



GLOBAL COMMISSION ON
HIV and the *e*AW

RISKS, RIGHTS & HEALTH

SUPPLEMENT

JULY 2018

The content, analysis, opinions and policy recommendations contained in this publication do not necessarily reflect the views of the United Nations Development Programme.

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ABBREVIATIONS

2030 Agenda	United Nations Agenda for Sustainable Development
AIDS	Acquired immune deficiency syndrome
ART	Anti-retroviral therapy
ARV	Anti-retroviral
DNA	Deoxyribonucleic acid
DR-TB	Drug-resistant tuberculosis
FOSTA	Fight Online Sex Trafficking Act
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
GPS	Global Positioning System
HCB	Hepatitis B virus
HCV	Hepatitis C virus
HIV	Human immunodeficiency virus
IACHR	Inter-American Commission on Human Rights
LGBT	Lesbian, gay, bisexual and transgender
MDR-TB	Multidrug resistant tuberculosis
NGO	Non-governmental organisation
NHS	National Health Service
OST	Opioid substitution treatment
PrEP	Pre-exposure prophylaxis
R&D	Research and development
RNA	Ribonucleic acid
SARS	Severe acute respiratory syndrome
SDG	Sustainable Development Goal
SII	Self-initiated intervention
STI	Sexually transmitted infection
TB	Tuberculosis
UK	United Kingdom
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session
US	United States
WHO	World Health Organization
XDR-TB	Extensively drug-resistant tuberculosis

THE GLOBAL COMMISSION ON HIV AND THE LAW

The Global Commission on HIV and the Law is an independent body that consists of fourteen distinguished individuals who advocate on issues of human rights, HIV, public health, law and development.

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The Commission, convened by the United Nations Development Programme (UNDP) on behalf of the Joint United Nations Programme on HIV/AIDS (UNAIDS), issued its flagship publication *Risks, Rights & Health* in 2012. The Supplement does not reopen the content and recommendations of the 2012 report. Instead it adds to and amplifies the findings of the 2012 report.

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EXECUTIVE SUMMARY

In 2012, the Global Commission on HIV and the Law called on countries to outlaw discrimination, repeal punitive laws and enact protective laws to promote public health and human rights for effective HIV responses. Today more than 89 countries have taken action to repeal or reform laws: some have repealed laws criminalizing HIV, same-sex relations, and drug possession, and others have enacted laws advancing reproductive rights, sex education, and the human rights of people living with or at risk from HIV.

In 2015, at the United Nations (UN) General Assembly, countries unanimously adopted the 2030 Agenda for Sustainable Development (2030 Agenda). The 2030 Agenda, grounded in human rights principles, established an ambitious target to end the epidemics of AIDS and tuberculosis (TB). The 2030 Agenda made a bold pledge to leave no one behind.

This Supplement highlights developments since 2012 in science, technology, law, geopolitics, and funding that affect people living with or at risk from HIV and its co-infections. The recommendations add to and amplify those of the Commission's 2012 report *Risks, Rights & Health*, which remain as relevant as they were six years ago.

FINDINGS

HIV treatment increased but AIDS is not over; other epidemics loom. Of the estimated 36.7 million people living with HIV, 20.9 million were receiving anti-retroviral therapy (ART) by mid-2017, almost triple the number in 2010. Declines in new HIV infections among adults are far too slow, threatening further progress towards the end of the AIDS epidemic. HIV continues to be a disease of the vulnerable, marginalised and criminalised—gay men and other men who have sex with men, transgender people, people who use drugs, sex workers, prisoners, migrants and the sexual partners of these populations. Key populations and their sexual partners account for 47% of new HIV infections in 2017. Adolescent girls and young women aged 15-24 suffered 20 percent of all new HIV infections.

Progress is also dogged by epidemic **viral hepatitis** and **tuberculosis**, co-infections that complicate and threaten the lives of people with HIV, and vice-versa. About 2.8 million people living with HIV are co-infected with hepatitis C virus (HCV) and 2.6 million with hepatitis B virus (HBV). Globally, more than 13 percent of people with TB tested for HIV received positive results, and TB is the leading cause of HIV-related deaths. New medications can cure HCV within two to three months with minor side-effects. More countries are using legal and policy remedies to bring down high costs of medicines to increase treatment access. But lack of investment in research and development (R&D) of new diagnostics and tolerable treatments for TB, a disease of the poor, has made cure of this ancient disease elusive for far too many people.

Science leapt forward. Three major studies have proved that HIV-positive people with viral loads sufficiently suppressed by ART pose a zero risk of transmission. At the same time, pre-exposure prophylaxis (PrEP), taken as prescribed, protects the uninfected from contracting HIV in almost all instances. These facts have helped lawyers defend against prosecutions for HIV exposure and transmission based on the misconception that HIV is a “deadly weapon.” Still, advocates are concerned about the misuse of DNA analyses to infer transmission and the use of artificial intelligence to identify HIV “suspects.”

Online markets for medications and “self-initiated interventions” such as readily available HIV tests are enabling people to care for their own health reliably and without stigma, even where products are sometimes inaccessible or illegal in the countries where these people reside. But efficacy, safety, and privacy are concerns, and effective regulation is needed.

Civic space shrank. Between 2012 and 2015, more than 60 countries drafted or enacted laws, or stepped up enforcement of older ones, to outlaw, harass, vilify, attack, or bankrupt civil society organisations and international

aid groups that help them. Lesbian, gay, bisexual and transgender (LGBT) people have been targeted with special brutality, including through “anti-homosexuality propaganda” laws. A virtual public square, the Internet, also became a site of corporate exploitation, government surveillance, content manipulation, and incitement to violence against “undesirables.”

Donor funding dropped. In 2015, donor funding for HIV fell by 13 percent. “Middle-income countries” now shoulder more than half the burden for financing HIV responses. Funding gaps extend to TB and viral hepatitis as well. New economic realities require financial innovation. But there is no substitute for solidarity between the wealthy and the poor - an approach that has yielded significant progress in the global AIDS response. Latest data shows no significant new commitments from donors and donor government funding for HIV decreased in 2017.

Criminalisation persisted. As of July 2018, 68 countries criminalise HIV non-disclosure, exposure or transmission, or allow the use of HIV status to enhance charges or sentences on conviction. HIV prosecutions have been reported in 69 countries. Belarus, Canada, Russia and the United States lead in the number of prosecutions. In some countries TB patients have been criminalised for not adhering to and completing treatment.

Anti-sex work laws remain problematic. Several countries have adopted the “end-demand” model of arresting sex workers’ clients rather than the workers themselves. With the noble intent of ending human trafficking, in 2018 the United States (US) passed legislation allowing legal action against websites that host ads for paid sexual services. Sex workers say that such laws erode their safety, control and earnings. New research concludes that decriminalisation of adult consensual sex work could significantly reduce HIV infection among sex workers.

The war on drugs goes on. Some countries decriminalised possession of small quantities of drugs. Still, depending on the locality, people who use drugs often remain excluded from HIV, TB, and hepatitis treatments, or are subjected to coerced or confined TB treatment. Imprisoned patients are lost to follow up. Mothers who use drugs were especially vulnerable, locked up while pregnant to compel recovery and threatened with loss of child custody if they failed to pursue treatment after birth.

Borders tightened. With the 258 million migrants, including 28.5 million refugees and asylum seekers, some countries adopted restrictive immigration policies, including visa denials, screenings, and deportation based on health status.

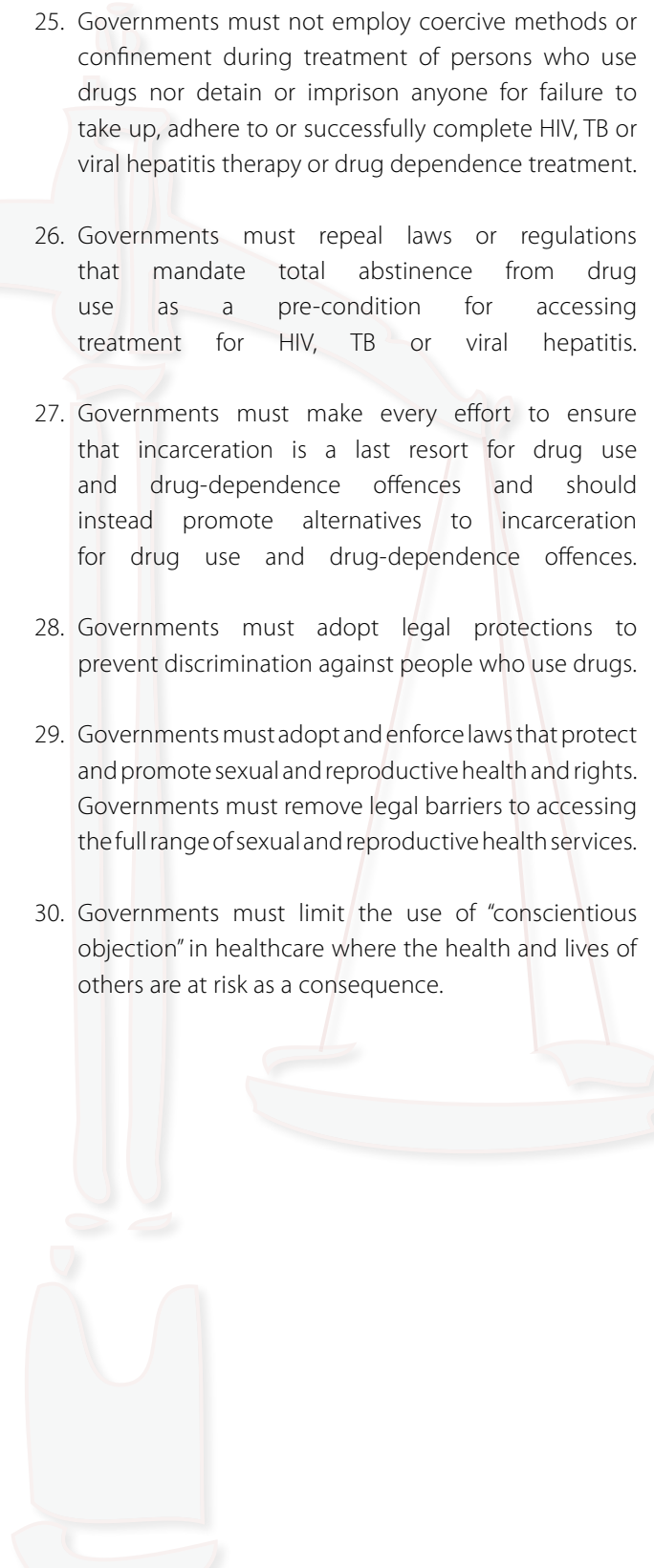
Women and girls left further behind. Criminalisation, discrimination and violence continue to undermine women’s and girls’ ability to protect their health and realise their rights. Sexual and reproductive health and HIV are closely linked. Legal and human rights barriers continue to impede access to sexual and reproductive health services and increase women’s and girls’ vulnerability and risk. Healthcare providers in over 70 jurisdictions have used conscientious objection to deny care to women and girls. The 2017 US “global gag rule” is compounding risk and increasing vulnerability.

RECOMMENDATIONS

In addition to the recommendations made in the Commission’s 2012 report *Risks, Rights & Health*, to ensure effective, sustainable health responses consistent with universal human rights obligations, the following measures must be adopted as a matter of urgency:

1. Governments must prohibit in law all forms of discrimination against people living with and vulnerable to HIV, TB or viral hepatitis. Governments must take steps to repeal or amend any laws or policies that discriminate against people based on HIV, TB or hepatitis status.
2. Governments and other funders of biomedical R&D must urgently increase investments in R&D of new health technologies, including diagnostics, medicines and vaccines for HIV, TB and viral hepatitis. Governments and public funders of R&D must consider and implement alternative policies such as tax incentives and prize awards to encourage R&D investment by the private sector in neglected diseases such as TB.
3. Governments must ensure that everyone living with or at risk of acquiring HIV, TB, or viral hepatitis has affordable access to the most effective, high-quality health technologies, including diagnostics, medicines and vaccines for HIV, TB and viral hepatitis.

