HUMAN RIGHTS AND GENDER EQUALITY

5

KEY FINDINGS

HUMAN RIGHTS

- Failing to address the human rights of key populations at higher risk of exposure to HIV facilitates the growth of the epidemic and enhances its socially damaging effects.
- Punitive laws that affect people living with HIV, or other people at higher risk of exposure, remain widespread. Laws protecting such people exist in many countries, but there are not enough data to show whether they are actively or widely enforced.
- Stigma, discrimination, and violence against transgender people, and men who have sex with men, increase their risk of HIV infection and also for their male and female partners.

GENDER EQUALITY

- The vulnerability of women and girls to HIV remains particularly high in sub-Saharan Africa; 80% of all women in the world living with HIV live in this region.
- Efforts to promote universal access to HIV prevention, treatment, care and support services require a sharper focus on women and girls. Fewer than half of countries report having a specific budget for HIV-related programmes addressing women and girls.
- Despite evidence that beneficial behaviour change can be achieved, few HIV programmes engage men and boys.

» **Human rights and gender equality are critical to effective responses to HIV**

In the context of HIV, protections comprise legal approaches that implement international human rights commitments as well as efforts to address harmful social and gender norms that put women, men, and children at increased risk of HIV infection and increase its impact. A rights-based approach to HIV requires: realization and protection of the rights people need to avoid exposure to HIV; enabling and protecting people living with HIV so that they can live and thrive with dignity; attention to the most marginalized within societies; and empowerment of key populations through encouraging social participation, promoting inclusion and raising rights-awareness. Significant advances have been made in expanding HIV prevention, treatment, care, and support services in recent years but some key populations at higher risk such as sex workers, people who inject drugs, and men who have sex with men, remain often underserved. Resources directed towards the needs of these populations, including support for them to claim and exercise their rights, are often not proportional to the degree to which they are affected by the epidemic.

Stigma and discrimination

In 2010, 91% of governments reported that they address stigma and discrimination as cross cutting issues in their national strategies. Further, from nongovernmental sources that have consistently reported on the National Composite Policy Index (NCPI) since 2006, reports of programmes to address stigma and discrimination have doubled in less than five years (92% in 2010 against 46% in 2006). This improvement indicates increased acknowledgement of the importance of working to eliminate stigmatization of, and discrimination against, people living with HIV.

However, these reports refer only to the existence of such programmes. They do not confirm whether efforts are implemented at sufficient scale and of a quality to make real and sustained improvements to the lives of people living with HIV and other members of key populations at higher risk of exposure.

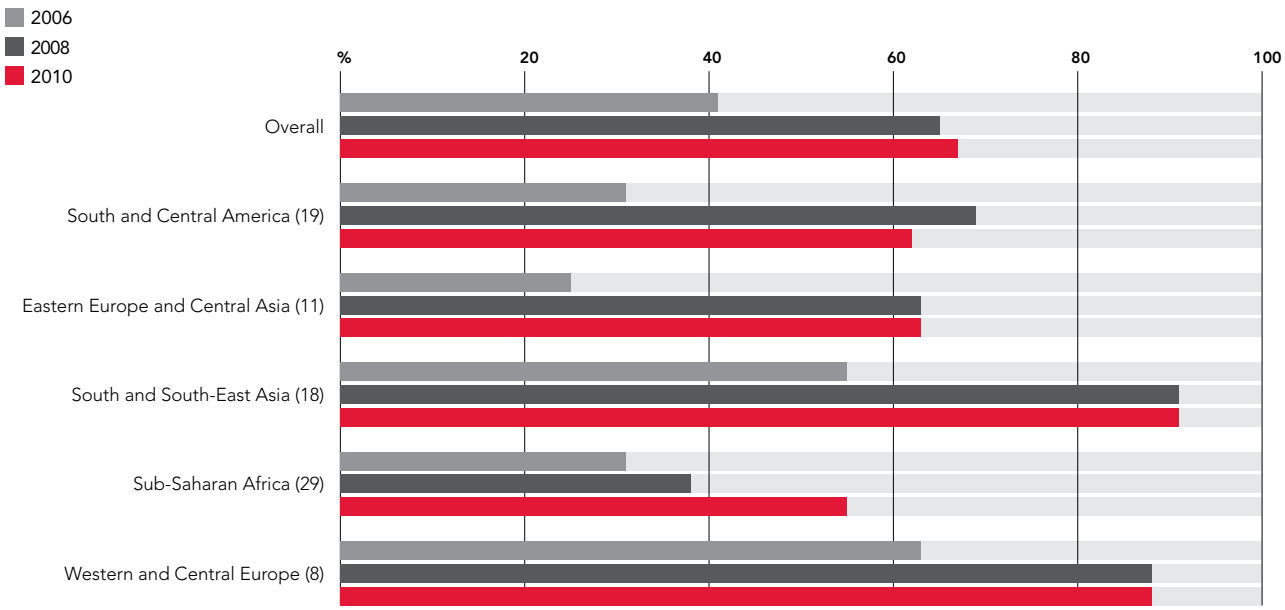
In 2008–2009, the UNAIDS Secretariat commissioned the International HIV/AIDS Alliance to review the national AIDS planning documents of 56 countries to ascertain whether they included programmes to increase access to justice and reduce stigma and discrimination (e.g. law reform; know your rights/legal literacy; and human rights training for service providers, provision of legal services, and programmes supporting the human rights of women and

Figure 5.1

Countries with laws or regulations that create obstacles

Percentage of countries in which nongovernmental sources report laws or regulations that create obstacles to effective HIV prevention, treatment, care, and support for population groups at higher risk and other vulnerable population groups.

Source: Country Progress Reports 2006, 2008, 2010.



The following regions are not displayed due to insufficient countries: Caribbean, Middle East and North Africa, East Asia, Oceania, and North America.

girls). This study (to be published in 2010) found that, although about 90% of country activity plans included stigma and discrimination reduction programmes, fewer than 50% of countries costed or budgeted such programmes. Further, the review indicated that countries rarely included a comprehensive package of programmes to reduce stigma and discrimination in their national strategies (1).

The United Nations Development Programme, UNAIDS, and the Global Fund to Fight AIDS, Tuberculosis and Malaria examined whether human rights programmes were included in the Global Fund's HIV portfolio for Rounds 6 and 7. This 2009-2010 study found that one third of the key human-rights programmes identified by Country Coordinating Mechanisms as being necessary for an effective HIV response were not implemented. The same study also found that less than one quarter of planned programmes explicitly engaged men who have sex with men, transgender people, people who use drugs, sex workers, and prisoners (2).

Results from the People Living with HIV Stigma Index illustrate the need to increase efforts to reduce stigma and discrimination as part of national HIV responses. The Index, currently being rolled out in more than 70 countries and with preliminary results from 10 now available (Bangladesh, China, Dominican Republic, Fiji, Myanmar, Paraguay, Rwanda, United Kingdom—including a separate component for Scotland—and Zambia), provides rich evidence of the multi-layered ways in which stigma and discrimination manifest in the lives of people living with HIV.

In China, for example, more than 30% of people living with HIV said they had been subject to verbal abuse, 9% had been physically harassed, 14% refused employment, and 12% denied health care (2). In Paraguay, 12% were excluded from social gatherings, 11% were physically harassed and 9% physically assaulted (3). In Rwanda, more than 50% were verbally insulted, 36% physically harassed and 20% physically assaulted, 65% experienced loss of job or income and 88% were denied access to family planning services due to their HIV status (4). In the United Kingdom, 17% reported having been denied health care (5).

High percentages of respondents in all countries reported internalized stigma: feeling ashamed, guilty, suicidal, and blameworthy.

An extensive survey by the nongovernmental organization representatives of the UNAIDS Programme Coordinating Board in 2010 showed that people living with HIV and key populations at higher risk continue to experience high levels of HIV-related stigma and discrimination. Slightly less than half of respondents experienced negative attitudes or exclusion from family members. Other experiences in at least one third of the sample included loss of employment, refusal of care by health care workers, social or vocational exclusion, and/or involuntary disclosure (6). Several examples from the UNGASS narrative reports (7) also show that stigma and discrimination continue to hinder effective HIV responses. Narrative reports from Cambodia, Malaysia, Nepal, and Pakistan include stigma and discrimination as barriers to providing prevention, treatment, and care services to key population groups and to providing treatment and care for people living with HIV (8).

Several countries reported that stigma and discrimination in health care facilities adversely affect access to and the provision of services. For example, in Central and South America, several reports note that some health care personnel are likely to discriminate against people living with HIV and deny services to population groups at higher risk such as sex workers and men who have sex with men; in Mexico, service providers may treat people who inject drugs as "delinquents" (8). Country progress reports for 2010 from Lesotho, Mozambique and Senegal (7) mentioned stigma and discrimination towards sex workers and sexual minorities as barriers to their accessing health services, HIV testing, and HIV treatment.

There continue to be reports from many parts of the world of violence against and murder of individuals based on their perceived or actual sexual orientation (9–11). For example, the shadow report submitted under UNGASS reporting on Honduras described several murders and a climate of impunity for perpetrators of violations of human rights that seriously undermines the HIV response (12). Such grave situations call for concerted action and advocacy by both human rights and HIV stakeholders.

Meaningfully involving people living with and vulnerable to HIV in national HIV responses is a part of realizing human rights.

SOURCES TO ASSESS STIGMA AND DISCRIMINATION

UNGASS country report narratives

Country progress reports submitted by governments (7) include a narrative on progress made in the AIDS response. Often these include narratives that provide a rich context on the impact of stigma and discrimination. In some instances nongovernmental organizations also submit shadow reports, which provide a point of view different from the official version. Together, they may provide a realistic picture of national and community efforts to eliminate stigma and discrimination.

