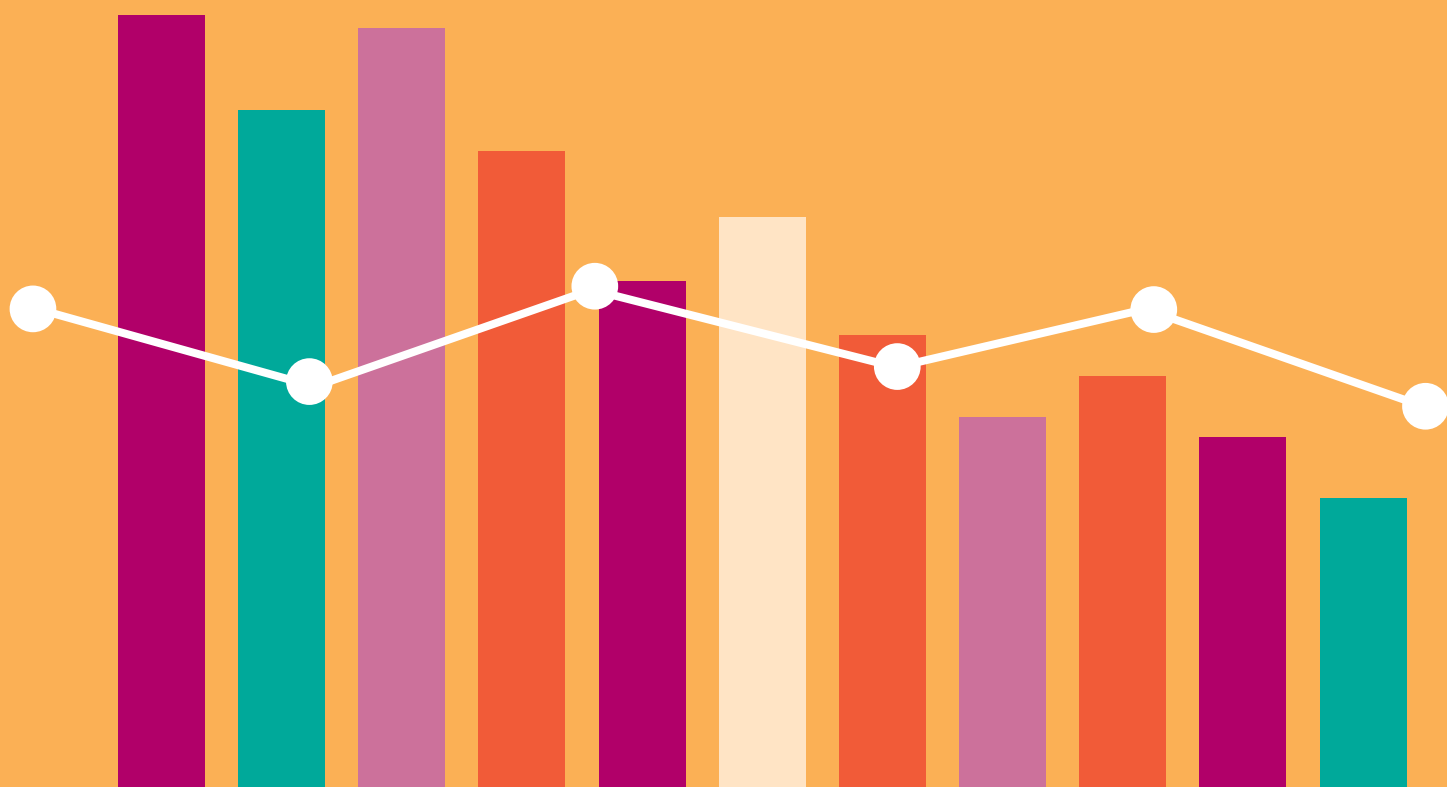


# WHO COUNTS, WHAT COUNTS, AND WHO COUNTS WHAT?

An advocates' guide to monitoring stigma and discrimination reduction in the Global Partnership for Action to Eliminate all Forms of HIV-related Stigma and Discrimination



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



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Design by Jane Shepherd.



## WHAT'S THIS GUIDE FOR?

This advocates' guide has been developed as a tool to support community advocates track progress towards the goal of eliminating all forms of HIV-related stigma and discrimination and thus contributing to achieving the goal of ending AIDS as a public health threat by 2030.

Monitoring and evaluating (M&E) generates numbers (data) and stories (narratives) which can be used for accountability and advocacy. It gives us evidence to say what's working, what's not, and what we need more of to address gaps and improve results.

We have created this guide as a community-friendly tool to sit alongside the technical guidance developed by UNAIDS on evidence-based programming to address HIV-related stigma and discrimination, and M&E to measure progress.\* It has been developed with the support of a steering group made up of people living with HIV from Uganda, Kenya, South Africa and Thailand. The document has also been field-tested with networks of women living with HIV and key populations, and adolescent girls and young women in Uganda, Nigeria and Jamaica.

## WHO'S THIS GUIDE FOR?

The intended audiences are community advocates, especially Global Partnership for Action to Eliminate all Forms of HIV-Related Stigma and Discrimination (Global Partnership) country focal points and their networks, networks of people living with HIV, networks of women living with HIV, networks of young people living with HIV and networks of key populations, such as sex workers, people who use drugs, and LGBTQI+ groups and organisations.



\* Monitoring and evaluating programmes to eliminate HIV and key population stigma and discrimination in six settings: Guidance provided by the Global Partnership for Action to Eliminate all Forms of HIV-related Stigma and Discrimination, 2023.

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## SECTION 1

### WHAT ARE WE TALKING ABOUT?



#### **HIV-related stigma and discrimination: a persistent challenge**

HIV and AIDS have been with us since the early 1980s. Since the beginning, stigma and discrimination have been a characteristic of this disease, and five decades later, it's still an issue. People stigmatise or hold discriminatory attitudes towards people who are living with HIV, and towards those who they think might have it. These attitudes are underpinned by values and beliefs about the way we believe or expect others to behave: what we think individuals should 'be' and 'do'. These beliefs and attitudes can result in negative thoughts and/or actions, which sometimes stop people from accessing the information, services and support they need either to protect themselves from acquiring HIV, or to live well with it. Worse still, when we hear these negative attitudes and beliefs from people all around us – including our families, communities, work colleagues, service providers and even laws, we end up believing them, internalising them, and turning them on ourselves. This is called internalised or 'self' stigma.<sup>1</sup>

Stigma and discrimination related to a health condition like HIV can only be harmful. That's why the global AIDS response has recognised the elimination of stigma and discrimination as a cornerstone of the response, alongside prevention and treatment. With the progress in treatment and prevention of HIV, stigma and discrimination have also gone down, but we are still off track. Across 55 countries with recently available data, on average almost 60% of the general public still hold discriminatory attitudes towards people living with HIV.<sup>2</sup>



#### **Enough is enough**

We need to end HIV-related stigma and discrimination and uphold human rights if we are going to reach global targets. That's why the current global AIDS strategy has new targets, including that less than 10% of people living with HIV and key populations experience stigma and discrimination by 2025.

1. Both terms are used in this guide, to mean the same thing.  
2. UNAIDS (2022) [In Danger: Global AIDS Update](#), p72.



In the Global AIDS Monitoring (GAM) framework, there are currently seven indicators to measure progress towards this target:<sup>3</sup>

1. Percentage of women and men 15–49 years old who report discriminatory attitudes towards people living with HIV.
2. Percentage of people living with HIV who report internalised stigma.
3. Percentage of people living with HIV who report experienced stigma and discrimination in the general community in the last 12 months.
4. Percentage of people living with HIV who report experiences of HIV-related discrimination in healthcare settings.
5. Proportion of people living with HIV who have experienced rights abuses in the last 12 months and have sought redress.
6. Percentage of people who are members of a key population who report having experienced stigma and discrimination in the last 6 months.
7. Avoidance of health services among key populations because of stigma and discrimination.



