REALIZING RIGHTS
Pervasive discrimination and structural inequalities are forcing ostracized populations further into the shadows and sabotaging efforts to end the AIDS epidemic. Embedded in social relations and codified into laws and policies, these injustices rob millions of the prospect of healthy and fulfilling lives—and they fuel a global HIV epidemic that is now in its fifth decade. The COVID-19 pandemic has further increased and reinforced these inequalities and systemic discrimination, particularly through shutdowns, which have especially harmed women and marginalized populations (1, 2).
Alongside scaling up the availability of biomedical tools for curbing the HIV pandemic, countries must take action to meet their broader human rights obligations and reduce the underlying inequalities and intersecting forms of discrimination that hold back progress against the global HIV epidemic. Doing so requires reforms in the legal sphere, changing harmful societal norms, widening the distribution of resources and opportunities across societies, and increasing the involvement of community-led organizations in planning, providing and monitoring services (3). These reforms are the basis of the 10–10–10 targets for 2025, which encompass key changes that are needed to remove societal and legal impediments to an enabling environment for HIV services.

“(T)he full realization of all human rights and fundamental freedoms for all is an essential element in the global response to the HIV epidemic, including in the areas of prevention, testing, diagnosis, treatment, care and support, and that such a response reduces a person’s vulnerability to HIV.”

DECRIMINALIZATION

Criminalization of certain activities or behaviours exposes key populations and people living with HIV to harm by forcing them away from the support and services that can help them protect their health (4, 5). This includes the criminalization of sex work, same-sex sexual relations, gender diversity and expression, HIV exposure or non-disclosure, and the use of narcotic drugs or their possession for personal use.

For example, a study conducted in 10 sub-Saharan African countries found that severe criminal penalties for same-sex sexual relations were associated with an almost eight times greater risk of HIV infection among gay men and other men who have sex with men compared with places without such laws (6). Similarly, a meta-analysis of studies found that the risk of sexual or physical violence is nearly threefold greater in settings where sex work is intensively policed (7). Another study in sub-Saharan Africa found that HIV prevalence among sex workers was seven times lower in countries that had even partially decriminalized sex work, compared to countries that maintained a criminalizing approach to sex work (4). There also is evidence linking the criminalization of drug use with increased internal stigma and violence, poorer access to services and negative effect on HIV prevention and treatment for people who use drugs (8, 9).

The Global Commission on HIV and the Law recommends that countries apply human rights and public health principles to remove or reform laws and policies that stop people from accessing the HIV and other health services they need (10). That is why countries need to take immediate steps towards full decriminalization and adopt law enforcement practices that support, rather than impede, HIV responses. Furthermore, the use of more general laws to target people living with HIV and key populations—such as those relating to vagrancy or petty offences—also must end.

Dozens of countries have moved towards a more enabling legal environment (see Chapter 1), usually in response to the advocacy and activism of marginalized populations and their organizations. Belgium is the most recent country to decriminalize sex work (see the Belgium feature story in this Chapter), while similar reforms have been introduced in parts of Australia (New South Wales, the Northern Territory and Victoria) (11). In New Zealand, which in 2003 became the first country to decriminalize sex work, sex workers have the same rights as other workers, including occupational health and safety and human rights protection (12). India’s Supreme Court also recently affirmed that sex workers are entitled to equal protection under the law, issuing directives for protecting sex workers from police violence and harassment, and ensuring their access to social services (13).

Since 2016, at least six countries have removed laws criminalizing same-sex sexual relations, and at least nine have introduced legal avenues for changing gender markers and names without the requirement of undergoing gender-reassignment surgery (14).

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1 Other countries where sex work is legal or decriminalized include: Austria, Ecuador, Germany, Greece, the Netherlands, New Zealand, the Plurinational State of Bolivia, Switzerland and Uruguay.
2 The countries are: Angola, Bhutan, Botswana, Gabon, India and the Seychelles.
3 The countries are: Belgium, Chile, France, Greece, Iceland, Luxembourg, Pakistan, Portugal and Uruguay.
Other countries, most recently Zimbabwe, have reformed their laws that criminalize HIV transmission or non-disclosure (15). Unfortunately, other countries have also altered their laws during that period to permit harsher sentences in cases of HIV exposure (16).

Inequality is deeply seated in global drug policies, which disproportionately affect people who are marginalized on the basis of their gender, ethnicity, sexual orientation and socioeconomic status. The Global Drug Policy Index—which documents, measures and compares national-level drug policies—reveals a deep divide in states’ approaches to drugs, with the scores of the five countries at the top of the rankings being three times higher than the five lowest ranking countries (17).

Some jurisdictions have already made this enabling change. In November 2020, Oregon became the first state in the United States of America to decriminalize possession of all drugs and increase access to supportive health services (18). More recently, the Canadian province of British Columbia was successfully granted an exemption from federal drug laws, allowing it to decriminalize the possession of small amounts of harder drugs, while Thailand is the first country in Asia and the Pacific outside of Australia to decriminalize the possession of marijuana for personal use (19, 20).

“The community at large are happy with this verdict [of the Supreme Court of India] and we hope that all the recommendations will be followed by all, especially the police and the press, who have been specifically mentioned. We hope that the government at the central and state level will provide support to all sex workers in all possible ways. We hope that the recommendations will . . . diminish stigma and discrimination, which is often faced by members of this community.”

- Ms. Bharati Dey and Ms. Bishakha Laskar, of the Durbar Mahila Samanwaya Committee, a collective of about 65,000 sex workers in West Bengal, India, commenting on a ruling by the Supreme Court of India that sex workers have equal protection under the law

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4 Countries that have adopted harsher sentences in cases of HIV exposure include Colombia, Mexico, Mozambique and the Philippines.

5 Countries with the highest scores are those that have and implement drug policies in alignment with the UN principles of human rights, health and development.
In March 2022, UNAIDS launched Unbox Me to advocate for the rights of transgender children in the lead-up to the International Transgender Day of Visibility. In India, more than 90% of transgender people leave their homes or are thrown out by the age of 15 years. Inevitably, many live on the street with no money or education, often relying on sex work. Stigma and discrimination and criminalization tend to make transgender and gender-diverse people invisible, with extreme forms of discrimination leading to even the denial of the existence of gender-diverse people.
Recent months have seen important advances in efforts to decriminalize sex work, with sex workers achieving legislative victories in Belgium and the Australian state of Victoria. In an ironic twist, the COVID-19 pandemic, which caused such devastation to sex workers across the world, actually spurred action to protect the health, rights and well-being of sex workers.