4. Governments must establish legal protections to safeguard the privacy and confidentiality of social media users, digital health technologies, online healthcare records, electronic medical records and communications with healthcare providers. Governments must protect sensitive health information such as HIV status or hepatitis or tuberculosis infection against unjustifiable access and impose strong penalties on those that violate users' rights.
5. Governments must stop the use of laws restricting the registration and operation of civil society organisations or their sources of funding to curtail their activities. Where any such laws have been enacted, countries must repeal or refrain from enforcing them.
6. Governments must enact laws that provide an enabling environment for civil society organisations to operate, including those providing services to populations living with or affected by HIV, TB or viral hepatitis.
7. Governments must refrain from enacting laws that require non-heterosexual sexual orientations to be portrayed as inherently inferior.
8. Donors and governments must sustain support to civil society programmes and legal reform efforts aimed at defending and promoting the human rights of people living with HIV, TB or viral hepatitis, particularly in marginalised groups.
9. Assuming that the transition from international to domestic funding continues, donors must ensure that they do not desert countries with inadequate resources for effective responses to HIV and its co-infections.
10. Governments must assume greater responsibility for financing their HIV, TB and hepatitis responses. This includes ensuring sufficient investment in human rights programmes for law reform and access to justice.
11. Governments and the private sector must adjust their policies and subventions for universal health coverage to focus on the rights of individuals to access the highest attainable standard of health. They must not derogate from individual rights provided in international human rights law by reference to economic classifications of national wealth that result in derogations from these human rights.
12. Governments must prohibit the non-consensual use by law enforcement or private entities of digitally-collected or stored private information, especially data related to sexual and reproductive health. Such data must not be used for discriminatory purposes or for commercial surveillance, profiling or targeting, except as provided by law, with the informed consent of the subjects and in circumstances consistent with universal human rights.
13. Governments must stop the censorship and restriction on Internet access and communication except where provided by law that is consistent with universal human rights law. Governments must facilitate the use of Internet and evidence-based information, education and communications platforms to promote access to health and rights information and services.
14. Governments must refrain from denying entry, restricting their travel within national borders or deporting people living with HIV, TB or viral hepatitis based on their positive status. Governments must repeal such laws where they exist.
15. Governments must not mandate universal HIV, TB, or viral hepatitis testing of foreign nationals. If such laws or policies exist, they should be repealed or abolished. Any requirements to undergo such tests should only occur where provided for by law, for proper purposes consistent with universal human rights law.
16. Governments must provide migrants, including asylum seekers or refugee applicants, access to the full range of health services including for HIV, TB and viral hepatitis regardless of immigration status. Governments must provide this standard of care in detention and confinement settings.
17. Governments must amend laws and policies that deter health seeking among migrant populations, such as requirements to show national identification documents, residence cards, or to only receive treatment in their home region or country.

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18. In countries where HIV criminalisation laws still exist, courts must require proof, to the applicable criminal law standard, of intent to transmit HIV. The intent to transmit HIV cannot be presumed or derived solely from knowledge on the part of the accused of positive HIV status and/or non-disclosure of that status; from engaging in unprotected sex; by having a baby without taking steps to prevent mother-to-child transmission of HIV; or by sharing drug injection equipment.
 19. Governments must ensure that, where an HIV-specific law has been repealed, there is a restriction on the application of any general laws to the same effect either for HIV or TB.
 20. Governments must prohibit the prosecution—under HIV-specific statutes, drug laws, or child abuse and neglect laws—of women living with HIV for choices they make during and after pregnancy, including about breastfeeding children.
 21. Whenever HIV arises in the context of a criminal case, police, lawyers, judges and where applicable, juries, must be informed by the best available scientific evidence concerning the benefits and consequences of appropriate therapy, and the individual and community advantages of maintaining such therapy.
 22. Governments must ensure that HIV status is not used as such to justify pre-trial detention, segregation in detention or prison, or harsher or more stringent sentences or conditions of parole or probation following release from custody.
 23. Governments must refrain from adopting laws based on the “end-demand” model of sex work control and repeal such laws where they exist.
 24. Governments must not pass laws prohibiting, penalising, or enabling legal action against Internet site owners or other media interests that accept advertisements for sex work. If such laws have been adopted, the governments concerned must repeal them.
 25. Governments must not employ coercive methods or confinement during treatment of persons who use drugs nor detain or imprison anyone for failure to take up, adhere to or successfully complete HIV, TB or viral hepatitis therapy or drug dependence treatment.
 26. Governments must repeal laws or regulations that mandate total abstinence from drug use as a pre-condition for accessing treatment for HIV, TB or viral hepatitis.
 27. Governments must make every effort to ensure that incarceration is a last resort for drug use and drug-dependence offences and should instead promote alternatives to incarceration for drug use and drug-dependence offences.
 28. Governments must adopt legal protections to prevent discrimination against people who use drugs.
 29. Governments must adopt and enforce laws that protect and promote sexual and reproductive health and rights. Governments must remove legal barriers to accessing the full range of sexual and reproductive health services.
 30. Governments must limit the use of “conscientious objection” in healthcare where the health and lives of others are at risk as a consequence.

INTRODUCTION: SIX YEARS ON...

Six years since its publication, the report of the Global Commission on HIV and the Law, *Risks, Rights & Health*, remains relevant. A legal environment that respects, protects and fulfils human rights, and promotes overall health and well-being, is an efficient and effective means of reducing the risks and the toll of disease on people and resources.¹ Laws alone are insufficient to achieve these objectives, but bad laws are a serious impediment to health and good laws can contribute to good health.

The overarching recommendations of the Global Commission on HIV and the Law are as urgent as ever:

- Outlaw discrimination and violence against people who are living with and vulnerable to HIV;
- Repeal laws that control and punish people who are living with and vulnerable to HIV; and
- Adopt laws and policies that enable effective prevention, treatment, and care and uphold human rights.

These principles find strong endorsement in the 2030 Agenda, grounded in the human rights principles of the dignity of the individual, equality, and non-discrimination.² Sustainable Development Goal (SDG) 16 envisions "... peaceful and inclusive societies...[and] access to justice for all...". SDG 3 commits the international community to "ensure healthy lives and promote well-being for all at all ages".³ The targets of SDG 3 include:

- Ending the epidemics of AIDS, TB, and other diseases;
- Combatting hepatitis;
- Ensuring universal access to sexual and reproductive healthcare services;
- Supporting research and development of vaccines and medicines especially for diseases that primarily affect developing countries; and
- Providing access to affordable essential medicines and vaccines.⁴

The 2030 Agenda boldly pledges to leave no one behind, and to reach the furthest behind first.⁵

Several other global agreements, declarations and strategies echo the messages of the Commission's 2012 report.⁶ Such declarations and blueprints are crucial, as are the legal and policy reforms proposed to realise them. However, such reforms take time. In the last six years, UNDP, in partnership with other UN entities, civil society and development partners, has supported governments in 89 countries to advance the recommendations of the Global Commission on HIV and the Law. Taking up one of the Commission's most pressing recommendations, in 2015, then-UN Secretary General Ban Ki-moon established the High-Level Panel on Access to Medicines.⁷ This panel made recommendations for addressing incoherencies and longstanding misalignments between international human rights, trade, intellectual property, and the public health objectives of the 2030 Agenda and the SDGs.⁸

PROGRESS

To people living with and vulnerable to HIV, the past half-decade has delivered remarkable advances. In 2012, the World Health Organization (WHO) issued guidelines for the use of pre-exposure prophylaxis (PrEP), a combination of anti-retroviral medicines that significantly reduces the risk of HIV transmission.⁹ By 2017, three major studies had provided robust evidence that ART can suppress a person's HIV viral load to undetectable levels. The statistical risk of HIV transmission from a person living with HIV whose viral load is suppressed is zero.¹⁰ The tools for preventing and treating HIV are better than ever.¹¹ However, it is not yet time to declare victory in the struggle to end AIDS.

Access to HIV treatment has greatly expanded. Of the estimated 36.7 million people worldwide living with HIV, 20.9 million were receiving ART by mid-2017, almost triple the number in 2010. New HIV infections are down 11 percent among adults and 47 percent among children.¹² New medications can cure HCV, an HIV co-infection, in almost all cases, within two to three months, with minimal side effects.¹³

The legal picture is brighter in some respects. Thanks in large part to unceasing pressure from civil society, many governments have updated or repealed some of the worst laws criminalising HIV exposure, transmission, and non-disclosure, and the possession and use of illicit drugs.¹⁴ Every year more legal codes remove the stigma of criminalisation for LGBT people, enact positive protections against discrimination, and empower the formation of legally-recognised relationships and families.¹⁵

REGRESSION

Despite these encouraging advances, this half-decade has also witnessed several examples of stagnation and even backsliding on progress for those living with HIV and its co-infections. While new HIV infections decline, the number of people living with HIV has risen steadily: There are an estimated 2.7 million more people today living with HIV than there were in 2010.¹⁶ Members of marginalised populations – gay men and other men who have sex with men, people who use drugs, sex workers, transgender people, prisoners, and their sexual partners – accounted for 47 percent of new infections in 2017.¹⁷ Viral hepatitis and TB, the leading co-infections for people living with HIV, are treatable, yet millions are not being treated. The new treatments for HCV are too expensive for millions to access.¹⁸ Governments, funders and biomedical companies have invested little in developing diagnostics, vaccines, or medicines for TB, a disease of poverty and inequality, making the cure of this ancient disease elusive for far too many people.

Highly lamentable is the failure to stop infection and death among young people. Adolescent girls and young women aged 15-24 account for 20 percent of all new HIV infections, despite accounting for just 11 percent of the population.¹⁹

These marginalised populations, in many places, are under attack by the very governments that are obliged to protect their health and rights. With alarming vigour, many governments are rescinding women's reproductive rights, persecuting LGBT people, sex workers, and people who use drugs, and stifling the civil society groups that provide services, hold governments to account and mobilize calls for justice. These wrongs are happening despite the clear evidence presented in the report of the Global Commission on HIV and the Law that outreach to and collaboration with key populations have positive benefits for reversing the HIV epidemic.

Persecution, along with economic hardship and violent conflict are among the causes driving an unprecedented number of people from their homes: 258 million migrants, including 28.5 million refugees and asylum seekers, are now in search of safety and hope.²⁰ With uncertain access to food, clean water and health services, they are vulnerable to illness and violence, including gender-based and sexual violence.²¹ This massive displacement, which should trigger a greater outpouring of aid and solidarity, instead receives insufficient attention in the news-cycle and the political discourse.²²

In another blow to global solidarity, donor funding for AIDS fell by 13 percent in 2015, the same year that countries adopted the 2030 Agenda and pledged to leave no one behind.²³ More than half the financial burden of the HIV epidemic in the so-called low- and middle-income countries now rests on domestic governments.²⁴ In reality, some of these countries are the least able to afford such expenditures and many will fail to reach the SDG targets.

THE FUTURE

This Supplement builds on the 2012 report by highlighting recent developments in HIV-related science and the legal environment, both for better and for worse. It links these to the evolving global political and funding situation. The Supplement particularly highlights the worrying medical, social, and fiscal impact of HIV's close companions, TB and viral hepatitis. The need to focus on HIV, TB and viral hepatitis in this Supplement is based on a greater understanding of the extent to which these diseases interact. The risk of acquiring any of the three diseases creates reciprocal, interdependent effects²⁵ and the populations living with and vulnerable to these diseases often suffer from stigma, discrimination and punitive laws, policies and practices. In this Supplement, the Commission offers further and more detailed recommendations regarding the law in light of the new realities. Finally, as in 2012, the Supplement amplifies the voices of people living with and vulnerable to HIV, and now, those living with TB and viral hepatitis, as well as their families, sexual partners and communities. It recognises and highlights the work of those dedicated to making human rights declarations and public health strategies an everyday reality. It is for these individuals and their dependants that the bold vision for global human rights, justice and development, set forth in the 2030 Agenda and in the original report of the Global Commission on HIV and the Law, must be achieved.

Snapshot of progress (2012-2018)



Laws

Some countries have reformed their laws to promote more evidence- and rights-based responses to HIV.

- HIV criminalisation laws have been removed in a number of countries – for example, Ghana, Greece, Honduras, Kenya, Malawi, Mongolia, Switzerland, Tajikistan, Venezuela, Zimbabwe, and two states in the US.
- Other countries including Belize, Mauritius, Mozambique, Nauru, Palau, São Tomé and Príncipe, Seychelles and Trinidad and Tobago have decriminalised adult, consensual same-sex relations.
- A number of countries have decriminalised some aspects of drug possession or use – for example, Canada, Colombia, Jamaica, Norway and Uruguay have decriminalised possession of small amounts of cannabis, and Jamaica expunged the criminal records of low-level drug offenders.
- Some countries have taken important steps to improve access to sexual and reproductive healthcare services for young people – for example, women and girls led successful advocacy in Costa Rica, Ecuador, El Salvador and Guatemala for laws recognising the right to comprehensive sexuality education.
- Several countries have taken steps to enact or reform laws to protect women from violence - for example, Tunisia recently passed a law to end violence against women in public and private life and Jordan and Lebanon have closed “marry-your-rapist” loopholes in their legal codes.