### But that's not all ... looking at HIV-related stigma and discrimination through a gender lens

We know that HIV impacts on some sections of society more than others because of gender inequality and other forms of social marginalisation, like homophobia, transphobia and the criminalisation of sex work and drug use. Women and girls in their diversity and gender non-conforming people are disproportionately impacted by HIV – including in the way they experience HIV-related stigma and discrimination.

#### MARJORIE'S STORY<sup>4</sup>

Marjorie was excited to discover she was pregnant with her first child. She went to the clinic to confirm the pregnancy and enrol in antenatal care. The nurse said she should get tested for HIV, and told Marjorie not to worry, explaining this was a normal part of pregnancy care. When Marjorie went back for her results, the nurse told her that she was HIV positive and explained that there was an excellent treatment Marjorie could take that would keep her and her baby well. The nurse also told Marjorie to ask her husband to come in for an HIV test. When Marjorie suggested this to her husband, he was reluctant, but did the test. It was negative. They have been together for counselling to learn how to stay together in a so-called 'discordant' relationship, and they have been given a lot of advice, but Marjorie's husband's parents and family are putting pressure on him to divorce Marjorie and find another wife.


3. The Global AIDS Monitoring (GAM) framework is a set of measures that countries' national AIDS programmes use to measure progress on HIV and AIDS. The indicator framework and guidelines for 2023 are here: [Global AIDS Monitoring 2023: Indicators and questions for monitoring progress on the 2021 Political Declaration on HIV and AIDS](#). (unaids.org)


4. Adapted from [Good Practice Guide: Gender-transformative HIV programming](#) (aidsalliance.org)

It's useful to look at four different **domains**<sup>5</sup> of stigma and discrimination and explore how each of them has a gender-related aspect:

<b>Domain 1</b>	<b>Drivers and facilitators</b>
Description	<p>Things that <b>drive</b> HIV-related stigma and discrimination include fear of infection, blame, judgement, cultural and religious bias (pre-existing stigma and discrimination against certain groups of people, e.g. sex workers).</p> <p>Things that <b>facilitate</b> these attitudes include misinformation (for example, the belief that HIV infection leads to death, belief that HIV can be passed on through touching or kissing), and social and sexual norms – beliefs and expectations about how women and men should behave, dress and their roles and responsibilities; beliefs about what 'type' of person gets HIV.</p>
Examples of how this domain has a gender aspect	<ul style="list-style-type: none"> <li>● Women's reproductive role means they tend to be tested before men (in ante-natal care); if they test positive, they can be blamed for bringing HIV into the family and accused of having affairs or sexual promiscuity. The social expectation that women will be sexually inexperienced when they marry and faithful to their partner makes it 'worse' if they are assumed not to be these things. In comparison, having many sexual partners, being sexually experienced and having affairs is often seen as a sign of power and status in men.</li> <li>● Sex workers seen as 'vectors of transmission' and undeserving of equitable access to services and protection from violence; carrying condoms can be used as a justification to arrest a woman on the grounds of sex work. Equally, it may be culturally inappropriate or unacceptable for women to request or insist on condom use, which is often associated with promiscuity, sex work or casual sex.</li> <li>● Women's more limited access to comprehensive sexuality education, and (in some countries) lower levels of both accurate knowledge about HIV transmission and prevention, and agency to make and enact decisions around HIV prevention.</li> <li>● Lack of confidentiality in health services; HIV 'markers' such as weight gain/lypodystrophy, and not breastfeeding, which particularly affect women.</li> <li>● Women living with HIV seen as promiscuous; sex workers and women who use drugs seen as bad mothers; same sex relationships seen as 'unnatural' and the cause of disease.</li> <li>● Men's typically lower level of accessing healthcare is also partly as a result of gender norms and stereotypes, as well as other factors that make health services less accessible to men (e.g. opening times). This in turn has further gendered implications for women as sexual partners and caregivers.</li> </ul>

5. Adapted from Stangl, A.L., Earnshaw, V.A., Logie, C.H. et al. The Health Stigma and Discrimination Framework: a global, crosscutting framework to inform research, intervention development, and policy on health-related stigmas. *BMC Med* 17, 31 (2019). <https://doi.org/10.1186/s12916-019-1271-3>.

	<b>Domain 2 Experiences and practices</b>
Description	<p>The <b>lived realities</b> of women, men and gender diverse people living with HIV – their experiences of stigma and discrimination in different settings, including internalised/self stigma.</p> <p>The <b>negative attitudes and/or discriminatory actions</b> (e.g. gossip, name-calling, avoidance, etc.) towards people living with HIV, women and marginalised populations in different settings (community, workplace, schools, health services, justice setting and in emergency/humanitarian situations).</p>
Examples of how this domain has a gender aspect	<ul style="list-style-type: none"> <li>● Internalised feelings of otherness or loss of worth in relation to masculinity or femininity (not feeling like a ‘proper man’ or ‘proper woman’); withdrawal from/denial of relationships and fertility desires/motherhood; fear of or self blame for vertical transmission.</li> <li>● Women living with HIV experience stigma in relation to their reproductive health: they may be pressured or forced to avoid having children, terminate pregnancy, or be coercively sterilised.</li> <li>● Women and transgender people are frequently gossiped about, called names, and verbally abused on the basis of their actual or perceived HIV status.</li> <li>● Transgender women may be thrown out of their homes, face discrimination and violence in communities, and experience judgement and ridicule in health services, and denied appropriate medical services.</li> <li>● Adolescent girls and young women judged by healthcare workers for being sexually active.</li> <li>● Women’s lower economic power vis-à-vis men’s, can mean that women are more vulnerable to divorce, abandonment and/or intimate partner violence or coercion and abuse at household level, following an HIV diagnosis.</li> </ul>

	<b>Domain 3 Stigma ‘markers’</b>
Description	<p>This refers to <b>what is being stigmatised</b> – for example, HIV status, sexual diversity, poverty, ethnicity, age, drug use, sex work, disability</p>
Examples of how this domain has a gender aspect	<ul style="list-style-type: none"> <li>● In women, other stigma markers include marital status (being single, divorced), fertility/not being a mother, not breastfeeding, weight/body shape, dress/appearance, etc.</li> <li>● Double/triple or ‘compound’ stigma and discrimination that women living with HIV face when HIV stigma and discrimination are combined with discrimination and stigma on the basis of gender, sex work, drug use, LBT (lesbian, bi-sexual, transgender) identity, among others.</li> </ul>





Domain 4	Outcomes
Description	<b>The onward result(s) of experiencing stigma and discrimination</b> , for example; experiencing stigma and discrimination in healthcare services can lead to avoidance of services. Other outcomes are withdrawal from social interactions, poor treatment outcomes, internalised stigma, mental health problems, among others.
Examples of how this domain has a gender aspect	Gender-based violence, unplanned pregnancy, trauma, avoidance of intimate relationships, unrealised fertility desires, poor sexual and reproductive health and rights, poor mental health and low self-esteem which may lead to the normalisation or tolerance of intimate partner violence, and lack of retention in care.

CASE STUDY



The International Community of Women Living with HIV (ICW) has conducted a gender analysis of recent People Living with HIV Stigma Index (Stigma Index) 2.0 data, as well as a qualitative research component into the experiences of stigma and discrimination in the form of reproductive coercion and violence experienced by women living with HIV in healthcare settings, globally.<sup>6</sup> These include coercion or pressure from healthcare providers in relation to contraception, breastfeeding, birth method, as well as forced and coerced sterilisation and/or other forms of abuse, mistreatment and violence. The report describes how HIV is one axis of discrimination that intersects with other forms of discrimination, such as a person’s gender, influencing how and whether sexual and reproductive health services are provided for women and girls living with HIV.

