HIV-related stigma and discrimination: the challenge

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- Fast Tracks Cities
- German Federal Ministry of Health
- Global Fund
- HIV Outcomes initiative
- Prevention Access Campaign (Undetectable=Untransmittable)
- Spanish Federation of Municipalities and Provinces (FEMP)
- UNITE Parliamentarians network for Global Health

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Acronyms

AAE	AIDS Action Europe
AIDS	Acquired Immunodeficiency Syndrome
EATG	European AIDS Treatment Group
ECDC	European Centre for Diseases Prevention and Control
ECHR	European Convention on Human Rights
EEA	European Economic Area
EU	European Union
HIV	Human immunodeficiency virus
HRQoL	Health-Related Quality of Life
MSM	Men who have Sex with Men
PrEP	Pre-Exposure Prophylaxis
SDG	Sustainable Development Goals
STIs	Sexually Transmitted Infections
UN	United Nations
UNAIDS	United Nations Programme on HIV/AIDS
WHO	World Health Organization

1. Introduction

From the very beginning of the human immunodeficiency virus (HIV) epidemic stigma and discrimination have harmed people with HIV and the communities most affected by the condition. The first, and most important, response to such stigma has always come from people with HIV with and affected by HIV themselves. They have organised, supported each other, educated the public, clinicians and politicians, and insisted on their rights. This continues to be the case today. In response to such activism, research has been undertaken, medical practice transformed, laws and policies changed, even if very often too slowly and too haphazardly. From the 1990s onwards, the international community has made a series of commitments to address HIV, all of which have included actions and targets on HIV-related stigma and discrimination[1].

The current Sustainable Development Goals (SDGs) were agreed in 2015 by government representatives of the international community, including the European Union (EU) and member states of the European Economic Area (EEA), as part of the **2030 Agenda for Sustainable Development**. The **SGD 10.2** emphasises social, economic, and political inclusion irrespective of age, gender, or any other status. This includes the removal of discriminatory laws, policies, and practices as well as the promotion of appropriate policies and legislation (**SGD 10.3**). Specifically, the **SDG 3.3** sets out the goal of ending the 'acquired immunodeficiency syndrome (AIDS) epidemic' by 2030. **The United Nations (UN) Political Declaration on HIV and AIDS: Ending Inequalities and Getting on Track to End AIDS by 2030** (2021), also agreed to by the EU and its member state governments, sets out in more detail how the global community is to end the HIV epidemic. Ending the HIV epidemic means not just ending onward transmission but also dismantling the human rights barriers that harm and leave people with HIV and other key populations behind. Governments commit 'to urgent and transformative action to combat the social, economic, racial and gender inequalities, restrictive and discriminatory laws, policies and practices, stigma and multiple and intersectional forms of discrimination, including based on HIV status, and human rights violations that perpetuate the global AIDS epidemic'[2]. The COVID-19 pandemic, as well as economic and humanitarian crises, have recently slowed, stalled or even in some instances

1 There were, for example, UN Declarations of Commitment relating to HIV in 2001, 2006, 2011 and 2016, prior to the most recent Declaration in 2021.

2 Political Declaration on HIV and AIDS: Ending Inequalities and Getting on Track to End AIDS by 2030; 2021, paragraph 1. Available at: https://www.unaids.org/en/resources/documents/2021/2021_political-declaration-on-hiv-and-aids.

reversed the real progress being made[3]. For example, up to 70% of HIV clinics were disrupted in WHO Eastern Europe and it was estimated that about 25,143 individuals with HIV were not diagnosed in 2020 because of the pandemic[4]. But in any case, progress has not been sufficient for the EU and all its member states to meet the 2030 target. Why is that? All biomedical tools are now available to end the HIV epidemic and provide well-being for people with HIV. The barriers are social (attitudes, behaviours, laws and policies) all too often still pervaded by HIV-related stigma and discrimination.

3 See, for example, UNAIDS Global AIDS Update 2022, page 4, ECDC 'Operational considerations for the provision of the HIV continuum of care for refugees from Ukraine in the EU/EEA' 5 July 2022, and UN Political Declaration on HIV and AIDS: Ending Inequalities and Getting on Track to End AIDS by 2030, paragraph 1(e).

4 See https://hivoutcomes.eu/the-impact-of-covid-19-on-hiv-in-europe/.

2. The HIV epidemic in Europe

The overall picture of the HIV epidemic in Europe is of real but fragile progress, not yet consistently on track to meet the 2030 target, and with the burden of HIV falling on stigmatised and socially excluded populations. Relevant data underline the need for urgent action, and that such action has to address inequalities if it is to be effective. In 2021[5], there were 784,484 people with HIV in the EU/EEA[6] and 2,300,000[7] people with HIV in the WHO Europe region as a whole[8]. HIV infection rates per 100,000 of the general population differ significantly across the region[9].

Whilst overall the EU/EEA is seeing evidence of a decline in new diagnosis rates over the last decade, trends at a country level vary. About two-thirds of EU/EEA countries have seen such a decline, but the European Centre for Disease Prevention and Control (ECDC) reports that in some countries in the EU/EEA rates are in fact increasing significantly[10]. There can also be alarming increases in new diagnoses among specific groups such as men who have sex with men (MSM)[11]. Many European countries are currently not on track to meet the UN 2030 targets.

5 ECDC. 'Continuum of HIV care. Monitoring implementation of the Dublin Declaration on partnership to fight HIV/AIDS in Europe and Central Asia: 2021 progress report'. Stockholm: ECDC; 2022. Available at: www.ecdc.europa.eu/en/publications-data/continuum-hiv-care-monitoring-implementation-dublin-declaration-partnership-fight.

6 Of whom 91,784 (12%) remained undiagnosed. See ECDC. 'Continuum of HIV care. Monitoring implementation of the Dublin Declaration on partnership to fight HIV/AIDS in Europe and Central Asia: 2021 progress report'. Annex 1 pages 34-35.

7 Based on data from 47 countries reporting to ECDC (out of a total of 55). See ECDC. 'Continuum of HIV care. Monitoring implementation of the Dublin Declaration on partnership to fight HIV/AIDS in Europe and Central Asia: 2021 progress report', page 10.

8 In the 47 countries reporting the relevant data, 431,938 (18%) of the total number of people with HIV remained undiagnosed. ECDC. 'Continuum of HIV care. Monitoring implementation of the Dublin Declaration on partnership to fight HIV/AIDS in Europe and Central Asia: 2021 progress report', page 11.

9 In 2021, 16,624 new HIV diagnoses were reported across the EU/EEA and 106,508 across all of WHO Europe region. New diagnoses in Russia account for 55% of new diagnoses in the whole region and those in Ukraine 14%. ECDC/WHO Europe. 'HIV/AIDS surveillance in Europe 2022-2021 data', page xiii.

10 ECDC/WHO Europe. 'HIV/AIDS surveillance in Europe 2022-2021 data', page xi. Cyrus, Slovakia and Bulgaria.

11 ECDC/WHO Europe. 'HIV/AIDS surveillance in Europe 2022-2021 data', page xi. There are increases in new diagnosis rates among MSM, especially migrant MSM, in nearly a third of EU countries. Bulgaria, Cyprus, Iceland, Ireland, Lithuania, Malta, Romania and Slovakia.

There is a continuing unbalanced burden of HIV on key populations[12]. In the EU/EEA, 40% of new diagnoses in 2021 were among MSM and 3.5% among people who inject drugs[13]. Heterosexual men accounted for 14.8% of new diagnoses and heterosexual women for 14.4%[14]. Migrants[15] accounted for 42% of those newly diagnosed in the EU/EEA in 2021: 14% from sub-Saharan Africa, 10% from Latin America and the Caribbean, 8% from other countries in central and Eastern Europe and 3% from other countries in Western Europe[16] [17] [18]. However, surveillance information on transgender people in Europe lag significantly behind data on other key populations.

To end the HIV epidemic by 2030, it is necessary to meet the ('Continuum of Care') 90-90-90 targets by 2020 and the 95-95-95 target by 2025[19]. ECDC continues to analyse European regional data against the 90-90-90 benchmark from 2014 to enable comparison of progress over time[20]. Eighteen European countries in 2021, including five EU member states, were still over 10% off meeting the

12 UNAIDS estimate that, globally, transgender women are 14 times more likely to acquire HIV than adult women, people who inject drugs are 35 times more likely to acquire HIV than those who do not, female sex workers 24 times more likely to do so than adult women, and MSM 28 times more likely than adult men. See https://www.unaids.org/sites/default/files/media_asset/UNAIDS_FactSheet_en.pdf.

13 ECDC/WHO Europe. 'HIV/AIDS surveillance in Europe 2022-2021 data' ECDC; 2022, page x. Within the EU/EEA area, respective percentages of diagnosis among key populations can vary significantly between countries as they do between WHO Europe sub-regions. For example, though overall the proportion of new diagnoses among people who inject drugs is low in the EU/EEA, they accounted for 24% of diagnoses in Latvia and 20% in Greece; and there is likewise significant variation across the whole WHO Europe region in the key populations most affected by the HIV epidemic. Whilst in the West sub-region and EU/EEA sex between men was the main route of transmission, heterosexual transmission and injecting drug use were the main routes of transmission in the East. ECDC/WHO Europe. 'HIV/AIDS surveillance in Europe 2022-2021 data', page ix.

