**Submission**


**Consultation on Human Rights in the HIV Response:**
**Regional and Subregional Strategies and Best Practices**
**12 – 13 February 2019, Geneva**


**This submission is made on behalf of global networks of people living with HIV (GNP+), gay men and other men who have sex with men (MPact Global Action for Gay Men's Health and Rights), sex workers (the Global Network of Sex Workers-led Organisations and Networks), people who use drugs (International Network of People who Use Drugs), and allied HIV civil society organizations (the International Council of AIDS Services Organizations, Aidsfonds, the World Council of Churches-Ecumenical Advocacy Alliance, and Frontline AIDS) and as part of the Free Space Process Collaborative and with the support from PITCH[1] program and LM Davis, International Consultant. It relates to the *Consultation on Human Rights in the HIV Response: Regional and Subregional Strategies and Best Practices*.[2]**

This submission focuses on three issues: A) how widespread and systematic discrimination in fulfilment of human rights for PLHIV and key populations undermines the expansion of Universal Health Coverage (UHC); B) human rights responsibilities of donors in "transition"; and C) the important role of UPR review for accountability in the HIV response.

### A) Challenges in Expanding Universal Health Coverage for Key Populations

In recent years, the focus on particular diseases has been shifting towards reaching the goal of addressing all health needs under the goal of universal health coverage (UHC),[3] prominently featured in the Sustainable Development Goals (SDGs) adopted in 2015.[4] The World Health Organization (WHO) defines UHC as coverage where all people and communities can use effective preventive, curative, and other much-needed health services without exposure to financial hardship.[5] States are moving to strengthen domestic health financing and to expand Universal Health Coverage (UHC). We welcome this move to accelerate progressive realization of the right to highest attainable standard of health.[6] However, with the integration of HIV programming under a larger umbrella of UHC come persistent challenges for populations that have experienced widespread discrimination in fulfillment of their economic, social, civil and political rights. Unless states take specific measures, the move to expand UHC will undermine global progress towards the end of HIV.

*Discrimination, criminalization and violence* - The WHO *Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations* define key populations as including people living with HIV, men who have sex with men, people who inject drugs, sex workers, transgender people, and people in prisons and other closed settings.[7] WHO notes that "punitive legislation and policing practices, stigma and discrimination, poverty, violence and high levels of homelessness in some sub-populations" all impede their access to health services and increase their vulnerability to the epidemic.[8] To address this, WHO recommends that states decriminalize sex work, same-sex sexuality and drug use. It also recommends funding a package of interventions to specifically reach key populations.[9] The Human Rights Committee, Committee on Economic, Social, and Cultural Rights (CESCR) and Committee on the Elimination of all forms of Discrimination Against Women (CEDAW) have called for decriminalization of discriminatory laws and practices that punish individuals based on their sexual orientation and gender identity.[10] In 2017, Human Rights Council Resolution 36

explicitly condemned imposition of the death penalty for same-sex sexual behavior.[11] The Special Rapporteur on the Right to Health has called for states to decriminalize drug use and sex work.[12]

However, criminalization of key populations remains widespread. Over 70 countries criminalize consensual same-sex behavior.[13] Trans people are criminalized and prosecuted in 57 countries.[14] Sex work, drug use and possession of drugs are also criminalized by a majority of countries.[15] Criminalization is linked to police abuse, including sexual violence and extortion of bribes. Numerous studies have demonstrated that fear of seeking health care due to criminalization is a formidable barrier to seeking HIV services.[16] Criminalization of HIV non-disclosure, exposure, and transmission also severely undermines the HIV response: arrests and related sensationalized media coverage spread false information—e.g, that an HIV diagnosis is a death sentence, or that any person living with HIV (regardless of viral load) will transmit the virus.[17]

Furthermore, related discrimination against people living with HIV and key populations is widely documented by national and regional networks of key populations within employment, housing, education and health. Health sector discrimination can include denial of services by medical providers, changes of treatment, imposition of additional fees, forced discharge, segregation or quarantine, denial of child birth information, forced sterilization, breach of privacy, and public humiliation.[18] Across 19 countries, one in five PLHIV report being denied health care.[19]