Experiences of mistreatment and coercion in sexual and reproductive health services among women living with HIV are driven by judgemental and discriminatory views held by healthcare providers regarding how women got HIV, as well as the healthcare providers’ own perception of their role in preventing onward transmission of HIV to a woman’s intimate partner(s) and babies. The choice, agency and bodily autonomy of women and girls living with HIV has often been denied them as a result.

This research underlines how pregnancy, childbirth and motherhood exist as a site of gender-based violence among women, girls and gender diverse people, and how shockingly prevalent – and normalised – reproductive violence (also called obstetric violence) is, irrespective of a woman’s HIV status. Only 11 women out of about 200 involved in the scan described a positive experience of accessing sexual and reproductive health services. The additional layer of HIV-related stigma and discrimination makes these services almost impossible for women living with HIV to navigate without encountering some form of disrespect, mistreatment, coercion or violence.

6. Report forthcoming.

## SECTION 2

### WHO COUNTS, WHAT COUNTS, AND WHO COUNTS WHAT?

The Global Partnership has developed technical guidance on M&E, to support national governments to design and evaluate their stigma and discrimination interventions. To measure how well these are going, we need indicators across all six of the Global Partnership settings that can be measured at community level, by communities themselves. It's important that the community is involved in monitoring progress because this is where HIV-related stigma and discrimination are felt most.

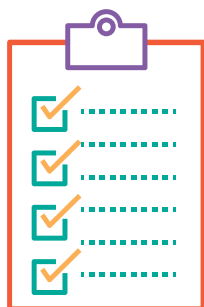


#### RESOURCES ON M&E FOR PROGRAMMING

The focus of this guide is not to provide M&E guidance for programming. If you want to monitor your own work on stigma and discrimination, the forthcoming Global Partnership M&E Guide includes information and example indicators to monitor programming in each of the six settings.

In addition, you should find the following guides helpful:

- UNAIDS (2019) [Rights-based monitoring and evaluation of national HIV responses.](#)
- UNAIDS (2020) [Evidence for eliminating HIV-related stigma and discrimination: Guidance for countries to implement effective programmes to eliminate HIV-related stigma and discrimination in six settings.](#)
- UNAIDS (2021) [Establishing community-led monitoring of HIV services.](#)

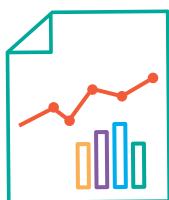


#### From accountability to donors to accountability to communities

**Monitoring and evaluation (M&E)** - also referred to as **monitoring, evaluation and learning (MEL)** or **monitoring, evaluation, accountability and learning (MEAL)** or **planning, monitoring, evaluation and learning (PMEL)** - is a form of research, based on data collection and analysis. Its purpose is to measure change.

M&E is often seen as a process that donors ask for in order to justify how their money is being used. But, more importantly, it is a political process that involves the same kinds of choices as our programme design and advocacy priorities.

Within M&E, there are two significant areas of choice to be made: **what** to measure and **how to measure it**. With these two choices in mind, we can design M&E so that it includes **measuring community empowerment** as an important outcome of stigma-reduction work, and so that it is **empowering** in the way we do it. This helps shift the direction of M&E from donor accountability to community accountability, whereby M&E is used to support and advocate for communities' expressed needs and priorities.



### Different approaches to M&E: qualitative, quantitative and participatory

There are a range of different methods and approaches for doing M&E. Typically, M&E methods are described as **quantitative** (looking at numbers, e.g. number of unintended pregnancies, or number of people reached by an intervention) or **qualitative** (looking at narratives, e.g. exploring social context, causal factors and perceptions).

- **Quantitative** approaches tend to use surveys and questionnaires, and data collected at the level of the healthcare service, for example.
- **Qualitative** methods are more descriptive, tend to be small-scale and can be more subjective, using methods like interviews and focus group discussions.



Most M&E uses a combination or 'mixed methods' approach whereby the qualitative provides a narrative to give context and texture to the quantitative. For advocacy initiatives, it can be difficult to quantify results, and so more qualitative approaches may be used.



### Data disaggregation

Regardless of whether the data collected is qualitative or quantitative, data disaggregation is essential for understanding the different ways in which an issue or response impact on different groups of people. Disaggregation means that you divide your data by categories such as sex/gender, age and other factors, such as key population groups or level of income.



### Participatory approaches

Traditionally, there has been a belief that M&E (especially evaluations) should be led by 'external' stakeholders, namely, researchers who don't have a personal or political interest in what is being measured. This adds to the objectivity of the data collection and findings but, on the other hand, it may miss out on vital information, precisely because the data collection is done by external parties who don't understand the specific context or priorities of the communities they are researching. Usually, the main focus is on quantifiable data, which may be supplemented with some small-scale qualitative data collection.



In participatory approaches, the community being researched is also involved in leading or shaping the research. They use the principle of **meaningful engagement of the affected community** – in this case, people living with HIV. It has the benefit of addressing the power imbalance between researchers and the community being researched, where researchers are often seen as authoritative, well-resourced, extractive and removed from the problems facing the community, while the community is often seen as being poor or under-resourced, uneducated and powerless. This is particularly important in health-related stigma research for reducing the marginalisation and resulting health inequities faced by stigmatised groups. Increasingly, participatory M&E approaches are being recognised as valid, reliable, relevant and respectful of local knowledge, among other things.

Using participatory methods, the leadership, agency and value of the researched community claims space and visibility. The gathered data is owned by and remains in the community and is analysed – or at least validated – by them. Like other forms of research, participatory M&E disaggregates data by sex/gender, age and other factors, such as key population groups and/or HIV status. It considers safety and ethical issues for both researchers and researchees – for example, whether participation in the research could unintentionally expose an individual’s HIV status, sexual orientation and/or identity as a sex worker. The difference is that decisions in the design of the research are informed by lived experience and local realities.

Finally, participatory research uses **empowerment approaches**, which could include capacity-building training to members of the community as researchers (and paying them!) or combining data collection with awareness sessions (e.g. human rights, gender-based violence, SRHR). It can also provide linkages to care, including psycho-social care and support.

#### CASE STUDY

**The People Living with HIV Stigma Index** (Stigma Index) is an example of a quantitative research method which uses a participatory approach. It essentially counts the number of people living with HIV who experience stigma and discrimination in a range of settings and forms.

What makes it participatory?

- The indicators (or questions) were developed and agreed through extensive consultation with people living with HIV.
- The roll-out of the Stigma Index is led by people living with HIV and follows a particular methodology of ‘side by side’ data collection. This (literally) positions the researcher alongside the respondent while they work through the questionnaire together. You can read more about the Stigma Index in Annex A, page 30.



## Feminist approaches to M&E

Feminist or gender-transformative approaches to M&E are even more explicitly critical of power and privilege in the production of knowledge. They focus particularly on gender inequality and look at the intersection of gender with other socio-economic factors, such as race, ethnicity, age, sexuality, among others. As well as using participatory principles,<sup>7</sup> feminist approaches privilege the voices of women, girls and gender non-conforming people and communities in their diversity, recognising that these are often silenced or go unheard. They also include measures (indicators) that look at whether women, girls and gender non-conforming people have gained power at different levels (individual, relationship, community, institution, society). Feminist M&E approaches also acknowledge and address the structural inequalities present in common evaluation practice.<sup>8</sup>

### CASE STUDY

**Social Development Direct** led an evaluation of UNAIDS programmes to prevent and address violence against women and girls (VAWG).

What makes it feminist?