14 Route of transmission was unknown for 26.6% of new diagnoses.

15 Defined as people originating from outside the country in which they were diagnosed.

16 ECDC/WHO Europe. 'HIV/AIDS surveillance in Europe 2022-2021 data'. ECDC; 2022, page xi.

17 It should be noted that a high proportion of migrants acquire HIV after arrival in their country of destination. One study of migrants diagnosed in 57 clinics across Western Europe found that 63% had acquired HIV post-migration. ECDC Report 'HIV and Migrants: Monitoring implementation of the Dublin Declaration on partnership to fight HIV/AIDS in Europe and Central Asia (2018 progress report)'. ECDC; 2020, pages 7-8.

18 Late diagnosis rates remain high overall in the EU/EEA at 56% and vary significantly between different sub-populations. See ECDC/WHO Europe. 'HIV/AIDS surveillance in Europe 2022-2021 data', page xii.

19 At least 95% of people with HIV diagnosed, of whom at least 95% should be in treatment, of whom at least 95% should have an undetectable viral load (this means that in total at least 86% of all people with HIV should have an undetectable viral load).

20 There are significant differences in outcome between WHO Europe sub-regions. For example, for the percentage of those on treatment who are not virally suppressed, where for both West and East sub-regions this is only 7% but for the Centre it is 22%. ECDC/WHO Europe. 'HIV/AIDS surveillance in Europe 2022-2021 data', pages 16-18.

overall 90-90-90 target, never mind the upwardly revised target of 95-95-95[21]. Despite significant improvement in reporting of progress toward the 90-90-90 targets, it is important to mention that 16 countries lack data to measure process toward the overall target, and most countries in Europe lack data on measuring progress toward the 90-90-90 targets for key populations[22]. Therefore, more progress is needed in the reporting of this data by key population if we are to ensure the United Nations programme on HIV/AIDS (UNAIDS) targets are equitably met. Furthermore, it is necessary to place special emphasis on the 10-10-10 UNAIDS targets for removing societal and legal barriers to HIV services by the year 2025. People with HIV, women, girls, and other people at risk of and affected by HIV who experience gender-based violence, stigma, and discrimination must be reduced to less than 10%. Simultaneously, it is necessary to ensure that less than 10% of countries have restrictive legal and policy environments that prevent and limit people from accessing HIV services. There is a need for EU/EEA countries to provide updated information regarding the status of those targets.

21 ECDC. 'Continuum of Care: Monitoring implementation of the Dublin Declaration 2021 progress report (2022)', page 15.

22 ECDC. 'Continuum of Care: Monitoring implementation of the Dublin Declaration 2021 progress report (2022)', page 8.

3. Stigma and discrimination. The evidence of harms to health

The term stigma derives from the ancient Greek language and, in particular, from the verb «στίζω», which means to carve, to mark as a sign of shame, punishment or disgrace. Currently there is no single definition of stigma, but it is commonly agreed to involve negative attitudes, feelings and beliefs about people in relation to some characteristic they possess or have attributed to them, in this case having HIV. HIV-related stigma is a complex phenomenon that has several manifestations, some of which have an external source (e.g., structural, enacted, institutional, or public stigma, or stigma by association)[23] and others have an internal source (e.g., anticipated, internalised or affiliated stigma)[24]. Discrimination is where people act on stigma and prejudice, treating someone differently and negatively based on a characteristic. Discrimination also has various forms and manifestations. It can, for example, be actions or omissions, direct or indirect, or by association[25]. Different manifestations of stigma and discrimination require different responses and interventions. The overall response must be multi-level[26].

Given the inextricable relationship between HIV and other stigmatised identities and associations, 'HIV-related stigma' has been defined comprehensively

23 Structural stigma is stigma embedded in institutions and manifested in laws, policies and cultural norms, for example. Enacted stigma is the external expression of stigma, for example in discrimination or humiliation. Public stigma refers to the stigmatising attitudes held by the general public. Stigma by association is the stigma experienced by those associated with stigmatised individuals such as relatives or carers.

24 Anticipated stigma is where someone perceives, fears or expects they will be stigmatised and very often then acts in order to avoid such anticipated stigma or protect themselves from it. Internalised stigma is stigma as experienced by the person stigmatised, in which the person shares (or 'adopts') those stigmatising feelings in relation to themselves. Affiliated stigma is the term used for the negative feelings that relatives of stigmatised individuals develop towards themselves, as they perceive the associative stigma that prevails in society.

25 Discrimination can be 'direct', when a person is treated, based on some characteristic, less favourably than someone else. However, it can also be 'indirect' when an apparently neutral provision, criterion or practice would put persons with a particular characteristic at a disadvantage compared with others. Discrimination can also be by 'association' (for example the spouse or family member or carer of someone with a relevant characteristic such as HIV), or by 'perception', where someone experiences discrimination on the basis of a characteristic they are perceived to have even if that is not in fact the case.

26 See Anne L. Stangl *et al.* 'The Health Stigma and Discrimination Framework: a global, crosscutting framework to inform research, intervention development, and policy on health-related stigmas'. *BMC Medicine.* 17: Article 31 (2019).

by UNAIDS as 'negative beliefs, feelings and attitudes towards people with HIV, groups associated with people with HIV (e.g., families of people with HIV), and other key populations at higher risk of HIV infection, such as people who inject drugs, sex workers, MSM, and transgender people'[27]. In the European context, migrants from high-endemic countries should also be added as a key population due to the intersectional stigma they face based on their ethnicity and legal status as undocumented immigrants.

Stigma and discrimination are themselves harms, irrespective of the further damage they do. They undermine the dignity and equality of all human beings; they damage human rights and their exercise under equal conditions; they assault a human being's personhood and sense of self; and they demean and corrupt society and those who stigmatise and discriminate.

In addition, research has identified health-related harms from HIV stigma and discrimination. These include avoidance of healthcare and treatment, suboptimal adherence to antiretroviral treatment, non-disclosure of HIV status and sensitive information (e.g., number of sexual partners or types of sexual encounters) to healthcare staff, avoidance of HIV support organisations and social services[28] [29], or an important underrepresentation of people with HIV in non-HIV clinical studies, especially cancer trials[30]. Avoidance of care results in late diagnosis[31], poor retention in care and non-adherence to treatment, all of which harm the health of those individuals as well as increasing risks to public health. Stigma and discrimination result in internalised stigma and poor mental health, non-disclosure of status to sexual partners[32], and missed opportunities to test for co-morbidities[33].

27 UNAIDS. 'Evidence for eliminating HIV-related stigma and discrimination'; 2020, page 7.

28 Chambers, L.A., Rueda, S., Baker, D.N. et al. 'Stigma, HIV and health: a qualitative synthesis'. *BMC Public Health.* 15: 848 (2015).

29 Sergio Rueda et al. 'Examining the associations between HIV-related stigma and health outcomes in people with HIV/AIDS: a series of meta-analyses'. *BMJ Open*. 6(7): e011453 (2016).

30 Vora, Kruti B., *et al*. 'Exclusion of patients with HIV from cancer immune checkpoint inhibitor trials', *Scientific Reports.* 11: 6637 (2021).

31 Gesesew Hailay A. *et al.* 'Significant association between perceived HIV related stigma and late presentation for HIV/AIDS care in low and middle-income countries: A systematic review and meta-analysis'. *PLoS One*. 12(3): e0173928 (2017).

32 Rueda S. *et al.* 'Examining the associations between HIV-related stigma and health outcomes in people with HIV/AIDS: a series of meta-analyses'. *BMJ Open*. 6(7): e011453 (2016). Deribe K. *et al.* 'Disclosure experience and associated factors among HIV positive men and women clinical service users in southwest Ethiopia *BMC Public Health*'. 8(1):81 (2008) Brou H. *et al.* 'When do HIV-infected women disclose their HIV status to their male partner and why? A study in a PMTCT programme, Abidjan'. *PLoS Med.* 4(12): 342 (2007).

33 Including tuberculosis, viral hepatitis and STIs, all of which disproportionately affect populations with high HIV incidence.

4. Evidence of HIV-related stigma and discrimination in Europe

4.1. Experiences of people with HIV

Evidence of HIV-related stigma in Europe further illustrates the wide range of harms that arise. Experiences of discrimination among people with HIV in Europe have been captured both in country specific surveys by the people with HIV Stigma Index[34] and recently in a pan-European survey undertaken by ECDC along with the European AIDS Treatment Group (EATG) and the AIDS Action Europe (AAE)[35].

Significant rates of **internalised stigma** have a profound and ongoing impact on well-being and mental health for people with HIV. The ECDC/EATG/AAE survey found that across Europe 28% agreed or strongly agreed that they were ashamed of their HIV status and 27%, because of their HIV status, had poor self-esteem. In some countries, the people with HIV Stigma Index found such internalised stigma is even more prevalent. For example, in Greece[36] and Lithuania[37] 51% of people with HIV 'felt guilty' of their HIV status respectively[38]. In Portugal, the percentage stands at 31%[39]. Such stigma contributes to poor mental health and social isolation (including from families, friends and partners), as well as the avoidance of vital services.

Stigma and discrimination are also experienced from family and friends and from wider society. In the ECDC/EATG/AAE survey, 24% reported having been rejected by friends, 17% had been threatened, verbally abused or physically harmed by their sexual partner and 11% by family or friends, 15% had been blackmailed and 16% had received discriminatory remarks or been gossiped about by family. There was a strong association between experience of such stigma from others and internalised stigma, worse health status and low life satisfaction scores. The same picture emerges from the various people with HIV Stigma Index surveys, which also reveal how such experiences deter from social engagement.