The Global AIDS Strategy demands attainment of ambitious but achievable targets among key population groups. Among the groups most heavily affected by HIV are female sex workers, who are 30 times more likely than women in the general population to acquire HIV. Studies show that decriminalization of sex work would avert 33–46% of new HIV infections among sex workers and their clients over 10 years (21).

In March 2022, Belgium became the first country in Europe to decriminalize sex work (see box), and the only other country in the world to do so after New Zealand. The push to decriminalize sex work received strong and influential support from academic experts and Vincent Van Quickenborne, the Belgian Minister of Justice. Under the new law, self-employed sex workers have the same rights as other self-employed people, including access to the same social protection measures afforded to other labour sectors. The new law also decriminalizes third parties, who will no longer be penalized for opening a bank account or renting out space to a sex worker, and it allows sex workers to advertise their services.

The strong vote in favor of decriminalization (71-4, with 40 abstentions) was a direct result of advocacy by sex workers for strengthened social protection during COVID-19, which raised government and public awareness. “Belgium has a high standard of living because of a huge safety net, which we can be really proud of,” said Daan Bauwens, director of Utsopi, a sex worker organization. “So people were actually quite shocked [to learn] that sex workers just had no government support [during the COVID-19 pandemic] when every other sector did . . . People could see lines of sex workers in the streets queuing for food distributions.”

Mr Van Quickenborne said he felt relieved and satisfied after the vote. “The existence of sex work is an undeniable reality in every society. And it shouldn’t be a taboo when adult sex workers freely choose to do this. Providing a legislative framework not only acknowledges and respects sex workers; it also vastly improves their lives,” the Minister said. “We are the second country in the world to give such extensive recognition and rights to sex workers. I hope many other countries will soon follow our example.”

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An “Appéro Pute”, a monthly meeting held by Utsopi to engage the sex workers community on a safe space where they can talk about their work with their peers, to share their concerns, to give ideas in what to collectively do in the organization. Brussels, Belgium, July 2022.
DECRIMINALIZATION VS LEGALIZATION OF SEX WORK

Legalization is a term often confused with decriminalization. According to the Global Network of Sex Work Projects, decriminalization refers to the removal or absence of criminal or other laws that oppress sex workers, whereas legalization is the introduction of laws that aim to impose state regulation and control sex work (2). Examples of legalization include local planning laws that restrict the number, location and rules of operation for sex work businesses, or public health laws that require mandatory registration and/or compulsory sexually transmitted infection (STI) or HIV testing for sex workers. This leads to a two-tiered system of legal and illegal sex workers, which can result in exploitative working conditions and human rights violations for those who are illegal. Criminal sanctions also may be applied for non-compliance of legalization conditions (22).

Decriminalization does not necessarily imply the absence of some form of regulation that aims to respect and protect the human and labour rights of sex workers, like occupational health and safety standards. This is distinct from legalization, where state regulation is designed to control and limit sex work and is often enforced by the police.

The decision by legislators in Belgium follows a decision earlier in 2022 by the parliament of the Australian state of Victoria to decriminalize sex work and introduce legal protections for sex workers. The Victoria law removes offences and criminal penalties associated with sex work, eliminates the registration and licensing system that had been in place, repeals the criminalization of HIV transmission, and ends mandatory testing and condom use provisions. The Victoria legislation was the result of open, transparent and inclusive consultation and collaboration between government champions and sex worker organizations.

“Repealing these laws will have a positive impact on sex workers by reducing discrimination and improving access to peer education, HIV prevention, [and] testing and treatment services, which will improve public health outcomes for the whole community,” said Jules Kim, CEO of Scarlet Alliance, Australian Sex Workers Association. While the bill serves as an important advance for sex workers, Dylan O’Hara, acting manager of Vixen, a peer sex worker organization in Victoria, vows that sex workers will “keep advocating for other vital reforms needed to ensure that decriminalization leaves no sex worker behind.”

Removal of these laws is an important step towards protecting and promoting the health and well-being of sex workers. Even when sex worker arrests are rare under criminal laws, the uncertainties created when criminal penalties are on the books can cause anxiety among sex workers. “Enforcement was pretty arbitrary [before decriminalization],” recalls Daan Bauwens of Utsopi. “Sometimes sex workers would be targeted and prosecuted at random for advertising for themselves. [It was] not a good situation for their rights or their psychological well-being.”

Decriminalization not only removes these anxieties, but it also recognizes sex workers as integral members of society. “We can say that Belgium recognizes you as a worker, a person with the same rights as any other!” said Laïs, board member and co-president of Utsopi. “This is huge! Even more than the practical for me is what it means to us on a personal level. We’re not invisible anymore.”

Sex workers and politicians stand in front of Parliament House in Melbourne, Australia, as the Decriminalization of Sex Work Act 2022 passes the Parliament of Victoria’s Upper House on 10 Feb 2022.

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STIGMA AND DISCRIMINATION STILL BLOCK THE WAY FORWARD

More than 40 years into the HIV epidemic, stigma and discrimination continue to ruin lives and undermine efforts to end AIDS. Overlapping forms of discrimination humiliate people, deter them from using health and other essential services, and harm their health. People who are already marginalized, including those belonging to key populations, are especially vulnerable and are routinely exposed to discrimination and mistreatment, even when seeking health care (24–27).

The People Living with HIV Stigma Index studies are an informative source of data on experiences of stigma and discrimination among people living with HIV. More than 100 countries have completed surveys since the Index was introduced in 2008, with more than 100,000 people living with HIV participating in the process. The findings from these studies support other evidence about the pervasive and pernicious nature of stigma and discrimination and its effect on people living with HIV and key populations everywhere (see Chapter 1). Integrated biological and behavioural surveillance surveys have also been instrumental in providing epidemiological evidence on stigma and discrimination to help policymakers, programme planners and implementers steer the HIV response.

The People Living with HIV Stigma Index studies are an informative source of data on experiences of stigma and discrimination among people living with HIV.

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6 The People Living with HIV Stigma Index is a community-led research initiative that gathers data on the various forms of stigma and discrimination experienced by people living with HIV. It is managed by the PLHIV International Partnership (a coalition led by the Global Network of People Living with HIV), the International Community of Women living with HIV and UNAIDS, with support from the Johns Hopkins University.

