

International Human Rights References to Sexual and Reproductive Health and Rights

(regarding LGBT populations and
HIV/AIDS and STIs)

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Introduction

ILGA-Europe has commissioned the production of this reference guide within a joint project “Prevention and Empowerment in the Commonwealth of Independent States (PRECIS)”, coordinated by COC Netherlands and financed by the Ministry of Foreign Affairs of the Netherlands. The project aims at improving the sexual and reproductive health and enhancing the human rights of LGBT people in seven countries of Eastern Europe and Central Asia: Armenia, Azerbaijan, Georgia, Kyrgyzstan, Kazakhstan, Moldova and Ukraine. Thus the primary target audiences of the guide are LGBT advocates in the countries belonging to the PRECIS partnership. However, the guide is applicable to, and can be used by, a wide international readership. The production of the reference guide has also been supported by Sigrid Rausing trust.

This document is structured in a simple way as follows:

- **Opening Lines**
- **Core Documents**
- **Supporting Documents**

This section, **Opening Lines**, explains the purpose of this compilation of international human rights standards and describes its overall structure. It provides a short explanation of how international human rights instruments work and their status in international law. It also outlines a number of cross-cutting human rights instruments and texts which are raised in the context of HIV and AIDS. Having set out some core definitions as used throughout this compilation, the section concludes with a short analysis of how the term “sexual orientation” has developed in different United Nations forums.

Texts in blue italics are direct quotations from the instruments and the texts themselves

The second section **Core Documents** comprises two parts;

1 – 9 place the following instruments and texts in context, quoting from the documents themselves

- 1 Bill of Human Rights – the right to health
 - 1.1 The Universal Declaration of Human Rights, 1948
 - 1.2 The International Covenant On Economic, Social and Cultural Rights, 1966 (into force 1976)
 - 1.3 The International Covenant On Civil and Political Rights, 1966 (into force 1976)
- 2 International Human Rights Instruments – the right to health
 - 2.1 The International Convention on the Elimination of all forms of Racial Discrimination (ICERD, 1965, into force 1969)
 - 2.2 Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) (1979, into force since 1981)
 - 2.3 Convention on the Rights of the Child, 1989 (into force 1990)
- 3 The International United Nations Conference on Population and Development, 1994
- 4 The Fourth World Conference on Women, Beijing, 1995

8 The former Commission on Human Rights (today Human Rights Council), 1946/2006

9 The World Health Organization strategy, 2004

10–17 present the full texts of some core international documents on health and SRHR

10 Universal Declaration of Human Rights, 1948

11 International Covenant on Economic, Social and Cultural Rights, 1966

12 General Comment No. 14 (2000). The right to the highest attainable standard of health, 2000

13 Chapter VII of the International Conference on Population and Development's Programme of Action: reproductive rights and reproductive health, 1994

14 The UNGASS Declaration of Commitments on HIV/AIDS, 2001

15 The OHCHR/UNAIDS Guidelines on HIV/AIDS, 1998

16 Resolution E/CN.4/2004/49, 2004

17 Resolution 2005/84, 2005

18 UNAIDS epidemic updated reports December 2006, press release

19 The Millennium Development Goals and the Three Ones, 2000

The final part of this document, **Supporting Documents, 1-75**, is a collection of references, all web linked, from a variety of organisations and agencies, arranged under the following headings: youth, women and gender, sexual health and rights, sex work, regional overviews, monitoring and surveillance, migration, MSM, LGBT, human rights and HIV, global perspectives and discrimination. Relevant keywords (e.g. gay, sexual health, etc) have been highlighted under the title/explanation, and if any of the countries (Armenia, Azerbaijan, Georgia, Kyrgyzstan, Kazakhstan, Moldova and Ukraine) have been mentioned, it is noted in the entry.

Supporting Documents 76-104 contain country reports, summary profiles, a shadow report (Ukraine) and a variety of other documents specific to these countries in relation to their work on HIV/AIDS.

Glossary of terms used in this document

AIDS	Acquired Immuno-Deficiency Syndrome
CESCR	Committee of Economic, Social and Cultural Rights
CHR	Commission on Human Rights
CPD	Commission on Population & Development
ECOSOC	Economic and Social Council
GA	(United Nations) General Assembly
HIV	Human Immunodeficiency Virus
ICCPR	International Covenant on Civil and Political Rights
ICERD	International Convention on the Elimination of All Forms of Racial Discrimination
CEDAW	Convention on the Elimination of all forms of Discrimination Against Women
CRC	Convention on the Rights of the Child
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICPD	International Convention on Population and Development (Cairo)
IPPF	International Planned Parenthood Federation
ILO	International Labour Organization
LGBT (IQ)	Lesbian, Gay, Bisexual, Transgender (Intersex and Queer /or/ Questioning)
MDG	Millennium Development Goals
MSM	Men who have Sex with Men
NGO	Non-Governmental Organisation
OHCHR	Office of the High Commissioner for Human Rights
PfA	Platform for Action (Beijing)
PoA	Programme of Action (Cairo)
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infection
UDHR	Universal Declaration of Human Rights
UN	United Nations
UNAIDS	United Nations AIDS (programme)
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNHCR	United Nations Human Rights Council
UNODC	United Nations Office of Drugs and Crime
WFP	World Food Programme
WHO	World Health Organization
WSW	Women who have Sex with Women

ILGA-Europe has created this compilation of international human rights references to sexual and reproductive health and rights (SRHR) to assist advocates locate, interpret and utilise existing international instruments and standards in their own work. There is a particular focus throughout this compilation on statements and progress made in relation to HIV/AIDS and other sexually transmitted infections (STIs) as relevant to LGBT persons.

It is hoped that this compilation will help advocates use international human rights instruments more effectively in their work domestically and regionally, and at the same time increase their knowledge of the references themselves and their place within international human rights law and discourse.

Sexual and reproductive health and rights are constituent parts of the fundamental **right to health**. As many international bodies, and as various international human rights instruments dealing with health and human rights have underlined, the right to health does not only include the right to be healthy (as in, an absence of illness or disease), but “***the right of everyone to the enjoyment of the highest attainable standard of physical and mental health***” (e.g. Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), 1966 – see **Core Documents 1.2** and **10**).

“Everyone has the right to the enjoyment of the highest attainable standard of physical and mental health. States should take all appropriate measures to ensure, on a basis of equality of men and women, universal health care services, including those related to reproductive health care, which includes family planning and sexual health. Reproductive health care programmes should provide the widest range of services without any form of coercion.”

(**Principle 8** of the International Conference on Population and Development’s Programme for Action, ICPD, Cairo, 1994 - see **Core Documents 3** and **14**)
<http://www.iisd.ca/cairo/program/p07002.html>

Historically, the right to health has been considered as belonging to a group of rights known as social, economic and cultural rights as this right was originally enshrined in the ICESCR. However, in the mid-1990s international institutions, such as the United Nations Population Fund (UNFPA), the World Health Organization (WHO) and the International Planned Parenthood Association (IPPA), elaborated a Charter of Sexual and Reproductive Rights (<http://www.unfpa.org/swp/1997/box8.htm>) which sought to bring together relevant economic and social rights on the one hand and civil and political rights on the other, in the context of sexual and reproductive rights. Relevant civil and political rights included the right to life, the right to privacy, as well as the right to freedom of thought and association.

For many years there was a tendency to regard civil and political rights as having primacy over economic, social and cultural rights even though lip service was paid to the idea of the indivisibility of all human rights. Partly this view resulted from the belief that economic, social and cultural rights could not be enforced through the courts in the same way that civil and political rights might. The balance between these sets of rights was partly redressed as a result of the, the Vienna Declaration, adopted by the World Conference on Human Rights on 25 June 1993, which confirmed that human rights are “***indivisible, interdependent and interrelated***” (<http://www.unhcr.ch/huridocda/huridoca>).

[nsf/\(Symbol\)/A.CONF.157.23.En?OpenDocument](#)). Moreover, increasingly courts have been willing to recognize that economic, social and cultural rights can be made subject to judicial scrutiny.

The term sexual and reproductive health and rights (SRHR) normally covers four different, albeit interlinked, components - reproductive health, reproductive rights, sexual health and sexual rights. Definitions for each of these are given below.

Reproductive health and reproductive rights were the first of these expressions to be employed, although in different contexts. The term 'reproductive health' was first developed by institutions, such as the World Health Organization, in the early-1980s, while the earliest references to 'reproductive rights' are mostly found in non-institutional frameworks, and among women's groups of the 1970s and 1980s.

In terms of advocacy, LGBT people and sex workers have shared concerns in that they are all particularly vulnerable to violations of their rights, including sexual health rights (as well as the fact that many sex workers are LGBT). These violations place them at particular risk of HIV and other STIs. The protection of the sexual health and human rights of sexually marginalized groups is important both for their rights as individuals (to determine their own sexual practice and identities) and as a contribution to the global struggle against HIV/AIDS.

(Paragraph adapted from texts of the Open Society Institute, <http://www.soros.org/>)

The Cairo and the Beijing Conferences (1994 and 1995 - **Core Documents 3** and **4**) established and legitimized notions of reproductive rights, as well as 'sexual health' and 'sexual rights'. Paragraph 7.3 of the Cairo conference Program of Action speaks about reproductive and sexual health and reproductive rights: "**[...] reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other relevant United Nations consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. [...]**" (see full text in **Core Document 12**, paragraph 7.3).

Although the Platform for Action of the Beijing Conference does not explicitly mention sexual rights, paragraph 96 (see point 52 of **Core Document 16** Resolution E/CN.4/2004/49 and its footnote 32) spells out what their elements should be: "**The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health [...]**".

Human rights

Discrimination on the ground of sexual orientation or gender identity can take a multitude of forms and may involve violations of any of the rights guaranteed by international human rights instruments. These may range from civil and political rights, such as the right to life, freedom from torture and inhuman and degrading treatment or freedom of assembly, association or expression, as well as economic, social and cultural rights, such as the right to education, the right to social security and health.

A major issue of concern that remains largely ignored in human rights discourse is that of multiple discrimination: race, gender, disability, age, poverty and sexual orientation or gender identity. People suffering from multiple discrimination may be even more exposed to human rights violations and even less in a position to claim their rights and to obtain remedies. For example, as highlighted by the Special Rapporteur on Violence Against Women, lesbian women could ***“be targeted for rape specifically because of their sexual orientation in order for the aggressor to prove [the victim’s] womanhood”***.

(Report of the Special Rapporteur on Violence against Women, its Causes and Consequences, 2005.
www.icj.org/IMG/pdf/soos.pdf)

Current indicators used by UNAIDS, the WHO and other international agencies are not able to develop information regarding the needs of individuals in the context of sexual and reproductive health based on multiple forms of discrimination, such as an injecting drug user who is also a sex worker and lesbian, gay, bisexual or transgendered. In the absence of such data it is difficult for activists to make the case for the allocation of additional financial resources from governments and development agencies to address the specific needs of such groups. As the World AIDS Campaign (WAC) put it ‘What gets measured, gets done’ – see **Supporting Document 44**.

However, it should be noted that in January 2007, the Special Rapporteur on the right to the highest attainable standard of health, Paul Hunt, has said ***‘More specifically, however, when looking at a health system from the right-to-health perspective, what are the key components that need to be present? For example, from a human rights perspective a health system will have to include an adequate system for the collection of health data; otherwise, it will be impossible for the State, or any other interested party, to monitor the progressive realization of the right to health. Moreover, the data must be disaggregated on certain grounds, such as sex, age and urban/rural, otherwise it will be impossible to monitor the progressive realization of the right to health in relation to vulnerable populations, such as women, children and those living in remote rural communities.’***

see A/HRC/4/28 of 17/01/2007 Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt.
<http://daccessdds.un.org/doc/UNDOC/GEN/G07/102/97/PDF/G0710297.pdf?OpenElement>

The social stigmatization of human beings on the grounds of their real or perceived sexual orientation or gender identity leaves them more exposed to violence and human rights abuses. This social

stigmatization also increases the climate of impunity and indifference to human rights violations committed against LGBT victims.

adapted from the ***Joint Oral Statement by the International Commission of Jurists (ICJ) and International Federation for Human Rights Leagues (FIDH)***

to the CHR on 21 November 2006 re;/ sexual orientation and human rights

http://www.fidh.org/article.php3?id_article=2539

and

International Human Rights References to Human Rights Violations on the grounds of Sexual Orientation and Gender identity

International Commission of Jurists, Geneva, October 2006

www.icj.org/IMG/UN_references_on_SOGI.pdf

Treaties and other international standards

International legal instruments take the form of a **Treaty** (also called **agreement, convention, covenant** or **charter**), which is binding on the contracting States. When negotiations are completed, the text of a treaty is established as authentic and definitive and is “signed” to that effect by the representatives of States. There are various means by which a State expresses its consent to be bound by a treaty. The most common are **ratification** or **accession**. A new treaty is “ratified” by those States which have negotiated the instrument. A State which has not participated in the negotiations may, at a later stage, “accede” to the treaty. The treaty enters into force when a pre-determined number of States have ratified or acceded to the treaty.

When a State ratifies or accedes to a treaty, that State may make **reservations** to one or more articles of the treaty, unless reservations are prohibited by the treaty.

Some treaties have **Protocols** attached to them that qualify the terms of that treaty. Some of these are compulsory and some are optional (for example, the ICCPR and CRC). When acceding to or ratifying a treaty, all States will need to review their domestic laws, policies and practices to ensure that they are consistent with their obligations under the treaty. Often existing laws will need to be amended or new legislation passed.

Treaties and other conventions create legally binding obligations upon the States signing them. All treaties are of equal legal effect with the exception of the UN Charter (Article 103), which prevails in the case of conflict with another treaty (i.e. between states).

During the last 40 years, a range of international commitments has developed and has been confirmed by a variety of instruments that do not fall into the traditional categories of “treaty” or “custom” or “general principles.” The legal status of these instruments, which are often referred to as “**soft law**”, has been a major subject of discussion among legal scholars and human rights activists. The instruments include **Declarations, Codes of Conduct, Guidelines** and other promulgations of the political organs of the United Nations system, **Operational Directives** of the multilateral development institutions, and **Resolutions** and other statements by non-governmental organisations. Although they do not possess the strict characteristic of recognized enforceability as commonly understood for law, depending on the circumstances, they may possess significant normative weight.

Soft laws, also known as **non-binding international standards**, are important because, as States concur that certain principles bind them, in statements of acceptance or the evolution of State practice following them, they can ‘harden’ and become ‘law’ at some point in both the international and domestic contexts.

Many “soft law” instruments are the product of international meetings organized under the auspices of international organisations, such as International Conference on Population and Development, 1994 (**Core Document 3**), and the Fourth World Conference on Women in Beijing in 1995 (**Core Document**

4). These meetings typically conclude with the issuance of instruments entitled “Declaration”, “Programme of Action”, or “Platform for Action”. The instruments are the product of long and often contentious negotiations, and are, perhaps, the most important work products of conferences attended by representatives of almost all nations in the world. They are not drafted in the form of legally enforceable instruments, however, and can best be understood as political pronouncements; that at least to some degree represent official decisions of the States which drafted and signed them.

They also may record the content of existing customary international law on particular matters. As such, although they are not “hard law,” they evince official governmental positions on particular issues, may articulate the substance of existing legal norms and/or create expectations for the future development of international law in the areas being addressed. Often they are at the beginning of a continuum emphasizing increasingly higher degrees of normative specificity that eventually may culminate in conventional binding treaty obligations.

Room for difference

With the exception of a small group of so-called “non-derogable” rights, the human rights provided for in international instruments are neither absolute nor precise in their meaning. It is essential that one recognizes this. Human rights as they are expressed in international law are limited. Typically, the very instrument that guarantees certain rights also expressly provides for their qualification. Thus, for example, many of the rights covered by the International Covenant on Civil and Political Rights (**Core Document 1.3**) are first stated in the starkest of terms – everyone has the right to liberty, and everyone has the right to freedom of expression and security (articles 9 and 19). There then follows a paragraph in each article outlining in broad terms the conditions under which the right can be limited – for example, where necessary to protect public health or morals, or as necessary in a democracy, or to safeguard national security.

There are a number of reasons why this qualified expression of human rights has been adopted. The most direct reason is that it is simply not possible or desirable for individual human rights to be defined precisely, nor for their application to countless different circumstances to be predicted. In any case, it would not be desirable to insist upon any particular human right being rigidly complied with in every single case.

For these reasons, degrees of discretion are provided for in all international treaties in respect of how, and to what degree, human rights are protected. This “elbow room” or “margin of appreciation” (as it is referred to in legal terms) is, of course, exercised by the States themselves. Laws enacted domestically in order to meet international obligations may, therefore, differ from State to State, and yet still comply with the basic terms of the right. The scope for such discretion before it is considered to have gone “too far” is a moot point. Indeed, it is not an exaggeration to say that the search for where that line is the never-ending task of lawmakers (including judges) in both the international and domestic arenas.

The so-called “non-derogable” group of rights includes rights such as the freedom from torture, freedom from slavery and the arbitrary deprivation of life.

In November 2006, 29 Human Rights experts (including a former United Nations High Commissioner

for Human Rights, as well as UN independent experts, members of UN treaty bodies, judges, activists, and academics) met to confirm legal standards for how governments and other actors should end violence, abuse, and discrimination against lesbian, gay, bisexual, and transgender people, and ensure full equality. They produced a set of 29 principles, known as the Yogyakarta Principles. Economic, social and cultural rights are discussed under principles 12-18, where the concern has been expressed about laws that “prohibit gender reassignment surgery for transsexuals or require intersex persons to undergo such surgery against their will”.

see <http://yogyakartaprinciples.org/> for the text of the Principles and the list of members of the group

Respecting, Protecting and Fulfilling rights

A useful framework has been developed under international human rights conventions that oblige States that are parties to undertake three kinds of duties. These are to respect rights by not violating them, to protect rights by taking positive action against third party violators, and to fulfil rights by employing governmental means to afford individuals the full benefit of human rights. These duties affect SRHR in a variety of ways.

The duty to **respect** individuals’ rights to SRHR obliges States and those that they employ to be guarded when taking action that may restrict individuals’ reproductive and sexual autonomy. For example, misuse of individuals’ identifiable health information on HIV/AIDS or STI’s by government offends those individuals’ rights to privacy as expressed in the ICCPR.

The duty to **protect** rights requires States to take action to prevent violations of rights committed by private persons or organisations. This is an area of growing concern to human rights tribunals, at both domestic and international levels, as States downsize governmental bureaucracies by giving over State functions to private agencies, as can be seen in many areas of health care services. States cannot evade their human rights obligations by delegating power to private sector agencies. States whose governments leave private violations of human rights unattended or unaddressed are in breach of their own duty to protect human rights, as articulated in the Bill of Rights (UDHR, ICCPR and ICESCR).

The duty to **fulfil** rights requires States to take appropriate legislative, administrative, judicial, budgetary, economic and other measures to achieve individuals’ full realization of their human rights. Discharge of the duty to fulfil human rights sometimes requires States to balance competing human rights or to find a basis of maximum accommodation of the human rights of individuals that may be in conflict with each other. For instance, respect for individuals’ religious convictions compels States to allow conscientious objection to participate in such procedures as artificial contraception or abortion, but the human rights of women require that reasonable provision be made for their access (actual or informational) to such services. Where health services are available only through facilities provided by religious institutions in a certain country, the PoA of the 1994 IPCD (Chapter VII – see **Core Document 13**) obliges that State to provide such services through a public clinic or some such provider.

Accountability

An increasingly important process for developing State accountability for SRHR is the publication of Concluding Observations by treaty monitoring bodies on reports submitted by States. The United Nations Human Rights System works through two different sets of mechanisms. They are called the “treaty-based” mechanisms, and the “extra-conventional” (or “non-treaty-based”) mechanisms.

“Treaty-based” mechanisms

The “treaty-based” mechanisms are committees. When a State ratifies one of the UN’s human rights treaties, it agrees to be monitored periodically to see how it is obeying the treaty’s terms. The committees – also called “treaty bodies” - do this investigating (its members are experts in the particular field). This document mentions six of the human rights treaties, which the UN has produced, with six committees:

- The Human Rights Committee (HRC) monitors States’ compliance with the International Covenant on Civil and Political Rights (ICCPR).
- The Committee on Economic, Social, and Cultural Rights (CESCR) monitors States’ compliance with the International Covenant on Economic, Social, and Cultural Rights.
- The Committee on the Elimination of Discrimination against Women (CEDAW) monitors States’ compliance with the Convention on the Elimination of All Forms of Discrimination against Women.
- The Committee Against Torture (CAT) monitors States’ compliance with the Convention Against Torture and other Cruel, Inhuman, or Degrading Treatment or Punishment.
- The Committee on the Elimination of Racial Discrimination (CERD) monitors States’ compliance with the International Convention on the Elimination of All Forms of Racial Discrimination.
- The Committee on the Rights of the Child (CRC) monitors States’ compliance with the Convention on the Rights of the Child (the Children’s Convention)

See [Making the Mountain Move: An Activist’s Guide to How International Human Rights Mechanisms Can Work for You](#),

www.iglhrc.org/files/iglhrc/reports/unguide.pdf for an elaboration on the work of each of these committees.

While a committee is considering a State’s record and preparing its own judgment, it welcomes comments by NGOs on whether the State has complied with the treaty. Any NGO can submit such comments. These comments are called “shadow reports” because they “shadow” the report that the State itself submits to the committee.

It must be pointed out that within the general relationship of international and domestic laws, international human rights instruments occupy a singularly important position. This is largely due to the fact that a number of international human rights instruments provide for the right of individual petition or complaint. This allows certain individuals to lodge a petition or complaint with the relevant supervisory body to the effect that their individual rights have been infringed by the action or inaction of the State. This mechanism has proved over time to be a particularly important agent for change within signatory states (the prime example of this mechanism being the individual complaint system under the European Convention of Human Rights).

There are several reasons why advocates could consider bringing individual cases before international tribunals and courts. These include:

1. They may offer victims of human rights violations a remedy, which cannot otherwise be obtained from the State
2. They may help to set valuable precedents as regards the protection of the human rights of LGBT people as well as other groups
3. They may involve recognition of individual violations of human rights and as such both serve to shame the state in question and lend credibility to the issue being raised in the advocates' own country
4. They may help to tackle the impunity of state and by doing so lend moral support to those whose rights are being violated in different signatory states.

There are naturally a number of risks involved in litigation at the international or regional levels. Litigation can be a lengthy process (normally involving exhaustion of domestic remedies) and can involve discussion of complex legal arguments. Not all cases will be won, and some cases - perhaps due to poor fact patterns or because they are premature - can lead to negative judgments which set back advocacy efforts at the international or regional level.

Extra-conventional (or non-treaty based) mechanisms

Most of the "treaty-based" mechanisms move slowly. They document patterns of abuses, and remind States of their standing obligations. But they are not the best places to turn when an urgent situation arises - when someone faces immediate violence or danger, when you need to put quick pressure on a State to act. The "extra-conventional" mechanisms are the place to turn for more urgent action. Their name simply means that they are not tied to treaties, or "conventions" - they operate independently.

At the centre of the extra-conventional mechanisms is the UN Human Rights Council (established in 2006 to replace the overly politicized and heavily criticized UN Commission on Human Rights (1946-2006)) (see **Core Document 8**). Under the terms of General Assembly Resolution 60/251, the Human Rights Council is a subsidiary body of the General Assembly that reports directly to the General Assembly instead of ECOSOC (as the Commission did). It is composed of 47 member States elected in a secret ballot by an absolute majority of the General Assembly (as opposed to the previous Commission which had a rotating membership appointed by respective governments to represent their positions), taking into account candidates' contribution to the promotion and protection of human rights and voluntary pledges and commitments, and according to equitable geographic distribution amongst the five regional groups 13 States from the African Group, 13 from the Asian Group; six from the Eastern European Group, eight from GRULAC, and seven from WEOG. For a list of members see <http://www.un.org/ga/60/elect/hrc/>). After serving two consecutive terms, members are not re-eligible for election for one year. Any member that commits gross and systematic violations of human rights can be suspended by the General Assembly by a two-thirds majority.

This Council is the central UN forum for discussing human rights. It has assumed all the mandates, mechanisms, functions, and responsibilities of the former Commission and is required to maintain a

system of special procedures, expert advice, and a complaint procedure. It is expected to review these mandates, mechanisms, functions, and responsibilities in order to improve and, where necessary, rationalize them. The arrangements and practices of the Commission on NGO and NHRI (National Human Rights Institutions) participation are carried over to the Council, which is expected to ensure their most effective contribution. The Council will submit an annual report to the General Assembly, which is also required to review the status of the Council within five years of its creation. The Council met for the first time on 19 June 2006.

(See the International Service for Human Rights for more information on this, as well as a manual for NGO advocates written in the months of the HRC's inception in 2006 at <http://www.ishr.ch/>)

The principle ways that have been devised for getting information to the Council, and for the Council to respond to such information, are the Special Rapporteurs and Working Groups (the scope and function of the Working Groups are being reviewed and adjusted at the time of writing this Compilation of References, but can be looked at through the UN Human Rights Council webpage <http://www.ohchr.org/english/bodies/>). Special Rapporteurs can be written to and approached directly and advocates should be aware that this is often the most effective mechanism to get issues included, heard and included by the relevant Committee. This in turn can advance the particular concern in the domestic national setting, as making such submissions to a UN forum can have a shaming effect on the offending government, and the weight of UN official statement or sanction on the issue can create both pressure to act for the national government, as well as lend immense credibility to the advocates' claim. In the case of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, the Special Rapporteur: Mr Paul Hunt (New Zealand), and the Secretariat is Ms Dragana Korljan (Tel: (41 22) 917 9721, Fax: (41 22) 917 9010, E-mail: <mailto:dkorljan@ohchr.org>).

One of the most important innovations of the new HRC is be the **Universal Periodic Review** (UPR) of governments' human rights records. All countries are subject to review under this process, which will be a major step away from the selectivity that so often afflicted the Commission on Human Rights in the identification of countries to be scrutinized.

The GA resolution creating the HRC provides the basic guidelines for the UPR: universality, objectivity, cooperation and interactivity.

As set out in the GA resolution, members of the HRC must be reviewed during their term of membership. Because the terms of the initial members will be staggered, those with the shortest terms should be reviewed first in order to complete their reviews during their abbreviated term of membership (see **Core Document 8** for how the information that comes into the UPR process is analyzed).

Advocates should be aware of a few other ways of approaching the Human Rights Council. One of these is called the '1503 procedure' as it was set up by the ECOSOC under Resolution 1503 and was last amended in 2000 (under the auspices of the Commission on Human Rights). This procedure allows for people to write directly to the Council, asking it to investigate patterns of human rights violations.

At the moment, anyone can write such a petition, but because there is currently a backlog of around 200,000 complaints on file, the Council will only get to a tiny percentage of these each year.

Another way to influence the Council is to actually testify at its meetings. Again, the relatively newly formed HRC is adjusting the mechanisms and regulations of such an approach, but essentially it sets aside time on each of its agenda items for NGOs to speak. Currently, this opportunity is only available to NGOs that have consultative status with ECOSOC (e.g. ILGA-Europe). However, many of those NGOs who do have consultative status may be willing to speak out on LGBT issues provided they fall within their own respective mandates.

This section is partially adapted from International Lesbian and Gay Human Rights Commission's

***Making the Mountain Move: An Activist's Guide to How
International Human Rights Mechanisms Can Work for You,***
www.iglhrc.org/files/iglhrc/reports/unguide.pdf

Timeline for sexual and reproductive health and rights references in the international context

Year	Mechanism	Organisation	Relevance
1948	Declaration	UDHR	Source of all future human rights documents
1966	Treaty	ICESCR	Defines and binds nations to respect health rights
1996	Treaty	ICCPR	Defines attendant conditions, such as privacy, which allow health
1965	Treaty	ICERD	Health in context of non-discrimination
1979	Treaty	CEDAW	Duty to protect the health of women
1989	Treaty	CRC	Nation's duty to protect health of children- education of parents, etc
1994	PoA	IPCD	Defines SRH in international context
1995	PfA	BEIJING	Defines SRHR and gender roles in relation to spread of HIV
1998	Guidelines	OHCHR/UNAIDS	Extensive mention of MSM re: human rights and HIV – core guidance document
2000	Policy	MDG	Sixth goal - reverse trend in spread of AIDS by 2015 – requires capacity building
2001	Declaration	UNGASS	Declares link between human rights and HIV/AIDS – stigmatisation, etc
2004	Comment	UNCHR (Spec Rapp)	Points to sexual orientation and reminds States of their duty to respect, protect and fulfil health rights
2004	Strategy	WHO strategy	5 key actions defined, MSM recognised, national failures and homophobia noted
2005	Resolution	CHR – res 2005/84	Resolution to push States to support HIV & human rights re SRHR
1946/ 2006	Resolutions	UNCHR/HRC	Urges States to put SRHR into their HIV prevention strategies and to fight HIV-related discrimination.

Language

Core definitions

Sexual health

Sexual health is a state of physical, emotional, mental and social wellbeing in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.

(World Health Organization, 2004)

Sexual rights

Sexual rights embrace human rights that are already recognized in national laws, international human rights documents and other consensus statements. They include the right of all persons, free of coercion, discrimination and violence, to:

- *the highest attainable standard of sexual health, including access to sexual and reproductive health care services;*
- *seek, receive and impart information related to sexuality;*
- *sexuality education;*
- *respect for bodily integrity;*
- *choose their partner;*
- *decide to be sexually active or not;*
- *consensual sexual relations;*
- *consensual marriage;*
- *decide whether or not, and when, to have children; and*
- *pursue a satisfying, safe and pleasurable sexual life.*

The responsible exercise of human rights requires that all persons respect the rights of others.

(World Health Organization, 2004)

Further, according to Resolution E/CN.4/2004/49 [see **Core Document 15**, paragraph 54]

(endorsement by the ECOSOC of the Special Rapporteur: Report on reproductive and sexual rights)

“Sexual rights include the right of all persons to express their sexual orientation, with due regard for the well-being and rights of others, without fear of persecution, denial of liberty or social interference”.

Reproductive health

“Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for the regulation of fertility which are not against the law, and the right of access to appropriate health-care services

that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases.” (Paragraph 7.2, of the Programme of Action of the International Conference on Population and Developmentt, 1994, **Core Documents 3** and **12**)

Reproductive rights

“Bearing in mind the above definition, reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. ...” (Paragraph 7.3, of the Programme of Action of the International Conference on Population and Developmentt, 1994 Core **Documents 3** and **12**)

Sexual orientation

Sexual orientation refers to each person’s capacity for profound emotional, affectional and sexual attraction to, and intimate and sexual relations with, individuals of a different gender or the same gender or more than one gender;

Heterosexuality refers to those whose primary attractions are to people of the different sex. Such individuals are sometimes referred to as straight.

- *Homosexuality* refers to those whose primary attractions are to people of the same sex. Typically, men who are attracted to men are referred to as gay and women who are attracted to women are referred to as lesbians (though they may also identify as gay).
- *Bisexuality* refers to those who are attracted to both sexes; such individuals are often referred to as bisexual or bi.
- Some individuals avoid labels such as straight, gay, or bi and may refer to themselves as same-gender loving or use no label at all.
- *Queer* is now used more often as an all-encompassing term that refers to all individuals who defy sexual or gender norms, including transgender or transsexual individuals.
- *LGBT(IQ)* is also used to refer to those within this group and stands for lesbian-gay-bisexual-transgender (intersex and queer /or/ questioning).

Gender Identity

Gender identity refers to each person’s deeply felt internal and individual experience of gender, which may or may not correspond with the sex assigned at birth, including the personal sense of the body (which may involve, if freely chosen, modification of bodily appearance or function by medical, surgical or other means) and other expressions of gender, including dress, speech and mannerisms;

The umbrella term **transgender** is used for people whose gender identity and/or gender expression differs from the sex they were assigned at birth. The term may include, but is not limited to: transsexuals, intersex people, cross-dressers, and other gender variant people. ILGA-Europe is aware that the issues relating to intersex people can be significantly different and need to be addressed separately where relevant.

- **Transsexual** (or “trans”) persons are individuals who identify with a different sex than that associated with the biological sex that was ascribed to them at birth. A transsexual person can be male-to-female or female-to-male. Additionally, some people who are undergoing hormone therapy, but who do not intend to undergo surgery, also refer to themselves as transsexual.
- Transsexual women who were born biologically male are often referred to as *MTF*, which stands for male-to-female. Transsexual men who were born biologically female are often referred to as *FTM*, which stands for female-to-male.
- Transgender and transsexual people may identify as straight, gay, lesbian, bi or any other sexual orientation. In other words, sexual orientation and gender identity are independent of each other.

(The definitions presented here for sexual orientation and gender identity find source in definitions offered by the Centre for Women and Men at UCLA, <http://www.thecenter.ucla.edu/sexorien.html>)

MSM

MSM (men who have sex with men or ‘men having sex with men’, or ‘sex between men’) is a public health term describing any man who has sex with another man, whether occasionally, regularly, or as an expression of a gay identity. The term is meant to be descriptive without attaching an identity or meaning to the behaviour, so that health interventions – especially HIV/AIDS education and services – can be directed to persons on the basis of need. UNAIDS and other policy-makers use the term to describe one of four particularly ‘marginalized groups’ – the others being sex workers, injecting drug users and prison populations (UNAIDS Global Report 2006 – see **Core document 5**). While useful or strategic as a term (minimum offense to hetero-centered policy), it can also be used to avoid or deny a right to an identity. The equivalent term **WSW** does not appear in public policy documents, although it does in research – see **Supporting Document 7** – Amnesty’s *Women and HIV/AIDS*).

(MSM description adapted from texts from the Open Society Institute, 2007 <http://www.soros.org/>)

‘Coded’ references

The most commonly ‘coded’ references for LGBT populations in international documentation and referencing are as follows:

At risk populations (which include MSM, Sex Workers, Injecting Drug Users and Prison populations), At risk groups, Marginalized populations, Marginalized groups, High risk populations, High risk groups, Vulnerable groups, Vulnerable populations, MSM (men who have sex with men / men having sex with men, sex between men)

Lesbians, bisexual women and transgender persons' sexual and reproductive health and rights concerns are assumed under the *women's* and *gender equality* (or *discrimination based on gender*) headings, and sexual and reproductive health and rights are referred to without specifying the subject's sexual orientation or gender identity (i.e. a hetero-normative stance informs references for the most part).

Supporting Documents 72, 73 and 74
offer glossaries and usages of language from UNAIDS, UNESCO and the Panos institute.

Language – packed with values

For many years advocates in international fora have been promoting the inclusion of the term **sexual orientation** as part of a strategy to promote the recognition of the rights of LGBT. Since the 1994 *Toonen v. Australia* case (see **Core Document 7**), where the UN Human Rights Committee (HRC), which monitors State compliance with the International Covenant on Civil and Political Rights (ICCPR – see **Core Document 1.3**), ruled that sodomy laws punishing consensual adult homosexual conduct violate the rights to privacy and non-discrimination protected by the Covenant, many advocates and activists have been pushing for the term's inclusion in various other international fora, instruments and statements. In the case of *Toonen v. Australia*, the HRC held that the term "sex" in the ICCPR should be understood to include '**sexual orientation**', thereby ensuring that it too enjoyed protected status under the Covenant's equality clauses. It also noted that criminalization of homosexual practices hampered HIV prevention "**by driving underground many of the people at risk of infection**".

(see the Montreal Declaration, 2006

<http://www.declarationofmontreal.org/DeclarationofMontreal.pdf>)

The inclusion of this term has been highly controversial at the UN level not least because it has fed into an already acrimonious debate between different groups of States regarding a whole range of issues from the right to development, recognition of the rights of indigenous people, sexual and reproductive rights and racism. A number of UN member States, denying the existence of diverse sexual identities in their own cultures, have argued that the recognition of LGBT people runs contrary to their own societal, cultural and religious values. They have done so in terms which seek to dismiss the claims of LGBT people by associating them with Western traditions of individualism and decadence and casting themselves as the defenders of traditional values and the family. The fact that these countries have signed up to the Universal Declaration of Human Rights (1948 – see **Core Document 10**) does not preclude disagreement.

The first substantive discussion on sexual orientation at a UN forum took place in 1995 at the Beijing Conference on Women. The **draft** Platform for Action contained four references to sexual orientation, all of which were eventually deleted (at a notorious meeting that went until 4am on a Friday) because agreement could not be reached on their inclusion (33 States supported the inclusion and 20 objected).

Conservative States viewed the conference as being feminist-driven, representing a significant threat to traditional family models. Seeing this feminist agenda as anti-family, promoting homosexuality, allowing abortion on demand, and removing parental rights, they said the Platform appeared to be the vehicle through which feminist ideology would infiltrate governmental systems worldwide. For example, according to the Platform, gender roles are considered to be socially constructed, not innate. Furthermore, the majority of members at the Platform refused to define gender as either biologically male or female, thus allowing the inclusion of transsexuals by certain governments. The Platform also redefined the family by stating: "In different cultural, political and social systems, various forms of the family exist", thus paving the way for gay or lesbian partners to raise children as a family. The text also catered for reproductive rights, and undermined parental rights since it regarded children as

autonomous. Not surprisingly perhaps, the trend of recent UN human rights discourse to deconstruct and redefine the natural (traditional) family has prompted conservative NGOs to raise awareness to the supposed threats that this trend poses to society.

(The last three paragraphs are adapted from a paper *Irreverent or Irrelevant? The United Nations and Gay Rights*, by Lebanese diplomat Sami Zeidan, published in the Harvard Law School journal – The Record. <http://media.www.hlrecord.org/media/storage/paper609/news/2005/10/06/Opinion/Irreverent.Or.Irrelevant.The.United.Nations.And.Gay.Rights-1013429.shtml>)

Five years later in 2000, when Mary Robinson, UN High Commissioner for Human Rights, delivered a controversial statement substantially in favour of the right to free sexual orientation at the Beijing+5 review conference (see www.mwa.govt.nz/news-and-pubs/publications/international/beijing5.pdf – Supplemental Result) there was a revolt by many of the low- and middle income countries, expressed by the delegate from Pakistan who said that Western delegates were ‘holding the women of the world hostage to one term - sexual orientation - when their real needs are clean water and help in overcoming illiteracy’.

At the 59th session of the Commission on Human Rights in 2003, the Brazilian Government introduced a draft resolution on “Human Rights and Sexual Orientation”, which expressed concern at the occurrence of human rights violations against persons because of their sexual orientation, called upon States to promote and protect the human rights of all persons regardless of their sexual orientation and asked the High Commissioner for Human Rights and the Special Procedures to pay attention to the issue. The draft resolution did not attempt to create a new body of rights, but sought to reaffirm existing non-discrimination principles established under international human rights law. However, the draft faced strong opposition from the Organization of the Islamic Conference (OIC), and less vocally the Holy See, with the OIC proposing 55 amendments to the text (interestingly **Armenia** and **Ukraine** voted for inclusion of the term ‘sexual orientation’). Finally the Chair proposed that consideration of the draft be postponed until the following year.

In 2004, at the 60th session of the Commission, sexual rights had unprecedented visibility, but they also came under sustained attack. Issues of sexual autonomy, sexual orientation and sexual and reproductive health and rights were challenged at every turn, across four resolutions: extrajudicial, summary or arbitrary executions; violence against women; the right to everyone to the enjoyment of the highest attainable standard of physical and mental health, and human rights and sexual orientation; consideration of the latter was postponed until the 61st session in 2005.

At this 61st session, the Commission on Human Rights did not consider a resolution specifically on sexual orientation. However, many statements were made in support of non-discrimination on the basis of sexual orientation as well as in support of a specific resolution on sexual orientation. Notably, during the plenary debate under Item 17, New Zealand spoke on behalf of itself and 31 other countries stressing the need for action in this area and urging that the Commission “not be silent for too much longer” on matters of sexuality and non-discrimination on the basis of sexual orientation. Furthermore, during the High-Level Segment of the Commission, Canada’s address stressed the necessity to make progress in “fighting discrimination based on sexual orientation and gender

identity". Another significant development was the statement by Luxembourg under Agenda Item 6 stressing "the unacceptability of any discrimination based on sexual orientation" and its concern about continued human rights violations on the same basis.

On 15 March, 2006, the General Assembly adopted resolution A/RES/60/251 to establish the Human Rights Council (see **Core Document 8**). On 1st December, 2006, at the 3rd session of the HRC, the following joint statement on behalf of 54 States was delivered by Norwegian Ambassador, H.E Strommen:

I have the honour to make this statement on human rights violations based on sexual orientation and gender identity on behalf of the following 54 States... (including **Moldova** and **Ukraine**)

- At its recent session, the Human Rights Council received extensive evidence of human rights violations based on sexual orientation and gender identity, including deprivation of the rights to life, freedom from violence and torture.
- We commend the attention paid to these issues by the Special Procedures, treaty bodies and civil society. We call upon all Special Procedures and treaty bodies to continue to integrate consideration of human rights violations based on sexual orientation and gender identity within their relevant mandates.
- We express deep concern at these ongoing human rights violations. The principles of universality and non-discrimination require that these issues be addressed. We therefore urge the Human Rights Council to pay due attention to human rights violations based on sexual orientation and gender identity, and request the President of the Council to provide an opportunity, at an appropriate future session of the Council, for a discussion of these important human rights issues.