- They worked with an advisory group of women living with HIV in their diversity to support the evaluation design, data collection and analysis.
- Country teams were established, including a national consultant representing one or more affected communities and an advisory group member.
- The evaluation ensured women living with HIV in their diversity were reached and consulted in the data collection.

These principles were reflected in the budget and workplan, for example by budgeting for the advisory group members and the national consultants to be paid; re-defining conflict-of-interest clauses to ensure that women representing HIV networks and organisations were not excluded as co-consultants or informants; compensation for participants of interviews and focus group discussions; and, co-creating the methodology and findings. As a result of using feminist principles in this evaluation, more women living with and affected by HIV who were engaged in VAWG-reduction activities were reached through the research, and their knowledge and expertise reflected in the findings.<sup>9</sup>

7. The foundational values of participatory praxis: equity, justice, dignity, participation, non-othering, accountability, transparency, reflexivity, flipping power dynamics. From Sprague et al (2019) Participatory praxis as an imperative for health-related stigma research. *BMC Med.* doi: [10.1186/s12916-019-1263-3](https://doi.org/10.1186/s12916-019-1263-3)

8. [Feminist evaluation](https://www.betterevaluation.org) (betterevaluation.org)

9. [Towards more inclusive and feminist approaches in evaluation of HIV programming - transforming principles into practice](https://www.sddirect.org.uk) (sddirect.org.uk)



### Focus on gender

What is Stigma Index data telling us about who we are reaching with stigma reduction programmes, and who are we not reaching?

#### CASE STUDY

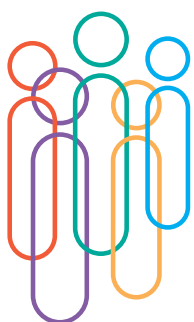


**Argentina's 2021 Stigma Index study report** is unique in having both a strong focus on gender throughout the report, and a whole section of the report on women, including transgender women, with its own conclusions. The section situates the experience of women living with HIV in the context of gender norms and imbalances of power in Argentina more broadly, as well as making links to global commitments towards women, girls, and gender equality in the context of HIV. It highlights how HIV-related stigma and discrimination together with gender inequality already create a **double** barrier to HIV prevention, treatment and care, while other factors of marginalisation create a **triple** layer of stigma and discrimination for lesbian women, transgender women, women who do sex work, women involved in drug use, young women, indigenous women, and poor women.

## SECTION 3

# THE GLOBAL PARTNERSHIP'S SIX PRIORITY SETTINGS

### 1. Community setting



#### What is Stigma Index data telling us?

Stigma Index 2.0 survey data highlight self-stigma, as well as stigma and discrimination at household and community levels as major barriers to reaching global HIV prevention and treatment targets. For example, in Ghana, data from the Stigma Index survey<sup>10</sup> and other sources<sup>11</sup> pointed to self-stigma as an important challenge in the country's HIV response. The findings show that self-stigma in the form of fear of rejection (reported by 62% of respondents) and shame (56%) are barriers to status disclosure, particularly among women. On the other hand, enacted stigma, in the form of stigmatising gossip (56%), verbal harassment (31%) and physical abuse (9%) from community members was also reported by people living with HIV.



#### Vision

People living with HIV of all ages and genders, as well as LGBTQI+ people, sex workers, people who use drugs and other vulnerable populations are able to live freely, accept their HIV status, access treatment and claim their human rights.



#### What changes do we want to see?

- Self-acceptance, self-reliance and self-determination - both as people living with HIV and as LGBTQI+, sex workers, people who use drugs and other vulnerable populations.
- Peer-led education and empowerment for all people living with HIV, especially newly diagnosed people.
- Well-resourced people living with HIV networks and support groups.
- Equitable social, sexual and gender norms, protected by legal and cultural normative frameworks, and promoted through comprehensive sexuality education.
- Elimination of all forms of sexual and gender-based violence, including domestic and intimate partner violence and the outlawing of marital rape, female genital mutilation (FGM) and early, child and forced marriage or unions, and all other forms of discrimination against women.

10. Report forthcoming.

11. For example, [HIV Stigma and Status Disclosure in Three Municipalities in Ghana](#). (nih.gov)

- Implementation of anti-stigma and discrimination laws, with the involvement of duty bearers and key stakeholders in prevention of stigma and discrimination.
- Accessible, accurate information on HIV prevention and treatment, and SRHR translated in local and refugee languages to facilitate easy uptake of services.
- Meaningful involvement of people living with HIV in all areas of life.



### What indicators will we use to measure our results?

- Number or percentage of women living with HIV who experience gender-based violence in any setting (intimate partner, household, community, healthcare, workplace, police or other institutional setting, e.g. prison and incarcerated settings).
- Positive media coverage of people living with HIV.
- Number or percentage of people holding equitable social, sexual and gender norms.
- Number or percentage of people in the general population aware of U=U.
- Number or percentage of people living with HIV reporting stigma in any setting, including self-stigma.
- Number or percentage of people living with and affected by HIV who have adequate and accurate information on HIV prevention, treatment and care, and the legal rights of people living with HIV.
- Percentage coverage of comprehensive sexuality education.

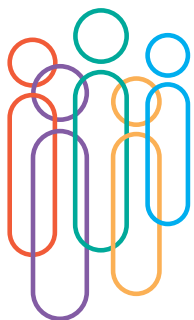


### Focus on gender

What are some of the different issues and realities affecting men, women and transgender or gender non-conforming persons living with HIV? Women typically learn their HIV status first, before male partners, because they are tested in antenatal care. What implications does this have for stigma and discrimination at the household level? (See Marjorie's story on page 5 for some insights.)



## 2. Workplace setting



### What is Stigma Index data telling us?

According to data from the Stigma Index, large numbers of people living with HIV continue to experience stigma and discrimination in the workplace (including as members of staff working within healthcare institutions and in the educational sphere).<sup>12</sup> This is a major factor in the high levels of unemployment among people living with HIV, especially women and young people, and their reliance on the informal economy to survive. In Uganda for example, Stigma Index data over time reveals that the workplace remains one of the places in their lives where people are least likely to disclose their status.<sup>13</sup>



### Vision

Workplaces where people living with HIV are treated equally.



### What changes do we want to see?

- Implementation of equal opportunity laws that protect people living with HIV from discrimination in the workplace (including pressure to resign, termination of employment, changing of job descriptions or denial of promotion).
- No mandatory HIV testing (and related disclosure) as part of recruitment, pension entitlement or work visa processes, or barring people living with HIV from certain types of employment, such as the armed forces, police or prison services, hospitality industry, among others.
- Workplace policies and practices (communicated and implemented with clear reporting lines, etc.) that protect the right to confidentiality of medical information, cover recruitment, promotion, opportunities for skills development and advancement.
- Strong measures to prevent workplace harassment on the basis of health status, and sexual orientation or gender identity.
- Organisational cultures that support people living with HIV, including through orientation of new staff, and penalties for perpetrators of HIV-related stigma in the workplace, including disclosure of another person's status, and confidential reporting lines.
- Strong workplace prevention, testing and treatment programmes with linkage to care.

12. Global Network of People Living with HIV (2018) [HIV and stigma and discrimination in the world of work: Findings from the People Living with HIV Stigma Index](#).

13. Uganda Stigma Index reports [2013](#) and [2019](#)



### **What indicators will we use to measure our results?**

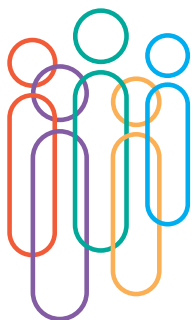
- Number or percentage of people living with HIV reporting that their HIV status was disclosed to an employer or co-workers without their consent.
- Number or percentage of people living with HIV reporting that they had been refused employment or lost a source of income or job because of their HIV status.
- Number or percentage of people living with HIV reporting that they were forced to get tested for HIV or disclose their status in order to apply for a job.