National Composite Policy Index

The National Composite Policy Index (NCPI) is an integral part of the core UNGASS indicators, which comprises a series of questions on each country's legal and policy landscape in relation to HIV. The NCPI is divided into two parts: (a) the government's responses to the questions and (b) the responses of civil society organizations, the United Nations and bilateral agencies (nongovernmental sources). Most questions are answered yes/no. The answers are not independently verified but provide a snapshot of how different organizations view the various national AIDS policies and their implementation.

People Living with HIV Stigma Index

The People Living with HIV Stigma Index is an innovative way to measure HIV-related stigma and discrimination experienced by people living with HIV. National networks of people living with HIV lead the implementation of the Index. The Index is supported jointly by the Global Network of People Living with HIV, International Community of Women Living with HIV, International Planned Parenthood Federation and UNAIDS.

The Greater Involvement of People Living with HIV (GIPA) has been a key human rights principle within the HIV response since the Paris Declaration of 1994. In 2010, governments in 96% of countries reported that their national HIV strategy explicitly addressed the involvement of people living with HIV, up from 75% in 2006. Civil society has been leading efforts to assess the nature and quality of this participation. The Global Network of People Living with HIV has implemented the GIPA Report Card in six countries and is currently implementing assessments in four others. In Kenya, 33% of respondents indicated that they either "somewhat agreed" or "strongly agreed" that people living with HIV were meaningfully involved in developing the country's national AIDS plan; in Nigeria, the figure was 60%; and in Zambia, 66%. Fear of stigma was cited as one of the most significant barriers to greater involvement in the national response in all three countries (13).

Laws, policies, and regulations that create obstacles to effective HIV responses are increasingly acknowledged but too often remain

Countries increasingly acknowledge the demonstrated and potential negative effects of punitive legislation, policies, and regulations on access to, and uptake of, HIV prevention, treatment, care, and support services and on the rights and dignity of people living with or vulnerable to HIV (14). In 2006, nongovernmental sources in 41% of countries reported that the countries had laws, policies, or regulations that posed obstacles to effective HIV service provision for key populations at higher risk. In 2010, sources in 67% of the same countries reported the existence of such obstacles. In Asia and the Pacific, nearly 90% of nongovernmental sources reported the existence of laws that pose obstacles to effective HIV responses for key populations at higher risk. In the Middle East and North Africa 56% of countries, and 55% in sub-Saharan Africa reported similar laws.

Government and civil society responses to the National Composite Policy Index (NCPI) in this area differ notably. In 2010, the governments of 78 countries (46% of those reporting) acknowledged the existence of laws, regulations, and policies that obstructed access to prevention, treatment, care, and support services for populations at higher risk; in contrast, civil society from 106 countries (62%) reported the same (Figure 5.1).

These reports do not capture the full reality of laws that can act as obstacles to the HIV response. For instance, 79 countries and territories criminalize same-sex sexual relations between consenting adults, with six countries retaining the possibility of applying the death penalty for such acts (15). More than 100 countries criminalize some aspect of sex work (16,17). Fifty-one countries, territories, and entities are reported to impose some form of restriction on the entry, stay, and residence of people living with HIV (Figure 5.2) (18,19).

In their narrative UNGASS reports (7), several countries recognized that criminalization of same-sex practices, sex work, and/or provision of sterile needles and syringes, and of punitive law enforcement are barriers to fully effective HIV responses. Bangladesh, for example, reports that existing laws are often used to harass vulnerable people, leading to the weakening of programme

REMOVING PUNITIVE AND DISCRIMINATORY LAWS: HIV-RELATED RESTRICTIONS ON ENTRY, STAY, AND RESIDENCE

In 2010, a number of countries lifted their HIV-related restrictions on entry, stay, and residence: the United States of America (January); China (April); and Namibia (July). However, such restrictions continue in 51 countries—an indicator of the discrimination still faced by people living with HIV in today's highly mobile world..

Figure 5.2

HIV-related restrictions on entry, stay, or residence

A total of 51 countries, territories, and areas impose some form of restriction on the entry, stay, or residence of people living with HIV based on their HIV status.

Source: Mapping of Restrictions on the entry, stay and residence of people living with HIV (UNAIDS, May 2009), and latest developments as of July 2010.

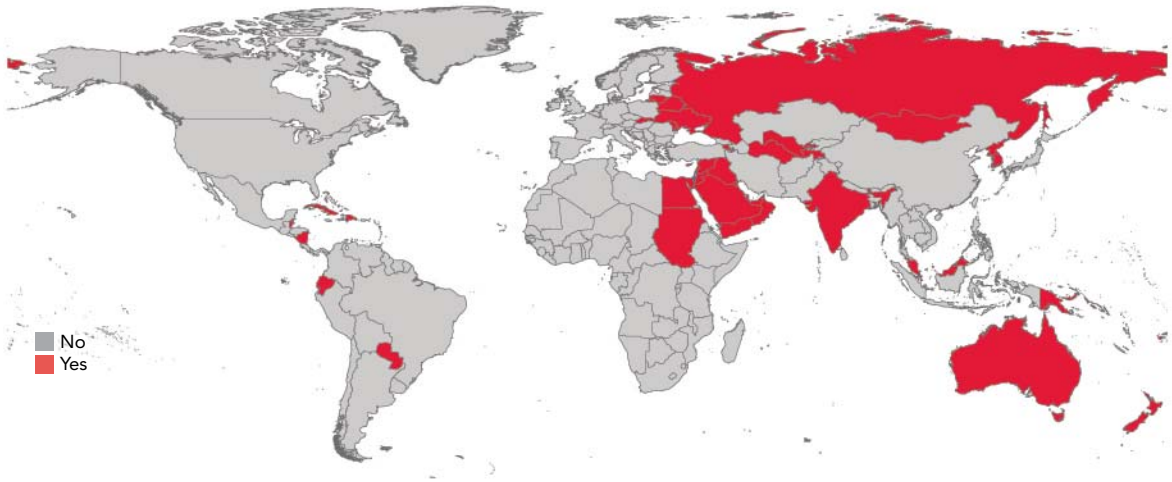
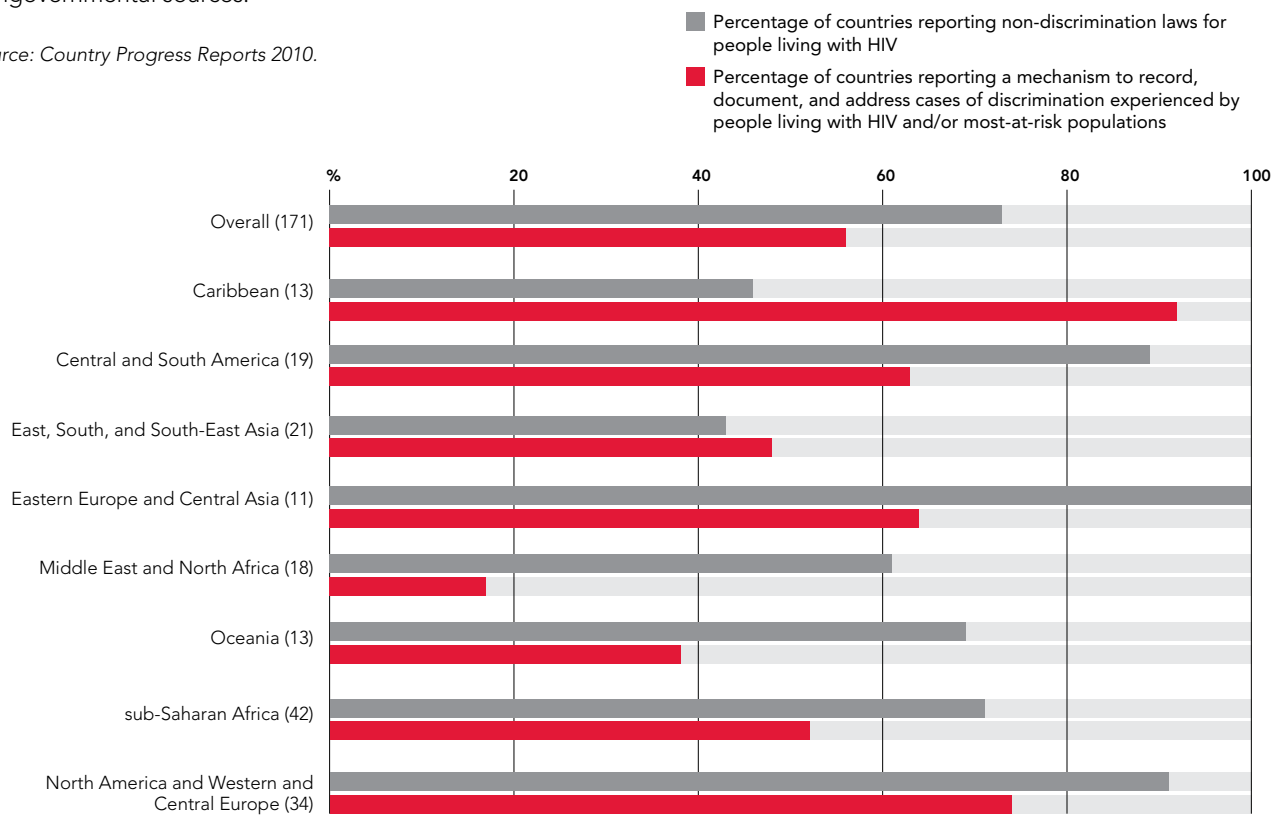


Figure 5.3

Legal protections against discrimination for people living with HIV

Percentage of countries with legal protections against discrimination for people living with HIV and mechanisms for redress, as reported by nongovernmental sources.