7 A further iteration of the survey, Stigma Index 2.0, is under way. Eight countries (Benin, Burkina Faso, Côte d’Ivoire, Kenya, Lesotho, Nigeria, Togo and Ukraine) have implemented it, and 40 others are in the process of doing so.
CREATING NON-STIGMATIZING HEALTH-CARE SERVICES AND SPACES

Judgmental and hostile attitudes of health workers, breaches of confidentiality, poor care and advice, and even outright denial of treatment continue to be reported by people living with and at risk of HIV when accessing health-care services (28–29). These experiences undercut people's trust in medical advice and deter them from seeking or remaining in care when they need it—which compromises their health and undermines efforts to end the AIDS epidemic (30).

Health services must be offered in ways that are respectful, understanding and friendly to everyone—including key populations and people living with HIV—and they should be free of stigma and discrimination. That requires having policies that oblige health-care providers to offer timely and quality health care to all, without discrimination, and training staff to understand and respond appropriately to people's realities and needs, especially those of young people (31, 32). Community-led monitoring activities, like the Ritshidze project in South Africa, are vital for holding health-care providers accountable (33).

“For me, they don’t know I am a sex worker. I don’t want to them to know, because the treatment will be bad for me. They are not treating other sex workers well.”

– A sex worker using the Bloemspruit clinic in South Africa’s Free State Province during a March 2021 interview with the Ritshidze project
BUILDING MOMENTUM TO ELIMINATE HIV-RELATED STIGMA AND DISCRIMINATION

Countries are stepping up their efforts to eliminate stigma and discrimination. Across 131 countries reporting between 2017–2022, 94 stated that government-established formal mechanisms were in place for key populations and people living with HIV to report abuse and discrimination and to seek redress. In 2022, community representatives and nongovernmental partners in 84 countries reported barriers to accessing justice through formal and informal mechanisms: these barriers include affordability constraints (35 countries) and limited awareness or knowledge of how to use such mechanisms (47 countries). Community-led and other nongovernmental organizations have set up procedures in 53 countries to record and deal with individual complaints, while 81 countries have mechanisms in place for accessing affordable legal services.

Many of these efforts are underway in the 30 countries that have joined the Global Partnership for Action to Eliminate HIV-related Stigma and Discrimination since its launch in 2018.8 The Global Partnership combines the efforts of governments, civil society, donors, academia and the UN to end HIV-related stigma and discrimination through political commitments on evidence-informed interventions. To do this, it is facilitating technical assistance and supporting efforts to remove stigma and discrimination from the health care, justice, education, workplace, humanitarian and community settings.

The Partnership’s efforts have led to 19 countries accelerating stigma and discrimination reduction in priority settings.9

8 The 30 countries that joined the Partnership are: Angola, Argentina, Botswana, Central African Republic, Costa Rica, Côte d’Ivoire, the Democratic Republic of the Congo, Ecuador, the Gambia, Guatemala, Guinea, Guyana, the Islamic Republic of Iran, Jamaica, Kazakhstan, Kyrgyzstan, the Lao People’s Democratic Republic, Lesotho, Liberia, Mozambique, Nepal, Papua New Guinea, the Philippines, the Republic of Moldova, Senegal, South Africa, Tajikistan, Thailand, Uganda and Ukraine.

9 The countries are: Central African Republic, Côte d’Ivoire, the Democratic Republic of the Congo, the Gambia, Guinea, the Islamic Republic of Iran, Jamaica, Kazakhstan, Kyrgyzstan, the Lao People’s Democratic Republic, Liberia, Nepal, Papua New Guinea, the Republic of Moldova, Senegal, South Africa, Thailand, Uganda and Ukraine.
“The attitude towards most people is bad. Because of the bad attitude, I will always hide the fact that I am a sex worker. I have seen people [sex workers] getting shouted at, so I don’t want to be shouted at. Sex workers are always complaining that they are attended to last and they are told your job is at night so there is no hurry . . . most sex workers have decided not to go to the clinic anymore . . . gay people are also badly treated. They are always shouted at.”

– A sex worker using Phuthaditjhaba clinic in South Africa during an August 2021 interview with the Ritshidze project

Eighteen have also introduced legal reforms and/or increased access to justice for key populations. For example, in Central African Republic, the ministries of health and justice are working with parliamentarians to decriminalize HIV transmission, better protect the human rights of people living with HIV and key populations, and lower the age of consent for HIV testing. Similarly, the Islamic Republic of Iran promulgated its first-ever antidiscrimination regulation in health-care settings at the end of 2020, which requires that both public and private health-care facilities protect people living with HIV and key populations from stigma and discrimination. Service providers are receiving training on the subject, and standard operating procedures have been updated to support implementation of the policies.

Jamaica, Nepal, Papua New Guinea, South Africa and Thailand are among the other countries that are now directing more concerted efforts at reducing HIV-related stigma and discrimination, and Côte d’Ivoire, Malawi and Uganda now have HIV-sensitive workplace policies. A model plan for action for western and central Africa has also facilitated the drafting and costing of action plans for reducing stigma and discrimination in six countries in that region.

The countries are: Angola, Argentina, the Central African Republic, the Democratic Republic of the Congo, the Gambia, Guinea, Jamaica, Kazakhstan, Kyrgyzstan, the Lao People’s Democratic Republic, Liberia, Nepal, the Republic of Moldova, Senegal, South Africa, Thailand, Ukraine and Uganda.

The countries are: Côte d’Ivoire, the Democratic Republic of the Congo, the Gambia, Guinea, Liberia and Senegal.
While decriminalization of HIV and key populations is the ultimate goal of civil society advocates, organizations across the Middle East and North Africa are using legal reform to address stigma and discrimination and change hearts and minds across the region.

In Lebanon, Soins Infirmiers et Développement Communautaire (SIDC), a nongovernmental organization dedicated to HIV prevention and care, has worked for 10 years to document human rights violations against people living with HIV and key populations in order to better respond to and understand the inequalities that drive the HIV epidemic. As part of its work, SIDC is now working to advance a comprehensive anti-discrimination law to enable a more inclusive, effective national HIV response in Lebanon.

SIDC’s efforts come at an important time. While Lebanon’s overall HIV prevalence is low, the HIV burden is high (12%) among gay men and other men who have sex with men. The country’s national HIV response is taking place after decades of political instability, recent popular protests and the collapse of the national currency. The poverty rate has also doubled since 2019, leaving more than 80% of the population living in poverty in 2021, and the influx of millions of refugees from Iraq, Palestine and the Syrian Arab Republic has placed further strains on the country’s health and social services.

Furthermore, stigma and discrimination against people living with HIV and key populations are embedded in Lebanon’s national laws and policies. Same-sex sexual relations are criminalized, as are sex work and drug use and possession. These laws, as well as the broader social stigma they reflect and reinforce, reduce service access for key populations.