34 See https://www.stigmaindex.org/about-the-stigma-index/.

35 See AIDSmap: www.aidsmap.com/news/oct-2022/stigma-and-discrimination-against-people-hiv-are-big-issue-ever.

36 PLWH Stigma Index Greece 2017, page 29.

37 PLWH Stigma Index Greece 2017, page 29.

38 PLWH Stigma Index Lithuania 2018, page 9.

39 PLWH Stigma Index Portugal 2021, page 24.

Of particular concern is **stigma and discrimination experienced in healthcare**. In the ECDC/EATG/AAE survey 33% of respondents had perceptions of poor treatment in a healthcare setting in the previous 12 months, 29% had heard staff gossiping about them and 23% had had healthcare refused or delayed. A similar pattern was evident in dental care[40]. Such treatment means people with HIV avoid healthcare services (36%) and worry about being treated differently (56%). Again, this is borne out by people with HIV Stigma Index surveys which also show how this results in non-disclosure of HIV status to clinical staff[41], to lack of trust in confidentiality of patient records[42], to discriminatory practice in sexual and reproductive health[43], to delays in testing and in accessing treatment and care and to failures in adherence to medication and to non-retention in care[44]. It is especially appalling that stigma and discrimination also take place within HIV-specialist clinics[45]. Some key populations such as people who inject drugs and sex workers are especially affected by healthcare discrimination[46] [47]. The greater prevalence of comorbidities among people with HIV[48] means more call on a wider range of health specialties, all of which need to be HIV-literate and stigma-free. There are also concerns about treatment of people with HIV in care homes[49] and this will continue to be an urgent issue to address as the population of people with HIV

40 28% had at some point avoided dental services because they expected to be treated differently; 37% were afraid to go to dental services because they worried someone might find out about their status; 22% had ever been treated differently by dentists/dental staff; and 12% had ever been refused dental care. Again, there was an association between experience of stigma and worse life satisfaction scores.

41 PLWH Stigma Index Germany 202, page 39. PLWH Stigma Index Lithuania 2018, pages 37-38.

42 PLWH Stigma Index Greece 2017, page 50.

43 See for example PLWH Stigma Index Moldova 2018, page 43, and PLWH Stigma Index Lithuania 2018, page 39.

44 PLWH Stigma Index Belarus 2022. Table 16, page 42 and PLWH Stigma Index Ukraine 2020, pages 55-58.

45 PLWH Stigma Index Lithuania 2018, page 37.

46 PLWH Stigma Index Ukraine 2020, page 69 and see data from Belarus on stigma and discrimination more commonly experienced by women in healthcare services than men at PLWH Stigma Index Belarus 2022, page 12.

47 The social acceptance of LGBTI people in the EU, FRA 14 May 2020 EU-LGBTI II. A long way to go for LGBTI equality.

48 People with HIV experience a high rate of comorbidities, including co-infections such as tuberculosis and hepatitis B and C, as well as non-communicable diseases such as cancers, cardiovascular disease, hypertension, chronic kidney disease, diabetes and osteoporosis, and mental health disorders including anxiety and depression, and alcohol and drug use disorders. Sometimes these are the result of HIV itself and other times caused by a range of social, environmental and behavioural determinants. HIV Outcomes Factsheet 'Comorbidities'.

49 See National Aids Trust and Care. 'HIV: A guide for care providers' 2015. See also National Aids Trust and Care Inspectorate 'Care of people with HIV: practice note' (2019).

ages[50]. Rates of **discrimination experienced in employment** are lower than in healthcare (partly because HIV disclosure is less relevant than in a clinical setting) but in the ECDC/EATG/AAE survey 11% had either been denied employment or fired at some point because of their HIV status and 15% had been treated poorly in the workplace. There is also evidence that anticipated stigma deters people with HIV from seeking or remaining in jobs or in applying for promotions[51]. Another important issue is the requirement of HIV testing for entry and employment, and the prohibition of stay or residence based on HIV status in some counties. The existence of these practices undermines efforts to prevent and treat HIV as well as promoting stigma and discrimination. All EU/EEA countries prohibit these practices, but two countries in Europe (Ukraine and Bosnia) still require HIV testing for work, study or residency permits and can deny residency permits on the basis of HIV status[52]. In general, only a few people with HIV know about their **rights to complain about discrimination and seek redress**. For example, in the Lithuanian people with HIV Stigma Index survey only 5% of respondents knew there were laws in place to protect them from discrimination[53]. In Ukraine and Portugal, 83% and 81% of those who had experienced discrimination in the previous 12 months took no action, citing such reasons as lack of knowledge of where to go/what to do, no confidence in a successful outcome, and fear that their HIV status would be disclosed[54].

It must be remembered that most people with HIV not only experience discrimination because of their HIV status but also because of other aspects of their identity ('**multiple discrimination**'). In Germany, for example, the people with HIV Stigma Index found that 32% reported one other characteristic in addition to HIV where discrimination had been experienced, 18% reported two additional characteristics and 15% reported three or more[55]. Women, MSM, ethnic minorities, sex workers, people who inject drugs, transgender people, prisoners: all experience high rates of discrimination independently of their HIV status. The German people with HIV Index survey found 'the more stigmatised characteristics people with HIV possess, or have attributed to them, the higher is their level of internalised HIV stigmatisation'[56].

The Fundamental Rights Agency has surveyed experiences of discrimination across Europe amongst women, LGBTIQ+ communities and racial/ethnic minori-

50 A Dutch study has modelled the median age of HIV patients in the Netherlands as increasing from 43.9 years in 2010 to 56.6 years by 2030, with the proportion of those over 50 increasing in the same period from 28% of all patients to 73%. Sabin C. and Reiss P. 'Epidemiology of ageing with HIV: what can we learn from cohorts?' AIDS June 2017 Vol. 31.

51 See PLWH Stigma Index Greece 2017, page 30 and Lithuania 2018, page 11.

52 See https://www.unaids.org/sites/default/files/media_asset/hiv-related-travel-restrictions-explainer_en.pdf.

53 PLWH Stigma Index Lithuania 2018, page 42.

54 PLWH Stigma Index 2020 Ukraine, pages 78-79 and PLWH Stigma Index Portugal 2021, page 35.

55 PLWH Stigma Index Germany 2021, page 84.

56 PLWH Stigma Index Germany, page 85.

ties. Women in Europe continue to experience significant and unacceptable levels of gender-based violence, intimate partner violence and psychological violence, resulting in, for example, depression, anxiety, loss of self-confidence, sleeplessness and difficulties in relationships[57]. There is evidence that women with HIV are especially vulnerable to gender-based violence[58]. Similarly, 43% of LGBTIQ+ people said they had experienced discrimination in the previous 12 months[59], and 16% in healthcare[60] (rising to 52% amongst those whose health was 'very bad' and to 34% among transgender people)[61]. This results in healthcare avoidance and non-disclosure, undermining the HIV response. Racial discrimination remains common in housing, employment and access to goods and services, as well as hate speech and experience of racial harassment (24% in the previous 12 months), usually not reported to the police[62].

Being from a stigmatised key population can affect the likelihood of experiencing HIV-related stigma and discrimination, and how it is experienced ('**intersectional stigma and discrimination**'). The ECDC/EATG/AAE survey found that sex workers and prisoners with HIV were more likely to experience HIV stigma than MSM, for example, and in different contexts. Intersectional stigma is also evidence in national surveys. For example, the additional HIV stigma experienced by prisoners in Greece[63] and the much greater isolation and difficulties in disclosure experienced by women with HIV in the United Kingdom (compared with men with HIV)[64].

57 European Agency for fundamental rights. 'Violence against Women. An EU-wide survey' (2014).

58 See https://www.unwomen.org/en/what-we-do/hiv-and-aids/violence-against-women. See also Dhairyawan R. *et al*. 'Intimate partner violence in women with HIV attending an inner city clinic in the UK: prevalence and associated factors'. *HIV Medicine.* 14(5) 303-310 (2023), and National Aids Trust and Care Inspectorate. 'Changing Perceptions: Talking about HIV and our Relationships', page 16 (2018).

59 European Agency for Fundamental Rights 14 May 2020 EU-LGBTI II. A long way to go for LGBTI equality, page 10. This is worse than the 37% of the FRA's previous 2012 survey.

60 European Agency for Fundamental Rights. '2020 EU-LGBTI II A long way to go for LGBTI equality', page 33.

61 See European Agency for Fundamental Rights. LGBTI survey data explorer https://fra.europa.eu/en/publication/2020/eu-lgbti-survey-results#publication-tab-3.

62 See summary of European Agency for Fundamental Rights surveys in EU Communication 'A Union of equality: EU anti-racism action plan 2020-2025' COM 565 final, pages 3 and 5 (2020). There are high rates of HIV among migrant populations from sub-Saharan Africa. In that context, it is important to note that those from sub-Saharan Africa were among the groups most likely to report racial discrimination in the previous 12 months (24%).

63 PLWH Stigma Index Greece 2017, pages 21-22, 29-30.

64 European Agency for Fundamental Rights. 'Changing Perceptions: Talking about HIV and attitudes', pages 6, 9 (2018).

4.2. Public attitudes

In addition to surveying people with HIV to know about their experiences of stigma and discrimination, the degree and nature of HIV-related stigma and discrimination can also be assessed by asking questions of the general public ('public stigma'). Whilst there have been improvements in attitudes and understanding, significant minorities retain stigmatising views, especially when asked about scenarios involving proximity to someone with HIV. For example, in France 21% would be uneasy if one of their child's teachers was HIV positive (rising to 33% amongst under-35s)[65], and in Spain 36% would be uncomfortable in this scenario[66]. There is good understanding of the correct ways in which HIV is transmitted, but far too many also believe that HIV can be transmitted through such impossible means as kissing, coughing or spitting, or a mosquito bite[67], There is low knowledge of the breakthroughs in treatment as prevention, or that a person with HIV who is on treatment and has an undetectable viral load cannot transmit HIV (Undetectable = Untransmittable or U=U). There is a clear association between such poor understanding of modes of transmission and stigmatising attitudes. Poor understanding amongst younger people is a real concern and a reminder of the need to continue to inform new generations of the facts around HIV, a key anti-stigma, as well as preventive, intervention.