See full text (list of 54 countries, etc)

http://www.ilga.org/news_results.asp?LanguageID=1&FileCategory=44&ZoneID=7&FileID=944

In March 2007, a joint statement of LSVD Germany, ILGA-Europe and LBL Denmark was presented to the Human Rights Council (HRC). The High Commissioner's for Human Rights responded: "On a related question of discrimination, but from a different point of view, I'd like to address the issue that was put by the gay, lesbian, bisexual and transgender groups advocating the promotion of human rights in their environment. On that issue I wish to stress that all rights-holders are entitled to turn to their government to ensure their protection from violence, in particular from State-sponsored violence, and this principle of human security - protection of human life and security - suffers no exception, and has to be applied regardless of any personal characteristic, so that protection against violence, based in large part on prejudice, I think needs to be addressed by all governments. In the same way, it's incumbent on States to exercise restraint in the use of their criminal sanctions so as to not unduly invade rights of privacy"

Although the High Commissioner has been very supportive in the past, this is the first time that these issues have been addressed within the plenary chamber of the Council.

http://www.ilga.org/news_results.asp?FileID=1038

This account of the developments at the UN around the term "sexual orientation" since 1994, illustrates the scale of the challenge facing activists in getting sexual orientation overtly named (and

the distance that must be traversed before the words lesbian, gay, bisexual and transgender will be included) in international human rights instruments and standards, including those relating to sexual and reproductive health and rights. In the face of HIV/AIDS, it is hugely important that LGBT advocates can define for their own national governments where specific populations are being referred to in the international instruments so that lesbian, gay, bisexual and transgender people can play a central role in policies and practices in regards to their own health.

Sexual Orientation in the UN

Toonen v. Australia	1994	Word 'sex' in ICCPR interpreted to mean sexual orientation
Draft FWCW, Beijing	1995	Rejection of four appearances of the words 'sexual orientation'
Beijing+5	2000	Conservative states reject HCHR's call for free sexual orientation – debate occurs
UNCHR 59th session	2003	Debates and refuse Brazil's draft Resolution on human rights and sexual orientation
UNCHR 60th session	2004	Discussion postponed until next year
Special Rapporteur	2004	Resolution E.CN.4/2004/49 clearly identifies sexual orientation as a ground for discrimination re; HIV
UNCHR 61st session	2005	Unified call for specific resolution on sexual orientation made by 31 countries
Human Rights Council	2006	2006 Human rights violations re: sexual orientation – submission made by Norway (for 54 countries)
Human Rights Council	2007	HCHR responds at plenary session about the promotion of human rights for LGBT

Core Documents

relating to sexual and
reproductive rights and health
for lesbian, gay, bisexual and
transgendered people

1 The right to health in the International Bill of Human Rights

The right to health is enshrined in the **International Bill of Human Rights** which includes the **Universal Declaration of Human Rights** (1948), the **International Covenant on Civil and Political Rights** (ICCPR, 1966, into force since 1976) and the **International Covenant on Economic, Social and Cultural Rights** (ICESC, 1966, into force since 1976).

Although sexual orientation or Sexual and Reproductive Health and Rights are not referred to directly, it is understood they are included, as the fundamental right to health exists for every member of the human family.

1.1 The Universal Declaration of Human Rights Art. 25.1

Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control

The full text of the Universal Declaration is reproduced in

Core document 10

<http://unesdoc.unesco.org/images/0014/001466/146628m.pdf>

This webpage, from the 31 May 2006 (the 40th anniversary of the creation of the International Covenant on Economic, Social and Cultural Rights) lists the major international and regional instruments for Human Rights. It also provides an interesting snapshot of which instruments of the 192 member States have signed under the following headings: prevention of discrimination, genocide, terrorism, torture, slavery, aliens, workers, women, children and combatants,

1.2 The International Covenant on Economic, Social and Cultural Rights

The full text of the International Covenant on Economic, Social and Cultural Rights is reproduced in

Core document 11

http://www.unhchr.ch/html/menu3/b/a_ccpr.htm

The full text of the **ICESCR** is reproduced here. This webpage from the Office of the High Commissioner for Human Rights acts as a portal for other OHCHR pages.

1.2

Art. 12

1. *The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.*
2. *The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:*
 - (a) *The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;*
 - (b) *The improvement of all aspects of environmental and industrial hygiene;*
 - (c) *The prevention, treatment and control of epidemic, endemic, occupational and other diseases;*
 - (d) *The creation of conditions which would assure to all medical service and medical attention in the event of sickness.*

Interpretation of the ICESCR

As mentioned earlier, the *right to health* is different from the right to be healthy. This conclusion follows the definition of health and the *right to health* given by international institutions. Indeed, the Preamble of the World Health Organization's Constitution states that:

'Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.'

The right to health embraces a series of socio-economic factors. This is confirmed by the **General Comment No. 14** (2000) made by the Committee of Economic, Social and Cultural Rights (CESCR) on the International Covenant on Economic, Social and Cultural Rights (ICESCR). Indeed, with respect to the article 12.1 of the ICESCR mentioned above, the CESCR underline that *"the right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health"*

The full text of General Comment No.14 is reproduced in **Core document 12**

[http://www.unhcr.ch/tbs/doc.nsf/\(symbol\)/E.C.12.2000.4.En?OpenDocument](http://www.unhcr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En?OpenDocument)

This **General Comment No. 14** is an important reference source for the interpretation of the ICESCR

In **General Comment No 14**, the Committee on Economic, Social and Cultural Rights (CESCR) suggests a broader interpretation of the article 2.2 of the ICESCR, which does not explicitly mention discrimination on the ground of sexual orientation:

Paragraph 18 - ...the Covenant proscribes any discrimination in access to health care and underlying determinants of health, as well as to means and entitlements for their procurement, on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation and civil, political, social or other status, which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health.

The right to health is broader than the right to be healthy and includes a wide range of components, involving different kinds of obligations for States. General Comment No. 14 identifies some core

1.2

obligations, which are of immediate relevance for States. With respect to discrimination:

Paragraph 43a - In General Comment No. 3, the Committee confirms that States parties have a core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights enunciated in the Covenant, including essential primary health care. Accordingly, in the Committee's view, these core obligations include at least the following obligations:

(a) To ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups.

Concerning HIV/AIDS:

Paragraph 44 (a-e) - The Committee also confirms that the following are obligations of comparable priority:

(a) To ensure reproductive, maternal (pre-natal as well as post-natal) and child health care;

(b) To provide immunization against the major infectious diseases occurring in the community;

(c) To take measures to prevent, treat and control epidemic and endemic diseases;

(d) To provide education and access to information concerning the main health problems in the community, including methods of preventing and controlling them;

(e) To provide appropriate training for health personnel, including education on health and human rights.

1.3

The International Covenant on Civil and Political Rights

<http://www.ohchr.org/english/law/ccpr-one.htm>

The full text of the **ICCPR** is reproduced here. This webpage from the Office of the High Commissioner for Human Rights acts as a portal for other OHCHR pages.

Although the ICCPR does not mention explicitly the right to health, it is recognized due to the definition of the right to health mentioned earlier that elements of the enjoyment of the right to attain the highest standard of physical and mental health are implicit in a number of civil rights.

Some examples are:

Art.1.2

All peoples may, for their own ends, freely dispose of their natural wealth and resources [...]. In no case may a people be deprived of its own means of subsistence.

Art. 7

No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation.

Art. 17, par. 1

No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence, or to unlawful attacks on his honor and reputation.

Art 19, par. 2

Everyone shall have the right to freedom of expression; this right shall include freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing or in print, in the form of art, or through any other media of his choice

1.3

Art. 23, par. 3

No marriage shall be entered into without the free and full consent of the intending spouses.

www.ilgaeurope.org/.../file/Sweden%20%20Sex%20Orient%20and%20Gend%20ID%20issues%20in%20development.pdf

Sexual Orientation and Gender Identity Issues in Development

A Study of Swedish policy and administration of Lesbian, Gay, Bisexual and Transgender issues in international development cooperation (2005). This paper is an excellent resource from the Swedish International Development Cooperation Agency (SIDA). **Chapter 7** makes particular reference to changes made to the understanding and application of the International Covenant on Civil and Political Rights.

2 The right to health in the core international human rights instruments

2.1 The International Convention on the Elimination of All Forms of Racial Discrimination (ICERD) 1965, into force from 1969

<http://www.ohchr.org/english/law/cerd.htm>

Full text of the **ICERD** supplied here

Article 5 (e)

In compliance with the fundamental obligations laid down in article 2 of this Convention, States Parties undertake to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law, notably in the enjoyment of the following rights:

[...]

e) Economic, social and cultural rights, in particular:

iv) The right to public health, medical care, social security and social services.

2.2 The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) 1979, into force since 1981

<http://www.ohchr.org/english/law/cedaw.htm>

Full text of the **CEDAW** reproduced here

Art. 11.1 (f)

States Parties shall take all appropriate measures to eliminate discrimination against women in the field of employment in order to ensure, on a basis of equality of men and women, the same rights, in particular:

(f) The right to protection of health and to safety in working conditions, including the safeguarding of the function of reproduction.

2.3

Convention on the Rights of the Child (CRC) 1989, into force since 1990

<http://www.ohchr.org/english/law/crc.htm>

Full text of the **CRC** reproduced here

Art.19 par 1

States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.

Art. 24

1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.

2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:

(a) To diminish infant and child mortality;

(b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;

(c) To combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution;

(d) To ensure appropriate pre-natal and post-natal health care for mothers;

(e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents;

(f) To develop preventive health care, guidance for parents and family planning education and services.

3. States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.

4. States Parties undertake to promote and encourage international co-operation with a view to achieving progressively the full realization of the right recognized in the present article. In this regard, particular account shall be taken of the needs of developing countries.

3 The International United Nations Conference on Population and Development, Cairo, 1994

The full text of Chapter VII of the ICPD is reproduced in

Core document 13

<http://www.iisd.ca/cairo.html>

This Linkage page leads directly to the PROGRAM OF ACTION OF THE UN ICPD

Chapter VII – Reproductive rights and reproductive health where each section of the Chapter is presented

At the United Nations International Conference on Population and Development (ICPD) held in Cairo in 1994, 179 countries agreed that population and development are inextricably linked, and that empowering women and meeting people's needs for education and health, including reproductive health, are necessary for both individual advancement and balanced development.

The conference was very important in setting a **clearer international framework for reproductive rights and health**. On this occasion world leaders, UN agencies, high-ranking officials and NGO representatives agreed on a 20-year Programme of Action (PoA) which includes a special chapter (VII) on reproductive rights and health.

The PoA gives a very inclusive definition of reproductive rights and sexual health which acknowledges the difference between the right to health (and specifically to reproductive health) and the right to be healthy. The paragraph 7.2 of the PoA states out:

Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes.

Paragraph 7.4 of the PoA affirms that:

Reproductive health [...]. also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases.

The implementation of the present Program of Action is to be guided by the above comprehensive definition of reproductive health, which includes sexual health.

Reproductive rights are considered in the Program of Action as human rights enshrined in basic international instruments. Furthermore, paragraph 7.3 of the PoA explicitly includes reproductive rights:

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These rights [reproductive rights] rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes the right of all to make decisions concerning reproduction free of discrimination, coercion and violence as expressed in human rights documents.

The Program of Action does not mention explicitly **sexual rights**, although feminist groups at the ICPD lobbied for this inclusion. Nonetheless, the PoA mentions that reproductive health implies that people are able to have a satisfying and safe sex life.

The conference recognized a wide range of areas where reproductive and sexual health should be taken into account. They include:

- Family planning: the action plan stresses the importance of the free choice of couples to decide the number and spacing of their children. Couples have to be informed about family-planning programmes and about the use of modern contraceptives which represent an important opportunity for individual choice. Governments have to engage in ensuring everyone the right of voluntary choice in family planning.

- Sexually transmitted diseases and HIV prevention: reproductive health programmes have to increase their efforts to prevent, detect and treat sexually transmitted diseases. The important role of education, information and counselling is acknowledged. The distribution of high-quality condoms should be a component in all reproductive health programs.

- Human sexuality and gender relations: gender relations affect the ability of both men and women to achieve their sexual health and to manage their reproductive life. Sexual education should be supported as well as educational programmes aiming at protect women and children form any abuse.

- Adolescents: information and services should be provided in order to make adolescents more aware of their sexuality. Education should play an important role in making men respectful of women's right to self-determination and willing in sharing responsibilities with women in matters of sexuality and reproduction. Early child-bearing is recognized as an impediment to improvements in social, economic and educational status of women. Reproductive sexual education has to reduce the number of adolescent pregnancies.

The UN General Assembly organizes regular reviews of the implementation of the International Conference on Population and Development's Program of Action. In its *resolution 49/128 of 19 December 1994*, the General Assembly decided that the **Commission on Population and Development** (CPD), created in 1946 under the name of Population Commission, together with the Economic and Social Council (ECOSOC), would have a primary responsibility in the follow-up of the PoA adopted at the Cairo Conference. The CPD has an important role in assisting the ECOSOC in monitoring, reviewing and appraising the implementation of the PoA at international, national and regional level.

http://www.unfpa.org/icpd/icpd_poa.htm

This site offers the full text and contents of the **Program of Action of the International Conference on Population and Development**

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The thirty-seventh session of the CPD held in **2004**, 10 years after the ICPD, focused on the review and appraisal of the progress made in achieving the goals and objectives of the Program of Action of the Cairo Conference. On this occasion a discussion arose on national experiences in implementing the PoA and countries reported on progress on implementation, while recognizing that much has to be done in order to achieve the ICPD goals.

<http://www.unfpa.org/parliamentarians/news/newsletters/issue19.htm>

Short news report from **UNFPA Global Population Policy Update** on the 10th anniversary of the ICPD

The General Assembly commemorated the 10th anniversary of the ICPD in October 2004, during its fifty-ninth session. It was an opportunity for member States to affirm their commitments to the ICPD goals.

<http://www.un.orgNews/Press/docs/2004/ga10277.doc.htm>

General Assembly reaffirmation of ICPD, 2004

The most important conclusion reached was that there has been considerable progress made in reproductive and sexual health since the Cairo Conference - for example, the rise in the use of modern contraception worldwide. Nevertheless, new constraints, such as the lack of funding and deepening poverty in low- and middle-income countries, have made the path of this progress unpredictable. Some important problems have not been tackled - for example maternal mortality remains very high and HIV/AIDS continues to have an enormous impact on mortality. Transmission could be largely avoided by using condoms, which are an affordable and life-saving technology. The importance of access to reliable information on HIV/AIDS for young people was underlined.

The General Assembly as well as the ECOSOC and the ICPD recognized that the Program of Action adopted at the Cairo Conference would help the achievement of the **Millennium Development Goals**.

The Millennium Goals are reproduced in

Core document 19

<http://www.un.org/millenniumgoals/>

This page opens to each of the **8 Millennium Development Goals**. Activate the appropriate button on left of screen. Goals 4, 5 and 6 are discussed below

In September 2000, at the United Nations Millennium Summit, 189 world leaders agreed to a set of time-bound and measurable goals and targets for combating poverty, hunger, disease, illiteracy, environmental degradation and discrimination against women. Placed at the heart of the global agenda, they are now called the Millennium Development Goals (MDGs). The Summit's Millennium Declaration also outlined a wide range of commitments as regards respect for human rights, good governance and democracy.

http://www.unfpa.org/upload/lib_pub_file/551_filename_mdec_eng.pdf

This is the full text of the General Assembly's **United Nations Millennium Declaration** of August 2000

Three out of 8 Millennium goals are directly connected with sexual and reproductive health:

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GOAL 4: To reduce by three quarters, between 1990 and 2015, the maternal mortality ratio;

GOAL 5: To reduce by two thirds, between 1990 and 2015, the under-five mortality rate;

GOAL 6: To have halted by 2015, and begun to reverse, the spread of HIV/AIDS.

Taking into account the first and the second objective, the Millennium Development Goals Report 2006 shows some, although modest, improvements. For example, even if in general the under-5 mortality rate dropped between 1990 and 2004, Sub-Saharan Africa shows only very modest improvements (from 180/1000 to 168/1000). The target of a two-thirds reduction in under-fives' mortality looks very unlikely to be met by 2015. Indeed, the number of people living with HIV has been increasing annually.

<http://unstats.un.org/unsd/mdg/Resources/Static/Products/Progress2006/MDGReport2006.pdf>

This is the **Millennium Development Goals** report in PDF format. It analyses progress on each of the Goals by region, having compiled the results drawn in from all of the regions in the world, including CIS Europe and CIS Asia.

4 The Fourth World Conference on Women, Beijing, 1995

The United Nations Fourth World Conference on Women was held in Beijing, China in 1995. This was the largest meeting of the Global Women's Movement, where 40,000 women traveled from all over the world to participate in this historic gathering. The presence of so many women activists was not only a testament to the growing political power of women but it also lent credibility to the event itself and helped ensure that the key outcome from the Conference, the Platform for Action, although negotiated among UN member States, reflected women's global concerns. The Beijing conference confirmed the important principle of free choice and the definition of health, given on the occasion of the Cairo Conference (see **Core Document 3**).

The Beijing Declaration recognized the right of all women to control all aspects of their health, in particular their own fertility (paragraph 17) which is one of the bases for their empowerment. It also affirmed the principle that equal access between men and women to reproductive and sexual health should be assured.

<http://www.un.org/womenwatch/daw/beijing/platform/declar.htm>

This is the **Declaration** made at the Beijing Conference, 1995. Paragraph 30 also makes direct reference to sexual and reproductive health. Although four references were made in the Draft Declaration to the term 'sexual orientation', they resulted in huge debate at the Conference, and were eventually deleted.

The PFA, (par.89) defines health as:

A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity

<http://www.un.org/womenwatch/daw/beijing/platform/>

Full PFA text to be found here in separate files

Reproductive health implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so (see **Paragraph 94** of the Beijing Platform for Action for the full text).

Reproductive rights embrace certain human rights, such as the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children. And it includes their right to make decisions concerning reproduction free of discrimination, coercion and violence (again see **Paragraph 94**).

A whole chapter of the Beijing Program for Action focuses on **Women and Health**. Taking into account the fact that half of all adults infected with HIV/AIDS are women, **gender inequalities** between men and women are considered as obstacles to safe sex. It follows that tackling gender inequalities is a key strategy to fight the spread of HIV/AIDS and sexually transmissible diseases.

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Strategic objective C3 deals with gender sensitive initiatives in the field of HIV/AIDS:

Gender sensitive initiatives should be undertaken in order to address sexually transmitted diseases, HIV/AIDS and sexual and reproductive health issues.

The PFA identifies actions (see **Paragraph 108** of the Beijing Platform for Action) to be taken by governments, international organisations, NGOs, health professionals, pharmaceutical industries and the mass media to achieve the strategic objective C3. The need to involve women, especially those who are infected, in the implementation and evaluation of programs and policies on HIV/AIDS is stressed (action **a** related to objective C3). The national capacities to implement gender-sensitive programs and policies on HIV/AIDS have to be strengthened (action **g**). Furthermore, the importance of delivering information and providing education on HIV/AIDS to both women and men is recognized (actions **i** and **l**). Access to affordable and appropriate preventive services with respect to STIs, including HIV/AIDS, should be assured to everyone (action **m**). Gender oriented health programmes must be designed and implemented to assure access to health services for women and girls, and to tackle serious concerns, such as maternal mortality, whose reduction is one of the Millennium Development Goals.

The Commission on the Status of Women (CSW), a functional commission of the Economic and Social Council and the UN General Assembly, reviewed and appraised the Beijing Declaration and Program for Action in 2000 and 2005. On these occasions the emergency of the HIV/AIDS contamination was stressed. The CSW stated in its 49th session in 2005 that the devastating scale and the impact of HIV/AIDS required urgent action at all levels. Gender equality is seen as a key factor in the reduction of the vulnerability of women to HIV/AIDS.

5 The Joint United Nations Programme on HIV/AIDS (UNAIDS)

The full text of the OHCHR/UNAIDS Guidelines on HIV/AIDS is reproduced in **Core document 15**

UNAIDS was created in 1995 by a resolution of the Economic and Social Council. UNAIDS brings together the efforts of 10 UN agencies: **UNHCR, UNICEF, WFP, UNDP, UNFPA, UNODC, ILO, UNESCO, WHO**, the World Bank, to a global response to AIDS-HIV.

The Programs of Action adopted by the Cairo and Beijing conferences do not mention LGBT people, while dealing with reproductive and sexual health and rights. On the contrary UNAIDS documents identify clearly *men who have sex with men* as a vulnerable category and underline that homophobia is one of the most important obstacle to tackle the spreading of HIV/AIDS. 'Men who have sex with men' is considered a more inclusive term than gay or homosexual, because some men who have sex with men define their sexual orientation as heterosexual. Further, because some States refuse to recognize their homosexual and bisexual populations the employment of the term MSM, in the international context, is considered a more strategic choice in order to reach this vulnerable group and to tackle the spread of HIV/AIDS spread.

UNAIDS and the Office of the High Commissioner of Human Rights (OHCHR) published some International Guidelines on HIV/AIDS and Human Rights in 1998 (of which Guideline 6 was amended in 2002). These Guidelines represent a progressive and radical voice in regard to homosexuality. They stress the importance of taking a human rights-based approach into consideration in designing and implementing programs and strategies to fight HIV/AIDS. A Consolidated version was launched in August 2006 to coincide with the 16th International AIDS Conference and with the 10th anniversary of guidelines themselves.

http://www.ohchr.org/english/issues/hiv/docs/consolidated_guidelines.pdf

International Guidelines on HIV/AIDS and Human Rights, 2006 Consolidated Version

Discrimination, stigmatization and the criminalization of men to men sexual relations are the main obstacles to tackling the spread of HIV/AIDS within MSM. Indeed, *Guideline 4* states that:

States should review and reform criminal laws and correctional systems to ensure that they are consistent with international human rights obligations and are not misused in the context of HIV/AIDS or targeted at vulnerable groups.

The commentary elaborates as follows:

Criminal law prohibiting sexual acts (including adultery, sodomy, fornication and commercial sexual encounters) between consenting adults in private should be reviewed, with the aim of repeal. In any event, they should not be allowed to impede the provision of HIV/AIDS prevention and care services.

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On anti-discrimination and protective laws, Guideline 5 states in part that:

States should enact or strengthen anti-discrimination and other protective laws that protect vulnerable groups, people living with HIV/AIDS and people with disabilities from discrimination in both the public and private sectors

The commentary provides that:

Anti-discrimination and protective laws should be enacted to reduce human rights violations against men having sex with men, including in the context of HIV/AIDS, in order, inter alia, to reduce the vulnerability of men who have sex with men to infection by HIV and to the impact of HIV/AIDS. These measures should include providing penalties for the vilification of people who engage in same-sex relationships, giving legal recognition to same-sex marriages and/or relationships and governing such relationships with consistent property, divorce and inheritance provisions. The age of consent to sex and marriage should be consistent for heterosexual and homosexual relationships. Laws and police practices relating to assaults against men who have sex with men should be reviewed to ensure that adequate legal protection is given in these situations.

Finally, on women, children and other vulnerable groups, Guideline 8 states that:

States should, in collaboration with and through the community, promote a supportive and enabling environment for women, children and other vulnerable groups by addressing underlying prejudices and inequalities through community dialogue, specially designed social and health services and support to community groups.

The commentary notes that:

States should support the implementation of specially designed prevention and care programmes for those who have less access to mainstream programmes due to social or legal marginalisation, including men who have sex with men.

The Joint statement on condoms and HIV prevention of UNAIDS, UNFPA and WHO issued in July 2004, while recognizing the male latex condom as the single, most efficient and available technology to reduce the sexual transmission of HIV and other sexually transmitted infections, states that effective condoms promotion should target not only the general population but also people at higher risk of HIV exposure, especially women, younger people, sex workers and their clients, injecting drug users and men who have sex with men.

http://data.unaids.org/una-docs/condom-policy_jul04_en.pdf
Position Statement on Condoms and HIV Prevention, July 2004

A policy paper on *Intensifying HIV Prevention* was endorsed by the UNAIDS Coordination Board in mid-2005. This paper strategically recognizes the connection between the risk of getting infected by HIV and the vulnerability that makes some groups of people unable to protect themselves. Although

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comprehensive prevention programs for the general population should be available, the paper underlines that actions should be taken to identify key populations, which include men who have sex with men, and to address their specific needs.

http://data.unaids.org/una-docs/condom-policy_jul04_en.pdf

Intensifying HIV Prevention

This policy paper highlights the importance of including HIV prevention in programs dealing with sexual and reproductive health. The protection of sexual rights, such as the right to control one's own sexuality, free of coercion, discrimination and violence, is a key factor in preventing the sexual transmission of HIV. This is underlined in a special analysis jointly undertaken by the Guttmacher Institute and UNAIDS:

In conclusion, policymakers, donors, service providers, activists and academics at all levels must give more consideration to integrating HIV prevention into reproductive health services as appropriate—and to integrating reproductive health services into HIV-related programs. They must identify approaches that will work and under what conditions integration makes sense. They should assess what will be needed to move forward in terms of planning, logistics, monitoring and evaluation and to upgrade the competency and capacity of personnel, services and health systems. Finally, they must advocate for better policies and increased funding to support integration. The synergies resulting from integration will inevitably accelerate progress towards achieving the ambitious targets set by the global community over the past 10 years. As the HIV pandemic evolves, countries can no longer afford to overlook the new opportunities arising from integration.

<http://www.guttmacher.org/pubs/tgr/07/4/gr070407.pdf>

The role of reproductive health providers in preventing HIV, The Guttmacher Report, Geneva, 2004

A consultation between stakeholders (scholars, international organisations, NGOs) was organized by UNAIDS in November 2005 to deal with HIV prevention for men who have sex with men. Although the UNAIDS policy paper on HIV prevention mentioned vulnerable groups and men who have sex with men, it had not set up a specific framework for action in this field.

http://data.unaids.org/pub/Report/2006/JC1233-MSM_MeetingReport_en.pdf

Men who have Sex with Men, HIV Prevention and Care. Report of a UNAIDS stakeholder consultation, Geneva, 10-11 November 2005

The stakeholders' consultation aimed at designing more specific actions with respect to HIV prevention of MSM. This is an urgent issue, given that less than 10% of men who have sex with men globally have access to HIV prevention (this figure is approximate, as there is still a lack of high-quality epidemiological indicators). The consultation underlines the importance of promoting a rights-based approach in order to scale-up and intensify HIV prevention programs. That meant for example, ensuring the protection of health as a fundamental human right, monitoring human rights violations against men who have sex with men, repealing laws prohibiting male-to-male sex, mentioning MSM as a key affected group in plans for HIV prevention and care, supporting organisations at regional,

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national and international level dealing with sexual and reproductive rights. The consultation resulted in the elaboration of a comprehensive list of essential policy and programmatic actions to undertake:

Policy Actions

- 1. Repeal laws prohibiting male-to-male sex (e.g. existing sodomy laws).**
- 2. Ensure the existence of anti-discrimination legislation on the grounds of sexual orientation, gender identity and HIV status.**
- 3. Ensure specific reference is made to sexuality/sexual orientation in human rights frameworks and antidiscrimination legislation.**
- 4. Promote the effective enforcement of anti-discrimination laws as above.**
- 5. Take action to eliminate: stigma in healthcare settings; homophobic violence.**
- 6. Ensure specific mention of men who have sex with men as a key affected group in plans for HIV prevention and care.**
- 7. Promote sexuality education, which includes respect for sexual diversity, gender equality, and gender identity.**
- 8. Actively monitor human rights violations against men who have sex with men and other sexual minorities.**
- 9. Encourage a strengthened relationship between members of the UNAIDS family with respect to work to meet the prevention, treatment and care needs of men who have sex with men.**
- 10. Promote wider understanding and action to ensure the protection of health as a fundamental human right regardless of sexual orientation or sexual identity.**
- 11. Promote best practices in stigma reduction relevant to men who have sex with men especially with respect to HIV.**
- 12. Ensure access to HIV prevention (including condoms) by men who have sex with men in all male settings and institutions.**
- 13. Ensure the active recruitment and involvement of sexual minorities including men who have sex with men in policy and decision making relating to HIV.**
- 14. Address gender issues through a broader approach which recognizes the rights and circumstances of transgendered people and men who have sex with men.**
- 15. Generalize concern for HIV and men who have sex with men throughout health education and health promotion.**
- 16. Promote research on rectal microbicides.**
- 17. Ensure sufficient resources for the conduct of good quality epidemiological and social research on men who have sex with men.**

Programmatic Actions

- 1. Undertake heightened advocacy among UNAIDS Cosponsors to ensure that concern for HIV prevention, treatment and care among men who have sex with men remains high on the agenda.**
- 2. Give support to and provide technical assistance to countries to build and/or improve a comprehensive programmatic response to men who have sex with men (focusing on prevention and care needs) in all national HIV plans.**
- 3. Help countries identify and define “comprehensive” programmes of relevance to men who have sex with men.**
- 4. Encourage multilateral and bilateral agencies to support men who have sex with men-related**

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HIV prevention and AIDS care programmes.

- 5. Promote initial training and continuing professional development on issues of relevance to HIV and men who have sex with men for national authorities and UN system agencies active in the response to AIDS**
- 6. Harness new opportunities to promote HIV prevention for men who have sex with men within expanded treatment access programmes.**
- 7. Review epidemiological surveillance protocols to insure that men who have sex with men are appropriately addressed within these, even in contexts where the epidemic is not directly driven by male-to-male sex.**
- 8. Ensure the production, dissemination and utilization of voluntary confidential counselling and testing guidelines that are more friendly to men who have sex with men.**
- 9. Provide/produce guidelines and technical assistance to reduce homophobia and ignorance among healthcare workers.**
- 10. Increase access to HIV treatment for men who have sex with men.**
- 11. Encourage good quality social and behavioral research on men who have sex with men even in countries that deny it exists.**
- 12. Promote greater recognition that male-to-male sex is a fact in all societies that should always be considered in all HIV prevention and care programming.**
- 13. Support civil society organisations at local, national and regional level in their work on HIV and sexual rights.**
- 14. Strengthen leadership by UNAIDS on men-who-have-sex-with-men issues.**
- 15. Create an Inter-Agency Task Team on HIV and men who have sex with men.**

At the national level, the rights of men who have sex with men have to be recognized and prevention, care and treatment of MSM should be included in any AIDS action framework. Furthermore, financial resources have to be re-allocated as in most countries funds available for HIV prevention program targeting MSM are inadequate.

These conclusions are confirmed in the UNAIDS policy brief on HIV and men who have sex with men, published in 2006. The need to draw attention to HIV prevention of MSM follows the fact that the HIV epidemic within MSM can be associated with the epidemic in the general population because MSM also have sex with women. For example, in some cities in Central and Eastern Europe, one third of men in gay venues reported having both male and female partners.

http://data.unaids.org/pub/BriefingNote/2006/20060801_Policy_Brief_MSM_en.pdf

UNAIDS, 2006, **Men who have Sex with Men**, Policy Brief

According to the 2006 UNAIDS Global Report fewer than one in twenty men who have sex with men have access to the HIV prevention and care services they need. Homophobia and laws criminalizing same-sex relations are considered as primary obstacles to effective HIV response. A lack of information and awareness of risk renders men who have sex with men a very vulnerable category. Further, in high-income countries achievements against HIV/AIDS for men who have sex with men are being eroded as there is a resurgence of sexual risk behaviors. UNAIDS emphasizes the promotion of prevention campaigns which include the promotion of high-quality condoms, training and education.

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Supporting LGBT organisations is recognized as an important strategy in promoting HIV prevention and care programs.

http://www.unaids.org/en/HIV_data/2006GlobalReport/default.asp

Portal to the full **Report on the global AIDS epidemic 2006**, UNAIDS (24mb)

http://data.unaids.org/pub/GlobalReport/2006/2006_GR_CH05_en.pdf

Chapter 5 of the UNAIDS report 2006: **At risk and neglected, 4 key populations**, including MSM and sex workers

Fact and figures related to the HIV/AIDS epidemic as well as progress achieved in each country can be found in this report. Newly Independent States' (NIS) profiles are annexed at the end of this compilation.

6 The United Nations General Assembly (UNGASS)

The full text of the UNGASS Declaration of Commitments on HIV/AIDS is reproduced in **Core document 14**

The General Assembly held a special session on HIV/AIDS in 2001, on the 20th anniversary of the first medical recognition of AIDS. The result is a *Declaration of Commitments* adopted by UN member States. Although this Declaration is not binding, it is a clear statement on what States agreed on fighting HIV/AIDS pandemic.

<http://www.ohchr.org/english/issues/hiv/ungass.htm>

For further information on the role of the UNGASS in the field of HIV/AIDS and the full text of the **Declaration of Commitments**

The Declaration recognizes clearly the connection between the prevention, care and treatment of HIV/AIDS and the protection of human rights and fundamental freedoms:

*Paragraph 16 - **The full realization of human rights and fundamental freedom is an essential element in a global response to HIV-AIDS [...] it reduces vulnerability to HIV/AIDS and prevents stigma and related discrimination against people living with or at risk of HIV/AIDS.***

The Declaration speaks out against discrimination and stigmatization of people living with HIV/AIDS and calls upon States to strengthen and enforce by 2003:

*Paragraph 58 - ... **legislation, regulations and other measures to eliminate all forms of discrimination against and to ensure the full enjoyment of all human rights and fundamental freedoms by people living with HIV/AIDS and members of vulnerable groups, in particular to ensure their access to, inter alia, education, inheritance, employment, health care, social and health services, prevention, support and treatment, information and legal protection, while respecting their privacy and confidentiality; and develop strategies to combat stigma and social exclusion connected with the epidemic.***

With respect to the most vulnerable groups, the Declaration does not explicitly mention men who have sex with men (MSM) but explicitly states that the vulnerable should be given priority in the prevention, care and treatment of HIV/AIDS. Paragraph 62 mentions activities which place individuals at HIV risk, such as risky and unsafe sexual behaviors. States are called upon to put in place:

*... **strategies, policies and programmes that identify and begin to address those factors that make individuals particularly vulnerable to HIV infection, including underdevelopment, economic insecurity, poverty, lack of empowerment of women, lack of education, social exclusion, illiteracy, discrimination, lack of information and/or commodities for self-protection, and all types of sexual***

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exploitation of women, girls and boys, including for commercial reasons. Such strategies, policies and programmes should address the gender dimension of the epidemic, specify the action that will be taken to address vulnerability and set targets for achievement

Furthermore, States committed themselves to develop or strengthen, by 2003, policies and programs:

to promote and protect the health of those identifiable groups which currently have high or increasing rates of HIV infection or which public health information indicates are at greatest risk of and most vulnerable to new infection as indicated by such factors as the local history of the epidemic, poverty, sexual practices, drug-using behaviour, livelihood, institutional location, disrupted social structures and population movements, forced or otherwise

See **Support document 52**, which is the **Progress Report on the Global Response to the HIV/AIDS Epidemic, 2003**

In June 2006, the General Assembly held a high level meeting on AIDS, on the fifth anniversary of the Declaration of Commitments, in order to review progress achieved and to make a new commitment adopting the Political Declaration which reconfirmed the main points of the 2001 Declaration, such as the connection between HIV/AIDS and human rights and the importance of fighting discrimination against people living with HIV/AIDS. The Declaration stressed the importance of access to medication in AIDS treatment. The 2006 report mentions men who have sex with men, sex workers, prison populations and injecting drug users as being groups who are “most at risk”.

http://data.unaids.org/pub/Report/2006/20060615_HLM_PoliticalDeclaration_ARES60262_en.pdf

Resolution adopted by the General Assembly 60/262. **Political Declaration on HIV/AIDS**

7 The UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health – resolution E/CN.4/2004/49

The full text resolution E/CN.4/2004/49 is reproduced in **Core document 16**.

The UN Commission on Human Rights established a three-year mandate for the Special Rapporteur in 2002 and it was extended in 2005 for three more years. Paul Hunt, the Special Rapporteur, gathers information on health from member States, inter-governmental organisations, NGOs and individuals. The Office of the Special Rapporteur sets up cooperation frameworks in the field of health with all relevant actors - including other UN agencies, reports, etc - throughout the world on the right to health and makes recommendations on measures, policies etc, which could promote that right or eliminate obstacles to attain it.

www.unhcr.ch/Huridocda/Huridoca.nsf/TestFrame/5f07e25ce34edd01c1256ba60056deff?Opendocument

Commission on Human Rights resolution 2002/31. **The right of everyone to the enjoyment of the highest attainable standard of physical and mental health**

It is important to underline that the Special Rapporteur receives individual complaints both in case of urgency, when a violation of the right to the enjoyment of the highest attainable standard of physical and mental health is occurring or when the violation has already occurred. The Special Rapporteur addresses urgent action letters to governments when such violations occur. Governments are asked to respond promptly to the Special Rapporteur and sometimes they are called on to take actions to redress situations involving the violation of the right to health. However, it should be noted that such requests by the Special Rapporteur are not enforceable on states.

<http://www.ohchr.org/english/bodies/chr/special/complaints.htm>

Complaints Procedure Assumed by the Human Rights Council

On the occasion on the 10th anniversary of the Cairo conference (2004), the Special Rapporteur dealt with reproductive and sexual rights in his report to the Commission on Human Rights. This is one of the most comprehensive statements on sexual and reproductive rights. It contains valuable statements regarding the relationship between these rights and LGBT people.

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<http://daccessdds.un.org/doc/UNDOC/GEN/G04/109/33/PDF/G0410933.pdf?OpenElement>
The right of everyone to the enjoyment of the highest attainable standard of physical and mental health. **Report of the Special Rapporteur**, Paul Hunt. Resolution **E/CN.4/2004/49**

With respect to the relation between sexual and reproductive health and human rights, the Special Rapporteur states in Paragraph 13:

Of course, not all sexual and reproductive ill-health represents a violation of the right to health or other human rights. Ill-health constitutes a human rights violation when it arises, in whole or in part, from the failure of a duty-bearer - typically a State - to respect, protect or fulfil a human rights obligation. Obstacles stand between individuals and their enjoyment of sexual and reproductive health. From the human rights perspective, a key question is: are human rights duty-bearers doing all in their power to dismantle these barriers?

The report affirms that sexual and reproductive ill-health represents a violation of human rights when it arises from the failure of the State to protect, respect or fulfil it.

The obligation to **protect** means that:

States should take steps to prevent third parties from jeopardizing the sexual and reproductive health of others, including through sexual violence and harmful cultural practices.

The obligation to **respect**:

requires States to refrain from denying or limiting equal access for all persons to sexual and reproductive health services, as well as the underlying determinants of sexual and reproductive health.

The obligation to **fulfil** requires:

States to give recognition to the right to health, including sexual and reproductive health, in national political and legal systems. Paragraph 4 states that health systems should provide for sexual and reproductive health services for all, including in rural areas, and States should carry out information campaigns to combat, for example, HIV/AIDS, harmful traditional practices and domestic violence.

The right to health, including sexual and reproductive health, encompasses sexual rights, which are defined as sexual freedoms by the Special Rapporteur:

The right to health, including sexual and reproductive health, encompasses both freedoms, such as freedom from discrimination, and entitlements.

Paragraphs 24 - 25 - In the context of sexual and reproductive health, freedoms include a right to control one's health and body. Rape and other forms of sexual violence, including forced pregnancy, non-consensual contraceptive methods (e.g. forced sterilization and forced abortion),

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female genital mutilation/cutting (FGM/C), and forced marriage all represent serious breaches of sexual and reproductive freedoms, and are fundamentally and inherently inconsistent with the right to health

States have the obligation to provide a wide range of sexual and reproductive health services including voluntary testing, counselling and treatment for sexually transmitted infections, including HIV/AIDS.

In paragraph 32, the Special Rapporteur refers to the prohibition against sexual orientation discrimination:

International human rights law proscribes discrimination in access to health care and the underlying determinants of health, and to the means for their procurement, on the grounds or race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation, and civil, political, social or other status that has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health.

Nonetheless, sexual minorities are still being denied equal access to sexual and reproductive health services:

Paragraph 33 - Discrimination and stigma continue to pose a serious threat to sexual and reproductive health for many groups, including women, sexual minorities, refugees, people with disabilities, rural communities, indigenous persons, people living with HIV/AIDS, sex workers, and people held in detention. [...]

Concerning LGBT people's access to health, in paragraph 39 the Special Rapporteur highlights:

Consistent with Toonen v. Australia and numerous other international and national decisions, they should ensure that sexual and other health services are available for men who have sex with men, lesbians, and transsexual and bisexual people. It is also important to ensure that voluntary counselling; testing and treatment of sexually transmitted infections are available for sex workers.

<http://www.ohchr.org/english/about/publications/docs/sdecisions-vol5.pdf>

See **page 133** of this OHCHR reference. It is the first successful homosexual case taken to the Human Rights Committee. Toonen argued that the ban on same-sex male acts in the Tasmanian Criminal Code violated his right to privacy and equality under the International Covenant on Civil and Political Rights (ICCPR) (Articles 17 and 26).

Sexual rights (see paragraph 54) are human rights and they include:

the right of all persons to express their sexual orientation, with due regard for the well-being and rights of others, without fear of persecution, denial of liberty or social interference.

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Further attention should be paid to the relationship between sexual and reproductive rights. Indeed, in paragraph 55 the Special Rapporteur underlines that:

Since many expressions of sexuality are non-reproductive, it is misguided to subsume sexual rights, including the right to sexual health, under reproductive rights and reproductive health. Given the nature of his mandate, the Special Rapporteur has a particular concern with the rights to sexual and reproductive health, hence the title of this section of the report. These rights, however, have to be understood in a broader human rights context that includes sexual rights.

8 The Human Rights Council (formerly the Commission on Human Rights)

The Commission on Human Rights was created in 1946 (and replaced by the Human Rights Council in 2006) by the General Assembly to foster international mechanisms aiming at the protection of human rights. The Commission was composed of 53 members, elected by the Economic and Social Council for a period of three years.

Procedures evolved over the years to strengthen the Commission's mandate – including Special Rapporteurs and Special Representatives. However, over the last years of the Commission, it increasingly came under criticism for its double standards and selectivity in the treatment of country situations and failure to address severe human rights violations occurring in many countries. The election of States with extremely poor human rights records as members of the Commission weakened its credibility. Furthermore, its institutional culture, which was characterized by excessive politicization, regional alliances, and block voting, and the use of procedural devices to prevent debate on proposed action against countries and on controversial issues weakened its functioning and ability to react to important human rights situations and fulfil its mandate.

As a result, the Council has a number of new features, such as longer and more frequent meetings, the ability to report directly to the General Assembly, a requirement to periodically review all States instead of a selected few, and a better election process, that provide greater opportunities for it to be a stronger and more effective mechanism than the Commission.