While Lebanon’s civil society has mobilized and innovated to provide HIV prevention and testing services for key populations, SIDC is also advocating for policy change and legal reform. In 2020, it assembled a team of lawyers to map articles and laws within the Lebanese Constitution that contain or refer to discrimination on the basis of gender, age, race, religion, sexual orientation, gender identity, incarceration and refugee status. To draft an anti-discrimination law and build support for its enactment, SIDC then held a series of meetings and round tables with different groups, including civil society organizations, ministries, national bodies, lawyers, judges and activists.
The resulting draft legislation aims to eliminate all forms of discrimination. A parliamentarian has agreed to champion the legal reform initiative and to convert the draft anti-discrimination law into legislation to be presented to the cabinet. The proposed legislation will be introduced in a newly elected parliament at a time of growing support for progressive legal reform in the country, offering a potential window of opportunity to align the country’s HIV-related legal and policy framework with human rights principles.

SIDC’s progress thus far underscores the importance of linking discrimination against people living with HIV and key populations with other inequalities that community advocates are also working to address. “In order to combat discrimination, we cannot speak of one discrimination and leave the rest out—it has to be all inclusive,” said Nadia Badran, executive director of SIDC. Wide-ranging alliances across society and government that extend beyond the health sector to include such sectors as justice and education offer the best hope for achieving meaningful change.
JAMAICA TAKES ACTION TO ADDRESS HUMAN RIGHTS AND BARRIERS TO HIV

Momentum is growing for concrete action on societal enablers in the HIV response. In 2020, Jamaica became one of the first countries to join the Global Partnership for Action to Eliminate All Forms of HIV-related Stigma and Discrimination. Since then, a pioneering partnership between civil society, the State Minister of Health and Wellness and parliamentary leaders has worked at the country level to translate this commitment into concrete action.

The need to take evidence-informed action to address human rights and barriers to HIV and other health and social services in Jamaica is evident: although Jamaica’s overall adult HIV prevalence is 1.3%, more than half (51%) of transgender women and 30% of gay men and other men who have sex with men are living with HIV.

Stigma and discrimination also remain critical impediments to progress towards ending AIDS in Jamaica. Nearly half (48%) of people living with HIV report experiencing stigma and discrimination due to their HIV status; 38% indicate they have delayed testing and 30% have delayed treatment initiation due to fear of stigma and discrimination (34). According to surveys, 83% of transgender women and 65% of gay men and other men who have sex with men experienced verbal abuse in the prior 12 months, with nearly half of transgender women experiencing physical violence (34). “The fear of stigma drives some persons underground and away from much-needed health services,” said Juliet Cuthbert Flynn, State Minister in the Ministry of Health and Wellness.

The Jamaica Partnership works to optimize coordination, coherence and accountability among governmental and nongovernmental actors and international development partners. Its goal is to remove sociopolitical, cultural and other barriers to an effective response. To accomplish this, the Partnership developed an operational plan, human rights scorecards for all stakeholders in the national response, annual reports, mid-term and end-of-year reports about the scorecard results, and an online reporting dashboard for results accountability.

To translate its vision into concrete actions to eliminate stigma and discrimination, the Partnership is focusing on building political support for necessary reforms. More than 140 people have been trained on how to engage political actors and build multistakeholder alliances. The Partnership has also held 11 meetings with political actors and influencers at the national and local levels with the aim of cultivating champions for ending AIDS and combating stigma and discrimination.
A high-level parliamentary meeting, facilitated by the State Minister in the Ministry of Health and Wellness and the Opposition Spokesperson on Health, resulted in an agreement to establish a bipartisan parliamentary caucus to address HIV-related stigma and discrimination. Having committed to periodically review data on stigma and discrimination, the parliamentary working group has agreed to develop and support protective legislation on same-sex sexual relations and sex work. The working group has also agreed to challenge harmful laws and host dialogues with people living with HIV and affected communities.

“The enhancement of people’s rights and collective efforts to ensure that every Jamaican can live a life free from stigma, discrimination and violence is not an issue of only one person, one entity or one political party,” said Morais Guy, Opposition Spokesperson on Health. “It is the business of all of us to work in partnership for the dignity of all Jamaicans.”
“GENDER-BLIND” PROGRAMMES ARE NOT WORKING

Despite advances towards gender equality in most regions, discrimination against women and girls in all their diversity still exists everywhere, harming their health and well-being and exposing them to heightened risk of HIV infection. In many societies, prevailing harmful gender norms also vilify sexual minorities and fuel the stigma and discrimination and violence directed at lesbian, gay, bisexual, transgender and intersex (LGBTI) communities.

Discriminatory laws and practices, harmful gender norms and pervasive gender inequalities diminish the autonomy of women and LGBTI individuals, expose them to violence, deny them control over their sexual and reproductive lives, and restrict their access to HIV and other services that can protect their health. These factors help stoke excessive HIV risks for women and adolescent girls, as seen in sub-Saharan Africa, and for young LGBTI people around the world.

Human rights, including sexual and reproductive health and rights, must be upheld.

Human rights, including sexual and reproductive health and rights (SRHR), must be upheld. Laws and policies that undermine public health and discriminate on the grounds of gender and sexuality should be replaced with ones that promote equality. That includes laws that require the consent of parents or legal guardians for women and adolescents to access HIV and other sexual and reproductive health services. Awareness-raising, community mobilization, legal literacy and access to justice should accompany these legislative changes—and those actions also need to reach and benefit women from key populations.

Social norms that perpetuate gender inequalities are not fixed: they can be challenged and changed, and gender-transformative programmes that prove successful at doing so should be implemented at a scale that can have societal impact. Even on a limited scale, some of these interventions are proving effective at reducing gender-based violence, promoting dialogue and shared decision-making around safer sex practices, and increasing uptake of HIV services for both women and men (35–40). Ultimately, however, HIV programmes and services too often remain gender-blind: much more can and must be done to bring gender inequality and gender justice to the fore in HIV responses, and to engage men and boys in those efforts. That requires strengthening and investing in women-led organizations and ensuring that they are meaningfully involved in shaping, implementing and monitoring HIV programmes.
IN DANGER

SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS ARE NOT A PRIVILEGE

The ability to freely make decisions about one’s sexual and reproductive health is at the heart of the empowerment of women, and it is central to their prospects for living healthy lives and avoiding HIV. Despite this, millions of women and adolescent girls miss out on sexual and reproductive health services. As a result, an estimated 257 million women and adolescent girls (aged 15 to 49 years) globally who want to avoid pregnancy are not using modern methods of contraception. A 2019 study of data from 47 countries found that about 40% of sexually active women wishing to avoid pregnancy were not using any contraceptive methods, and the United Nations Population Fund (UNFPA) estimates that approximately 121 million unintended pregnancies occur globally each year.