Source: Country Progress Reports 2010.



implementation supporting people at higher risk of exposure to HIV. Malaysia's report recognized the challenges posed by contradictory harm reduction and drug control policies. Reports from Botswana, Ghana, Malawi, Mozambique, and Zambia acknowledge that criminalizing homosexuality makes providing services to men who have sex with men more difficult. Reports from Lebanon, Saudi Arabia, and the Syrian Arab Republic also note that laws that prohibit adultery, homosexuality, and sex work may hinder HIV prevention efforts (7).

56%

Percentage of countries reporting having a mechanism to record and address cases of discrimination.

Studies confirm that punitive laws have negative effects on access to HIV services and on the claiming and exercise of human rights by men who have sex with men (20), sex workers (21,22), and people who use drugs (14,23,24). Among those working in the response to HIV another concern is the apparent increased trend of passing laws that criminalize HIV transmission and/or the failure to disclose one's HIV status. Such laws contradict the commitment made by governments in the Political Declaration on HIV/AIDS in 2006 "to promote a social and legal environment that is supportive of and safe for voluntary disclosure of HIV status" (25). Countries in North America and Western Europe have long criminalized HIV transmission, and about 20 countries in sub-Saharan Africa have also chosen to do so in the past six years (26).

Parallel to increased acknowledgement of laws that pose obstacles to HIV responses, more countries report the existence of laws and regulations that protect people living with or vulnerable to HIV from discrimination but data are insufficient to indicate whether they are adequately enforced. In 2010, nongovernmental sources in 71% of countries reported the existence of laws protecting people living with HIV from discrimination versus 67% in 2008 and 56% in 2006 (of the same 85 countries reporting in all three years). Most worrying, however, is that the 2010 data indicate that almost one third of countries still do not have such protective legislation. In addition, only 56% of countries report having a mechanism to record, document, and address cases of discrimination experienced by people living with HIV or other people vulnerable to HIV (Figure 5.3).

In 2010, governments in 106 countries (62%) reported having laws or regulations that specify protections for key populations at higher risk such as women, young people, men who have sex with men, people who inject drugs, sex workers, prisoners and migrants. Nongovernmental sources in 112 countries (65%) reported the same. In 2004, when the first UNGASS reports were submitted, nongovernmental sources in only 32% of countries reported the same (of the 88 countries reporting that year). This suggests increased understanding among policy makers that protective laws are important in effectively responding to HIV (Figure 5.4).

Despite reporting of an increase in protective laws, there is little evidence whether these laws are effectively enforced or whether people living with HIV and other people key in the response have access to justice or can seek redress for wrongs experienced. For instance, while nongovernmental sources in 61% of countries in North Africa and the Middle East report the existence of non-discrimination laws, only 17% report having mechanisms to record, document, and address cases of discrimination experienced by people living with or vulnerable to HIV.

Figure 5.4

Non-discrimination laws protecting key populations at higher risk

Countries in which nongovernmental sources report non-discrimination laws protecting key populations at higher risk.

Source: Country Progress Reports 2010.

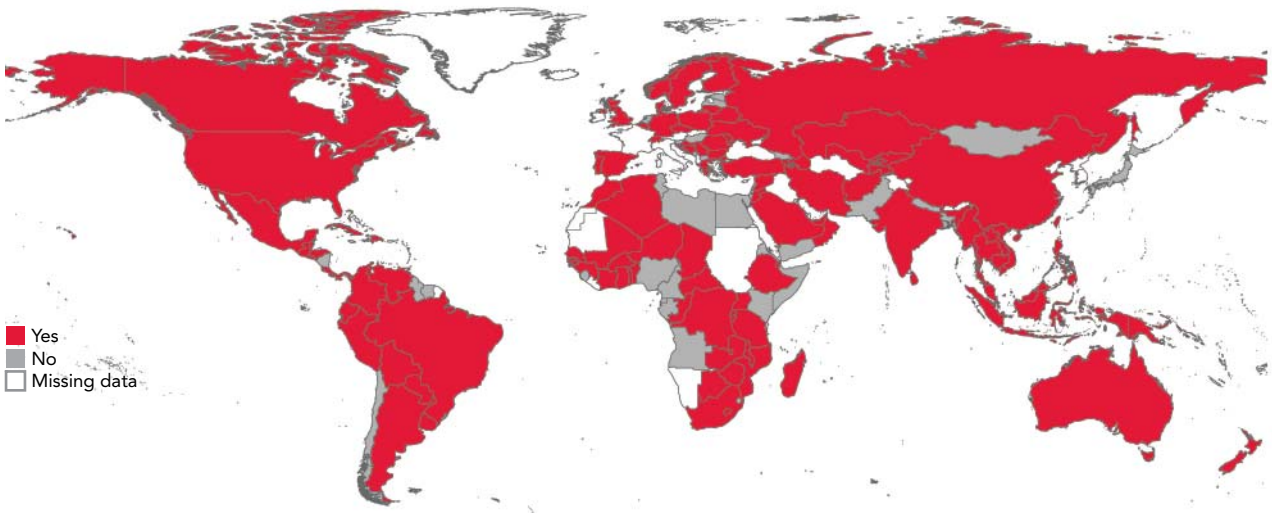
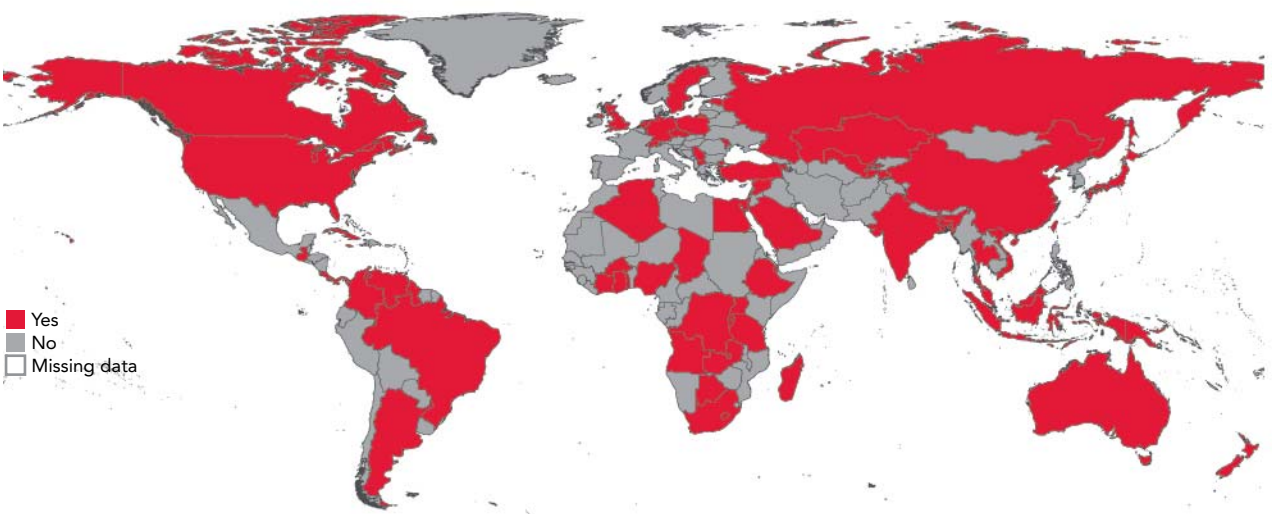


Figure 5.5

Legal aid for HIV casework

Countries in which nongovernmental sources report legal aid systems for HIV casework, 2010.

Source: Country Progress Reports 2010.



THE GLOBAL COMMISSION ON HIV AND THE LAW

On 24 June 2010, UNDP and UNAIDS launched the Global Commission on HIV and the Law composed of renowned and independent global leaders in the areas of law, public health policy and governance. The establishment of the Commission is an essential milestone in supporting countries to remove punitive laws, policies, practices, stigma and discrimination that block effective responses to HIV. The Commission is supported by a Technical Advisory Group of law, human rights and public health experts.

As an outcome of its first meeting in October 2010, the Commission will focus on the following issues: criminalization of sex workers, drug users, people living with HIV, men who have sex with men, gender inequality and violence against women, and legal barriers to treatment. Through its work, the Commission will marshal the evidence on the impact of the law on the HIV response, and make actionable recommendations on how to create effective, protective and enabling legal responses to HIV.

In the course of 2011, the Commission will hold a number of regional policy dialogues that will allow submissions from regional and national stakeholders, including governments, civil society, people living with HIV and representatives of key populations. These submissions will shape the final report and recommendations of the Commission, expected in December 2011.

Access to HIV-related legal services is one effective means to protect the human rights of people living with HIV and other key populations as are efforts to sensitize officials engaged in the administration of justice. However, nongovernmental sources in only 51% of countries report having legal aid systems for HIV casework. Although this represents an increase from 2006, when 33% of countries reported having such systems, the figure has remained the same since 2008. Legal aid systems appear to be more common in high-income countries, with 75% of countries reporting such systems (NCPI), whereas only 48% of low-income countries and 40% of lower-middle-income countries report having them (Figure 5.5).