### **Focus on gender**

How do gender power relations play out in the workplace? Can employees safely report sexual harassment in the workplace? What rights protections exist for women, men and gender non-conforming people in informal work settings? What proportion of unpaid domestic or care work is undertaken by women and girls? How is this work valued?

### 3. Education setting



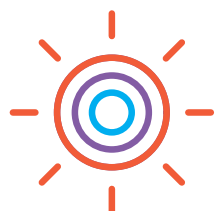
#### What is Stigma Index data telling us?

The impact of stigmatising and discriminatory attitudes against people living with HIV and key populations on young people's – and adults' – full enjoyment of their right to education has probably never been measured. In some countries, HIV status is a barrier to access to college, scholarships, military service and other educational settings.<sup>14</sup> However, for many children and young people, disclosure to teachers and peers is the key issue and can play a key role in treatment adherence.<sup>15</sup> Fear of rejection, exclusion and bullying is a significant barrier to education, highlighting the vital importance of comprehensive sexuality education.<sup>16</sup> Research by UNESCO shows that LGBTQI+ students are up to five times more likely to experience violence than their non-LGBTQI+ peers.<sup>17</sup>



#### Vision

All children and young people living with HIV have full access to their right to education and to be treated as equals in educational settings.



#### What changes do we want to see?

- Laws and regulations that uphold the right of young people living with HIV to the highest standard of educational attainment and opportunities.
- School and college policies that prevent bullying and that protect the rights of children and young people to a full education regardless of their health status or medical conditions.
- Universal access to high quality, age-appropriate comprehensive sexuality education, including accurate information on HIV in primary and secondary schools.
- Training and sensitisation on HIV, including adherence support for children on antiretrovirals, for teachers and educational staff and management, with the involvement of parents/caregivers of children living with HIV.
- Adherence support, including food support and mental health support, and prevention against sexual and gender-based violence for children and adolescents living with HIV in schools.
- Social protection, including provision of scholarship for orphans and vulnerable children.

14. For discussion of how teachers living with HIV should be protected, please go to p.16.

15. [READY to Talk](http://frontlineaids.org) (frontlineaids.org).

16. Many children living with HIV are denied the right to education due to their poor health. Only half of children living with HIV have access to HIV treatment. UNAIDS, 2022.

17. United Nations Educational, Scientific and Cultural Organization (2016) [Out in the open: education sector responses to violence based on sexual orientation and gender identity/expression](#).



### What indicators will we use to measure our results?

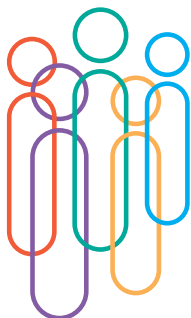
- Number or percentage of people reporting that their or their child's HIV status was disclosed in school without their consent.
- Number or percentage of people reporting that they were forced to get tested for HIV or disclose their status in order to attend an educational institution or get a scholarship.
- Number or percentage of girls enrolling in and completing secondary education.
- Quality of age-appropriate comprehensive sexuality education in schools, including accuracy of HIV messaging.
- School safety (including absence of bullying related to HIV status, and any form of sexual and gender-based violence, transphobia or homophobia).
- Number or percentage of children living with HIV with viral suppression.
- Number or percentage of children living with HIV expressing themselves in political affairs of their school.



### Focus on gender

Do girls have equitable access to primary, secondary and tertiary education? Are schools safe for girls, boys and gender non-conforming children? Are there clean, private spaces (e.g. bathrooms) where children can take antiretrovirals in private? Can girls safely attend school when they are on their period? How are gender norms entrenched or challenged in schools? Do schools teach comprehensive sexuality education?

## 4. Healthcare setting



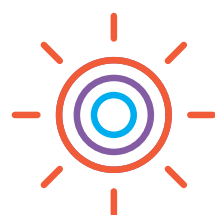
### What is Stigma Index data telling us?

According to Stigma Index data, in 17 out of 23 countries, more than 10% of people living with HIV continue to report stigma and discrimination in healthcare settings.<sup>18</sup> This often takes the form of differences in the way that people living with HIV are treated or receive care, judgemental comments from health professionals and breaches of confidentiality. There are also significant differences in how women and gender minorities experience healthcare.<sup>19</sup> It is estimated that one in three women living with HIV experience at least one form of discrimination related to their sexual and reproductive health in healthcare settings.<sup>20</sup> In Vietnam, almost a quarter (24.2%) of people who participated in the Stigma Index in 2020<sup>21</sup> reported experiencing discriminatory attitudes within health services. The most common forms were verbal abuse from staff and being advised not to have sex. People from key population groups reported higher rates; a third (33%) of men who have sex with men, and two-fifths (40%) of transgender women said they had experienced stigma and discrimination when seeking HIV-related services in the last 12 months.



### Vision

All people living with HIV are able to enjoy the highest attainable standard of health, defined as a state of complete physical, mental and social well-being.



### What changes do we want to see?

- Strong policies and practices that protect the equal rights of people living with HIV to patient confidentiality, privacy, informed consent and freedom from violence or coercion in healthcare settings.
- Healthcare providers and other facility staff who have accurate, up-to-date knowledge about HIV prevention, treatment and care (i.e. this is part of pre- and in-service medical training and workplace orientation for non-clinical staff).
- People living with HIV are involved in the training of medical personnel to share their knowledge as expert clients and lived experience of HIV.
- Youth and key population-friendly services.
- Policies that recognise and address the linkages between HIV, gender-based violence/intimate partner violence and mental health, and which promote an integration agenda with SRHR, tuberculosis and hepatitis C services.

18. UNAIDS (2022) *In Danger: UNAIDS Global AIDS Update 2022*. p.77

19. For discussion of how healthcare workers living with HIV should be protected, please see p.16.

20. [Global Partnership for Action to Eliminate All Forms of HIV-Related Stigma and Discrimination](https://teampata.org/) (teampata.org).

21. [Stigma Index: Vietnam 2020-2021](https://stigmaindex.org/) (stigmaindex.org).

- Clients receiving a warm reception by friendly, well-informed service providers, using accessible, respectful language that clients can understand.
- Health centres employing peer-educators/navigators and expert clients to support clients living with HIV to access treatment and adherence support, and to provide or link clients to psycho-social support.
- Engagement of men and boys in health-seeking behaviours and supporting female partners in antenatal care.



### What indicators will we use to measure our results?

- Number or percentage of women reporting that they have been pressured to use specific methods of contraception, infant feeding options, delivery options or to terminate a pregnancy (composite indicator).
- Number or percentage of people who report that their medical records are not kept confidential.
- Number or percentage of people reporting that they have been given differential family planning/SRHR treatment or advice based on their HIV status (composite indicator).
- Number or percentage of people that report stopping or delaying their treatment due to a bad experience with a healthcare worker.
- Number or percentage of people that report being tested for HIV, pressured into any medical procedure, or started on treatment without their knowledge or consent (combined indicator).
- Number or percentage of people that have been refused any type of healthcare service because of their HIV status.
- Number or percentage of facilities with confidential reporting systems that report stigma cases (and percentage reduction of stigma related cases reported at health facilities which report cases).
- Level of male involvement during antenatal care and accessing HIV testing services and HIV treatment at facility level.

### CASE STUDY



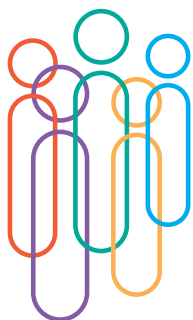
The READY to Care scorecard comprises a set of 15 standards developed by and for young people living with HIV in their diversity to support service providers to deliver quality health services that are youth-friendly, ethical, appropriate and uphold the rights and dignity of young people living with HIV.