This is not just a matter of absent or insufficient services: women and girls are frequently prevented from making their own decisions about sexual relations, contraceptive use and health-care needs. Women from key populations are especially affected, including when they are seeking health care. Data from 57 countries (the majority of them in sub-Saharan Africa) show that a little more than half (55%) of women aged 15 to 49 years who were married or with a partner made their own decisions about their sexual and reproductive health. Some countries still codify such restrictions: seven require spousal consent for married women to access any sexual and reproductive health services, and five require spousal consent for married women to take an HIV test.

Other inequities harden those constraints: Demographic and Health Survey data for 2017–2021 from 22 countries across five regions indicate that decision-making power about their own health care tends to be weakest among women and girls with the least education and in the lowest wealth quintile. Adolescent girls and young women tend to have the least control: they experience barriers that include laws that require parental or guardian consent for access to HIV or sexual and reproductive health services, stigmatizing attitudes towards sexually active adolescents and services that are tailored to the needs of married women.

In its 2021 report, the Independent High-Level Commission on the Nairobi Summit on ICPD25 Follow-up lamented a “moral and political failure ... [that was] evident in eroding services, lost financing and diminishing political accountability for sexual and reproductive health and rights.”

12 Sexual and reproductive health services encompass comprehensive sexuality education, contraception, family planning, antenatal and safe delivery care, post-natal care, services to prevent STIs (including HIV), and services aimed at preventive screening, diagnosis and treatment of reproductive health illnesses, including breast and cervical cancer.

13 The countries requiring spousal consent for married women to access any sexual and reproductive health services are Afghanistan, Botswana, China, Cuba, Eswatini, Kuwait and Lithuania. The countries requiring spousal consent for married women to take an HIV test are Afghanistan, Botswana, Cuba, Honduras and Poland.

The mistreatment and rights violations experienced by women living with HIV in health-care settings—including forced sterilization and coercive contraceptive practices—also must end. Chile’s public acknowledgment in May 2022 of international responsibility for sterilizing women living with HIV without their consent has set an important precedent (48).

Evidence from sub-Saharan Africa shows that removing or relaxing laws that require parental consent prior to HIV testing improves the health-seeking behaviours of adolescents and young people (49). Countries that have recently revised their laws or policies to make it easier for adolescents to access HIV testing and other HIV services include the Lao People’s Democratic Republic, Myanmar, Nepal, New Zealand, Papua New Guinea, the Philippines, Sri Lanka, Thailand and Viet Nam (50, 51).

Programmes can and should meet the diverse needs of adolescent girls and young women, including those living with HIV and/or belonging to key populations (47). Community-led interventions can have a huge impact, as seen when the Ashodaya Samithi ran integrated HIV and sexual and reproductive health services for sex workers in Mysore, South India (52). Community-driven monitoring that is linked to complaint and redress mechanisms can also enable women and girls to hold health-care providers accountable for the services they provide or withhold.

Access can be improved further by integrating and linking SRHR, HIV and gender-based violence services, offering them at drop-in centres, using community outreach and peer support, and taking advantage of mobile phone technologies and social media platforms (53). SRHR services that are more adolescent-responsive and youth-friendly, adopt sex-affirmative (or sex-positive) approaches, and are provided in supportive and nonjudgmental ways are more likely to be accessed and used. They are also more effective: a recent meta-analysis of studies found that sex-affirmative and pleasure-centred approaches in condom programmes contributed to reductions in HIV and other STIs (54–56).

Inequalities skew women’s access to sexual and reproductive health services. Poorer women and those in rural areas tend to have the least access to contraceptive information and services (Figures 3.1 and 3.2) (57). Research reviews show that the unmet need for family planning, maternal health and other sexual and reproductive health services is especially high among female key populations, including sex workers and women who inject drugs (58). Criminalizing laws, stigma and discrimination in health-care settings, and economic hardship restrict their access to services and undermine their ability to safely pursue their reproductive intentions (53).

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15 The proportion of sex workers using any sexual and reproductive health service in the previous year doubled to 51%, uptake of cervical cancer screening and treatment increased significantly from 12% to 56%, and HIV testing in the previous three months increased from 26% to 73%.
FIGURE 3.1 Percentage of currently married women aged 15 to 49 years who are using a contraceptive method and make their own decisions regarding sexual relations, contraceptive use and their own health care, by wealth quintile, countries with available data, 2017–2021

FIGURE 3.2 Percentage of currently married women aged 15 to 49 years who are using a contraceptive method and who make their own decisions regarding sexual relations, contraceptive use and health care, by place of residence, countries with available data, 2017–2021


Analysis done by UNFPA shows that countries and territories with higher levels of gender inequality, as measured by the United Nation Development Programme (UNDP) Gender Inequality Index, had higher rates of unintended pregnancy in 2015–2019 (Figure 3.3). Irrespective of the country income group, gender inequality stood out as the strongest predictor of unintended pregnancy. Programmes that seek to broaden and strengthen women’s access to SRHR services have to confront and change these underlying inequalities.
**FIGURE 3.3** Correlation between unintended pregnancy rate, 2015–2019, and gender inequality index, 2019

Gender-based violence continues to be a global crisis. Analysis by the World Health Organization (WHO) shows that an estimated 736 million women and adolescent girls aged 15 years and older in 2018 had experienced physical or sexual violence from an intimate partner and/or a non-intimate partner at least once in their lifetime (59).

Women living with HIV and those belonging to key populations and gender-diverse communities face even higher risks of violence. According to one estimate, 45–75% of adult female sex workers have experienced physical and/or sexual workplace violence (59). Repressive policing practices are estimated to increase sex workers’ risks of physical or sexual violence threefold and to increase their risk of contracting HIV or other STIs twofold (7). Transgender women and women who inject drugs also report high rates of physical violence, especially from partners, but also at the hands of law enforcement officials (61–63). In studies from sub-Saharan Africa, HIV-positive women were found to be at considerable risk of violence from their male partners after disclosing their HIV status (61). Another review of 14 studies from sub-Saharan Africa found that between 18% and 63% of women living with HIV had experienced intimate partner violence during pregnancy (65). Physical, sexual and other forms of violence against LGBTI persons, including conflict-related sexual violence, also remain consistently high in many parts of the world, although they are often underreported (66–70).