Gender equality

Although gender relationships, practices and HIV epidemics differ around the world, power imbalances, harmful social gender norms, gender-based violence and marginalization clearly increase the vulnerability of both women and men to HIV infection. The consequences of gender inequalities in terms of low socioeconomic and political status, unequal access to education, and fear of violence, add to the greater biological vulnerability of women and girls being infected with HIV. Too often they have little capacity to negotiate safer sex, access the services they need, and utilize opportunities for empowerment (27). In nearly all countries in sub-Saharan Africa and certain Caribbean countries, the majority of people living with HIV are women, especially girls and women aged 15–24 years (28,29).

In sub-Saharan Africa, women are more likely to become infected with HIV than are men (Figure 5.6). The most recent prevalence data show that in sub-Saharan Africa, 13 women become infected for every 10 men infected. One half of people living with HIV globally are women and 76% of all HIV-positive women live in sub-Saharan Africa.

Conversely, traditional roles and societal values related to masculinity might encourage boys and men to adopt risky behaviours, including excessive alcohol use and concurrent sexual relationships, so increasing their risk of acquiring and transmitting HIV. Many harmful norms related to masculinity and femininity also stigmatize transgender people, men who have sex with men, and other sexual minorities.

Levels of new HIV infections in sub-Saharan Africa continue to remain higher among women, a pattern that applies to every subregion in sub-Saharan Africa. Female-to-male ratios of new HIV infections range from 1.22:1 in West and East Africa to 1.33:1 in southern Africa, despite the different types of epidemics and predominant modes of transmission in these subregions.

In other regions, men are more likely to be infected with HIV than women, often in concentrated epidemics involving men who have sex with men or people who inject drugs. Men who have sex with men continue to bear a high burden of HIV infection even in regions with generalized epidemics. In sub-Saharan Africa, HIV programming has largely neglected same-sex behaviour because of homophobia and the widespread criminalization of homosexuality.

Figure 5.6

People newly infected with HIV, 2009

Number of people newly infected with HIV annually by sex and geographical region, 2009.

Source: UNAIDS 2010.

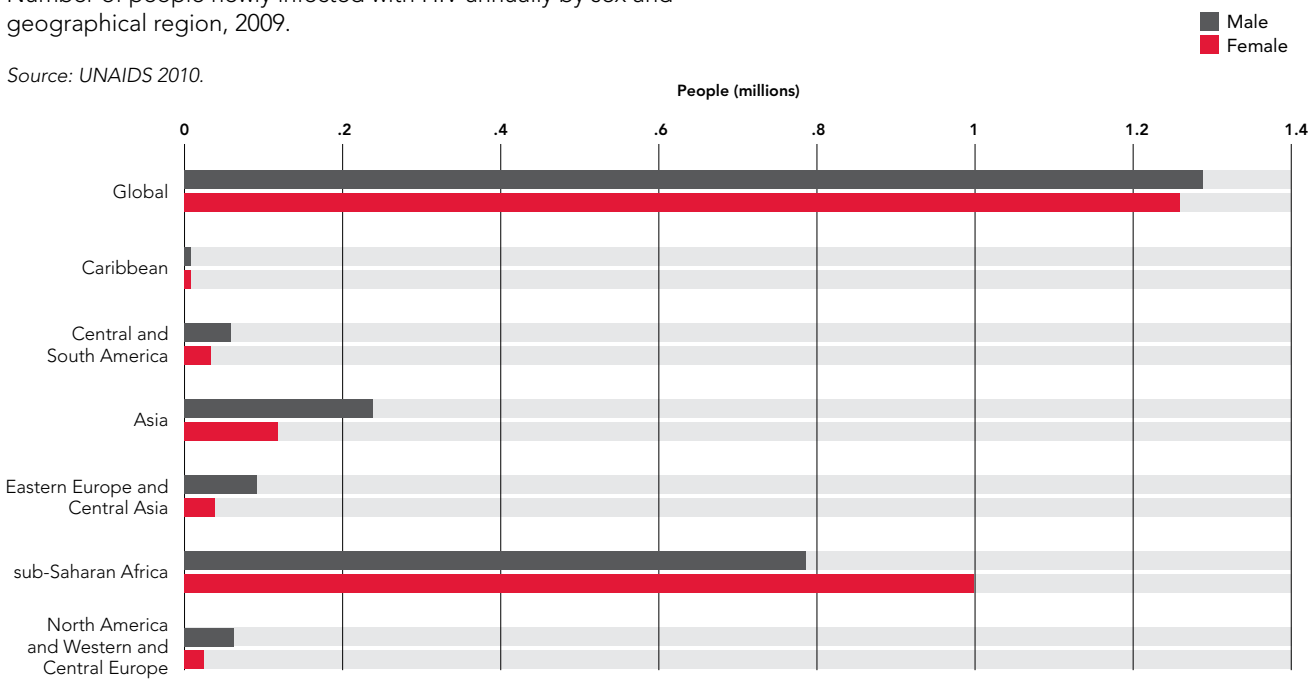
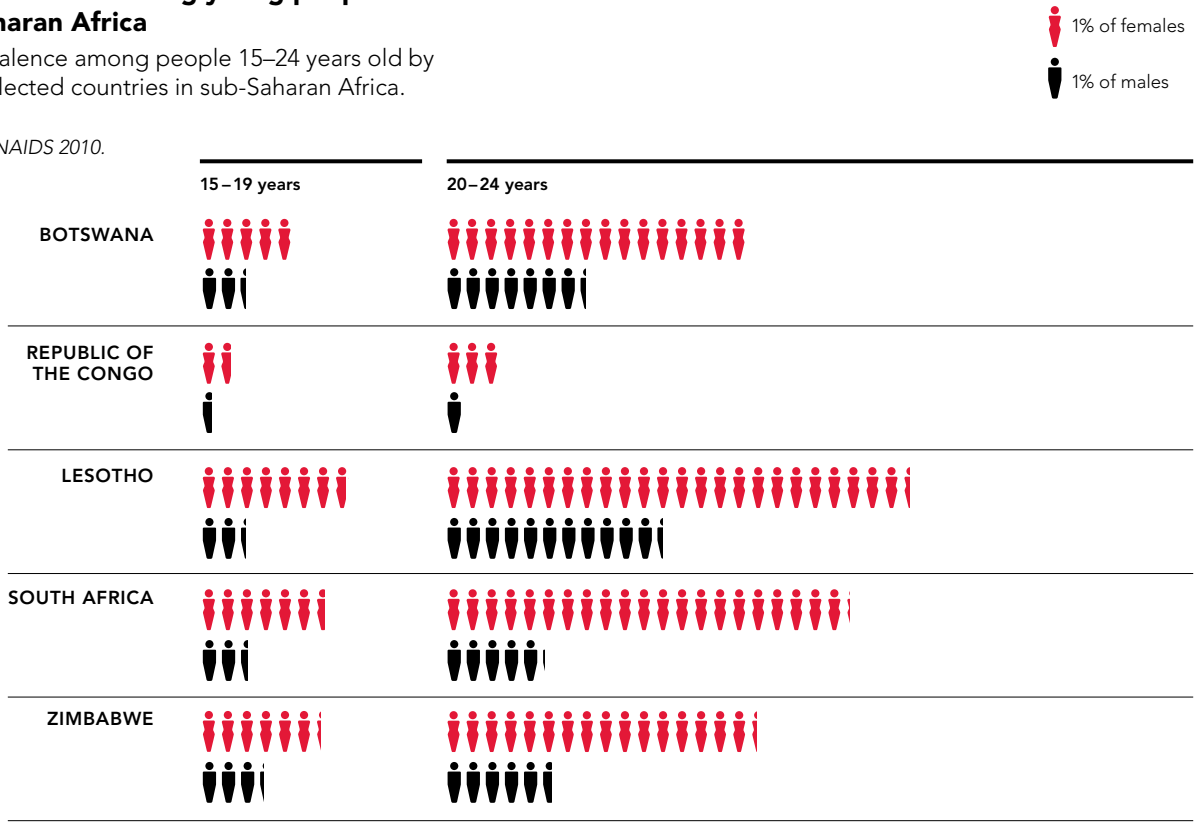


Figure 5.7

HIV prevalence among young people in sub-Saharan Africa

HIV prevalence among people 15–24 years old by sex in selected countries in sub-Saharan Africa.

Source: UNAIDS 2010.



Research has found significantly higher levels of infection among men who have sex with men than among men in general, and has also confirmed that many men who have sex with men also have sex with women (30). Understanding the complexities of relationships engaged in by some married and long-term partners is important in focusing the HIV response. A recent study conducted in Botswana, Malawi, and Namibia found that 34% of men who have sex with men were married to women, and a total of 54% reported sex with both men and women in the previous six months (31). Marriage thus serves as a way to protect against possible prosecution and stigma against men who have sex with men (32,33). In Asia, data obtained through the Asia Intimate Partner Transmission Study (34) indicate that women are predominantly infected by their husband or intimate partner. For example, recent data on HIV infection patterns in India reveal that 90% of women in India were infected within long-term relationships.

"THE NUMBER OF COUNTRIES WITH A SPECIFIC BUDGET FOR HIV ACTIVITIES RELATED TO WOMEN IS LOW: 46% OF REPORTING COUNTRIES."

Sociocultural practices significantly contribute to the risk of HIV infection, especially among young women

The effects of gender constructs are reflected in HIV infection rates among young women in Africa. Demographic and health surveys in selected countries in Africa show that young women are at particularly high risk of HIV infection, with rates substantially increasing among women 20–24 years old versus 15–19 years old (Figure 5.7). This is probably because young women, who are biologically more susceptible to HIV than men, also often have older male sexual partners, who are more likely than younger men to be infected with HIV. As a result, while levels of HIV infection among men rise slowly and peak at a lower level than female infection rates when men are in their mid- to late thirties, prevalence among women rises rapidly at a young age, with higher peaks when women are in their late twenties (35).