Similarly, in public attitudes to key populations there is both real and welcome progress over time but also substantial variation in attitudes between countries, with significant minorities (or in some cases majorities) still holding stigmatising attitudes. For example, when asked if they agreed that gay, lesbian and bisexual people should have the same rights as heterosexual people, 76% of the public surveyed across the EU agreed (up five percentage points from 2015). There was, however, significant variation between countries, from 98% in Sweden to 31% in Slovakia. Only a minority agreed in seven countries, and in nine countries the percentage agreeing had decreased from 2015[68]. This is in the context of

65 AIDES 'VIH/hépatites: la face cachée des discriminations', page 9 (2017).

66 Fuster Ruiz de Apodaca M.J. *et al*. 'Evolución de las Creencias y Actitudes de la Población Española hacia las Personas con VIH desde 2008 hasta 2021'. Ministerio de Sanidad, Coordinadora Estatal de VIH y Sida y Universidad de Alcalá. Madrid, page 25 (2022).

67 See for example, AIDES. 'VIH/hépatites: la face cachée des discriminations' (2017), AIDES. 'La nouvelle sociologie du VIH' Harris Interactive for Gilead Sciences, analysed by Francoscopie September 2020, NAT/FAST Track Cities London 'HIV: Public knowledge and attitudes 2021', Fuster Ruiz de Apodaca MJ., Prats C. 'Evolución de las Creencias y Actitudes de la Población Española hacia las Personas con VIH desde 2008 hasta 2021' Ministerio de Sanidad, Coordinadora Estatal de VIH y Sida y Universidad de Alcalá. Madrid 2022.

68 Eurobarometer September 2019 Discrimination in the European Union Factsheet. The social acceptance of LGBTI people in the EU, page 3. A similar pattern is evident for two other questions around same-sex sexual relationships and same-sex marriage. For all three questions, support has declined since 2015 in five countries (Bulgaria, Czech, Ireland, Hungary and Slovakia), though the overall EU percentage has for each question risen.

increasing state-sanctioned or permitted LGBTIQ+-phobia in parts of Europe[69]. Public attitudes concerning transgender people indicate a similar trend. In 2019, 65% of Europeans felt comfortable having a transgender co-worker. This percentage represents an increase of 9% compared to 2015. It should be noted, however, that the levels vary greatly between countries, with the highest percentages found in the Netherlands (92% in 2019 and 81% in 2015), Sweden (90% in 2019 and 88% in 2015), and the lowest percentages in Bulgaria (24% in 2019 and 2015) and Hungary (33% in 2018 and 41% in 2015)[70]. Attitudes to race reveals the same progress, variation and significant continuing minorities with discriminatory attitudes[71].

4.3. Access to clinical services

People at risk of or with HIV can be denied access to necessary HIV services by national legal provisions or policy decisions. In particular, in relation to pre-exposure prophylaxis (PrEP), a key prevention intervention, ECDC has found that national eligibility criteria in many countries deny PrEP access to sex workers, people who inject drugs, prisoners and undocumented migrants[72]. More generally, undocumented/irregular migrants are unable to access HIV testing and/or treatment in many European countries, despite international human rights law, the universal character of the SDGs and the arguments from public health and cost-effectiveness[73]. There is of course also very often a wider denial of access to important health services for undocumented migrants. This harms the health of those with HIV and denies testing opportunities for those undiagnosed[74].

69 The EU LGBTIQ Equality Strategy also voices serious concern at 'a worrying trend in parts of the EU of more frequent anti-LGBTIQ incidents such as attacks on LGBTIQ public events including Pride marches, so-called declarations of 'LGBTIQ ideology-free zone', and homophobic intimidation at carnival festivities. Civil society organisations protecting and advancing the rights of LGBTIQ people increasingly report that they face hostility, coinciding with the rise of the anti-gender (and anti-LGBTIQ) movement. It is imperative that Member States react quickly to reverse these new developments'. EU LGBTIQ Equality Strategy 2020-2025 COM(2020) 698 final, page 2.

70 Eurobarometer Discrimination in the European Union 2019, page 128.

71 Eurobarometer Discrimination in the European Union 2019, pages 9-11, 13.

72 ECDC 'Pre-Exposure Prophylaxis for HIV Prevention in Europe and Central Asia: Monitoring implementation of the Dublin Declaration …-2020/201 progress report', page 3.

73 See ECDC Report 'HIV and Migrants: Monitoring implementation of the Dublin Declaration … (2018 progress report)' 2020, pages 14-15, European HIV Legal Forum 'Accessing HIV prevention, testing, treatment care and support in Europe as a migrant with irregular status in Europe: A comparative 16-country legal survey' Revised edition March 2018 pages, 9-13, and FRA 'Cost of exclusion from healthcare. The case of migrants in an irregular situation: summary' 2015.

74 Furthermore, the Fundamental Rights Agency has identified a number of practical obstacles to healthcare for undocumented migrants even where such care should be in theory be accessible. FRA 'Migrants in an irregular situation: access to healthcare in 10 European Union Member States' 2011, page 7.

Blood donation has been prohibited since the 1980s for groups with a higher HIV prevalence (e.g., MSM, transgender people). Today, LGBT+ people continue to face blanket bans or lengthy deferral periods in Europe. A total of 18 European countries have abolished discrimination against MSM and transgender people in blood donation by 2023. However, 16 EU countries still maintain discriminatory laws in this area. Some of these countries have recently begun to take steps toward achieving equality. Germany banned discrimination in blood donation in 2022 (although the law has not yet been implemented) and Belgium and Estonia have shortened their deferral periods[75].

The current war in Ukraine highlights the importance of non-discriminatory, high quality HIV prevention, treatment and care for internally displaced persons and refugees in humanitarian crises. There are targets that by 2025 90% of people in humanitarian settings have access to integrated HIV services[76] and that 95% of people in humanitarian settings at risk of HIV use appropriate, prioritised, people-centred and effective combination prevention options[77].

4.4. Employment and insurance exclusions

Exclusions in employment, often dating back to the early years of the HIV epidemic when less was known about transmission and treatment was not available, too often remain in place. In Spain a comprehensive review at national, regional and local level has uncovered a number of such prohibitions, for example at the national level from public employment in the police, customs services and prison estate, and in their relevant training institutions[78]. Issues can also be found in other countries[79] and similar reviews to that of Spain are recommended[80]. There is no clinical reason to exclude someone with HIV from employment (though there may

75 See https://ilga-europe.org/blog/countries-end-discrimination-blood-donation/.

76 The expanded version of this target in the Global AIDS Strategy 2021-2026 (page 140) is that 90% of people in humanitarian settings have access to integrated tuberculosis, hepatitis C and HIV services, in addition to programmes to address gender-based violence, that include HIV post-exposure prophylaxis, emergency contraception and psychological first aid.

77 UN Political Declaration on HIV and AIDS: Ending inequalities and getting on track to end AIDS by 2030, paragraph 67(j).

78 www.pactosocialvih.ed and Miguel A Ramiro Avilés 'Legal drivers to eradicate HIV-related discrimination in Spain' Presentation IAPAC Fast Track Cities Conference Seville October 2022. It is worth noting that the national prohibitions cited in Spain also applied to a number of other long-term conditions, illustrating how action on HIV stigma can bring wider benefits.

79 See for example France AIDES Rapport discriminations 2015, page 15, 17-21, and Remaides 109 Automne/Oct 2019, pages 14-21, and Germany https://germany.detailzero.com/news/320194/Hessen-Marburg-HIV-positive-student-is-excluded-from-the-university.html. In the UK in recent years exclusions have been abolished for surgeons, airline pilots and frontline military personnel.

80 Such critical reviews should look not only at employment but access to all goods and services. To give some examples from issues recently experienced by people with HIV, assisted reproduction, family law rights such as adoption and custody, tattooing/plastic surgery.

exceptionally be some requirements around viral load in relation to clinical staff undertaking exposure-prone medical procedures).

Insurance can also be impossible or very difficult to get for people with HIV, or prohibitively expensive[81]. Not having life insurance can have a knock-on effect on other issues, such as getting a mortgage[82]. It also appears that the requirement in the EU to have health insurance to be eligible for a student visa means some students with HIV are either unable to study in EU countries or study without a right of access to HIV care or other chronic condition that requires hospital pharmacy drugs[83]. Some EU countries have attempted to reverse this situation. In 2018, Spain recognised the right of people with HIV not to be discriminated against when purchasing private insurance. However, the rule has not been effective as some insurance companies continue to refuse to cover people with HIV or impose onerous conditions based on the serological status of the individual[84]. For this reason, the Spanish Ministry of Health continues to collaborate with the Spanish Union of Insurance and Reinsurance Entities (UNESPA) on reviewing the processes for contracting life insurance by people with HIV.