Some key populations additionally face the use of torture in the name of treatment. In 2012, twelve UN agencies called for the closure of compulsory drug detention and rehabilitation centers.[20] However, hundreds of thousands of people are still detained in such facilities.[21,22] PAHO has similarly warned against services purporting to "cure" homosexuality.[23] Other forms of compulsory treatment include forced sterilization of women and transgender people, forced anal exams, and intersex genital mutilation.[24] In 2014, the Global Fund to Fight AIDS, TB and Malaria adopted a policy on not funding compulsory treatment programs or facilities.[25]

These diverse and pervasive forms of criminalization and discrimination combine to create high rates of violence against key populations, including torture, sexual violence, intimate partner violence, assault, murder and in some countries, extrajudicial execution by police.[26]

*Right to participation* - Over the past decades, inclusive multi-stakeholder governance mechanisms were established for global and national HIV programming and financing, making the HIV sector more democratic and transparent than many other areas of economic and social rights. The move to integrate HIV programming into mainstream health programming could roll back these significant gains. At the international level, both UNAIDS and the Global Fund governance boards include representatives of PLHIV and key populations, as do national Country Coordinating Mechanisms; and at every level, consultations and convenings on HIV planning routinely include representatives of PLHIV and key populations. With the shift to integrate HIV governance into UHC, these may be replaced with less inclusive and transparent mechanisms and processes. While Human Rights Council Resolution 38 called for greater participation by civil society in national planning, a study of four countries found that many community leaders lacked basic information on the processes.[27]

This may be especially challenging considering closing civic space in many countries. Key populations and PLHIV who advocate for their rights, including their right to participate in national and local health planning and resource allocation processes, also face discriminatory restrictions on their rights to freedom of association and expression.[28] Some states use "LGBT propaganda" laws to limit the right to freedom of association. [29] In a survey of 194 countries[30], only 56%, 109 countries, permit LGBTIQ organizations to legally register as LGBTIQ organizations. In just 28%, 55 countries, LGBTIQ organizations exist but they cannot legally register as LGBTIQ organizations. Other states refuse to

register organizations advocating for people who use drugs and/or sex workers, because these groups are criminalized. This impedes their ability to participate in planning, prioritizing, budgeting, implementation and evaluation of HIV services. Community-led HIV responses have proven essential to increase access to and quality of services, both by delivering services themselves, and by removing structural barriers to access for key populations (*See Annex*).

*Undermining global progress on HIV* -  The combined result of the discriminatory environment described above is that many national plans and budgets under-resource programs to reach key populations. For example, an assessment of 45 National Strategic Plans in Africa found that despite climbing HIV incidence among key populations, only 41 plans mentioned gay men and other men who have sex with men and only 10 referred to transgender people.[31] Many countries have failed to gather the epidemiological data they need to plan appropriately: numerous gaps in data on HIV among key populations persist.[32] While CEDAW and the Committee on the Rights of the Child (CRC) have called for states to increase funding for harm reduction, global coverage of essential harm reduction services for people who use drugs is critically low.[33] While the 2016 Political Declaration committed to ensuring that at least 30% of all HIV resources are invested in community-led HIV responses, UNAIDS finds no clear evidence that this is underway.[34]

African leaders gathered in February 2019 in Addis Ababa, in advance of the 32nd African Union Summit, to launch a new initiative aimed at accelerating progress towards UHC. According to WHO, African countries are increasing domestic investments in health with 35 out of 55 AU Member States having increased the percentage of their GDP invested in health. However, data from countries that criminalize same-sex sexual behavior demonstrate that they spend fewer resources on HIV services to reach men who have sex with men.[35]

As a result, UNAIDS reported in 2018 that the global HIV response is "at a precarious point."[36] While HIV has declined globally by 18%, it is not declining quickly enough to meet the SDG on health; in some locations, like Eastern Europe and Central Asia or Middle East and North Africa, incidence rates have plateaued or increased among key populations. Key populations account for almost half of new infections worldwide. Globally, "the risk of acquiring HIV is 13 times higher for female sex workers, 27 times higher among men who have sex with men, 23 times higher among people who inject drugs and 12 times higher for transgender women."[37] A simple scale-up of domestic resources for health alone will not reach key populations unless the broader challenges of criminalization, discrimination, and violence are tackled.