Civil society

Civil society continues to play a vital role in the fight for dignity and justice, leading efforts on legal awareness, legal aid, strategic litigation, law reform and advocacy. For example, the Regional HIV Legal Network provides people with HIV and marginalised groups access to quality free legal aid in Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Kyrgyzstan, Moldova, Russia and Ukraine. The Middle East Network on Legal Aid, a civil society coalition, provides legal aid services for people living with HIV and marginalised groups in a number of countries. Strategic litigation led by civil society, in several countries such as Belize, Botswana, India, Kenya, Malawi, Uganda and Ukraine, has advanced the rights of those most vulnerable to HIV.



Funding

Scaling up human rights programmes such as law reform and access to justice takes time and requires substantial investment. The 2017-2022 strategy of the Global Fund to Fight AIDS, TB and Malaria: Investing to End the Epidemics has a high-level objective on human rights which calls for scaling up human rights programmes and interventions to support women and girls, such as those to advance sexual and reproductive health and rights.

THE LAW: ADVANCING JUSTICE AND PROTECTION



Our engagement with the parliament committees, especially the committee on HIV and AIDS, has made it possible for our organisation to attain the objectives in the work that we are involved in, that of ensuring access to treatment for all as part and parcel of bringing change and development to Malawi.

Malawi Network of People Living with HIV/AIDS

In the past six years dozens of states and jurisdictions have taken steps, informed by evidence and human rights obligations, towards ending AIDS. These include:

- Decriminalising HIV exposure, non-disclosure and unintentional transmission;
- Decriminalising consensual same-sex relations;
- Legally recognising same-sex relationships;
- Decriminalising or legalising possession and personal use of identified illicit drugs;
- Making reproductive and sexual healthcare services more accessible to adolescents, in part by lowering the age of consent; and
- Tackling harmful cultural practices such as child, early, and forced marriage.

In short, a range of countries have ceased punishing people who are vulnerable to HIV, and instead have begun to use the law to protect their rights to life, health, bodily autonomy, equality and privacy.³⁶

Civil society and organisations of people living with and affected by HIV have been on the frontlines, leading advancements in justice and protection. For example:

- Serbia's Centre for the Empowerment of Youth has investigated claims of discrimination by dentists against people living with HIV.³⁷
- LGBT groups in Belize have collaborated to advance the rights of their members through the courts.³⁸
- While fighting for repeal of punitive laws, the sex worker organisation Alliance of Women Fighting for Change brought together police, health providers, and sex workers to find ways to work around repressive laws. In Uganda, one in three sex workers are HIV-positive.³⁹
- In 2012, the Law Enforcement and HIV Network published a Statement of Support for harm reduction approaches, signed by over 10,000 police and police agencies around the world.⁴⁰
- In May 2018, Irish citizens voted to recognise and uphold women's right to abortion in law, by a two-to-one majority, after achieving a similar result in May 2015 to confer equal legal recognition on same-sex relationships.

Courts leading the way

MALAWI: EL v Republic (2016)³¹

A woman living with HIV and on ART was convicted under Section 192 of the Penal Code for an “unlawful, negligent or reckless act that is likely to spread a disease dangerous to life.” Her crime: breastfeeding a child while living with HIV. Although the child did not contract HIV, EL was charged nonetheless. Without a lawyer, EL pleaded guilty and was sentenced to nine months’ imprisonment. Later with legal representation, EL appealed to the High Court. She relied on evidence drawn from Malawi’s HIV policy and the WHO and UNICEF Guidelines on HIV and Infant Feeding. These and the fact that she was on ART established the infinitesimal chance of her transmitting HIV to the child. The ruling illustrated the importance of grounding judicial decisions in scientific evidence and affirmed the law’s function in protecting people living with HIV from “the unjust consequences of public panic.”

INDIA: Kaushal Kishore Tripathi v Lal Ram Sarup TB Hospital and others (2016)³²

The petitioner was diagnosed with TB in 2013. As the drugs prescribed failed to slow the course of the young woman’s illness, her family travelled 660 miles to access bedaquiline – a new treatment for drug-resistant TB (DR-TB), at a government hospital in New Delhi. The hospital denied the petitioner access because she was not a New Delhi resident. The young woman had extensively drug-resistant TB (XDR-TB) confirmed by a drug susceptibility test (DST) in 2014, as well as extensive clinical history of treatment failure. The hospital wanted another DST done in 2016 before it would consider providing bedaquiline. Bedaquiline is only available in a handful of Indian cities and then only for the small number of patients with laboratory evidence of XDR-TB. The family based her claim on the grounds that the woman had a right to life-saving treatment, claiming that her medical history indicated a likelihood of XDR-TB. The Court ordered that bedaquiline be administered to the petitioner and also required the national drug regulatory agency to process her application for another drug-resistant TB drug, delamanid, within 24 hours. The petition also led the Government of India to remove the residency criterion for bedaquiline eligibility.

CANADA: Attorney General of Canada v Bedford and others (2013)³³

The applicants, three advocates for sex workers’ rights, argued that Canada’s prostitution laws were unconstitutional. Even though prostitution, as such, was legal under Canadian law, the Criminal Code outlawed a number of related acts, such as operating a “bawdy house”, using public communication for the purposes of prostitution, and living off its gains. The applicants argued that such laws deprived sex workers of their right to security of work by forcing them to work secretly. In 2012, Ontario’s Court of Appeal ruled that some of the law’s prohibitions violated the Canadian Charter of Rights and Freedoms and were unconstitutional. In 2013, the Supreme Court of Canada ruled unanimously that all such restrictions were unconstitutional and directed Parliament to amend the laws in accordance with its ruling. The Canadian Government propounded the amended law on 6 November 2014 in compliance with the deadline given by the Supreme Court.

BOTSWANA: ND v Attorney General of Botswana and others (2017)³⁴

A transgender man petitioned the Court to compel the Registrar of the National Registration of Botswana to issue new identity documents to reflect his male gender. The High Court ordered the Registrar to change the gender marker on the document from female to male. “Gender identity constitutes the core of one’s sense of being and is an integral (part) of a person’s identity,” the Court observed. “Legal recognition of the applicant’s gender identity is therefore part of the [fundamental] right to dignity and freedom to express himself in a manner he feels ... comfortable with.” The Court declared that lack of such recognition in Botswana exposed transgender persons to discrimination, stigma, and harassment. It noted the distress that the applicant experienced when required to explain intimate details of his life to strangers whenever he sought routine services. That ordeal amounted to a violation of his right to privacy, which the state could prevent or minimise by allowing him to change the gender stated on his identity document.

TRINIDAD & TOBAGO: Jason Jones v Attorney General of Trinidad and Tobago (2017)³⁵

The claimant petitioned the court to strike down Sections 13 and 16 of the Sexual Offence Act and by so doing to decriminalise consensual sexual relations between persons of the same sex. Responding to the State’s argument that the law was needed to maintain traditional family values, the court asked, “What is a traditional family? If it is limited to a mother, father and children, then ... the rationale for keeping that template is no longer sufficiently important as the rationale for denying the claimant’s fundamental rights. For example, single-parent families are becoming the norm, which is unsettling to many traditionalists despite its reality.” In ruling the two sections of the Act unconstitutional, the court recognised that “the beliefs of some, by definition, [are] not the belief of all”. It held that the Constitution of the Republic of Trinidad and Tobago protected all.

SCIENCE



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When the Commission's report was published in 2012, HIV had long ceased to be a deadly disease. Instead, with ART, HIV had been transformed to a chronic condition with which people could live long, fulfilling lives. With highly active ART, an HIV-positive mother could give birth and nurse without passing the virus on to her baby.³⁶ Today scientists know and speak with increasing authority on the role of ART as HIV prevention.³⁷

TREATMENT AS PREVENTION

Three major studies prove decisively that ART can suppress a person's HIV viral load to less-than-measurable levels, bringing sexual transmission rates for HIV statistically to zero.³⁸ The proved effects of ART have transformed the daily lives of people living with HIV. This is giving rise to new and different public health campaigns, policies and strategies worldwide.³⁹ This fact can and must change the law and its enforcement.

PrEP

In 2012, WHO first published guidance on the use of oral PrEP for sero-discordant couples, transgender women and men who have sex with men.⁴⁰ PrEP, has been shown to be safe and effective at preventing HIV, when taken as prescribed.⁴¹ Today, over 40 countries are offering PrEP to those most vulnerable to contracting HIV.⁴² Costs are a concern, for rich as well as poorer countries.⁴³ However, even at the highest prices, the economic considerations strongly support the public health case: the costs of HIV

Scientists never like to use the word never. But I think in this case we can say that the risk of transmission from an HIV-positive person who takes treatment and has an undetectable viral load may be so low as to be unmeasurable, and that's equivalent to saying they are non-infectious. It's an unusual situation when the overwhelming evidence base in science allows us to be confident that what we are saying is fact.

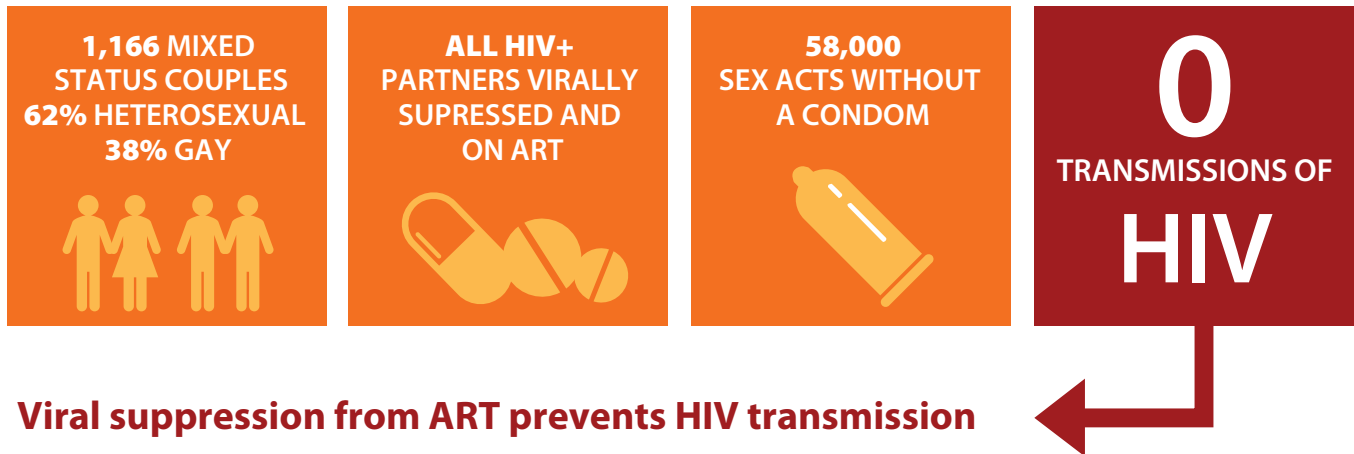
Anthony Fauci, Director, National Institute for Allergies & Infectious Diseases, United States

dwarf those of providing PrEP to everyone at high risk.⁴⁴ This realisation was at the heart of the ruling of the Court of Appeal of England and Wales in the United Kingdom confirming that the power to commission and fund PrEP lies with the competence of the National Health Service (NHS) England.⁴⁵ However, PrEP is still not available in most parts of the world.⁴⁶

According to WHO, PrEP is an additional HIV prevention choice and should not replace or undermine other effective, well-established HIV prevention interventions such as condom use.⁴⁷ The consistent use of latex condoms is still a highly effective means of preventing the spread of HIV and other sexually transmitted infections (STIs). In fact, an increase in potentially risky sex without condoms, in communities where PrEP is more widely used, has worrying ramifications for the transmission of other diseases.⁴⁸ While these concerns make the case for complementary efforts on STI prevention, they do not justify not providing PrEP to people who are at high risk of acquiring HIV.

The Partner Study found that daily PrEP use among sero-discordant couples was even more effective than we thought.