One of the most important innovations of the new HRC is the **Universal Periodic Review** (UPR) of governments' human rights records. All countries are subject to review under this process which will be a major step away from the selectivity that so often afflicted the Commission on Human Rights in the identification of countries to be scrutinized.

The order to fulfil the criteria of proceeding based on objective and reliable information as called for by the GA resolution, the UPR should begin with the assembly of information by professional staff and human rights experts:

- The date of the UPR for each State is set well in advance to facilitate the participation of interested parties; the HRC bureau appoints an independent expert, selected from a roster prepared by the Office of the High Commissioner, as session rapporteur for each State who carries out a full visit to that State and who prepares a background note on the human rights situation in the State;
- The Office of the High Commissioner prepares a summary of U.N. reports on the country concerned, drawn from the reports of the special procedures, treaty-monitoring bodies, and, where appropriate, peacekeeping and peace-building missions and OHCHR field presences;
- OHCHR further prepares summaries of available reports on the country from domestic, regional, and international non-governmental and inter-governmental organisations.

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Finally, based on all of the materials assembled, the session rapporteur prepares written questions for the State sufficiently in advance of the scheduled review session so the state can respond in full and members of the HRC can review the State's response.

The next phase of the review should be a cooperative mechanism providing the interactive dialogue contemplated in the HRC resolution.

- The State concerned makes a presentation of its record of fulfilling its human rights obligations and the challenges it faces in doing so. It answers the questions prepared by the session rapporteur;
- Presentations are made by national human rights institutions (if any), regional mechanisms (if any), and nongovernmental organisations;
- The State responds to the comments made and questions posed by others.

Each UPR should have an outcome document, including conclusions and recommendations. After the session is over, the session rapporteur should prepare a statement on the human rights situation with particular emphasis on recommendations and on proposals for remedying human rights problems identified in the review, including building state capacity, and obtaining outside assistance for doing so. That statement is reviewed, debated, and adopted at a subsequent session of the HRC.

This text is adapted from Human Rights Watch web page at

<http://hrw.org/backgrounder/un/un0506/3.htm>

More information available on the **UN Office of the High Commissioner for Human Rights'** website

<http://www.ohchr.org/english/bodies/chr/index.htm>

On 15 March, 2006, the General Assembly adopted resolution A/RES/60/251 to establish the Human Rights Council. On 27 March, 2006, the Commission on Human Rights concluded its 62nd and final session when the Human Rights Council took up special Procedures adopted within the Commission on Human Rights, and some rules were changed. One of the most important is that the General Assembly can, by a majority of two-third of votes, declare a country, which committed gross violations of human rights, ineligible for membership at the Human Rights Council.

Unlike the Commission that met once a year, the HRC meets for a minimum of three sessions for a total of no less than ten weeks per year, with the ability to convene additional sessions at the request of any member and supported by one third of the membership of the Council.

The responsibilities of the Council, as set out in the General Assembly Resolution, are to:

- Undertake a Universal Periodic Review (UPR), based on objective and reliable information, of the fulfilment by each State of its human rights obligations and commitments in a manner which ensures universality of coverage and equal treatment with respect to all States;
- Address situations of violations of human rights, including gross and systematic violations, and make recommendations;
- Contribute, through dialogue and cooperation, towards the prevention of human rights violations and respond promptly to human rights emergencies;
- Serve as a forum for dialogue on thematic issues on all human rights;
- Make recommendations with regard to the promotion and protection of human rights;
- Make recommendations to the General Assembly for the further development of international law

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in the field of human rights;

- Work in close cooperation in the field of human rights with governments, regional organisations, NHRIs, and civil society;
- Assume the role and responsibilities of the Commission relating to the work of the Office of the United Nations High Commissioner for Human Rights;
- Promote universal respect for the protection of all human rights and fundamental freedoms for all, without distinction of any kind and in a fair and equal manner;
- Promote the full implementation of human rights obligations undertaken by States and follow-up to the goals and commitments related to the promotion and protection of human rights emanating from United Nations conferences and summits;
- Promote human rights education and learning as well as advisory services, technical assistance, and capacity-building, to be provided in consultation with and with the consent of the States concerned;
- Promote the effective coordination and the mainstreaming of human rights within the UN system.

<http://www.ohchr.org/english/bodies/hrcouncil/>

Further information on the **Human Rights Council**

The former Commission on Human Rights was supported by the Office of the High Commissioner for Human Rights (OHCHR) in the initiatives taken in the field of HIV/AIDS - providing information and assisting the reports of the Secretary-General to the Commission on progress made by States to combat the epidemic. The Commission adopted two resolutions on a regular basis: a bi-annual one dealing with the protection of human rights in the context of HIV/AIDS, and an annual one on access to medication.

Resolution 2005/84 is the most recent one dealing with human rights and HIV/AIDS. The resolution emphasizes the importance of the protection and observance of human rights for all ***“as to reduce the vulnerability to HIV/AIDS, to prevent AIDS/HIV-related discrimination and stigma and to reduce the impact of HIV/AIDS”***

The full text of the Commission on Human Rights resolution 2005/84 is reproduced in **Core document 17**

http://ap.ohchr.org/documents/E/CHR/resolutions/E-CN_4-RES-2005-84.doc

The protection of human rights in the context of human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) Human Rights Resolution 2005/84

With respect to discrimination against people living with HIV/AIDS the Commission recalls by the resolution that:

HIV-related stigma and discrimination are major obstacles to an effective HIV/AIDS response and that discrimination on the basis of HIV or AIDS status, actual or presumed, is prohibited by existing international human rights law, and that the term “or other status” in non-discrimination provisions in international human rights texts should be interpreted to cover health status, including HIV/AIDS

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Furthermore the Commission urges States:

to ensure that their laws, policies and practices, including workplace policies and practices, respect human rights in the context of HIV/AIDS and promote effective programmes for the prevention and treatment of HIV/AIDS and the prohibition of HIV-related discrimination, including through voluntary testing and counselling, education, media and awareness-raising campaigns, improved and equitable access to high-quality goods and health care, particularly to safe and effective medication, assistance to educate people infected with and affected by HIV/AIDS about their rights and to assist them in realizing their rights

Concerning sexual and reproductive health and rights, the Commission, in paragraph 6, urges States to:

Integrate sexual and reproductive health programs and the promotion and protection of reproductive rights, [...], as strong and robust components of their national strategies on HIV/AIDS, and stresses that women have the right to have control over and to decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence.

Although the resolution does not explicitly mention LGBT people, it refers to vulnerable groups in soliciting:

Comments from governments, United Nations organs, programmes and specialized agencies and international and non-governmental organisations on the steps they have taken to promote and implement, where applicable, programmes to address the urgent HIV-related human rights of women, children and vulnerable groups in the context of prevention, care and access to treatment [...]

The resolution 2005/23 on access to medication in the context of pandemics such as HIV/AIDS, tuberculosis and malaria, calls States to adopt national policies which would promote:

The accessibility and affordability for all without discrimination, including the most vulnerable or socially disadvantaged groups of the population, as well as infants and children, of pharmaceutical products or medical technologies used to treat and/or prevent pandemics such as HIV/AIDS, tuberculosis, malaria or the most common opportunistic infections that accompany them

Furthermore the Commission adopted the resolution 2003/28 by which it calls, in paragraph 3, upon States:

To guarantee that the right of everyone to the enjoyment of the highest attainable standard of physical and mental health will be exercised without discrimination of any kind.

to pay special attention to the situation of vulnerable groups, including by the adoption of positive measures, in order to safeguard the full realization of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health

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and also in **paragraph 5**:

to protect and promote sexual and reproductive health as integral elements of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

[http://www.unhcr.ch/Huridocda/Huridoca.nsf/\(Symbol\)/E.CN.4.RES.2003.28](http://www.unhcr.ch/Huridocda/Huridoca.nsf/(Symbol)/E.CN.4.RES.2003.28).

En?Opendocument

The right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Commission on Human Rights **resolution 2003/28**

9 The World Health Organization

In 2004, the World Health Organization endorsed the definition of reproductive and sexual health included in the Program of Action of the International Conference on Population and Development. The WHO strategy on reproductive health adopted by the World Health Assembly in 2004 recognizes that:

The adoption of these [reproductive and sexual health] at the ICPD marked the beginning of a new era and the achievements of the past decade are many and profound.

<http://www.who.int/reproductive-health/strategy.htm>

Paragraph 07 of the **Reproductive Health Strategy**, 2004

This strategy has been developed following the resolution WHA55.19 on WHO's contribution to the achievement of development goals in the United Nations Millennium Declaration which asked the WHO General Director to develop a strategy to attain the international goals related to reproductive health.

<http://www.emro.who.int/cah/pdf/WHA55.pdf>

WHO's contribution to achievement of the development goals of the United Nations Millennium Declaration, 2002

The strategy produced comprises three parts. The first one shows discrepancies between global goals and global realities. With respect to sexually transmitted infections:

Together, these aspects of reproductive and sexual ill-health (maternal and prenatal mortality and morbidity, cancers, sexually transmitted infections and HIV-AIDS) account for nearly 20% of the global burden of ill-health for women and some 14% for men.

Paragraph 22 of the Reproductive Health Strategy states:

...WHO estimates unsafe sex to be the second important global risk factor to health.

The strategy recognizes and is based upon some core human rights set out in international human rights instruments such as:

the right of all persons to the highest attainable standard of health; the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so; the right of women to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence; the right of men and women to choose a spouse and to enter into marriage only with their free and full consent; the right of access to relevant health information; and the right of everyone to enjoy the benefits of scientific progress and its applications.

WHO proposes to Member States five key action areas:

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- 1 ***Strengthening health systems capacity***
- 2 ***improving information for priority setting***
- 3 ***mobilizing political will***
- 4 ***creating supportive legislative and regulatory frameworks***
- 5 ***strengthening monitoring, evaluation and accountability.***

Drawing on the OHCHR/ UNAIDS Guideline on HIV/AIDS (quoted above – in **Core Document 5**), WHO Action area 2 is important with respect to men who have sex with men because of the lack of epidemiological and social data related to this group in most countries. As the WHO strategy highlights ***“improved data collection and analysis are essential bases for selecting among competing priorities for action and for aiming health-system interventions”***.

Action areas 3 and 4 are also important in the wake of what is explained in this context: the *UNAIDS/ OHCHR Guidelines on HIV/AIDS and Human Rights* call upon States to review criminal law which prohibits sexual acts between men, and the Special Rapporteur on the right to health emphasizes that discrimination is a key factor in making MSM more vulnerable to HIV infection.

Most recent data on HIV/AIDS infection show that prevention programmes get better results when addressed to the most vulnerable people. It is the conclusion made by the World Health Organization in a press release on November 21 2006, taking into account the AIDS epidemic updates report published jointly with UNAIDS, which recognizes that:

In many countries HIV prevention programmes are not reaching the people most at risk of infection, such as young people, women and girls, men who have sex with men, sex workers and their clients, injecting drug users and ethnic and cultural minorities.

<http://www.who.int/hiv/mediacentre/news62/en/index.html>

“Global AIDS epidemic continues to grow”, November 2006

http://www.who.int/hiv/mediacentre/2006_EpiUpdate_en.pdf

AIDS epidemic update, December 2006

With respect to strategies set out by international organisations to address HIV/AIDS, the national role in implementing HIV/AIDS programs is very important, but WHO underlines a failure in this field since:

There is an increasing evidence of HIV outbreaks among sex who have sex with men but most national AIDS programmes fail to address the specific needs of these people. [...]

The people at highest risk, men who have sex with men, sex workers and injecting drug users, are not adequately reached through HIV prevention and treatment strategies because not enough is known about their particular situation and realities.

Homophobia is acknowledged as one of the drivers of the epidemic whose understanding is ***“absolutely fundamental to the long-term response to AIDS”***.

10 The Universal Declaration of Human Rights

Adopted and proclaimed by General Assembly resolution 217 A (III) of 10 December 1948

- **Preamble:** Whereas recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world,
- Whereas disregard and contempt for human rights have resulted in barbarous acts which have outraged the conscience of mankind, and the advent of a world in which human beings shall enjoy freedom of speech and belief and freedom from fear and want has been proclaimed as the highest aspiration of the common people,
- Whereas it is essential, if man is not to be compelled to have recourse, as a last resort, to rebellion against tyranny and oppression, that human rights should be protected by the rule of law,
- Whereas it is essential to promote the development of friendly relations between nations,
- Whereas the peoples of the United Nations have in the Charter reaffirmed their faith in fundamental human rights, in the dignity and worth of the human person and in the equal rights of men and women and have determined to promote social progress and better standards of life in larger freedom,
- Whereas Member States have pledged themselves to achieve, in cooperation with the United Nations, the promotion of universal respect for and observance of human rights and fundamental freedoms,
- Whereas a common understanding of these rights and freedoms is of the greatest importance for the full realization of this pledge,
- Now, therefore, The General Assembly proclaims this Universal Declaration of Human Rights as a common standard of achievement for all peoples and all nations, to the end that every individual and every organ of society, keeping this Declaration constantly in mind, shall strive by teaching and education to promote respect for these rights and freedoms and by progressive measures, national and international, to secure their universal and effective recognition and observance, both among the peoples of Member States themselves and among the peoples of territories under their jurisdiction.

Article 1. All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.

Article 2. Everyone is entitled to all the rights and freedoms set forth in this

- Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. Furthermore, no distinction shall be made on the basis of the political, jurisdictional or international status of the country or territory to which a person belongs, whether it be independent, trust, non-self-governing or under any other limitation of sovereignty.

Article 3. Everyone has the right to life, liberty and security of person.

Article 4. No one shall be held in slavery or servitude; slavery and the slave trade shall be prohibited in all their forms.

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Article 5. No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.

Article 6. Everyone has the right to recognition everywhere as a person before the law.

Article 7. All are equal before the law and are entitled without any discrimination to equal protection of the law. All are entitled to equal protection against any discrimination in violation of this Declaration and against any incitement to such discrimination.

Article 8. Everyone has the right to an effective remedy by the competent national tribunals for acts violating the fundamental rights granted him by the constitution or by law.

Article 9. No one shall be subjected to arbitrary arrest, detention or exile.

Article 10. Everyone is entitled in full equality to a fair and public hearing by an independent and impartial tribunal, in the determination of his rights and obligations and of any criminal charge against him.

Article 11. (1) Everyone charged with a penal offence has the right to be presumed innocent until proved guilty according to law in a public trial at which he has had all the guarantees necessary for his defence. (2) No one shall be held guilty of any penal offence on account of any act or omission which did not constitute a penal offence, under national or international law, at the time when it was committed. Nor shall a heavier penalty be imposed than the one that was applicable at the time the penal offence was committed.

Article 12. No one shall be subjected to arbitrary interference with his privacy, family, home or correspondence, nor to attacks upon his honour and reputation. Everyone has the right to the protection of the law against such interference or attacks.

Article 13. (1) Everyone has the right to freedom of movement and residence within the borders of each State. (2) Everyone has the right to leave any country, including his own, and to return to his country.

Article 14. (1) Everyone has the right to seek and to enjoy in other countries asylum from persecution. (2) This right may not be invoked in the case of prosecutions genuinely arising from non-political crimes or from acts contrary to the purposes and principles of the United Nations.

Article 15. (1) Everyone has the right to a nationality. (2) No one shall be arbitrarily deprived of his nationality nor denied the right to change his nationality.

Article 16. (1) Men and women of full age, without any limitation due to race, nationality or religion, have the right to marry and to found a family. They are entitled to equal rights as to marriage, during marriage and at its dissolution. (2) Marriage shall be entered into only with the free and full consent of the intending spouses. (3) The family is the natural and fundamental group unit of society and is entitled to protection by society and the State.

Article 17. (1) Everyone has the right to own property alone as well as in association with others. (2) No one shall be arbitrarily deprived of his property.

Article 18. Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief, and freedom, either alone or in community with others and in public or private, to manifest his religion or belief in teaching, practice, worship and observance.

Article 19. Everyone has the right to freedom of opinion and expression; this right includes freedom to hold opinions without interference and to seek, receive and impart information and ideas through any media and regardless of frontiers.

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Article 20. (1) Everyone has the right to freedom of peaceful assembly and association. (2) No one may be compelled to belong to an association.

Article 21. (1) Everyone has the right to take part in the government of his country, directly or through freely chosen representatives. (2) Everyone has the right of equal access to public service in his country. (3) The will of the people shall be the basis of the authority of government; this will shall be expressed in periodic and genuine elections which shall be by universal and equal suffrage and shall be held by secret vote or by equivalent free voting procedures.

Article 22. Everyone, as a member of society, has the right to social security and is entitled to realization, through national effort and international co-operation and in accordance with the organisation and resources of each State, of the economic, social and cultural rights indispensable for his dignity and the free development of his personality.

Article 23. (1) Everyone has the right to work, to free choice of employment, to just and favourable conditions of work and to protection against unemployment. (2) Everyone, without any discrimination, has the right to equal pay for equal work. (3) Everyone who works has the right to just and favourable remuneration ensuring for himself and his family an existence worthy of human dignity, and supplemented, if necessary, by other means of social protection. (4) Everyone has the right to form and to join trade unions for the protection of his interests.

Article 24. Everyone has the right to rest and leisure, including reasonable limitation of working hours and periodic holidays with pay.

Article 25. (1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control. (2) Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

Article 26. (1) Everyone has the right to education. Education shall be free, at least in the elementary and fundamental stages. Elementary education shall be compulsory. Technical and professional education shall be made generally available and higher education shall be equally accessible to all on the basis of merit. (2) Education shall be directed to the full development of the human personality and to the strengthening of respect for human rights and fundamental freedoms. It shall promote understanding, tolerance and friendship among all nations, racial or religious groups, and shall further the activities of the United Nations for the maintenance of peace. (3) Parents have a prior right to choose the kind of education that shall be given to their children.

Article 27. (1) Everyone has the right freely to participate in the cultural life of the community, to enjoy the arts and to share in scientific advancement and its benefits. (2) Everyone has the right to the protection of the moral and material interests resulting from any scientific, literary or artistic production of which he is the author.

Article 28. Everyone is entitled to a social and international order in which the rights and freedoms set forth in this Declaration can be fully realized.

Article 29. (1) Everyone has duties to the community in which alone the free and full development of his personality is possible. (2) In the exercise of his rights and freedoms, everyone shall be subject only to such limitations as are determined by law solely for the purpose of securing due recognition and respect for the rights and freedoms of others and of meeting the just requirements of

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morality, public order and the general welfare in a democratic society. (3) These rights and freedoms may in no case be exercised contrary to the purposes and principles of the United Nations.

Article 30. Nothing in this Declaration may be interpreted as implying for any State, group or person any right to engage in any activity or to perform any act aimed at the destruction of any of the rights and freedoms set forth herein.

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The International Covenant on Economic, Social and Cultural Rights

Adopted and opened for signature, ratification and accession by General Assembly resolution 2200A (XXI) of 16 December, 1966 - entry into force 3 January 1976, in accordance with article 27

Preamble

The States Parties to the present Covenant,

Considering that, in accordance with the principles proclaimed in the Charter of the United Nations, recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world,

Recognizing that these rights derive from the inherent dignity of the human person,

Recognizing that, in accordance with the Universal Declaration of Human Rights, the ideal of free human beings enjoying freedom from fear and want can only be achieved if conditions are created whereby everyone may enjoy his economic, social and cultural rights, as well as his civil and political rights,

Considering the obligation of States under the Charter of the United Nations to promote universal respect for, and observance of, human rights and freedoms,

Realizing that the individual, having duties to other individuals and to the community to which he belongs, is under a responsibility to strive for the promotion and observance of the rights recognized in the present Covenant,

Agree upon the following articles:

PART I

Article 1

1. All peoples have the right of self-determination. By virtue of that right they freely determine their political status and freely pursue their economic, social and cultural development.
2. All peoples may, for their own ends, freely dispose of their natural wealth and resources without prejudice to any obligations arising out of international economic co-operation, based upon the principle of mutual benefit, and international law. In no case may a people be deprived of its own means of subsistence.
3. The States Parties to the present Covenant, including those having responsibility for the administration of Non-Self-Governing and Trust Territories, shall promote the realization of the right of self-determination, and shall respect that right, in conformity with the provisions of the Charter of the United Nations.

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PART II**Article 2**

1. Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.
2. The States Parties to the present Covenant undertake to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.
3. Developing countries, with due regard to human rights and their national economy, may determine to what extent they would guarantee the economic rights recognized in the present Covenant to non-nationals.

Article 3

The States Parties to the present Covenant undertake to ensure the equal right of men and women to the enjoyment of all economic, social and cultural rights set forth in the present Covenant.

Article 4

The States Parties to the present Covenant recognize that, in the enjoyment of those rights provided by the State in conformity with the present Covenant, the State may subject such rights only to such limitations as are determined by law only in so far as this may be compatible with the nature of these rights and solely for the purpose of promoting the general welfare in a democratic society.

Article 5

1. Nothing in the present Covenant may be interpreted as implying for any State, group or person any right to engage in any activity or to perform any act aimed at the destruction of any of the rights or freedoms recognized herein, or at their limitation to a greater extent than is provided for in the present Covenant.
2. No restriction upon or derogation from any of the fundamental human rights recognized or existing in any country in virtue of law, conventions, regulations or custom shall be admitted on the pretext that the present Covenant does not recognize such rights or that it recognizes them to a lesser extent.

PART III**Article 6**

1. The States Parties to the present Covenant recognize the right to work, which includes the right of everyone to the opportunity to gain his living by work which he freely chooses or accepts, and will take appropriate steps to safeguard this right.
2. The steps to be taken by a State Party to the present Covenant to achieve the full realization of this right shall include technical and vocational guidance and training programmes, policies and techniques to achieve steady economic, social and cultural development and full and productive employment under conditions safeguarding fundamental political and economic freedoms to the individual.

Article 7

The States Parties to the present Covenant recognize the right of everyone to the enjoyment of just and favorable conditions of work which ensure, in particular:

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(a) Remuneration that provides all workers, as a minimum, with:

- (i) Fair wages and equal remuneration for work of equal value without distinction of any kind, in particular women being guaranteed conditions of work not inferior to those enjoyed by men, with equal pay for equal work;
 - (ii) A decent living for themselves and their families in accordance with the provisions of the present Covenant;
- (b) Safe and healthy working conditions;
- (c) Equal opportunity for everyone to be promoted in his employment to an appropriate higher level, subject to no considerations other than those of seniority and competence;
- (d) Rest, leisure and reasonable limitation of working hours and periodic holidays with pay, as well as remuneration for public holidays

Article 8

1. The States Parties to the present Covenant undertake to ensure:

- (a) The right of everyone to form trade unions and join the trade union of his choice, subject only to the rules of the organisation concerned, for the promotion and protection of his economic and social interests. No restrictions may be placed on the exercise of this right other than those prescribed by law and which are necessary in a democratic society in the interests of national security or public order or for the protection of the rights and freedoms of others;
- (b) The right of trade unions to establish national federations or confederations and the right of the latter to form or join international trade-union organisations;
- (c) The right of trade unions to function freely subject to no limitations other than those prescribed by law and which are necessary in a democratic society in the interests of national security or public order or for the protection of the rights and freedoms of others;
- (d) The right to strike, provided that it is exercised in conformity with the laws of the particular country.

2. This article shall not prevent the imposition of lawful restrictions on the exercise of these rights by members of the armed forces or of the police or of the administration of the State.

3. Nothing in this article shall authorize States Parties to the International Labour Organization Convention of 1948 concerning Freedom of Association and Protection of the Right to Organize to take legislative measures which would prejudice, or apply the law in such a manner as would prejudice, the guarantees provided for in that Convention.

Article 9

The States Parties to the present Covenant recognize the right of everyone to social security, including social insurance.

Article 10

The States Parties to the present Covenant recognize that:

- 1. The widest possible protection and assistance should be accorded to the family, which is the natural and fundamental group unit of society, particularly for its establishment and while it is responsible for the care and education of dependent children. Marriage must be entered into with the free consent of the intending spouses.
- 2. Special protection should be accorded to mothers during a reasonable period before and after childbirth. During such period working mothers should be accorded paid leave or leave with adequate social security benefits.
- 3. Special measures of protection and assistance should be taken on behalf of all children and young persons without any discrimination for reasons of parentage or other conditions. Children and young

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persons should be protected from economic and social exploitation. Their employment in work harmful to their morals or health or dangerous to life or likely to hamper their normal development should be punishable by law. States should also set age limits below which the paid employment of child labour should be prohibited and punishable by law.

Article 11

1. The States Parties to the present Covenant recognize the right of everyone to an adequate standard of living for himself and his family, including adequate food, clothing and housing, and to the continuous improvement of living conditions. The States Parties will take appropriate steps to ensure the realization of this right, recognizing to this effect the essential importance of international co-operation based on free consent.

2. The States Parties to the present Covenant, recognizing the fundamental right of everyone to be free from hunger, shall take, individually and through international co-operation, the measures, including specific programmes, which are needed:

(a) To improve methods of production, conservation and distribution of food by making full use of technical and scientific knowledge, by disseminating knowledge of the principles of nutrition and by developing or reforming agrarian systems in such a way as to achieve the most efficient development and utilization of natural resources;

(b) Taking into account the problems of both food-importing and food-exporting countries, to ensure an equitable distribution of world food supplies in relation to need.

Article 12

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

(a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;

(b) The improvement of all aspects of environmental and industrial hygiene;

(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;

(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

Article 13

1. The States Parties to the present Covenant recognize the right of everyone to education. They agree that education shall be directed to the full development of the human personality and the sense of its dignity, and shall strengthen the respect for human rights and fundamental freedoms. They further agree that education shall enable all persons to participate effectively in a free society, promote understanding, tolerance and friendship among all nations and all racial, ethnic or religious groups, and further the activities of the United Nations for the maintenance of peace.

2. The States Parties to the present Covenant recognize that, with a view to achieving the full realization of this right:

(a) Primary education shall be compulsory and available free to all;

(b) Secondary education in its different forms, including technical and vocational secondary education, shall be made generally available and accessible to all by every appropriate means, and in particular by the progressive introduction of free education;

(c) Higher education shall be made equally accessible to all, on the basis of capacity, by every

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appropriate means, and in particular by the progressive introduction of free education;

(d) Fundamental education shall be encouraged or intensified as far as possible for those persons who have not received or completed the whole period of their primary education;

(e) The development of a system of schools at all levels shall be actively pursued, an adequate fellowship system shall be established, and the material conditions of teaching staff shall be continuously improved.

3. The States Parties to the present Covenant undertake to have respect for the liberty of parents and, when applicable, legal guardians to choose for their children schools, other than those established by the public authorities, which conform to such minimum educational standards as may be laid down or approved by the State and to ensure the religious and moral education of their children in conformity with their own convictions.

4. No part of this article shall be construed so as to interfere with the liberty of individuals and bodies to establish and direct educational institutions, subject always to the observance of the principles set forth in paragraph 1 of this article and to the requirement that the education given in such institutions shall conform to such minimum standards as may be laid down by the State.

Article 14

Each State Party to the present Covenant which, at the time of becoming a Party, has not been able to secure in its metropolitan territory or other territories under its jurisdiction compulsory primary education, free of charge, undertakes, within two years, to work out and adopt a detailed plan of action for the progressive implementation, within a reasonable number of years, to be fixed in the plan, of the principle of compulsory education free of charge for all.

Article 15

1. The States Parties to the present Covenant recognize the right of everyone:

(a) To take part in cultural life;

(b) To enjoy the benefits of scientific progress and its applications;

(c) To benefit from the protection of the moral and material interests resulting from any scientific, literary or artistic production of which he is the author.

2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for the conservation, the development and the diffusion of science and culture.

3. The States Parties to the present Covenant undertake to respect the freedom indispensable for scientific research and creative activity.

4. The States Parties to the present Covenant recognize the benefits to be derived from the encouragement and development of international contacts and co-operation in the scientific and cultural fields.

PART IV

Article 16

1. The States Parties to the present Covenant undertake to submit in conformity with this part of the Covenant reports on the measures which they have adopted and the progress made in achieving the observance of the rights recognized herein.

2. (a) All reports shall be submitted to the Secretary-General of the United Nations, who shall transmit copies to the Economic and Social Council for consideration in accordance with the provisions of the present Covenant;

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(b) The Secretary-General of the United Nations shall also transmit to the specialized agencies copies of the reports, or any relevant parts thereof, from States Parties to the present Covenant which are also members of these specialized agencies in so far as these reports, or parts thereof, relate to any matters which fall within the responsibilities of the said agencies in accordance with their constitutional instruments.

Article 17

1. The States Parties to the present Covenant shall furnish their reports in stages, in accordance with a Program to be established by the Economic and Social Council within one year of the entry into force of the present Covenant after consultation with the States Parties and the specialized agencies concerned.
2. Reports may indicate factors and difficulties affecting the degree of fulfilment of obligations under the present Covenant.
3. Where relevant information has previously been furnished to the United Nations or to any specialized agency by any State Party to the present Covenant, it will not be necessary to reproduce that information, but a precise reference to the information so furnished will suffice.

Article 18

Pursuant to its responsibilities under the Charter of the United Nations in the field of human rights and fundamental freedoms, the Economic and Social Council may make arrangements with the specialized agencies in respect of their reporting to it on the progress made in achieving the observance of the provisions of the present Covenant falling within the scope of their activities. These reports may include particulars of decisions and recommendations on such implementation adopted by their competent organs.

Article 19

The Economic and Social Council may transmit to the Commission on Human Rights for study and general recommendation or, as appropriate, for information the reports concerning human rights submitted by States in accordance with articles 16 and 17, and those concerning human rights submitted by the specialized agencies in accordance with article 18.

Article 20

The States Parties to the present Covenant and the specialized agencies concerned may submit comments to the Economic and Social Council on any general recommendation under article 19 or reference to such general recommendation in any report of the Commission on Human Rights or any documentation referred to therein.

Article 21

The Economic and Social Council may submit from time to time to the General Assembly reports with recommendations of a general nature and a summary of the information received from the States Parties to the present Covenant and the specialized agencies on the measures taken and the progress made in achieving general observance of the rights recognized in the present Covenant.

Article 22

The Economic and Social Council may bring to the attention of other organs of the United Nations, their subsidiary organs and specialized agencies concerned with furnishing technical assistance any matters arising out of the reports referred to in this part of the present Covenant which may assist such bodies in deciding, each within its field of competence, on the advisability of international measures likely to contribute to the effective progressive implementation of the present Covenant.

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Article 23

The States Parties to the present Covenant agree that international action for the achievement of the rights recognized in the present Covenant includes such methods as the conclusion of conventions, the adoption of recommendations, the furnishing of technical assistance and the holding of regional meetings and technical meetings for the purpose of consultation and study organized in conjunction with the Governments concerned.

Article 24

Nothing in the present Covenant shall be interpreted as impairing the provisions of the Charter of the United Nations and of the constitutions of the specialized agencies which define the respective responsibilities of the various organs of the United Nations and of the specialized agencies in regard to the matters dealt with in the present Covenant.

Article 25

Nothing in the present Covenant shall be interpreted as impairing the inherent right of all peoples to enjoy and utilize fully and freely their natural wealth and resources.

PART V**Article 26**

1. The present Covenant is open for signature by any State Member of the United Nations or member of any of its specialized agencies, by any State Party to the Statute of the International Court of Justice, and by any other State which has been invited by the General Assembly of the United Nations to become a party to the present Covenant.
2. The present Covenant is subject to ratification. Instruments of ratification shall be deposited with the Secretary-General of the United Nations.
3. The present Covenant shall be open to accession by any State referred to in paragraph 1 of this article.
4. Accession shall be effected by the deposit of an instrument of accession with the Secretary-General of the United Nations.
5. The Secretary-General of the United Nations shall inform all States which have signed the present Covenant or acceded to it of the deposit of each instrument of ratification or accession.

Article 27

1. The present Covenant shall enter into force three months after the date of the deposit with the Secretary-General of the United Nations of the thirty-fifth instrument of ratification or instrument of accession.
2. For each State ratifying the present Covenant or acceding to it after the deposit of the thirty-fifth instrument of ratification or instrument of accession, the present Covenant shall enter into force three months after the date of the deposit of its own instrument of ratification or instrument of accession.

Article 28

The provisions of the present Covenant shall extend to all parts of federal States without any limitations or exceptions.

Article 29

1. Any State Party to the present Covenant may propose an amendment and file it with the Secretary-General of the United Nations. The Secretary-General shall thereupon communicate any proposed amendments to the States Parties to the present Covenant with a request that they notify him

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whether they favor a conference of States Parties for the purpose of considering and voting upon the proposals. In the event that at least one third of the States Parties favors such a conference, the Secretary-General shall convene the conference under the auspices of the United Nations. Any amendment adopted by a majority of the States Parties present and voting at the conference shall be submitted to the General Assembly of the United Nations for approval.

2. Amendments shall come into force when they have been approved by the General Assembly of the United Nations and accepted by a two-thirds majority of the States Parties to the present Covenant in accordance with their respective constitutional processes.

3. When amendments come into force they shall be binding on those States Parties which have accepted them, other States Parties still being bound by the provisions of the present Covenant and any earlier amendment which they have accepted.

Article 30

Irrespective of the notifications made under article 26, paragraph 5, the Secretary-General of the United Nations shall inform all States referred to in paragraph 1 of the same article of the following particulars:

(a) Signatures, ratifications and accessions under article 26;

(b) The date of the entry into force of the present Covenant under article 27 and the date of the entry into force of any amendments under article 29.

Article 31

1. The present Covenant, of which the Chinese, English, French, Russian and Spanish texts are equally authentic, shall be deposited in the archives of the United Nations.

2. The Secretary-General of the United Nations shall transmit certified copies of the present Covenant to all States referred to in article 26.

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General Comment No. 14 (2000). Committee of Economic, Social and Cultural Rights (CESCR) The right to the highest attainable standard of health. E/ C.12/2000/4.

1. Health is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity. The realization of the right to health may be pursued through numerous, complementary approaches, such as the formulation of health policies, or the implementation of health programmes developed by the World Health Organization (WHO), or the adoption of specific legal instruments. Moreover, the right to health includes certain components which are legally enforceable. (1)

2. The human right to health is recognized in numerous international instruments. Article 25.1 of the Universal Declaration of Human Rights affirms: “Everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care and necessary social services”. The International Covenant on Economic, Social and Cultural Rights provides the most comprehensive article on the right to health in international human rights law. In accordance with article 12.1 of the Covenant, States parties recognize “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”, while article 12.2 enumerates, by way of illustration, a number of “steps to be taken by the States parties ... to achieve the full realization of this right”. Additionally, the right to health is recognized, *inter alia*, in article 5 (e) (iv) of the International Convention on the Elimination of All Forms of Racial Discrimination of 1965, in articles 11.1 (f) and 12 of the Convention on the Elimination of All Forms of Discrimination against Women of 1979 and in article 24 of the Convention on the Rights of the Child of 1989. Several regional human rights instruments also recognize the right to health, such as the European Social Charter of 1961 as revised (art. 11), the African Charter on Human and Peoples’ Rights of 1981 (art. 16) and the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights of 1988 (art. 10). Similarly, the right to health has been proclaimed by the Commission on Human Rights, (2) as well as in the Vienna Declaration and Program of Action of 1993 and other international instruments. (3)

3. The right to health is closely related to and dependent upon the realization of other human rights, as contained in the International Bill of Rights, including the rights to food, housing, work, education, human dignity, life, non-discrimination, equality, the prohibition against torture, privacy, access to information, and the freedoms of association, assembly and movement. These and other rights and freedoms address integral components of the right to health.

4. In drafting article 12 of the Covenant, the Third Committee of the United Nations General Assembly did not adopt the definition of health contained in the preamble to the Constitution of WHO, which conceptualizes health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. However, the reference in article 12.1 of the Covenant to “the highest attainable standard of physical and mental health” is not confined to the right to health care.

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On the contrary, the drafting history and the express wording of article 12.2 acknowledge that the right to health embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment.

5. The Committee is aware that, for millions of people throughout the world, the full enjoyment of the right to health still remains a distant goal. Moreover, in many cases, especially for those living in poverty, this goal is becoming increasingly remote. The Committee recognizes the formidable structural and other obstacles resulting from international and other factors beyond the control of States that impede the full realization of article 12 in many States parties.

6. With a view to assisting States parties' implementation of the Covenant and the fulfilment of their reporting obligations, this General Comment focuses on the normative content of article 12 (Part I), States parties' obligations (Part II), violations (Part III) and implementation at the national level (Part IV), while the obligations of actors other than States parties are addressed in Part V. The General Comment is based on the Committee's experience in examining States parties' reports over many years.

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I. Normative content of article 12

7. Article 12.1 provides a definition of the right to health, while article 12.2 enumerates illustrative, non-exhaustive examples of States parties' obligations.

8. The right to health is not to be understood as a right to be healthy. The right to health contains both freedoms and entitlements. The freedoms include the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. By contrast, the entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health.

9. The notion of "the highest attainable standard of health" in article 12.1 takes into account both the individual's biological and socio-economic preconditions and a State's available resources. There are a number of aspects which cannot be addressed solely within the relationship between States and individuals; in particular, good health cannot be ensured by a State, nor can States provide protection against every possible cause of human ill health. Thus, genetic factors, individual susceptibility to ill health and the adoption of unhealthy or risky lifestyles may play an important role with respect to an individual's health. Consequently, the right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health.

10. Since the adoption of the two International Covenants in 1966 the world health situation has changed dramatically and the notion of health has undergone substantial changes and has also widened in scope. More determinants of health are being taken into consideration, such as resource distribution and gender differences. A wider definition of health also takes into account such socially-related concerns as violence and armed conflict. (4) Moreover, formerly unknown diseases, such as Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome (HIV/AIDS), and others that have become more widespread, such as cancer, as well as the rapid growth of the world population, have created new obstacles for the realization of the right to health which need to be taken into account when interpreting article 12.

11. The Committee interprets the right to health, as defined in article 12.1, as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health. A further important aspect is the participation of the population in all health-related decision-making at the community, national and international levels.

12. The right to health in all its forms and at all levels contains the following interrelated and essential elements, the precise application of which will depend on the conditions prevailing in a particular State party:

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(a) Availability. Functioning public health and health-care facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the State party. The precise nature of the facilities, goods and services will vary depending on numerous factors, including the State party's developmental level. They will include, however, the underlying determinants of health, such as safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs, as defined by the WHO Action Program on Essential Drugs. (5)

(b) Accessibility. Health facilities, goods and services (6) have to be accessible to everyone without discrimination, within the jurisdiction of the State party. Accessibility has four overlapping dimensions:

Non-discrimination: health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds. (7)

Physical accessibility: health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons with HIV/AIDS. Accessibility also implies that medical services and underlying determinants of health, such as safe and potable water and adequate sanitation facilities, are within safe physical reach, including in rural areas. Accessibility further includes adequate access to buildings for persons with disabilities.

Economic accessibility (affordability): health facilities, goods and services must be affordable for all. Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households.

Information accessibility: accessibility includes the right to seek, receive and impart information and ideas (8) concerning health issues. However, accessibility of information should not impair the right to have personal health data treated with confidentiality.

(c) Acceptability. All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.

(d) Quality. As well as being culturally acceptable, health facilities, goods and services must also be scientifically and medically appropriate and of good quality. This requires, inter alia, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation.

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13. The non-exhaustive catalogue of examples in article 12.2 provides guidance in defining the action to be taken by States. It gives specific generic examples of measures arising from the broad definition of the right to health contained in article 12.1, thereby illustrating the content of that right, as exemplified in the following paragraphs. (9)

Article 12.2 (a). The right to maternal, child and reproductive health

14. “The provision for the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child” (art. 12.2 (a)) (10) may be understood as requiring measures to improve child and maternal health, sexual and reproductive health services, including access to family planning, pre- and post-natal care, (11) emergency obstetric services and access to information, as well as to resources necessary to act on that information. (12)

Article 12.2 (b). The right to healthy natural and workplace environments

15. “The improvement of all aspects of environmental and industrial hygiene” (art. 12.2 (b)) comprises, inter alia, preventive measures in respect of occupational accidents and diseases; the requirement to ensure an adequate supply of safe and potable water and basic sanitation; the prevention and reduction of the population’s exposure to harmful substances such as radiation and harmful chemicals or other detrimental environmental conditions that directly or indirectly impact upon human health. (13) Furthermore, industrial hygiene refers to the minimization, so far as is reasonably practicable, of the causes of health hazards inherent in the working environment. (14) Article 12.2 (b) also embraces adequate housing and safe and hygienic working conditions, an adequate supply of food and proper nutrition, and discourages the abuse of alcohol, and the use of tobacco, drugs and other harmful substances.

Article 12.2 (c). The right to prevention, treatment and control of diseases

16. “The prevention, treatment and control of epidemic, endemic, occupational and other diseases” (art. 12.2 (c)) requires the establishment of prevention and education programmes for behavior-related health concerns such as sexually transmitted diseases, in particular HIV/AIDS, and those adversely affecting sexual and reproductive health, and the promotion of social determinants of good health, such as environmental safety, education, economic development and gender equity. The right to treatment includes the creation of a system of urgent medical care in cases of accidents, epidemics and similar health hazards, and the provision of disaster relief and humanitarian assistance in emergency situations. The control of diseases refers to States’ individual and joint efforts to, *inter alia*, make available relevant technologies, using and improving epidemiological surveillance and data collection on a disaggregated basis, the implementation or enhancement of immunization programmes and other strategies of infectious disease control.

Article 12.2 (d). The right to health facilities, goods and services (15)

17. “The creation of conditions which would assure to all medical service and medical attention in the event of sickness” (art. 12.2 (d)), both physical and mental, includes the provision of equal and timely access to basic preventive, curative, rehabilitative health services and health education; regular

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screening programmes; appropriate treatment of prevalent diseases, illnesses, injuries and disabilities, preferably at community level; the provision of essential drugs; and appropriate mental health treatment and care. A further important aspect is the improvement and furtherance of participation of the population in the provision of preventive and curative health services, such as the organisation of the health sector, the insurance system and, in particular, participation in political decisions relating to the right to health taken at both the community and national levels.