*Recommendations*
- States should invest maximum available resources to fulfill the right to health, increasing investments in evidence-based HIV prevention, including harm reduction, and in community-led HIV programs, as agreed in the 2016 UN Political Declaration.
- States should adopt measures to prevent HIV, including decriminalizing HIV non-disclosure, exposure, and transmission, all aspects of consensual adult sex work including clients and third parties, same-sex relations, gender expression, and drug use, and providing legal gender recognition to transgender people.
- States should invest in and implement comprehensive prevention interventions recommended by WHO that focus on gay men and other men who have sex with men, people who use drugs, sex workers, transgender people, and other groups that are vulnerable to HIV infection.
- States should identify concrete measures to combat social and cultural attitudes leading to discrimination, and to reduce discrimination and end violence against people living with HIV, gay men and other men who have sex with men, people who use drugs, sex workers, and transgender people in the public and private sectors.

- States should act immediately to end torture and other coercive practices in the name of treatment, including compulsory treatment of people who inject drugs, "conversation" therapy aiming to alter same-sex sexual behavior, forced sterilization of women and transgender people, forced anal exams, and intersex genital mutilation.
- States should refrain from the use of compulsory treatment for people who use drugs, sex workers, and lesbian, gay, bisexual and transgender people.
- States should uphold the rights to freedom of association, assembly and expression by people living with HIV, gay men and other men who have sex with men, people who use drugs, sex workers, and transgender people without discrimination, in accordance with the International Covenant on Civil and Political Rights.
- States should promote the participation of civil society and communities representing people living with HIV, gay men and other men who have sex with men, people who use drugs, sex workers, and transgender people at the highest levels in all health planning and decision-making processes that affect them.
- Future multilateral planning and financing mechanisms that are established for health should ensure that representatives of affected population are adequately represented in their governance boards.

## B) Human rights in development cooperation for health

The world has made significant progress in the fight against HIV in part due to a significant scale-up in global health financing. However, abrupt termination of donor support for key populations programming in some countries can result in retrogressive measures. States have a joint and individual responsibility to cooperate in financial assistance to fulfill the right to health.[38] Retrogressive measures, whether through commission or omission, constitute a violation of that right.[39]

In many countries that criminalize key populations, programs to address HIV among key populations were initiated with international funding. In recent years, donors have begun to terminate ODA to middle-income countries in order to focus investment in lower-income countries, where HIV burden is higher. While some middle-income countries do have the resources to finance their response, state reluctance to finance health services for criminalized and stigmatized key populations may result in abrupt closure of life-saving programs when donors divest, resulting in state retrogression on the right to health.

As a result, in some contexts where donors have divested, there is increased HIV incidence and mortality among key populations. Both donor and recipient states have legal obligations for these impacts. In no case should donors abruptly terminate support for health programs that lack confirmed alternative funding sources, if the closure of those programs could directly cause harm or death.

The gradual process of "transition," or donor divestment, may in other cases mean a slower demise of the community-led HIV response for PLHIV and key populations. In this process, the scope of community programs may gradually diminish, organizations may rely increasingly on volunteer time and resources, and their reach and impact will reduce: retrogression by omission.

Currently there is no international legal framework outlining obligations of health donors, though they may wield life-or-death power inregards to health. The *UN Framework on Business and Human Rights*, the "Ruggie Framework", sets out human rights standards that broadly include aid.[40] General Comment 14 encourages States parties to attend to human rights in their lending and financing

policies, without elaborating specifics.[41] Some donors have voluntarily accepted human rights obligations, such as the Global Fund; others, such as the World Bank, have been reluctant.[42]

The Robert Carr Fund for Civil Society Networks offers a good practice of direct funding of key populations and PLHIV networks, using a technically sound approach that prioritizes human rights principles and programming.[43] Similarly, the Evaluation's main conclusion of the Global Fund's Community Rights and Gender Special Initiative said that investment in communities brought significant value-added - being strategic and timely and filling an identified and urgent gap in the global TA/capacity building architecture. The Initiative – is responding to the specific need to strengthen the meaningful engagement of communities/civil society in the Global Fund's processes and to ensure the inclusion of technically sound Human rights related interventions in Concept Notes and grants.

*Recommendations*

- States should continue to strengthen their cooperation to pursue development programs that promote the right to health for people living with HIV and people vulnerable to HIV, including investing in services and advocacy by organizations that are directly led by those populations, including key populations.
- States should invest in national, regional, and international consortia that convene and are led by people living with and vulnerable to HIV, including key populations, and that coordinate advocacy for human rights.
- States, UN human rights mechanisms, WHO and UNAIDS should build on the *UN Framework on Business and Human Rights* to develop a set of clear guidelines and accountability measures for development cooperation on the right to health. These should clarify the respective responsibilities of donor and aid recipient states in the planning and implementation of both investment and divestment.