Nelly Mugo, Principal Research Scientist, Kenya Medical Research Institute



Viral suppression from ART prevents HIV transmission

Source: Rodger A. et al (2016), *Sexual activity without condoms and risks of HIV transmission in serodifferent couples when the HIV-positive partner is using suppressive antiretroviral therapy* JAMA. 2016;316(2):171–181. doi:10.1001/jama.2016.5148 and and AVERT, *Treatment as prevention (TasP) for HIV*,[2017]. Available at <https://www.avert.org/professionals/hiv-programming/prevention/treatment-as-prevention>

CO-INFECTIONS

A potentially optimistic outlook for HIV is clouded by two other epidemic illnesses: TB and viral hepatitis. People living with HIV are disproportionately susceptible to these co-infections and vice-versa.⁴⁹ These co-infections tax fragile, over-extended health systems. They threaten already limited health budgets.⁵⁰

VIRAL HEPATITIS

Hepatitis is a virus that causes a chronic and potentially fatal liver disease. Globally, an estimated 240 million people are living with HBV and 130-150 million with HCV. There are 8 million new infections yearly between the two.⁵¹ Experts warn that without a more urgent, comprehensive response, little progress will be made in reducing these numbers in the next half-century.⁵² About 2.8 million people living with HIV are co-infected with HCV and 2.6 million with HBV.⁵³ Viral hepatitis progresses more rapidly to liver damage in people living with HIV, while also undermining the management of the HIV infection.⁵⁴ Globally viral hepatitis results in an estimated 1.4 million deaths a year from complications including cirrhosis, liver cancer, and liver failure—a comparable number to the deaths caused by TB and HIV.⁵⁵ The number of people dying from viral hepatitis is climbing.⁵⁶

In high-prevalence countries, the main mode of transmission of HBV is from mother-to-child.⁵⁷ The most

common way to contract HCV is through sharing needles from injecting drugs—although the virus can also spread through non-sterilized medical and dental tools as well as blood products, tattoo needles, and shared razors.⁵⁸ Of the estimated 12 million people worldwide who inject drugs,⁵⁹ 67 percent have HCV.⁶⁰ “Chemsex”—the use of crystallised methamphetamine and other amphetamine stimulants to intensify the sexual experience—has also been linked to risky behaviour such as sex without condoms, increasing rates of HIV and HCV transmission.⁶¹

Like HIV, both HBV and HCV can be prevented through safer sex, ensuring safe blood products and harm reduction, including the provision of clean needles for people who inject drugs.⁶² HBV is treatable, usually with lifelong medication.⁶³

Research for the treatment and cure of HCV, a disease of both rich and poor, has been well-funded resulting in an effective treatment for HCV. Direct acting antivirals, such as sofosbuvir, daclatasvir and lepidasvir, can cure more than 95 percent of people with HCV in two to three months, often with minor side effects. However, licenses negotiated between patent-holders to other manufacturers have resulted in widely varying prices for these drugs.⁶⁴ Competition may reduce prices in some instances, but excessive prices where patent rights guarantee monopolies can drain the budgets of countries excluded from voluntary

licensing agreements or from pricing discounts. Even richer countries are struggling: Canada, Italy and the US were rationing treatment for HCV at various stages, due to the high costs of medication or advanced progression of HCV.⁶⁵

When prices fall, more people are able to access treatment. Egypt, the country hardest hit by HCV, negotiated a 99 percent discount on sofosbuvir in 2014.⁶⁶ When it set up an Internet registration site, 100,000 people signed up for treatment the first day. Patients began flying in from other countries. A generic version, recently launched and manufactured in Egypt, brought the price to about \$82 per course - or as little as a dollar a day.⁶⁷ This was the price at which Yusuf Hamied, Managing Director of Cipla, an Indian generic manufacturer, committed to providing ART in 2001, dramatically altering the course of the global HIV response. In 2015, Portugal instituted universal access to HCV treatment, followed by France in 2016.⁶⁸ When Australia offered discounted HCV treatment through the national Pharmaceutical Benefits Scheme, the number of people starting treatment jumped from 7,296 in 2015 to 26,360 in less than a year. It continues to rise rapidly.⁶⁹

TUBERCULOSIS

Tuberculosis, an ancient infection, is one of the world's top 10 causes of death.⁷⁰ It is, above all, a disease of poverty and inequality. It disproportionately affects those who are malnourished or living in sub-standard conditions, as well as people who use drugs or who are prisoners. One-fourth of the world's population carries the TB bacterium.⁷¹ Without immediate action, an estimated 28 million people will die of TB by 2030.⁷² People living with HIV are 21 to 34 times more likely to develop active TB compared to those without HIV, with the speed of progression from latent TB to active TB shrinking from years to weeks.⁷³ Thirty-seven percent of deaths in people living with HIV are due to TB,⁷⁴ making TB a major cause of AIDS-related deaths.

Largely because TB afflicts the poor almost exclusively, investment in research and development of effective diagnostics, medicines and vaccines is under-resourced. In the high disease-burden countries of the developing world, access to advanced, expensive diagnostics, including rapid molecular tests, remains low. National programmes rely on old and often inaccurate tests. As a result, millions of people with active TB survive a long time before diagnosis, or are never diagnosed at all.⁷⁵ In rich countries such as the US,

TB overwhelmingly afflicts low-income people of colour,⁷⁶ who are most dependent on publicly-funded healthcare. In 2017, for instance, New York City's health department reported the largest spike in new TB infections for 26 years, which it attributed to drastic funding cuts for healthcare to vulnerable populations.⁷⁷

Even in countries where treatment for drug-sensitive TB is both affordable and available, many factors contribute to treatment failures which in turn lead to drug-resistant strains of TB. Regimens for multidrug resistant TB (MDR-TB) and XDR-TB take as long as two years to complete, though a new shorter regimen has recently been recommended for specific cases.⁷⁸ Treatment of this kind involves expensive, toxic drugs, hundreds of painful injections, and thousands of pills, with side effects ranging from severe vomiting to blindness.⁷⁹ Recent trials concluded that people living with MDR-TB and HIV face a 22 percent higher risk of developing irreversible hearing loss when they have to use the injectable treatments, than those who are HIV-negative.

Even the most aggressive medicines cure XDR-TB in only 30 to 50 percent of cases.⁸⁰ Even more disturbing than the barely-tolerable side effects for some DR-TB treatments is the fact that the only two effective medicines to treat DR-TB that have emerged in the past 40 years are neither available nor affordable to the vast majority of patients in need. Pricing and registration barriers have severely limited the availability of bedaquiline and delamanid in developing countries, particularly those with the highest burdens of disease. Reports indicate that fewer than 17,000 courses of bedaquiline and 1,500 courses of delamanid have been procured by national TB programmes globally even though approximately 480,000 people fell ill with DR-TB in 2016.⁸¹ Cost remains a key barrier with delamanid available through the Global Drug Facility at a cost of \$1,700 per course of treatment. Yet, studies have shown that large scale generic production of bedaquiline and delamanid could increase the number of patients able to access treatment between five and ten-fold with no increase in procurement expenditure.⁸²

Various human rights declarations and covenants recognise the right to health⁸³ and the right to benefit from scientific progress.⁸⁴ Both the right to health and the right to benefit from science require that new health technologies be accessible and affordable to all who need them.⁸⁵ These

declarations and covenants also guarantee the rights of scientists, inventors, and artists to receive financial rewards of their labours. The balance is not always easy to strike. Still, this latter right belongs only to natural persons, not corporations.⁸⁶ Research and the dissemination of its fruits cannot be guided by corporate priorities nor can they be manipulated to respond only to the drive for profits, for both leave millions behind.

As with HIV and viral hepatitis, HIV and TB each accelerate the progression and complicate the treatment of the other.⁸⁷ HIV, TB, and hepatitis are partners in serious and sometimes fatal health crises. And as with HIV, TB is preventable. Sadly, the levels of investments in TB prevention therapy by most governments remains lamentably low. National programmes for HIV, TB and viral hepatitis should be integrated. In doing so, governments must allocate resources equitably among them, so that none eclipses the other.

A recent open letter by the United Nations Special Rapporteur on the Right to Health to the co-facilitators of the first ever UN High-Level Meeting on Tuberculosis noted that the current level of decline in TB cases would lead to the SDG target of ending TB by 2030 actually only being met by the year 2182. The letter also included this sobering assessment:

“The lack of adequate progress in the TB response can largely be attributed to the failure of States to adopt and implement effective, rights-based, and cost-effective strategies, including universal access to good quality prevention, testing and treatment, including rapid diagnostic tests, new drugs and community-based care, legal protections against discrimination and for privacy and confidentiality, access to information about the disease, its symptoms and prevention and treatment options, and intensified efforts to address stigma and the underlying determinants of health, such as water, sanitation, the environment, housing, and food.”⁸⁸

ONLINE SOLUTIONS, AND CAUTIONS

Equally promising as any new medicine or diagnostic are the innovations in the ways that therapies can be delivered and used. “Self-initiated interventions” (SIIs) include HIV and pregnancy self-tests as well as digital health technologies such as wireless medical devices and mobile health applications with capacity to electronically store, access and

share medical records and information. These can enable people living with HIV and its co-infections to reliably and with less stigma make more informed decisions and take more control of their healthcare at home.⁸⁹ However, SIIs and digital health technologies also present concerns about safety, quality, and effectiveness.

Online buying clubs and markets can provide access to health technologies where they are either unaffordable or legally prohibited.⁹⁰ Social media such as gay dating sites offer forums to talk about HIV, share sero-status, or even receive health reminders.⁹¹ However, the Internet also opens avenues to privacy violations, both intentional and unwitting. Until 2018, the gay dating app Grindr, which has 3.6 million users worldwide, shared information about individuals’ HIV status with two data analytics companies. It did so together with Global Positioning System (GPS) data, phone numbers and emails, potentially enabling the identification of specific users.⁹² In a different incident, a sexual health clinic mistakenly revealed the email addresses of patients receiving their HIV newsletter.⁹³ Data breaches of this kind are not limited to the online sphere. In 2017, in separate incidents, two major healthcare corporations - a pharmacy chain and an insurance provider - revealed the HIV status of thousands of patients by leaving personal information visible through transparent envelope windows.⁹⁴ Depending on the circumstances, such disclosures can lead to stress, job loss, harassment, arrest or incarceration. Key populations in particular have concerns about risks and lack of protections for privacy.⁹⁵ Digital health interventions and healthcare providers that use digital platforms must include stringent protections for user safety and effective safeguards for product safety, efficacy and cost.

RECOMMENDATIONS:

To ensure effective, sustainable health responses consistent with universal human rights obligations, the following measures must be adopted as a matter of urgency:

1. Governments must prohibit in law all forms of discrimination against people living with and vulnerable to HIV, TB and viral hepatitis. Governments must take steps to repeal or amend any laws or policies that discriminate against people based on HIV, TB or hepatitis status.
2. Governments and other funders of biomedical R&D must urgently increase investments in R&D of new health technologies, including diagnostics, medicines and vaccines for HIV, TB and viral hepatitis. Governments and public funders of R&D must consider and implement alternative policies including tax incentives and prize awards to encourage R&D investment by the private sector in neglected diseases such as TB.
3. Governments must ensure that everyone living with or at risk of acquiring HIV, TB, or viral hepatitis has affordable access to the most effective, high-quality health technologies, including diagnostics, medicines and vaccines for HIV, TB and viral hepatitis.
4. Governments must establish legal protections to safeguard the privacy and confidentiality of social media users, digital health technologies, online healthcare records, electronic medical records and communications with healthcare providers. Governments must protect sensitive health information such as HIV status or hepatitis or tuberculosis infection against unjustifiable access and impose strong penalties on those that violate users' rights.



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There are new pieces of legislation almost every week – on foreign funding, restrictions in registration or association, anti-protest laws, gagging laws...You can visibly watch the space shrinking.

James Savage, Director, Human Rights Defenders Programme, Amnesty International

At the time of the Commission's 2012 report, it was hard to imagine the rise of populism and many of the repressive laws and policies that have emerged since that time. Policies of isolating and suppressing minorities and civil society have proliferated, leading to the disempowerment of both the most vulnerable in society and the organisations that provide essential services and hold governments to account. Denied protection of their human rights, every individual, particularly those living with and vulnerable to HIV, TB, and viral hepatitis, is at risk.

