Stay the Rights Course

UNAIDS Reference Group on HIV and Human Rights[1]

Statement to the 2011 United Nations High Level Meeting on AIDS

Epidemic at a crossroads

1. **HIV continues to demand the most urgent attention and action by governments, civil society, the international community, and the United Nations.** Thirty million people have died of AIDS since the epidemic was first identified 30 years ago, and 33.3 million people are living with HIV today. Every year 2.6 million people throughout the world continue to be infected with HIV. In terms of human suffering, and loss of life, the impact of HIV in its first 30 years has been both unexpected and devastating. Only one third of those in need of treatment are receiving it, with some 9 million still in need.

2. **The 2011 High-Level Meeting is an opportunity to pay tribute to the three-decade response to the epidemic and its spectacular progress.** The combination of early diagnosis and antiretroviral therapy (ART) has, for those with access to treatment, transformed HIV and AIDS from a death sentence to a chronic manageable condition. People with access to quality health care can generally take for granted that they will live a long and healthy life with HIV. They can work productively, raise their families, and hopefully avoid some of the stigma and discrimination that continues to plague those affected by HIV. Evidence shows that people on ART are much less infectious to others, meaning that treatment reaps HIV prevention benefits for entire communities.

3. **The central challenge of the next five years is to diagnose and make life-saving treatment available to all who need it but are not receiving it, particularly but not exclusively in the developing world.** An estimated 1.2 million people in low and middle-income countries initiated ART in 2009, representing a 30% increase from 2008. But this still leaves over 9 million people in need of treatment according to new World Health Organization (WHO) guidelines. Many of those currently on treatment will need to switch to much more expensive regimens as they develop resistance to their first-line medicines. Meeting the treatment gap in time for the Millennium Development Goals can be accomplished with increased funding to the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), expansion of bilateral HIV programmes, such as the US President's Emergency Plan for AIDS Relief (PEPFAR) and increased investment and commitment by the national governments to their own HIV-affected citizens. This will require maximum use of flexibilities in the international patent regime to ensure the competition needed to lower the price of second-line and third-line treatments and their production in generic form. Most of all, it will require the same combination of urgency, human rights advocacy and political will that drove the first era of the HIV response.

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[1] **The UNAIDS Reference Group on HIV and Human Rights was established in 2002 to advise the Joint United Nations Programme on HIV/AIDS on all matters relating to HIV and human rights. The Reference Group speaks with an independent voice; thus, its views do not necessarily reflect the views of the UNAIDS Secretariat or any of the UNAIDS Cosponsors.**

The people affected

4. **Women and girls, men who have sex with men, transgender people, sex workers, people who use drugs, prisoners, young people, persons with disabilities and other vulnerable groups are all fully entitled to respect for, and protection of, their human rights, and to explicit recognition by the United Nations General Assembly.** The primary mode of transmission of HIV remains the transmission of bodily fluids through sex, injecting drug use and pregnancy–deeply personal behaviours that stir as much controversy today as they did at the beginning of the epidemic. Every principle of effective HIV programming suggests that empowering those at risk to protect themselves from infection—to exercise informed and safe sexual autonomy, to use condoms and sterile syringes, to receive treatment to prevent parent-to-child transmission, and increasingly to use newer prevention methods, such as male circumcision and pre-exposure prophylaxis, as well as benefit from the prevention effects of treatment—works better than coercing, criminalizing or marginalizing them.

5. **Punishing drug use through "wars on drugs" and over-incarceration of people who use drugs is an inappropriate and rights-violating response to a public health challenge. It does far more to fuel HIV risk than drug use itself.** In accordance with public health evidence and human rights principles, governments ought to treat drug dependence as a health condition and fully implement harm reduction models such as needle and syringe programs, opiate substitution therapy, overdose prevention, and safer injection facilities. In particular, governments should close down compulsory drug detention centres that deny due process to detainees and replace these centres with community-based alternatives.

6. **Addressing HIV requires confronting in a completely non-judgmental manner sex outside the context of traditional heterosexual marriage, whether sex between men, sex between young people, or sex in exchange for money or other goods.** So-called culture wars may persist related to sex and sexuality, but they must not distract from the central task of ensuring sufficient coverage, uptake and adherence of HIV services for key populations. As an urgent priority, governments must address violence and discrimination against sex workers and men who have sex with men, including illegal police practices such as harassment, extortion, arbitrary arrest, and rape committed in the name of enforcing anti-sodomy and anti-prostitution laws. Ultimately, governments should repeal laws against prostitution and sodomy, ensure access to legal aid for key populations, and provide platforms for constructive exchange about these issues as a substitute for the vicious polarization that is currently occurring. This is a human rights issue for those impacted as well as for the broader society and is urgent in endemic, high and low prevalence countries.

7. **Actors at every level of the HIV response must stop paying lip service to the rights of women and girls, and invest in tangible programs that empower women and girls to assert their sexual and reproductive autonomy and rights, including freedom from violence and coercion.** Where women and girls make up half or more of those infected with HIV, they should be receiving through programmes half or more of the resources budgeted for the HIV response. These resources should support proven programmes that address the full range of women's and girls' needs and rights over their life cycles. They should further support the creation of an enabling legal environment that criminalizes all forms of violence against women including marital rape, guarantees access to reproductive health care, protects women living with HIV from forced and coerced sterilization, and ensures women's equal access to property and inheritance.