### C) Making UN Human Rights and Sustainable Development Implementation Reviews Work for HIV

Reporting by states to UN health and human rights mechanisms, including annual reporting of epidemiological data and expenditures on HIV programming, is essential to monitoring progress in fulfillment of the right to health.[44] States should routinely, annually report to UNAIDS on HIV, including among key populations, using the GAM reporting framework. This includes reporting on financing of the HIV response, using the National AIDS Spending Assessment (NASA). Currently, few countries report on all key populations, and fewer report on financing using the NASA. Having this data would substantially support the UN human rights mechanisms to ensure accountability and progressive realization of the right to health.

At the same time, welcoming this week's consultation by the UN Independent Expert on SOGI on issues relating to data and LGBT persons, we call on UN agencies to work together to develop clear guidance to member states and donors on protecting the right to privacy and informed consent for all as part of HIV data-gathering activities. This should include strong recommendations on the use of data that can identify individuals in contexts of stigma, discrimination and criminalization, such as biometric data; on respecting and protecting informed consent; and guidance on data-gathering partnerships with the private sector.

The Human Rights Council and treaty bodies should use this data in their peer review processes. They should ensure recommendations on HIV are legally sound and consistent with international standards. An assessment by PITCH and Bridging the Gaps, Making the Universal Periodic Review

[work for HIV](#), examines the inclusion of HIV-related issues in the two most recent UPR cycles, completed between 2006 and 2017. It finds that the UPR process is contributing to change at the national level, and helping to hold States parties accountable for addressing human rights related to HIV. It is recommended that UNAIDS work with the Human Rights Council to address gaps, for example by developing a checklist of issues and standards for use by treaty bodies in periodic reviews.

Among the findings, this submission highlights:

- Out of a total of 193 States reviewed, 129 (67%) raised HIV-related issues in their national reports, as compared to UN and civil society reports from 166 countries including HIV-related issues;
- Over eight years, 97 States under review received a total of 346 HIV-related recommendations. Of those 346 recommendations, 314 (91%) were accepted by States parties;
- A number of critical HIV-related human rights issues have not received adequate attention through the UPR process, such as criminalization of HIV non-disclosure, exposure, and transmission; and
- There was little focus on the human rights of key populations in the context of HIV.

With regard to the Sustainable Development Goals, HIV is now included within the broader Goal 3 on Health, which includes a specific agreed upon Indicator on HIV incidence by age, sex, and key populations in the 2030 Agenda. The Voluntary National Reviews are the main mechanism of review of national SDG implementation, but it is regrettable that even fewer VNRs in 2018 included any mention of HIV compared to 2017. Only 28 of the 46 reporting States covered HIV in 2018, and of those, only 12 reported any incidence data. A mere eight States mentioned key populations, with only five including disaggregated data on key populations, and no state VNR report mentioned trans people in the context of HIV.

Significantly more HIV data are available than suggested by the VNRs and UPR, and yet most Member States missed the opportunity to rely on these data in the 2030 Agenda framework and human rights mechanisms.

*Recommendations*
- States should report annually to UNAIDS on HIV epidemiological data, including among key populations, and on expenditures in the HIV response.
- States should take measures to develop and implement standards that protect the right to privacy and informed consent in all data-gathering activities for health.
- States should use the UPR and VNR processes to convene national multi-stakeholder dialogues and cooperative mechanisms that bring together government, civil society and representatives of gay men and other men who have sex with men, people who use drugs, sex workers, and transgender people to review progress and identify future actions.


# Conclusion

The Human Rights Council Consultation on Human Rights in the HIV Response provides an important opportunity to strengthen the global effort to reach the end of HIV by 2030, in line with the Sustainable Development Goals and the 2016 UN Political Declaration.[45] Ending AIDS as a public health threat by 2030 is only possible if all states respect, protect, and fulfill human rights.

States must increase their efforts to reach key populations vulnerable to HIV, including gay men and other men who have sex with men, people who use drugs, sex workers, transgender people, and people in prisons and other closed settings, who are systematically left behind due to historical discrimination, criminalization, and violence. Discriminatory restrictions on freedom of association and expression further impede the ability of PLHIV and key populations to participate in health planning and financing, to the detriment of the global response. As states roll out Universal Health Coverage (UHC), they must address the concerns above, or UHC will not reach the people who need it most.