4.5. Punitive laws

The Political Declaration 2021 commits governments to end **punitive laws against people with HIV and key populations**, which contribute significantly to stigma and discrimination. With regard to **criminalisation of HIV non-disclosure, exposure and HIV transmission**, Europe has made progress that now needs to be strengthened. Since Denmark suspended its HIV-specific criminal law in 2011, only Sweden maintains its HIV disclosure obligation, which can be found in the Communicable Diseases Act. There is an option for the treating physician to remove the disclosure obligation if the patient is adherent and undetectable, but law does not regulate it. Furthermore, no country in Western and Central Europe have HIV-specific criminal laws (e.g., prosecutions for intentional transmission), as recommended by the UN[85].

81 Miguel A Ramiro Avilés 'Legal drivers to eradicate HIV-related discrimination in Spain' Presentation IAPAC Fast Track Cities Conference Seville October 2022, and https://www.nat.org.uk/press-release/people-hiv-still-struggling-access-insurance.

82 See UNAIDS 'Evidence for eliminating HIV-related stigma and discrimination' 2020, page 49.

83 http://gtt-vih.org/files/active/1/Infovihtal_170_ING.pdf, and communication from Czech AIDS Help.

84 See Ramiro Avilés, M. Á., & del Val Bolívar Oñoro, M. (2022). HIV and Access to Private Insurance in Spain, *European Journal of Health Law*, *30*(2), 203-221. doi: https://doi.org/10.1163/15718093-bja10098.

85 This is not only a recommendation of UNAIDS but of a number of other international human rights bodies including WHO, UNDP, the Global Commission on HIV and the Law, and the relevant human rights committee. See Economic and Social Committee General Comment No.22 (2016) on the right to sexual and reproductive health, paragraph 40. There are especially high prosecution rates in Belarus and Ukraine, and, within the EU, in Austria, Czech Republic, Spain and Sweden, but most countries have seen some prosecutions. For country details and policy analysis see www.hivjustice.net.

However, five countries in Eastern Europe (two of which are members of the EU) still apply HIV-specific criminal laws. Today, 21 countries of Western and Central Europe and 1 country of Eastern Europe have applied general non-HIV specific criminal laws[86]. Evidence points to poor understanding of HIV and transmission risk in court proceedings, and inconsistent and inadequate prosecutorial practice[87], both of which the UN has sought to amend with guidance[88]. The ECDC/EATG/AAE survey found that 28% of people with HIV were concerned about being criminalised, an indicator of internalised and anticipated stigma. With 15% of that same survey sample having been threatened, verbally abused or physically harmed because of their status in the previous 12 months, the deterrent impact of criminalisation on trust in and access to the protections of law enforcement is a great concern.

Same-sex sexual relationships are lawful in all European countries, which is to be welcomed and celebrated. However, discriminatory treatment in law, including failures in protection, go beyond basic decriminalisation to encompass equality and non-discrimination, family rights, legal gender recognition, asylum and immigration issues, and hate crime, for example. On these wider measures of LGBTIQ+ human rights, as analysed by the European Region of the International Lesbian, Gay, Bisexual, Trans and Intersex Association (ILGA-Europe), the EU's overall 'score' is just 48%[89]. One example, out of the 27 EU members states, discrimination in healthcare on the basis of sexual orientation is only unlawful in 17 countries, with in one further country it being unlawful only in some regions, and in the other nine countries it not being unlawful. **Transgender and intersex rights** also are very inconsistent in such areas as legal gender recognition and bodily integrity. Surveys both of public opinion and of experiences of LGBTIQ+ people indicate both overall progress in attitudes but also significant remaining prejudice, with wide variation across EU countries, which has to be addressed[90]. Failures in legal protection both reflect such prejudice and reinforce it.

UNAIDS recommends **decriminalisation of possession of small amounts of drugs for personal use** yet criminalisation remains the default response in the EU. According to the Talking Drugs website, only 11 EU countries having

86 See the report 'Advancing HIV Justice 4: Understanding Commonalities, Seizing Opportunities', published by the HIV Justice Network. Available at https://www.hivjustice.net/publication/advancing4/.

87 Fuster Ruiz de Apodeca. 'Content analysis of Spanish judgments addressing the sexual transmission of HIV: 1996-2016'. *AIDS Care.* 31(2): 265-269 (2019).

88 See Policy Brief: HIV criminalization UNAIDS/UNDP 2008 Introduction, UNDP Guidance for Prosecutors on HIV-related Criminal Cases (2021) Executive Summary, and Expert consensus statement on the science of HIV in the context of criminal law conclusions Barré-Sinoussi *et al. JIAS* Vol 21 Issue 7 July 2018.

89 See ILGA Europe's Rainbow Europe website at www.rainbow-europe.org for further information.

90 Eurobarometer September 2019 Discrimination in the European Union Factsheet. The social acceptance of LGBTI people in the EU, FRA 14 May 2020 EU-LGBTI II. A long way to go for LGBTI equality.

introduced some form of decriminalisation[91]. In most countries, many people who inject drugs are targeted by law enforcement, arrested, prosecuted and incarcerated, with the inevitable risks to personal safety and health, deterrents to healthcare, as well as resultant stigma and discrimination. The UN High Commissioner for Human Rights quotes research suggesting decriminalisation of drug use increases knowledge of HIV status and viral suppression by 14%[92]. The EU Drugs Strategy 2021-25 notes positively the decriminalisation of possession in some member states and encourages alternatives to coercive sanctions[93]. The Strategy also recommends the implementation of evidence-based harm reduction measures both in the community and in prison settings. Whilst there has been a welcome increase within Europe in availability of opioid agonist therapy and needle and syringe programmes, there is only very limited implementation in prisons, and other important and effective measures in the community such as drug consumption rooms and Naloxone provision are far less common[94]. However, coverage levels (even in community settings) that falls below the threshold needed for an impact on public health. Thus, further efforts should be made to ensure sustainable financing of harm reduction services and their integration into universal health coverage policies. This denial of evidence-based healthcare adds to HIV risk and other health harms and can be considered discriminatory. Hence, it is important to work not only from a healthcare perspective but also from a human rights approach. In order to understand the needs of civil society, European politicians must strengthen their relationships with it.

UNAIDS also recommends **the decriminalisation of sex work**. Only a few countries have implemented decriminalisation, often involving registration processes, which are themselves burdensome and counterproductive. Most countries criminalise organisation of sex work, as well as selling and/or purchase. The UN High Commissioner for Human Rights quotes research indicating that 'According to modelling estimates, the decriminalisation of sex work could avert as many as 33 to 46 per cent of HIV infections among sex workers and their clients over a decade'[95]. A meta-analysis of research by the London School of Hygiene and Tropical Medicine found globally that sex workers in legally punitive environments were three times more likely to experience sexual or physical violence and twice as likely to acquire HIV or another sexually transmitted infection (STIs)[96]. It is not

91 https://www.talkingdrugs.org/drug-decriminalisation.

92 50th Session Human Rights Council, 13 June-8 July 2022, Report of UN High Commissioner for Human Rights 'Human Rights and HIV/AIDS', paragraph 44.

93 EU Drugs Strategy 2021-25, paragraph 7.4.

94 For details see Harm Reduction International 'The Global State of Harm Reduction 2022'.

95 50th Session Human Rights Council, 13 June-8 July 2022, Report of UN High Commissioner for Human Rights 'Human Rights and HIV/AIDS', paragraph 44.

96 Sex work and HIV in Europe ICRSWE 2021, page 10.

surprising, given the high degree of criminalisation, that sex worker-led organisations report unsafe working, poverty and homelessness, violence and harassment, including from law enforcement, and stigma and discrimination, for example in healthcare which means avoidance of healthcare services and non-disclosure of status and health risks.

5. Why must Europe act? Legal obligations under international human rights treaties

Urgently and effectively addressing HIV stigma and discrimination is a legal obligation of the EU and its member states based in international human rights treaties. In relation to all the human rights treaties set out below, states have an obligation 'to respect, protect and fulfil' the rights they contain[97].

The provisions of the core UN human rights treaties[98] are legally binding on all ratifying countries, which include all EU member states. They assert the dignity and equality of humanity, and discrimination is prohibited in the enjoyment of fundamental rights, including on grounds of HIV status [99] [100] [101].

There is also a right to the highest attainable standard of physical and mental health[102] which includes obligations not to discriminate in healthcare provision, to provide relevant health information (including on HIV), and to ensure access to sexual and reproductive health services and participation in health-related decision-making. It extends to prevention, diagnosis, treatment and care, and requires equal access for prisoners or detainees, minorities, asylum seekers and undocumented/irregular migrants. It involves human rights training for healthcare staff and effective redress where rights are breached[103].

97 'The obligation to respect means that States must refrain from interfering with or curtailing the enjoyment of human rights. The obligation to protect requires States to protect individuals and groups against human rights abuses. The obligation to fulfil means that States must take positive action to facilitate the enjoyment of basic human rights'. www.un.org/en/about-us/udhr/foundation -of-international-human-rights-law.

98 The Universal Declaration of Human Rights (UDHR), articles 1 and 2, the International Covenant on Civil and Political Rights (ICCPR), articles 2, 3 and 26, and the International Covenant on Economic, Social and Cultural Rights (ICESCR), articles 2 and 3.

99 Political Declaration on HIV and AIDS: Ending Inequalities and Getting on Track to End AIDS by 2030; 2021, page 14. Point e. Available at: https://www.unaids.org/en/resources/documents/2021/2021_political-declaration-on-hiv-and-aids.

100 The Commission on Human Rights has confirmed that 'other status' in the ICCPR and other international treaties is to be interpreted to include health status, including HIV status, see resolutions 1995/44 of 3 March 1995 and 1996/43 of 19 April 1996.