STIFLING CIVIL SOCIETY

Civil society is at the heart of the response to HIV and its co-infections. Between 2012 and 2015, 60 countries passed 120 laws restricting the activities of non-governmental organisations (NGOs) with more than one-third of such laws related to foreign funding of NGOs.⁹⁶ Shrinking civic space not only cripples groups defending human rights and civil liberties, it also enables further repression and condones corruption by reducing the ranks of independent watchdogs of government and corporate entities. New burdens imposed on civil society sometimes threaten health and life as well. This is because NGOs and grassroots community organisations must often act as the *de facto* providers of health, education and social services where governments fail to supply such services. Stigma, criminalisation, and official denial can distort the assessment of need and the success of programmes by driving vulnerable populations underground. The lack of data on these populations creates a paradox which reinforces their invisibility.⁹⁷

REPRESSION, NEW AND RENEWED

Discriminatory “morality” and laws against “promotion of homosexuality” (or “anti-propaganda” laws) are being promulgated in the name of religion or national security. The architects of such laws often proclaim themselves to be defenders of culture and tradition, although many such laws are often remnants of colonial-era statutes. These laws are typically vaguely worded, affording authorities broad latitude in enforcing them. In Algeria, for example, a 2014 iteration of an article of the Penal Code provided fines or imprisonment in the case of any person who possessed, disseminated or displayed anything that constituted a “breach of modesty.”⁹⁸ In Malaysia, the Federal Court overturned a lower court’s decision and restored a ban on “crossdressing” by Muslim transgender persons.⁹⁹

Since 2012, some governments have enacted laws forbidding groups that engage LGBT people to register as officially sanctioned NGOs, striking not just at the activities but also the organisational structures of civil society. Without registration, these groups cannot sign a lease, open a bank account, or apply for a public-assembly permit. China, India, and Russia have blocked donations to HIV-related

human rights NGOs. New laws have interrupted donations from abroad, implying that they constitute covert enemy actions in collusion with local civil society antagonistic to traditional culture.¹⁰⁰

Civil society organisations from a number of African countries report that in spite of constitutional provisions protecting free speech and assembly, civil society activities have been seriously impeded through overregulation, bureaucratic obstacles, surveillance, and funding limits.¹⁰¹ Following the 2013 passage of the Russian Federation law “For the Purpose of Protecting Children from Information Advocating for a Denial of Traditional Family Values,” state-controlled media gave voice to homophobic statements expressed by politicians, religious leaders, and other public figures. Human rights and LGBT rights defenders could not effectively respond as any such response would itself have been classified as “propaganda.” The negative consequences of such laws extend to the beneficiaries of civil society groups who can end up without access to essential health information and services. The “anti-propaganda” law of the Russian Federation also led to a ban by the authorities of web-resources providing basic information on LGBT issues, including on HIV prevention and support for gay and bisexual men living with HIV.¹⁰²

In some instances, civil society is using the law to resist such attacks. For example, in Uganda, litigation led to the invalidation of the Anti-Homosexuality Act that had imposed severe punishments on gay persons.¹⁰³

CLOSING THE FUNDING GAP

According to UNAIDS, donor funding for HIV is currently running \$7.2 billion short of what is needed to end AIDS as a public health threat.¹⁰⁴ Donor government spending on HIV in low- and middle-income countries declined by 13 percent or more than \$1 billion from 2014 to 2015. Latest reports show no significant new commitments from donors and donor government funding has still not returned to its peak level in 2014.¹⁰⁵

The taxonomy of high-, middle- and low-income countries, the analytical classification of the national economies based on gross national income rather than the number of people living in poverty or wealth distribution, has further muddied the waters. This taxonomy has no reflection in international human rights law, nor is it reflected in the SDGs. It is therefore not permissible to diminish or deprive individuals of human rights guaranteed by law on the basis of economic classification, however convenient this taxonomy may be for other purposes.

As economic growth moves poorer countries to middle-income status in the international classification of overall national wealth, their eligibility for donor assistance diminishes. And yet two-thirds of the poor and the majority of people with TB and untreated HIV live in middle-income countries.¹⁰⁶ Funding strategies of health donors encourage countries to assume more of the burden. In 2016, domestic resources accounted for 57 percent of resources for HIV in low- and middle-income countries.¹⁰⁷

Of an estimated \$9.2 billion per year needed to adequately support TB prevention, diagnosis and treatment, only \$6.9 billion was made available in 2017.¹⁰⁸ The total cost of implementing WHO's Global Health Sector Strategy on Viral Hepatitis for 2016–2021 is \$ 11.9 billion alone¹⁰⁹; much more by way of donations is needed to meet this target.¹¹⁰ Advocates express concern that the slow pace of reducing new HIV infections compared with galloping increases in TB and hepatitis will fuel "AIDS fatigue" and lead donors to neglect HIV even further. Of course, donors will set their own priorities.¹¹¹ Unfortunately, the needs of people living with and vulnerable to HIV, TB and viral hepatitis may not neatly conform to categories determined by governments, philanthropic bodies and multilateral organisations. Vulnerable and marginalised people will certainly be left further behind.

DONOR PRIORITIES

How will countries that struggle to provide the most basic healthcare make up the growing shortfall in donations? The answer is that some will not. If past experience is anything to go by, the first subventions to fall will be those supporting human rights programming. Already such programmes are limping along, wounded by the decline in funding. In 2015 UNAIDS calculated that \$137 million was provided for the global human rights response to HIV each year, a fraction of spending on the overall HIV response in low- and middle-

income countries alone. Among so called low- and middle-income countries reporting to UNAIDS, a mere 0.13 percent of total AIDS spending was allocated for human rights advancement. Most HIV organisations naturally integrate the protection of human rights into their advocacy and services. With smaller donations anticipated, however, these organisations expect to see the capacity to advance HIV-related human rights decline even further.¹¹² As for the often slower and longer-term work of legal and policy reform, a lack of adequate data makes it is hard to know either how much is spent or how much of that money remains available.

The fact that only 1% of overall global AIDS resources address human rights programming offers a critical and urgent opportunity for private philanthropy to exercise its unique power to fund where others won't, and to mobilize civil society to hold all donors accountable to their commitments to fully fund efforts to combat those human rights abuses that have long fuelled the epidemic.

**John Barnes, Executive Director,
Fundors Concerned about AIDS**

The example of Romania illustrates how diminishing resources and the denial of human rights combine to hurt people in need. With Global Fund support, Romania launched a highly praised needle and syringe exchange and opioid substitution programme in 2010. Then, under the new Global Fund policy transitioning out of middle-income countries, Romania lost the Global Fund's support. The government did not fill the gap, with dire consequences for many individuals: HIV prevalence among people who inject drugs surged from 3.3 percent in 2009 to 27.5 percent in 2013. A specific HIV outbreak among drug users around 2011 has been directly linked to the significant decline in harm reduction services following the Global Fund transition out of the country.¹¹³

INEQUALITY AND SOLIDARITY

When international donations decline, global bodies remind donors of their obligations to uphold economic solidarity. Some countries step in when other countries step back, as when the restoration of the US "global gag rule"

in 2017 inspired a range of countries to contribute to the Netherlands-led “She Decides” Fund, which aims to promote access to family planning goods and services, sex education, safe abortion, and maternity care.¹¹⁴

While development slowly narrows the gap between countries, income and wealth inequalities *within* countries are widening. Between 2012 – 2016, 10 percent of the top income earners received 63 percent of the national income in South Africa; 55 percent in Brazil and 47 percent in the US.¹¹⁵

In Africa the countries with the highest HIV prevalence—in order, Swaziland, Lesotho, Botswana, South Africa, and Namibia,¹¹⁶ are also the world’s seven most unequal economies in terms of wealth distribution.¹¹⁷

As they assume more of the costs of HIV and its co-infections, national governments will be compelled to identify efficiencies.¹¹⁸ Progressive taxation, such as Zimbabwe’s 3 percent AIDS levy on individuals’ income and corporate profits¹¹⁹, could potentially contribute to rebuilding public infrastructure and meeting the needs of people living with HIV, TB or viral hepatitis.

More wealth in fewer hands creates more poverty.¹²⁰ The importance of eradicating poverty is recognised by the first SDG. A commitment to attacking today’s growing economic inequalities is a pledge to solidarity and to the rights, health, and well-being of all the world’s people.

PRIVATE SECTOR RESPONSIBILITY

Given the increasing globalised economic role that the private sector plays, its role in fighting HIV, TB and viral hepatitis has become more important than ever.

Standards of conduct for business, such as the ones developed by the UN Office of the Commissioner for Human Rights on tackling discrimination against LGBT people,¹²¹ are a new approach to harnessing the potential of the private sector for societal improvement. Many of the companies that have committed to the business standards argue that improved conditions for LGBT people will ultimately benefit their company’s moral and economic bottom line.¹²²

Other companies have opted to support efforts in the fight against HIV more directly. For example, Viiv Healthcare, a

producer of ARV medicines, started a foundation supporting civil society groups working on HIV particularly groups working with key populations.¹²³ Product (Red) is an example of companies coming together to increase resources for Global Fund-financed programmes.¹²⁴

Biomedical companies have a specific role to play in the fight against HIV, TB, viral hepatitis and other epidemics. While some producers of ARV medicines, and in particular some patent holders, have been accused of price gouging,¹²⁵ in several cases this has led to reduced prices for poorer countries as patent holders grant the right to manufacture cheaper generic medicines. Companies benefitting from epidemics have a special role to play in making and keeping medicines accessible for all in need.

The private sector can also support HIV and sexual health efforts by connecting dating site or application users to health services and facilitating awareness among vulnerable groups of the availability of medicines.

SURVEILLANCE, VIRTUAL AND ‘INTELLIGENT’

For people living in repressive spaces, cyberspace can be an open civic space, a place to connect with partners, friends, associates and allies, to access and share information, including on sex education or information on safe practices. Yet a range of governments are increasingly monitoring and censoring the use of the Internet by groups and individuals whom they deem to be undesirable. In 2017 there was a dramatic increase in efforts by governments to manipulate information on social media, censor mobile connectivity, restrict video streaming, arrest people trying to record human rights abuses, and carry out cyberattacks on news outlets, political opposition and human rights defenders.¹²⁶

In 2016, 38 countries initiated criminal processes based on social media posts or sharing or “liking” content on Facebook. Thirty countries engaged in political interference of discussion on social media, disseminating misinformation, attacking opponents, and fuelling violence. Some governments are using social media platforms like Facebook and Instagram to identify and arrest gay people and those who “follow” them.¹²⁷ In addition to violating privacy, this is making it more difficult to use these platforms to provide essential health and rights information.

Other new technologies present potential for misuse. Of particular concern has been the advent of artificial intelligence facial recognition. Police and immigration authorities use this software to identify criminal suspects. However, critics say the systems are no more than crude, inaccurate racial profiling dressed up as science.¹²⁸ Several academics have published research concluding that facial recognition technology could also identify the subject's sexual orientation.¹²⁹ The article, which appeared to lack peer review, has been dismissed by critics as "junk science."¹³⁰ Nevertheless, employed without the subject's knowledge or consent, artificial intelligence facial recognition of this kind violates the right to privacy of those affected.

BARRED BORDERS

Repressive legislation extends to immigration, affecting migrants seeking new homes for their families. Globally, there are an estimated 258 million migrants, 28.5 million of whom are refugees and asylum seekers.¹³¹ For migrants

living with HIV and its co-infections, repressive laws and policies can be life-threatening.

While images of migrants on the move to Europe in search of safety and opportunity is widely covered in international media, in fact the developing world, including some of the world's poorest countries, hosts 84 percent of the world's displaced persons.¹³² Even in countries with well-financed systems for processing migration and asylum applications, new and harsh laws exclude undocumented migrants from national or local services or social insurance programmes essential to human existence and survival.¹³³

FEAR OF CONTAGION

Migration, especially when caused by sudden and dangerous events, frequently exposes those involved to fatigue, malnutrition, shortages of water and inadequate access to treatment. These conditions are great challenges to human health. In some regions, migration itself is



an independent risk factor for HIV and other infections and diseases.¹³⁴ In South-East Asia, for instance, the HIV prevalence among migrants to Thailand from Cambodia, Myanmar, southern China and Vietnam is up to four times that of their respective general populations.¹³⁵ Health risks are exacerbated in areas of armed conflict, where healthcare facilities are demolished and healthcare workers flee, along with other residents. The same is true of countries such as Venezuela, which since 2015 has seen AIDS deaths double because of an ongoing economic and political crisis.¹³⁶ Some groups of migrants bear a higher risk of TB depending on their places of origin, yet they face barriers in accessing treatment, care and support services.¹³⁷

Immigration authorities may use health status to set conditions on the provision of visas. They may decline to issue visas or decide to deport foreign nationals. According to researchers, the United Arab Emirates requires any foreign national applying for a work permit to be tested for HIV with the result that those found to be HIV-positive are liable to be deported immediately.¹³⁸ Such policies violate the universal human rights to confidentiality and informed consent, privacy, bodily integrity, and medical care. The fear of deportation or of being denied refugee status based on HIV-positive status may discourage people, rather than encourage them, from accessing testing and, where available, ART or other healthcare. In the case of TB, deportation can also increase the risk of treatment interruption. This in turn increases the likelihood of developing drug-resistant forms of TB.¹³⁹

Recent epidemics such as severe acute respiratory syndrome (SARS) and Ebola, as well as instances of bioterrorism have heightened the vigilance and hostility of many governments. Tougher immigration policies can reinforce myths about infections and distort public health messages and responses.¹⁴⁰ This is especially so for stigmatised diseases like HIV and TB which may be viewed as “foreign” imports.

