potential data source(s)	Website	Dataset/indicator description	Types of disaggregation
National context				
Income category	World Bank	https://datatopics.worldbank.org/world-development-indicators/the-world-by-income-and-region.html	The World Bank classifies economies for analytical purposes into four income groups: low, lower-middle, upper-middle and high income. For this purpose, it uses gross national income (GNI) per capita data in US dollars.	N/A
Human rights treaty ratifications	Office of the United Nations High Commissioner for Human Rights (OHCHR)	https://indicators.ohchr.org	Data are compiled on which treaties every country has signed or ratified, with any reservations noted. It provides an overview of national human rights commitments.	N/A
Treaty monitoring body concluding observations and recommendations	OHCHR	https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/TBSearch.aspx?Lang=en	Database of all work by UN Treaty Bodies, including reports submitted by countries and responses, concluding observations and recommendations of Treaty Bodies. They provide insight into progress towards treaty implementation and areas of concern.	N/A
Sustainable Development Goal (SDG) indicator database	United Nations Department of Economic and Social Affairs (UN DESA)	https://unstats.un.org/sdgs/dataportal	Data on each SDG including, for example, multidimensional poverty (SDG1), education (SDG4), experiences of discrimination (SDG10) and social protection coverage (SDG13).	Cannot be disaggregated
Demographic and Health Survey (DHS)	USAID/ICF	https://dhsprogram.com	Household survey of nationally representative data on population, health, HIV and nutrition.	Disaggregation includes by age, sex, wealth, rural/urban, districts and race/ethnicity
Multiple Indicator Cluster Survey	UNICEF	https://mics.unicef.org	Household survey of nationally representative data, focusing mainly on those issues that directly affect the lives of children and women.	Disaggregation includes by age, sex, wealth, geography and race/ethnicity

Data	Potential data source(s)	Website	Dataset/indicator description	Types of disaggregation
Human rights score	Oxford University	https://ourworldindata.org/human-rights	The scores capture the extent to which physical integrity of citizens is protected from government killings, torture, political imprisonments, extrajudicial executions, mass killings and disappearances. Higher scores mean fewer such abuses.	Cannot be disaggregated
Civics category	Civics	https://www.civics.org/index.php/what-we-do/innovate/civics-monitor	The CIVICUS Monitor is a research tool that provides close to real-time data on the state of civil society and civic freedoms in 196 countries. The data streams feed into individual country pages and updates, which provide verified and up-to-date information on the state of freedom of association, peaceful assembly and expression.	At-risk populations
Global Health security index	NTI	https://www.ghsindex.org/	The Global Health Security Index is an assessment and benchmarking of health security and related capabilities across 195 countries. It benchmarks health security in the context of other factors critical to fighting outbreaks, such as political and security risks, the broader strength of the health system, and country adherence to global norms.	By category

Annex 3. Who is being left behind in efforts to end AIDS?

This section provides an overview of some of the information known about groups generally understood to be most left behind in current HIV responses. People can belong to more than one of these groups at once, and this might change over time. The priority populations that are more likely to experience HIV-related vulnerabilities and unequal outcomes will also vary between and within countries based on the epidemiological, legal, economic, social, cultural, gender and political contexts. Situating these vulnerabilities within unequal power dynamics, understanding the complexity of layered identities and behaviours, and how these change over time, can help pinpoint where targeted efforts are needed at a more granular level in order to reach those left behind with HIV-related information and services. For the Joint Programme, this can help inform appropriate activities to support countries and communities. For all identified priority populations, it remains essential to consider the heterogeneous, dynamic nature of individuals, as individual identities are multifaceted and evolving. Some of the many factors that shape the HIV inequalities experienced by identified priority populations are discussed later in this framework.

Below is relevant information concerning some priority populations other than women and girls and the identified key populations. These additional priority populations have been identified by the Joint Programme as being generally at higher risk of exposure to HIV and least likely to have access to comprehensive HIV prevention, treatment and care services compared with the general population.

Other priority populations

While ending AIDS by 2030 requires a continued focus on key populations, there are other populations that bear a significant burden of HIV infections in some locations and who are at risk of being left behind. In eastern and southern Africa, for example, only 32% of new infections in 2020 were identified as being among recognized key populations and their sexual partners (70).