Violence and the fear of violence stoke the excessive HIV and other health risks experienced by many women and girls, especially those from marginalized communities (71). It can block their attempts to negotiate condom use and hinder their ability to access HIV and other health services, including taking pre-exposure prophylaxis (PrEP), testing for HIV, being linked to HIV care, starting and adhering to antiretroviral therapy, and achieving viral suppression (72–77). Many women also avoid disclosing their HIV-positive status to their partners or family members for fear of possible violence (71, 75, 78). Abuse during pregnancy makes it less likely that women will seek HIV testing or services to prevent vertical transmission to their newborns (65, 79). Men who are perpetrators of violence against women also tend to be at higher risk of transmitting or acquiring HIV themselves, as shown in studies from Cameroon and Nepal (80, 81).
Interventions to reduce gender-based violence and tackle its linkages with HIV must be prioritized and integrated into national HIV responses, with accompanying budget allocations (3). Countries have a long way to go; states are directing insufficient resources and efforts at the problem. A WHO study published in 2021 found that less than half (42%) of 153 countries were allocating funding to policies that address violence against women (82).16 It is estimated that less than 1% of total global overseas development assistance goes to violence against women programmes (83).

Despite this, there are ample actions and multisectoral approaches that can shift the unequal power relations that underpin violence, protect people at risk of violence and support survivors. They should be made integral to the HIV response (84–86). An important component of such an approach involves investing in the prevention of violence against and among children and adolescent girls and boys, including through education (87). In addition, efforts to shift attitudes about gender-based violence need to start early: in many countries, younger generations are just as likely as their parents’ generation to justify violence against women (88–89). Demographic and Health Survey data from 24 countries for 2017–2021 show that at least 40% of young men and women (aged 15–24 years) in 11 of those countries said a husband was justified in physically assaulting his wife in certain circumstances (43).

Schools and other places of learning have to ensure safe conditions and provide education that promotes zero tolerance for gender-based violence and fosters equitable gender norms.

Good practices for gender-transformative and empowering interventions exist and should be implemented on a much greater scale—and with increased investment—in order to reduce HIV and violence against women (39, 90–92). Interventions that are tailored to the needs of adolescents—and those aimed at the social and economic empowerment of women—need greater attention and support, as do group education and community mobilization aimed at transforming harmful gender norms and practices (93). Approaches that are community-led and bundle together different interventions tend to be more successful at countering gender-based violence (94, 95). Organized social support and referrals for safety, counselling and seeking legal redress—as well as broader social protections—are all vital elements of a meaningful response. Health-care providers need the training and resources to respond appropriately, as do law enforcement officials (94, 96, 97).

Ultimately, much greater accountability is needed. Failure to hold perpetrators accountable, poor reporting mechanisms, reluctance to prioritize gender-based violence as a human rights issue and insufficient effort to tackle the problem in a systematic manner create a culture of impunity that allows the violence to continue (98).

16 For countries outside the Americas, the data were for 2018–2019; for those in the Americas, the data were for 2020.
IMPACT OF COVID-19 ON GIRLS AND WOMEN IN NIGERIA AND SOUTH AFRICA

Reports of the surge in gender-based violence during the COVID-19 pandemic due to increased isolation from social and economic protective networks and greater social and economic stress warned of the risk that it posed to decades of hard-fought gains for women’s rights and well-being.

In 2021, UNAIDS joined with community-based organizations and research partners to undertake cross-sectional surveys of girls and women living with or at risk of HIV in Nigeria and South Africa to gauge the COVID-19 pandemic’s impact on their lives. Participants were recruited from June to December 2021 using a combination of venue-based and snowball convenience sampling methods.1 In Nigeria, researchers surveyed 4541 women and girls over the age of 15 years in 10 states with a high burden of HIV; 62% were under the age of 30, and 47% were living with HIV. In South Africa, 2812 women and girls over the age of 15 years from four high HIV burden provinces participated, including 61% under the age of 30 and 45% who were living with HIV.

A third (30%) of the 6689 women and girls reported experiencing gender-based violence since the start of the COVID-19 pandemic, with adolescent girls and women living with HIV being more exposed to violence (Figure 3.3). Thirteen per cent of the 6689 respondents reported facing more violence than before the COVID-19 pandemic. Compared to older women, adolescent girls and young women (aged 15 to 24 years) were consistently more likely to have experienced each form of violence or abuse studied: physical and sexual violence or emotional and economic abuse from intimate partners, or non-intimate partner sexual violence.

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1 The study population included consenting women aged >15 years old who self-reported living with HIV or who were at high risk of HIV and from key and vulnerable groups. This included adolescent girls and young women (defined as those aged 15 to 24 years), sex workers (defined as women engaged in commercial sex work), LGBTI women (women self-identifying as having sex with women exclusively, having sex with women and men, having non-heterosexual sexual orientations or being transgender), people on the move (defined as migrants, refugees, asylum seekers, returning migrants and displaced people), women with disabilities (defined as a person who has long-term physical or sensory impairments) and women who use drugs (defined for this study as women injecting or using illegal drugs).
FIGURE 3.3 Percentage of the study population who reported having experienced gender-based violence since the start of the COVID-19 pandemic, by HIV status


Note: Respondents \((n = 5922)\); missing \((n = 452)\). Data collected between June and December 2021 in Nigeria and South Africa.

FIGURE 3.4 Association of gender-based violence with other characteristics in the study population, by country


Note: Nigerian participants = 2413. Data collected between June and October 2021 in 10 states in Nigeria. South African participants = 1290. Data collected between September and December 2021 in Eastern Cape, Gauteng, KwaZulu Natal and Western Cape.
The study found that girls and women living with HIV were more likely than HIV-negative girls and women to experience gender-based violence. Furthermore, victims of gender-based violence in both Nigeria and South Africa are respectively more than two (aOR 2.12; 95% CI: 1.56–2.88) and three (aOR 3.31; 95% CI: 1.97–5.58) times more likely to report severe symptoms of depression and anxiety than those who are not victims of violence. Those on the move and those engaging in sex work have the highest odds of experiencing gender-based violence (Figure 3.4).

Since the start of the COVID-19 pandemic, more women (10% in Nigeria and 15% in South Africa) reported using sex work or transactional sex to sustain their livelihoods, and 9% of sex workers in Nigeria and 5% in South Africa had started engaging in more frequent condomless sex. Women who sell or trade sex reported experiencing a substantial drop in income (53% in Nigeria and 38% in South Africa) since the start of the pandemic.