THE RIGHT INTENTIONS

Human rights instruments since World War II reiterate and elaborate the principles that all migrants are entitled to freedom from arbitrary detention, slavery, torture, and to the enjoyment of rights such as the rights to health, housing, and education.¹⁴¹ Recent reports stress the importance of keeping the administration of general public services separate from immigration enforcement.¹⁴² However, the asserted right of nations to regulate immigration can conflict with this basic human right to sanctuary.¹⁴³

Domestic statutes sometimes affirm universal human rights principles and guarantee access to HIV and health services to migrants. For instance, laws in several European countries entitle migrant children access to the same healthcare as their nationals receive. Sometimes they cover migrants’ healthcare costs.¹⁴⁴ It is unclear whether these laws are being implemented.¹⁴⁵ For example, across the European Union, unaccompanied refugee children are frequently denied healthcare, education, and permanent housing. In 2017 the British press revealed that the NHS was turning away thousands of undocumented migrants in the UK in need of urgent healthcare.¹⁴⁶ Effective implementation of inclusive laws which grant access to healthcare services to migrants can only contribute to stemming the tide of HIV and its co-infections.

RECOMMENDATIONS:

To ensure effective, sustainable health responses consistent with universal human rights obligations, the following measures must be adopted as a matter of urgency:

1. Governments must stop the use of laws restricting the registration and operation of civil society organisations or their sources of funding to curtail their activities. Where any such laws have been enacted, countries must repeal, or refrain from enforcing, them.
2. Governments must enact laws that provide an enabling environment for civil society organisations to operate, including those providing services to populations living with or affected by HIV, TB or viral hepatitis.
3. Governments must refrain from enacting laws that require non-heterosexual sexual orientations to be portrayed as inherently inferior.
4. Donors and governments must sustain support to civil society programmes and legal reform efforts aimed at defending and promoting the human rights of people living with HIV, TB, and viral hepatitis, particularly for marginalised groups.
5. Assuming that the transition from international to domestic funding continues, donors must ensure that they do not desert countries with inadequate resources for effective responses to HIV and its co-infections.
6. Governments must assume greater responsibility for financing their HIV, TB and viral hepatitis responses. This includes ensuring sufficient investment in human rights programmes for law reform and access to justice.
7. Governments and the private sector must adjust their policies and subventions for universal healthcare to focus on the rights of individuals to access the highest attainable standard of health. They must not derogate from individual rights provided in international human rights law by reference to economic classifications of national wealth that result in derogations from these human rights.
8. Governments must prohibit the non-consensual use by law enforcement or private entities of digitally-collected or stored private information, especially data related to sexual and reproductive health. Such data must not be used for discriminatory purposes or for commercial surveillance, profiling or targeting, except as provided by law, with the informed consent of the subjects and in circumstances consistent with universal human rights.
9. Governments must stop the censorship and restriction on internet access and communication except where provided by law that is consistent with universal human rights law. Government must facilitate the use of internet and evidence-based information, education and communications platforms to promote access to health and rights information and services.
10. Governments must refrain from denying entry, restricting their travel within national borders or deporting people with HIV, TB or viral hepatitis based on their positive status. Countries must repeal such laws where they exist.
11. Governments must not mandate universal HIV, TB or viral hepatitis testing of foreign nationals. If such laws or policies exist, they should be repealed or abolished. Any requirements to undergo such tests should only occur where provided for by law, for proper purposes consistent with universal human rights law.
12. Governments must provide migrants, including asylum seekers or refugee applicants, access to the full range of health services including for HIV, TB and viral hepatitis regardless of immigration status. Governments must provide this standard of care in detention and confinement settings.
13. Governments must amend laws and policies that deter health seeking among migrant populations, such as requirements to show national identification documents, residence cards, or to only receive treatment in their home region or country.

PUNISHMENT



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The use of laws and policies to discriminate against people living with HIV, TB or viral hepatitis, or to criminalise sex work, drug use, same sex relations or expressions of identity, are often enacted and enforced in the name of public health and safety. However, they usually result in the opposite, especially for marginalised groups. These laws can be considered “status offences” insofar as they criminalise categories of people seen as deviant, immoral or subversive. People have several intersecting identities. They may not just be a transgender woman or a person who uses drugs. They may also be a sex worker, a refugee or a member of a racial minority. Thus, repressive laws affect people in multiple ways, to the detriment of their health, freedom and well-being.

PEOPLE WITH HIV

In 2012, the Commission reported that 60 countries had criminal or civil laws penalising HIV non-disclosure, exposure or transmission, even if unintentional.¹⁴⁷ As of July 2018, 68 countries criminalise HIV non-disclosure, exposure or transmission or allow the use of HIV status to enhance charges or sentences on conviction. Sometimes statutes allow the use of HIV status to enhance or aggravate criminal

Most [HIV criminalisation] laws are appallingly broad, and many of the prosecutions under them have been wickedly unjust. HIV criminalisation is bad, bad policy...It undermines the remarkable scientific advances and proven public health strategies that open the path to vanquishing AIDS by 2030.

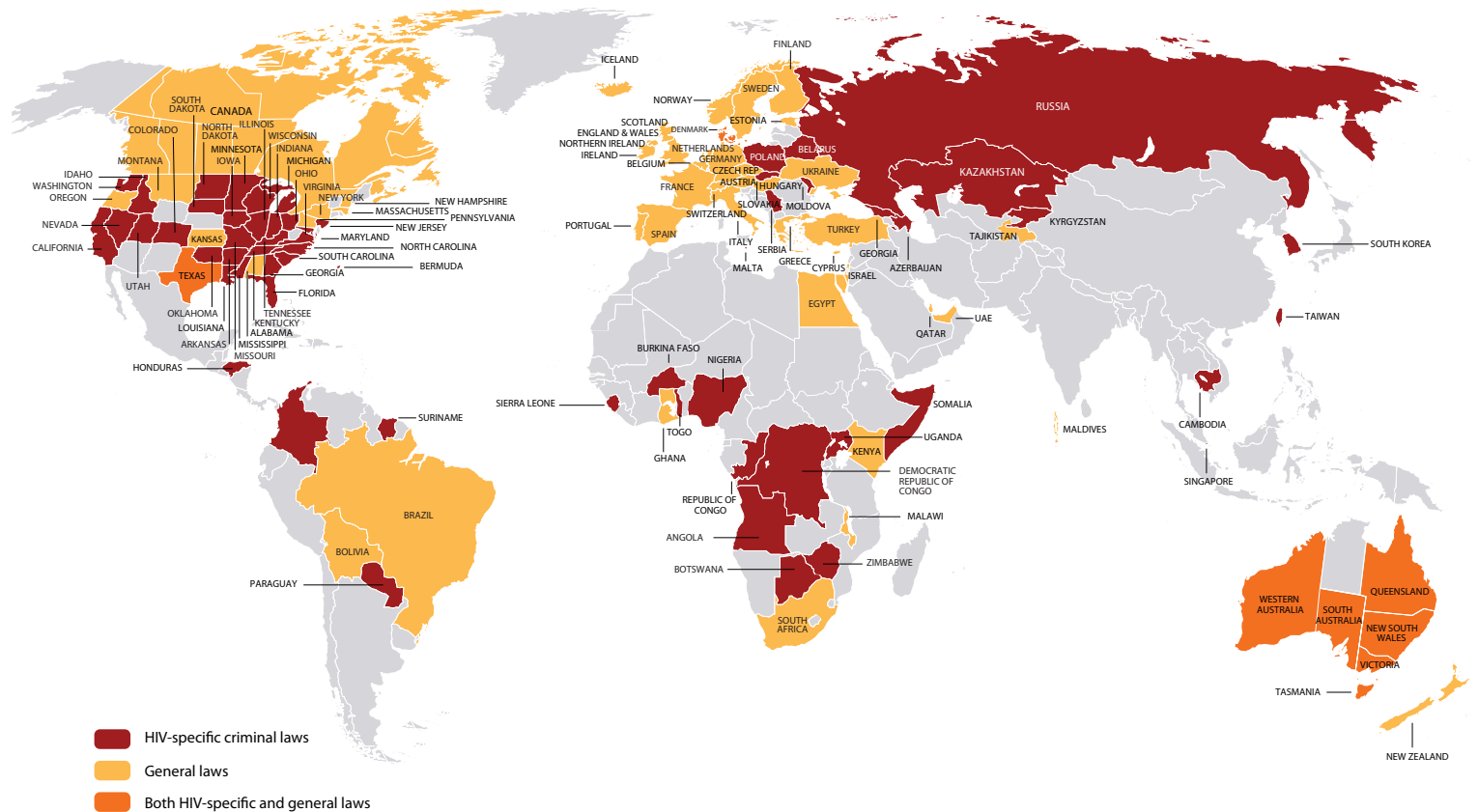
Edwin Cameron,
Justice of the Constitutional Court of South Africa

charges or sentences. Not all countries with HIV-specific laws have enforced them. Other countries have applied general laws, such as attempted murder, poisoning, bodily harm or sexual assault laws against people living with HIV. As of September 2017, HIV prosecutions had been reported in 69 countries with Belarus, Russia, Canada and the United States in the top four.¹⁴⁸ As more countries heed advocacy to repeal HIV-specific criminalisation laws, attention must be paid to these overly broad general laws which have the potential of being used to prosecute not only people living with HIV, but also people with HIV-co-infections.¹⁴⁹

Conviction for an HIV-related sex offence carry even graver consequences than the primary custodial or financial punishment as lawmakers impose longer prison sentences for “sex offenders”, as well as imposing the requirement to list in public sex offender registers, crippling restrictions on work, residence, travel and family relations, and deportation of non-citizens.¹⁵⁰

These laws blatantly disregard up-to-date knowledge on the science of HIV-related risks and harms.¹⁵¹ Recent research strongly supports the findings of the Commission’s 2012 report that HIV criminalisation fails to encourage safer behaviour; it may even result in greater risks.¹⁵²

PROSECUTING THE VIRUS



Source: HIV Justice Network. Countries where prosecutions have ever taken place [as of September 2017]. Available at <http://www.hivjustice.net/site/countries/>

The safety of my office was shattered and physician-patient privilege was lost by the intrusion of these criminalisation charges... Nearly 30 percent of my colleagues confirm that they too have had criminal prosecutions invade their patient relationships. Criminalization laws do nothing to advance individual or public health, but...have the potential to corrupt the physician-patient relationship which I believe can be a powerful tool in the armamentarium to address the epidemic.

Wendy Armstrong, Director, Infectious Disease Fellowship Training Programme, Emory University, US

prosecutor congratulated her on helping put a “scumbag” behind bars, the doctor felt defeated as her fundamental oath to “do no harm” had been violated and she was reduced to a person who had harmed, rather than helped, her patient.¹⁵³

My life will not be the same after facing HIV criminalisation. My 30 years as a nurse and dedicated to saving lives have been erased. I have spent almost a year in prison. I have been branded a criminal and a killer even though I have harmed no one.

Rosemary Namubiru, convicted Ugandan nurse living with HIV

Less often discussed, however, is the impact of these laws on healthcare professionals. A physician compelled to testify in the US at the criminal trial of her HIV-positive patient described being put in the position of betraying both her own ethics and the patient’s privacy and trust. When the

JUSTICE AND SCIENCE

The proved fact that a fully suppressed viral load means a zero chance of HIV transmission¹⁵⁴ can help lawyers defend clients who face harsh penalties for allegedly exposing sexual partners to HIV. However, advocates worry that using suppressed viral load as an argument for innocence can imply that those who are less able to achieve viral suppression, owing to a range of social or economic determinants, are more likely to be found guilty, exacerbating biases in criminal legal systems against people who may be the least able to access care.¹⁵⁵

Phylogenetic analysis, a methodology by which scientists can compare partial DNA or RNA sequences from different sources to infer evolutionary relationships among them, has given scientists great insight into HIV transmission and prevention. Phylogenetics can definitively rule out a link between one person's HIV and that of another person if the strains are different. However, phylogenetics has severe limits as a forensic tool because even where it establishes a link between two people, it cannot confirm the direction or time of transmission, that is, whether person B contracted HIV from A or vice versa or from a third person C who may have contracted it from A.¹⁵⁶ Thus, phylogenetics cannot prove a connection beyond reasonable doubt.¹⁵⁷

Another troubling development is the potential misuse of phylogenetics in disease surveillance programmes. Epidemiologists can analyse DNA data derived from HIV drug-resistance tests to identify molecular or transmission "clusters"¹⁵⁸ with the intention of containing the virus. However, people living with HIV fear that this confidential information could sometimes be used coercively or punitively against individuals.¹⁵⁹

SEX WORKERS



The consensus reached by the 2030 Agenda is an extraordinary opportunity to consolidate achievements in terms of women's rights, promoting the right to decent and recognised work, as well as access to health services for the prevention of HIV... Sex workers are not the problem but part of the solution.