### Focus on gender

Are we providing holistic services for young women, men and transgender people living with HIV? Who uses them and who doesn't? How friendly are these services? Are they accessible and acceptable to younger adolescents, and young women, men and transgender people living with HIV?

## 5. Justice setting



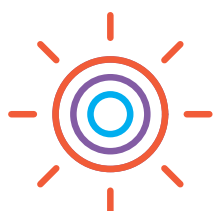
### What is Stigma Index data telling us?

A large number of countries around the world continue to criminalise people living with HIV and people at high risk of HIV, including sex workers, people who use drugs, and people in same sex relationships. 82 countries have laws that specifically criminalise HIV non-disclosure, exposure and transmission for prosecution based on general criminal laws,<sup>22</sup> and four countries have reported laws that criminalise vertical transmission of HIV.<sup>23</sup> Other examples of stigma and discrimination include travel restrictions on people living with HIV, mistreatment by law enforcement officials and a lack of access to justice in cases of human rights violations relating to a person's HIV status. In addition, young people often face age-restrictive laws that prevent them from accessing HIV and other SRHR services independently, without the consent or accompaniment of parents and guardians.



### Vision

Equal access to justice for all people living with HIV. HIV status is regarded as irrelevant within the criminal justice system.



### What changes do we want to see?

- A globally standardised law that protects the rights and interests of people living with HIV including in workplace, education and healthcare settings as well as their right to travel, and the right to non-disclosure of their HIV status.
- Strong measures to protect people living with HIV who are detained or imprisoned from having their HIV status disclosed without their consent.
- Full access to prevention, treatment and care for all prisoners and detainees, including the right for detainees in jail to contact their treatment sites while awaiting sentencing.
- Legal literacy and awareness among communities especially around sexual and reproductive health and rights.
- Involvement of communities in formation of laws and policies, and peer-led legal literacy to sensitise people living with HIV about their legal rights.
- Training for police and law enforcement officers on HIV-related stigma and discrimination.

22. A total of 82 countries (111 jurisdictions including states within Mexico, Nigeria and the US). See, HIV Justice Network (2022) [Advancing HIV Justice 4: Understanding Commonalities, Seizing Opportunities](#).

23. HIV Justice Network (2022) [Advancing HIV Justice 2: Building momentum in global advocacy against HIV criminalisation](#).

- Involvement of communities in human rights monitoring mechanisms, such as the Universal Periodic Review, and reporting on the Convention of Elimination of all forms of Discrimination against Women (CEDAW).



#### **What indicators will we use to measure our results?**

- Number of people reporting that their HIV status was disclosed to authority figures (police, judges, law enforcement officials, etc.) without their consent.
- Number of people reporting that they were arrested or taken to court on a charge related to their HIV status.
- Number of people reporting that they are not taking treatment or stopped because they were in prison or detained awaiting sentencing and treatment was not available.
- Number of people who report receiving legal services or redress after experiencing HIV-related discrimination or violence.
- Representation of community members in the formulation, dissemination and monitoring of laws and policies.
- Presence of mechanisms addressing and monitoring human rights violations.

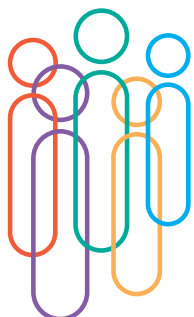


#### **Focus on gender**

How do laws that criminalise HIV transmission impact on women, men and transgender or gender non-conforming people? Do women and gender non-conforming people know their rights and where to go to seek redress? What can sex workers and LGBTQI+ people do if they are wrongfully arrested and detained? Do young women have access to SRHR information and services, including family planning, HIV testing and safe abortion care without parental or partner consent?



## 6. Emergency setting



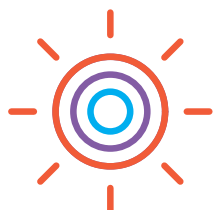
### What is Stigma Index data telling us?

HIV stigma and discrimination in emergency and humanitarian or conflict settings is really hard to measure because there's so much going on. But evidence from COVID-19 shows that factors driving HIV vulnerability (e.g. poverty, lower educational levels, sexual and gender-based violence, early marriage, lack of comprehensive sexuality education, and criminalisation of sex work, drug use and non-conforming sexuality and gender identity) also drive heightened hardship or vulnerability in other health emergencies. And that people who are already marginalised face similar barriers to accessing social protection and emergency support in times of crisis as they do in 'normal' times. During COVID-19, key populations were often blamed, shamed and targeted, leading to increased human rights violations among these populations. Travel and movement restrictions and adapted service delivery methods can make involuntary disclosure of HIV status more likely, potentially exposing individuals to HIV-related stigma and discrimination.



### Vision

Equitable access to social protection and essential services for people living with HIV in emergency and humanitarian situations.



### What changes do we want to see?

- Strong and inclusive social protection measures for people living with and most affected by HIV.
- Integrated HIV prevention, treatment and care, hepatitis C, tuberculosis, comprehensive SRHR and post-gender-based violence care considered essential services at primary care level with 24-hour access to emergency services.
- Meaningful involvement of people living with and most affected by HIV in country emergency preparedness plans and strategies.
- Funding for community-led and -based organisations to implement decentralised, flexible and adaptive, community-based healthcare initiatives (e.g. multi-month dispensing, greater emphasis on self-care SRHR/HIV technologies and modalities, home visits if safe for clients, among others.). Adequate remuneration for outreach workers and service providers, proper training (including in data collection) and resourced with adequate protective and safety equipment.
- Strengthened collaboration between health and community systems, and greater trust between community and state actors.
- Mainstreaming of human rights-based approaches in emergency and humanitarian responses and programmes.

- Decent pay and working conditions, including adequate protective and safety equipment.



#### **What indicators will we use to measure our results?**

- Number or percentage of people living with, at risk of and affected by HIV and AIDS who have access to one or more social protection benefits.
- Number or percentage of people within humanitarian setting at risk of HIV using appropriate, prioritised, people-centred and effective combination prevention options.
- Number or percentage of people in humanitarian settings who have access to integrated tuberculosis, hepatitis C, SRHR and HIV services, in addition to programmes to address gender-based violence (including intimate-partner violence), which include HIV post-exposure prophylaxis, emergency contraception and psychological first aid.
- Number or percentage of emergency/humanitarian responses using a human rights based approach.



#### **Focus on gender**

In what ways do humanitarian crises expose gender inequality (including heightened risk/prevalence of sexual and gender-based violence, and harmful practices such as female genital mutilation (FGM) and child marriage) and threaten gains towards gender equality? What specific risks do adolescent girls and young women face as a result of humanitarian crises, disaster or conflict - or the measures to contain them? How do crises impact on women's and girls' SRHR including access to contraceptive services, maternal care and safe abortion care? What additional support do women, girls and gender non-conforming people living with HIV need in emergency situations, including those living with disabilities or internally displaced persons?

## SECTION 4

### WHAT NEXT?

So, using the indicators suggested under the six settings above, as well as those already used in GAM, what should communities be doing to understand whether we are making an impact on HIV-related stigma and discrimination?

#### Stigma Index

1. Make sure your Stigma Index data is up to date; include full implementation of the Stigma Index in your country's Global Fund proposal and/or PEPFAR Country Operational Plan (COP).
2. Make sure Stigma Index results are validated by community members, including people living with HIV from key populations, and women and girls.
3. Look at what the Stigma Index data is telling you and use it to design and advocate for community-led interventions on HIV stigma reduction in the priority settings, or include in programmes on HIV prevention, treatment and care (see Annex A: Using Stigma Index for Advocacy).
4. When implementing a new Stigma Index study, consider including a gender approach throughout the report, and a section of the report on women, including transgender women, with its own conclusions.