Article 12. Special topics of broad application ***Non-discrimination and equal treatment***

18. By virtue of article 2.2 and article 3, the Covenant proscribes any discrimination in access to health care and underlying determinants of health, as well as to means and entitlements for their procurement, on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation and civil, political, social or other status, which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health. The Committee stresses that many measures, such as most strategies and programmes designed to eliminate health-related discrimination, can be pursued with minimum resource implications through the adoption, modification or abrogation of legislation or the dissemination of information. The Committee recalls General Comment No. 3, paragraph 12, which states that even in times of severe resource constraints, the vulnerable members of society must be protected by the adoption of relatively low-cost targeted programmes.

19. With respect to the right to health, equality of access to health care and health services has to be emphasized. States have a special obligation to provide those who do not have sufficient means with the necessary health insurance and health-care facilities, and to prevent any discrimination on internationally prohibited grounds in the provision of health care and health services, especially with respect to the core obligations of the right to health. (16) Inappropriate health resource allocation can lead to discrimination that may not be overt. For example, investments should not disproportionately favor expensive curative health services which are often accessible only to a small, privileged fraction of the population, rather than primary and preventive health care benefiting a far larger part of the population.

Gender perspective

20. The Committee recommends that States integrate a gender perspective in their health-related policies, planning, programmes and research in order to promote better health for both women and men. A gender-based approach recognizes that biological and socio-cultural factors play a significant role in influencing the health of men and women. The desegregation of health and socio-economic data according to sex is essential for identifying and remedying inequalities in health.

Women and the right to health

21. To eliminate discrimination against women, there is a need to develop and implement a comprehensive national strategy for promoting women's right to health throughout their life span. Such a strategy should include interventions aimed at the prevention and treatment of diseases affecting women, as well as policies to provide access to a full range of high quality and affordable

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health care, including sexual and reproductive services. A major goal should be reducing women's health risks, particularly lowering rates of maternal mortality and protecting women from domestic violence. The realization of women's right to health requires the removal of all barriers interfering with access to health services, education and information, including in the area of sexual and reproductive health. It is also important to undertake preventive, promotive and remedial action to shield women from the impact of harmful traditional cultural practices and norms that deny them their full reproductive rights.

Children and adolescents

22. Article 12.2 (a) outlines the need to take measures to reduce infant mortality and promote the healthy development of infants and children. Subsequent international human rights instruments recognize that children and adolescents have the right to the enjoyment of the highest standard of health and access to facilities for the treatment of illness. (17)

The Convention on the Rights of the Child directs States to ensure access to essential health services for the child and his or her family, including pre- and post-natal care for mothers. The Convention links these goals with ensuring access to child-friendly information about preventive and health-promoting behaviour and support to families and communities in implementing these practices. Implementation of the principle of non-discrimination requires that girls, as well as boys, have equal access to adequate nutrition, safe environments, and physical as well as mental health services. There is a need to adopt effective and appropriate measures to abolish harmful traditional practices affecting the health of children, particularly girls, including early marriage, female genital mutilation, preferential feeding and care of male children. (18) Children with disabilities should be given the opportunity to enjoy a fulfilling and decent life and to participate within their community.

23. States parties should provide a safe and supportive environment for adolescents, that ensures the opportunity to participate in decisions affecting their health, to build life-skills, to acquire appropriate information, to receive counselling and to negotiate the health-behaviour choices they make. The realization of the right to health of adolescents is dependent on the development of youth-friendly health care, which respects confidentiality and privacy and includes appropriate sexual and reproductive health services.

24. In all policies and programmes aimed at guaranteeing the right to health of children and adolescents their best interests shall be a primary consideration.

Older persons

25. With regard to the realization of the right to health of older persons, the Committee, in accordance with paragraphs 34 and 35 of General Comment No. 6 (1995), reaffirms the importance of an integrated approach, combining elements of preventive, curative and rehabilitative health treatment. Such measures should be based on periodical check-ups for both sexes; physical as well as psychological rehabilitative measures aimed at maintaining the functionality and autonomy of older persons; and attention and care for chronically and terminally ill persons, sparing them avoidable pain and enabling them to die with dignity.

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Persons with disabilities

26. The Committee reaffirms paragraph 34 of its General Comment No. 5, which addresses the issue of persons with disabilities in the context of the right to physical and mental health. Moreover, the Committee stresses the need to ensure that not only the public health sector but also private providers of health services and facilities comply with the principle of non-discrimination in relation to persons with disabilities.

Indigenous peoples

27. In the light of emerging international law and practice and the recent measures taken by States in relation to indigenous peoples, (19) the Committee deems it useful to identify elements that would help to define indigenous peoples' right to health in order better to enable States with indigenous peoples to implement the provisions contained in article 12 of the Covenant. The Committee considers that indigenous peoples have the right to specific measures to improve their access to health services and care. These health services should be culturally appropriate, taking into account traditional preventive care, healing practices and medicines. States should provide resources for indigenous peoples to design, deliver and control such services so that they may enjoy the highest attainable standard of physical and mental health. The vital medicinal plants, animals and minerals necessary to the full enjoyment of health of indigenous peoples should also be protected. The Committee notes that, in indigenous communities, the health of the individual is often linked to the health of the society as a whole and has a collective dimension. In this respect, the Committee considers that development-related activities that lead to the displacement of indigenous peoples against their will from their traditional territories and environment, denying them their sources of nutrition and breaking their symbiotic relationship with their lands, has a deleterious effect on their health.

Limitations

28. Issues of public health are sometimes used by States as grounds for limiting the exercise of other fundamental rights. The Committee wishes to emphasize that the Covenant's limitation clause, article 4, is primarily intended to protect the rights of individuals rather than to permit the imposition of limitations by States. Consequently a State party which, for example, restricts the movement of, or incarcerates, persons with transmissible diseases such as HIV/AIDS, refuses to allow doctors to treat persons believed to be opposed to a government, or fails to provide immunization against the community's major infectious diseases, on grounds such as national security or the preservation of public order, has the burden of justifying such serious measures in relation to each of the elements identified in article 4. Such restrictions must be in accordance with the law, including international human rights standards, compatible with the nature of the rights protected by the Covenant, in the interest of legitimate aims pursued, and strictly necessary for the promotion of the general welfare in a democratic society.

29. In line with article 5.1, such limitations must be proportional, i.e. the least restrictive alternative must be adopted where several types of limitations are available. Even where such limitations on grounds of protecting public health are basically permitted, they should be of limited duration and subject to review.

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II. States parties' obligations

General legal obligations

30. While the Covenant provides for progressive realization and acknowledges the constraints due to the limits of available resources, it also imposes on States parties various obligations which are of immediate effect. States parties have immediate obligations in relation to the right to health, such as the guarantee that the right will be exercised without discrimination of any kind (art. 2.2) and the obligation to take steps (art. 2.1) towards the full realization of article 12. Such steps must be deliberate, concrete and targeted towards the full realization of the right to health. (20)

31. The progressive realization of the right to health over a period of time should not be interpreted as depriving States parties' obligations of all meaningful content. Rather, progressive realization means that States parties have a specific and continuing obligation to move as expeditiously and effectively as possible towards the full realization of article 12. (21)

32. As with all other rights in the Covenant, there is a strong presumption that retrogressive measures taken in relation to the right to health are not permissible. If any deliberately retrogressive measures are taken, the State party has the burden of proving that they have been introduced after the most careful consideration of all alternatives and that they are duly justified by reference to the totality of the rights provided for in the Covenant in the context of the full use of the State party's maximum available resources. (22)

33. The right to health, like all human rights, imposes three types or levels of obligations on States parties: the obligations to *respect*, *protect* and *fulfil*. In turn, the obligation to fulfil contains obligations to facilitate, provide and promote. (23) The obligation to respect requires States to refrain from interfering directly or indirectly with the enjoyment of the right to health. The obligation to protect requires States to take measures that prevent third parties from interfering with article 12 guarantees. Finally, the obligation to *fulfil* requires States to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health.

Specific legal obligations

34. In particular, States are under the obligation to *respect* the right to health by, *inter alia*, refraining from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum seekers and illegal immigrants, to preventive, curative and palliative health services; abstaining from enforcing discriminatory practices as a State policy; and abstaining from imposing discriminatory practices relating to women's health status and needs. Furthermore, obligations to respect include a State's obligation to refrain from prohibiting or impeding traditional preventive care, healing practices and medicines, from marketing unsafe drugs and from applying coercive medical treatments, unless on an exceptional basis for the treatment of mental illness or the prevention and control of communicable diseases. Such exceptional cases should be subject to specific and restrictive conditions, respecting best practices and applicable international standards, including the Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care. (24) In addition, States should refrain from limiting access to contraceptives and other means of maintaining sexual and reproductive health, from censoring, withholding or intentionally

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misrepresenting health-related information, including sexual education and information, as well as from preventing people's participation in health-related matters. States should also refrain from unlawfully polluting air, water and soil, e.g. through industrial waste from State-owned facilities, from using or testing nuclear, biological or chemical weapons if such testing results in the release of substances harmful to human health, and from limiting access to health services as a punitive measure, e.g. during armed conflicts in violation of international humanitarian law.

35. Obligations to *protect* include, inter alia, the duties of States to adopt legislation or to take other measures ensuring equal access to health care and health-related services provided by third parties; to ensure that privatization of the health sector does not constitute a threat to the availability, accessibility, acceptability and quality of health facilities, goods and services; to control the marketing of medical equipment and medicines by third parties; and to ensure that medical practitioners and other health professionals meet appropriate standards of education, skill and ethical codes of conduct. States are also obliged to ensure that harmful social or traditional practices do not interfere with access to pre- and post-natal care and family-planning; to prevent third parties from coercing women to undergo traditional practices, e.g. female genital mutilation; and to take measures to protect all vulnerable or marginalized groups of society, in particular women, children, adolescents and older persons, in the light of gender-based expressions of violence. States should also ensure that third parties do not limit people's access to health-related information and services.

36. The obligation to *fulfil* requires States parties, *inter alia*, to give sufficient recognition to the right to health in the national political and legal systems, preferably by way of legislative implementation, and to adopt a national health policy with a detailed plan for realizing the right to health. States must ensure provision of health care, including immunization programmes against the major infectious diseases, and ensure equal access for all to the underlying determinants of health, such as nutritiously safe food and potable drinking water, basic sanitation and adequate housing and living conditions. Public health infrastructures should provide for sexual and reproductive health services, including safe motherhood, particularly in rural areas. States have to ensure the appropriate training of doctors and other medical personnel, the provision of a sufficient number of hospitals, clinics and other health-related facilities, and the promotion and support of the establishment of institutions providing counselling and mental health services, with due regard to equitable distribution throughout the country. Further obligations include the provision of a public, private or mixed health insurance system which is affordable for all, the promotion of medical research and health education, as well as information campaigns, in particular with respect to HIV/AIDS, sexual and reproductive health, traditional practices, domestic violence, the abuse of alcohol and the use of cigarettes, drugs and other harmful substances. States are also required to adopt measures against environmental and occupational health hazards and against any other threat as demonstrated by epidemiological data. For this purpose they should formulate and implement national policies aimed at reducing and eliminating pollution of air, water and soil, including pollution by heavy metals such as lead from gasoline. Furthermore, States parties are required to formulate, implement and periodically review a coherent national policy to minimize the risk of occupational accidents and diseases, as well as to provide a coherent national policy on occupational safety and health services. (25)

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37. The obligation to *fulfil (facilitate)* requires States *inter alia* to take positive measures that enable and assist individuals and communities to enjoy the right to health. States parties are also obliged to *fulfil (provide)* a specific right contained in the Covenant when individuals or a group are unable, for reasons beyond their control, to realize that right themselves by the means at their disposal. The obligation to *fulfil (promote)* the right to health requires States to undertake actions that create, maintain and restore the health of the population. Such obligations include: (i) fostering recognition of factors favouring positive health results, e.g. research and provision of information; (ii) ensuring that health services are culturally appropriate and that health care staff are trained to recognize and respond to the specific needs of vulnerable or marginalized groups; (iii) ensuring that the State meets its obligations in the dissemination of appropriate information relating to healthy lifestyles and nutrition, harmful traditional practices and the availability of services; (iv) supporting people in making informed choices about their health.

International obligations

38. In its General Comment No. 3, the Committee drew attention to the obligation of all States parties to take steps, individually and through international assistance and cooperation, especially economic and technical, towards the full realization of the rights recognized in the Covenant, such as the right to health. In the spirit of article 56 of the Charter of the United Nations, the specific provisions of the Covenant (articles 12, 2.1, 22 and 23) and the Alma-Ata Declaration on primary health care, States parties should recognize the essential role of international cooperation and comply with their commitment to take joint and separate action to achieve the full realization of the right to health. In this regard, States parties are referred to the Alma-Ata Declaration which proclaims that the existing gross inequality in the health status of the people, particularly between developed and developing countries, as well as within countries, is politically, socially and economically unacceptable and is, therefore, of common concern to all countries. (26)

39. To comply with their international obligations in relation to article 12, States parties have to respect the enjoyment of the right to health in other countries, and to prevent third parties from violating the right in other countries, if they are able to influence these third parties by way of legal or political means, in accordance with the Charter of the United Nations and applicable international law. Depending on the availability of resources, States should facilitate access to essential health facilities, goods and services in other countries, wherever possible and provide the necessary aid when required. (27) States parties should ensure that the right to health is given due attention in international agreements and, to that end, should consider the development of further legal instruments. In relation to the conclusion of other international agreements, States parties should take steps to ensure that these instruments do not adversely impact upon the right to health. Similarly, States parties have an obligation to ensure that their actions as members of international organisations take due account of the right to health. Accordingly, States parties which are members of international financial institutions, notably the International Monetary Fund, the World Bank, and regional development banks, should pay greater attention to the protection of the right to health in influencing the lending policies, credit agreements and international measures of these institutions.

40. States parties have a joint and individual responsibility, in accordance with the Charter of the United Nations and relevant resolutions of the United Nations General Assembly and of the World

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Health Assembly, to cooperate in providing disaster relief and humanitarian assistance in times of emergency, including assistance to refugees and internally displaced persons. Each State should contribute to this task to the maximum of its capacities. Priority in the provision of international medical aid, distribution and management of resources, such as safe and potable water, food and medical supplies, and financial aid should be given to the most vulnerable or marginalized groups of the population. Moreover, given that some diseases are easily transmissible beyond the frontiers of a State, the international community has a collective responsibility to address this problem. The economically developed States parties have a special responsibility and interest to assist the poorer developing States in this regard.

41. States parties should refrain at all times from imposing embargoes or similar measures restricting the supply of another State with adequate medicines and medical equipment. Restrictions on such goods should never be used as an instrument of political and economic pressure. In this regard, the Committee recalls its position, stated in General Comment No. 8, on the relationship between economic sanctions and respect for economic, social and cultural rights.

42. While only States are parties to the Covenant and thus ultimately accountable for compliance with it, all members of society - individuals, including health professionals, families, local communities, intergovernmental and non-governmental organisations, civil society organisations, as well as the private business sector - have responsibilities regarding the realization of the right to health. State parties should therefore provide an environment which facilitates the discharge of these responsibilities.

Core obligations

43. In General Comment No. 3, the Committee confirms that States parties have a core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights enunciated in the Covenant, including essential primary health care. Read in conjunction with more contemporary instruments, such as the Program of Action of the International Conference on Population and Development, (28) the Alma-Ata Declaration provides compelling guidance on the core obligations arising from article 12. Accordingly, in the Committee's view, these core obligations include at least the following obligations:

- (a)** To ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups;
- (b)** To ensure access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone;
- (c)** To ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water;
- (d)** To provide essential drugs, as from time to time defined under the WHO Action Program on Essential Drugs;
- (e)** To ensure equitable distribution of all health facilities, goods and services;
- (f)** To adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population; the strategy and plan of action shall be devised, and periodically reviewed, on the basis of a participatory and transparent process; they shall include methods, such as right to health indicators and benchmarks, by which

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progress can be closely monitored; the process by which the strategy and plan of action are devised, as well as their content, shall give particular attention to all vulnerable or marginalized groups.

44. The Committee also confirms that the following are obligations of comparable priority:

- (a)** To ensure reproductive, maternal (pre-natal as well as post-natal) and child health care;
- (b)** To provide immunization against the major infectious diseases occurring in the community;
- (c)** To take measures to prevent, treat and control epidemic and endemic diseases;
- (d)** To provide education and access to information concerning the main health problems in the community, including methods of preventing and controlling them;
- (e)** To provide appropriate training for health personnel, including education on health and human rights.

45. For the avoidance of any doubt, the Committee wishes to emphasize that it is particularly incumbent on States parties and other actors in a position to assist, to provide “international assistance and cooperation, especially economic and technical” (29) which enable developing countries to fulfil their core and other obligations indicated in paragraphs 43 and 44 above.

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III. Violations

46. When the normative content of article 12 (Part I) is applied to the obligations of States parties (Part II), a dynamic process is set in motion which facilitates identification of violations of the right to health. The following paragraphs provide illustrations of violations of article 12.

47. In determining which actions or omissions amount to a violation of the right to health, it is important to distinguish the inability from the unwillingness of a State party to comply with its obligations under article 12. This follows from article 12.1, which speaks of the highest attainable standard of health, as well as from article 2.1 of the Covenant, which obliges each State party to take the necessary steps to the maximum of its available resources. A State which is unwilling to use the maximum of its available resources for the realization of the right to health is in violation of its obligations under article 12. If resource constraints render it impossible for a State to comply fully with its Covenant obligations, it has the burden of justifying that every effort has nevertheless been made to use all available resources at its disposal in order to satisfy, as a matter of priority, the obligations outlined above. It should be stressed, however, that a State party cannot, under any circumstances whatsoever, justify its non-compliance with the core obligations set out in paragraph 43 above, which are non-derogable.

48. Violations of the right to health can occur through the direct action of States or other entities insufficiently regulated by States. The adoption of any retrogressive measures incompatible with the core obligations under the right to health, outlined in paragraph 43 above, constitutes a violation of the right to health. Violations through *acts of commission* include the formal repeal or suspension of legislation necessary for the continued enjoyment of the right to health or the adoption of legislation or policies which are manifestly incompatible with pre-existing domestic or international legal obligations in relation to the right to health.

49. Violations of the right to health can also occur through the omission or failure of States to take necessary measures arising from legal obligations. Violations through *acts of omission* include the failure to take appropriate steps towards the full realization of everyone's right to the enjoyment of the highest attainable standard of physical and mental health, the failure to have a national policy on occupational safety and health as well as occupational health services, and the failure to enforce relevant laws.

Violations of the obligation to respect

50. Violations of the obligation to respect are those State actions, policies or laws that contravene the standards set out in article 12 of the Covenant and are likely to result in bodily harm, unnecessary morbidity and preventable mortality. Examples include the denial of access to health facilities, goods and services to particular individuals or groups as a result of *de jure* or *de facto* discrimination; the deliberate withholding or misrepresentation of information vital to health protection or treatment; the suspension of legislation or the adoption of laws or policies that interfere with the enjoyment of any of the components of the right to health; and the failure of the State to take into account its legal obligations regarding the right to health when entering into bilateral or multilateral agreements with other States, international organisations and other entities, such as multinational corporations.

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Violations of the obligation to protect

51. Violations of the obligation to protect follow from the failure of a State to take all necessary measures to safeguard persons within their jurisdiction from infringements of the right to health by third parties. This category includes such omissions as the failure to regulate the activities of individuals, groups or corporations so as to prevent them from violating the right to health of others; the failure to protect consumers and workers from practices detrimental to health, e.g. by employers and manufacturers of medicines or food; the failure to discourage production, marketing and consumption of tobacco, narcotics and other harmful substances; the failure to protect women against violence or to prosecute perpetrators; the failure to discourage the continued observance of harmful traditional medical or cultural practices; and the failure to enact or enforce laws to prevent the pollution of water, air and soil by extractive and manufacturing industries.

Violations of the obligation to fulfil

52. Violations of the obligation to fulfil occur through the failure of States parties to take all necessary steps to ensure the realization of the right to health. Examples include the failure to adopt or implement a national health policy designed to ensure the right to health for everyone; insufficient expenditure or misallocation of public resources which results in the non-enjoyment of the right to health by individuals or groups, particularly the vulnerable or marginalized; the failure to monitor the realization of the right to health at the national level, for example by identifying right to health indicators and benchmarks; the failure to take measures to reduce the inequitable distribution of health facilities, goods and services; the failure to adopt a gender-sensitive approach to health; and the failure to reduce infant and maternal mortality rates.

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IV. Implementation at the National level

Framework legislation

53. The most appropriate feasible measures to implement the right to health will vary significantly from one State to another. Every State has a margin of discretion in assessing which measures are most suitable to meet its specific circumstances. The Covenant, however, clearly imposes a duty on each State to take whatever steps are necessary to ensure that everyone has access to health facilities, goods and services so that they can enjoy, as soon as possible, the highest attainable standard of physical and mental health. This requires the adoption of a national strategy to ensure to all the enjoyment of the right to health, based on human rights principles which define the objectives of that strategy, and the formulation of policies and corresponding right to health indicators and benchmarks. The national health strategy should also identify the resources available to attain defined objectives, as well as the most cost-effective way of using those resources.

54. The formulation and implementation of national health strategies and plans of action should respect, inter alia, the principles of non-discrimination and people's participation. In particular, the right of individuals and groups to participate in decision-making processes, which may affect their development, must be an integral component of any policy, Program or strategy developed to discharge governmental obligations under article 12. Promoting health must involve effective community action in setting priorities, making decisions, planning, implementing and evaluating strategies to achieve better health. Effective provision of health services can only be assured if people's participation is secured by States.

55. The national health strategy and plan of action should also be based on the principles of accountability, transparency and independence of the judiciary, since good governance is essential to the effective implementation of all human rights, including the realization of the right to health. In order to create a favourable climate for the realization of the right, States parties should take appropriate steps to ensure that the private business sector and civil society are aware of, and consider the importance of, the right to health in pursuing their activities.

56. States should consider adopting a framework law to operationalize their right to health national strategy. The framework law should establish national mechanisms for monitoring the implementation of national health strategies and plans of action. It should include provisions on the targets to be achieved and the time-frame for their achievement; the means by which right to health benchmarks could be achieved; the intended collaboration with civil society, including health experts, the private sector and international organisations; institutional responsibility for the implementation of the right to health national strategy and plan of action; and possible recourse procedures. In monitoring progress towards the realization of the right to health, States parties should identify the factors and difficulties affecting implementation of their obligations.

Right to health indicators and benchmarks

57. National health strategies should identify appropriate right to health indicators and benchmarks. The indicators should be designed to monitor, at the national and international levels, the State party's

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obligations under article 12. States may obtain guidance on appropriate right to health indicators, which should address different aspects of the right to health, from the ongoing work of WHO and the United Nations Children's Fund (UNICEF) in this field. Right to health indicators require disaggregation on the prohibited grounds of discrimination.

58. Having identified appropriate right to health indicators, States parties are invited to set appropriate national benchmarks in relation to each indicator. During the periodic reporting procedure the Committee will engage in a process of scoping with the State party. Scoping involves the joint consideration by the State party and the Committee of the indicators and national benchmarks which will then provide the targets to be achieved during the next reporting period. In the following five years, the State party will use these national benchmarks to help monitor its implementation of article 12. Thereafter, in the subsequent reporting process, the State party and the Committee will consider whether or not the benchmarks have been achieved, and the reasons for any difficulties that may have been encountered.

Remedies and accountability

59. Any person or group victim of a violation of the right to health should have access to effective judicial or other appropriate remedies at both national and international levels. (30) All victims of such violations should be entitled to adequate reparation, which may take the form of restitution, compensation, satisfaction or guarantees of non-repetition. National ombudsmen, human rights commissions, consumer forums, patients' rights associations or similar institutions should address violations of the right to health.

60. The incorporation in the domestic legal order of international instruments recognizing the right to health can significantly enhance the scope and effectiveness of remedial measures and should be encouraged in all cases. (31) Incorporation enables courts to adjudicate violations of the right to health, or at least its core obligations, by direct reference to the Covenant.

61. Judges and members of the legal profession should be encouraged by States parties to pay greater attention to violations of the right to health in the exercise of their functions.

62. States parties should respect, protect, facilitate and promote the work of human rights advocates and other members of civil society with a view to assisting vulnerable or marginalized groups in the realization of their right to health.

12 V. Obligations of actors other than States parties

63. The role of the United Nations agencies and programmes, and in particular the key function assigned to WHO in realizing the right to health at the international, regional and country levels, is of particular importance, as is the function of UNICEF in relation to the right to health of children. When formulating and implementing their right to health national strategies, States parties should avail themselves of technical assistance and cooperation of WHO. Further, when preparing their reports, States parties should utilize the extensive information and advisory services of WHO with regard to data collection, disaggregation, and the development of right to health indicators and benchmarks.

64. Moreover, coordinated efforts for the realization of the right to health should be maintained to enhance the interaction among all the actors concerned, including the various components of civil society. In conformity with articles 22 and 23 of the Covenant, WHO, The International Labour Organization, the United Nations Development Programme, UNICEF, the United Nations Population Fund, the World Bank, regional development banks, the International Monetary Fund, the World Trade Organization and other relevant bodies within the United Nations system, should cooperate effectively with States parties, building on their respective expertise, in relation to the implementation of the right to health at the national level, with due respect to their individual mandates. In particular, the international financial institutions, notably the World Bank and the International Monetary Fund, should pay greater attention to the protection of the right to health in their lending policies, credit agreements and structural adjustment programmes. When examining the reports of States parties and their ability to meet the obligations under article 12, the Committee will consider the effects of the assistance provided by all other actors. The adoption of a human rights-based approach by United Nations specialized agencies, programmes and bodies will greatly facilitate implementation of the right to health. In the course of its examination of States parties' reports, the Committee will also consider the role of health professional associations and other non-governmental organisations in relation to the States' obligations under article 12.

65. The role of WHO, the Office of the United Nations High Commissioner for Refugees, the International Committee of the Red Cross/Red Crescent and UNICEF, as well as non governmental organisations and national medical associations, is of particular importance in relation to disaster relief and humanitarian assistance in times of emergencies, including assistance to refugees and internally displaced persons. Priority in the provision of international medical aid, distribution and management of resources, such as safe and potable water, food and medical supplies, and financial aid should be given to the most vulnerable or marginalized groups of the population.

Adopted on 11 May 2000.

Notes

1. For example, the principle of non-discrimination in relation to health facilities, goods and services is legally enforceable in numerous national jurisdictions.

2. In its resolution 1989/11.

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3. The Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care adopted by the United Nations General Assembly in 1991 (resolution 46/119) and the Committee's General Comment No. 5 on persons with disabilities apply to persons with mental illness; the Program of Action of the International Conference on Population and Development held at Cairo in 1994, as well as the Declaration and Program for Action of the Fourth World Conference on Women held in Beijing in 1995 contain definitions of reproductive health and women's health, respectively.

4. Common article 3 of the Geneva Conventions for the protection of war victims (1949); Additional Protocol I (1977) relating to the Protection of Victims of International Armed Conflicts, art. 75 (2) (a); Additional Protocol II (1977) relating to the Protection of Victims of Non-International Armed Conflicts, art. 4 (a).

5. See WHO Model List of Essential Drugs, revised December 1999, WHO Drug Information, vol. 13, No. 4, 1999.

6. Unless expressly provided otherwise, any reference in this General Comment to health facilities, goods and services includes the underlying determinants of health outlined in paragraphs 11 and 12 (a) of this General Comment.

7. See paragraphs 18 and 19 of this General Comment.

8. See article 19.2 of the International Covenant on Civil and Political Rights. This General Comment gives particular emphasis to access to information because of the special importance of this issue in relation to health.

9. In the literature and practice concerning the right to health, three levels of health care are frequently referred to: *primary health* care typically deals with common and relatively minor illnesses and is provided by health professionals and/or generally trained doctors working within the community at relatively low cost; *secondary health* care is provided in centres, usually hospitals, and typically deals with relatively common minor or serious illnesses that cannot be managed at community level, using specialty-trained health professionals and doctors, special equipment and sometimes in-patient care at comparatively higher cost; *tertiary health* care is provided in relatively few centres, typically deals with small numbers of minor or serious illnesses requiring specialty-trained health professionals and doctors and special equipment, and is often relatively expensive. Since forms of primary, secondary and tertiary health care frequently overlap and often interact, the use of this typology does not always provide sufficient distinguishing criteria to be helpful for assessing which levels of health care States parties must provide, and is therefore of limited assistance in relation to the normative understanding of article 12.

10. According to WHO, the stillbirth rate is no longer commonly used, infant and under-five mortality rates being measured instead.

11. *Prenatal* denotes existing or occurring before birth; *perinatal* refers to the period shortly before and after birth (in medical statistics the period begins with the completion of 28 weeks of gestation

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and is variously defined as ending one to four weeks after birth); *neonatal*, by contrast, covers the period pertaining to the first four weeks after birth; while *post-natal* denotes occurrence after birth. In this General Comment, the more generic terms pre- and post-natal are exclusively employed.

12. Reproductive health means that women and men have the freedom to decide if and when to reproduce and the right to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice as well as the right of access to appropriate health-care services that will, for example, enable women to go safely through pregnancy and childbirth.

13. The Committee takes note, in this regard, of Principle 1 of the Stockholm Declaration of 1972 which states: “Man has the fundamental right to freedom, equality and adequate conditions of life, in an environment of a quality that permits a life of dignity and well-being”, as well as of recent developments in international law, including General Assembly resolution 45/94 on the need to ensure a healthy environment for the well-being of individuals; Principle 1 of the Rio Declaration; and regional human rights instruments such as article 10 of the San Salvador Protocol to the American

Convention on Human Rights

14. ILO Convention No. 155, art. 4.2.

15. See paragraph 12 (b) and note 8 above.

16. For the core obligations, see paragraphs. 43 and 44 of the present General Comments.

17. Article 24.1 of the Convention on the Rights of the Child.

18. See World Health Assembly resolution WHA47.10, 1994, entitled “Maternal and child health and family planning: traditional practices harmful to the health of women and children”.

19. Recent emerging international norms relevant to indigenous peoples include the ILO Convention No. 169 concerning Indigenous and Tribal Peoples in Independent Countries (1989); articles 29 (c) and (d) and 30 of the Convention on the Rights of the Child (1989); article 8 (j) of the Convention on Biological Diversity (1992), recommending that States respect, preserve and maintain knowledge, innovation and practices of indigenous communities; Agenda 21 of the United Nations Conference on Environment and Development (1992), in particular chapter 26; and Part I, paragraph 20, of the Vienna Declaration and Program of Action (1993), stating that States should take concerted positive steps to ensure respect for all human rights of indigenous people, on the basis of non-discrimination. See also the preamble and article 3 of the United Nations Framework Convention on Climate Change (1992); and article 10 (2) (e) of the United Nations Convention to Combat Desertification in Countries Experiencing Serious Drought and/or Desertification, Particularly in Africa (1994). During recent years an increasing number of States have changed their constitutions and introduced legislation recognizing specific rights of indigenous peoples.

20. See General Comment No. 13, paragraph 43.

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21. See General Comment No. 3, para. 9; General Comment No. 13, paragraph 44.

22. See General Comment No. 3, para. 9; General Comment No. 13, paragraph 45.

23. According to General Comments Nos. 12 and 13, the obligation to fulfil incorporates an obligation to *facilitate* and an obligation to provide. In the present General Comment, the obligation to fulfil also incorporates an obligation to promote because of the critical importance of health promotion in the work of WHO and elsewhere.

24. General Assembly resolution 46/119 (1991).

25. Elements of such a policy are the identification, determination, authorization and control of dangerous materials, equipment, substances, agents and work processes; the provision of health information to workers and the provision, if needed, of adequate protective clothing and equipment; the enforcement of laws and regulations through adequate inspection; the requirement of notification of occupational accidents and diseases, the conduct of inquiries into serious accidents and diseases, and the production of annual statistics; the protection of workers and their representatives from disciplinary measures for actions properly taken by them in conformity with such a policy; and the provision of occupational health services with essentially preventive functions. See ILO Occupational Safety and Health Convention, 1981 (No. 155) and Occupational Health Services Convention, 1985 (No. 161).

26. Article II, Alma-Ata Declaration, Report of the International Conference on Primary Health Care, Alma-Ata, 6-12 September 1978, in: WHO, "Health for All" Series, No. 1, WHO, Geneva, 1978.

27. See paragraph 45 of this General Comment.

28. Report of the International Conference on Population and Development, Cairo, 5-13 September 1994 (United Nations publication, Sales No. E.95.XIII.18), chap. I, resolution 1, annex, chaps. VII and VIII.

29. Covenant, art. 2.1.

30. Regardless of whether groups as such can seek remedies as distinct holders of rights, States parties are bound by both the collective and individual dimensions of article 12. Collective rights are critical in the field of health; modern public health policy relies heavily on prevention and promotion which are approaches directed primarily to groups.

31. See General Comment No. 2, paragraph 9.

13 Chapter VII of the International Conference on Population and Development's Programme of Action: Reproductive Rights and Reproductive Health

A. Reproductive rights and reproductive health

Basis for action

7.2. Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases.

7.3. Bearing in mind the above definition, reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. In the exercise of this right, they should take into account the needs of their living and future children and their responsibilities towards the community. The promotion of the responsible exercise of these rights for all people should be the fundamental basis for government- and community-supported policies and programmes in the area of reproductive health, including family planning. As part of their commitment, full attention should be given to the promotion of mutually respectful and equitable

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gender relations and particularly to meeting the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality. Reproductive health eludes many of the world's people because of such factors as: inadequate levels of knowledge about human sexuality and inappropriate or poor-quality reproductive health information and services; the prevalence of high-risk sexual behaviour; discriminatory social practices; negative attitudes towards women and girls; and the limited power many women and girls have over their sexual and reproductive lives. Adolescents are particularly vulnerable because of their lack of information and access to relevant services in most countries. Older women and men have distinct reproductive and sexual health issues which are often inadequately addressed.

7.4. The implementation of the present Program of Action is to be guided by the above comprehensive definition of reproductive health, which includes sexual health.

Objectives

7.5. The objectives are:

- (a) To ensure that comprehensive and factual information and a full range of reproductive health-care services, including family planning, are accessible, affordable, acceptable and convenient to all users;
- (b) To enable and support responsible voluntary decisions about child-bearing and methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law and to have the information, education and means to do so;
- (c) To meet changing reproductive health needs over the life cycle and to do so in ways sensitive to the diversity of circumstances of local communities.

Actions

7.6. All countries should strive to make accessible through the primary health-care system, reproductive health to all individuals of appropriate ages as soon as possible and no later than the year 2015. Reproductive health care in the context of primary health care should, inter alia, include: family-planning counselling, information, education, communication and services; education and services for prenatal care, safe delivery and post-natal care, especially breast-feeding and infant and women's health care; prevention and appropriate treatment of infertility; abortion as specified in paragraph 8.25, including prevention of abortion and the management of the consequences of abortion; treatment of reproductive tract infections; sexually transmitted diseases and other reproductive health conditions; and information, education and counselling, as appropriate, on human sexuality, reproductive health and responsible parenthood. Referral for family-planning services and further diagnosis and treatment for complications of pregnancy, delivery and abortion, infertility, reproductive tract infections, breast cancer and cancers of the reproductive system, sexually transmitted diseases, including HIV/AIDS should always be available, as required. Active discouragement of harmful practices, such as female genital mutilation, should also be an integral component of primary health care, including reproductive health-care programmes.

7.7. Reproductive health-care programmes should be designed to serve the needs of women, including adolescents, and must involve women in the leadership, planning, decision-making, management, implementation, organisation and evaluation of services. Governments and other organisations should take positive steps to include women at all levels of the health-care system.

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7.8. Innovative programmes must be developed to make information, counselling and services for reproductive health accessible to adolescents and adult men. Such programmes must both educate and enable men to share more equally in family planning and in domestic and child-rearing responsibilities and to accept the major responsibility for the prevention of sexually transmitted diseases. Programmes must reach men in their workplaces, at home and where they gather for recreation. Boys and adolescents, with the support and guidance of their parents, and in line with the Convention on the Rights of the Child, should also be reached through schools, youth organisations and wherever they congregate. Voluntary and appropriate male methods for contraception, as well as for the prevention of sexually transmitted diseases, including AIDS, should be promoted and made accessible with adequate information and counselling.

7.9. Governments should promote much greater community participation in reproductive health-care services by decentralizing the management of public health programmes and by forming partnerships in cooperation with local non-governmental organisations and private health-care providers. All types of non-governmental organisations, including local women's groups, trade unions, cooperatives, youth programmes and religious groups, should be encouraged to become involved in the promotion of better reproductive health.

7.10. Without jeopardizing international support for programmes in developing countries, the international community should, upon request, give consideration to the training, technical assistance, short-term contraceptive supply needs and the needs of the countries in transition from centrally managed to market economies, where reproductive health is poor and in some cases deteriorating. Those countries, at the same time, must themselves give higher priority to reproductive health services, including a comprehensive range of contraceptive means, and must address their current reliance on abortion for fertility regulation by meeting the need of women in those countries for better information and more choices on an urgent basis.

7.11. Migrants and displaced persons in many parts of the world have limited access to reproductive health care and may face specific serious threats to their reproductive health and rights. Services must be particularly sensitive to the needs of individual women and adolescents and responsive to their often powerless situation, with particular attention to those who are victims of sexual violence.

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B. Family planning

Basis for action

7.12. The aim of family-planning programmes must be to enable couples and individuals to decide freely and responsibly the number and spacing of their children and to have the information and means to do so and to ensure informed choices and make available a full range of safe and effective methods. The success of population education and family-planning programmes in a variety of settings demonstrates that informed individuals everywhere can and will act responsibly in the light of their own needs and those of their families and communities. The principle of informed free choice is essential to the long-term success of family-planning programmes. Any form of coercion has no part to play. In every society there are many social and economic incentives and disincentives that affect individual decisions about child-bearing and family size. Over the past century, many Governments have experimented with such schemes, including specific incentives and disincentives, in order to lower or raise fertility. Most such schemes have had only marginal impact on fertility and in some cases have been counterproductive. Governmental goals for family planning should be defined in terms of unmet needs for information and services. Demographic goals, while legitimately the subject of government development strategies, should not be imposed on family-planning providers in the form of targets or quotas for the recruitment of clients.

7.13. Over the past three decades, the increasing availability of safer methods of modern contraception, although still in some respects inadequate, has permitted greater opportunities for individual choice and responsible decision-making in matters of reproduction throughout much of the world. Currently, about 55 per cent of couples in developing regions use some method of family planning. This figure represents nearly a fivefold increase since the 1960s. Family-planning programmes have contributed considerably to the decline in average fertility rates for developing countries, from about six to seven children per woman in the 1960s to about three to four children at present. However, the full range of modern family-planning methods still remains unavailable to at least 350 million couples world wide, many of whom say they want to space or prevent another pregnancy. Survey data suggest that approximately 120 million additional women world wide would be currently using a modern family-planning method if more accurate information and affordable services were easily available, and if partners, extended families and the community were more supportive. These numbers do not include the substantial and growing numbers of sexually active unmarried individuals wanting and in need of information and services. During the decade of the 1990s, the number of couples of reproductive age will grow by about 18 million per annum. To meet their needs and close the existing large gaps in services, family planning and contraceptive supplies will need to expand very rapidly over the next several years. The quality of family-planning programmes is often directly related to the level and continuity of contraceptive use and to the growth in demand for services. Family-planning programmes work best when they are part of or linked to broader reproductive health programmes that address closely related health needs and when women are fully involved in the design, provision, management and evaluation of services.

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Objectives

7.14. The objectives are:

- (a) To help couples and individuals meet their reproductive goals in a framework that promotes optimum health, responsibility and family well-being, and respects the dignity of all persons and their right to choose the number, spacing and timing of the birth of their children;
- (b) To prevent unwanted pregnancies and reduce the incidence of high-risk pregnancies and morbidity and mortality;
- (c) To make quality family-planning services affordable, acceptable and accessible to all who need and want them, while maintaining confidentiality;
- (d) To improve the quality of family-planning advice, information, education, communication, counselling and services;
- (e) To increase the participation and sharing of responsibility of men in the actual practice of family planning;
- (f) To promote breast-feeding to enhance birth spacing.

Actions

7.15. Governments and the international community should use the full means at their disposal to support the principle of voluntary choice in family planning.

7.16. All countries should, over the next several years, assess the extent of national unmet need for good-quality family-planning services and its integration in the reproductive health context, paying particular attention to the most vulnerable and underserved groups in the population. All countries should take steps to meet the family-planning needs of their populations as soon as possible and should, in all cases by the year 2015, seek to provide universal access to a full range of safe and reliable family-planning methods and to related reproductive health services which are not against the law. The aim should be to assist couples and individuals to achieve their reproductive goals and give them the full opportunity to exercise the right to have children by choice.

7.17. Governments at all levels are urged to institute systems of monitoring and evaluation of user-centred services with a view to detecting, preventing and controlling abuses by family-planning managers and providers and to ensure a continuing improvement in the quality of services. To this end, Governments should secure conformity to human rights and to ethical and professional standards in the delivery of family planning and related reproductive health services aimed at ensuring responsible, voluntary and informed consent and also regarding service provision. In-vitro fertilization techniques should be provided in accordance with appropriate ethical guidelines and medical standards.

7.18. Non-governmental organisations should play an active role in mobilizing community and family support, in increasing access and acceptability of reproductive health services including family planning, and cooperate with Governments in the process of preparation and provision of care, based on informed choice, and in helping to monitor public- and private-sector programmes, including their own.