The collaborative nature of HIV financing poses a challenge that the UN human rights system should address. Globally, important progress on HIV has been made due to an unprecedented mobilization of funding through overseas development aid (ODA). In numerous countries, ODA enabled health services for key populations to be established for the first time, preventing the spread of HIV and saving millions of lives. The UN human rights system should elaborate obligations for both ODA donors and recipients, to strengthen their mutual accountability for the HIV response.

Reporting by states to UN health and human rights mechanisms is essential to ensuring accountability. The UPR process has contributed in important ways, but our review of recommendations to date show that closer collaboration with UNAIDS can help to ensure UPR recommendations are legally sound, and consistent with international standards. Similarly, reporting on SDG implementation must include more robust coverage of HIV programming at the national level.

## About our networks and organisations

The partnerships below represent dozens of national and regional key populations networks, which are made up of civil society organizations led by sex workers; current and former people who use drugs; gay, bisexual and other men who have sex with men; people living with HIV; and transgender, intersex and non-binary people; as well as other HIV civil society organizations.

**The Free Space Process** comprises global HIV, civil society, and key and vulnerable population networks, including the Ecumenical Advocacy Alliance, Global Action for Trans Equality (GATE), MPACT, the Global Network of People Living with HIV (GNP+), the Global Network of Sex Workers-led Organisations and Networks (NSWP), HIV Young Leaders Fund, International Community of Women Living with HIV, the International Council of AIDS Service Organizations (ICASO), the International HIV/AIDS Alliance, the International Treatment Preparedness Coalition (ITPC), and the International Network of People who use Drugs (INPUD).

**The Partnership to Inspire, Transform and connect the HIV response (PITCH)** is a five year strategic partnership between Aidsfonds, the International HIV/AIDS Alliance, and the Dutch Ministry of Foreign Affairs, funded by the Dutch Ministry of Foreign Affairs as part of their "Dialogue and Dissent" development cooperation programme. It is focused on building the capacity of local civil society organisations (CSOs) to advocate for equal rights and access to services for key populations in Kenya, Uganda, Nigeria, Zimbabwe, Myanmar, Indonesia, Ukraine, Mozambique and Vietnam..

# Annex - Impact of community responses for health

There are a growing number of evidence-based examples of the concrete and significant impact of community responses. These extend across all of the SDGs – not only Goal 3, but others, such as Goals 1 (no poverty), 5 (gender equality), 10 (reduced inequality) and 16 (peace, justice and strong institutions). They have proven essential to increase access to and quality of services, both by providing services themselves, and by overcoming and removing structural barriers to access, particularly for key populations. In many countries, key populations and PLHIV who advocate for their rights, including their right to participate in national and local health planning and resource allocation processes, face discriminatory restrictions on their rights to freedom of association and expression.[46] This impedes their ability to participate in planning, prioritizing, budgeting, implementation and evaluation of HIV services.

**Definitions of 'community responses'**

| Term | Examples of definitions |
|---|---|
| **Community responses** | **The World Bank** states that community responses are: *"The combination of actions and steps taken by communities, including the provision of goods and services, to prevent and/or address a problem to bring about social change". [47]*<br><br>**The Global Fund** states that community responses are**: *"The means by which communities act on the challenges and needs they face." [48]*<br><br>**UNAIDS and the Stop AIDS Alliance** state that, in the context of HIV, community responses are: *"The collective of community-led activities in response to HIV.[49]* |

Increased recognition of community responses for health can now be seen within the:

- **Global frameworks on health and development** that serve as the umbrella strategies for all stakeholders at national, regional and international levels. As one example, the 2030 Agenda for Sustainable Development calls for multi-stakeholder partnerships across the SDGs, within efforts to 'leave no one behind'[50],
- **International commitments on individual diseases** that set out the priorities and targets for national governments and other stakeholders. As one example, the Global Technical Strategy and Targets for Malaria 2016-2030 cites *"country ownership and leadership, with the involvement and participation of communities"* as one of its principles[51]. Meanwhile, the 2016 United Nations Political Declaration on HIV and AIDS[52] affirmed the critical role of communities in advocacy and coordination, and also committed to *"expanding community-led service delivery to cover at least 30 per cent of all service delivery by 2030."[53]*
- **Strategies of global institutions** that provide leadership and guidance on health. As one example, WHO's 13th General Programme of Work commits to an approach to communicable diseases that expands community engagement and positions community-based services, health promotion and disease prevention as central to Universal Health Coverage[54]. Also, WHO's Framework on Integrated People-Centred Health Services emphasises the importance of communities in health services that are coordinated around people's needs, respect their preferences, and are safe, effective, timely, affordable and of acceptable quality[55].