#### Community-led research and advocacy

5. Supplement Stigma Index data with other community-led research and advocacy, looking deeper into stigma and discrimination in the priority settings using a gender lens, and/or a population-specific focus (for example, experience of transgender sex workers living with HIV in justice settings; experience of adolescent mothers living with HIV in education settings).
6. Hold community dialogues with relevant stakeholders to highlight how stigma and discrimination prevents access to HIV prevention, treatment and care.

#### Gender-based violence and human rights monitoring and response

7. Monitor gender-based violence and human rights violations at the community level using tools like Rights – Evidence – ACTION (REAct), and use data for advocacy.

#### Community-led monitoring

8. Implement community-led monitoring to assess the accessibility, acceptability, affordability and quality of services, using a gender and human rights lens to hold services accountable to people living with HIV in all their diversity (See Annex B: Community-led monitoring).
9. Ensure networks of women living with HIV and in all their diversity are capacitated to and included in the implementation of community-led monitoring.

## Bringing it all together: M&E checklist

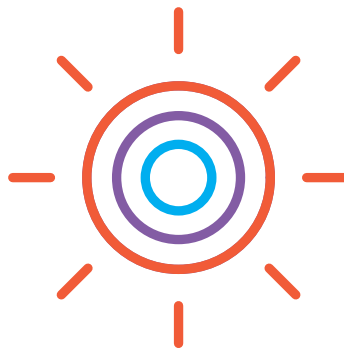
These tips apply to any and all of the above ways of monitoring the progress of the Global Partnership and using your data for advocacy.

- ✓ **Be inclusive:** how are women, men and gender diverse people included in the data collection and/or advocacy?
- ✓ **Promote the voice and visibility** of women and girls and marginalised communities.
- ✓ **Build skills, knowledge and capacity** on human rights, gender transformative approach, intersectionality, SRHR, and HIV.
- ✓ **Provide wrap-around support:** technical, logistical and financial.
- ✓ **Use a gender lens:** look at the questions marked with the gender sign to consider areas you may have missed.
- ✓ Think about **what you want to measure and how** you want to measure it: use a mixed methods participatory approach with feminist principles.
- ✓ **Engage global networks of people living with HIV** like GNP+ and ICW for support to ensure technical quality, links to relevant resources and movements, and to bring it to a wider platform.
- ✓ **Work with your country UNAIDS office** and global partnership focal points.
- ✓ **Include the different domains of stigma and discrimination** in your research – drivers/facilitators, experiences, stigma markers and outcomes.
- ✓ **Select indicators and outcome measures** to track progress towards gender equality and human rights.
- ✓ **Disaggregate your data** – at a minimum by sex/gender and age, and other characteristics as appropriate (disability, sexuality, key population identity, etc.).

### Finally ...

It is important to remember that using M&E for advocacy is no different to HIV advocacy projects and programmes that use data to improve policy and increase budgets. Although it is important to dedicate time and resources to M&E within your organisation, it is not necessary to have a dedicated M&E officer if you have advocacy programme staff.

Even a simple M&E framework that tracks a small number of indicators will in many cases be sufficient. A large complex M&E system is unlikely to be used by busy advocates. A common pitfall of choosing indicators for measuring results is a belief that 'what gets measured gets done.' This can lead to an overly long 'laundry list' of indicators, which is both impracticable to measure and doesn't always provide the most compelling or priority data.



## ANNEX A

### USING STIGMA INDEX DATA FOR ADVOCACY

GNP+ has developed an advocacy toolkit, [Measure it, Act on it, Do it](#), to achieve change, to support community advocates to develop advocacy strategies focused on eliminating stigma and discrimination using key findings and recommendations from [Stigma Index reports](#).

Specifically, the advocacy toolkit aims to:

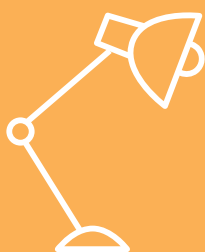
- provide a set of practical tools that support community advocates to take concrete steps to turn the data and key findings of Stigma Index reports into practical advocacy actions
- help networks of people living with HIV to identify and take forward advocacy actions based on the key findings and recommendations from Stigma Index reports.

A wide range of resources are also available here: [GNP+](#), [Stigma Index](#) and [Global Partnership](#).

Even if you don't have a recent Stigma Index report, you can use past reports and the most recent data available. Being able to compare data sets to look at the trajectory of change - the direction of travel - can help identify 'sticky' areas where greater advocacy is needed. Below are some examples of using Stigma Index data for advocacy.<sup>24</sup>

#### CASE STUDY

#### Addressing gender-based HIV discrimination in Kazakhstan

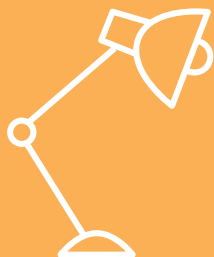


In 2019, a coalition of people living with HIV networks and civil society organisations in Kazakhstan developed a shadow report on discrimination and violence against women who use drugs, women living with HIV, sex workers and women in prison to highlight government inaction on delivering the National Plan against Stigma and Discrimination for 2018-2019. They included statistics from the 2015 Stigma Index Report on the high numbers of women living with HIV that had experienced forced abortions from medical personnel and who had never received counselling on reproductive health. The shadow report was presented by women living with HIV at the CEDAW meeting in March 2019 and led to the CEDAW Committee, including specific language on discrimination against women living with HIV and women who use drugs in their formal list of issues and questions to the government.

24. Examples from, [Measure it, Act on it, Do it](#) (stigmaindex.org)

CASE STUDY

**Addressing healthcare provider fear in Vietnam**



The Stigma Index study conducted in Vietnam in 2014 found high rates of many types of stigma and discrimination against people living with HIV. The Vietnam Network of People Living with HIV (VNP+) successfully used the findings to influence Ministry of Health guidelines for strengthening activities to reduce stigma and discrimination related to HIV in healthcare facilities. A survey of stigma and discrimination in healthcare was conducted by the Ministry of Health in Ho Chi Minh City in late 2016, with what the Vietnamese Authority of AIDS Control (VAAC) described as ‘eye-opening’ results. 73% of healthcare workers surveyed reported a fear of HIV infection via routine care for people living with HIV and 60% of people living with HIV reported a fear that their medical records would not be kept confidential.

Working closely with the community, VAAC and VNP+ conducted a pilot project to engage the community with healthcare worker training and set up a community advisory board in Binh Duong. After nine months of the community interventions in Binh Duong, fear of HIV infection had considerably subsided among healthcare workers and reported experiences of discrimination were down from 25% to 15%.

## ANNEX B

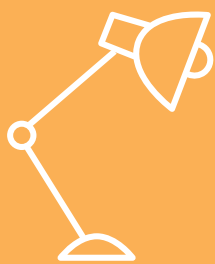
### COMMUNITY-LED MONITORING

Community-led monitoring means different things to different people. In national public health systems, community-led monitoring is viewed as a real-time way to track drug stock-outs and quality of care, but is not considered to be about monitoring, documenting and responding to human rights violations.

According to UNAIDS, the purpose of community-led monitoring is wider - to serve as a **surveillance and accountability community mechanism** (i.e. a watchdog function) for health services. "HIV community-led monitoring is an accountability mechanism for HIV responses at different levels, led and implemented by local community-led organisations of people living with HIV, networks of key populations, other affected groups or other community entities."<sup>25</sup>

Using community-led monitoring, communities collect and analyse data on the availability, accessibility, acceptability, affordability and appropriateness of HIV care and services as well as the level of awareness about services among community members. This can provide real-time strategic information from the point-of-care to use at the national level on the coverage and quality of policies, services and programmes, and on the perspective of a diverse set of stakeholders. Community-led monitoring also empowers communities by strengthening the capacity of communities to design and lead research, and collect, analyse and use data that is owned by them for advocacy.