Data from sub-Saharan Africa indicate that women also engage in multiple concurrent partnerships (36). A recent ethnographic study conducted in the United Republic of Tanzania showed that both parents and daughters widely accepted transactional sex, including sex for power, pleasure, and material gain. The authors conclude that programmes that encourage young women to incorporate demands for safer sex into negotiations for gifts and money may ultimately be more effective than those that seek only to restrict transactional sex or highlight its health risks (37). Another study found that more affluent women are at greater risk of contracting HIV, as they are more mobile, more likely to live in an urban area, and more able to afford a lifestyle that includes having a higher number of sexual partners (38).

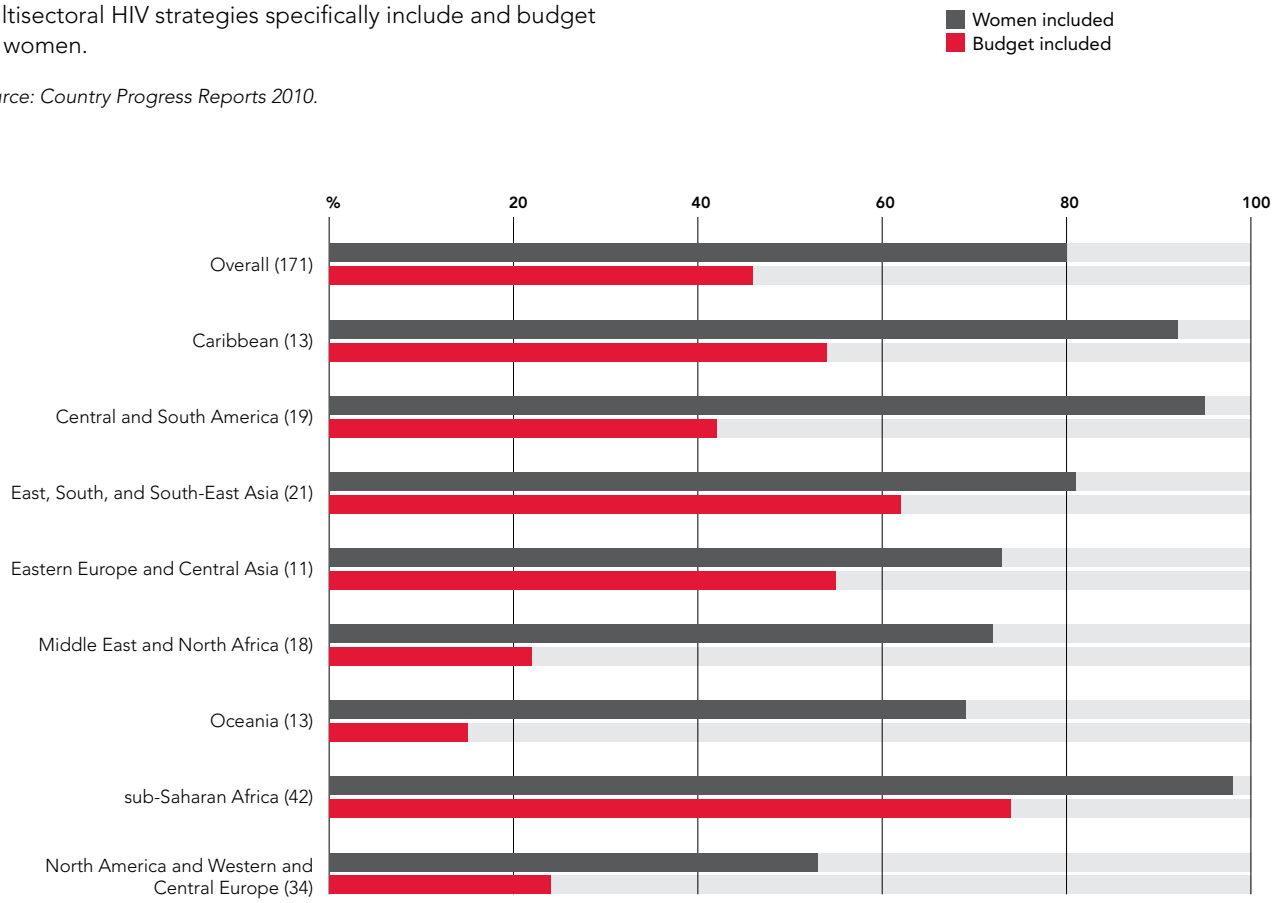
A 2009 study in Brazil (39) shows men who have sex with men have much higher levels of HIV infection than men in general (10.5% versus 0.8%). The study found that although men who have sex with men report more casual sexual partners than men in general, condom use among was only at about 50%, despite a comprehensive programme to increase condom use among men who have sex with men. Furthermore, young men who have sex with men used condoms with slightly less frequency than men in general (54% versus 57%) (39).

Figure 5.8

Multisectoral HIV strategies specifically including and budgeting for women

Percentage of countries in which governments report that multisectoral HIV strategies specifically include and budget for women.

Source: Country Progress Reports 2010.



Women are included in HIV strategies but budgetary allocations are insufficient

Governments in 80% of countries (137 of 171) reported that they include women as a specific component of a multisectoral HIV strategy, but the rate of inclusion of women differs by geographical regions (Figure 5.8). The number of countries with a specific budget for HIV activities related to women is considerably lower: 46% (79 of the 171) reporting countries. Among countries in sub-Saharan Africa, nearly all strategic plans include interventions benefiting women, and three quarters of countries allocate budget accordingly, indicating a greater awareness of the need for and benefits of women-centred AIDS responses.

"VIOLENCE AND THE THREAT OF VIOLENCE CAN HAMPER WOMEN'S ABILITY TO ADEQUATELY PROTECT THEMSELVES FROM HIV INFECTION AND/OR ASSERT HEALTHY SEXUAL DECISION-MAKING."

The HIV epidemic is intertwined with sexual and reproductive health

Data on unmet sexual and reproductive health needs, especially among young women a population highly affected by HIV and violence, underline the urgency to address Millennium Development Goals 3, 4, 5 and 6 simultaneously. A WHO report on women and health (40) highlights the critical role of gender inequality in increasing vulnerability to HIV infection and other conditions and limiting access to health care services and information. A review of maternal mortality data revealed that HIV-related causes contributed to at least 20% of maternal deaths (41).

Countries with high HIV prevalence rates among young women are equally challenged by high teenage pregnancy rates, and the consequences of unintended pregnancies in terms of unsafe abortion.

According to WHO, each year about 16 million women 15–19 years old around the world give birth, with most living in sub-Saharan Africa. In addition, at least 2.5 million adolescents have unsafe abortions every year (42). Further, anecdotal reports indicate that women living with HIV are pressured, and even forced, to undergo sterilization or to have an abortion.

Recent research carried out by civil society on sexual and reproductive health policies, undertaken in 12 countries in sub-Saharan Africa, Central and South America, the Caribbean, South-East Asia, and Eastern Europe by GESTOS, Brazil (43) confirms that countries have reproductive and sexual health policies oriented towards women in place but generally fail to translate these into comprehensive services, leaving many sexual and reproductive health needs unmet.

Violence and HIV infections are often associated and require integrated responses

Violence and the threat of violence can hamper women's ability to adequately protect themselves from HIV infection and/or assert healthy sexual decision-making. In addition, women living with HIV are more likely to experience violence due to their HIV status (44).

The WHO study also found that many women have a traumatic experience when engaging in sexual intercourse for the first time, with the prevalence of forced first sex among adolescent girls younger than 15 years ranging between 11% and 45% globally. In addition, younger women, especially those 15–19

Figure 5.9

Violence against women

Proportion of ever-married women 15–49 years old who ever experienced physical or sexual violence from their most recent spouse or co-resident partner, by country, 2008 or most recent survey.

Source: Demographic Health Surveys, 2002-2008, excepting Bangladesh, Ethiopia, Japan, Kenya, Samoa, Serbia, Tanzania and Thailand (WHO Multi-Country Study on Women's health and Domestic Violence, 2004).