101 There is separately also a clearly stated principle of the equality of women and men. Other rights relevant to the inequalities often experienced by people with HIV include the right to privacy, the right to be free from cruel, inhuman or degrading punishment, and the right to work. The Handbook on HIV and Human Rights for National Human Rights Organisations published by UNAIDS and the Office of the High Commissioner for Human Rights gives a full and helpful account of the relevance of these internationally applicable human rights to people with HIV.

102 Art 12 of ICESCR.

103 See General Comment No.14 (2000) of the Committee on Economic, Social and Cultural Rights

There are further international human rights treaties, which address and prohibit the discrimination experienced more broadly by key and priority populations affected by HIV, discrimination which both increases vulnerability to HIV acquisition and which compounds and intensifies their experience of HIV stigma and discrimination. These include the **International Convention on the Elimination of All Forms of Racial Discrimination**[104], the **Convention on the Elimination of All Forms of Discrimination against Women**[105] [106] and **Convention on the Rights of Persons with Disabilities**[107]**.**

In addition, there are legal obligations at the European level to address discrimination. The **European Convention on Human Rights (ECHR)** is signed and ratified by all EU member states and almost all other European countries[108], and its provisions are part of the general principles of European Union law[109]. The ECHR prohibits under Article 14 discrimination in the enjoyment of ECHR rights against people with HIV[110] and some of the key populations most affected by HIV[111] (for example, MSM, transgender people, prisoners, migrants)[112] [113].

The Committee is the UN Treaty Body for the ICESCR. Human rights treaty bodies are committees of independent experts that monitor implementation of the main international human rights treaties. Their General Comments, whilst not legally binding in the same way international treaties and conventions themselves are, are considered 'highly authoritative interpretations' and thus very relevant in legal cases and complaints, and are often cited in court judgments. See General Comment No. 14 paragraphs. 16, 32, 34, 44, 59-62.

104 International Convention on the Elimination of All Forms of Racial Discrimination, articles 5(e) (iv) and 7.

105 Convention on the Elimination of All Forms of Discrimination against Women, article 12.

106 The Convention on the Elimination of All Forms of Discrimination against Women EDAW treaty body, the Committee on the Elimination of All Forms of Discrimination against Women, has issued a General Comment No.24 on Women and Health (1999) which provides further legal detail and guidance on the requirements of the Convention, including at paragraph 18 reference to HIV and other STIs. The paragraph references unequal power relations, the right to access sexual health services, the specific needs of female sex workers, and 'without prejudice or discrimination, the right to sexual health information, education and services for all women and girls'. The General Comment also stresses the imperative to end gender-based violence, the need for a national strategy for women's health and for the involvement of women in health decision-making. There is, in particular, a focus on the diversity of women's needs. Older women, adolescent women and girls, migrant women, women with disabilities, women with mental health problems. In any actions to address discrimination, their distinct and specific needs must be addressed.

107 Convention on the Rights of Persons with Disabilities, articles 4 and 8.

108 The exceptions are Belarus and Russia.

109 Treaty on European Union, article 6(3).

110 *Kiyutin v Russia* 2700/10 2011.

111 European Court of Human Rights Guide on Art 14 of the ECHR and Art 1 of Protocol No.12 to the Convention. Prohibition of Discrimination, pages 36-43.

112 The text of article 14 does not explicitly list all these protected characteristics but does after specifying some grounds add 'or other status', which the European Court of Human Rights (ECtHR) has subsequently interpreted so as to include these characteristics within its protections.

113 Articles of the ECHR have been used in successful litigation on hate crime, discrimination at

These ECHR rights are not relevant only to litigation, however important that might be to redress specific and individual wrongs. States also have 'positive obligations'[114] to ensure that these rights are enjoyed by those with HIV within their jurisdictions. Therefore, to enact and implement legal protections, provide redress, and ensure the necessary material and practical conditions are in place for the right to be enjoyed[115]. Inaction by the state in relation to such a positive obligation is unlawful[116]. There is thus a legal obligation on European countries to address proactively HIV-related stigma and discrimination.

The EU's founding values are 'human dignity, freedom, democracy, equality, the rule of law and respect for human rights, including the rights of persons belonging to minorities. These values are common to Member States in a society in which pluralism, non-discrimination, tolerance, justice, solidarity and equality between women and men prevail'[117]. The EU's Charter of Fundamental Rights reflects these values[118].

In addition, there is specific EU legislation that prohibits discrimination in goods and services, employment and occupation on grounds of sex[119] and racial or ethnic origin[120], and a directive against discrimination at work on grounds of religion or belief, disability, age or sexual orientation[121]. Were these directives to be consistently and fully implemented, and the relevant non-discrimination rights actually enjoyed across the EU, great progress would be made in addressing HIV and intersectional discrimination.

There remain, however, some gaps in legal protections at the EU level. Only a limited number of characteristics/grounds are cited at Articles 10 and 19 of the

work, breaches of confidentiality, inappropriate immigration controls, and inadequate redress failure to provide adequate medical care, prison conditions, confidentiality of personal health information, discrimination on grounds of health status, deportation of seriously ill persons, failure to investigate a possible breach of the ECHR, and medical negligence. See for more details ECtHR Factsheet 'Health' August 2022.

114 See Akanji-Kombe 'Positive obligations under the European Convention on Human Rights': Human rights handbooks No.7 2007 Council of Europe.

115 In other words, the obligation 'to respect, to protect and to fulfil' cited above.

116 Such breaches by inaction include the failure to investigate possible rights violations properly (see *Beizaras and Levickas v Lithuania* 2020 where there was a failure to investigate and prosecute homophobic social media posts, and *Sabalic v Croatia* 2014, a failure by the authorities to respond adequately to a violent homophobic attack).

117 Article 2 of the TEU. There are two principal treaties on which the EU is based. The Treaty on European Union (TEU), signed in Maastricht in 1992, and the Treaty on the Functioning of the European Union (TFEU), signed in Rome in 1957. Both treaties have been amended a number of times since their original agreement.

118 See https://commission.europa.eu/aid-development-cooperation-fundamental-rights/your-rights-eu/eu-charter-fundamental-rights_en.

119 Directives 2004/113EC and 2006/54EC.

120 Directive 2000/43EC.

121 Directive 2007/78EC.

Treaty on the Functioning of the European Union as a basis for EU action against discrimination. They do not, for example, include HIV[122], or health status generally, or gender identity and expression. A more comprehensive list of grounds with an open reference to 'other status' is recommended[123]. It would also be useful to amend the list of 'EU crimes' in the treaty on European Union to include hate crime[124]. A number of proposed directives also need to be agreed: on strengthening the powers and mandates of national equality bodies[125], on combating violence against women and domestic violence[126], on extending protection from discrimination beyond the workplace for age, disability, sexual orientation, and religion or belief[127].

122 Whilst it can be argued that people with HIV are protected under disability provisions, this has not been confirmed as yet in case law.

123 Equinet 'Expanding the List of Protected Grounds within Anti-Discrimination Law in the EU' 2021 Executive Summary. Equinet also call for any amendment to the Treaty also to allow for action in relation to multiple, additive and intersectional discrimination. Noting the high threshold of unanimity required for such Treaty change, Equinet also calls in the meantime for equality bodies across Europe to work together to improve discrimination protections, raise awareness of rights and collaborate with civil society.

124 The EU's LGBTIQ Equality Strategy calls for consideration of whether hate crime should be added to the list of 'EU crimes' under Art 83(1) of the TEU, which allows for the European Parliament and Council by directives to establish minimum rules concerning the definition of criminal offences and sanctions in relation to serious crimes.

125 See https://ec.europa.eu/commission/presscorner/detail/en/ip_22_7507.

126 See https://eur-lex.europa.eu/legal-content/EN/TXT/HTML/?uri=CELEX:52022PC0105&-from=EN Ratification of the Istanbul Convention, the Council of Europe convention on preventing and combating violence against women and domestic violence is also recommended in the EU Gender Equality Strategy, as well as agreement of this directive.

127 See proposed Directive COM(2008)462.

6. Why must Europe act? International policy commitments

The **UNAIDS Global AIDS Strategy 2021-26** provides further policy detail to the overarching commitments contained in the Agenda for Sustainable Development 2030 (with the SDGs) and the 2021 UN Political Declaration on HIV and AIDS. It applies an 'inequalities lens' to the HIV epidemic, with a focus on human rights, gender equality, and stigma and discrimination, as well as the relevance of the SDGs. Failure to achieve the 'societal enabler' targets (such as the 10-10-10) will mean an additional 2.5 million new HIV infections and 1.7 million AIDS-related deaths globally by 2030[128]. To avoid this outcome, financial investment in 'societal enablers' must increase from the $1.3 billion (or 7% of total HIV expenditure) in 2019 to $3.1 billion (11% of total expenditure) by 2025[129].

The 'unpacking' of the 10-10-10 commitments from the Political Declaration 2021 (below in bold) relating to stigma, discrimination and human rights provide an essential and detailed template for policy priorities.

Less than 10% of people with HIV and key populations experience stigma and discrimination:

- Less than 10% of people with HIV report internalised stigma by 2025.
- Less than 10% of people with HIV report experiencing stigma and discrimination in healthcare and community settings by 2025.
- Less than 10% of key populations (e.g., MSM, sex workers, people who inject drugs) report experiencing stigma and discrimination by 2025.
- Less than 10% of the general population report discriminatory attitudes towards people with HIV by 2025.
- Less than 10% of health workers report negative attitudes towards people with HIV by 2025.
- Less than 10% of health workers report negative attitudes towards key populations by 2025.
- Less than 10% of law enforcement officers report negative attitudes towards key populations by 2025.