#### CASE STUDY



Women4GlobalFund (W4GF) has developed an **Accountability Toolkit** to enable women living with HIV in their diversity to use community-led monitoring to: assess the effectiveness of Global Fund-supported programmes and services, including by gathering client perspectives; use the findings to advocate for countries to advance gender equality and uphold human rights; build and strengthen strategic partnerships between communities and implementing organizations to promote women's meaningful involvement; and to assess their own effectiveness as W4GF advocates in Global Fund processes at the national level. The toolkit is being implemented by women living with HIV representing diverse communities in India, Cameroon and Tanzania. An overarching goal of the project is to empower women, through the use of community-led monitoring, to provide effective oversight of programmes that are supported by the Global Fund in a transparent and systematic manner, and with the key goal of ensuring quality of care and access.

25. UNAIDS (2021) [Establishing community-led monitoring of HIV services – Principles and process](#) p.4 (viewed 25th October 2021).





### About GNP+

The Global Network of People Living with HIV (GNP+) is led by people living with HIV and represents and serves every person living with HIV. GNP+ is committed to representing the needs and priorities of those who are underserved, marginalised, or excluded from health and other services and are prevented from participating in the decisions that impact their lives. GNP+ builds broad partnerships with individuals, organisations and institutions to increase influence. Using the power of evidence-based advocacy, the network challenges governments and global leaders to improve access to quality HIV prevention, treatment, care and support services. Their vision is a world where all people living with HIV are free from stigma and discrimination, have their rights recognised, dignity respected and have universal access to treatment and care.



### About ICW

The International Community of Women Living with HIV (ICW) is the only global network by and for women living with HIV. ICW speaks for and represents all women living with HIV. ICW is committed to addressing the various forms of oppression that HIV-positive women face around the world. They maintain a bottom-up strategy in which the opinions of members drive the agenda because ICW believe that the experiences of members should inform what they do and how they do it. ICW operates through ten regional networks in 120 nations. ICW advocates for the needs of women, young women, adolescents, and girls living with HIV in important global decision-making arenas through their global advocacy programme, which guarantees that women living with HIV really have a voice in the formation of policy that affects their life.



### About the Global Partnership

The Global Partnership for Action to Eliminate all Forms of HIV-related Stigma and Discrimination (Global Partnership) was created in 2018. The partnership is a multi-stakeholder platform, harnessing the combined power of governments, civil society, bilateral and multilateral donors, academia and the United Nations (UN) to eliminate HIV-related stigma and discrimination and to inspire countries to take action to remove critical barriers to HIV services. The Global Partnership is a community-led and driven initiative, co-convened by UNAIDS, UNDP, UN Women, GNP+ and the Global Fund; advised by a Technical Working Group and supported by a 'community of practice' at regional and country level. It is a critical vehicle for action to mobilise all countries to reach the societal enabler 10-10-10 targets and implement the Global AIDS Strategy. To date 35 countries<sup>26</sup> have joined the partnership, committing to end HIV-related stigma and discrimination through evidence-based interventions in six priority settings: community, health, justice, education, workplace and emergency/humanitarian.

26. Angola, Argentina, Botswana, Brazil, Cambodia, Central African Republic, Costa Rica, Côte d'Ivoire, Democratic Republic of the Congo, Dominican Republic, Ecuador, Gambia, Guatemala, Guinea, Guyana, Iran, Jamaica, Kazakhstan, Kenya, Kyrgyzstan, Laos, Lesotho, Liberia, Luxembourg, Moldova, Mozambique, Nepal, Papua New Guinea, Philippines, Senegal, South Africa, Tajikistan, Thailand, Uganda, Ukraine.



## About the People Living with HIV Stigma Index

The People Living with HIV Stigma Index (Stigma Index) is a tool to gather experiences of HIV-related stigma and discrimination which can be compared across time and place within one country. It was developed in 2008 and revised in 2018 (Stigma Index 2.0). To date, the Stigma Index has been conducted in over 100 countries.

The updated and strengthened Stigma Index 2.0 (2018) has been designed to capture the multiple and intersecting layers of stigma and discrimination faced by sex workers, lesbian, bisexual, gay, transgender and intersex (LBGTI) people, and people who use drugs. It reflects the latest context in the HIV response globally and has now been completed in 38 countries, and is underway in an additional 40 countries.

The Stigma Index was developed to prove that it is possible to measure stigma and to provide much-needed data and evidence that could be used to advocate for the rights of people living with HIV. Importantly, it was designed to be used by and for people living with HIV and was created to reflect and support the Greater Involvement of People living with HIV and AIDS (GIPA) principle, where people living with HIV networks are empowered to lead the whole implementation of the study.

In countries that have implemented the Stigma Index more than once, there is evidence that efforts to address HIV-related stigma and discrimination have been successful. For example, Repeated Stigma Index surveys over time in Nigeria (2011, 2014 and 2021) have shown a steady decline in the experience of HIV-related stigma, including a reduction in internalised stigma and in stigma and discrimination experienced within the health sector. However, the Stigma Index 2.0 carried out in 2021<sup>27</sup> found that 22% of people living with HIV still experienced some form of stigma or discrimination related to their HIV status in the last 12 months, and persistently high levels of internalised stigma with around three-quarters of participants expressing that they find it hard to disclose their HIV status, two-thirds preferring to hide their status, and a third reporting feelings of guilt or shame in relation to their HIV status. Common experiences of 'enacted stigma' include having their status disclosed without their consent, and being pressured into testing for HIV (both experienced by one in five of the survey respondents), as well as verbal abuse, gossip and stigmatising comments. On the whole, rights abuses were not reported, attributable to a lack of awareness of rights and what to do in the case of violations.

27. Network of People Living with HIV/AIDS in Nigeria (NEPWHAN) (2021) Nigeria People Living with HIV Stigma Index Survey 2.0 Report.

**Global AIDS Strategy 10-10-10 targets with sub-targets<sup>28</sup>**

<b>Less than 10% of people living with HIV experience stigma and discrimination</b>
Less than 10% of people living with HIV report internalised stigma by 2025
Less than 10% of people living with HIV report experiencing stigma and discrimination in healthcare and community settings by 2025
Less than 10% of key populations report experiencing stigma and discrimination by 2025
Less than 10% of the general population report discriminatory attitudes towards people living with HIV by 2025
Less than 10% of health workers report negative attitudes towards people living with HIV and key populations by 2025
Less than 10% of law enforcement officers report negative attitudes towards key populations by 2025
<b>Less than 10% of women, girls, people living with HIV and key populations experience gender inequality and violence</b>
Less than 10% of women and girls experience physical or sexual violence from an intimate partner by 2025
Less than 10% of key populations experience physical or sexual violence by 2025
Less than 10% of people living with HIV experience physical or sexual violence by 2025
Less than 10% of people support inequitable gender norms by 2025
Greater than 90% of HIV services are gender-responsive by 2025
<b>Less than 10% of countries have punitive laws and policies</b>
Less than 10% of countries criminalise sex work, possession of small amounts of drugs, same-sex sexual behaviour, and HIV transmission, exposure or non-disclosure by 2025
Less than 10% of countries lack mechanisms for people living with HIV and key populations to report abuse and discrimination and seek redress by 2025
Less than 10% of people living with HIV and key populations lack access to legal services by 2025
More than 90% of people living with HIV who experienced rights abuses have sought redress by 2025

28. UNAIDS (2021) Global AIDS Strategy 2021-2026 – End Inequalities. End AIDS.