Across all regions, identifying priority populations is highly contextual and requires a close look at the people who fall within and across groups. For instance, even within identified key populations, the people who may be at elevated risk of HIV include: women and adolescent girls and their male partners; people in prisons and other closed settings; young people; children; people with disabilities; ethnic and racial minorities; people in humanitarian and conflict situations, including refugees and internally displaced persons; migrants; people in uniform; indigenous peoples; and people living in poverty (21). This list also lends itself to intersecting inequalities, as people may fall into one, some or even most of these categories simultaneously. Additional groups also may experience poorer outcomes after an HIV infection because of particular challenges in accessing testing and treatment services, and they may have greater risk of comorbidities. This includes older persons living with HIV, who may or may not fall within any of the populations discussed.

The following population descriptions are meant only to serve as a non-exhaustive resource when considering who is being left behind in the progress towards ending AIDS, recognizing

that people may fall within several of these categories at once. While there are many populations that may warrant particular attention in order to reveal and address HIV-related inequalities in a given context, the descriptions below offer basic information on some of the priority populations that should be routinely considered when conducting a situational analysis of HIV-related inequalities, a process that is introduced above in the section on “How to apply an inequalities lens: practical application of the theory” and further detailed in the Toolkit. When there are HIV-related data available for these populations, understanding can remain limited in instances where disaggregation is limited and inconsistent; for example, data may be disaggregated by sex but not by age, or by geographical location but not by ethnicity or race.

Children and young people continue to experience major gaps in HIV prevention, testing and treatment. In 2021, only 52% of children (aged 0 to 14 years) living with HIV were accessing treatment, and only 41% of children living with HIV were virally suppressed (8). Of the children not on treatment, 60% of them are aged 5 to 14 years. Often the terms “children,” “young people” or “adolescents” are used without further defining who is understood to fall within this category (71). Overall, compared to adults, adolescents living with HIV (aged 10 to 19 years) are less likely to know their HIV status, receive antiretroviral therapy and achieve viral suppression (25). Among those aged 15 to 19 years, girls are at much higher risk of HIV infection and much more likely to be living with HIV than their male peers. Significant declines in new infections among young people (aged 15 to 24 years) have been made in the past decade, particularly in eastern and southern Africa. However, in most countries, progress has been quite limited among young key populations, who account for 20–40% of new HIV infections among key populations (25, 44).

Outside of sub-Saharan Africa, men and boys (aged 15–49 years) accounted for 65% of new HIV infections in 2021 (8). Globally, there are more men than women within key populations, and among their sexual partners, men are less likely than women to access HIV testing and treatment services—despite these numbers and the focus on these populations. The testing and treatment gap between men and women living with HIV is striking. Globally, in 2021, men living with HIV were less likely to receive antiretroviral therapy than women living with HIV: while 80% of women living with HIV received antiretroviral therapy in 2021, only 70% of men living with HIV accessed treatment (8). Likewise, rates of viral suppression are markedly higher among women living with HIV globally (74%) than among men living with HIV (65%) (8). Again, the differences among the men and boys—who face different forms of inequalities among them—remain to be fully explored.

People in prisons are 7.2 times more likely to be living with HIV than adults in the general population. Compared to other women, women in prison are five times more likely to be living with HIV. Of the estimated 11 million people held in prisons, 4.2% of them were living with HIV as of 2020. In addition to HIV, people in prisons and other closed settings are known to have a high prevalence of hepatitis B, hepatitis C and tuberculosis infections. Transgender prisoners are known to be particularly vulnerable: when transgender people are accommodated according to their sex assigned at birth, they are at particular risk of rape and sexual assault (72).