The human rights approach

8. **Thirty years of experience compel the conclusion that the human rights approach to HIV, boldly promoted from the outset by the United Nations and others, is the best way to achieve health, dignity and security in the context of this epidemic**. The human rights approach recognizes that:

    - Rich and poor countries alike have mutual obligations to contribute to overcoming the HIV epidemic, including to achieve non-discrimination and the minimum core content of the human right to the highest attainable standard of health; and
    - People living with, affected by and vulnerable to HIV are entitled to respect for, protection of and fulfilment of their full range of human rights as enshrined in the Universal Declaration of Human Rights and subsequent human rights treaties.

    This approach has been adopted by the World Health Organization and the Joint United National Programme on HIV/AIDS (UNAIDS) and has been endorsed by resolutions of the Human Rights Council, multiple UN treaty bodies and successive declarations by the UN General Assembly. The UNAIDS 2011-2015 Strategy both recognises human rights as one of the three pillars to be observed by UNAIDS, and recognises that human rights are critical for the full attainment of each of the other two pillars of HIV treatment and prevention.

9. **The reasons that inspired the adoption of the human rights approach to HIV are as true today as they were at the outset of the epidemic.** From a legal perspective, all UN Member States are obliged to conform to international human rights law as envisaged by the UN Charter and by the international treaties and customary law on human rights. From a practical perspective, the development and provision of HIV prevention, treatment, care and support services has always depended on people living with and affected by HIV demanding it as their right, and on governments recognizing it as their duty. Calculations based on charity, equity, utilitarianism, and other factors have not been, and cannot be, the basis for sustainable access to treatment, prevention, care and support in the context of HIV. In addition, experience has shown that strategies to reduce HIV infections are more effective if the vulnerable populations most at risk of infection are confident that their human rights will be respected. As stigma and discrimination are reduced and rights are respected these populations are brought into meaningful contact with services that protect their own health and thereby the health of their communities. These are lessons that the HIV movement has taught advocates for global health generally.

10. **Unfortunately, some challenge the importance of a human rights approach for a successful response to HIV.** They do this for a variety of reasons, including: pitting costs saving and "efficiency" against national and international human rights obligations to meet the rights to health and non-discrimination; the feeling that AIDS advocacy has resulted in disproportionate funding for HIV compared to other health threats and that it is unjust or unethical to spend resources on AIDS treatment, while many people do not have access to cheaper treatments for other diseases; the reluctance of governments to recognize the provision of prevention and treatment as their obligation; moral disapproval of or the unwillingness to extent human rights to some of the persons and groups vulnerable to HIV; frustration and weariness over the duration of the epidemic; distractions caused by other contemporary global priorities; and cultural and religious objections to the human rights approach that has so far informed the global strategy against HIV. These reasons are politically motivated and do not challenge the basic premise for a human rights approach that has sustained 30 years of the HIV response.

Five non-negotiables

11. ***Member States should reaffirm the emphasis on a human rights approach to HIV that mutually obliges rich and poor nations to fulfil the human rights to health and non-discrimination and that respects, protects and fulfils the human rights of people living with, affected by and vulnerable to HIV and AIDS.*** The human rights approach has brought great success and saved millions of lives, and now is not the time for national governments, donors or the United Nations to betray the fundamental principles of human rights. The future of the HIV response depends not on altering the human rights approach, but on extrapolating that approach into a global movement for the right to health more broadly, recognizing that the real human rights violation is not that the HIV response receives 'too much', but that other elements of the right to health do not receive what it takes to realize them. Any retrogression in respect for the human rights of those living, affected by or vulnerable to HIV will have an immediate and undesirable impact on the HIV epidemic and on the societies and economies of the nations in which those persons live.
12. ***Member States should reaffirm their shared responsibility to realize the human rights to health and non-discrimination by setting clear targets for funding the HIV response from now until the achievement of the Millennium Development Goals in 2015.*** The current shortfall in funding for HIV is not the result of an economic crisis but a crisis of priorities. HIV and AIDS have not received too much attention and too many resources, but rather have set the standard of robust international solidarity and commitment that should be maintained, increased and replicated for other health, justice and human rights issues which have enjoyed less attention and fewer resources. The massive gains in access to HIV prevention, treatment and care services made possible through the Global Fund will be jeopardized if high-income governments fail to adequately replenish the Global Fund. Recipient governments must likewise increase their own domestic spending for HIV programmes and honour their commitments to increase general health spending.
13. ***Member States should commit to utilising, to the fullest extent possible, flexibilities under the TRIPS agreement to lower the price of essential medicines.*** This includes providing sufficient funding to build national capacity to use TRIPS flexibilities, opposing the inclusion of "TRIPS-Plus" provisions in bilateral and multi-lateral trade agreements, opposing the misapplication of anti-counterfeit laws and agreements to enforce intellectual property rights and initiating and supporting alternative means of pharmaceutical development to the current international patent system.
14. ***Member States should renew and reaffirm their commitment to the removal of laws, policies, practices, stigma and discrimination that block effective responses to AIDS.*** This includes several types of laws, policies and practices: those that effectively criminalize people living with and vulnerable to HIV; those that permit violence and discrimination against women and enforce their legal and economic dependence on men; those that impede access to HIV services, including treatment, prevention and palliative care; those that limit access of young people to HIV information, education and services; and those that limit the social rights of people living with HIV to health-care, work, residency and housing, and education.
15. ***Member States should reaffirm the centrality of people living with HIV to the response as well as their human rights to non-discrimination, treatment as prevention, and meaningful participation.*** As HIV treatment and prevention collapse into one and the same thing, the international community must renew its commitment to place people living with HIV at the centre of the response, by empowering them through Positive Health Dignity and Prevention to live successfully with HIV, maintain their health, dignity and security and prevent the onward transmission of HIV, and to participate meaningfully in all aspects of the response to HIV.