7.19. As part of the effort to meet unmet needs, all countries should seek to identify and remove all the major remaining barriers to the utilization of family-planning services. Some of those barriers

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are related to the inadequacy, poor quality and cost of existing family-planning services. It should be the goal of public, private and non-governmental family-planning organisations to remove all programme-related barriers to family-planning use by the year 2005 through the redesign or expansion of information and services and other ways to increase the ability of couples and individuals to make free and informed decisions about the number, spacing and timing of births and protect themselves from sexually transmitted diseases.

7.20. Specifically, Governments should make it easier for couples and individuals to take responsibility for their own reproductive health by removing unnecessary legal, medical, clinical and regulatory barriers to information and to access to family-planning services and methods.

7.21. All political and community leaders are urged to play a strong, sustained and highly visible role in promoting and legitimizing the provision and use of family-planning and reproductive health services. Governments at all levels are urged to provide a climate that is favourable to good-quality public and private family-planning and reproductive health information and services through all possible channels. Finally, leaders and legislators at all levels must translate their public support for reproductive health, including family planning, into adequate allocations of budgetary, human and administrative resources to help meet the needs of all those who cannot pay the full cost of services.

7.22. Governments are encouraged to focus most of their efforts towards meeting their population and development objectives through education and voluntary measures rather than schemes involving incentives and disincentives.

7.23. In the coming years, all family-planning programmes must make significant efforts to improve quality of care. Among other measures, programmes should:

- (a) Recognize that appropriate methods for couples and individuals vary according to their age, parity, family-size preference and other factors, and ensure that women and men have information and access to the widest possible range of safe and effective family-planning methods in order to enable them to exercise free and informed choice;
- (b) Provide accessible, complete and accurate information about various family-planning methods, including their health risks and benefits, possible side effects and their effectiveness in the prevention of the spread of HIV/AIDS and other sexually transmitted diseases;
- (c) Make services safer, affordable, more convenient and accessible for clients and ensure, through strengthened logistical systems, a sufficient and continuous supply of essential high-quality contraceptives. Privacy and confidentiality should be ensured;
- (d) Expand and upgrade formal and informal training in sexual and reproductive health care and family planning for all health-care providers, health educators and managers, including training in interpersonal communications and counselling;
- (e) Ensure appropriate follow-up care, including treatment for side effects of contraceptive use;
- (f) Ensure availability of related reproductive health services on site or through a strong referral mechanism;
- (g) In addition to quantitative measures of performance, give more emphasis to qualitative ones that take into account the perspectives of current and potential users of services through such means as effective management information systems and survey techniques for the timely evaluation of services;

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(h) Family-planning and reproductive health programmes should emphasize breast-feeding education and support services, which can simultaneously contribute to birth spacing, better maternal and child health and higher child survival.

7.24. Governments should take appropriate steps to help women avoid abortion, which in no case should be promoted as a method of family planning, and in all cases provide for the humane treatment and counselling of women who have had recourse to abortion.

7.25. In order to meet the substantial increase in demand for contraceptives over the next decade and beyond, the international community should move, on an immediate basis, to establish an efficient coordination system and global, regional and subregional facilities for the procurement of contraceptives and other commodities essential to reproductive health programmes of developing countries and countries with economies in transition. The international community should also consider such measures as the transfer of technology to developing countries to enable them to produce and distribute high-quality contraceptives and other commodities essential to reproductive health services, in order to strengthen the self-reliance of those countries. At the request of the countries concerned, the World Health Organization should continue to provide advice on the quality, safety and efficacy of family-planning methods.

7.26. Provision of reproductive health-care services should not be confined to the public sector but should involve the private sector and non-governmental organisations, in accordance with the needs and resources of their communities, and include, where appropriate, effective strategies for cost recovery and service delivery, including social marketing and community-based services. Special efforts should be made to improve accessibility through outreach services.

13 C. Sexually transmitted diseases and prevention of human immunodeficiency virus (HIV)

Basis for action

7.27. The world-wide incidence of sexually transmitted diseases is high and increasing. The situation has worsened considerably with the emergence of the HIV epidemic. Although the incidence of some sexually transmitted diseases has stabilized in parts of the world, there have been increasing cases in many regions.

7.28. The social and economic disadvantages that women face make them especially vulnerable to sexually transmitted infections, including HIV, as illustrated, for example, by their exposure to the high-risk sexual behaviour of their partners. For women, the symptoms of infections from sexually transmitted diseases are often hidden, making them more difficult to diagnose than in men, and the health consequences are often greater, including increased risk of infertility and ectopic pregnancy. The risk of transmission from infected men to women is also greater than from infected women to men, and many women are powerless to take steps to protect themselves.

Objective

7.29. The objective is to prevent, reduce the incidence of, and provide treatment for, sexually transmitted diseases, including HIV/AIDS, and the complications of sexually transmitted diseases such as infertility, with special attention to girls and women.

Actions

7.30. Reproductive health programmes should increase their efforts to prevent, detect and treat sexually transmitted diseases and other reproductive tract infections, especially at the primary health-care level. Special outreach efforts should be made to those who do not have access to reproductive health-care programmes.

7.31. All health-care providers, including all family-planning providers, should be given specialized training in the prevention and detection of, and counselling on, sexually transmitted diseases, especially infections in women and youth, including HIV/AIDS.

7.32. Information, education and counselling for responsible sexual behaviour and effective prevention of sexually transmitted diseases, including HIV, should become integral components of all reproductive and sexual health services.

7.33. Promotion and the reliable supply and distribution of high-quality condoms should become integral components of all reproductive health-care services. All relevant international organisations, especially the World Health Organization, should significantly increase their procurement. Governments and the international community should provide all means to reduce the spread and the rate of transmission of HIV/AIDS infection.

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D. Human sexuality and gender relations

Basis for action

7.34. Human sexuality and gender relations are closely interrelated and together affect the ability of men and women to achieve and maintain sexual health and manage their reproductive lives. Equal relationships between men and women in matters of sexual relations and reproduction, including full respect for the physical integrity of the human body, require mutual respect and willingness to accept responsibility for the consequences of sexual behaviour. Responsible sexual behaviour, sensitivity and equity in gender relations, particularly when instilled during the formative years, enhance and promote respectful and harmonious partnerships between men and women.

7.35. Violence against women, particularly domestic violence and rape, is widespread, and rising numbers of women are at risk from AIDS and other sexually transmitted diseases as a result of high-risk sexual behaviour on the part of their partners. In a number of countries, harmful practices meant to control women's sexuality have led to great suffering. Among them is the practice of female genital mutilation, which is a violation of basic rights and a major lifelong risk to women's health.

Objectives

7.36. The objectives are:

- (a) To promote adequate development of responsible sexuality, permitting relations of equity and mutual respect between the genders and contributing to improving the quality of life of individuals;
- (b) To ensure that women and men have access to the information, education and services needed to achieve good sexual health and exercise their reproductive rights and responsibilities.

Actions

7.37. Support should be given to integral sexual education and services for young people, with the support and guidance of their parents and in line with the Convention on the Rights of the Child, that stress responsibility of males for their own sexual health and fertility and that help them exercise those responsibilities. Educational efforts should begin within the family unit, in the community and in the schools at an appropriate age, but must also reach adults, in particular men, through non-formal education and a variety of community-based efforts.

7.38. In the light of the urgent need to prevent unwanted pregnancies, the rapid spread of AIDS and other sexually transmitted diseases, and the prevalence of sexual abuse and violence, Governments should base national policies on a better understanding of the need for responsible human sexuality and the realities of current sexual behaviour.

7.39. Active and open discussion of the need to protect women, youth and children from any abuse, including sexual abuse, exploitation, trafficking and violence, must be encouraged and supported by educational programmes at both national and community levels. Governments should set the necessary conditions and procedures to encourage victims to report violations of their rights. Laws addressing those concerns should be enacted where they do not exist, made explicit, strengthened and enforced, and appropriate rehabilitation services provided. Governments should also prohibit the production and the trade of child pornography.

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7.40. Governments and communities should urgently take steps to stop the practice of female genital mutilation and protect women and girls from all such similar unnecessary and dangerous practices. Steps to eliminate the practice should include strong community outreach programmes involving village and religious leaders, education and counselling about its impact on girls' and women's health, and appropriate treatment and rehabilitation for girls and women who have suffered mutilation. Services should include counselling for women and men to discourage the practice.

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E. Adolescents

Basis for action

7.41. The reproductive health needs of adolescents as a group have been largely ignored to date by existing reproductive health services. The response of societies to the reproductive health needs of adolescents should be based on information that helps them attain a level of maturity required to make responsible decisions. In particular, information and services should be made available to adolescents to help them understand their sexuality and protect them from unwanted pregnancies, sexually transmitted diseases and subsequent risk of infertility. This should be combined with the education of young men to respect women's self-determination and to share responsibility with women in matters of sexuality and reproduction. This effort is uniquely important for the health of young women and their children, for women's self-determination and, in many countries, for efforts to slow the momentum of population growth. Motherhood at a very young age entails a risk of maternal death that is much greater than average, and the children of young mothers have higher levels of morbidity and mortality. Early child-bearing continues to be an impediment to improvements in the educational, economic and social status of women in all parts of the world. Overall for young women, early marriage and early motherhood can severely curtail educational and employment opportunities and are likely to have a long-term, adverse impact on their and their children's quality of life.

7.42. Poor educational and economic opportunities and sexual exploitation are important factors in the high levels of adolescent child-bearing. In both developed and developing countries, adolescents faced with few apparent life choices have little incentive to avoid pregnancy and child-bearing.

7.43. In many societies, adolescents face pressures to engage in sexual activity. Young women, particularly low-income adolescents, are especially vulnerable. Sexually active adolescents of both sexes are increasingly at high risk of contracting and transmitting sexually transmitted diseases, including HIV/AIDS, and they are typically poorly informed about how to protect themselves. Programmes for adolescents have proven most effective when they secure the full involvement of adolescents in identifying their reproductive and sexual health needs and in designing programmes that respond to those needs.

Objectives

7.44. The objectives are:

- (a) To address adolescent sexual and reproductive health issues, including unwanted pregnancy, unsafe abortion and sexually transmitted diseases, including HIV/AIDS, through the promotion of responsible and healthy reproductive and sexual behaviour, including voluntary abstinence, and the provision of appropriate services and counselling specifically suitable for that age group;
- (b) To substantially reduce all adolescent pregnancies.

Actions

7.45. Recognizing the rights, duties and responsibilities of parents and other persons legally responsible for adolescents to provide, in a manner consistent with the evolving capacities of the adolescent, appropriate direction and guidance in sexual and reproductive matters, countries must

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ensure that the programmes and attitudes of health-care providers do not restrict the access of adolescents to appropriate services and the information they need, including on sexually transmitted diseases and sexual abuse. In doing so, and in order to, inter alia, address sexual abuse, these services must safeguard the rights of adolescents to privacy, confidentiality, respect and informed consent, respecting cultural values and religious beliefs. In this context, countries should, where appropriate, remove legal, regulatory and social barriers to reproductive health information and care for adolescents.

7.46. Countries, with the support of the international community, should protect and promote the rights of adolescents to reproductive health education, information and care and greatly reduce the number of adolescent pregnancies.

7.47. Governments, in collaboration with non-governmental organisations, are urged to meet the special needs of adolescents and to establish appropriate programmes to respond to those needs. Such programmes should include support mechanisms for the education and counselling of adolescents in the areas of gender relations and equality, violence against adolescents, responsible sexual behaviour, responsible family-planning practice, family life, reproductive health, sexually transmitted diseases, HIV infection and AIDS prevention. Programmes for the prevention and treatment of sexual abuse and incest and other reproductive health services should be provided. Such programmes should provide information to adolescents and make a conscious effort to strengthen positive social and cultural values. Sexually active adolescents will require special family-planning information, counselling and services, and those who become pregnant will require special support from their families and community during pregnancy and early child care. Adolescents must be fully involved in the planning, implementation and evaluation of such information and services with proper regard for parental guidance and responsibilities.

7.48. Programmes should involve and train all who are in a position to provide guidance to adolescents concerning responsible sexual and reproductive behaviour, particularly parents and families, and also communities, religious institutions, schools, the mass media and peer groups. Governments and non-governmental organisations should promote programmes directed to the education of parents, with the objective of improving the interaction of parents and children to enable parents to comply better with their educational duties to support the process of maturation of their children, particularly in the areas of sexual behaviour and reproductive health.

14 THE UNGASS Declaration of Commitments on HIV/AIDS, 2001

- 1.** We, Heads of State and Government and Representatives of States and Governments, assembled at the United Nations, from 25 to 27 June 2001, for the twenty-sixth special session of the General Assembly convened in accordance with resolution 55/13, as a matter of urgency, to review and address the problem of HIV/AIDS in all its aspects as well as to secure a global commitment to enhancing coordination and intensification of national, regional and international efforts to combat it in a comprehensive manner;
- 2.** Deeply concerned that the global HIV/AIDS epidemic, through its devastating scale and impact, constitutes a global emergency and one of the most formidable challenges to human life and dignity, as well as to the effective enjoyment of human rights, which undermines social and economic development throughout the world and affects all levels of society — national, community, family and individual;
- 3.** Noting with profound concern, that by the end of the year 2000, 36.1 million people worldwide were living with HIV/AIDS, 90 per cent in developing countries and 75 per cent in sub-Saharan Africa;
- 4.** Noting with grave concern that all people, rich and poor, without distinction of age, gender or race are affected by the HIV/AIDS epidemic, further noting that people in developing countries are the most affected and that women, young adults and children, in particular girls, are the most vulnerable;
- 5.** Concerned also that the continuing spread of HIV/AIDS will constitute a serious obstacle to the realization of the global development goals we adopted at the Millennium Summit;
- 6.** Recalling and reaffirming our previous commitments on HIV/AIDS made through:

 - The United Nations Millennium Declaration of 8 September 2000;
 - The Political Declaration and Further Actions and Initiatives to Implement the Commitments made at the World Summit for Social Development of 1 July 2000;
 - The Political Declaration and Further Action and Initiatives to Implement the Beijing Declaration and Platform for Action of 10 June 2000;
 - Key Actions for the Further Implementation of the Program of Action of the International Conference on Population and Development of 2 July 1999;
 - The regional call for action to fight HIV/AIDS in Asia and the Pacific of 25 April 2001;
 - The Abuja Declaration and Framework for Action for the Fight Against HIV/ AIDS, Tuberculosis and other Related Infectious Diseases in Africa, 27 April 2001;
 - The Declaration of the Ibero-America Summit of Heads of State of November 2000 in Panama;
 - The Caribbean Partnership Against HIV/AIDS, 14 February, 2001;
 - The European Union Program for Action: Accelerated Action on HIV/ AIDS, Malaria and Tuberculosis in the Context of Poverty Reduction of 14 May 2001;
 - The Baltic Sea Declaration on HIV/AIDS Prevention of 4 May 2000;
 - The Central Asian Declaration on HIV/AIDS of 18 May 2001;

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- 7.** Convinced of the need to have an urgent, coordinated and sustained response to the HIV/AIDS epidemic, which will build on the experience and lessons learned over the past 20 years;
- 8.** Noting with grave concern that Africa, in particular sub-Saharan Africa, is currently the worst affected region where HIV/AIDS is considered as a state of emergency, which threatens development, social cohesion, political stability, food security and life expectancy and imposes a devastating economic burden and that the dramatic situation on the continent needs urgent and exceptional national, regional and international action;
- 9.** Welcoming the commitments of African Heads of State or Government, at the Abuja Special Summit in April 2001, particularly their pledge to set a target of allocating at least 15 per cent of their annual national budgets for the improvement of the health sector to help address the HIV/AIDS epidemic; and recognizing that action to reach this target, by those countries whose resources are limited, will need to be complemented by increased international assistance;
- 10.** Recognizing also that other regions are seriously affected and confront similar threats, particularly the Caribbean region, with the second highest rate of HIV infection after sub-Saharan Africa, the Asia-Pacific region where 7.5 million people are already living with HIV/AIDS, the Latin America region with 1.5 million people living with HIV/AIDS, and the Central and Eastern European region with very rapidly rising infection rates; and that the potential exists for a rapid escalation of the epidemic and its impact throughout the world if no specific measures are taken;
- 11.** Recognizing that poverty, underdevelopment and illiteracy are among the principal contributing factors to the spread of HIV/AIDS and noting with grave concern that HIV/AIDS is compounding poverty and is now reversing or impeding development in many countries and should therefore be addressed in an integrated manner;
- 12.** Noting that armed conflicts and natural disasters also exacerbate the spread of the epidemic;
- 13.** Noting further that stigma, silence, discrimination, and denial, as well as lack of confidentiality, undermine prevention, care and treatment efforts and increase the impact of the epidemic on individuals, families, communities and nations and must also be addressed;
- 14.** Stressing that gender equality and the empowerment of women are fundamental elements in the reduction of the vulnerability of women and girls to HIV/AIDS;
- 15.** Recognizing that access to medication in the context of pandemics such as HIV/AIDS is one of the fundamental elements to achieve progressively the full realization of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health;
- 16.** Recognizing that the full realization of human rights and fundamental freedoms for all is an essential element in a global response to the HIV/AIDS pandemic, including in the areas of prevention, care, support and treatment, and that it reduces vulnerability to HIV/AIDS and prevents stigma and related discrimination against people living with or at risk of HIV/AIDS;

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17. Acknowledging that prevention of HIV infection must be the mainstay of the national, regional and international response to the epidemic; and that prevention, care, support and treatment for those infected and affected by HIV/AIDS are mutually reinforcing elements of an effective response and must be integrated in a comprehensive approach to combat the epidemic;

18. Recognizing the need to achieve the prevention goals set out in this Declaration in order to stop the spread of the epidemic and acknowledging that all countries must continue to emphasize widespread and effective prevention, including awareness-raising campaigns through education, nutrition, information and health-care services;

19. Recognizing that care, support and treatment can contribute to effective prevention through increased acceptance of voluntary and confidential counselling and testing, and by keeping people living with HIV/AIDS and vulnerable groups in close contact with health-care systems and facilitating their access to information, counselling and preventive supplies;

20. Emphasizing the important role of cultural, family, ethical and religious factors in the prevention of the epidemic, and in treatment, care and support, taking into account the particularities of each country as well as the importance of respecting all human rights and fundamental freedoms;

21. Noting with concern that some negative economic, social, cultural, political, financial and legal factors are hampering awareness, education, prevention, care, treatment and support efforts;

22. Noting the importance of establishing and strengthening human resources and national health and social infrastructures as imperatives for the effective delivery of prevention, treatment, care and support services;

23. Recognizing that effective prevention, care and treatment strategies will require behavioural changes and increased availability of and non-discriminatory access to, inter alia, vaccines, condoms, microbicides, lubricants, sterile injecting equipment, drugs including anti-retroviral therapy, diagnostics and related technologies as well as increased research and development;

24. Recognizing also that the cost availability and affordability of drugs and related technology are significant factors to be reviewed and addressed in all aspects and that there is a need to reduce the cost of these drugs and technologies in close collaboration with the private sector and pharmaceutical companies;

25. Acknowledging that the lack of affordable pharmaceuticals and of feasible supply structures and health systems continue to hinder an effective response to HIV/AIDS in many countries, especially for the poorest people and recalling efforts to make drugs available at low prices for those in need;

26. Welcoming the efforts of countries to promote innovation and the development of domestic industries consistent with international law in order to increase access to medicines to protect the health of their populations; and noting that the impact of international trade agreements on access to or local manufacturing of, essential drugs and on the development of new drugs needs to be further evaluated;

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- 27.** Welcoming the progress made in some countries to contain the epidemic, particularly through: strong political commitment and leadership at the highest levels, including community leadership; effective use of available resources and traditional medicines; successful prevention, care, support and treatment strategies; education and information initiatives; working in partnership with communities, civil society, people living with HIV/AIDS and vulnerable groups; and the active promotion and protection of human rights; and recognizing the importance of sharing and building on our collective and diverse experiences, through regional and international cooperation including North/South, South/South cooperation and triangular cooperation;
- 28.** Acknowledging that resources devoted to combating the epidemic both at the national and international levels are not commensurate with the magnitude of the problem;
- 29.** Recognizing the fundamental importance of strengthening national, regional and subregional capacities to address and effectively combat HIV/AIDS and that this will require increased and sustained human, financial and technical resources through strengthened national action and cooperation and increased regional, subregional and international cooperation;
- 30.** Recognizing that external debt and debt-servicing problems have substantially constrained the capacity of many developing countries, as well as countries with economies in transition, to finance the fight against HIV/AIDS;
31. Affirming the key role played by the family in prevention, care, support and treatment of persons affected and infected by HIV/AIDS, bearing in mind that in different cultural, social and political systems various forms of the family exist;
- 32.** Affirming that beyond the key role played by communities, strong partnerships among Governments, the United Nations system, intergovernmental organisations, people living with HIV/AIDS and vulnerable groups, medical, scientific and educational institutions, non-governmental organisations, the business sector including generic and research-based pharmaceutical companies, trade unions, media, parliamentarians, foundations, community organisations, faith-based organisations and traditional leaders are important;
- 33.** Acknowledging the particular role and significant contribution of people living with HIV/AIDS, young people and civil society actors in addressing the problem of HIV/AIDS in all its aspects and recognizing that their full involvement and participation in design, planning, implementation and evaluation of programmes is crucial to the development of effective responses to the HIV/AIDS epidemic;
- 34.** Further acknowledging the efforts of international humanitarian organisations combating the epidemic, including among others the volunteers of the International Federation of Red Cross and Red Crescent Societies in the most affected areas all over the world;
- 35.** Commending the leadership role on HIV/AIDS policy and coordination in the United Nations system of the UNAIDS Program Coordinating Board; noting its endorsement in December 2000 of the Global Strategy Framework for HIV/AIDS, which could assist, as appropriate, Member States

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and relevant civil society actors in the development of HIV/AIDS strategies, taking into account the particular context of the epidemic in different parts of the world;

36. Solemnly declare our commitment to address the HIV/AIDS crisis by taking action as follows, taking into account the diverse situations and circumstances in different regions and countries throughout the world;

Leadership

Strong leadership at all levels of society is essential for an effective response to the epidemic

Leadership by Governments in combating HIV/AIDS is essential and their efforts should be complemented by the full and active participation of civil society, the business community and the private sector

Leadership involves personal commitment and concrete actions

At the national level

37. By 2003, ensure the development and implementation of multisectoral national strategies and financing plans for combating HIV/AIDS that: address the epidemic in forthright terms; confront stigma, silence and denial; address gender and age-based dimensions of the epidemic; eliminate discrimination and marginalization; involve partnerships with civil society and the business sector and the full participation of people living with HIV/AIDS, those in vulnerable groups and people mostly at risk, particularly women and young people; are resourced to the extent possible from national budgets without excluding other sources, inter alia international cooperation; fully promote and protect all human rights and fundamental freedoms, including the right to the highest attainable standard of physical and mental health; integrate a gender perspective; and address risk, vulnerability, prevention, care, treatment and support and reduction of the impact of the epidemic; and strengthen health, education and legal system capacity;

38. By 2003, integrate HIV/AIDS prevention, care, treatment and support and impact mitigation priorities into the mainstream of development planning, including in poverty eradication strategies, national budget allocations and sectoral development plans;

At the regional and subregional level

39. Urge and support regional organisations and partners to: be actively involved in addressing the crisis; intensify regional, subregional and interregional cooperation and coordination; and develop regional strategies and responses in support of expanded country level efforts;

40. Support all regional and subregional initiatives on HIV/AIDS including: the International Partnership against AIDS in Africa (IPAA) and the ECA-African Development Forum Consensus and Plan of Action: Leadership to Overcome HIV/ AIDS; the Abuja Declaration and Framework for Action for the Fight Against HIV/AIDS, Tuberculosis and Other Diseases; the CARICOM Pan-Caribbean Partnership Against HIV/AIDS; the ESCAP Regional Call for Action to Fight HIV/ AIDS in Asia and the Pacific; the Baltic Sea Initiative and Action Plan; the Horizontal Technical Cooperation Group on HIV/AIDS in Latin America and the Caribbean; the European Union Program for Action: Accelerated Action on HIV/AIDS, Malaria and Tuberculosis in the context of poverty reduction;

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41. Encourage the development of regional approaches and plans to address HIV/AIDS;

42. Encourage and support local and national organisations to expand and strengthen regional partnerships, coalitions and networks;

43. Encourage the United Nations Economic and Social Council to request the regional commissions within their respective mandates and resources to support national efforts in their respective regions in combating HIV/AIDS;

At the global level

44. Support greater action and coordination by all relevant United Nations system organisations, including their full participation in the development and implementation of a regularly updated United Nations strategic plan for HIV/AIDS, guided by the principles contained in this Declaration;

45. Support greater cooperation between relevant United Nations system organisations and international organisations combating HIV/AIDS;

46. Foster stronger collaboration and the development of innovative partnerships between the public and private sectors and by 2003, establish and strengthen mechanisms that involve the private sector and civil society partners and people living with HIV/AIDS and vulnerable groups in the fight against HIV/AIDS;

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Prevention

Prevention must be the mainstay of our response

- 47.** By 2003, establish time-bound national targets to achieve the internationally agreed global prevention goal to reduce by 2005 HIV prevalence among young men and women aged 15 to 24 in the most affected countries by 25 per cent and by 25 per cent globally by 2010, and to intensify efforts to achieve these targets as well as to challenge gender stereotypes and attitudes, and gender inequalities in relation to HIV/AIDS, encouraging the active involvement of men and boys;
- 48.** By 2003, establish national prevention targets, recognizing and addressing factors leading to the spread of the epidemic and increasing people's vulnerability, to reduce HIV incidence for those identifiable groups, within particular local contexts, which currently have high or increasing rates of HIV infection, or which available public health information indicates are at the highest risk for new infection;
- 49.** By 2005, strengthen the response to HIV/AIDS in the world of work by establishing and implementing prevention and care programmes in public, private and informal work sectors and take measures to provide a supportive workplace environment for people living with HIV/AIDS;
- 50.** By 2005, develop and begin to implement national, regional and international strategies that facilitate access to HIV/AIDS prevention programmes for migrants and mobile workers, including the provision of information on health and social services;
- 51.** By 2003, implement universal precautions in health-care settings to prevent transmission of HIV infection;
- 52.** By 2005, ensure: that a wide range of prevention programmes which take account of local circumstances, ethics and cultural values, is available in all countries, particularly the most affected countries, including information, education and communication, in languages most understood by communities and respectful of cultures, aimed at reducing risk-taking behaviour and encouraging responsible sexual behaviour, including abstinence and fidelity; expanded access to essential commodities, including male and female condoms and sterile injecting equipment; harm reduction efforts related to drug use; expanded access to voluntary and confidential counselling and testing; safe blood supplies; and early and effective treatment of sexually transmittable infections;
- 53.** By 2005, ensure that at least 90 per cent, and by 2010 at least 95 per cent of young men and women aged 15 to 24 have access to the information, education, including peer education and youth-specific HIV education, and services necessary to develop the life skills required to reduce their vulnerability to HIV infection; in full partnership with youth, parents, families, educators and health-care providers;
- 54.** By 2005, reduce the proportion of infants infected with HIV by 20 per cent, and by 50 per cent by 2010, by: ensuring that 80 per cent of pregnant women accessing antenatal care have information, counselling and other HIV prevention services available to them, increasing the availability of and by providing access for HIV-infected women and babies to effective treatment to reduce mother-to-child transmission of HIV, as well as through effective interventions for HIV-infected women, including voluntary and confidential counselling and testing, access to treatment, especially anti-retroviral therapy and, where appropriate, breast milk substitutes and the provision of a continuum of care;

14 Care, support and treatment

Care, support and treatment are fundamental elements of an effective response

55. By 2003, ensure that national strategies, supported by regional and international strategies, are developed in close collaboration with the international community, including Governments and relevant intergovernmental organisations as well as with civil society and the business sector, to strengthen health care systems and address factors affecting the provision of HIV-related drugs, including anti-retroviral drugs, inter alia affordability and pricing, including differential pricing, and technical and health care systems capacity. Also, in an urgent manner make every effort to: provide progressively and in a sustainable manner, the highest attainable standard of treatment for HIV/AIDS, including the prevention and treatment of opportunistic infections, and effective use of quality-controlled anti-retroviral therapy in a careful and monitored manner to improve adherence and effectiveness and reduce the risk of developing resistance; to cooperate constructively in strengthening pharmaceutical policies and practices, including those applicable to generic drugs and intellectual property regimes, in order further to promote innovation and the development of domestic industries consistent with international law;

56. By 2005, develop and make significant progress in implementing comprehensive care strategies to: strengthen family and community-based care including that provided by the informal sector, and health care systems to provide and monitor treatment to people living with HIV/AIDS, including infected children, and to support individuals, households, families and communities affected by HIV/AIDS; improve the capacity and working conditions of health care personnel, and the effectiveness of supply systems, financing plans and referral mechanisms required to provide access to affordable medicines, including anti-retroviral drugs, diagnostics and related technologies, as well as quality medical, palliative and psycho-social care;

57. By 2003, ensure that national strategies are developed in order to provide psycho-social care for individuals, families, and communities affected by HIV/AIDS;

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HIV/AIDS and human rights

Realization of human rights and fundamental freedoms for all is essential to reduce vulnerability to HIV/AIDS

Respect for the rights of people living with HIV/AIDS drives an effective response

58. By 2003, enact, strengthen or enforce as appropriate legislation, regulations and other measures to eliminate all forms of discrimination against, and to ensure the full enjoyment of all human rights and fundamental freedoms by people living with HIV/AIDS and members of vulnerable groups; in particular to ensure their access to, inter alia education, inheritance, employment, health care, social and health services, prevention, support, treatment, information and legal protection, while respecting their privacy and confidentiality; and develop strategies to combat stigma and social exclusion connected with the epidemic;

59. By 2005, bearing in mind the context and character of the epidemic and that globally women and girls are disproportionately affected by HIV/AIDS, develop and accelerate the implementation of national strategies that: promote the advancement of women and women's full enjoyment of all human rights; promote shared responsibility of men and women to ensure safe sex; empower women to have control over and decide freely and responsibly on matters related to their sexuality to increase their ability to protect themselves from HIV infection;

60. By 2005, implement measures to increase capacities of women and adolescent girls to protect themselves from the risk of HIV infection, principally through the provision of health care and health services, including sexual and reproductive health, and through prevention education that promotes gender equality within a culturally and gender sensitive framework;

61. By 2005, ensure development and accelerated implementation of national strategies for women's empowerment, promotion and protection of women's full enjoyment of all human rights and reduction of their vulnerability to HIV/AIDS through the elimination of all forms of discrimination, as well as all forms of violence against women and girls, including harmful traditional and customary practices, abuse, rape and other forms of sexual violence, battering and trafficking in women and girls;

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Reducing vulnerability

The vulnerable must be given priority in the response

Empowering women is essential for reducing vulnerability

62. By 2003, in order to complement prevention programmes that address activities which place individuals at risk of HIV infection, such as risky and unsafe sexual behaviour and injecting drug use, have in place in all countries strategies, policies and programmes that identify and begin to address those factors that make individuals particularly vulnerable to HIV infection, including underdevelopment, economic insecurity, poverty, lack of empowerment of women, lack of education, social exclusion, illiteracy, discrimination, lack of information and/or commodities for self-protection, all types of sexual exploitation of women, girls and boys, including for commercial reasons; such strategies, policies and programmes should address the gender dimension of the epidemic, specify the action that will be taken to address vulnerability and set targets for achievement;

63. By 2003, develop and/or strengthen strategies, policies and programmes, which recognize the importance of the family in reducing vulnerability, inter alia, in educating and guiding children and take account of cultural, religious and ethical factors, to reduce the vulnerability of children and young people by: ensuring access of both girls and boys to primary and secondary education, including on HIV/AIDS in curricula for adolescents; ensuring safe and secure environments, especially for young girls; expanding good quality youth-friendly information and sexual health education and counselling service; strengthening reproductive and sexual health programmes; and involving families and young people in planning, implementing and evaluating HIV/AIDS prevention and care programmes, to the extent possible;

64. By 2003, develop and/or strengthen national strategies, policies and programmes, supported by regional and international initiatives, as appropriate, through a participatory approach, to promote and protect the health of those identifiable groups which currently have high or increasing rates of HIV infection or which public health information indicates are at greatest risk of and most vulnerable to new infection as indicated by such factors as the local history of the epidemic, poverty, sexual practices, drug using behaviour, livelihood, institutional location, disrupted social structures and population movements forced or otherwise;

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Children orphaned and made vulnerable by HIV/AIDS

Children orphaned and affected by HIV/AIDS need special assistance

65. By 2003, develop and by 2005 implement national policies and strategies to: build and strengthen governmental, family and community capacities to provide a supportive environment for orphans and girls and boys infected and affected by HIV/AIDS including by providing appropriate counselling and psycho-social support; ensuring their enrolment in school and access to shelter, good nutrition, health and social services on an equal basis with other children; to protect orphans and vulnerable children from all forms of abuse, violence, exploitation, discrimination, trafficking and loss of inheritance;

66. Ensure non-discrimination and full and equal enjoyment of all human rights through the promotion of an active and visible policy of de-stigmatization of children orphaned and made vulnerable by HIV/AIDS;

67. Urge the international community, particularly donor countries, civil society, as well as the private sector to complement effectively national programmes to support programmes for children orphaned or made vulnerable by HIV/AIDS in affected regions, in countries at high risk and to direct special assistance to sub-Saharan Africa;

Alleviating social and economic impact To address HIV/AIDS is to invest in sustainable development

68. By 2003, evaluate the economic and social impact of the HIV/AIDS epidemic and develop multisectoral strategies to: address the impact at the individual, family, community and national levels; develop and accelerate the implementation of national poverty eradication strategies to address the impact of HIV/AIDS on household income, livelihoods, and access to basic social services, with special focus on individuals, families and communities severely affected by the epidemic; review the social and economic impact of HIV/AIDS at all levels of society especially on women and the elderly, particularly in their role as caregivers and in families affected by HIV/AIDS and address their special needs; adjust and adapt economic and social development policies, including social protection policies, to address the impact of HIV/AIDS on economic growth, provision of essential economic services, labour productivity, government revenues, and deficit-creating pressures on public resources;

69. By 2003, develop a national legal and policy framework that protects in the workplace the rights and dignity of persons living with and affected by HIV/AIDS and those at the greatest risk of HIV/AIDS in consultation with representatives of employers and workers, taking account of established international guidelines on HIV/AIDS in the workplace;

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Research and development

With no cure for HIV/AIDS yet found, further research and development is crucial

70. Increase investment and accelerate research on the development of HIV vaccines, while building national research capacity especially in developing countries, and especially for viral strains prevalent in highly affected regions; in addition, support and encourage increased national and international investment in HIV/AIDS-related research and development including biomedical, operations, social, cultural and behavioural research and in traditional medicine to: improve prevention and therapeutic approaches; accelerate access to prevention, care and treatment and care technologies for HIV/AIDS (and its associated opportunistic infections and malignancies and sexually transmitted diseases), including female controlled methods and microbicides, and in particular, appropriate, safe and affordable HIV vaccines and their delivery, and to diagnostics, tests, methods to prevent mother-to-child transmission; and improve our understanding of factors which influence the epidemic and actions which address it, inter alia, through increased funding and public/private partnerships; create a conducive environment for research and ensure that it is based on highest ethical standards;

71. Support and encourage the development of national and international research infrastructure, laboratory capacity, improved surveillance systems, data collection, processing and dissemination, and training of basic and clinical researchers, social scientists, health-care providers and technicians, with a focus on the countries most affected by HIV/AIDS, particularly developing countries and those countries experiencing or at risk of rapid expansion of the epidemic;

72. Develop and evaluate suitable approaches for monitoring treatment efficacy, toxicity, side effects, drug interactions, and drug resistance, develop methodologies to monitor the impact of treatment on HIV transmission and risk behaviours;

73. Strengthen international and regional cooperation in particular North/South, South/South and triangular cooperation, related to transfer of relevant technologies, suitable to the environment in prevention and care of HIV/AIDS, the exchange of experiences and best practices, researchers and research findings and strengthen the role of UNAIDS in this process. In this context, encourage that the end results of these cooperative research findings and technologies be owned by all parties to the research, reflecting their relevant contribution and dependent upon their providing legal protection to such findings; and affirm that all such research should be free from bias;

74. By 2003, ensure that all research protocols for the investigation of HIV-related treatment including anti-retroviral therapies and vaccines based on international guidelines and best practices are evaluated by independent committees of ethics, in which persons living with HIV/AIDS and caregivers for anti-retroviral therapy participate;

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HIV/AIDS in conflict and disaster affected regions

Conflicts and disasters contribute to the spread of HIV/AIDS

75. By 2003, develop and begin to implement national strategies that incorporate HIV/AIDS awareness, prevention, care and treatment elements into programmes or actions that respond to emergency situations, recognizing that populations destabilized by armed conflict, humanitarian emergencies and natural disasters, including refugees, internally displaced persons and in particular, women and children, are at increased risk of exposure to HIV infection; and, where appropriate, factor HIV/AIDS components into international assistance programmes;

76. Call on all United Nations agencies, regional and international organisations, as well as non-governmental organisations involved with the provision and delivery of international assistance to countries and regions affected by conflicts, humanitarian crises or natural disasters, to incorporate as a matter of urgency HIV/AIDS prevention, care and awareness elements into their plans and programmes and provide HIV/AIDS awareness and training to their personnel;

77. By 2003, have in place national strategies to address the spread of HIV among national uniformed services, where this is required, including armed forces and civil defence force and consider ways of using personnel from these services who are educated and trained in HIV/AIDS awareness and prevention to assist with HIV/AIDS awareness and prevention activities including participation in emergency, humanitarian, disaster relief and rehabilitation assistance;

78. By 2003, ensure the inclusion of HIV/AIDS awareness and training, including a gender component, into guidelines designed for use by defence personnel and other personnel involved in international peacekeeping operations while also continuing with ongoing education and prevention efforts, including pre-deployment orientation, for these personnel;

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Resources**The HIV/AIDS challenge cannot be met without new, additional and sustained resources**

79. Ensure that the resources provided for the global response to address HIV/AIDS are substantial, sustained and geared towards achieving results;

80. By 2005, through a series of incremental steps, reach an overall target of annual expenditure on the epidemic of between US\$ 7 billion and US\$ 10 billion in low and middle-income countries and those countries experiencing or at risk of experiencing rapid expansion for prevention, care, treatment, support and mitigation of the impact of HIV/AIDS, and take measures to ensure that needed resources are made available, particularly from donor countries and also from national budgets, bearing in mind that resources of the most affected countries are seriously limited;

81. Call on the international community, where possible, to provide assistance for HIV/AIDS prevention, care and treatment in developing countries on a grant basis;

82. Increase and prioritize national budgetary allocations for HIV/AIDS programmes as required and ensure that adequate allocations are made by all ministries and other relevant stakeholders;

83. Urge the developed countries that have not done so to strive to meet the targets of 0.7 per cent of their gross national product for overall official development assistance and the targets of earmarking of 0.15 per cent to 0.20 per cent of gross national product as official development assistance for least developed countries as agreed, as soon as possible, taking into account the urgency and gravity of the HIV/AIDS epidemic;

84. Urge the international community to complement and supplement efforts of developing countries that commit increased national funds to fight the HIV/AIDS epidemic through increased international development assistance, particularly those countries most affected by HIV/AIDS, particularly in Africa, especially in sub-Saharan Africa, the Caribbean, countries at high risk of expansion of the HIV/AIDS epidemic and other affected regions whose resources to deal with the epidemic are seriously limited;

85. Integrate HIV/AIDS actions in development assistance programmes and poverty eradication strategies as appropriate and encourage the most effective and transparent use of all resources allocated;

86. Call on the international community and invite civil society and the private sector to take appropriate measures to help alleviate the social and economic impact of HIV/AIDS in the most affected developing countries;

87. Without further delay implement the enhanced Heavily Indebted Poor Country (HIPC) Initiative and agree to cancel all bilateral official debts of HIPC countries as soon as possible, especially those

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most affected by HIV/AIDS, in return for their making demonstrable commitments to poverty eradication and urge the use of debt service savings to finance poverty eradication programmes, particularly for HIV/AIDS prevention, treatment, care and support and other infections;

88. Call for speedy and concerted action to address effectively the debt problems of least developed countries, low-income developing countries, and middle-income developing countries, particularly those affected by HIV/AIDS, in a comprehensive, equitable, development-oriented and durable way through various national and international measures designed to make their debt sustainable in the long term and thereby to improve their capacity to deal with the HIV/AIDS epidemic, including, as appropriate, existing orderly mechanisms for debt reduction, such as debt swaps for projects aimed at the prevention, care and treatment of HIV/AIDS;

89. Encourage increased investment in HIV/AIDS-related research, nationally, regionally and internationally, in particular for the development of sustainable and affordable prevention technologies, such as vaccines and microbicides, and encourage the proactive preparation of financial and logistic plans to facilitate rapid access to vaccines when they become available;

90. Support the establishment, on an urgent basis, of a global HIV/AIDS and health fund to finance an urgent and expanded response to the epidemic based on an integrated approach to prevention, care, support and treatment and to assist Governments inter alia in their efforts to combat HIV/AIDS with due priority to the most affected countries, notably in sub-Saharan Africa and the Caribbean and to those countries at high risk, mobilize contributions to the fund from public and private sources with a special appeal to donor countries, foundations, the business community including pharmaceutical companies, the private sector, philanthropists and wealthy individuals;

91. By 2002, launch a worldwide fund-raising campaign aimed at the general public as well as the private sector, conducted by UNAIDS with the support and collaboration of interested partners at all levels, to contribute to the global HIV/ AIDS and health fund;

92. Direct increased funding to national, regional and subregional commissions and organisations to enable them to assist Governments at the national, subregional and regional level in their efforts to respond to the crisis;

93. Provide the UNAIDS co-sponsoring agencies and the UNAIDS secretariat with the resources needed to work with countries in support of the goals of this Declaration;

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Follow-up

Maintaining the momentum and monitoring progress are essential

At the national level

94. Conduct national periodic reviews involving the participation of civil society, particularly people living with HIV/AIDS, vulnerable groups and caregivers, of progress achieved in realizing these commitments and identify problems and obstacles to achieving progress and ensure wide dissemination of the results of these reviews;

95. Develop appropriate monitoring and evaluation mechanisms to assist with follow-up in measuring and assessing progress, develop appropriate monitoring and evaluation instruments, with adequate epidemiological data;

96. By 2003, establish or strengthen effective monitoring systems, where appropriate, for the promotion and protection of human rights of people living with HIV/AIDS;

At the regional level

97. Include HIV/AIDS and related public health concerns as appropriate on the agenda of regional meetings at the ministerial and Head of State and Government level;

98. Support data collection and processing to facilitate periodic reviews by regional commissions and/or regional organisations of progress in implementing regional strategies and addressing regional priorities and ensure wide dissemination of the results of these reviews;

99. Encourage the exchange between countries of information and experiences in implementing the measures and commitments contained in this Declaration, and in particular facilitate intensified South-South and triangular cooperation;

At the global level

100. Devote sufficient time and at least one full day of the annual General Assembly session to review and debate a report of the Secretary-General on progress achieved in realizing the commitments set out in this Declaration, with a view to identifying problems and constraints and making recommendations on action needed to make further progress;

101. Ensure that HIV/AIDS issues are included on the agenda of all appropriate United Nations conferences and meetings;

102. Support initiatives to convene conferences, seminars, workshops, training programmes and courses to follow up issues raised in this Declaration and in this regard encourage participation in and wide dissemination of the outcomes of: the forthcoming Dakar Conference on Access to Care for HIV Infection; the Sixth International Congress on AIDS in Asia and the Pacific; the XII International Conference on AIDS and Sexually Transmitted Infections in Africa; the XIV International Conference on

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AIDS, Barcelona; the Xth International Conference on People Living with HIV/AIDS, Port of Spain; the II Forum and III Conference of the Latin American and the Caribbean Horizontal Technical Cooperation on HIV/AIDS and Sexually Transmitted Infections, La Habana; the Vth International Conference on Home and Community Care for Persons Living with HIV/AIDS, Changmai, Thailand;

103. Explore, with a view to improving equity in access to essential drugs, the feasibility of developing and implementing, in collaboration with non-governmental organisations and other concerned partners, systems for voluntary monitoring and reporting of global drug prices;

We recognize and express our appreciation to those who have led the effort to raise awareness of the HIV/AIDS epidemic and to deal with its complex challenges;

We look forward to strong leadership by Governments, and concerted efforts with full and active participation of the United Nations, the entire multilateral system, civil society, the business community and private sector;

And finally, we call on all countries to take the necessary steps to implement this Declaration, in strengthened partnership and cooperation with other multilateral and bilateral partners and with civil society.