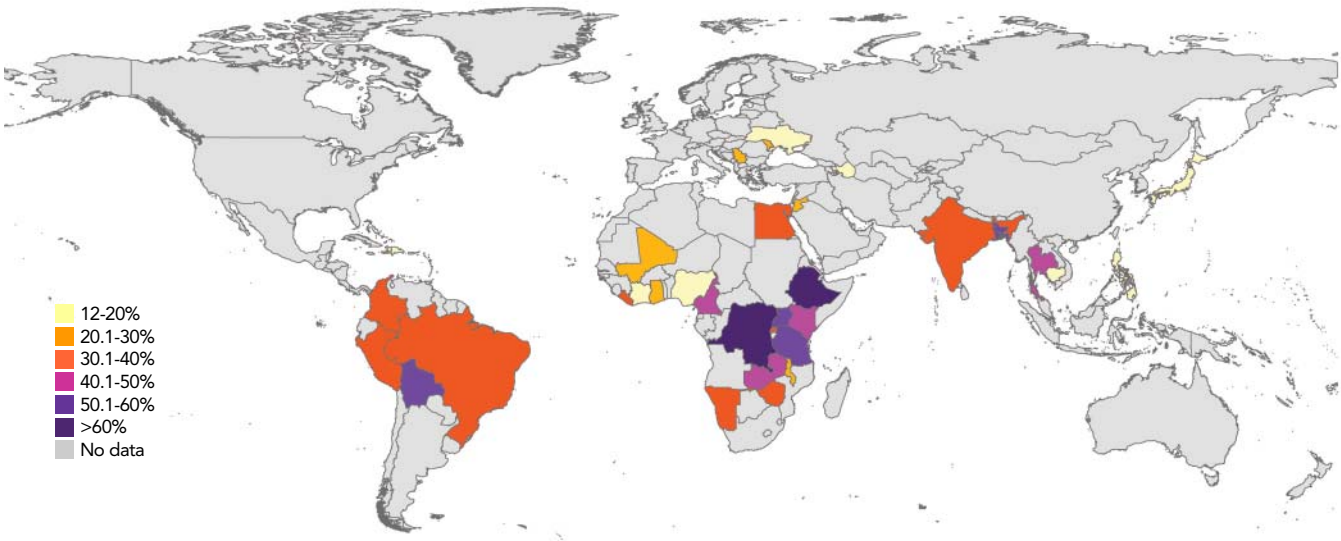
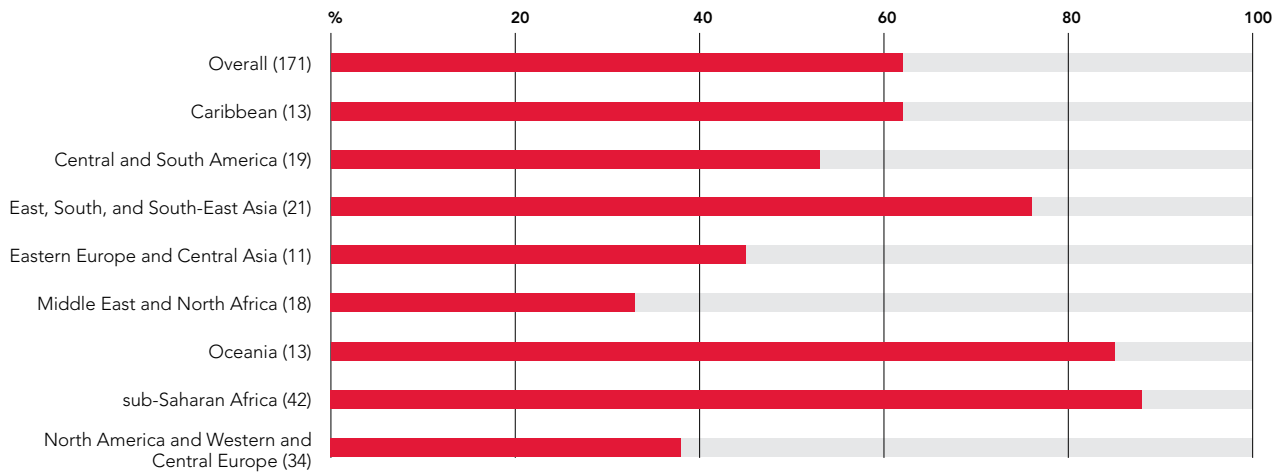


Figure 5.10

Governments involving men in reproductive health programmes

Percentage of countries in which governments report involving men in reproductive health programmes through information, education and communication, 2010.

Source: Country Progress Reports 2010.



years old, were generally at higher risk of physical and/or sexual violence by a partner. In Swaziland, which has one of the highest levels of HIV prevalence, a 2007 study (45) showed that 33% of females 13–24 years old reported experiencing some form of sexual violence before reaching 18 years of age.

A 2010 study in South Africa (46) confirmed the association between violence and HIV infection. Power inequity in relationships and intimate partner violence increased the incident risk of HIV infection among young South African women. Prevalence of the population-attributable risk was 14% for power inequity in relationships and 12% for intimate partner violence. The GESTOS research (43) found that few countries have undertaken focused actions to prevent violence or to empower women survivors of violence. This finding is confirmed by the recent WHO/UNAIDS publication (44), indicating that effective programmatic models such as Stepping Stones, IMAGES, and Sasa! have so far only been incorporated to a limited extent in the HIV response. It is notable that countries might have laws in place to punish rapists, but few have legislation that penalizes domestic violence (43).

"MEN WHO HAVE SEX WITH MEN AND TRANSGENDER PEOPLE ALSO FACE INCREASED VULNERABILITY TO HIV INFECTION DUE TO VIOLENCE AND STIGMA."

Figure 5.9 shows that the prevalence of violence against women can be as high as 50% in some countries. The limited availability of epidemiological data on violence underlines the urgent need for additional evidence to guide policy and programmatic action to address it.

UNGASS reports for several countries in sub-Saharan Africa (7) outline the increased HIV vulnerability of women due to violence and sexual coercion and highlight the link with armed conflict, including sexual violence against women in refugee camps. Other countries underline that violence against sex workers affects their capacity to insist on the use of condoms. Reporting on gender-based violence is not even. Outside sub-Saharan Africa, UNGASS reports are silent on violence against women and girls. In sub-Saharan Africa, countries have not reported on violence against men who have non-heterosexual identities or practices and transgender people.

Men who have sex with men and transgender people also face increased vulnerability to HIV infection due to violence and stigma. Historically, community-based organizations, rather than nationally funded HIV programmes, have led in attempting to increase access for men who have sex with men and transgender people. Such "self-help" efforts are hampered where homosexuality is criminalized, as in sub-Saharan Africa, where men who have sex with men experience violence, live under the threat of anti-sodomy laws, and are often excluded from HIV responses (47).

Engaging men is crucial in effectively responding to HIV

Despite evidence of positive changes in men's and boys' behaviour and attitudes when they participate in programmes that address HIV, sexual and reproductive health, and gender-based violence (48), few such programmes are in operation (49). UNGASS reporting also confirms that governments in only 60% of countries report having promoted greater involvement of men

in reproductive health programmes in information, education, and communication on reproductive health (Figure 5.10). The failure to engage men also directly affects their health. For example, fewer men than women access HIV-related treatment. ■

ACTION ITEMS

HUMAN RIGHTS

- Laws, policies, and regulations that create obstacles to effective HIV responses are increasingly acknowledged by key actors in the response. Countries should now take action to decriminalize sex workers, people who use drugs, men who have sex with men and transgender people, and reform other laws that block effective responses to HIV.
- Despite increased reporting on protective laws, countries and other stakeholders should establish effective enforcement mechanisms and provide people living with HIV and other key populations with access to justice and redress through HIV-related legal services and legal literacy programmes.
- Although progress has been noted, HIV-related stigma and discrimination are still highly prevalent globally and are not yet being sufficiently addressed. Countries and other stakeholders should urgently scale up comprehensive programmes that build capacities of HIV-related service providers, address stigma and discrimination in laws, institutions and communities, and empower those affected by HIV.
- To help to realize human rights in the context of HIV, there must be more meaningful involvement of people living with and those vulnerable to HIV in national HIV responses, as well as meaningful coverage of all affected populations. The GIPA principles must be fully implemented.

GENDER EQUALITY

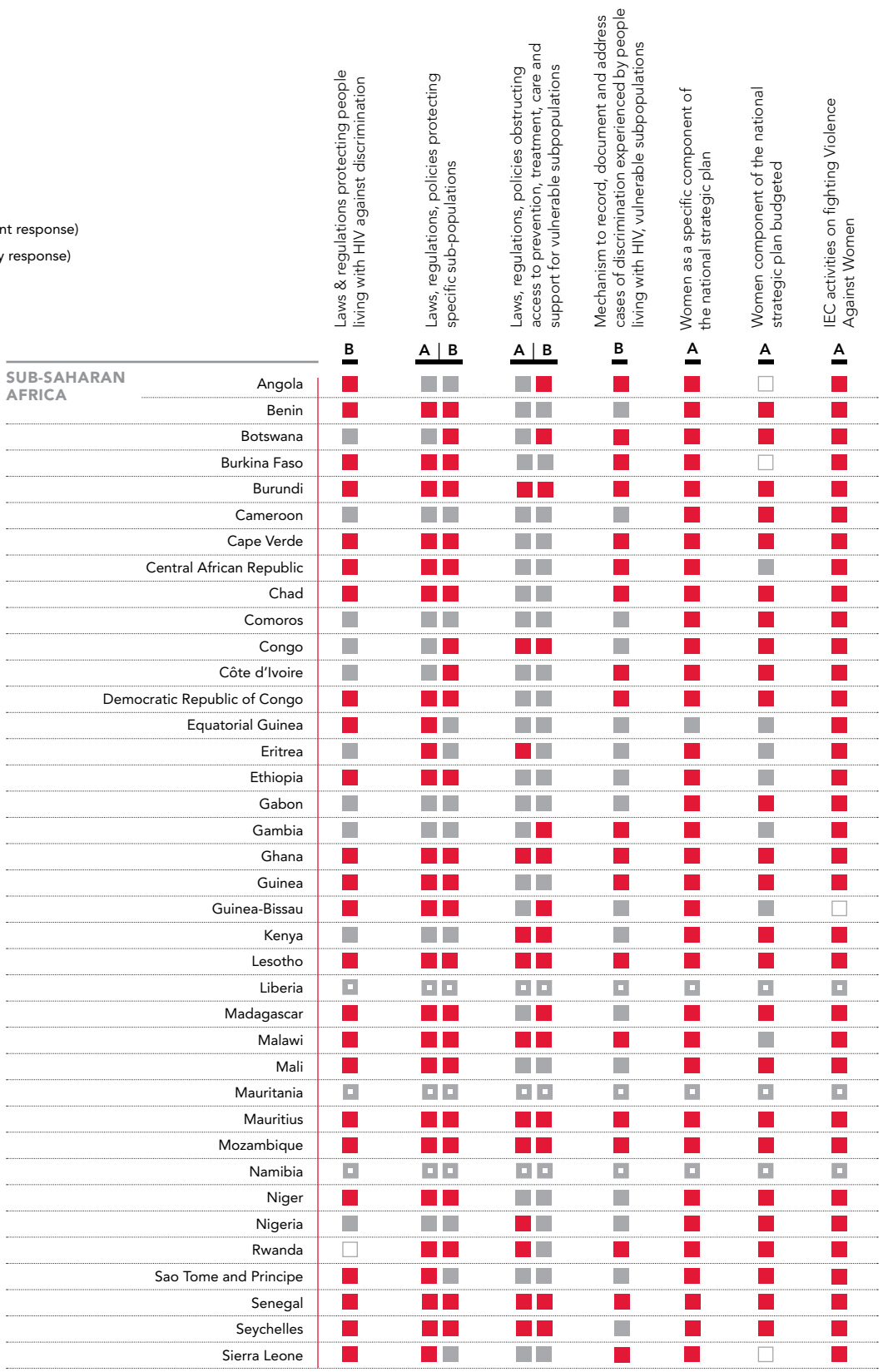
- To achieve universal access goals towards HIV prevention, treatment, care and support, the AIDS response needs to be women and girls centred and include a dedicated budget to address their needs.
- Given that violence is widespread and that there is a clear association between violence against women and the spread of HIV, national HIV responses must include specific interventions to address violence.
- All countries need to ensure that women have access to integrated quality HIV and sexual and reproductive health services that enable women to exercise their rights.
- Men and boys need to be engaged in innovative approaches to change harmful social and cultural practices and norms, as part of HIV prevention.
- Countries need to address the needs of men who have sex with men through prevention interventions that go beyond health service provision.