RedTraSex Latin America Network of Sex Workers

Female sex workers are on average 13.5 times more likely to be living with HIV than women of reproductive age.¹⁶⁰ As described in the Commission's 2012 report, sex-work-related violence, stigma, and most of all, criminalisation, exacerbate the risk of contracting HIV.

In recent decades in several countries, sex worker policy has been influenced by a framing of the sex worker as victim and the client as exploiter, thereby rejecting a scenario where adult parties engaged in a voluntary and consensual exchange of services for financial and other benefits. The "end-demand," or "Nordic," model exemplifies this approach. It criminalises clients rather than sex workers. Although it is not clearly established that such initiatives deter or reduce sex work or HIV transmission,¹⁶¹ several countries, including Canada,

France, and Northern Ireland, have enacted similar laws, promoting them as a progressive response to an age-old conundrum.¹⁶²

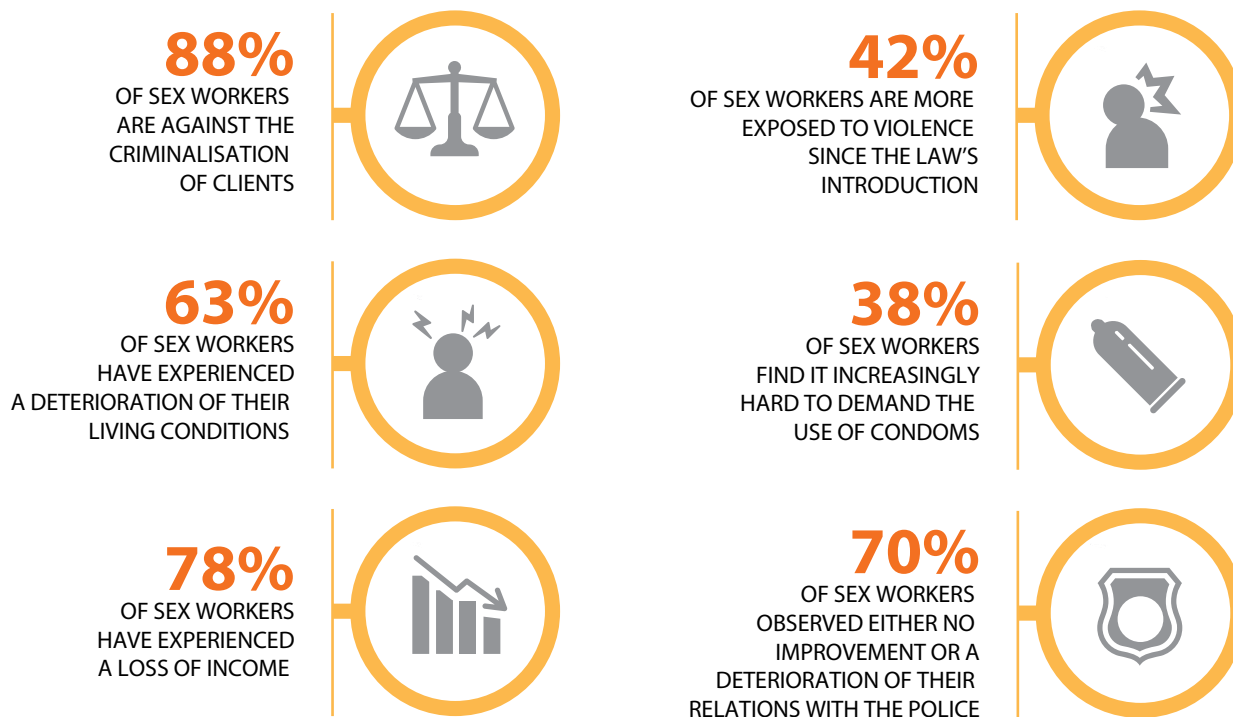
The Swedish Sex Purchase Act of 1999, which criminalises the client and those living off the earnings of sex work, is held up as a success story by the Swedish government.¹⁶³ However, some Swedish and international scholars question their assessment.¹⁶⁴ A 2014 review of the legislation by the Swedish Association for Sexuality Education and Malmo University found that it was unclear to what extent mobile phones and the Internet, rather than the law, may have accelerated the reduction in street sex work by bringing buyers and sellers together electronically.¹⁶⁵ Another 2014 study, supported by Sweden's Public Health Agency, revealed problems for sex workers in accessing healthcare and HIV prevention, as well as sex workers' lack of confidence in the authorities and a reluctance both to contact health services and get tested for HIV and other STIs.¹⁶⁶ The study also revealed that stigma against sex workers remains widespread, making it difficult

for sex workers to get help from social services and the police, and stoking their fear of eviction or loss of custody of their children.¹⁶⁷

After France adopted the "end-demand" model in 2016, the majority of nearly 600 sex workers surveyed a year later by an international humanitarian aid organisation said the new law had a detrimental effect on [their] safety, health and overall living conditions. Thirty-eight percent said it negatively affected their ability to negotiate safer sex as male clients felt that the burden of legal risk was no longer on the sex worker but on them, the clients under the new law.¹⁶⁸ In all, 88 percent of the sex workers surveyed opposed the criminalisation of clients.¹⁶⁹

As increasing numbers of sex workers go online to advertise services and conduct business transactions, lawmakers are also adopting laws to "protect" them in cyberspace. In 2018, the United States enacted the Allow States and Victims to Fight Online Sex Trafficking Act (FOSTA). This makes it easier

IMPACT OF CRIMINALISING SEX WORKERS' CLIENTS IN FRANCE



Source: Le Bail H. and Giametta C. (2018), *What do sex workers think about the French Prostitution Act: A study on the impact of the Law from 13 April 2016 against the 'prostitution system' in France.* Figures represent the % of the 583 sex workers who took part in the survey. Available at <https://www.medecinsdumonde.org/sites/default/files/ENGLISH-Synth%C3%A8se-Rapport-prostitution-BD.PDF>

for individuals and law enforcement to shut down websites which they assert are abetting trafficking by accepting sex advertisements.¹⁷⁰

Sex worker organisations that lobbied unsuccessfully to stop the law claimed that FOSTA would rob them of independence, income and safety by driving their work underground. It would send them onto the street where they were more likely to get arrested, and it would block channels through which they could share information and access peer-counselling.¹⁷¹ The use of online platforms to advertise their services enhances sex workers' safety, autonomy, and control over their working conditions. Although mainly American-owned, such Internet platforms are global, so sex workers are potentially affected worldwide.

The evidence is stronger than ever that criminalisation of sex work results in a heightened HIV risk and "end demand" models do not lessen it.¹⁷² A review of 27 countries found that "countries that have legalised some aspects of sex work have significantly lower HIV prevalence among sex workers," especially if such legalisation operates in concert with fair and effective law enforcement.¹⁷³ Another study concluded: "Decriminalisation of sex work would have the greatest effect on the course of HIV epidemics across all settings, averting 33 to 46 percent of HIV infections in the next decade."¹⁷⁴

PEOPLE WHO USE DRUGS

Drugs have destroyed many lives, but wrongheaded governmental policies have destroyed many more. I think it's obvious that after 40 years of war on drugs, it has not worked.

Kofi Annan, former UN Secretary General

Levels of HCV co-infection are extremely high among people who use drugs.¹⁷⁶ Of an estimated 15.6 million people who inject drugs worldwide, almost one in six are living with HIV. Over half have HCV.¹⁷⁷ Criminalisation of the possession, use and cultivation of small amounts of illicit drugs leaves a trail of damage for people living with HIV and its co-infections. As described in the Commission's 2012 report, criminalisation drives people who use drugs underground. This leads to

unsafe practices which, in turn, increase the risk of infection for both them and their sexual partners in the wider community. A 2017 systematic review further supports this finding, concluding that criminalisation of drug users undermines HIV prevention and treatment.¹⁷⁸

PEOPLE IN PRISONS

Criminalising the possession and use of even small quantities of illicit drugs means that many would-be law-abiding people who use drugs run the risk of imprisonment. In one study, over 60 percent of people who inject drugs had been incarcerated at some point in their lives.¹⁷⁹

Incarceration increases susceptibility to disease.¹⁸⁰ Needle-sharing and tattooing contribute to HIV rates as high as 40 percent among people who inject drugs in prison,¹⁸¹ where the risk of developing active TB is 23 times higher than average.¹⁸² The UN Standard Minimum Rules for Treatment of Prisoners, promulgated in 1955 and now called the Nelson Mandela Rules, mandate that prisoners should "enjoy the same standards of healthcare that are available in the community," without charge or discrimination. This is to include "continuity of treatment and care, including for HIV, viral hepatitis, TB and other infectious diseases, as well as for drug dependence."¹⁸³ Unfortunately, most prisons around the world are not following these rules. Only 40 countries have at least one prison that offers access to HIV treatment or opioid substitution treatment (OST).¹⁸⁴

The situation outside the prisons is not much better: Less than 1 percent of people who inject drugs live in countries where needle syringe exchange and OST levels are categorised as high, that is, more than 200 needle-syringes distributed per year per person who injects.¹⁸⁵

Progress, when it occurs, is too slow. After 20 years of pressure from public health experts and advocates, including through litigation before the courts, in 2018 the Canadian government finally conceded to provide needle-exchange programmes in prisons.¹⁸⁶

TREATMENT DENIED OR COMPELLED

In spite of their high susceptibility to illness,¹⁸⁷ people who use drugs are commonly barred from HCV treatment programmes, some pre-emptively, others

From “objects to subjects”

For two decades the members of the Network of Sex Workers of Latin America and the Caribbean (RedTraSex) have been empowering themselves to create a legal environment in which they can perform their work safely and with dignity acceptable to themselves. Working in 14 countries, RedTraSex has won legal recognition as an industrial union in Argentina, Colombia, Guatemala, Nicaragua and Peru. The group has published guidelines for unbiased and respectful healthcare practices, trained 8,900 law enforcement officials across the region between 2013 - 2018, and persuaded police and prosecutors to address legal and human rights violations by security and police, including extortion, theft, and forced sex. In 2017 the sex workers prompted the Inter-American Commission on Human Rights (IACHR) to hold its first hearing for women sex workers. After this gathering, the IACHR urged Member States in the region to design regulations and policies guaranteeing the human rights of sex workers, including measures to protect their lives and end stigmatisation and discrimination against them.

“We went from being objects to subjects of policies and actions in favour of ourselves,” RedTraSex wrote. “[Persecution has] united us, forged our identity as sex workers and . . . encouraged us to establish our organisations, instead of lowering our heads.”¹⁷⁵

through burdensome counter-productive bureaucratic requirements.

At the same time, some jurisdictions force people with TB to undergo treatment and, if they resist, they are detained and compelled to submit to treatment. In Kenya TB patients who do not adhere to their TB treatment risk custodial sentences. In 2016 three Kenyans successfully challenged their eight-month prison sentence.¹⁸⁸ In some places, expectant mothers who use drugs are detained and forced into drug treatment, sometimes for the duration of their pregnancy.¹⁸⁹

The ramifications of abandoning people who use drugs can be severe. When authorities of the Russian Federation abruptly ended methadone treatment in Crimea in 2014 when that territory was seized from Ukraine, patients went back to street drugs. Some left Crimea. Many died.¹⁹⁰ In 2016 the Russian Federation acknowledged its millionth case of HIV, with the epidemic leaking from the margins back into the general population.¹⁹¹

‘UNFIT’ MOTHERS

For women, the intersection of poverty, criminalisation, motherhood, and illicit drugs can be deadly. Poorly educated women in poorer countries are often forced into the drug trade, in Latin America as “mules” smuggling

contraband over borders,¹⁹² or in Thailand, Afghanistan and Myanmar as small farmers cultivating opium poppies.¹⁹³ For these minor sometimes coerced acts, women face harsh penalties that may exceed those commonly imposed for rape or murder.¹⁹⁴ International and domestic anti-drug policies are the leading cause of the rising incarceration of women.¹⁹⁵ Once in prison the likelihood of female prisoners contracting HIV, TB or viral hepatitis climbs significantly.