15 The OHCHR/UNAIDS Guidelines on HIV/AIDS

(Originally drafted in 1996, and published in 1998. Guideline 6 was amended in 2002, and on the 10th anniversary of their publication, they were re-issued as Consolidated Guideline, 2006 – **Core document 5**)

The OHCHR/UNAIDS Guidelines on HIV/AIDS and Human Rights, 1998

- 1 States should establish an effective national framework for their response to HIV/AIDS, which ensures a coordinated, participatory, transparent and accountable approach, integrating HIV/AIDS policy and Program responsibilities across all branches of government.
- 2 States should ensure, through political and financial support, that community consultation occurs in all phases of HIV/AIDS policy design, Program implementation and evaluation and that community organisations are enabled to carry out their activities, including in the field of ethics, law and human rights, effectively.
- 3 States should review and reform public health laws to ensure that they adequately address public health issues raised by HIV/AIDS, that their provisions applicable to casually transmitted diseases are not inappropriately applied to HIV/AIDS and that they are consistent with international human rights obligations.
- 4 States should review and reform criminal laws and correctional systems to ensure that they are consistent with international human rights obligations and are not misused in the context of HIV/AIDS or targeted against vulnerable groups.
- 5 States should enact or strengthen anti-discrimination and other protective laws that protect vulnerable groups, people living with HIV/AIDS and people with disabilities from discrimination in both the public and private sectors, ensure privacy and confidentiality and ethics in research involving human subjects, emphasise education and conciliation, and provide for speedy and effective administrative and civil remedies.
- 6 States should enact legislation to provide for the regulation of HIV-related goods, services and information, so as to ensure widespread availability of qualitative prevention measures and services, adequate HIV prevention and care information and safe and effective medication at an affordable price.
- 7 States should implement and support legal support services that will educate people affected by HIV/AIDS about their rights, provide free legal services to enforce those rights, develop expertise on HIV-related legal issues and utilize means of protection in addition to the courts, such as offices of

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ministries of justice, ombudspersons, health complaint units and human rights commissions.

States, in collaboration with and through the community, should promote a supportive and enabling environment for women, children and other vulnerable groups by addressing underlying prejudices and inequalities through community dialogue, specially designed social and health services and support to community groups.

9

States should promote the wide and ongoing distribution of creative education, training and media programmes explicitly designed to change attitudes of discrimination and stigmatization associated with HIV/AIDS to understanding and acceptance.

10

States should ensure that government and the private sector develop codes of conduct regarding HIV/AIDS issues that translate human rights principles into codes of professional responsibility and practice, with accompanying mechanisms to implement and enforce these codes.

11

States should ensure monitoring and enforcement mechanisms to guarantee the protection of HIV-related human rights, including those of people living with HIV/AIDS, their families and communities.

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States should co-operate through all relevant programmes and agencies of the United Nations system, including UNAIDS, to share and should ensure effective mechanisms to protect human rights in the context of HIV/AIDS at international level.

Background

In mid-2005, the UNAIDS policy position paper on *Intensifying HIV Prevention* (see **Core document 5**) was endorsed by the Program Coordinating Board. It offers a comprehensive response to undertaking HIV prevention in the context of treatment scale-up. The paper addresses the needs of minority populations and especially vulnerable groups, as well as the general population. However, it does not specify in detail the policy and programmatic actions that need to be undertaken when working with different groups.

This UNAIDS stakeholder meeting aimed to add detail to the actions necessary with respect to the situation, circumstances and needs of men who have sex with men. The overall goal was to identify successful and promising practices in HIV prevention with different groups of men who have sex with men based on work to date. A related goal lay in identifying work that still needs to be undertaken to strengthen international, national and local responses.

More specific aims for the current meeting include identifying:

- key needs and priorities in work with men who have sex with men with respect to HIV prevention, treatment, care and impact mitigation;
- ways of strengthening programmatic and policy actions at country level for men who have sex with men and HIV prevention, treatment, care and impact mitigation; and
- the roles of key stakeholders in the above process, including national governments, international and national nongovernmental organisations and the UN system.

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The meeting brought together a wide range of experts - including Program managers, representatives of international and national non-governmental organisations, researchers, policy-makers and practitioners with successful experience in HIV prevention, care and impact mitigation among men who have sex with men.

Opening comments

Dr Purnima Mane and Dr Anindya Chatterjee opened the meeting. Dr Mane indicated that at the July 2005 Gleneagles G8 Summit, leaders had called upon UNAIDS and WHO to move towards achieving universal access to HIV treatment by 2010. The more recent September 2005 World Summit had called for a scaling up of responses to HIV and AIDS, through prevention, care, treatment and support, and the mobilization of additional resources from national, bilateral, multilateral and private sources.

Countries are to be encouraged to set their own targets, so that they own the strategies and have a real commitment to meeting them.

Current indicators suggest that less than 10% of men who have sex with men globally have access to the HIV prevention and AIDS care services they need. Many factors contribute to this situation including societal and community denial, stigma and discrimination, and human rights abuse. Scaling up interventions for men who have sex with men is sensitive and difficult because doing so often raises the visibility of the men themselves, with concomitant consequences for interpersonal and community relationships (especially in contexts where sex between men is taboo, criminalized or denied) and personal safety.

Globally, there exists a profound lack of understanding of the needs and circumstances of men who have sex with men. There is a paucity of relevant epidemiological information and male-to-male HIV transmission may be obscured within apparently heterosexual patterns of viral transmission. There is also deep seated confusion concerning who men who have sex with men are. It is a fact that in many parts of the world men who have sex with men are married, and also a fact that they are less a group set apart than a key constituent of the general population. Crucially, in many parts of the world sex between men is not associated with a particular individual or social identity and may not be openly talked about.

Despite early evidence of success in preventing male-to-male HIV transmission, there is evidence in some countries of a resurgence of risk behaviours, most notably in the 'North' but also elsewhere. There are many possible reasons for this, but central among them must be the lack of focused HIV prevention measures built upon best practice and appropriately brought to scale. It is within this context that the present meeting took place.

Male same-sex behaviour in low- and middle income countries - what do we know and what do we need to do?

A short presentation was given by Carlos Cáceres from Cayetano Heredia University, Lima, Peru based on recently completed work for UNAIDS. This sought to address the continuing problem whereby, through lack of evidence, national authorities deny that men who have sex with men are a part of their reality.

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The aim of the research was to gather together information on a global scale as a means of countering denial by presenting empirical, largely quantitative, information. The aim has to be qualified, however, because there is at present insufficient information of high quality to come up with reliable epidemiological indicators. Sample sizes are often small, respondents have been chosen adventitiously and the focus is usually on the most easily identifiable groups and populations. The majority of available studies come from Latin America from South Asia. Very little work has been undertaken in Sub-Saharan Africa.

An extraordinarily wide range of lifetime prevalence rates of male-to-male sex (6-20%) are indicated in the studies, highlighting problems of both the paucity of good quality information and of the difficulties of comparison across contexts in which male-to-male sex may be heavily or not so heavily stigmatized. Cáceres and colleagues' investigation also attempted to come up with a set of relevant HIV prevalence ranges, after factoring in the differing quality and scope of data. These vary from 2% or less to 20% or more, depending on the region. Statistical data of the kind presented are, however, useful because they offer a 'hard' case which can be persuasive to national authorities and those with a responsibility for future HIV programming. It must be recognized, however, that behavioural measures such as those obtained do not engage with the more nuanced aspects of male-to-male sexuality.

In discussion, a range of issues was explored. They included limitations of the method of analysis outlined and its failure to take into account different identities and 'subject positions'; the importance of taking action now and not delaying until perfect information is available; the dangers of using language such as the term 'prevalence of MSM' which carries associations of surveillance and stigmatization; and the importance of using civil society estimates alongside of official statistics in developing country-level estimates.

National situations and contexts

A series of linked presentations were given by members of the meeting, highlighting country level issues and concerns.

Africa

Describing issues of relevance to **Senegal**, Cheikh Niang drew attention to the importance of ethnographic work to identify the multiplicity of relevant identities/non-identities pertaining to male-to-male sexuality. It is important also to consider why some people do not adopt specific identities in respect of male-to-male sexual behaviours. Under the impact of modernisation and globalization, new groupings of men who have sex with men are forming in Senegal; there are also many informal networks. These groupings and networks need to be included and integrated into an effective response.

Glenn de Swardt talked of issues of relevance to **South Africa**. The country has a liberal constitution with respect to homosexuality, but a President who has had some problems engaging with HIV. This presents unique challenges for male-to-male HIV prevention. Qualitative data is needed to capture the dynamics of the epidemic and make it alive in people's minds. 'Sex-positive' approaches are needed because gay and other men who have sex with men have been told so often that their sex is bad. There is a critical need to promote access to and use of water-based lubricants. It is important to understand how people of non-heterosexualities find safety in groups and create alternative family structures (kinship of

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choice). These need to be integrated into community-based prevention strategies.

Othman Mellouk described the work of ALCS (Moroccan AIDS Service Organization) in **Morocco**. ALCS has been working since 1995. It is very much a gay-friendly organisation, and identity politics are intrinsic to its agenda. A strong position is taken on human rights as well as the health issues. Working in a predominantly traditional Muslim context has its challenges. Initially, ALCS did not work closely with government, but this has changed over time. Big issues to be addressed include HIV treatment access, discrimination, condom distribution (especially in prisons), and the challenge of working in a legally ambiguous environment.

Asia

Don Baxter described some of the challenges and opportunities in **Australia**. Among gay and other homosexually active men, there have been reported increases in sexual risk behaviour since the introduction of antiretroviral treatment. In recent times, there has also been a rise in levels of HIV infection as well as the incidence of other sexually transmitted infections. As yet there are no effective programmatic solutions. Recent ongoing changes in the gay community mean that HIV and being gay mean different things to younger gay men than they did in the past. This presents major challenges for community development work.

Kim Mulji and Ruben del Prado reported that in **India** capacity building for the scaling-up of successful programmes is a key issue, as well as matters of finance. The situation is made more complex by the fact that policy towards HIV prevention and men who have sex with men can be variable—both between ministries and between AIDS Societies at State level. To date, men who have sex with men have not been a priority group for antiretroviral therapy roll out. While there are networks for HIV-positive people in India, these might be better linked into men who have sex with men work. There is some evidence, however the National AIDS Control Organization will give greater emphasis to men who have sex with men in its next five-year plan. It is to be hoped that this will result in a more programmatic approach to work than has sometimes been evident in the past. Additional issues that need to be tackled include stigma and discrimination, condom availability for men who have sex with men, and the training of health care workers in relevant issues and a non-judgemental approach.

Wan Yanhai and Chung To spoke about issues of relevance to **China**. Throughout the country, there is a large diversity of needs and constituencies to address. The experience of larger cities is not the same as that in smaller cities or non-urban areas, where male-to-male sexual networks may be harder to work with. The Government has made significant progress in recognizing the issue of male-to-male sexual health and HIV in the last year. However, despite the fact that gay communities are now more active in China, the political environment is not open or transparent. Some nongovernmental organisations do not have legal status and so it is difficult for them to have long-term development plans. There are currently between 30 to 40 gay groups in China and hundreds of web sites. This has created competition for funds. Overcoming 'in-fighting' is a major challenge.

Latin America

Fernando Seffner spoke about issues of special relevance in **Brazil**. Against the backdrop of a generally positive national response, challenges remain. They include the importance of ensuring

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good linkage between HIV prevention and AIDS care; respect for the rights of those who are most vulnerable; and ensuring access to the full range of prevention measures known to be successful. A range of different ‘publics’ need to be involved in, and spoken to, through HIV prevention activities. It is crucial that the politics of HIV and concern for men who have sex with men remain high on the agenda and that HIV prevention is not likened to a technical response.

Mario Pecheny described the situation in **Argentina**. Key priorities include how best to bring about an integration between primary and secondary care, and how to ensure that the needs of lesbians, gay men, bisexuals and transgendered (LGBT) people are equitably met in HIV programming. Legal status remains a big issue, especially for transgendered people, and LGBT issues need to be more fully integrated into the work of public and private health systems. The predominant discourse is one of there being a heterosexual epidemic—this needs to change especially in a context where there are large numbers of infections acquired through male-to-male sex. Outreach to rural areas is also a priority.

In **Jamaica**, homosexual behaviour between men remains illegal. In this context, Boris Bloomfield talked about the need for a stronger and more programmatic response. Key to success must be the decriminalization of homosexuality as well as efforts to reduce stigma especially among health care providers. Parties offer a significant environment in which HIV prevention can take place and services can be taken to people. A key challenge exists concerning the lack of anonymity faced by men who have sex with men in the context of community-based interventions. This can be a major difficulty in smaller Caribbean communities.

With respect to **Peru**, Carlos Cáceres talked of the need for better evidence on the extent of sex between men, and its differences in different contexts. There is an urgent necessity to address stigma and discrimination associated with ‘non-heterosexual sexualities’. It is vital too to de-naturalize the perception that high HIV prevalence is the norm among men who have sex with men. More work needs to take place with doctors and health care workers to redress stigma and discrimination. Special issues are relevant to the circumstances of transgendered individuals whose needs may not be understood by health care providers. Efforts are needed to counter the negative responses of some church groups and to ensure that health care workers come to understand HIV prevention among men who have sex with men as being a priority.

Europe and North America

Anne-Lise Middelthon describes aspects of the current situation in **Norway**. Since 1985, the Norwegian Gay Men’s Health Committee has been funded by Government to undertake HIV/AIDS programmes. Recent data indicated increasing prevalence of untreated sexually transmitted infections among men who have sex with men. Within the gay community, there is a need both to sustain safer-sex and to ‘keep condom culture alive.’ The goal must be that of securing and sustaining ‘real ownership’ so that targeted groups can have the last say in project work. This presents unique challenges. To date, much work has been communication-based. However, HIV prevention work is not only about knowledge but also about skills and context. It is also important to remember that gay men and other men who have sex with men are a part of the general population and need to be addressed as such, as well as via more specialized forms of activity.

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Ted Myers described how **Canada** had been fortunate in being able to learn from the best of its southern neighbour's approach to HIV prevention whilst learning from its mistakes. Early initiatives had been led not by central government, provincial governments or local governments but by communities and activists. Prevention models have generally been both sex positive and explicit.

Despite Canada's reputation for being liberal and progressive, HIV-related stigma still persists and prevention efforts does not seem to have brought down the rise in infection amongst men who have sex with men. Currently, there is a dearth of good prevention research. The sense of gay community has changed and both activists and Programme developers need to know how to respond to this. There remains too little dialogue between people living with HIV and HIV-negative communities.

Eric Fleutelot described how in **France** there is currently a distinct lack of good data concerning HIV transmission among men who have sex with men. In the context of what may be a very dynamic epidemic, there is little reliable data on incidence. It is important to recognize that while the French epidemic as a whole is heterosexual, 'nationally acquired HIV' occurs predominantly among men who have sex with men. Ongoing debate persists in relation to risk reduction versus risk elimination, the risks of oral sex, and when to encourage HIV testing. There has been some move towards the promotion of gay health as a more encompassing approach to health promotion among men who have sex with men. The sexual transmission of hepatitis C is also of growing concern.

Michael Hauserman reported on the current situation in **Switzerland**. Recent Federal Government statistics indicate that 33% of all new HIV infections are amongst men who have sex with men. Key issues to be addressed include changes in gay men's behaviour subsequent to the availability of antiretroviral therapy. More gay men are reporting having unprotected anal sex, but importantly these changes are not inscribed with a 'barebacking' culture per se. Few HIV positive people currently attend gay-oriented services for treatment—they go to mainstream medical services instead. As for the future, it is important not to reduce male-to-male sexual health issues to HIV alone. Depression and anxiety are also major concerns.

Zoran Jordanov reported that in **Macedonia**, HIV prevention among men who have sex with men is relatively new. Treatment and care remain largely absent. Limited research has been carried out to date but the little information that exists suggests that stigma and denial are widespread. Many men who have sex with men do not identify as gay but see themselves simply as 'men'. Confidentiality is not well observed in medical contexts. As a result, people are not willing to take an HIV antibody test for fear of being recognized. Nevertheless, with the support of outside agencies innovative work is beginning to take place.

Finally, David Winters described the current context in the **USA**. Here, there is strong evidence of men who have sex with men has been marginalized from the start within the epidemic. In the USA, the incidence and prevalence of HIV cannot be understood without reference to race, class and other fundamental disparities. There remains an urgent need to create an enabling environment such that the State is obliged to provide basic services, regardless of people's sexual orientation. Sexuality education needs to be recognized as a fundamental human right. There is a need for better data on gay and other men who have sex with men, to ensure that their interests are taken account of in

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budget allocation.

‘Sero-selection’ is becoming a key issue affecting partner choice and transmission. This and related concerns need to be explored further.

In discussion, a variety of points were raised. They included the following.

- 1) The continuing lack of good quality epidemiological, behavioural and social data so that we can better understand the issues to be addressed.
- 2) The need for a stronger evidence base and the importance of balancing qualitative and quantitative work in understanding men who have sex with men’s circumstances, situations and needs.
- 3) Issues of legality and human rights—and the respective roles of governments and different government departments in responding to these concerns (including the decriminalisation of homosexuality where relevant).
- 4) The importance of promoting condoms—how best to keep condom culture alive.
- 5) How best to scale up—too often small and often piecemeal projects are taking the place of a coherent and enduring national response.
- 6) The need to recognize the place and needs of transgendered people within the epidemic.
- 7) The need to keep pace with both changing and emerging nature of gay and other communities of men who have sex with men.
- 8) The need to recognize that there are increased numbers of infections through male-to-male sex throughout the developing world.
- 9) The need to recognize the existence of different forms of unprotected sex among gay and other men who have sex with men—for example positive-positive sex, and not all of which can be encompassed by the rubrics of ‘barebacking’.
- 10) The importance of sero-sorting and partner selection based on HIV status as new issues.

There followed some discussion of the role of UNAIDS in future work with men who have sex with men. Among the priority issues highlighted were the importance of the following points.

- 1) Using internationally agreed human rights instruments and global guidelines as leveraging points for a more comprehensive and equitable response.
- 2) Acting as an advocate for those who might otherwise be marginalized in the face of the epidemic.
- 3) Promoting recognition of the role of culture, religion and gender stereotypes as determinants of negative responses towards men who have sex with men in the face of the epidemic.
- 4) Undertaking advocacy for rights-based, scaled-up and inclusive responses in HIV prevention, treatment and care.
- 5) Being proactive in relation to meeting the needs of men who have sex with men with respect to HIV prevention, treatment and care, including encouraging recognition of their diversity and changes over time.

Regional issues

Discussion then focused on the identification of regional issues and concerns relevant to the advancement of HIV prevention, treatment and care. Participants divided into four affinity groups based on place of residence or work. Each group was then invited to identify a range of priorities for action at regional level.

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Africa

- 1) In general, there are legal and religious issues pertaining to the influence of Islamic and Christian belief systems that need to be tackled if progress is to be made. Even in contexts where discrimination on grounds of sexuality is outlawed and rights are protected (e.g. in South Africa with respect to constitutional rights), this does not necessarily ameliorate prejudice.
- 2) Because of the illegality of male-to-male sex in many contexts and resultant stigma, it is difficult to get good data of relevance to HIV prevention, treatment and care among men who have sex with men.
- 3) There are huge differences between and within countries in the way people identify themselves sexually, so 'hard' comparative data is often difficult to come by.
- 4) There may be important generational differences with respect to openness about and willingness to discuss sexuality (including male-to-male sex).
- 5) There is an urgent need for better training on research among men who have sex with men. To date, it has been difficult or sometimes impossible to involve communities in research and policy formation.
- 6) The view still exists in many African communities that homosexuality and male-to-male sex is not indigenous and has been imported from outside.
- 7) New technologies, including the internet, present new opportunities for information sharing and community building.
- 8) There has to date been a greater emphasis on primary prevention but at the expense of support for people living with HIV.
- 9) Country-level policies towards groups such as men who have sex with men are often influenced by donor priorities and discourse. These raise questions about who controls the HIV prevention agenda and what kinds of sexualities can be addressed.

Latin America and Caribbean

- 1) There is enormous diversity across the region. Data indicate that there are concentrated HIV epidemics among men who have sex with men in some countries. In other places, more generalized epidemics prevail.
- 2) Some Latin American countries do not have laws prohibiting sex between men. In others, male-to-male sex is illegal.
- 3) Some countries have universal access to antiretroviral therapy. In others, access is uneven or is in the process of being developed.
- 4) A few countries have undertaken campaigns against homophobia and hate crimes based on sexuality. In others, a more negative discourse prevails.
- 5) There are important 'horizontal' linkages between Latin American countries that can be built upon in advancing HIV prevention treatment and care agendas, including work with men who have sex with men. The Brazilian AIDS Program has been regionally very influential.
- 6) Nongovernmental and civil society organisations can sometimes feel like 'prisoners' to treatment-centred and epidemiological approaches. There is a need to retain their vitality and closeness to the grass roots, not to have them reduced to being to epidemiological targets. It is critical to maintain the intactness of different agendas and stances.
- 7) Efforts need to be directed towards the public health sector to make practice in HIV prevention treatment and care for men who have sex with men stronger and better.
- 8) There may be profound differences of need and response between urban and rural areas—for

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example, in relation to attitudes towards men who have sex with men, responses to HIV, local epidemiology and so on.

- 9) In perhaps the majority of countries, 'bisexuals' remain invisible.
- 10) General approaches to male sexual health are still lacking.

Asia

- 1) There is a lack of leadership amongst governments across the region, combined with a lack of money earmarked for HIV prevention, treatment and care for men who have sex with men, and lack of education concerning male-to-male sexuality.
- 2) Stigma concerning male-to-male sex remains common—but its legal status varies across the region (partly corresponding to legacies of colonialism).
- 3) Generally health departments find it difficult to challenge the authority of interior or home affairs ministries with respect to homophobic policies or practice.
- 4) Across all countries there is a social divide between the urban rich and rural poor.
- 5) In some countries, through advocacy, activism and education men who have sex with men have been able to influence the development of national HIV strategies and plans.

Europe and North America

- 1) There is enormous diversity of situation and experience within and across the countries of Europe and North America.
- 2) In perhaps the majority of countries, access to HIV treatment is now a top priority.
- 3) Concomitantly, however, increasing rates of HIV infection can be found among men who have sex with men in many (but not all) of these countries.
- 4) The advent of new prevention technologies and strategies raise new issues (e.g. in relation to 'negotiated safety', positive-positive sex, sero-sorting, etc).
- 5) HIV prevention to be renewed and sustained over time.
- 6) Sustained effort is needed to promote public concern for the HIV-related needs of gay men and other men who have sex with men at all policy levels.

A recurrent theme

Across all regions, a core problem was identified as hampering the development of HIV prevention, treatment and care with men who have sex with men. Put quite simply, there is lack of funding because there is a lack of evidence; and there is a lack of evidence because there is a lack of funding.

From understanding to action

Dr Purnima Mane and Dr Anindya Chatterjee drew the meeting's attention to two documents on which views were welcomed: these were the (i) UNAIDS policy position paper on *Intensifying HIV Prevention* and (ii) the UNAIDS Position Paper on HIV and *Men who have Sex with Men*.

Dr Purnima Mane introduced the first of these papers by explaining that the intention was to energise the emphasis placed on HIV prevention in the context of treatment. Of key concern is the fact that the number of people living with HIV is rising, while prevention coverage remains poor. There needs to be greater emphasis on the real synergy between treatment and prevention. What though does this mean for future work with men who have sex with men?

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Key aspects of the general way forward are described in the UNAIDS Position Paper on *HIV and Men who have Sex with Men* on which comments were welcomed, but publication of which predates the policy position paper described above. Detailed feedback on this latter document should be provided to the UNAIDS Secretariat.

In the interim, the meeting was convened to focus on two key questions: namely, (i) the essential policy and programmatic actions that need to be taken to scale and intensify HIV prevention; and (ii) the key elements of a successful national-level response. A wide range of options were identified as listed below.

Essential policy and programmatic actions

Policy actions

1. Repeal laws prohibiting male-to-male sex (e.g. existing sodomy laws).
2. Ensure the existence of anti-discrimination legislation on the grounds of sexual orientation, gender identity and HIV status.
3. Ensure specific reference is made to sexuality/sexual orientation in human rights frameworks and antidiscrimination legislation.
4. Promote the effective enforcement of anti-discrimination laws as above.
5. Take action to eliminate: stigma in healthcare settings; homophobic violence.
6. Ensure specific mention of men who have sex with men as a key affected group in plans for HIV prevention and care.
7. Promote sexuality education, which includes respect for sexual diversity, gender equality, and gender identity.
8. Actively monitor human rights violations against men who have sex with men and other sexual minorities.
9. Encourage a strengthened relationship between members of the UNAIDS family with respect to work to meet the prevention, treatment and care needs of men who have sex with men.
10. Promote wider understanding and action to ensure the protection of health as a fundamental human right regardless of sexual orientation or sexual identity.
11. Promote best practices in stigma reduction relevant to men who have sex with men especially with respect to HIV.
12. Ensure access to HIV prevention (including condoms) by men who have sex with men in all-male settings and institutions.
13. Ensure the active recruitment and involvement of sexual minorities including men who have sex with men in policy and decision making relating to HIV.
14. Address gender issues through a broader approach which recognizes the rights and circumstances of transgendered people and men who have sex with men.
15. Generalize concern for HIV and men who have sex with men throughout health education and health promotion.
16. Promote research on rectal microbicides.
17. Ensure sufficient resources for the conduct of good quality epidemiological and social research on men who have sex with men.

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Programmatic Actions

1. Undertake heightened advocacy among UNAIDS Cosponsors to ensure that concern for HIV prevention, treatment and care among men who have sex with men remains high on the agenda.
2. Give support to and provide technical assistance to countries to build and/or improve a comprehensive programmatic response to men who have sex with men (focusing on prevention and care needs) in all national HIV plans.
3. Help countries identify and define “comprehensive” programmes of relevance to men who have sex with men.
4. Encourage multilateral and bilateral agencies to support men who have sex with men-related HIV prevention and AIDS care programmes.
5. Promote initial training and continuing professional development on issues of relevance to HIV and men who have sex with men for national authorities and UN system agencies active in the response to AIDS
6. Harness new opportunities to promote HIV prevention for men who have sex with men within expanded treatment access programmes.
7. Review epidemiological surveillance protocols to insure that men who have sex with men are appropriately addressed within these, even in contexts where the epidemic is not directly driven by male-to-male sex.
8. Ensure the production, dissemination and utilization of voluntary confidential counselling and testing guidelines that are more friendly to men who have sex with men.
9. Provide/produce guidelines and technical assistance to reduce homophobia and ignorance among healthcare workers.
10. Increase access to HIV treatment for men who have sex with men.
11. Encourage good quality social and behavioural research on men who have sex with men even in countries that deny it exists.
12. Promote greater recognition that male-to-male sex is a fact in all societies that should always be considered in all HIV prevention and care programming.
13. Support civil society organisations at local, national and regional level in their work on HIV and sexual rights.
14. Strengthen leadership by UNAIDS on men-who-have-sex-with-men issues.
15. Create an Inter-Agency Task Team on HIV and men who have sex with men.

Key elements of a national level response

A number of elements were identified as central to coherent and potentially successful national-level responses to HIV prevention, treatment and care for men who have sex with men.

- 1) **National commitment to protect the rights of men who have sex with men.** There should be clear and unequivocal national government commitment to protect the rights of men who have sex with men. This requires commitment from all parts of the government including National AIDS Councils and ministries of health, as well as others, including ministries of interior/home affairs and education, the police and the judiciary.
- 2) **Genuine community participation and representation in planning and implementation.** Tokenism and lack of transparency should be avoided and appropriate selection of community representatives should be ensured.

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3) Prioritize the special needs of men who have sex with men in the national strategic plans.

There should be a specific HIV prevention and AIDS treatment and care plan for men who have sex with men as part of the one agreed national AIDS action framework. Planning and Programme implementation of this plan should proceed from a sound epidemiological, behavioural and contextual evidence base. A comprehensive set of programmes should include peer-led education, outreach work, availability and access to HIV counselling and testing, sexually transmitted infection treatment, condoms and lubricants, AIDS treatment and care. Such a plan should ensure that an environment is created that enables programmes for men who have sex with men to operate effectively.

4) Increase coverage and fully fund programmes for men who have sex with men. Coverage and resource allocation for programmes aimed at men who have sex with men in most countries is inadequate. Implementing scaled up programmes requires on-going and sustained financial commitments. This is necessary to allow programmatic expansion, long-term planning, institutional strengthening and capacity building. As scaling up takes place, quality assurance procedures should also be put in place to monitor programmes developed and services provided.

5) Create a vocal constituency for men who have sex with men. Advocacy for HIV prevention, treatment and care for men who have sex with men is a key element of scaling up response and appropriate resource allocation should be made. Alliances should be built between epidemiologists, social scientists, politicians, human rights groups, lawyers, clinicians, journalists, groups of men who have sex with men and civil society organisations.

Apportioning responsibility

By way of conclusion, discussion moved to the responsibilities of national governments, international and national nongovernmental organisations and UNAIDS in supporting a comprehensive response to HIV prevention among men who have sex with men.

The meeting agreed that **national government** responsibilities included ensuring the development of comprehensive HIV prevention, treatment and care programmes in which work with men who have sex with men is integral. These programmes should ensure that men who have sex with men have access to the full range of HIV prevention options as well as HIV treatment and care, on an equitable basis with other populations and groups. National governments also have a responsibility to educate and inform people about HIV, tackle stigma and discrimination on grounds of sexuality and HIV, and defend the programmes that have been put in place. National authorities need to be active at times but also need to know when not to react, especially to forms of opposition that might undermine their success in protecting the rights and meeting the needs of diverse constituencies of men who have sex with men.

International and national nongovernmental organisations, on the other hand, have a key role to play in advocacy for government action, in working with national authorities, but also in holding governments to account. They have a special role to play in stimulating and supporting positive community responses to the epidemic; in promoting good practice; and in ensuring strategic alliances with other groups. The latter include organisations that may not yet be active in meeting the needs of men who have sex with men, but which are in a position to make a positive contribution to HIV prevention, treatment and care, respectful of the circumstances and rights of men who have sex with

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men. International and national nongovernmental organisations have a responsibility to be clear about their commitments, goals and roles as well as the partnerships they enter into. They may be able to reach parts of society not easily accessible to national (and local) authorities and have a special role to play in work with vulnerable and 'hard to reach' groups. Their work, however, should not absolve national governments of their responsibility for HIV prevention, treatment and care including among men who have sex with men.

Both the **Secretariat and Cosponsors of UNAIDS** have responsibility for developing better understanding of issues relevant to HIV prevention and men who have sex with men throughout the UN system. To this effect, they may wish to consider the creation of a reference group on HIV and men who have sex with men to help guide them in their work. Work should also take place towards the development of a position paper on men who have sex with men and HIV for consideration first by the Committee of Cosponsoring Organizations and then endorsement by the UNAIDS Program Coordinating Board. Beyond this, UNAIDS has a responsibility for developing guidance to theme groups issues of relevance to HIV and men who have sex with men, and how to take forward programming with their national counterparts. Additional actions to be considered include closer work with the Special Rapporteur on the Right to Health of the United Nations Commission on Human Rights (to ensure that the rights of men who have sex with men are duly considered), with the United Nations Development Program (to promote relevant legal reform), and to ensure that the UNAIDS Action Plan for Intensifying Prevention is specific in its recommendations concerning future work with men who have sex with men.

Concluding comments

Dr Purnima Mane closed the meeting by thanking participants for their time and contributions. She indicated that UNAIDS took very seriously the comments and recommendations that had been made.

Key priorities for the future included ensuring greater 'presence' for work on HIV prevention and men who have sex with men. She was heartened by the strong emphasis given throughout the meeting to issues of gender and human rights, as well as the need to promote a strong evidence base. She looked forward to future occasions upon which a stakeholder consultation might take place and undertook to ensure that the UNAIDS Position Paper on *HIV and Men who have Sex with Men* was further developed prior to dissemination.

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The UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health

Introduction

1. The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health presented his preliminary report to the Commission on Human Rights at its fifty-ninth session in April 2003 (E/CN.4/2003/58). The report outlines the approach the Special Rapporteur proposes to take to his mandate, including basic objectives, main themes and key initiatives to be pursued. In its resolution 2003/28, the Commission on Human Rights took note of the preliminary report with interest and invited the Special Rapporteur to pay particular attention to the linkages between poverty reduction strategies and the right to health, as well as between the realization of this right and aspects of discrimination and stigma. It further asked him to give particular attention to the identification of best practices for the effective operationalization of the right to health. The Commission requested the Special Rapporteur to pursue his analysis of the issues of neglected diseases, including very neglected diseases, and the role of health impact assessments. It asked him to submit an annual report to the Commission on the activities undertaken in the course of his mandate, as well as an interim report to the General Assembly.

Recent activities

2. The Special Rapporteur submitted his first interim report to the General Assembly (A/57/427) in November 2003. The report reflects on the activities of, and issues of particular interest to, the Special Rapporteur in the period since his preliminary report to the Commission. It addresses the issue of right to health indicators which, in the view of the Special Rapporteur, can help States and others recognize when national and international policy adjustments are required. The report also provides an introductory overview of some of the conceptual and other issues arising from right to health good practices. It addresses the Special Rapporteur's concern about the continuing obstacles to ensuring access to prevention and treatment for HIV/AIDS, and it also highlights the need to address the right to health implications of neglected diseases. In its resolution 2003/18, the Commission on Human Rights invited all special rapporteurs whose mandates deal with economic, social and cultural rights to comment on the proposal for an optional protocol to the International Covenant on Economic, Social and Cultural Rights. Accordingly, in his interim report the Special Rapporteur made some observations on this issue.

3. In October 2003, at the invitation of the Canadian Society for International Health (CSIH) and Action Canada for Population and Development (ACPD), the Special Rapporteur attended the Tenth Annual Canadian Conference on International Health, at which he delivered a keynote presentation on "The

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right to health: new opportunities and challenges". While visiting Canada, the Special Rapporteur attended a series of informal meetings with Ottawa-based officials at the Canadian International Development Agency, the Department of Justice Canada, the Department of Foreign Affairs and International Trade, and Health Canada. Additionally, he met with several civil society organisations in Ottawa and participated in a round table discussion, with non-governmental organisations (NGOs), on the right to health. He also met with representatives of indigenous communities to discuss issues concerning aboriginal health and related policies at federal and provincial levels. The Special Rapporteur is most grateful to all those who organized or participated in these meetings, and especially to CSIH and ACPD for the initial invitation to visit Canada.

4. While in the United States of America to present his interim report to the General Assembly, the Special Rapporteur took the opportunity to meet with World Health Organization (WHO) representatives in New York and representatives of the United Nations Population Fund (UNFPA). He also met with officials working on the Millennium Project, as well as Millennium Development Goal Task Force members. He spoke at a conference, organized by the New York University Center for Human Rights and Global Justice, on human rights and the Millennium Development Goals. The Special Rapporteur travelled to Washington D.C. for meetings at the World Bank to discuss poverty and health issues. In both New York and Washington, the Special Rapporteur met with members of a number of NGOs. Other activities undertaken by the Special Rapporteur during the reporting period are reflected in the report of the Secretary-General on economic, social and cultural rights (E/CN.4/2004/38, paragraphs 11 and 15).

Individual communications

5. In accordance with resolution 2002/31, paragraph 5 (a), the Special Rapporteur has received information on the right to health from NGOs and individuals. Some of this information has included alleged violations of the right to health. Several of these allegations have related to a lack of access to health care, goods and services for detainees or prisoners. In some cases, State authorities have allegedly denied access to health care for people in detention who were in need of medical assistance. Information has also been received on allegations involving the persecution of health professionals on account of their professional activities; discrimination against particular individuals or groups on the basis of their health status, including HIV/AIDS; non-consensual medical treatment; abusive treatment of mental health patients; and denial of health services for migrant workers. The Special Rapporteur wishes to emphasize that some of the allegations that have been brought to his attention would appear to be extremely serious and highly credible.

6. In the light of resolution 2002/31, paragraph 5 (a)-(d) inclusive, the Special Rapporteur has responded to some of the information received by writing to the Government concerned, either together with other special procedure mandates or independently, inviting comment on the allegation, seeking clarification, reminding the Government of its obligations under international law in relation to the right to health and requesting information, where relevant, on steps being taken by the authorities to redress the situation in question. The Special Rapporteur is grateful for the responses he has received from a few Governments. He urges all Governments to respond promptly to his communications and, in appropriate cases, to take all steps necessary to redress situations involving the violation of the right to health.

16 I. The rights to sexual and reproductive health

7. The International Conference on Population and Development (ICPD), held in Cairo in 1994, was a landmark event because participating States recognized that sexual and reproductive health is fundamental to individuals, couples and families, as well as to the social and economic development of communities and nations. The Conference signalled a move away from narrowly focused family planning programmes, placed women at the centre of an integrated approach to reproduction, and recognized that human rights have a crucial role to play in relation to sexual and reproductive health. The following year, this new approach was reaffirmed at the Fourth World Conference on Women held in Beijing. **1**

8. As part of his contribution to the tenth anniversary of ICPD, the Special Rapporteur is devoting this section of his report to sexual and reproductive health. These issues are among the most sensitive and controversial in international human rights law, but they are also among the most important. Their sensitivity and importance is reflected in the Millennium Development Goals that derive from the Millennium Declaration. On the one hand, the Goals do not expressly refer to sexual and reproductive health; on the other hand, at least three of the eight Goals – on maternal health, child health and HIV/AIDS – are directly related to sexual and reproductive health. **2** The Special Rapporteur encourages all actors to recognize explicitly that sexual and reproductive health issues have a vital role to play in the global struggle against poverty.

9. As confirmed by the Commission on Human Rights in 2003, “sexual and reproductive health are integral elements of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”. **3** This report explores the implications of this crucial proposition by drawing upon world conference outcomes, in particular ICPD, the Fourth World Conference on Women and their respective five-year reviews, as well as international human rights instruments, including the Universal Declaration of Human Rights, the Convention on the Elimination of All Forms of Discrimination against Women, the International Covenant on Economic, Social and Cultural Rights and the Convention on the Rights of the Child. The following discussion is also informed by the key principles that shape human rights, in particular non-discrimination, equality and privacy, as well as the integrity, autonomy, dignity and well-being of the individual.

10. Not only are sexual and reproductive health issues sensitive, controversial and important, they are also large and complex. The following observations are not comprehensive. The Special Rapporteur hopes, however, that they will contribute to a deeper appreciation of one of the achievements of ICPD: the recognition that human rights have an indispensable role to play in relation to sexual and reproductive health. He also hopes that the following paragraphs will encourage a greater awareness that ICPD, the Fourth World Conference on Women and the United Nations human rights system represent mutually reinforcing norms and processes.

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The magnitude of the challenge

11. Sexual and reproductive ill health gives rise to nearly 20 per cent of the global burden of ill health for women and 14 per cent for men. In 2000, an estimated 529,000 women died from pregnancy-related causes, most of which were avoidable; 99 per cent of maternal deaths occur in developing countries. In States in transition and developing countries, more than 120 million couples are not using any contraception despite their wish to avoid or space children. About 80 million women annually experience unintended pregnancies, some 45 million of whom have abortions. Of this number, some 19 million women undergo unsafe abortions, resulting in 68,000 deaths, i.e. 13 per cent of all pregnancy-related deaths. **5** Apart from mortality, unsafe abortion also gives rise to high rates of morbidity.