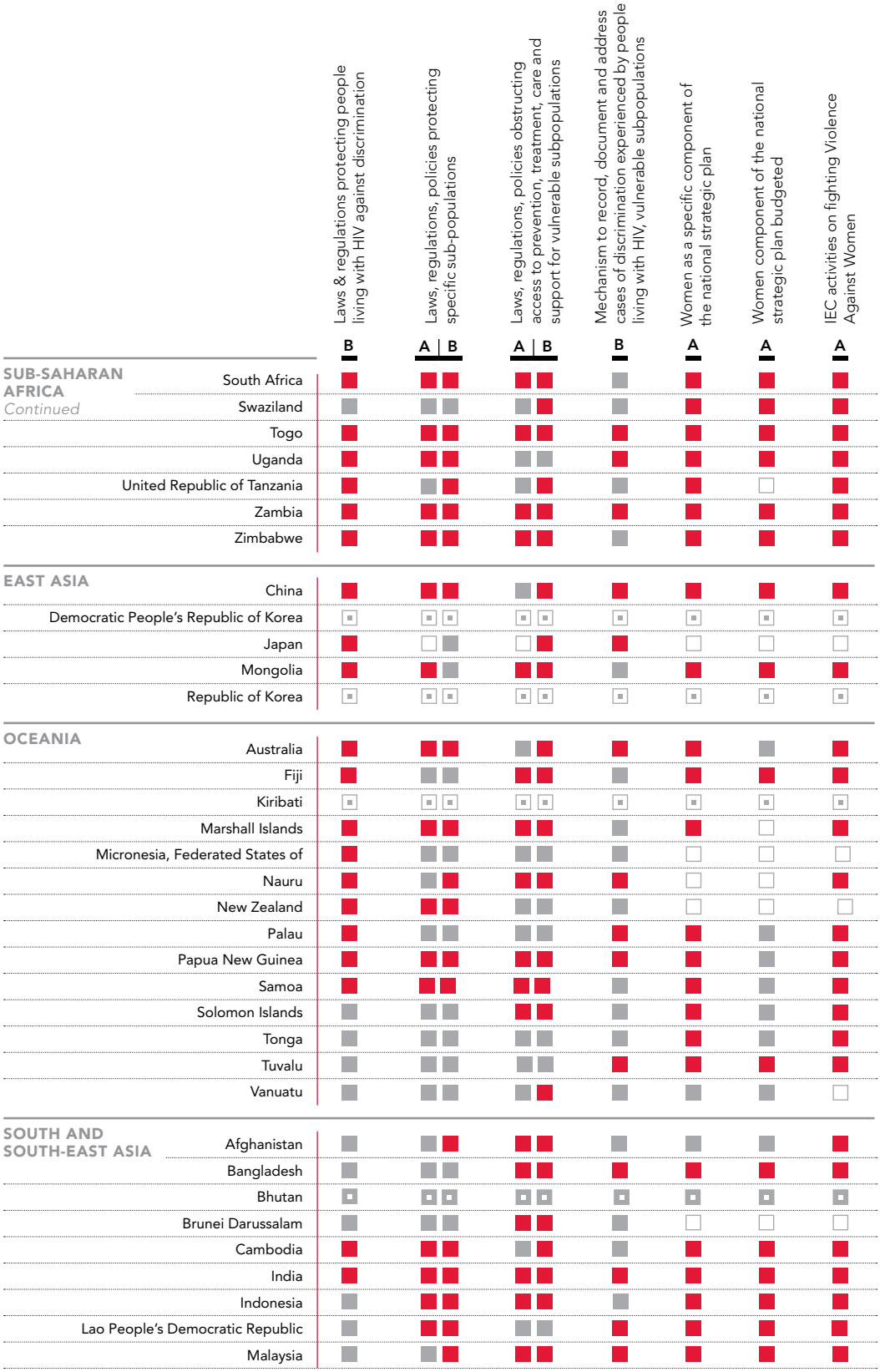
SCORECARD: HUMAN RIGHTS AND GENDER EQUALITY

- Yes/Agree
- No/Disagree
- Data not available
- No NCPI report
- No UNGASS report

A NCPI Part A (government response)

B NCPI Part B (civil society response)




Laws & regulations protecting people living with HIV against discrimination
Laws, regulations, policies protecting specific sub-populations
Laws, regulations, policies obstructing access to prevention, treatment, care and support for vulnerable subpopulations
Mechanism to record, document and address cases of discrimination experienced by people living with HIV, vulnerable subpopulations
Women as a specific component of the national strategic plan
Women component of the national strategic plan budgeted
IEC activities on fighting Violence Against Women
B
A | B
A | B
B
A
A
A
SUB-SAHARAN AFRICA Continued
South Africa
Swaziland
Togo
Uganda
United Republic of Tanzania
Zambia
Zimbabwe
EAST ASIA
China
Democratic People's Republic of Korea
Japan
Mongolia
Republic of Korea
OCEANIA
Australia
Fiji
Kiribati
Marshall Islands
Micronesia, Federated States of
Nauru
New Zealand
Palau
Papua New Guinea
Samoa
Solomon Islands
Tonga
Tuvalu
Vanuatu
SOUTH AND SOUTH-EAST ASIA
Afghanistan
Bangladesh
Bhutan
Brunei Darussalam
Cambodia
India
Indonesia
Lao People's Democratic Republic
Malaysia

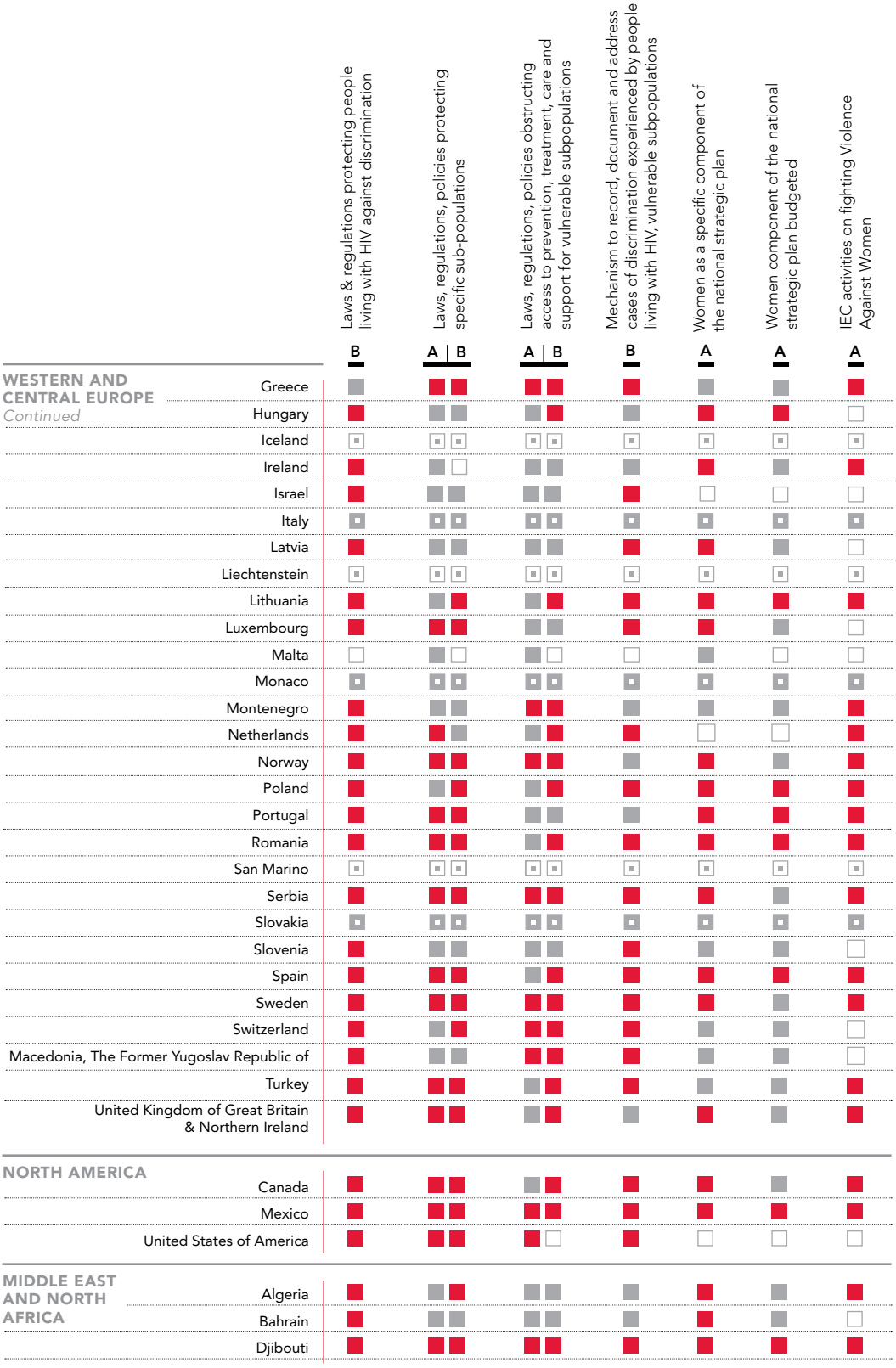
SCORECARD: HUMAN RIGHTS AND GENDER EQUALITY