Less than 10% of people with HIV, women and girls and key populations experience gender-based inequalities and violence:

- Less than 10% of women and girls experience physical or sexual violence from an intimate partner by 2025.

128 UNAIDS Global AIDS Strategy 2021-26, page 40.

129 UNAIDS Global AIDS Strategy 2021-26, page 103.

- Less than 10% of key populations (e.g., MSM, sex workers, people who inject drugs) experience physical or sexual violence by 2025.
- Less than 10% of people with HIV experience physical or sexual violence by 2025.
- Less than 10% of people support inequitable gender norms by 2025.
- Greater than 90% of HIV services are gender-responsive by 2025.
- Less than 10% of countries have punitive laws and policies:
- Less than 10% of countries criminalize sex work, possession of small amounts of drugs, same-sex sexual behaviour, and HIV transmission, exposure or non-disclosure by 2025.
- Less than 10% of countries lack mechanisms for people with HIV and key populations to report abuse and discrimination and seek redress by 2025.
- Less than 10% of people with HIV and key populations lack access to legal services by 2025.
- More than 90% of people with HIV who experienced rights abuses have sought redress by 2025[130].

There are also the following relevant 2025 targets in the Political Declaration, most also then disaggregated in the Global AIDS Strategy by key population, geography and level of risk:

- **95% of people at risk of HIV use combination prevention[131].**
- **95-95-95 achievement of the HIV 'treatment cascade[132].**
- **95% of women access sexual and reproductive health services[133].**
- **95% coverage of services for eliminating vertical transmission[134].**
- **90% of people with HIV with, at risk of an affected by HIV are provided with people-centred and context-specific integrated services[135].**
- **Community-led organisations to deliver 30% of testing and treatment services, 80% of HIV prevention services, and 60% of programmes supporting the achievement of societal enablers[136].**

130 UNAIDS Global AIDS Strategy 2021-26. Annex 1, pages 131-139.

131 Political Declaration on HIV and AIDS: Ending Inequalities and Getting on Track to End AIDS by 2030 [2021], paragraph 60.

132 Political Declaration on HIV and AIDS: Ending Inequalities and Getting on Track to End AIDS by 2030 [2021], paragraph 61.

133 Political Declaration on HIV and AIDS: Ending Inequalities and Getting on Track to End AIDS by 2030 [2021], paragraph 63.

134 Political Declaration on HIV and AIDS: Ending Inequalities and Getting on Track to End AIDS by 2030 [2021], paragraph 62.

135 Political Declaration on HIV and AIDS: Ending Inequalities and Getting on Track to End AIDS by 2030 [2021], paragraph 67 'people-centred and context-specific integrated services for HIV and other communicable diseases, non-communicable diseases, sexual and reproductive health care and gender-based violence, mental health, palliative care, treatment of alcohol dependence and drug use, legal services and other services they need for their overall health and well-being'.

136 Political Declaration on HIV and AIDS: Ending Inequalities and Getting on Track to End AIDS

A wide range of broader international policy commitments, if implemented, will play a vital role in ending HIV-related stigma and discrimination. These include the **Political Declaration of the high-level meeting on universal health coverage agreed by the UN General Assembly 2019**[137], the **Beijing Declaration 1995 and Platform for Action** on gender equality[138], and the **International Labour Organization Recommendation No.200 concerning HIV and AIDS and the world of work (2010)**[139].

Similarly, on the practical question of how to address HIV stigma and discrimination effectively, UNAIDS provides advice and support. The **Global Partnership for Action to Eliminate All Forms of HIV-related Stigma and Discrimination**[140] has been established to support countries in reviewing and addressing HIV stigma. In addition, UNAIDS has published **'Evidence for eliminating HIV-related stigma and discrimination'** in 2020, bringing together the scientific evidence as to what seems effective in addressing stigma and discrimination[141].

Over the last twenty years, human rights and a commitment to combat stigma, discrimination and gender inequality have been at the heart of EU HIV policy, with the Dublin Declaration 2004[142] as a key milestone and an ongoing commitment of the EU, EU member states and other European country signatories[143].

by 2030 [2021], paragraph 64 'Societal enablers' are interventions addressing societal and policy obstacles to the HIV response, and establishing instead a supportive environment conducive to a rational and effective HIV response, for example the 10-10-10 targets, see https://www.globalhealthlearning.org/taxonomy/term/2023.

137 Political Declaration of the high-level meeting on universal health coverage agreed by the UN General Assembly 2019, paragraph 70, 14, 68, 67.

138 See Beijing Declaration, paragraphs. 17, 30, 24, 29 and Platform for Action sections, B2, C2 and C4, and paragraph 108.

139 ILO Recommendation No.200 concerning HIV and AIDS and the world of work 2010, paragraphs 3, 24-29.

140 It was established, by UNDP, the UN Entity for Gender Equality and the Empowerment of Women, GNP+, the UNAIDS Secretariat, and the NGO delegation to UNAIDS PCB. See https://www.unaids.org/en/topic/global-partnership-discrimination.

141 https://www.unaids.org/en/resources/documents/2020/eliminating-discrimination-guidance. There are also important partnerships such as the Fast-track Cities initiative (with as at January 2023 117 European cities participating) which have a focus on addressing HIV stigma and discrimination and can provide evidence on implementation of anti-stigma interventions www.fast-trackcities.org.

142 Dublin Declaration on Partnership to fight HIV/AIDS in Europe and Central Asia 2004, see paragraph 20 for a strong commitment to combating stigma and discrimination, and reviewing critically in this context laws, policies and practice.

143 There have been a number of HIV-specific Communications and Action Plans since 2006. Communication from the Commission to the Council and the European Parliament on combating HIV/AIDS within the European Union and in the neighbouring countries, 2006-2009/* COM/2005/0654 final; Communication from the Commission to the Council and the European Parliament on combating HIV in the European Union and neighbouring countries, 2009-2013 COM/2009/0569 final; Action Plan on HIV/AIDS in the EU and neighbouring countries 2014-16 SWD(2014) 106 final. There is also a recent Commission Staff Working Document Combatting HIV/AIDS, viral hepatitis and tu-

The EU current commitment to the SDGs, as set out for example in the '**Communication-Next steps for a sustainable European future. European action for sustainability (COM/2016/0739 final)**', includes explicit reference to the goal of 'ending AIDS' by 2030[144]. One important EU intervention to be highlighted is its consistent support for European civil society, for example through the EU Civil Society Forum and AIDS Action Europe, which has done much to ensure information sharing and cross-European support and that the voices of people with HIV with and affected by HIV are heard at the national and European level[145]. The EU support to Global Fund can also be highlighted as an example of response to HIV stigma and discrimination as the Breaking Down Barriers initiative (of which Ukraine is a part) promoted by the Global Fund focuses on the removal of human rights-and gender-related barriers to HIV services.

Furthermore, the fight against HIV-related stigma and discrimination must be seen as integral to **the current Commission's commitment to a 'Union of Equality'**, which means 'equality for all and equality in all its senses'[146]. Strategies have been published, for example, for gender (with combating gender violence as a key priority)[147], for race[148], and for LGBTIQ+ equality (with a raft of important proposals for the strengthening of EU equality law and its improved implementation and monitoring)[149] which are essential to the HIV stigma response. The proposed EU mental health strategy provides an important opportunity to address the mental health harm caused by stigma and discrimination, both for people with HIV and for key populations[150]. The current EU Drugs Strategy 2021-25 states that 'The stigmatisation linked to drug use and drug use disorders needs to be addressed'[151] and embeds the Strategy within a human rights framework which emphasises non-discrimination and the right to the highest attainable standard of physical and mental health for people who inject drugs[152]. Effectively addressing HIV-related stigma and discrimi-

berculosis in the EU and neighbouring countries. State of play, policy instruments and good practices (SWD(2018)387 final) which stresses the importance of tackling stigma and discrimination and supporting vulnerable groups, both within the EU and in access and neighbourhood policies.

144 Communication. Next steps for a sustainable European future-European action for sustainability COM/2016/0739 final paragraph 2.1.

145 Commission Staff Working Document Combatting HIV/AIDS, viral hepatitis and tuberculosis in the EU and neighbouring countries. State of play, policy instruments and good practices (SWD(2018)387 final), pages 17, 18, 21, 36.

146 'A Union that strives for more: My agenda for Europe. Political Guidelines for the next European Commission 2019-2024'.

147 EU Gender Equality Strategy 2020-2025.

148 EU Anti-racism action plan 2020-2025.

149 LGBTIQ Equality Strategy 2020-2025.

150 See https://ec.europa.eu/commission/presscorner/detail/en/speech_22_5493.

151 EU Drugs Strategy 2021-25, paragraph 6.4.

152 EU Drugs Strategy 2021-25, paragraphs 3 and 4.

nation has to be central to the coordinated effort of the EU's equality strategies.

Funding policy is an essential element in considering what actions are available to the EU[153]. Both **EU4Health 2021-27** and the **Citizens, equality, rights and values programme 2021-27** are relevant[154]. Funding programmes for pre-accession and neighbourhood policy countries also have been and should be used to support human rights, non-discrimination, gender equality, rights of minorities and the rule of law, all of which have a direct relevance to HIV-related stigma and discrimination[155] [156] [157]. There is of course overlap between EU neighbourhood policy and the **EU's Global Health Strategy** which recommits to meeting the SDGs by 2030, including explicitly that on HIV, with a strong focus on human rights, gender equality, discrimination and vulnerable/socially excluded groups[158].