Fifteen per cent of the world’s population lives with a disability of some kind (73). People with disabilities are more likely to experience intersecting vulnerabilities that put them at greater risk of HIV infection than people who do not have disabilities. Risk factors may include poverty, increased vulnerability to violence and limited access to social services such as education and health care (73). In 2014, the prevalence of violence against people with disabilities of any kind was 1.3 times higher than against people without disabilities; children with disabilities experience violence at a rate 3.7 times higher than their peers (74). Gender inequality also

compounds HIV vulnerability and unequal outcomes experienced by women and girls with disabilities, who are known to have lower education and face higher rates of poverty, livelihood insecurity and sexual violence than both women without disabilities and men with disabilities (75).

In some contexts, ethnic and racial minorities account for a disproportionately large percentage of new HIV infections and have significantly worse treatment outcomes. In the United States of America, Black people—who represent 13% of the country’s population—accounted for 41% of new HIV infections in 2019 (76). Mobile populations—including migrants, refugees and internally displaced persons—do not always experience higher rates of HIV infection than other local populations in their context, but migration can increase individual vulnerability to infection, restrict access to HIV services and worsen HIV outcomes (35). In addition to refugees and internally displaced persons, other crisis-affected populations represent an increasing proportion of people living with HIV. For instance, from 2013 to 2016, the ratio of people living with HIV affected by a humanitarian emergency rose from 1 in 20 to 1 in 14, and the overall number of people in need of humanitarian assistance and protection has continued to rise (77, 78). More than half of those living with HIV who were affected by a humanitarian emergency were estimated to lack access to antiretroviral therapy (79). Women face heightened HIV risk in humanitarian emergencies related to the devastating impact of sexual and gender-based violence (51). People living in climate-affected areas and/or conflict settings also may face a myriad of challenges in accessing prevention, treatment or care services, and those challenges may be as dynamic and fluid as the crises themselves. How ethnicity, race, migration status and presence in a humanitarian or conflict setting intersect with other forms of discrimination and inequality remains to be systematically addressed.

Identifying the location of the individuals experiencing inequalities in HIV risk and outcomes goes beyond regional or even national breakdowns. Still, it is important to note the vast spatial disparities between HIV infection rates: 54% of people living with HIV in the world live in the eastern and southern Africa region, despite this representing just 6.2% of the world’s population (46). At the national or subnational level, there may be specific disadvantages that heighten HIV risk experienced by those living in rural areas in one location, and other disadvantages experienced by the urban poor just a few kilometres away. Urbanization may change patterns of HIV-related inequalities over time. Spatial inequalities also exist between industrialized and non-industrialized regions and between central and remote regions with regard to the different dimensions of health and social protection services.

Priority populations may be highly mobile, such as economic migrants in transit; they also may be at the opposite extreme, such as those confined within in prisons or other closed settings (1). People’s vulnerability to HIV is not static, so identifying and supporting those being left behind requires regular monitoring and assessment.

Other factors

The above list of populations who may experience HIV-related inequalities is not meant to be exhaustive; rather, it is intended to encourage a wider look within, across and beyond recognized key populations, and to help identify additional factors around which HIV-related inequalities arise that may be specific to a given context. Depending on context, these additional factors might additionally include caste, class, religion and other factors. It will be important to identify how different populations are affected by these types of factors and ensure

that they are given due consideration in the process of understanding HIV-related inequalities and designing strategies to address them.

Annex 4. Addressing HIV-related inequalities and universal health care: exploring the synergies

At the end of 2019, 15.7 million people living with HIV globally did not have suppressed viral loads due to gaps across the testing and treatment cascade, which endangers their health and facilitates the further spread of HIV (1). Universal health coverage means ensuring that “all people have access to the health services they need, when and where they need them, without financial hardship” (80). Attention to each of the three dimensions of universal health coverage—coverage, quality and protection from financial hardship—can help reduce HIV-related services gaps and thus HIV-related inequalities. In turn, addressing HIV-related inequalities can contribute to achieving universal health coverage. This relationship is explored below, with a particular focus on the role of health systems in reducing HIV-related inequalities and promoting universal health coverage.

Access

Challenging geographies limit penetration of relevant HIV-related services in certain areas. This can include mountainous terrain, archipelagos or waterways that act as the only access point to a given area, or it may simply be the challenges associated with vast areas and dispersed populations. This, in turn, limits service access for people in these areas. The costs associated with providing services in such areas can be considered prohibitive, but with a focus on leaving no one behind, it remains critical to find ways to reach populations with services, wherever they live. This might require creativity to minimize costs, such as multimonth dispensing of antiretroviral therapy, promotion of HIV self-testing (with linkage to care), or sexuality education and community distribution of condoms.