Women who use illicit drugs are often designated by authorities as unfit mothers.¹⁹⁶ In some jurisdictions in the US, a history of drug use can trigger loss of parental rights for female prisoners.¹⁹⁷ Pregnant women who want to quit drugs or get ART to protect their children instead avoid clinics due to the risk of losing their children.¹⁹⁸ In Estonia, “when women call the police in cases of aggressive behaviour by their male partners, the police often inform child protection services. This may result in the loss of custody of the child. The police may also prosecute a woman for a drug offence, instead of protecting her from violence.”¹⁹⁹ Mothers may be forced to stop OST against WHO recommendations, in order to maintain custody of their children. If an active drug user gives birth in prison, the authorities commonly take away custody of the baby who is raised separately.²⁰⁰



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Underlying these practices are widespread stereotypes and myths about people who use drugs:

- They are reckless, weak-willed, and self-destructive;
- They will not comply with treatment for their addictions; and
- Their behaviours will render HIV, TB or viral hepatitis treatment ineffective.²⁰¹

In fact, people who use drugs ordinarily adhere to treatment as faithfully as other groups.²⁰² HCV therapeutics are effective even for people who continue to inject drugs, particularly if they are also on ART.²⁰³

END THE WAR

The first step to alleviating these miseries is to decriminalise the possession or cultivation of drugs for personal use and to correct the imbalance in global drug policy that skews the governing policy towards law enforcement at the expense of human rights and public health.²⁰⁴ The outcome

document of the 2016 United Nations General Assembly Special Session on the World Drug Problem²⁰⁵ won praise in many quarters as the strongest endorsement of a rights-based approach ever adopted in a UN drug control measure.²⁰⁶ In 2018, the UN Commission on Narcotic Drugs for the first time approved a resolution to remove stigma as a barrier to healthcare and services for people who use drugs.²⁰⁷ These developments are an encouraging sign of progress. However, without a systematic effort to embed human rights principles in drug control laws and policies, progress is likely to be very limited. In response, a broad coalition of lawyers, political leaders, academics, civil society, communities of people who use drugs and UN organisations is presently developing International Guidelines on Human Rights and Drug Control.²⁰⁸

RECOMMENDATIONS:

To ensure effective, sustainable health responses consistent with universal human rights obligations, the following measures must be adopted as a matter of urgency:

1. In countries where HIV criminalisation laws still exist, courts must require proof, to the applicable criminal law standard, of intent to transmit HIV. The intent to transmit HIV cannot be presumed or derived solely from knowledge on the part of the accused of positive HIV status and/or non-disclosure of that status; from engaging in unprotected sex; by having a baby without taking steps to prevent mother-to-child transmission of HIV; or by sharing drug injection equipment.
2. Governments must ensure that, where an HIV-specific law has been repealed, there is a restriction on the application of any general laws to the same effect either for HIV or TB.
3. Governments must prohibit the prosecution under HIV-specific statutes, drug laws, or child abuse and neglect laws, of women living with HIV for choices they make during and after pregnancy, including about breastfeeding children.
4. Whenever HIV arises in the context of a criminal case, police, lawyers, judges and where applicable, juries, must be informed by the best available scientific evidence concerning the benefits and consequences of appropriate therapy, and the individual and community advantages of maintaining such therapy.
5. Governments must ensure that HIV status is not used to justify pre-trial detention, segregation in detention or prison, or harsher or more stringent sentences or conditions of parole or probation following release from custody.
6. Governments must refrain from adopting laws based on the “end-demand” model of sex work control and repeal such laws where they exist.
7. Governments must not pass laws prohibiting, penalising, or enabling legal action against Internet site owners or other media interests that accept advertisements for sex work. If such laws have been adopted the governments concerned must repeal them.
8. Governments must not employ coercive methods or confinement during treatment of persons who use drugs nor detain or imprison anyone for failure to take up, adhere to or successfully complete HIV, TB or viral hepatitis therapy or drug dependence treatment.
9. Governments must repeal laws or regulations that mandate total abstinence from drug use as a pre-condition for accessing treatment for HIV, TB or viral hepatitis.
10. Governments must make every effort to ensure that incarceration is a last resort for drug use and drug-dependence offences and should instead promote alternatives to incarceration for drug use, and drug-dependence offences.
11. Governments must adopt legal protections to prevent discrimination against people who use drugs.

FURTHER BEHIND



ADOLESCENT GIRLS AND YOUNG WOMEN

As a young woman living with HIV, I want to see the integration of HIV and sexual and reproductive health services in one place.

Tranisha Arzah, peer advocate, Seattle, Washington

Sexual and reproductive health and HIV are closely linked. The same adolescent girls and young women disproportionately affected by HIV also face barriers to sexual and reproductive health services. Women living with HIV are more likely to experience violence,²⁰⁹ including violations of their sexual and reproductive rights.²¹⁰ Involuntary and coerced sterilisation and forced abortion among women living with HIV have been reported worldwide.²¹¹ Mandatory HIV testing for pregnant women may be a barrier to antenatal care. Legal barriers to sexual and reproductive care also impede progress in addressing HIV.

The Commission's 2012 report discussed the multiple and intersecting conditions, including legal barriers, which leave women and girls particularly vulnerable to HIV.²¹² By almost every measure of vulnerability, women, including transgender women, are disadvantaged in comparison to men.²¹³ Today it is clear that adolescent girls and young women are uniquely endangered. In 2015, adolescent girls and young women comprised 60 percent of those aged 15 to 24 years living with HIV and almost the same percentage of new HIV infections were among this cohort. There is no region in the world where HIV prevalence among females aged 15 to 24 does not exceed that among older women.²¹⁴ Worldwide, only 22 percent of females aged 15 to 24 years old have access to contraceptives, compared with 60 percent of women over 30.²¹⁵ Sexual and reproductive health services are unavailable to unmarried women in much of the world.²¹⁶ While there has been some progress on ending child marriage, one in four girls worldwide is married before she turns 18, in some places far younger than that, thereby increasing HIV risk.²¹⁷

The rights of girls and young women with disabilities are diminished by multiple perils.²¹⁸ Families and educators avoid talking to them about their bodies and feelings. Girls and young women with disabilities are often shamed, demeaned, and married off to anyone who will accept them, irrespective of their wishes.²¹⁹ They are more at risk of contracting HIV than boys and young men of the same age, yet they are less likely to receive information about safer sex, testing, or treatment.²²⁰

Globally, law and policy in more than 70 jurisdictions currently allow healthcare providers to refuse to provide health services to girls and young women based on claims of "conscience."²²¹ While these claims are mostly invoked in the case of the termination of pregnancies, reports suggest that healthcare providers are increasingly using "conscience" claims to deny access to contraceptives including condoms, and to refuse treatment to LGBT people and their families as well as women seeking sexual and reproductive health services.²²² Various human rights declarations and covenants protect the freedom to hold and express religious and ideological beliefs. However, they do not recognise a right of conscientious objection when those beliefs conflict with someone else's rights to health and life.²²³

For more than a quarter of a century, human rights advocates have asserted that sexual and reproductive health and rights are basic human rights.²²⁴ The right to sexual and reproductive health free from coercion, discrimination and violence is widely recognised in both international human rights treaties and normative documents. For example, the African Union's Maputo Protocol guarantees women's rights to health including sexual and reproductive health.²²⁵ Such commitments should be more extensively and consistently reflected in national laws. Countries must also act to remove legal barriers such as criminalisation, discrimination and violence in healthcare settings.²²⁶

GAGGED

Unless we can fill the \$80 million gap created by the "global gag rule", it will deprive millions of women of the contraception they need to prevent an unintended pregnancy, and it is the world's poorest women and girls who will bear the brunt.

Marjorie Newman-Williams, Marie Stopes International

The defence of sexual and reproductive rights and the delivery of healthcare services costs money. In 2017 the US—the world's largest HIV, health and family planning donor—began severely restricting the flow of funds by reinstating and expanding its Mexico City Policy, also known as the "global gag rule". This rule prohibits foreign organisations that receive family planning funds, now any health-related funds, from providing information or even talking about abortion. When this rule was previously reinstated in 2001, the loss of services resulted in more unsafe abortions in sub-Saharan Africa.²²⁷ The "global gag rule" forces organisations to make an excruciating choice to either forgo providing women and girls with a full range of sexual and reproductive health services or to shut down other crucial programmes such as HIV prevention and treatment, and maternal and child health services.

The 2017 "global gag rule" is already causing harm. An example is Family Health Options Kenya. Unable in good conscience to cease providing abortions in a country where the procedure is legal yet unsafe abortion is the leading cause of preventable death among women and girls of reproductive age, Family Health Options turned down grants

from US sources representing 60 percent of its budget. Immediately, it was forced to close a clinic and cancel 100 planned events.²²⁸ A nurse made the loss concrete by recalling a 13-year-old incest victim who arrived “suicidal.” She had

tried to end her pregnancy using herbs. Fortunately, that girl was able to safely terminate her unwanted pregnancy. Now others in similar situations will be forced to resort to risky, sometimes deadly, do-it-yourself measures.²²⁹

Boys and men: The price of masculinity

Harmful framings of masculinity, expressed in everything from domestic abuse to discriminatory laws, have adverse effects on women and girls. But such masculine norms can also hurt boys and men and put them at risk of acquiring HIV, STIs, and co-infections. Definitions of manhood that prioritise toughness and silence discourage boys and men from practising safe sex, getting tested for HIV, seeking and adhering to treatment, or even talking about sexuality. In all these areas, women do better than men. The notion of male invincibility encourages the overconsumption of alcohol and drugs, both risk factors for HIV. Stereotypical ideas of manliness also promote homophobia and transphobia. Stigma, harassment and criminalisation keep gay men and transgender people from seeking health services. Globally, men who have sex with men are 24 times more likely to acquire HIV than the general population. The risk to transgender women is 49 times higher. Male sex workers and men who inject drugs have higher HIV infection rates than women in the same key populations. TB rates are also higher among men. One contributor is that TB is ubiquitous in prison, where 90 percent of inmates are male. A transformation of harmful gender norms would benefit everyone, regardless of gender, and greatly enhance efforts to reduce the incidence of HIV.²³⁰

RECOMMENDATIONS:

To ensure effective, sustainable health responses consistent with universal human rights obligations, the following measures must be adopted as a matter of urgency:

1. Governments must adopt and enforce laws that protect and promote sexual and reproductive health and rights. Governments must repeal and replace laws that create barriers to accessing the full range of sexual and reproductive health services.
2. Governments must limit the use of “conscientious objection” in healthcare where the health and lives of others are or may be at risk as a consequence.

LOOKING AHEAD

In 2012, the Commission called on countries to make better use of the law to reduce the toll of HIV, one of the deadliest epidemics the world has seen. The last six years have clearly demonstrated the ways in which the law, on the books and on the ground, can protect and promote health and human rights – or imperil them. Science offers a profound glimpse of a world without AIDS. More people are getting HIV treatment than ever before. Yet countries are undermining that progress with laws conceived in prejudice and grounded in scientific ignorance. New health technologies multiply the odds of curtailing the co-infections of TB and viral hepatitis that complicate and exacerbate HIV, and vice-versa. Yet too many governments cede to private entities the power to determine which diseases get resources for research and who can access its fruits. The Internet, to some extent, frees individuals with access to it to care for their own and others' health safely, affordably and confidentially. The Internet also connects the traditionally powerless in fighting for health and rights. Yet governments are restricting these connections. They are stifling civil society organisations critical to the delivery of services and advocacy for justice. They are turning doctors and other healthcare professionals into agents obliged to report to the authorities those who are most vulnerable to hostile action. Yet the experience and lessons of the past 40 years have shown that hostility promotes isolation from the very information and support needed to stem the advance of epidemics.

The global human rights and public health communities have achieved a great deal working with and inspired by people living with HIV and their allies. But the job is not done. In a world that is changing at a faster pace than ever, epidemics and risks continue to evolve. So too must our response.

The Commission calls for a renewed and vigorous collaboration to end the epidemics of HIV, TB and viral hepatitis. The Commission also calls on countries to do more to unleash the power of the law in bridging the gap between vulnerability and resilience. Much is yet to be done and most urgently for the marginalised populations, young women and adolescent girls who are still, stubbornly, at greatest risk of illness and death. We will not end these epidemics until every nation's legal environment truly embodies the vision of the 2030 Agenda for Sustainable Development: a world of universal health, equality and human dignity, in which no one is left behind, and all have an equal chance to fulfil their potential.

ENDNOTES

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