WHO Europe has agreed **Regional Action Plans for ending HIV, viral hepatitis and STIs in the WHO European Region**. This is the first regional strategy to integrate approaches to HIV, viral hepatitis and STIs, reflecting the organisation of the **WHO Global Health Sector Strategies for the period 2022-2030.** These conditions disproportionately affect the same overlapping populations such as MSM, people who inject drugs, prisoners, transgender people, and sex workers and their clients. Planning services in an integrated way around affected individuals is both clinically and economically efficient. However, it is also itself an important destigmatising intervention, valuing the voices of these communities and optimising their healthcare[159] [160].

The focus on integration of services for people with HIV with, at risk of an affected by HIV is an important element in the current interest, welcome and

153 There is an impressive history of EU funding for HIV-related projects under the health programme for 2004-10, including on stigma and discrimination.

154 Regulation (EU) 2021/692 of the European Parliament and of the Council, paragraph 14.

155 IPA III Programming Framework for the period 2021-2027 C(2021) 8914 final, page 104.

156 Commission Joint Communication Eastern Partnership Policy beyond 2020 JOIN(2020) 7, paragraph 4.5.4.

157 Commission Joint Communication Eastern Partnership Policy beyond 2020 JOIN(2020) 7. final paragraph 4.3.1.

158 EU Global Health Strategy 2022, pages 4, 8-10, 28. And see European Parliament resolution 20 May 2021 'Accelerating progress and tackling inequalities towards ending AIDS as a public health threat by 2030'. P9_TA (2021)0250 strongly supportive of these priorities.

159 The move to such people-centred and integrated care is a key opportunity to 'design out' HIV-related stigma and discrimination, developing instead rights-based services for key populations, 'using differentiated service delivery through a range of different providers including PHC [primary health care] clinicians, specialist service providers and civil society' WHO European Region 'Regional Action Plans for Ending AIDS and the Epidemics of Viral Hepatitis and Sexually Transmitted Infections 2022-2030', page 14 Priority 1.1.

160 Both WHO global strategies and regional action plans align with the SDGs and with the UNAIDS Global Strategy in addressing human rights, gender equality, and stigma and discrimination, especially in health services. WHO Global Health Sector Strategies on, respectively, HIV, viral hepatitis and STIs for the period 2022-2030 Actions 8, 14, 15, 26, 27.

overdue, in health-related quality of life (HRQoL) for people with HIV. Success against HIV clinical markers is essential but not enough. As important are wider physical, mental and emotional health, social support, and freedom from stigma and discrimination if the holistic WHO definition of health is to be met. Development of HRQoL measures and their consistent monitoring are essential[161]. It is critical not only because of the better psychological and social outcomes involved in improved HRQoL, but also because of the evidence of its causal impact on the long-term health outcomes of people with HIV, such as multimorbidity, mortality and the number of hospitalisations[162].

161 See Study requested by ENVI Committee, European Parliament, November 2022 'Health-related quality of life in people with HIV', pages 27-28 and www.hivoutcomes.eu.

162 Lazarus, J.V. *et al*. 'Consensus statement on the role of health systems in advancing the long-term well-being of people with HIV'. *Nature Communications*. 12**:** 4450 (2021).

7. Conclusions

There are seven years left in which to meet the SDG of ending the AIDS epidemic. This Goal will be unattainable if HIV stigma and discrimination are not properly addressed and eliminated. This survey has shown how speedily attitudes can change for the better and how possible it is for governments to act decisively to improve law, policy and practice. **There is still time**. This survey also shows, however, that there is some way to go to end HIV stigma and discrimination in the EU and neighbouring countries. **There is still much to do, and it must be done urgently**.

Addressing HIV stigma and discrimination will not only benefit people with HIV, though that is reason enough, and the main reason, to act. As has been the case from the outset of the epidemic, the HIV response can and does have impacts far beyond the confines of this particular condition. To reduce HIV stigma requires us also to address the stigma and discrimination experienced by key populations and vulnerable groups such as MSM, transgender people, sex workers, people who inject drugs, prisoners, migrants. This will improve their health and well-being, enhance their economic and social participation, and benefit society as a whole. To prioritise involvement of patients and communities in decision-making, and develop integrated, person-centred care will mean better standards and outcomes across the health system. To establish human rights, stigma and discrimination training for healthcare workers, and effective pathways for complaint and redress, improves the experience of healthcare for all. To develop and enhance anti-stigma interventions contributes to efforts to tackle stigma in relation to connected conditions such as viral hepatitis, tuberculosis, COVID-19 or monkey pox, for example, and provides essential evidence and learning for wider anti-stigma interventions such as those around mental health.

Above all, to recommit to zero HIV stigma and discrimination is to recommit to consistent human rights-based policy and practice. A shown in the past, this is neither a luxury nor a distraction, but integral to all the SDGs and to meeting the interrelated crises and challenges now facing our planet.

8. Actions to address HIV-related stigma and discrimination

Europe will not meet the 2030 target to end the HIV epidemic if it does not successfully address HIV-related stigma and discrimination. It is a legal, a policy and an ethical imperative. Actions are required across a wide range of areas:

- **Action on political leadership:** to restate commitment to end the HIV epidemic and HIV-related stigma and discrimination, to implement and fully fund EU-wide and national anti-stigma strategies developed in partnership with affected communities and in line with UNAIDS evidence of effectiveness, and to implement the agreed EU equality strategies.
- **Action on monitoring:** to ensure data are collected in a reliable and timely way to monitor effectively all disaggregated international HIV-related targets, and to develop new standards and measures. This include collecting HRQoL indicators such as self-rated health, unmet mental health needs, non-discriminatory access and treatment of healthcare, unemployment, food insecurity or unstable housing. This information would provide a holistic view of the unmet needs of people with HIV.
- **Action on legal reform:** to improve legal protections at the EU and national level for people with HIV, women (especially around gender-based violence) and key populations, and to end inappropriate and harmful punitive laws (for example, around HIV non-disclosure/exposure/transmission, personal drug possession, sex work) as well as any remaining discriminatory exclusions or restrictions from employment, insurance or other services.
- **Action on healthcare access:** to ensure access for all women to sexual and reproductive healthcare and gender-sensitive health services more broadly, access for undocumented migrants (and those displaced by humanitarian crises) to HIV prevention, testing and treatment and other essential healthcare, access for all with clinical need to PrEP, and to develop integrated healthcare services (including mental health) for people with HIV and key populations. Depression and other mental disorders are common among people with HIV. There are individuals who are impacted by stigma in a number of settings, such as the workplace, family, and healthcare. Therefore, mental health screening should become an integral part of health services for people with HIV.
- **Action on needs-driven care:** to promote the co-creation of people-centred models of healthcare where patents become actively in-

volved in their treatment and have opportunity to accompany others. Patients and communities should be involved not only in decision-making, but also in the creation of health programmes and even service provision. This transformation should also contemplate the integration of services for HIV and other non-communicable diseases, sexual and reproductive health care, mental health, palliative care, treatment of alcohol dependence and drug use, and other services people with HIV need for their overall health and well-being.

- **Action on discrimination in healthcare and other public services:** to apply, monitor and review anti-discrimination standards and measures in healthcare, dentistry, domiciliary and residential care, law enforcement, prisons, and other relevant services, with appropriate training, sanctions and redress processes. Furthermore, public anti-stigma and anti-discrimination campaigns should be promoted through mass media and social media platforms. The promotion of TV series and documentaries that normalise the lives of people with HIV should be part of this initiative. Public awareness campaigns are essential for eliminating discriminatory attitudes towards people with HIV, MSM, people who inject drugs, transgender people, sex workers, and migrants.
- **Action in and with communities:** to achieve a significant proportion of community-led HIV services, to support effective anti-stigma interventions at the community level as recommended by UNAIDS, to improve human rights amongst people with HIV, young people, the general public and in specific communities as needed. It is important that countries, local parliamentarians, and civil society organizations collaborate closely to ensure a comprehensive and whole-society approach to the roadmap.
- **Action in education:** to address numerous misconceptions surrounding HIV transmission at society as a whole, specifically the understanding that if a person people with HIV is on ART treatment with a undetectable HIV viral load, the virus cannot be transmitted ("U=U"). Additionally, all individuals should have access to all prevention models available (e.g., condoms, PrEP, injectables for HIV prevention) as well as sexual education, anti-stigma, and anti-discrimination programmes. In particular, these strategies should address the needs of migrant populations, since they account for the majority of new HIV cases in Europe.

Since the beginning of the human immunodeficiency virus (HIV) epidemic, stigma and discrimination have harmed people living with HIV and the communities most affected by the condition. HIV-related stigma has complex and negative consequences on the physical and mental health as well as the health-related quality of life of people living with HIV. While significant progress had been made in reducing HIV-related stigma and discrimination in recent decades, critical challenges still remain at the national and international levels. The Sustainable Development Goal 3.3 and the United Nations Political Declaration on HIV sets out the goal of ending the acquired immunodeficiency syndrome epidemic by 2030. Addressing this task means not just ending onward transmission, but also dismantling the human rights barriers that harm and leave people living with HIV and other key populations behind. The elimination of HIV-related stigma and discrimination has been a political priority of the Spanish Presidency of the Council of the European Union in 2023. This report examines the different attempts and successes made by the member countries of the EU to eliminate HIV-related stigma and discrimination. In addition, it identifies key areas and gaps to develop future policies and strategies at the European level.

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