12. In addition, 340 million new cases of largely treatable sexually transmitted bacterial infections occur annually. Many are untreated. Millions of mostly incurable viral infections occur each year, including 5 million new HIV infections of which 600,000 are mother-to-child transmissions to infants. Six thousand young people aged 15-24 years become infected with HIV daily. In sub-Saharan Africa and South Asia, about 65 per cent of young people living with HIV/AIDS are female.

13. Of course, not all sexual and reproductive ill health represents a violation of the right to health or other human rights. Ill health constitutes a human rights violation when it arises, in whole or in part, from the failure of a duty-bearer - typically a State - to respect, protect or fulfil a human rights obligation. Obstacles stand between individuals and their enjoyment of sexual and reproductive health. From the human rights perspective, a key question is: are human rights duty-bearers doing all in their power to dismantle these barriers?

14. Many of the numerous obstacles to sexual and reproductive health are interrelated and entrenched. They operate at different levels: clinical care, the level of health systems, and the underlying determinants of health. **6** In addition to biological factors, social and economic conditions play a significant role in determining women's sexual and reproductive health. The low social status of girls and women frequently contribute to their sexual and reproductive ill health. Many women experience violence during pregnancy, which may give rise to miscarriage, premature labour and low birth weight. Some traditional views about sexuality are obstacles to the provision of sexual and reproductive health services, including reliable information, and these views have an especially damaging impact upon adolescents. **7** Poverty is associated with inequitable access to both health services and the underlying determinants of health. Too often, improvements in public health services disproportionately benefit those who are better off.

15. Applying human rights to these questions can deepen analysis and help to identify effective, equitable and evidence-based policies to address these complex problems. Crucially, human rights law places obligations on duty-bearers to do all they can to dismantle the barriers to sexual and reproductive health. In relation to sexual and reproductive health, human rights norms have the potential to inform and empower vulnerable individuals and disadvantaged communities. Before considering these issues further in the particular context of the right to health, some observations are required about the approaches of ICPD and the Fourth World Conference on Women to human rights and sexual and reproductive health.

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Cairo: some key definitions

16. Adopted by consensus, the International Conference on Population and Development Program of Action (A/CONF.171/13, chap. I, sect. 1) includes some principles and definitions that were groundbreaking in the context of sexual and reproductive health. They remain highly relevant today.

17. Chapter II confirms 15 principles that guided - and “will continue to” guide – participants at Cairo. Principle 1 begins: “All human beings are born free and equal in dignity and rights.” According to principle 8: “Everyone has the right to the enjoyment of the highest attainable standard of physical and mental health. States should take all appropriate measures to ensure, on a basis of equality of men and women, universal access to health-care services, including those related to reproductive health care, which includes family planning and sexual health.”

Principle 3 confirms: “The right to development is a universal and inalienable right and an integral part of fundamental human rights.” Several other principles refer explicitly to other human rights. In short, the principles provide a human rights framework upon which to construct sexual and reproductive health laws, policies, programmes and projects. **8**

18. Chapter VII - which, significantly, is entitled “Reproductive rights and reproductive health” - is a key chapter. Paragraphs 7.2 and 7.3 are lengthy, but they are so important in the present context that it is necessary to reproduce them:

“7.2. Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.

Implicit in the last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth, and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases.”

“7.3. Bearing in mind the above definition, reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. In the exercise of this right, they should take into account the needs of their living and future children and their

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responsibilities towards the community. The promotion of the responsible exercise of these rights for all people should be the fundamental basis for government- and community-supported policies and programmes in the area of reproductive health, including family planning.

Note that the Committee on Economic, Social and Cultural Rights has considered discrimination in access to health care on the grounds of sexual orientation as an issue of status. See General Comment 14, paragraph.18 on the right to the highest attainable standard of health. See E/C.12/2000/4, 411 August 2000. 9

19. The following year, the Fourth World Conference on Women adopted, also by consensus, identical provisions in the Beijing Platform for Action (A/CONF.177/20/Rev.1, chap. I, sect. I). **10** In Beijing, however, participants added: “The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences” (paragraph 96).

20. The Special Rapporteur will not analyse these provisions in detail but confine himself to three observations arising from the Cairo and Beijing consensus:

(a) In relation to sexual and reproductive health there are a number of interrelated and complementary human rights, such as those set out in paragraphs 7.2 and 7.3 of the ICPD Program of Action, e.g. “the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice”;

(b) The most encompassing of these rights is the “right to attain the highest standard of sexual and reproductive health”, which also resonates with principle 8;

(c) While there is obviously an intimate relationship between sexual health and reproductive health, ICPD and the Fourth World Conference on Women recognize that sexual health and reproductive health are also different and distinct dimensions of human well-being.

21. In the next section, the Special Rapporteur considers sexual and reproductive health in the context of the right to health and the Cairo and Beijing consensus. However, looking back at ICPD after 10 years, the Special Rapporteur is concerned about some limitations in relation to the definitions adopted. Accordingly, he makes some concluding remarks below on these issues.

Evolving standards and obligations

22. In his preliminary report, the Special Rapporteur outlined the scope of the international right to health by drawing upon existing norms and concepts such as freedoms, entitlements, immediate obligations, international assistance and cooperation (E/CN.4/2003/58, paragraphs. 22 to 36). In the present report, he begins to apply these approaches to sexual and reproductive health in the context of Cairo, Beijing and their respective five-year reviews. As he did in his preliminary report, the Special Rapporteur also draws upon the relevant jurisprudential and policy insights provided by United Nations human rights treaty bodies in the light of their experience examining States parties’ reports over many years. **11** He proceeds on the basis that sexual and reproductive health are “integral elements” of the right to health. **12**

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23. Inevitably, there is some overlap among the following paragraphs. For example, discrimination features in most sections and, additionally, a separate section is devoted to vulnerability, discrimination and stigma. In the view of the Special Rapporteur, this focus is appropriate because of the widespread and entrenched nature of multidimensional discrimination in the context of sexual and reproductive health. **13**

Freedoms

24. The right to health, including sexual and reproductive health, encompasses both freedoms, such as freedom from discrimination, and entitlements.

25. In the context of sexual and reproductive health, freedoms include a right to control one's health and body. Rape and other forms of sexual violence, including forced pregnancy, non-consensual contraceptive methods (e.g. forced sterilization and forced abortion), female genital mutilation/cutting (FGM/C), and forced marriage all represent serious breaches of sexual and reproductive freedoms, and are fundamentally and inherently inconsistent with the right to health.

26. Some cultural practices, including FGM/C, carry a high risk of disability and death. Where the practice exists, States should take appropriate and effective measures to eradicate it and other harmful practices, in accordance with their obligations under the Convention on the Rights of the Child. Early marriage, which disproportionately affects girls, is predominantly found in South Asia and sub-Saharan Africa, where over 50 per cent of girls are married by the age of 18. Among other problems, early marriage is linked to health risks including those arising from premature pregnancy. In the context of adolescent health, States are obliged to set minimum ages for sexual consent and marriage. **14**

27. It should be emphasized that although subject to progressive realization and resource constraints, the international right to health imposes various obligations of immediate effect (*ibid.*, paragraph 27). These immediate obligations include a duty on the State to respect an individual's freedom to control his or her health and body. For example, there is an immediate obligation on a State not to engage in forced sterilization and not to engage in discriminatory practices. In other words, the freedom components of sexual and reproductive health are subject to neither progressive realization nor resource availability.

Entitlements

28. The right to health includes an entitlement to a system of health protection, including health care and the underlying determinants of health, which provides equality of opportunity for people to enjoy the highest attainable level of health. **15** For example, women should have equal access, in law and fact, to information on sexual and reproductive health issues.

29. Thus, States have an obligation to ensure reproductive health and maternal and child health services, including appropriate services for women in connection with pregnancy, granting free services where necessary. **16** More particularly, States should improve a wide range of sexual and reproductive health services, including access to family planning, pre- and post-natal care, emergency obstetric services and access to information. The Special Rapporteur urges all duty-holders also to ensure access to such vital health services as voluntary testing, counselling and treatment for sexually

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transmitted infections, including HIV/AIDS, and breast and reproductive system cancers, as well as infertility treatment.

30. As pointed out in paragraph 11 above, unsafe abortions kill some 68,000 women each year, a right to life and right to health issue of enormous proportions. **17** Women with unwanted pregnancies should be offered reliable information and compassionate counselling, including information on where and when a pregnancy may be terminated legally. Where abortions are legal, they must be safe: public health systems should train and equip health service providers and take other measures to ensure that such abortions are not only safe but accessible. **18** In all cases, women should have access to quality services for the management of complications arising from abortion. Punitive provisions against women who undergo abortions must be removed.

31. Even when resources are scarce, States can achieve major improvements in the sexual and reproductive health of their populations. For example, Sri Lanka has made significant advances over the last decades in relation to sexual and reproductive health by improving education, increasing female literacy, enhancing the quality of health-care services, and making them more available and accessible. **19**

Vulnerability, discrimination and stigma

32. International human rights law proscribes discrimination in access to health care and the underlying determinants of health, and to the means for their procurement, on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation, and civil, political, social or other status that has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health (ibid., paragraphs. 26 and 59-68).

33. Nonetheless, discrimination and stigma continue to pose a serious threat to sexual and reproductive health for many groups, including women, sexual minorities, refugees, people with disabilities, rural communities, indigenous persons, people living with HIV/AIDS, sex workers, and people held in detention. Some individuals suffer discrimination on several grounds e.g. gender, race, poverty and health status (ibid., paragraph 62).

34. Discrimination based on gender hinders women's ability to protect themselves from HIV infection and to respond to the consequences of HIV infection. The vulnerability of women and girls to HIV and AIDS is compounded by other human rights issues including inadequate access to information, education and services necessary to ensure sexual health; sexual violence; harmful traditional or customary practices affecting the health of women and children (such as early and forced marriage); and lack of legal capacity and equality in areas such as marriage and divorce.

35. Stigma and discrimination associated with HIV/AIDS may also reinforce other prejudices, discrimination and inequalities related to gender and sexuality. The result is that those affected may be reluctant to seek health and social services, information, education and counselling, even when those services are available. This, in turn, contributes to the vulnerability of others to HIV infection.

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36. Adolescents and young people under 25 years of age are especially vulnerable in the context of sexual and reproductive health. Adolescence is a period characterized by sexual and reproductive maturation. Yet in many countries adolescents lack access to essential and relevant information and services in relation to sexual and reproductive health. Their need is acute. An estimated 16 per cent of all new HIV infections occur among those under age 15, while 42 per cent of new infections occur among those aged 15-24. Every year there are 100 million new, largely curable, reported cases of sexually transmitted infections among adolescents.

37. In the context of adolescent health, the Special Rapporteur recalls the right of children to “access information and material from a diversity of national and international sources, especially those aimed at the promotion of his or her social, spiritual and moral well-being and physical and mental health”; **20** respect of privacy and confidentiality, including in relation to medical information of adolescents; **21** and protections against all forms of abuse, neglect, violence and exploitation. **22** He also recalls the underlying principles of the Convention on the Rights of the Child, namely the child’s right to respect for its survival and development, its best interests and its evolving capacities, as well as the right to non-discrimination, and the importance of involving adolescents in an appropriate manner in developing measures designed for their protection. **23**

38. As has been noted, discrimination on the grounds of sexual orientation is impermissible under international human rights law. The legal prohibition of same-sex relations in many countries, in conjunction with a widespread lack of support or protection for sexual minorities against violence and discrimination, impedes the enjoyment of sexual and reproductive health by many people with lesbian, gay, bisexual and transgender identities or conduct. **24** Additionally, the Special Rapporteur recalls that the Human Rights Committee, in *Toonen v. Australia*, observed: “Criminalization of homosexual activity ... would appear to run counter to the implementation of effective education programmes in respect of HIV/AIDS prevention.” **25**

39. Arising from their obligations to combat discrimination, States have a duty to ensure that health information and services are made available to vulnerable groups. For example, they must take steps to empower women to make decisions in relation to their sexual and reproductive health, free of coercion, violence and discrimination. They must take action to redress gender-based violence and ensure that there are sensitive and compassionate services available for the survivors of gender-based violence, including rape and incest. States should ensure that adolescents are able to receive information, including on family planning and contraceptives, the dangers of early pregnancy and the prevention of sexually transmitted infections including HIV/AIDS, as well as appropriate services for sexual and reproductive health. Consistent with *Toonen v. Australia* and numerous other international and national decisions, they should ensure that sexual and other health services are available for men who have sex with men, lesbians, and transsexual and bisexual people. It is also important to ensure that voluntary counselling, testing and treatment of sexually transmitted infections are available for sex workers.

40. Finally, in the context of sexual and reproductive health, breaches of medical confidentiality may occur. Sometimes these breaches, when accompanied by stigmatization, lead to unlawful dismissal from employment, expulsion from families and communities, physical assault and other abuse. Also, a

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lack of confidentiality may deter individuals from seeking advice and treatment, thereby jeopardizing their health and well-being. Thus, States are obliged to take effective measures to ensure medical confidentiality and privacy.

Available, accessible, acceptable and good quality

41. Analytical frameworks or tools can deepen our understanding of economic, social and cultural rights, including the right to health (ibid., paragraphs. 33-36). One framework that is especially useful in the context of policy-making is that health services, goods and facilities, including the underlying determinants of health, shall be available, accessible, acceptable and of good quality. This analytical framework encompasses sexual and reproductive health. For example, sexual and reproductive health services, goods and facilities must be: available in adequate numbers within the jurisdiction of a State; accessible geographically, economically (i.e. be affordable) and without discrimination; culturally acceptable to, for example, minorities and indigenous peoples, as well as sensitive to gender and life-cycle requirements, and respectful of confidentiality; and scientifically and medically appropriate and of good quality.

42. When this framework is applied to sexual and reproductive health, it is clear that the key elements of availability, accessibility and so on are frequently absent. For example, in many countries, information on sexual and reproductive health is not readily available and, if it is, it is not accessible to all, in particular women and adolescents. Sexual and reproductive health services are often geographically inaccessible to communities living in rural areas. These services are sometimes not provided in a form that is culturally acceptable to indigenous peoples and other non-dominant groups. Lastly, services, and relevant underlying determinants of health, such as education, are often of substandard quality.

Respect, protect and fulfil

43. Another useful analytical framework is that States have specific obligations under international law to respect, protect and fulfil the right to health (ibid., paragraph 35). While the framework outlined in the preceding paragraphs (availability, etc.) is especially helpful in the context of policy-making, the respect, protect and fulfil framework is especially useful as a way of sharpening legal analysis of the right to health, including sexual and reproductive health.

44. The obligation to respect requires States to refrain from denying or limiting equal access for all persons to sexual and reproductive health services, as well as the underlying determinants of sexual and reproductive health. For example, it requires them to refrain from denying the right to decide on the number and spacing of children. The obligation to protect means that States should take steps to prevent third parties from jeopardizing the sexual and reproductive health of others, including through sexual violence and harmful cultural practices. For example, countries such as Burkina Faso, Ghana, Senegal and the United Kingdom of Great Britain and Northern Ireland, have enacted laws that specifically prohibit female genital cutting. The obligation to fulfil requires States to give recognition to the right to health, including sexual and reproductive health, in national political and legal systems. Health systems should provide for sexual and reproductive health services for all, including in rural areas, and States should carry out information campaigns to combat, for example, HIV/AIDS, harmful traditional practices and domestic violence.

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International assistance and cooperation

45. In addition to obligations at the domestic level, developed States have a responsibility to provide international assistance and cooperation to ensure the realization of economic, social and cultural rights in low-income countries. This responsibility arises from recent world conferences, including the Millennium Summit, as well as provisions of international human rights law. **26**

46. Thus, States should respect the right to health in other countries, ensure that their actions as members of international organisations take due account of the right to health, and that they pay particular attention to helping other States give effect to minimum essential levels of health. The donor community provides important funding for sexual and reproductive health care in many low-income countries. The Special Rapporteur urges those countries providing assistance to adopt a rights-based approach to their policies and programmes. For example, their funding should promote access to a wide range of services needed for the enjoyment of the right to sexual and reproductive health, including services and information that reduce the incidence of unsafe abortions.

47. Increasingly, bilateral and multilateral donors are providing health-budget - rather than project-specific - support. Broadly speaking, the Special Rapporteur welcomes such sector-wide approaches. However, it is of the first importance that sexual and reproductive health not be marginalized in a sectoral approach. There is a high risk of marginalization because of the sensitivities associated with some sexual and reproductive health issues. It is for this reason that the Special Rapporteur urges all actors, despite the sensitivities, to recognize explicitly the indispensable role of sexual and reproductive health in the struggle against poverty. Explicit recognition is important because what is unnamed is more likely to be unsupported.

Conclusion

48. The right to health requires that health policies, programmes and projects are participatory. The active and informed participation of all stakeholders can broaden consensus and a sense of “ownership”, promote collaboration and increase the chances of success. Since sexual and reproductive health are integral elements of the right to health, it follows that all initiatives for the promotion and protection of sexual and reproductive health must be formulated, implemented and monitored in a participatory manner.

49. The right to health also demands accountability. Without mechanisms of accountability, the obligations arising from the right to health are unlikely to be fully respected. This applies equally to the integral elements of sexual and reproductive health. Thus, all initiatives for the promotion and protection of sexual and reproductive health must include effective, accessible and transparent mechanisms of accountability in relation to all duty-bearers.

Concluding remarks: Cairo+10

50. In the preceding section, the Special Rapporteur considered sexual and reproductive health in the light of the right to health and the consensus adopted at Cairo and Beijing. As the Special Rapporteur has observed, the Cairo conference was a landmark event with notable achievements. However, as part of the 10-year review, it is timely to examine ICPD critically. It is in that context that the Special Rapporteur makes the following observations. **27**

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51. First, the two conferences confirmed that:

(a) Numerous human rights have a direct bearing upon sexual and reproductive health; **28**

(b) There are “reproductive rights”; **29**

(c) There is a “right to attain the highest standard of sexual and reproductive health”; **30**

(d) Sexual health and reproductive health are intimately related, but distinct, dimensions of human well-being. **31**

52. Second, while they recognized sexual health as distinct from reproductive health, they did not explicitly and unequivocally recognize sexual rights as distinct from reproductive rights. **32**

53. Third, they provided a short definition of sexual health: “the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases”. **33** A fuller definition of sexual health is a state of physical, emotional, mental and social well-being related to sexuality, not merely the absence of disease, dysfunction or infirmity; sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.

54. Fourth, sexuality is a characteristic of all human beings. It is a fundamental aspect of an individual’s identity. It helps to define who a person is. The Special Rapporteur notes the abiding principles that have shaped international human rights law since 1945, including privacy, equality, and the integrity, autonomy, dignity and well-being of the individual. The Special Rapporteur also notes the points made in paragraph 51 above, all of which have been widely accepted by the international community. In these circumstances, the Special Rapporteur has no doubt that the correct understanding of fundamental human rights principles, as well as existing human rights norms, leads ineluctably to the recognition of sexual rights as human rights. Sexual rights include the right of all persons to express their sexual orientation, with due regard for the well-being and rights of others, without fear of persecution, denial of liberty or social interference.

55. Fifth, the Special Rapporteur recommends that increased attention be devoted to a proper understanding of sexual health and sexual rights, as well as reproductive health and reproductive rights. **34** The contents of sexual rights, the right to sexual health and the right to reproductive health need further attention, as do the relationships between them. Since many expressions of sexuality are non-reproductive, it is misguided to subsume sexual rights, including the right to sexual health, under reproductive rights and reproductive health. Given the nature of his mandate, the Special Rapporteur has a particular concern with the rights to sexual and reproductive health, hence the title of this section of the report. These rights, however, have to be understood in a broader human rights context that includes sexual rights.

56. Finally, considered together, the rights to sexual and reproductive health have an indispensable role to play in the struggle against intolerance, gender inequality, HIV/AIDS and global poverty.

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II. Poverty and the right to health: The Niger's poverty reduction strategy

57. In his preliminary report to the Commission the Special Rapporteur identifies some particular projects that he would like to undertake, including an examination of poverty reduction strategies through the prism of the right to health. The report emphasizes that he will only undertake these projects so far as “resources and opportunities” permit. The Commission, in resolution 2003/28, invited the Special Rapporteur “to pay particular attention to the linkages between poverty reduction strategies and the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”.

58. In 2002, the Government of the Niger prepared its full Poverty Reduction Strategy (PRS) in the context of the Heavily Indebted Poor Countries Initiative. **35** In June 2003, the Government organized a Forum in Niamey to promote external support for its PRS. Representatives of the Office of the United Nations High Commissioner for Human Rights attended this meeting which, according to reports received by the Special Rapporteur, was both well organized and successful. To its credit, the Government of the Niger recognizes that human rights have an essential role to play in its struggle against poverty, a view that was expressly confirmed by the Prime Minister in his opening remarks to the Forum.

59. The Special Rapporteur took the opportunity presented by the Forum to prepare some preliminary comments, from the point of view of the right to health, on some of the health-related aspects of the PRS. On an informal basis, these brief comments were circulated among participants. The Special Rapporteur understands that his comments were welcomed by participants, including representatives of the Government.

60. Given the Commission's invitation to consider these issues, the Special Rapporteur wishes to make some remarks about poverty reduction strategies and the right to health. His remarks refer to the PRS and draw upon the comments that were distributed at the Forum. **36** The remarks are not comprehensive, but illustrative. Also, they are made on the basis of only a desk review of the PRS: the Special Rapporteur has neither visited the Niger, nor discussed the PRS with health professionals familiar with the Niger. Nonetheless, the Special Rapporteur suggests that it is possible to have a more constructive discussion about poverty reduction strategies and the right to health, in line with resolution 2003/28, if the discussion takes place in the context of a particular PRS.

61. In the Special Rapporteur's opinion, Niger's PRS is one of the best in francophone Africa. It has numerous features that, in the context of human rights generally and the right to health in particular, are commendable, including the following:

(a) The objective of the Strategy “to improve the overall level of ... health of the population, to broaden the access of communities, in particular rural ones, to safe water ... and to improve the quality of life of both urban and rural populations” (3.1); this reflects, inter alia, that the right to health extends beyond health care to encompass the underlying determinants of health, such as access to safe drinking water;

(b) The intention of the Government to initiate a strategic planning process in relation to HIV/AIDS as

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a first step towards implementation of a national strategic plan (4.2.3.3.2); this reflects one of the most important contemporary right to health issues: the HIV/AIDS pandemic;

(c) The objective of increasing the availability of essential drugs (5.3.2.1.1) and ensuring that essential, high-quality medicines are available at affordable prices (3.3.3.2.viii); this reflects, inter alia, that access to essential drugs is an integral component of the right to health.

62. Since these features reflect the international obligations of Niger with respect to the right to health, two observations are appropriate. First, an explicit reference in the PRS to these obligations would reinforce a number of the Strategy's objectives. Second, the growing body of international human rights law and practice can help to identify the specific interventions (e.g. policies and programmes) that are needed to achieve several of the Strategy's goals.

63. The following are five other illustrative issues from the PRS that merit further attention from the perspective of the right to health.

Vulnerable groups

64. Human rights - and the right to health - have a particular concern about those who are disadvantaged, marginal and living in poverty. This preoccupation is reflected in numerous human rights provisions, such as those relating to non-discrimination and equal treatment.

Experience suggests that general interventions designed for the whole population - or even interventions designed for those living in poverty - do not always benefit the most vulnerable and marginal. While Niger should be commended for identifying some vulnerable groups, such as women and children, in its PRS, it does not appear to acknowledge and address the particular health access issues of all marginal groups, such as the Niger's different ethnic or racial groups. Thus, further attention could usefully be given to the right to health of all vulnerable groups, including specific ethnic or racial groups, such as the country's nomadic populations. Particular health interventions for specific vulnerable groups will probably be needed.

Affordable essential drugs

65. According to the right to health, a State has an obligation to make essential drugs both available and accessible within its jurisdiction. Accessibility has a number of dimensions, including economic accessibility. Obviously, there is limited merit in a State ensuring that an essential drug is available within its jurisdiction if the drug is so expensive that only the rich can obtain it.

66. According to the PRS: "Essential drugs and vaccines will be made regularly available and accessible in health centres, as a result of a new drug pricing policy based on an analysis of costs and health-care payment capacity of the poor. At the same time, a sustainable cost recovery system will be established ... With respect to cost recovery, a new pricing policy will be put in place following an analysis of the actual capacity and willingness of consumers of health services to pay for health care. Following a feasibility study, a health insurance scheme will be implemented on a pilot basis" (5.2.2.1.2).

67. This quotation raises a number of crucial right to health issues. The reference to "a feasibility study" is to be welcomed: this study should include an assessment of the likely impact of the new scheme on

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the enjoyment of the right to health of those living in poverty. It is unclear whether user-fees will be charged and, if so, whether those living in poverty will be exempt or will receive other assistance to enable them to benefit from essential drugs. As the PRS is implemented, these issues will need careful attention.

Public health education and information

68. The right to health includes access to health-related education and information. From the point of view of the right to health, a pro-poor health policy should include education and information campaigns concerning the main health problems in local communities, including methods of prevention and control. As the PRS is reviewed, this element of the right to health deserves due attention.

International assistance and cooperation

69. In his previous reports, the Special Rapporteur remarks on the human rights concept of international assistance and cooperation which can be traced from the Universal Declaration of Human Rights, through to binding human rights treaties, such as the International Covenant on Economic, Social and Cultural Rights and the Convention on the Rights of the Child, and which resonates with recent world conference outcomes, including the Millennium Declaration. **37**

70. The enormous scale of the health problem confronting the Niger is relevant to the human rights concept of international assistance and cooperation. The PRS acknowledges the Niger's "alarming health situation with a mostly illiterate population; a constantly deteriorating environment with an impoverished economy" (4.2.3.3.3.). It remarks that the Niger has "provided the private sector with every opportunity to play the lead role, namely in the areas of production and commercial activities. Unfortunately, it is not yet dynamic enough to take over" (4.1.3.4). Significantly, it observes that two of the health-related Millennium Development Goals - reduction of maternal mortality by three quarters and reduction of child mortality by two thirds - "seem unrealistic for Niger" (3.3.3.2). In other words, it is clear from the PRS that Niger will not be able to realize even the minimum essential levels of the right to health in the foreseeable future without very considerable and sustained international assistance and cooperation. In 2002, the Joint Staff Assessment of the International Monetary Fund and the World Bank endorsed the PRS and concluded: "the current gaps in implementation capacity will require that external partners step up their technical assistance support in line with PRSP priorities" (para. 34).

71. Of course, this does not divest the Government of the Niger of its responsibility to do everything in its power to realize the right to health for all those in its jurisdiction. Clearly, the Government could do more to promote the right to health. For example, between 1994 and 2000 the Government earmarked only 6 per cent of its budget for health, well below the 10 per cent recommended by WHO (1.2.2.3.5). However, the point is that, as reflected in international human rights law and the Millennium Declaration, both the Government and its bilateral and multilateral partners have responsibilities in relation to the right to health in the Niger.

72. As the PRS puts it: "Development partners share equal responsibility with Niger authorities for achieving the ambitious goals set by the Millennium Declaration" (4.1.3.5). In these circumstances, it would seem appropriate for the PRS to refer not only to the Millennium Declaration, but also the human rights concept of international assistance and cooperation. It is on the basis of such a normative framework that a realistic, balanced and equitable sector-wide approach to health in the Niger can be constructed.

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Monitoring and accountability

73. The right to health introduces globally legitimized norms or standards from which obligations or responsibilities arise. These obligations have to be monitored and those responsible held to account. Without monitoring and accountability, the norms and obligations are likely to become empty promises. Accountability mechanisms provide rights-holders (e.g. individuals) with an opportunity to understand how duty-bearers have discharged their obligations, and it also provides duty-bearers (e.g. ministers and officials) with an opportunity to explain their conduct. In this way, accountability mechanisms help to identify when - and what - policy adjustments are necessary. Accountability tends to encourage the most effective use of limited resources, as well as a sense of shared responsibility among all parties. Transparent, effective and accessible accountability mechanisms are among the most crucial features of a human rights- and a right to health- approach to poverty reduction.

74. The PRS candidly acknowledges that its monitoring and evaluation mechanisms need strengthening (p. 11 and paragraph 6.1). Importantly, monitoring and accountability mechanisms are needed in relation to both national actors (e.g. Government) and international actors (e.g. bilateral and multilateral partners). Moreover, these mechanisms should be developed with the active participation of stakeholders, including those living in poverty, to help ensure that they are accessible, transparent and effective.

Conclusion

75. The Special Rapporteur suggests that the relevance of these observations is not confined to the Niger. As this discussion has tended to confirm, a right to health approach to poverty reduction does not imply a radically new approach; rather, it is likely to reinforce and enhance elements existing in many anti-poverty strategies. In the opinion of the Special Rapporteur, the integration of the right to health into poverty reduction strategies is one of the most important issues arising from his mandate. The general contribution of human rights to poverty reduction - equality, non-discrimination, participation, accountability and so on - is reasonably clear. **38** Now the pressing challenge is to clarify, on the basis of reliable evidence, the specific contribution of the right to health to poverty reduction. The Special Rapporteur remains keen to contribute to this challenging task, so far as his resources and opportunities permit.

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III. Neglected diseases

76. A recent WHO publication describes neglected diseases as those diseases that “affect almost exclusively poor and powerless people living in rural parts of low-income countries”. **39** They include Chagas’ disease, sleeping sickness and river blindness. In his preliminary report, the Special Rapporteur argues that “neglected diseases, very neglected diseases and the 10/90 disequilibrium are human rights issues.” **40** Subsequently, the Commission requested him to pursue an analysis of neglected diseases. In his report to the General Assembly, the Special Rapporteur explained how he had begun to take this issue forward (A/58/427, paragraphs 76-80). The Assembly’s subsequent resolution on the right to health included a paragraph on “diseases causing a heavy burden in developing countries”. **41** In the present report, the Special Rapporteur will not repeat what was set out in his earlier reports. Instead, he wishes to bring the Commission up to date on two developments regarding his work and neglected diseases, and to make one other observation.

77. First, in December 2003 the Special Rapporteur was invited to participate in the International Workshop on Intensified Control of Neglected Diseases convened by WHO, the German Federal Ministry of Health and Social Security (with the Robert Koch Institute, Berlin), the German Agency for Technical Cooperation and the United Nations Development Programme/World Bank/WHO Special Program for Research and Training in Tropical Diseases (TDR). Participants included a wide range of actors, including developing and developed States, international organisations, pharmaceutical companies, academics and NGOs. The Special Rapporteur presented a paper with some preliminary and brief reflections on the right to health - and human rights - dimensions of neglected diseases. **42** He found the meeting very fruitful and was encouraged by the response to his preliminary reflections, and is grateful to the organizers for the opportunity to participate in this event.

78. Second, in his report to the General Assembly the Special Rapporteur observed that he was meeting with TDR. He is pleased to confirm that TDR has recently agreed to provide him with modest financial support to enable him to obtain research assistance for a few weeks on the human rights dimensions of neglected diseases. This will enable him to deepen his human rights analysis of neglected diseases and report to the next session of the Commission and/or Assembly.

79. Briefly, one of the human rights dimensions of neglected diseases that the Special Rapporteur wishes to explore concerns international assistance and cooperation. International cooperation is needed to promote the development of new drugs, vaccines and diagnostic tools for diseases causing a heavy burden in developing countries. Additionally, however, there is a need to make existing drugs for neglected diseases more accessible to those impoverished populations that need them. The problem is not only one of neglected diseases; it is also an issue of neglected populations.

80. In that context, the Special Rapporteur takes this opportunity to welcome a recent Canadian initiative that may improve access to drugs in low-income countries. Following the decision of the World Trade Organization (WTO) on 30 August 2003 that countries producing generic copies of patented drugs under compulsory licence may now export drugs to countries with no or little manufacturing capacity, the Government of Canada introduced a bill into Parliament to amend the

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Patent Act and the Food and Drugs Act. If enacted, this initiative should make it easier for Canadian companies to produce, and developing countries to import, generic drugs at lower cost. This is an example of how a developed country can help to improve access to medicines in poor countries, thereby honouring its human rights responsibilities of international assistance and cooperation. The Special Rapporteur hopes that any amendments that might be made to the Canadian legislation fully reflect the spirit and scope of the Doha Declaration on the Trade Related Aspects of Intellectual Property Rights Agreement and Public Health, as well as Canada's concurrent human rights responsibilities. The Special Rapporteur encourages all WTO member States to make use of the full range of flexibilities available under international trade law to promote the right to health in developing countries.

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IV. The Right to health and violence prevention

81. The following paragraphs are a brief response to resolution 2003/28 in which the Commission invited all relevant special rapporteurs to report on the issue of violence prevention. The Special Rapporteur already addresses issues relating to violence and the right to health by responding to compelling information he receives from NGOs.⁴³ Also, the section in this report on the rights to sexual and reproductive health includes some reflections on violence. The present section contains a few preliminary observations on the relationship between the right to health and violence prevention. **44**

82. The links between human rights and violence prevention are well established. A lack of respect for human rights is often the root cause of violence, while specific acts of violence may themselves amount to a violation of human rights. Introducing a human rights approach to violence prevention brings to bear States' international obligations concerning risk factors for violence such as poverty, gender discrimination, lack of equal access to education, and other social and economic inequalities. At the same time, violence is increasingly recognized as a global public health problem. The WHO "World Report on Violence and Health", for example, highlights the importance of measuring violence in terms of its impact on health outcomes around the world, recognizing and addressing the underlying causes and risk factors for violence and reducing its consequences. Only recently, however, have public health and human rights approaches been conceived as complementary and mutually reinforcing contributions to the prevention of violence. **45**

83. To be effective and sustainable, violence prevention requires an appreciation of the synergies between these two approaches. As a first conceptual step, this requires defining violence in terms of both its health consequences and its human rights implications. The WHO report characterizes violence as "the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development, or deprivation."⁴⁶ By focusing broadly on violence as it relates to the health of individuals, and including outcomes beyond those that result in physical injury or death, this definition reflects an appreciation of the full impact of violence on the right to health of individuals, families and communities.

84. According to this definition, violence clearly has a direct impact on the enjoyment of the human right to health of those affected. It often results in significant physical, psychological and emotional harm to individual victims and contributes to social problems for individuals, families and communities. Indirect costs of violence such as medical expenses related to injuries, costs related to legal services, policing and incarceration, and lost earnings and decreased productivity may further impede the full realization of the right to health, as well as other related rights. These costs place an additional strain on scarce resources and may hinder the development of health systems.

85. States' international obligations to respect, protect and fulfil the right to health can have an important bearing on violence prevention efforts. The obligation to protect, for example, includes an obligation to take measures to protect vulnerable or marginalized groups, in particular women,

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children, adolescents and older persons, in the light of gender-based expressions of violence.

This involves integrating a gender perspective into health-related policies, planning, programmes and research in order to promote better health for women and men. The duty to fulfil includes an obligation to provide information campaigns about domestic violence, as well as accessible, good quality services for those needing treatment. States have an obligation to ensure that all relevant health personnel receive appropriate training so they can deal sensitively with the issues arising from violence.

86. These brief reflections tend to confirm that the right to health has an important role to play throughout the development and implementation of violence prevention policies. In his country missions, the Special Rapporteur will give particular attention to domestic violence in the context of the right to health.

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V. Conclusion

87. Throughout his work, the Special Rapporteur emphasizes the importance of a “policy approach” to the right to health, i.e. bringing the right to health to bear upon local, national and international policy-making processes. In this report, he has begun to explore what such an approach means, especially in relation to sexual and reproductive health, and poverty reduction.

88. The right to health - like all human rights - brings a set of globally agreed norms or standards, which give rise to governmental obligations in relation to which effective and transparent monitoring and accountability mechanisms are required. This combination of globally legitimized norms, obligations, monitoring and accountability empowers disadvantaged and marginalized individuals and communities. Policies that are based on human rights norms, including the right to health, are more likely to be effective, robust, sustainable, inclusive, equitable and meaningful for all members of society.

89. The Special Rapporteur encourages all Governments to integrate the right to health in an explicit and comprehensive way throughout their activities, as a means of reinforcing and enhancing their ongoing policies, strategies and programmes.

Notes

- 1** The new approach was reaffirmed at the respective five-year follow-up review conferences.
- 2** Other Millennium Development Goals concern the underlying determinants of health, e.g. those on extreme poverty and gender equality.
- 3** Commission on Human Rights resolution 2003/28, preamble and para. 6.
- 4** For various reasons, sexual and reproductive ill health is severely underestimated and so statistics fail to capture the full burden of such ill health. Nonetheless, data give some indications of the magnitude of the problem.
- 5** An unsafe abortion is a procedure for terminating an unwanted pregnancy performed either by persons lacking the necessary skills, or in an environment lacking the minimal medical standards, or both.
- 6** Examples of the underlying determinants of health are indicated in E/CN.4/2003/58, paragraph 23. In summary, they are social, economic and other conditions that bear upon health status, such as access to adequate sanitation, workplace conditions and education.
- 7** See *Making 1 Billion Count: Investing in Adolescents' Health and Rights*, UNFPA, 2003.
- 8** For one way in which the framework could be strengthened, see paragraph 54 of this report.
- 9** Paragraph 7.3 continues with some important sentences which have not been reproduced here because of the shortage of space.
- 10** Paragraphs 7.2 and 7.3 of the ICPD Program of Action are replicated in paragraphs 94 and 95 of the Beijing Platform for Action.
- 11** In particular, the Committee on the Elimination of Discrimination against Women, general recommendation 24, the Committee on the Rights of the Child, general comments No. 3 and No. 4, and the Committee on Economic, Social and Cultural Rights, general comment No. 14.
- 12** Commission on Human Rights resolution 2003/28.

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13 Also, one of the Rapporteur's twin themes is discrimination and stigma: see E/CN.4/2003/58, paragraph 41.

14 Committee on the Rights of the Child, general comment No. 4 on adolescent health and development, paragraphs 9 and 19.

15 E/CN.4/2003/58, para. 23. On underlying determinants of health, see endnote 6.

16 In relation to free services and pregnancy, see in particular the Committee on the Elimination of Discrimination against Women, art. 12.2.

17 Unsafe abortion also gives rise to high rates of morbidity.

18 Safe Abortion: Technical and Policy Guidance for Health Systems, World Health Organization, 2003.

19 Women's Health in South Asia, WHO Country Profile, Sri Lanka, available at <http://w3.whosea.org/nhd/pdf/61-64.pdf>.

20 Convention on the Rights of the Child, art. 17.

21 Ibid., art. 16 and the Committee on the Rights of the Child, general comment No. 4, para. 11.

22 Ibid., arts. 19, 32-36 and art. 38.

23 Convention on the Rights of the Child, arts. 2, 3, 5, 6, 12. Also Committee on the Rights of the Child, general comment No. 4, para. 12.

24 Other special rapporteurs have documented violence and discrimination based on sexual orientation. See, for example, report of the Special Rapporteur on extrajudicial, arbitrary or summary executions, Ms. Asma Jahangir (E/CN.4/2001/9), paras. 48-50 and report of the Special Rapporteur on the question of torture (A/56/156), paras. 17-25.

25 Human Rights Committee, *Toonen v. Australia*, 4 April 1994, (CCPR/C/50/D/488/1992), para. 8.5.

26 See E/CN.4/2003/58, para. 28 and A/58/427, paras. 30-34.

27 Of course, these observations relate to very few of the many issues in ICPD.

28 Cairo Program of Action, ICPD 7.3.

29 Ibid., chapter VII.

30 Ibid., para. 7.3.

31 Ibid., para. 7.2.

32 Although note paragraph 96 of the Beijing Platform for Action.

33 Cairo Program of Action, para. 7.2, the Beijing Platform for Action, para. 94.

34 There is growing academic literature on this subject. An excellent place to start is Rebecca Cook, Bernard Dickens and Mahmoud Fathalla, *Reproductive Rights and Human Rights: Integrating Medicine, Ethics, and Law*, Clarendon Press, 2003. On sexual rights, see Alice Miller, "Sexual but not Reproductive: Exploring the Junction and Disjunction of Sexual and Reproductive Rights", *Health and Human Rights: An International Journal*, vol. 4, No. 2, pp. 69-109.

35 Government of the Niger: Full Poverty Reduction Strategy, Niamey, January 2002, available online at http://poverty.worldbank.org/files/9355_NigerPRSP.pdf

36 The Government of the Niger has agreed that the Special Rapporteur, in this report, may draw upon his remarks to the Forum of June 2003. The Special Rapporteur is very grateful to the Government for its approval and wishes to emphasize that he has sole responsibility for these observations, which reflect his views as an independent expert.

37 E/CN.4/2003/58, para. 28, and A/58/427, paras. 32-36.

38 See, for example, the *Draft Guidelines: A Human Rights Approach to Poverty Reduction Strategies*

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prepared by the Office of the United Nations High Commissioner for Human Rights in September 2002, following a request from the Committee on Economic, Social and Cultural Rights.

39 WHO, *Global Defence against the Infectious Disease Threat*, 2002, p. 96.

40 E/CN.4/2003/58, para. 81. The 10/90 disequilibrium, or gap, refers to the fact that only about 10 per cent of health research and development is directed to the health problems of 90 per cent of the world's population.

41 General Assembly, resolution 58/173, para. 13.

42 This paper, entitled *Neglected Diseases, Social Justice and Human Rights: Some Preliminary Observations*, is available online at <http://www.who.int/hhr/news/en/>.

43 See paragraphs 5 and 6 of this report.

44 The *World Report on Violence and Health* (WHO, 2002) classifies violence into three main categories: "collective violence", "self-directed violence" and "interpersonal violence". The Special Rapporteur intends to address issues related to the right to health and armed conflict in future reports; for the purposes of this brief section, he confines his comments to self-directed and interpersonal violence.