Finally, the surveys showed that, compared to HIV-negative adolescent girls and young women, adolescent girls and young women living with HIV were more likely to eat less or skip meals since the start of the COVID-19 pandemic because there was insufficient money for food. They were also more likely to have received a special COVID-19 relief grant or other support measures. Nevertheless, these COVID-19 special support measures only reached 4% and 10% of those adolescent girls and young women living with HIV who had to eat less or skip meals in Nigeria and South Africa, respectively.

Adolescent girls and young women living with HIV were more likely to eat less or skip meals since the start of the COVID-19 pandemic.

The negative social and economic effects of the COVID-19 pandemic—including the worsening gender-based violence—are particularly felt among the most marginalized members of society. More feminist interventions to address these harms must be designed and implemented in collaboration with sex worker-led groups and women’s organizations and those for people living with HIV.

The findings from this cross-sectional survey provide some preliminary insights into how the COVID-19 pandemic may have exacerbated pre-existing vulnerability among women at high risk of HIV and those living with HIV in vulnerable populations. The ecological approach highlighted that it is not necessarily single factors, but rather how multiple factors intersect, that served to exacerbate vulnerability. Traditional risk factors such as age, the experience of gender-based violence, social status, poverty and household resilience worked together with restrictions in movement, lockdowns and the resulting economic shock to enhance the risk of already at-risk women in key and vulnerable groups. These intersections of risk need to be better understood and studied to design more resilient and responsive public health interventions for future pandemics.
Every child has the right to complete their schooling and have a quality education. When this right is upheld, it reduces poverty, improves health outcomes and stimulates social and economic development. The effects are especially strong for girls: their lifetime earnings rise, inequalities are reduced and social inclusion is strengthened (99–101). Their risk of acquiring HIV and other STIs is also reduced, as studies from India and southern Africa show (102–110). When Botswana extended mandatory secondary education, for instance, it found that each additional year of schooling after Year 9 was associated with a 12% reduction in girls’ risks of acquiring HIV (108).

Despite this, one in three adolescent girls (aged 10 to 19 years) from the poorest households around the world have never been to school (109). Poverty, gender discrimination, political conflict and humanitarian crises are the main factors keeping children out of school (110).

Barriers to girls’ education must be removed. The Education Plus initiative—convened by the United Nations Children’s Fund (UNICEF), UNFPA, the United Nations Entity for Gender Equality and the Empowerment of Women (UN Women), the United Nations Educational, Scientific and Cultural Organization (UNESCO) and UNAIDS—was launched in 2021 to ensure that all adolescent girls and young women in sub-Saharan Africa can access quality secondary education alongside vital education, socioeconomic opportunities and health services. The initiative is using high-level political advocacy to empower adolescent girls and young women and advance gender equality in sub-Saharan Africa—with secondary school education as a strategic entry point. It is also helping to mobilize coalitions and networks on a wide scale, including at the community level, to involve women’s, youth and civil society organizations, networks of women and girls living with HIV, teacher and parent associations, and cultural and faith leaders, and to bring them together around a common goal.
EARLIER GAINS ARE UNDER THREAT AGAIN

Prior to COVID-19, the past 20 years saw the number of girls not enrolled in school drop by 79 million globally. This was a result of decades of efforts to get more girls into the classroom and to narrow the gender gap in education access (111).

Despite this progress, girls still outnumbered boys among school-age children who were not attending primary school (32.3 million versus 26.8 million globally), their completion rates were lower and they were more likely than boys to be permanently excluded from education (111). In sub-Saharan Africa, about 38% of girls and 35% of boys of secondary school age were out of school in 2018, and in most of western and central Africa, both primary or secondary school-aged girls were more likely than boys to be out of school (112, 113). In addition, the quality of girls’ education in many countries still suffers due to discrimination they experience in their schools and communities (111).

The COVID-19 pandemic is making it even more difficult for girls to attend and stay in school. By late-2021, COVID-19-related school closures had affected more than 1.6 billion learners worldwide, according to UNICEF estimates. Country-level assessments (from Italy, Mexico, Pakistan and South Africa, for example) suggest that learning losses have been heavier for girls than boys (114). The pandemic threatens to reverse the gains of the past two decades, leaving an estimated 20 million more secondary school-aged girls out of school in developing countries (most of them in Africa) after the COVID-19 crisis has passed (115).

Education Plus urges governments to provide a free universal secondary education package for girls and boys that empowers adolescent girls and young women. The initiative emphasizes universal access to comprehensive sexuality education, fulfillment of SRHR, freedom from gender-based and sexual violence, school-to-work transitions, and economic security and empowerment for women. Twelve countries have committed at the highest political levels to implement the initiative: Benin, Cameroon, Gabon, the Gambia, Lesotho, Malawi, Senegal, Sierra Leone, South Africa, Uganda and Zambia. Some have already taken concrete action (see the Education Plus feature story in this Chapter), and investment cases are being prepared in Benin, Cameroon, Lesotho and Sierra Leone. Policy frameworks are also being developed in South Africa (on preventing pregnancies among learners and supporting school retention policies and arrangements for pregnant girls), Lesotho (on retaining learners in school), and Malawi and Sierra Leone (sector-wide strategies).
Education Plus is helping drive important changes in Africa. Sierra Leone, one of the first countries to join the initiative, is introducing free education in primary and secondary schools to help achieve gender parity. Its radical inclusion policy ensures that pregnant learners continue to access their education with the additional provision of social support services. A comprehensive sexuality education curriculum for junior secondary schools has been developed and schools are also being made more accessible, such as by installing ramps and providing other aids for learners with disabilities. A science, technology, engineering and mathematics scholarship scheme has also been introduced to enhance girls’ participation in science and industry.

Furthermore, the Education and Health ministries have developed a new school health strategy and operational plan to guide the delivery of school health services, including sexual and reproductive health services. Both ministries are working with the Ministry of Youth to ensure youth-friendly services are readily available at youth centres. In addition, the objectives of Education Plus have been integrated into Sierra Leone’s Education Sector Plan.

In Cameroon, only 49% of school-age girls were attending secondary school in 2019, and school drop-out rates were high, partly due to poverty, high numbers of early and unplanned pregnancies, and early marriage. The Government of Cameroon is now coordinating education-focused activities across 10 ministries, and it is working with more than 70 civil society organizations to identify and plan priority changes. A new policy on managing pregnant learners has just been instituted to ensure that pregnant girls have access to school and layered multisectoral support.