- **Value-added: Leaving no one behind.**
Community responses can use their local knowledge, reputation and networks to engage diverse communities, including those that other sectors cannot (or will not) reach. They can support people who are in remote areas or are socially marginalized, such as by providing differentiated models of care and using person-centered approaches. *As one example, in Thailand, Rainbow Sky set up a community-based clinic for migrant gay men, other men who have sex with men and transgender people, all of whom face severe stigma and are not reached by mainstream health services. The clients are referred by peer educators and receive a range of services, such as screening for sexually transmitted infections and counseling and testing for HIV.*[56]

  Box 1: Supporting marginalised populations

  > *"While states have the primary responsibility to guarantee health and human rights, when this responsibility is not fulfilled, community actors may need to act outside the formal public health systems to protect the health and human rights of people who are neglected, marginalised or criminalised. In many cases, communities provide services and support that are not otherwise being provided, or which are not accessible to key and most-affected populations."*
  > The Crucial Role of Communities: Strengthening Responses to HIV, Tuberculosis and Malaria, the Global Fund to Fight AIDS, Tuberculosis and Malaria

- **Value-added: Stigma reduction.** Community responses can build on their relationship with local communities and their knowledge of local cultures to increase accurate understanding about health issues and marginalised populations and, in turn, to contribute to stigma reduction. *As one example, in Samrong, Cambodia, improved TB treatment outcomes have been achieved through interventions by health volunteers, some of whom have had TB themselves. The volunteers seek out new suspected TB patients and organise village gatherings to teach people about the disease and its prevention. This approach has not only improved community members' access to TB services, but raised awareness and fought stigma about the disease.* [57]

- **Value-added: Decriminalization.** Funding for legal cases is critical. The International HIV/AIDS Alliance's Rapid Response Fund[58] funded a legal case for decriminalization of homosexuality. It recognizes the importance of upholding international law, which accepts that criminalization of private sexual relationships between consenting adults is a breach of human rights, as well as ensuring the right for all individuals to access public health and health-care facilities, goods and services. *One example, from Trinidad & Tobago: In April 2018, the LGBT rights activist Jason Jones won a landmark legal case against the government of Trinidad & Tobago, challenging the legality of the colonial-era 'buggery' law which prohibited same-sex relationships. Trinidad and Tobago was one of 37 countries in the Commonwealth still to criminalize homosexuality.*

- **Value-added: Violations of human rights.** Communities have highlighted the low level of awareness within the criminal justice system of human rights violations against people in same sex relations. Example: *The International HIV/AIDS Alliance supported the National Gay and Lesbian Human Rights Commission (NGLHRC), Kenya, in challenging the practice of forced anal examinations on people who are accused of same-sex relations. After losing the initial case, Kenya's Court of Appeal found in NGLHRC's favor in March this year. With low levels of understanding amongst judges, magistrates and prosecutors, having influenced the outcome of the initial case, NGLHRC received a Rapid Response Fund grant to carry out awareness training amongst these parties, ensuring a balanced judgement was reached.*

- **Value-added: Transgender rights.** A legal campaign gained public support through extensive advocacy work with national media and sensitization of government ministers to raise awareness of transgender issues. *Example: In November 2018, the Caribbean Court of Justice ruled that the law that makes it a criminal offence for a man or a woman to appear in public in*

*the clothing of a different gender for "an improper purpose" violates the Constitution of Guyana and is therefore void. Section 153(1)(xvlvii) of the Summary Jurisdiction (Offences) Act dates from 1893, but was still being actively enforced in 2009. In 2010, the Society Against Sexual Orientation Discrimination (SASOD) lodged a case to challenge the constitutional basis for the law, on behalf of four women who had been convicted under the law.. Guyana Trans United received a grant from the International HIV/AIDS Alliance's* Rapid Response Fund *to carry out this work and to support the submission of a white paper on law reform. A panel of four judges voted unanimously that it was unconstitutional and "violated the appellants' right to protection of the law and was contrary to the rule of law."*