- Yes/Agree
- No/Disagree
- Data not available
- No NCPI report
- No UNGASS report

A NCPI Part A (government response)

B NCPI Part B (civil society response)

		Laws & regulations protecting people living with HIV against discrimination	Laws, regulations, policies protecting specific sub-populations		Laws, regulations, policies obstructing access to prevention, treatment, care and support for vulnerable subpopulations		Mechanism to record, document and address cases of discrimination experienced by people living with HIV, vulnerable subpopulations	Women as a specific component of the national strategic plan	Women component of the national strategic plan budgeted	IEC activities on fighting Violence Against Women
		B	A	B	A	B	B	A	A	A
SOUTH AND SOUTH-EAST ASIA *Continued*	Maldives									
	Myanmar									
	Nepal									
	Pakistan									
	Philippines									
	Singapore									
	Sri Lanka									
	Thailand									
	Timor-Leste									
	Viet Nam									
EASTERN EUROPE AND CENTRAL ASIA	Armenia									
	Azerbaijan									
	Belarus									
	Georgia									
	Kazakhstan									
	Kyrgyzstan									
	Moldova, Republic of									
	Russian Federation									
	Tajikistan									
	Turkmenistan									
	Ukraine									
	Uzbekistan									
WESTERN AND CENTRAL EUROPE	Albania									
	Andorra									
	Austria									
	Belgium									
	Bosnia and Herzegovina									
	Bulgaria									
	Croatia									
	Cyprus									
	Czech Republic									
	Denmark									
	Estonia									
	Finland									
	France									
	Germany									


Laws & regulations protecting people living with HIV against discrimination
Laws, regulations, policies protecting specific sub-populations
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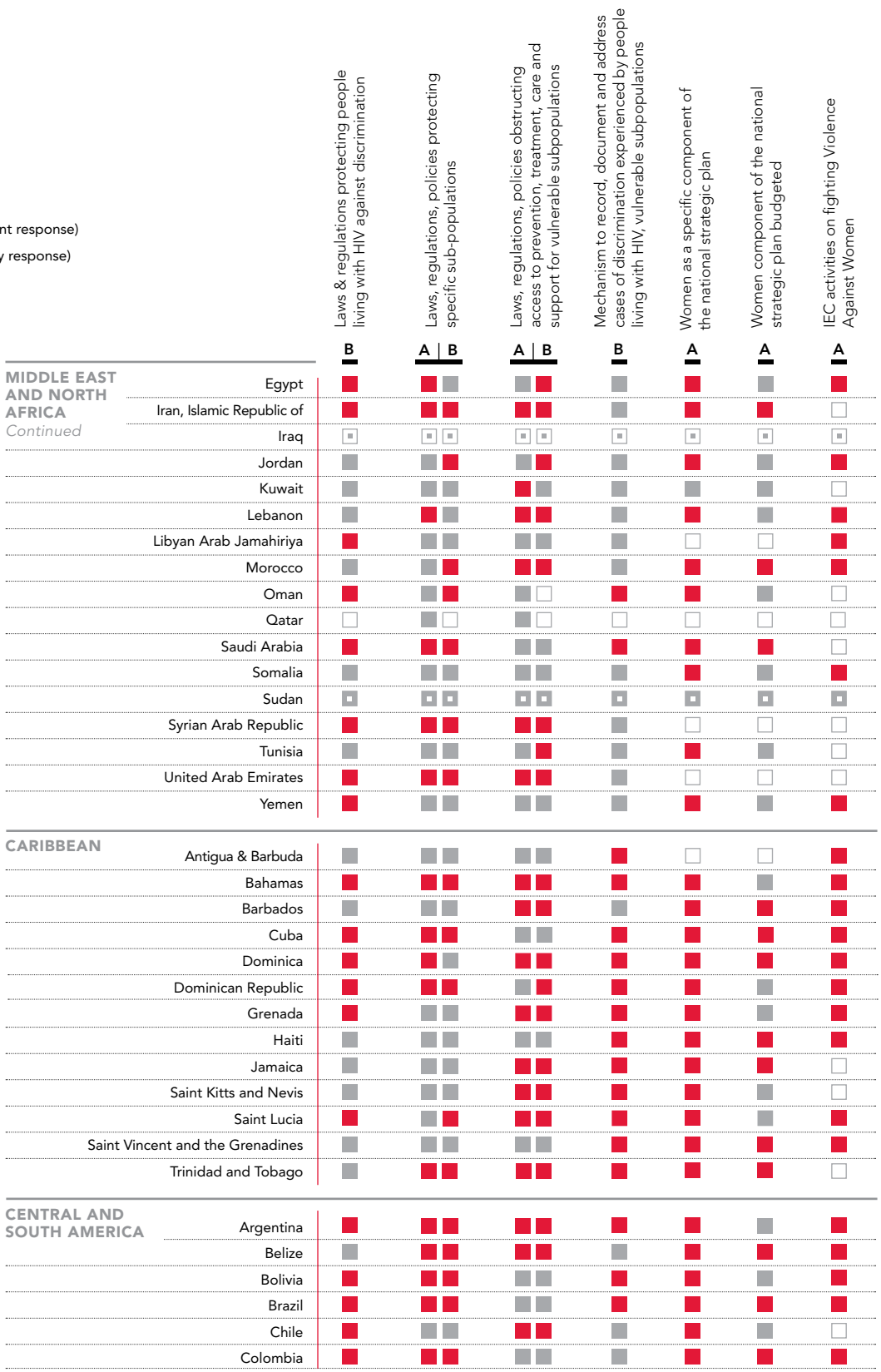
Mechanism to record, document and address cases of discrimination experienced by people living with HIV, vulnerable subpopulations
Women as a specific component of the national strategic plan
Women component of the national strategic plan budgeted
IEC activities on fighting Violence Against Women
B
A | B
A | B
B
A
A
A
WESTERN AND CENTRAL EUROPE
Continued
Greece
Hungary
Iceland
Ireland
Israel
Italy
Latvia
Liechtenstein
Lithuania
Luxembourg
Malta
Monaco
Montenegro
Netherlands
Norway
Poland
Portugal
Romania
San Marino
Serbia
Slovakia
Slovenia
Spain
Sweden
Switzerland
Macedonia, The Former Yugoslav Republic of
Turkey
United Kingdom of Great Britain & Northern Ireland
NORTH AMERICA
Canada
Mexico
United States of America
MIDDLE EAST AND NORTH AFRICA
Algeria
Bahrain
Djibouti

SCORECARD: HUMAN RIGHTS AND GENDER EQUALITY

- Yes/Agree
- No/Disagree
- Data not available
- No NCPI report
- No UNGASS report

A NCPI Part A (government response)

B NCPI Part B (civil society response)



		Laws & regulations protecting people living with HIV against discrimination	Laws, regulations, policies protecting specific sub-populations		Laws, regulations, policies obstructing access to prevention, treatment, care and support for vulnerable subpopulations		Mechanism to record, document and address cases of discrimination experienced by people living with HIV, vulnerable subpopulations	Women as a specific component of the national strategic plan	Women component of the national strategic plan budgeted	IEC activities on fighting Violence Against Women
		B	A	B	A	B	B	A	A	A
CENTRAL AND SOUTH AMERICA *Continued*	Costa Rica	■	■	■	■	■	■	■	■	□
	Ecuador	■	■	■	■	■	■	■	■	□
	El Salvador	■	■	■	■	■	■	■	■	□
	Guatemala	■	■	■	■	■	■	■	■	■
	Guyana	■	■	■	■	■	■	■	■	■
	Honduras	■	■	■	■	■	■	■	■	□
	Nicaragua	■	■	■	■	■	■	■	■	■
	Panama	■	■	■	■	■	■	■	■	■
	Paraguay	■	■	■	■	■	■	■	■	■
	Peru	■	■	■	■	■	■	■	□	■
	Suriname	■	■	■	■	■	■	■	■	□
	Uruguay	■	■	■	■	■	■	■	■	■
	Venezuela	■	■	■	■	■	■	■	■	■