Ensuring access also requires providing an appropriate range of services, including those for HIV. In some places, however, certain services might not be consistently available, such as diagnostic testing, viral load testing, early infant diagnosis or antiretroviral therapy. To address HIV-related inequalities, it is critical that the full range of required HIV-related services be made available to all who need them. It is important to assess availability across geographic areas to identify underserved areas and focus on particular population groups.

Inadequate access to antenatal care has been found to impede uptake of prevention services among pregnant women living with HIV. Globally, only about 60% of pregnant women receive the recommended level of antenatal care services, and many of them initiate antenatal care late, which can impede the possibility of early diagnosis of HIV and viral suppression before delivery (25). In 2018, 82% of pregnant women living with HIV were using antiretroviral therapy (81). Limited availability of paediatric HIV testing is known to be a key reason for poor treatment coverage among children. About 50% of children living with HIV are diagnosed through prevention of mother-to-child HIV transmission services, but there is limited paediatric testing available beyond this to identify, for example, infants who acquire HIV during breastfeeding more than six weeks after birth (25).

Around the world, important HIV-related services are unevenly available or entirely absent. For example, harm reduction services for people who inject drugs are rarely available at scale. The availability of HIV interventions tailored to people who engage in sex work or to gay men and other men who have sex with men is still low, including in many high-income countries, and the situation is even worse with regard to interventions tailored to support transgender people (8). People in prisons and other closed settings are often not provided with HIV services, despite the relative ease of reaching them, and access for people living with HIV is often interrupted on prison admission, transfer and release (1).

Adolescent-friendly services are a key component of HIV-related services, but they are often deprioritized, especially where legal or cultural norms deem adolescent sexual activity to be unacceptable. In some places, female adolescents living with HIV are less likely than older women living with HIV to have been diagnosed, and they are also less likely to receive antiretroviral therapy (82).

Very few health facilities are designed to facilitate access by people with disabilities, but this is a requirement for ensuring access to services for all. Beyond physical access to buildings, this also encompasses accessibility measures, such as creating written materials in Braille and providing sign language interpreters, which are rarely included in HIV services. Furthermore, services are often not provided in minority languages of a country, which might limit access to migrants and refugees, internally displaced people and indigenous people.

Quality

It is well recognized that for services to be effective, they must be of good quality. The provision of quality services encompasses the quality of biomedical care provided, as well as the user's experience of care. Where waiting times are long, drugs are out of stock, health workers disrespect clients and appointments are too rushed for clients to ask questions, quality is compromised. The perceived lack of quality (including a lack of confidentiality) and shortcomings in the ability of health workers to provide appropriate services for all populations are recognized factors that affect quality of care, particularly for key populations.

Where clients are not treated with dignity or they experience disparagement, disdain or discrimination, they are unlikely to find services acceptable, which can affect their willingness to remain engaged in care. As discussed above, fear or experiences of discrimination by health workers—whether related to HIV status, age, sexual orientation, gender identity or any other reason—constitutes a key barrier to the acceptability, access and use of services.

Inequalities in treatment access and outcomes arise when services do not specifically meet the needs of underserved populations who are not well served by mainstream health services. What is acceptable does not look the same for everyone, and differentiated approaches and support are often not in place to ensure appropriateness and continuity of care for all populations.

Protection from financial hardship

User fees attached to HIV-related services—as well as their “feeder” services, such as antenatal care or tuberculosis clinics—reduce the accessibility of services, even if they are available. Any fees attached to laboratory tests, diagnostic images or medications can limit the financial accessibility of HIV-related services, creating financial hardship and impeding progress towards universal health coverage.

Legal grounding for attention to each dimension of universal health coverage can be found in the right to health: coverage is encompassed by availability and accessibility, quality is covered by acceptability and quality, and avoiding financial catastrophe fits within the affordability aspect of accessibility (26).

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