In Benin, a committee of eight ministries is steering its Education Plus drive, and the Government has approved a set of activities that address the initiative’s main priorities. Free secondary education is a key objective, and the Government is examining the necessary legal and policy reforms, while UN agencies are helping it secure donor support to make this a reality.

Lesotho is preparing a school retention policy to keep learners in school, and it has begun a process to help girls return to school after the COVID-19-related closures in 2020–2021. A campaign has been launched to build support for free secondary education, backed by an investment case.

1 The core focus areas for Education Plus are: completion of quality secondary education; universal access to comprehensive sexuality education; fulfillment of SRHR; freedom from gender-based and sexual violence; successful school-to-work transitions; and economic security and empowerment for young women.
EDUCATION PLUS INITIATIVE
South Africa has launched a policy to prevent pregnancy among young girls and retain and support pregnant learners, while also connecting them to the necessary social protection and psychosocial support as part of efforts to reduce gender disparities in education.

“It is essential for girls to learn how to take care of themselves, but also to be given all the means necessary to do so,” says Ketcha Pertulla Ezigha, founder of Leap Girl Africa. “Knowledge and empowerment are crucial for protecting young girls and adolescents from dropping out of school, abuse and infectious diseases such as HIV.”
Even though an estimated 1 billion people (15% of the world’s population) have a disability, people with disabilities have been overlooked in many HIV responses (116). Data from sub-Saharan Africa suggest that the risk of HIV infection may be up to 1.5 times greater in men and 2.2 times greater in women with disabilities compared with people without disabilities (117).

That elevated risk is linked to several factors, as shown in studies from Burundi, Ethiopia and South Africa (118–120). Discrimination and the general neglect of the needs of people with disabilities can compromise their knowledge about HIV, limit their access to HIV and sexual and reproductive health services, and affect the quality of the care they receive (121, 122). Other factors affect their access to services, including the physical inaccessibility of services, incorrect assumptions that people with disabilities are not sexually active, and a lack of skills among health-care providers for serving and communicating with people with disabilities. A dearth of disaggregated data, poor governance and lack of financing are prolonging this situation (116, 122–125).

Consequently, studies suggest that people with disabilities are about 10% less likely to know their HIV status and receive antiretroviral therapy than people without disabilities (116, 126). Treatment adherence also tends to be low among people living with HIV and disabilities, and studies from the United States have found elevated AIDS-related mortality rates among this population (116, 127–129). It will be difficult to achieve the HIV testing and treatment targets without the full inclusion of people with disabilities (116).

Although it is late in coming, there is a growing recognition of the importance of including disability in a comprehensive HIV responsive. Fourteen of 18 national HIV strategic plans in eastern and southern Africa, for example, currently identify people with disabilities as a marginalized population that faces high risk of HIV infection, and national surveys and surveillance studies are beginning to collect disability-disaggregated data. The South African national strategic plan, in particular, is highly disability-inclusive and can serve as an example for other countries (130, 131). Civil society organizations can also promote inclusion by ensuring that people with disabilities are represented in the development of national strategic plans and in country coordinating mechanisms of the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund). Inclusive delivery of comprehensive sexuality education (such as in the Breaking the Silence approach in South Africa) and training on disabilities for health-care workers can help reduce vulnerability and risk (132, 133). In addition, HIV programmes should strengthen links with rehabilitation services so that people living with HIV and disabilities can thrive (116).

17 The United Nations Convention on the Rights of Persons with Disabilities requires countries to safeguard the rights of people with disabilities to participate and be included in all spheres of life. This includes the right to access health services.
BREAKING DOWN BARRIERS TO HIV AND SRHR SERVICES FOR PEOPLE WITH DISABILITIES IN KENYA

One billion people, or 15% of the global population, have one or more disabilities (117). In many parts of the world, their needs are often not fully taken into account within HIV and health service delivery, resulting in barriers to service access that include inaccessible facilities, a lack of services tailored to their needs and stigmatizing attitudes among healthcare workers (118).

Meeting the sexual and reproductive health needs of women with disabilities is an especially serious deficit. That is why the This Ability Trust, a women-led non-profit in Kenya dedicated to advancing the rights and inclusion of women and girls with disabilities, is working to ensure that these groups are not left behind when it comes to HIV and SRHR.

A recent survey by This Ability found that 53% of health-care workers do not prioritize the sexual and reproductive health needs of women with disabilities. “Society thinks that women with disabilities are not sexually active, and [it] leaves them out of information and health care,” said Anne Wanjiru, a disability activist from the coastal city of Mombasa. “Poverty compounds the problem. The consequence is that many women make wrong decisions concerning their sexual and reproductive health—or, rather, decisions on their sexuality are made for them without their consent.”

This Ability’s survey found that most health facilities had infrastructure that was inaccessible to women with disabilities, and only 20% of surveyed providers said that disability-related sessions had been integrated into pre-service training for medical and non-medical staff.

This Ability, however, did more than document the problem. With the support of UNFPA, it is working to close critical service gaps for women with disabilities.

Hesabika, a mobile platform developed by This Ability, sends information on sexual health, HIV, gender-based violence and COVID-19 twice a week in Kiswahili and English to more than 17,000 people. In 2021, during the 16 days of Activism on Violence against Women, This Ability also coordinated a five-day art festival focused on disability, sexuality and bodily autonomy. Finally, This Ability has used SKILLS, an e-learning platform, to train 90 health-care workers from nine counties on SRHR of women with disabilities.
Alongside these activities, This Ability operates a toll-free call-in line in eight of Kenya’s 47 counties. Through these call-in lines, eight women with disabilities, known as “Mama Siris” (after the word “Siri” in Kiswahili, which means “secret”), have provided information and advice on sexual health, HIV and gender-based violence to more than 8000 callers since the programme’s launch in 2020.

The call-in programme not only serves as an essential source of information and support for women with disabilities, but it has also empowered the Mama Siris themselves. “The change in the Mama Siris is amazing,” said Lizzie Kiama, founder and managing trustee for This Ability Trust. “Their skills and confidence have grown, they have acquired legitimacy in their communities and grown their leadership skills—to the point that several are considering running for local office in the next elections.”

These community-centred initiatives now need to be complemented by broader reforms. Tangible improvements are needed in health infrastructure, the type of health information available to women with disabilities, and the attitudes of health-care workers about HIV and SRHR for people with disabilities.
REFERENCES


32. Looking out for adolescents and youth from key populations: formative assessment on the needs of adolescents and youth at risk of HIV—case studies from Indonesia, the Philippines, Thailand and Viet Nam. Bangkok: UNICEF East Asia and Pacific Regional Office; 2019.