- **Value-added: Evidence-based advocacy.** Community stakeholders - such as activists and community-based organisations - can conduct unique advocacy that uses people's lived experiences to call for policy and legislative changes to improve access to and quality of health services, including for marginalised populations. Such efforts can be especially powerful when addressing issues such as human rights, funding and equitable access to medicines. *As one example, within a regional grant from the Global Fund, REDTRASEX supported advocacy by national organisations of sex workers in fourteen countries in Latin America and the Caribbean. The work included monitoring national budgets and expenditure for HIV and sexual and reproductive health and rights, with the findings used to advocate for policy and funding changes to benefit the rights and needs of sex workers.[59] Another example is the strong collaboration between civil society organisations (CSO), sex worker-led organisations and the Vietnamese Government that resulted in increased access to HIV testing and treatment services for sex workers. After ten years of community-led advocacy and co-piloting models, the Vietnamese government now recognizes the effectiveness of community-led responses and has decided to financially support sex worker-led organisations to implement the national HIV programme.*

- **Value-added: Research.** Community responses are uniquely placed to inform the design of research initiatives and implement processes to gather evidence and data of the real needs of communities, in particular those that are marginalised. *As one example, through a grant from the AIDS and Rights Alliance for Southern Africa, the Swaziland Association for Crime Prevention and the Rehabilitation of Offenders conducted the first ever study in Mbabane and Manzini on the distribution of people who use drugs (in terms of their age, gender, residence, family background and socio-economic status). The resulting population size estimates were used to improve the quality of community-based programmes, including for harm reduction[60]. Another example is the participatory research done by Handsoff! partners to collect evidence on violence among sex workers in Southern Africa. Evidence is used to accelerate community-led advocacy, for example through intensive lobbying SWEAT and Sisonke managed to convince the SAPS High Commissioner (highest ranked police officer) in South Africa to allow development of an integrated training (including PUD and LGTBI) for police officers on human rights, understanding sex work and needs, sexuality, gender identity and expression and drug use. In Zimbabwe, it resulted in a successful strategic litigation case, where it was successfully argued that the illegal arrest of nine women* was a **violation of the right to personal liberty** and the provision equality of the newly ratified 2013 Constitution.

- **Value-added: Gender equality.** Community responses can provide services that not only address the immediate health needs of community members, but the 'bigger picture' determinants (such as gender and legal status) that are the underlying causes of vulnerability and ill-health. *As one example, in Youna, Gambia, where communities are dominated by patriarchy and polygamy, peer educators use dramas to encourage men to engage in community health discussions. These focus on the role of men in providing moral and financial support to women to go for*

*intermittent preventive treatment of malaria in pregnancy and to access insecticide-treated bed nets. The results have included a three-fold increase in the use of nets.*[61]

- **Value-added: Accessibility of services.** Community responses can implement health and other interventions that are more accessible, flexible and tailored to the specific needs of local people. This, in turn, enables interventions to achieve better outcomes, in terms of both scale and quality. *As one example, in South Africa task-shifting to community-based health centres led to 81% of people living with HIV accessing ART and staying alive, compared to 67.2% of those supported in hospitals. Similarly, in Malawi, 95.5% of people supported by Community Health Workers accessed ART and stayed alive, compared to 75.8% of those who lacked such support[62]. Another example is the community-led approach of HOYMAS.* HOYMAS is a male sex worker led community based organisation that implements a comprehensive package of community led activities and services for male sex workers and men who have sex with other men (MSM). It *has shown its effects. The total number of sex workers testing HIV positive was lower in 2018 (2.7%) in comparison to 2015 (7%) when the clinic first opened its doors. At the same time, HOYMAS has expanded its work from one area to 17 sub-counties to reach underserved sex workers.*

- **Value-added: Holistic care.** Community responses can – in combination with other aspects of systems for health – ensure that community members receive comprehensive support that addresses them as whole people (with multi-faceted lives and needs) rather than just medical 'patients' or 'cases'. *As one example, in El Salvador, at a community center in Sonsonate, sex workers can receive literacy lessons alongside information about alcohol and drug abuse, HIV and dealing with difficult clients. This intervention not only helps HIV prevention, but empowers the sex workers by reducing their social exclusion and discrimination.*[63]

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[1] Partnership to Inspire, Transform and Connect the HIV Response (PITCH). A strategic Partnership between the Ministry of Foreign Affairs of the Netherlands, Aidsfonds and Frontline AIDS.

[2] This briefing paper was written by Sara L.M. Davis, Stephen Leonelli, and David Ruiz. The authors gratefully acknowledge input by Mikhail Golichenko.

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