45 For a useful volume on the links between violence, health and human rights, see *Health and Human Rights: An International Journal*, vol. 6, No. 2, 2003.

46 *World Report on Violence and Health* (WHO, 2002), p. 5.

17 The Commission on Human Rights - Resolution 2005/84

The protection of human rights in the context of human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS)

The Commission on Human Rights,

Recalling its resolutions 2003/47 of 23 April 2003, 2001/51 of 24 April 2001 and 1999/49 of 27 April 1999, as well as the Declaration of Commitment on HIV/AIDS adopted at the twenty-sixth special session of the General Assembly on HIV/AIDS in 2001, which affirms that the realization of human rights and fundamental freedoms for all is essential to reduce vulnerability to HIV/AIDS and that respect for the rights of people living with HIV/AIDS drives an effective response,

Noting with concern that, according to estimates by the Joint United Nations Program on HIV/AIDS (UNAIDS) and the World Health Organization, at the end of 2004 the number of people living with HIV was 39.4 million, including 4.9 million people newly infected with HIV in 2004, and the number of people who have died of AIDS since the beginning of the epidemic is more than 20 million, including the 3.1 million people who died of AIDS in 2004,

Noting with concern that, according to UNAIDS and the World Health Organization, in the last two years, the number of people living with HIV has risen in every region, with the steepest increases occurring in East Asia, Eastern Europe and Central Asia,

Noting with particular concern that, also according to UNAIDS and the World Health Organization, women and girls are disproportionately affected by the epidemic in that they comprise an increasing proportion of the people infected, particularly in sub-Saharan Africa where women account for 57 per cent of those infected, with young women aged 15 to 24 being three times more likely to be infected than young men of the same age, and in Eastern Europe, Asia and Latin America, where the proportion of infected women continues to grow,

Noting also with particular concern that the situation of children under 15 made vulnerable or orphaned by HIV/AIDS is worsening, with an estimated 2.2 million children living with HIV at the end of 2004, including 640,000 children newly infected that year; that 510,000 children died of AIDS in 2004 and 500,000 children are in need of HIV/AIDS treatment; and that 12 million children have been orphaned in sub-Saharan Africa, with the number expected to rise to more than 18 million by 2010,

Noting with concern that an estimated 95 per cent of all people infected with HIV live in the developing world, mostly in conditions of poverty, underdevelopment, conflict and inadequate measures for the prevention, care and treatment of HIV infection, and that marginalized groups in these societies are even more vulnerable to HIV infection and the impact of AIDS,

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Also noting with concern the devastating impact of HIV/AIDS, including increased mortality and morbidity among men, women and children; higher health and social costs; and, in hardest-hit countries, devastation of human and social capital and development gains, including the reduction of poverty, resulting in a major threat to the achievement of the internationally agreed development goals, including those contained in the United Nations Millennium Declaration,

Taking note of the fact that in the context of the “3 by 5” initiative to treat three million people by 2005, the World Health Organization and UNAIDS have estimated that 700,000 people in developing countries were receiving antiretroviral treatment by the end of 2004, which represented 12 per cent of the 5.8 million people in need of such treatment,

Emphasizing, in view of the increasing challenges presented by HIV/AIDS, the need for intensified efforts to ensure universal respect for and observance of human rights and fundamental freedoms for all so as to reduce vulnerability to HIV/AIDS, to prevent HIV/AIDS related discrimination and stigma, and to reduce the impact of HIV/AIDS,

Concerned that lack of full enjoyment of human rights by persons suffering from economic, social or legal disadvantage heightens the vulnerability of such persons to the risk of HIV infection and to its impact, if infected,

Recalling the Guidelines on HIV/AIDS and Human Rights as summarized in paragraph 12 of document E/CN.4/1997/37, including the summary of the *Revised Guideline 6: Access to prevention, treatment, care and support* (2002), which provide guidance to ensuring the respect, protection and fulfilment of human rights in the context of HIV/AIDS,

Taking note with interest of the reports by the United Nations special procedures that have devoted specific attention, in the context of their mandates, to the critical intersection between the protection of human rights and an effective response to the epidemic, among others, the Special Rapporteurs on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, on the question of torture, on the right to freedom of opinion and expression, on violence against women its causes and consequences, and on the sale of children, child prostitution and child pornography,

Also taking note with interest of general comment No. 3 on HIV/AIDS and the rights of the child, adopted by the Committee on the Rights of the Child at its thirty-second session in January 2003,

Welcoming the fact that positive steps in implementing previous resolutions have been taken, including the enactment of legislation in some countries to promote human rights in the context of HIV/AIDS and to prohibit discrimination against persons infected or presumed to be infected and members of vulnerable groups,

Welcoming also the significant role of UNAIDS in cooperation with relevant bodies of the United Nations system, in particular the Office of the United Nations High Commissioner for Human Rights, and of national and international non-governmental organisations, in particular organisations of

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people living with HIV/AIDS, in promoting and protecting human rights in the context of HIV/AIDS, including fighting discrimination against people living with HIV/AIDS, and in the full range of prevention, treatment and care activities,

Recalling that HIV-related stigma and discrimination are major obstacles to an effective HIV/AIDS response and that discrimination on the basis of HIV or AIDS status, actual or presumed, is prohibited by existing international human rights law, and that the term “or other status” in non-discrimination provisions in international human rights texts should be interpreted to cover health status, including HIV/AIDS,

Welcoming the report of the Secretary-General on the protection of human rights in the context of HIV and AIDS (E/CN.4/2005/79), which provides an overview of action taken by a number of Governments, specialized agencies and international and non-governmental organisations on the implementation of the Guidelines on HIV/AIDS and Human Rights, as summarized in paragraph 12 of document E/CN.4/1997/37, and their dissemination, and which addresses issues of technical cooperation for the promotion and protection of human rights in the context of HIV/AIDS,

Welcoming the appointment by the Secretary-General of Special Envoys on HIV/AIDS for Africa, Asia, the Caribbean and Eastern Europe,

- 1.** *Invites* States, United Nations organs, programmes and specialized agencies and international and non-governmental organisations to continue to take all necessary steps to ensure the respect, protection and fulfilment of HIV/AIDS-related human rights, as contained in the Guidelines on HIV/AIDS and Human Rights, as summarized in paragraph 12 of document E/CN.4/1997/37;
- 2.** *Calls* upon all States to implement in full the Declaration of Commitment on HIV/AIDS adopted at the twenty-sixth special session of the General Assembly on HIV/AIDS in 2001;
- 3.** *Invites* States, United Nations bodies and international and non-governmental organisations, including the international donor community, to further contribute to international cooperation and assistance, with a view to assisting developing countries, particularly the least developed countries, in the context of the “Three Ones” key principles of UNAIDS and in the context of HIV-related human rights through, inter alia, advancing HIV/AIDS prevention and care programmes, including the provision of youth-friendly and gender-sensitive health programmes, facilitating equal access to HIV-related treatment, and sharing knowledge and achievements concerning HIV-related issues;
- 4.** *Invites* States to develop, support and strengthen national mechanisms for protecting HIV-related human rights in consultation with relevant national bodies, including national human rights institutions and professional bodies, to monitor and enforce HIV-related human rights, to eliminate HIV-related stigma and discrimination, and to ensure that codes of professional conduct respect human rights and dignity in the context of HIV/AIDS, so that infected persons who reveal their HIV status, those presumed to be infected and other affected persons are protected from violence, stigmatization and discrimination;

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- 5.** *Urges* States to ensure that their laws, policies and practices, including workplace policies and practices, respect human rights in the context of HIV/AIDS and promote effective programmes for the prevention and treatment of HIV/AIDS and the prohibition of HIV-related discrimination, including through voluntary testing and counselling, education, media and awareness-raising campaigns, improved and equitable access to high-quality goods and health care, particularly to safe and effective medication, assistance to educate people infected with and affected by HIV/AIDS about their rights and to assist them in realizing their rights;
- 6.** *Urges* all States to integrate sexual and reproductive health programmes and the promotion and protection of reproductive rights, as understood in previous international commitments, such as the Program of Action adopted at the International Conference on Population and Development (Cairo, 5-13 September 1994) and the Beijing Declaration and Program for Action adopted at the Fourth World Conference for Women (Beijing, 4-15 September 1995), as strong and robust components of their national strategies on HIV/AIDS, and stresses that women have the right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence;
- 7.** *Requests* States to further develop and, where necessary, establish coordinated, participatory, gender-sensitive, transparent and accountable national policies and programmes for HIV/AIDS response and to translate national policies to district level and local action, involving in all phases of development and implementation non-governmental and faith- and community-based organisations, including women's organisations and advocacy groups and representatives of people living with HIV/AIDS and vulnerable groups;
- 8.** *Also requests* States to take all appropriate measures to protect the human rights of women and children in the context of HIV/AIDS, in particular to address gender inequality, violence against women and girls, harmful traditional practices, as well as the legal and social needs of children orphaned or made vulnerable by HIV/AIDS and the needs of their caregivers;
- 9.** *Calls upon* States to ensure full and equal access for women and children to HIV prevention, information, voluntary counselling and testing, education and care, as well as to high quality medication and treatment, including through the development of efficient national health systems with the necessary human resources, recognizing the need for youth friendly services and the appropriate role and responsibility of parents, families, legal guardians and caregivers in this regard;
- 10.** *Invites* the human rights treaty bodies, when considering reports submitted by States parties, to give particular attention to HIV-related rights and invites States to include appropriate HIV-related information in the reports they submit to the relevant treaty bodies;
- 11.** *Invites* States when preparing their progress reports to the General Assembly on the implementation of the Declaration of Commitment on HIV/AIDS to include information on human rights in the context of HIV/AIDS;

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12. *Requests* all special procedures and open-ended working groups of the Commission to continue to integrate the protection of HIV-related human rights within their respective mandates;

13. *Requests* the Secretary-General to invite Member States and the United Nations organs and programmes, as well as the specialized agencies, to integrate HIV-related human rights into their policies, programmes and activities, including those involving regional intergovernmental human rights and other bodies, and to involve non-governmental and faith- and community-based organisations and the private sector in all phases of development and implementation, to help ensure a system-wide approach, stressing the coordinating and catalytic role of UNAIDS;

14. *Also requests* the Secretary-General to solicit comments from Governments, United Nations organs, programmes and specialized agencies and international and non governmental organisations on the steps they have taken to promote and implement, where applicable, programmes to address the urgent HIV-related human rights of women, children and vulnerable groups in the context of prevention, care and access to treatment as described in the Guidelines on HIV/AIDS and Human Rights, as summarized in paragraph 12 of document E/CN.4/1997/37, and the present resolution, and to submit, in consultation with interested parties, a progress report to the Commission for consideration at its sixty-third session.

61st meeting

21 April 2005

[Adopted without a vote. See chap. XIV, E/CN.4/2005/L.10/Add.14]

18 ANNEX 8: UNAIDS epidemic updated reports December 2006, press release

Full report at http://www.unaids.org/en/HIV_data/epi2006/default.asp

Global AIDS epidemic continues to grow

New data also show HIV prevention programmes getting better results if focused on reaching people most at risk and adapted to changing national epidemics

Geneva, 21 November 2006 – The global AIDS epidemic continues to grow and there is concerning evidence that some countries are seeing a resurgence in new HIV infection rates which were previously stable or declining. However, declines in infection rates are also being observed in some countries, as well as positive trends in young people's sexual behaviours.

According to the latest figures published today in the UNAIDS/WHO *2006 AIDS Epidemic Update*, an estimated 39.5 million people are living with HIV. There were 4.3 million new infections in 2006 with 2.8 million (65%) of these occurring in sub-Saharan Africa and important increases in Eastern Europe and Central Asia, where there are some indications that infection rates have risen by more than 50% since 2004. In 2006, 2.9 million people died of AIDS-related illnesses.

New data suggest that where HIV prevention programmes have not been sustained and/or adapted as epidemics have changed—infection rates in some countries are staying the same or going back up.

In North America and Western Europe, HIV prevention programmes have often not been sustained and the number of new infections has remained the same. Similarly in low- and middle-income countries, there are only a few examples of countries that have actually reduced new infections. And some countries that had showed earlier successes in reducing new infections, such as Uganda, have either slowed or are now experiencing increasing infection rates.

“This is worrying—as we know increased HIV prevention programmes in these countries have shown progress in the past—Uganda being a prime example. This means that countries are not moving at the same speed as their epidemics,” said UNAIDS Executive Director Dr Peter Piot. “We need to greatly intensify life-saving prevention efforts while we expand HIV treatment programmes.”

HIV prevention works but needs to be focused and sustained

New data from the report show that increased HIV prevention programmes that are focused and adapted to reach those most at risk of HIV infection are making inroads.

Positive trends in young people's sexual behaviours—increased use of condoms, delay of sexual debut, and fewer sexual partners—have taken place over the past decade in many countries with

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generalized epidemics. Declines in HIV prevalence among young people between 2000 and 2005 are evident in Botswana, Burundi, Côte d'Ivoire, Kenya, Malawi, Rwanda, Tanzania and Zimbabwe.

In other countries, even limited resources are showing high returns when investments are focused on the needs of people most likely to be exposed to HIV. In China, there are some examples of focused programmes for sex workers that have seen marked increases in Page 2 of 3 condom use and decreases in rates of sexually transmitted infections, and programmes with injecting drug users are also showing progress in some regions. And in Portugal, HIV diagnoses among drug injectors were almost one third (31%) lower in 2005, compared with 2001, following the implementation of special prevention programmes focused on HIV and drug use.

Addressing the challenges: Know your epidemic

In many countries, HIV prevention programmes are not reaching the people most at risk of infection, such as young people, women and girls, men who have sex with men, sex workers and their clients, injecting drug users, and ethnic and cultural minorities. The report outlines how the issue of women and girls within the AIDS epidemic needs continued and increased attention. In sub-Saharan Africa for example, women continue to be more likely than men to be infected with HIV and in most countries in the region they are also more likely to be the ones caring for people infected with HIV.

According to the report, there is increasing evidence of HIV outbreaks among men who have sex with men in Cambodia, China, India, Nepal, Pakistan, Thailand and Viet Nam as well as across Latin America but most national AIDS programmes fail to address the specific needs of these people. New data also show that HIV prevention programmes are failing to address the overlap between injecting drug use and sex work within the epidemics of Latin America, Eastern Europe and particularly Asia.

"It is imperative that we continue to increase investment in both HIV prevention and treatment services to reduce unnecessary deaths and illness from this disease," said WHO Acting Director-General, Dr Anders Nordström. "In sub-Saharan Africa, the worst affected region, life expectancy at birth is now just 47 years, which is 30 years less than most high-income countries."

The *AIDS Epidemic Update* underlines how weak HIV surveillance in several regions including Latin America, the Caribbean, the Middle East, and North Africa often means that people at highest risk—men who have sex with men, sex workers, and injecting drug users—are not adequately reached through HIV prevention and treatment strategies because not enough is known about their particular situations and realities.

The report also highlights that levels of knowledge of safe sex and HIV remain low in many countries, as well as perception of personal risk. Even in countries where the epidemic has a very high impact, such as Swaziland and South Africa, a large proportion of the population do not believe they are at risk of becoming infected. "Knowing your epidemic and understanding the drivers of the epidemic such as inequality between men and women and homophobia is absolutely fundamental to the long-term response to AIDS. Action must not only be increased dramatically, but must also be strategic, focused and sustainable to ensure that the money reaches those who need it most," said Dr Piot.

The annual AIDS Epidemic Update reports on the latest developments in the global AIDS epidemic. With maps and regional estimates, the 2006 edition provides the most recent estimates on the epidemic's scope and human toll and explores new trends in the epidemic's evolution.

19 Millennium Development Goals and the Three Ones

The Millennium Development Goals (MDGs) are eight goals to be achieved by 2015 that respond to the world's main development challenges. The MDGs are drawn from the actions and targets contained in the **Millennium Declaration** that was adopted by 189 nations-and signed by 147 heads of State and governments during the **UN Millennium Summit** in September 2000.

The 8 MDGs break down into **18 quantifiable targets** that are measured by **48 indicators**. [Click for a full list of Goals, Targets and Indicators](#)

- ◆ Goal 1: Eradicate extreme poverty and hunger
- ◆ Goal 2: Achieve universal primary education
- ◆ Goal 3: Promote gender equality and empower women
- ◆ Goal 4: Reduce child mortality
- ◆ Goal 5: Improve maternal health
- ◆ Goal 6: Combat HIV/AIDS, malaria and other diseases
- ◆ Goal 7: Ensure environmental sustainability
- ◆ Goal 8: Develop a Global Partnership for Development

The MDGs:

- synthesise, in a single package, many of the most important commitments made separately at the international conferences and summits of the 1990s;
- recognise explicitly the interdependence between growth, poverty reduction and sustainable development;
- acknowledge that development rests on the foundations of democratic governance, the rule of law, respect for human rights and peace and security;
- are based on time-bound and measurable targets accompanied by indicators for monitoring progress; and
- bring together, in the eighth Goal, the responsibilities of developing countries with those of developed countries, founded on a global partnership endorsed at the International Conference on Financing for Development in Monterrey, Mexico in March 2002, and again at the Johannesburg World Summit on Sustainable Development in August 2002.

The Three Ones

Principles for the coordination of national AIDS responses

On 25 April 2004, UNAIDS, the United Kingdom and the United States co-hosted a high-level meeting at which key donors reaffirmed their commitment to strengthening national AIDS responses led by the affected countries themselves.

They endorsed the "Three Ones" principles, to achieve the most effective and efficient use of resources, and to ensure rapid action and results-based management:

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- One agreed HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners.
- One National AIDS Coordinating Authority, with a broad-based multisectoral mandate.
- One agreed country-level Monitoring and Evaluation System.

There has been a marked shift in the global response to the complex AIDS crisis, which continues to worsen. National responses are broader and stronger, and have improved access to financial resources and commodities. As well as increased commitments by affected countries themselves, the advent of the Global Fund to Fight AIDS, Tuberculosis and Malaria, the new AIDS programmes of the World Bank, expanding commitments from donor countries (especially the United States) and the work of private sector foundations has seen the total amount of funding on AIDS increase from US\$2.8 billion in 2002 to an estimated US\$4.7 billion in 2003.

While more resources are needed, there is an urgent need for greater support and collaboration with heavily-affected countries and to avoid duplication and fragmentation of resources.

It is this challenge that the “Three Ones” are specifically designed to address. Built on lessons learned over two decades, the “Three Ones” will help improve the ability of donors and developing countries to work more effectively together, on a country-by-country basis.

To learn more about the “Three Ones” and the April 2004 consultation in Washington, read the following documents:

“Three Ones” key principles Coordination of National Responses to HIV/AIDS”: Guiding principles for national authorities and their partner

Consultation on harmonization of international AIDS funding End-of-meeting agreement

Clearing the common ground for the “Three Ones” UNAIDS report of the consultation process leading up to the meeting

Supporting Documents

relating to sexual and reproductive rights and health for lesbian, gay, bisexual and transgendered people

Sexual and reproductive health and rights, like all other human rights, are rights with cross-cutting relevance. This means that certain human rights depend upon and require each other for their realisation, (as would be the case for example, for the sexual rights of a transgendered sex worker –she must be able to exercise her right to sexual health to be able to maintain her well being in the world).

As such, advocates need to concentrate work on specified areas in their attempts to create recognition for the sexual and reproductive health and rights of LGBT populations in their respective countries. The areas included here are: youth, women and gender, sexual health and rights, sex work, regional overviews, monitoring and surveillance, migration, MSM, LGBT, human rights and HIV, global perspectives and discrimination.

The following references are offered for the attention they draw to issues that bear connection to sexual and reproductive health and rights – a short description of each with **title** follows the **web link**. At the end of each entry is some of the search terms found (**Relevant keyword**) in the reference, and, where applicable, the **NIS countries** referred to.

Youth

http://www.unodc.org/pdf/event_2005-03-31_young_people.pdf

This 12pp UNAIDS document **At Great Risk of HIV/AIDS:**

1 **Young People in Eastern Europe and Central Asia of March 2005**, provides a snapshot of the issues facing the region.

Relevant keyword: sexual health, sex work, sexual orientation, vulnerable, marginalized groups and populations

NIS countries mentioned: Ukraine, Kazakhstan, Kyrgyzstan

<http://www.youthcoalition.org/DEV/mambo2/images/stories/SRRGUIDE/srr%20guide%20final%20version.pdf>

2 **A youth activists' guide to sexual and reproductive rights**

Claudia, A. and Kowalski-Morton, S. (2006) 'A Youth Activists' Guide to Sexual and Reproductive Rights', The Youth Coalition

This guide was written for young activists to provide an overview of the sexual and reproductive rights that are protected by international and regional human rights treaties and other agreements – such as the right to privacy or the right to be free from harmful practices – and to show how these rights apply to adolescents and young people. It also discusses ways that young people can advocate for their sexual and reproductive rights within their countries, regions, and globally.

Relevant keyword: sexual and reproductive health and rights

Women and gender

http://www.who.int/reproductive-health/publications/RHR_00_8/PDF/female_condom_guide_planning_programming.pdf

3 An extensive guide (82pp) by WHO (2000) on the **Female Condom**. Relevant keyword: sexual and reproductive health, sex work, vulnerable populations.

http://data.unaids.org/Publications/IRC-pub03/fcondompv_en.pdf

4

The Female Condom, 1997, this UNAIDS short document looks at the socio-sexual and physical benefits of the female condom.

<http://www.defendingwomen-defendingrights.org/contextualising.php>

5

The International Campaign on Women Human Rights Defenders is an international initiative for the recognition and protection of women who are activists advocating for the realization of all human rights for all, specifically including sexual and reproductive rights. The Campaign focuses on the situation of human rights activists defending women's rights and in particular calls attention to the violations experienced by lesbian, gay, bisexual, transgender and other rights activists on grounds of their sex and gender identities.

Relevant keyword: sexual and reproductive rights, women's rights, lesbian, gay, bisexual, transgender, marginalization, stigmatization, gender identity

6

http://www.unfpa.org/upload/lib_pub_file/308_filename_women_aids1.pdf

A major publication, of 2004, **Women and HIV/AIDS: Confronting the Crisis** is produced by UNAIDS UNIFEM and UNFPA. HIV/AIDS is no longer striking primarily men. Today, more than 20 years into the epidemic, women account for nearly half the 40 million people living with HIV worldwide. This report is an urgent call to action to address the triple threat of gender inequality, poverty and HIV/AIDS. By tackling these forces simultaneously, we can reduce the spread of the epidemic and its devastating consequences.

Relevant keyword: sexual and reproductive health, reproductive rights, sex work, vulnerable groups, marginalized groups

NIS countries mentioned: CIS, Kazakhstan, Ukraine, Moldova

7

<http://web.amnesty.org/library/Index/ENGACT770842004>

This document about **Women and HIV/AIDS** produced by Amnesty International in 2004 includes references to sexual orientation in the context of HIV/AIDS.

Relevant keyword: sexual orientation, sex work, vulnerable groups, women who have sex with women (WSW), bisexual women, lesbian

NIS countries mentioned: Moldova

8

<http://www.bridge.ids.ac.uk>

Gender and Sexuality Supporting Resources Collection

Good support documents on gender and sexuality

9

http://www.icw.org/files/20706_ICW_Survival_Kit.pdf - survival kit

<http://www.icw.org/survivalkitfactsheets> - fact sheets

**An information kit for HIV-positive women
ICW (1999) 'A Positive Women's Survival Kit'**

The sexual desires and rights to pleasure of HIV-positive women are often totally ignored. As a result, information which addresses the specific needs of women living with HIV is scarce. 'A Positive Woman's Survival Kit' has been produced by and for women living with HIV/AIDS from all over the world. The kit is available in English, French, Spanish, Russian, Urdu, Thai, Kiswahili and Portuguese.

Relevant keyword: lesbian, sex work

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Sexual and Reproductive Health and Rights

http://www.who.int/reproductive-health/publications/transforming_healthsystems_gender/m3.pdf

A sexual and reproductive rights training curriculum for health programmers, World Health Organization (2001) 'Transforming Health Systems: Gender and Rights in Reproductive Health. A Training Curriculum for Health Program Managers'

Promoting human rights, including non-discrimination on the basis of sex, is an obligation of all countries and is vital for achieving reproductive and sexual health. This module is designed to enable participants to: become familiar with basic concepts of rights, including sexual and reproductive rights; understand how rights are defined in international human rights documents, and how they are used by various actors at the international and national levels; learn about institutions which are promoting, monitoring, implementing and enforcing human rights norms relevant to reproductive and sexual health; and be able to apply human rights concepts and methodology to analyse reproductive health programmes.

Relevant keyword: sexual rights, reproductive rights, sexual orientation, gay, sex work

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www.reproductiverights.org/pdf/pub_bp_trendsirr_ece.pdf

Trends in Reproductive Rights: East Central Europe

Reproductive rights are critical to advancing the status of women. Such rights encompass two main principles: the right to reproductive health care and the right to reproductive self-determination. To effectively work toward advancing reproductive rights, governments and non-governmental organisations (NGOs) must understand the current state of laws and policies affecting reproductive rights in their countries. This briefing paper is intended to provide a general overview of the status of laws and policies that relate to key reproductive health and rights issues in the East Central Europe region. To help assess the efforts required for the promotion of reproductive rights, this publication also examines some of the common challenges in promoting and advancing reproductive rights in the region and provides recommendations to governments for women's full enjoyment of these rights.

Relevant keyword: reproductive rights

12

www.who.int/reproductive-health/hrp/progress/67.pdf

Progress, the SHR magazine, reports on WHO's most recent definitions on sexual health, 2004.

Relevant keyword: sexual and reproductive rights, lesbian, gender norm, sexual orientation

13

http://www.reproductiverights.org/pdf/pub_bp_brb.pdf

A guide to the work of the UN treaty monitoring bodies on sexual rights

Center for Reproductive Rights (2003) 'Bringing Rights to Bear: An Advocate's Guide to the Work of the UN Treaty Monitoring Bodies on Reproductive and Sexual Rights', New York

This report analyses how each of the six committees which monitor these treaties has incorporated reproductive and sexual health into its work. It highlights strategies for promoting reproductive and sexual rights by influencing the UN committees' recommendations. It also outlines a five-step strategy to facilitate working with UN committees, government, civil society and international organisations to give these standards practical effect and ensure their realisation through concrete measures at the national level.

Relevant keyword: sexual and reproductive health and rights

14

http://www.iglhrc.org/files/iglhrc/program_docs/3.%20Sexual_Rights.pdf*Sexual rights curriculum: moving beyond identity politics*

International Gay and Lesbian Human Rights Commission (IGLHRC), 'Sexual Rights: Moving Beyond Identity Politics Curriculum', presented at the Amnesty International Global Rights Conference, October 2002

What comes to your mind when you think about sexual rights? This curriculum, presented by the International Gay and Lesbian Human Rights Commission (IGLHRC) at the Amnesty International Global Rights Conference in 2002, presents a range of statements of sexual rights and asks participants to think about how each of these statements is different from or similar to their own vision. It also outlines the foundations of sexual rights in international human rights treaties and in key conference declarations.

Relevant keyword: LGBT, sexual rights, sexual health

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http://www.unfpa.org/upload/lib_pub_file/176_filename_rightsrh_eng.pdf

Recommendations from UNFPA on the **application of human rights to reproductive and sexual health**

Relevant keyword: sexual and reproductive health and rights

16

<http://www.euro.who.int/document/e74558.pdf>

This is WHO's Regional (Europe) Strategy for Sexual and Reproductive Health, 2001

Relevant keyword: men who have sex with men, MSM, vulnerable groups, sex work

NIS countries mentioned: NIS, Georgia, Azerbaijan, Ukraine, Moldova, Armenia, Kazakhstan, Kyrgyzstan

17

http://www.who.int/reproductivehealth/stis/docs/framework_priority_linkages.pdf

Good graphic representation of sexual and reproductive rights and HIV/AIDS

A Framework for Priority Linkages

Relevant keyword: sexual and reproductive health and rights

18

http://www.who.int/reproductivehealth/stis/docs/inventory_linkages_shr_hiv.pdf

Excellent booklet (PDF) providing links and abstracts to many resources **Sexual and Reproductive Health**

Relevant keyword: sexual and reproductive health and rights

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http://www.who.int/reproductivehealth/publications/strategy_small_en.pdf

World Health Organization 57th World Health Assembly A57/13 Provisional agenda item 12.10 15, April 2004 **Reproductive health Report by the Secretariat**

Relevant keyword: sexual health, gender equality, vulnerable populations

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Sex Workhttp://data.unaids.org/pub/Report/2006/jc1212-hivpreveasterneurcentrasia_en.pdf**HIV and sexually transmitted infection prevention among sex workers in Eastern Europe and Central Asia****Relevant keyword:** homosexual, bisexual, transgender, vulnerable populations, sex work, reproductive health, sexual health**NIS countries mentioned:** Moldova, Ukraine, Kazakhstan, Kyrgyzstan

21

<http://www.who.int/3by5/mediacentre/news28/en/>**HIV/AIDS prevention programmes for sex workers****Evans, C. (2004) 'Sex Work Toolkit', World Health Organization**

In many parts of the world, sex workers have been among the groups most vulnerable to and most affected by HIV since the beginning of the AIDS pandemic. This online toolkit is aimed at helping sex workers to protect themselves and their clients from infection by HIV and other STIs. The toolkit is a collection of more than 130 easily-accessible documents, manuals, reports and research studies, which are intended for use by people working with female, male and transgender sex workers.

Relevant keyword: sex work, sexual health, sexual rights

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Regional overviewswww.unaids.org/unaids_resources/images/UNGASS/200List of world organisations with **CSO accreditation****NIS countries mentioned:** Eastern Europe and Central Asia

23

http://www.undp.org/hiv/docs/regional_reps/europe_cis_regional_report.pdf**Regional report on the HIV situation in Eastern Europe and the CIS****Relevant keyword:** MSM, men who have sex with men, vulnerable groups, ostracized groups, sex work, gay**NIS countries mentioned:** Central Asia, Ukraine, Moldova, Kazakhstan, Kyrgyzstan, Armenia

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www.sdc-health.ch/priorities_in_health/communicable_diseases/hiv_aids/hiv_aids_sti_in_eastern_europe_and_central_asiaPaper on **HIV/AIDS/STI in Eastern Europe and Central Asia, 2002****Relevant keyword:** gay, MSM, bisexual, vulnerable groups, sex work, sexual health**NIS countries mentioned:** Georgia, Azerbaijan, Ukraine, Moldova, Kazakhstan, Kyrgyzstan

25

www.unaids.org/en/Publications/2005ungassreporting/default2005 **Country Progress Reports** – page that allows access to them all**NIS countries mentioned:** Georgia, Azerbaijan, Ukraine, Moldova, Armenia, Kazakhstan, Kyrgyzstan

26

www.medicusmundi.ch/mms/services/bulletin/bulletin200301/kap01/04zahorka.html

HIV/AIDS in Eastern Europe

Bulletin of Medicus Mundi Switzerland No. 88, April 2003

Relevant keyword: MSM, sex work**NIS countries mentioned:** Georgia, Azerbaijan, Ukraine, Kazakhstan, Kyrgyzstan

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www.ceehrn.org/EasyCEE/sys/files/CAdeclarationEN.pdf

The Central Asia Declaration on HIV/AIDS Prevention HIV/AIDS--a global emergency Central Asia at the threshold a large-scale epidemic, 2001

Relevant keyword: men who have sex with men

NIS countries mentioned: Ukraine, Moldova, Kazakhstan, Kyrgyzstan

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http://data.unaids.org/pub/EpiReport/2006/06-Eastern_Europe_and_Central_Asia_2006_EpiUpdate_eng.pdf

Report on **East Europe and Central Asia**

Relevant keyword: homosexual, MSM, gay, sex work

NIS countries mentioned: Georgia, Azerbaijan, Ukraine, Moldova, Armenia, Kazakhstan, Kyrgyzstan

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http://www.who.int/hiv/FS_EEurope_CAsia_Nov05_en.pdf

Eastern Europe and Central Asia fact sheet

The number of people living with HIV in Eastern Europe and Central Asia reached an estimated 1.6 million in 2005. Around 62,000 adults and children died of AIDS-related illnesses in 2005 and some 270,000 people were newly infected with HIV. Around 75% of the reported infections between 2000 and 2004 were in people younger than 30 years (in Western Europe, the corresponding figure was 33%).

NIS countries mentioned: Ukraine, Moldova, Kazakhstan

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www.unaids.org/en/Coordination/Regions/EasternEuropeAndCentralAsia.asp

Short UNAIDS eastern Europe report 2006

Relevant keyword: sex work

NIS countries mentioned: Georgia, Azerbaijan, Ukraine, Moldova, Armenia, Kazakhstan, Kyrgyzstan

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data.unaids.org/Publications/IRC-pub03/map98_en.pdf

MAP (Monitoring the Aids Pandemic) Seminal piece of work **The Determinants of the HIV/AIDS Epidemics in Eastern Europe**, 1998

Relevant keyword: homosexual, MSM, bisexual, sex work, vulnerable populations, vulnerable groups

NIS countries mentioned: Georgia, Azerbaijan, Ukraine, Moldova, Armenia, Kazakhstan, Kyrgyzstan

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data.unaids.org/Publications/IRC-pub06/jc1038-changingepidemic_en.pdf

The Changing HIV/AIDS Epidemic in Europe and Central Asia UNAIDS 2004

Relevant keyword: homosexual, bisexual, MSM, marginalized

NIS countries mentioned: Georgia, Azerbaijan, Ukraine, Armenia, Kazakhstan, Kyrgyzstan

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data.unaids.org/pub/EpiReport/2006/20061121_EPI_FS_EECA_en.pdf

Eastern Europe Fact Sheet 2006

NIS countries mentioned: Georgia, Azerbaijan, Ukraine, Armenia, Kazakhstan

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http://afew.org/english/HIV_Russia_Lancet_Hamers%20et%20al_March%202003.pdf

HIV and AIDS in eastern Europe Article from The Lancet, 2003

Relevant keyword: men who have sex with men, homosexual, bisexual

NIS countries mentioned: Georgia, Azerbaijan, Ukraine, Moldova, Armenia, Kazakhstan, Kyrgyzstan

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data.unaids.org/publications/irc-pub06/JC1151-crd-progrrep_en.pdf

From advocacy to action: a progress report on UNAIDS at country level, 2005 – from UNAIDS

Relevant keyword: men who have sex with men, sexwork, sexual and reproductive health and rights, vulnerable**NIS countries mentioned:** Georgia, Azerbaijan, Ukraine, Moldova, Armenia, Kazakhstan, Kyrgyzstan

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Monitoring and surveillance

www.euro.who.int/document/e74470.pdf

Introduction of Second- generation HIV Surveillance Guidelines in some Newly Independent States of Eastern Europe

Relevant keyword: men who have sex with men, sex work, vulnerable groups, homosexual**NIS countries mentioned:** NIS, Ukraine, Moldova, Kazakhstan, Kyrgyzstan

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www.icaso.org/ungass/indicators/cim2005_en.pdfUNGASS on HIV/AIDS Monitoring the Declaration of Commitment on HIV/AIDS **Guidelines on Construction of Core Indicators**, 2005**Relevant keyword:** men who have sex with men, sex workers

38

http://data.unaids.org/Publications/IRC-pub06/mainstreaming_aids%20in_dev_instr_rep_28nov05_en.pdfThis is the final report of a joint review commissioned by UNAIDS and UNDP of the experiences with mainstreaming HIV and AIDS in national development instruments, and of technical support provided to national partners in this area. **Mainstreaming AIDS****Relevant keyword:** sex work, vulnerable populations

Migration

39

data.unaids.org/Publications/IRC-pub01/JC370-2ndGeneration_en.pdf

Program Coordinating Board. Second ad hoc thematic meeting, New Delhi, 9-11 December, 1998. Provisional agenda item 5

Migration and HIV/AIDS**Relevant keyword:** men who have sex with men, gay, homosexual, sex work, marginalized populations, sub-populations at risk, reproductive health

40

data.unaids.org/Governance/PCB02/pcb_07_98_05_en.pdfUNAIDS Program coordinating board **Migration and AIDS**, 1998**Relevant keyword:** gay, sex work, vulnerable populations, sexual health**NIS countries mentioned:** Georgia, Ukraine, Moldova, Armenia

MSM

41

http://synkronweb.aidsalliance.org/graphics/secretariat/publications/msm0803_between_men_Eng.pdf

HIV/STI prevention for men who have sex with men

International HIV/AIDS Alliance (2003) 'Between Men: HIV/STI Prevention for Men Who Have Sex with Men', Key Population Series

Official indifference or hostility means that there are few prevention and care programmes for men who have sex with men in developing countries. It also means that little research has been undertaken to discover how many men are at risk and how best to provide them with the information they need to protect themselves and their sexual partners. 'Between Men' gives an overview of basic issues for men who have sex with men. The booklet also provides ideas for developing prevention programmes with and for these men. It is intended for NGOs starting HIV/STI prevention work with and for men who have sex with men.

Relevant keyword: gay, lesbian, LGBT, transgender, transsexual, sex work, marginalized group

42

data.unaids.org/Publications/IRC-pub03/mentu2000_en.pdf

MSM and HIV, UNAIDS 2000

Relevant keyword: lesbian, bisexual, transgendered, transsexual, MSM, sex work

LGBT

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www.ilga-europe.org/content/download/1801/11211/file/Sweden%20-%20Sex%20Orient%20and%20Gend%20ID%20issues%20in%20development.pdf

Sexual Orientation and Gender Identity Issues in Development

A Study of Swedish policy and administration of Lesbian, Gay, Bisexual and Transgender issues in international development cooperation

Excellent resource from SIDA – particularly **Ch 7**

Relevant keyword: LGBT, sexual orientation, gender identity

NIS countries mentioned: Moldova

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http://www.worldaidscampaign.info/index.php/en/campaigns/key_events/ungass_2006__1/the_wac_and_monitoring_ungass_progress

"What gets measured, gets done" **WAC monitoring UNGASS progress**

Relevant keyword: vulnerable groups

NIS countries mentioned: Ukraine

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www.fidh.org/article.php3?id_article=2539

Joint Oral Statement by the International Commission of Jurists (ICJ) and International Federation for Human Rights Leagues (FIDH)

Relevant keyword: same sex, sexual orientation, transgender, gay, lesbian, bisexual

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web.amnesty.org/library/Index/ENGIOR400042005?open&of=ENG-347

2005 **The Human Rights of Lesbian, Gay, Bisexual and Transgender People:** A primer to working with the United Nations Treaty Monitoring Bodies and the Special Procedures of the United Nations Commission on Human Rights

Relevant keyword: LGBT, sexual and reproductive health, sexual and reproductive rights

Human rights and HIV

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www.iglhrc.org/files/iglhrc/reports/unguide.pdf

Making the Mountain Move: An Activist's Guide to How International Human Rights Mechanisms Can Work for You, ILGHRC

Relevant keyword: LGBT, MSM, right to health, mental health

48

http://www.hsph.harvard.edu/xfbcenter/HIVAIDS_and_HRinNutshell-Webversion1.pdf

Human Rights in a Nutshell

A quick and useful guide for action, as well as a framework to carry HIV/AIDS and human rights actions forward, produced by the Program on International Health and Human Rights, François-Xavier Bagnoud Center for Health and Human Rights, Harvard School of Public Health and the International Council of AIDS Service Organizations (ICASO)

Relevant keyword: vulnerable populations, marginalised populations, MSM, sexual orientation

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www.hrea.org/learn/guides/lgbt.htm

Study Guide – Sexual orientation and human rights

Relevant keyword: LBGT, sexual orientation

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[www.unhchr.ch/Huridocda/Huridoca.nsf/\(Symbol\)/E.CN.4.1997.37.En?Opendocument](http://www.unhchr.ch/Huridocda/Huridoca.nsf/(Symbol)/E.CN.4.1997.37.En?Opendocument)

Commission on Human Rights, Fifty-third session

Further promotion and encouragement of human rights and fundamental freedoms, including the question of the Program and methods of work of the Commission. Alternative approaches and ways and means within the United Nations system for improving the effective enjoyment of human rights and fundamental freedoms.. Second International Consultation on HIV/AIDS and Human Rights (Geneva, 23-25 September 1996)

Relevant keyword: sexual and reproductive health and rights, MSM, marginalized groups, vulnerable groups

51

data.unaids.org/Publications/IRC-pub01/JC128-HRMachinery_en.pdf

UNAIDS 1997 **UNIADS Guide to the United Nations Human Rights Machinery**

Relevant keyword: sexual and reproductive health and rights, MSM, marginalized populations, vulnerable populations

Global perspectives

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http://www.unsystem.org/scn/publications/AnnualMeeting/hiv_reference/SCN_HIV_articles/hiv_aids_pandemic.htm.pdf

Follow-up to the 2001 United Nations General Assembly Special Session on HIV/AIDS **Progress Report on the Global Response to the HIV/AIDS Epidemic, 2003**

Relevant keyword: sexual orientation, sexual and reproductive health, sex work, vulnerable populations

NIS countries mentioned: Georgia, Azerbaijan, Ukraine, Moldova, Armenia, Kazakhstan, Kyrgyzstan, CIS, Eastern Europe, Central Asia

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data.unaids.org/pub/GlobalReport/2006/2006_GR-ExecutiveSummary_en.pdf

Executive Summary of the extensive **UN Global Report 2006**

Relevant keyword: MSM, sex workers, homophobia

NIS countries mentioned: Eastern Europe, Central Asia, Kyrgyzstan

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www.e-alliance.ch/resources/actionalerts/hivaids/101006/Universal_access_guidance_6_oct.pdf

Setting National Targets for Moving Towards Universal Access

Further guidance to complement “Scaling Up Towards Universal Access: Considerations for countries to set their own national targets for AIDS prevention, treatment, and care and support”

Relevant keyword: men who have sex with men, most-at risk population, sex workers, vulnerable populations, marginalized group

55

siteresources.worldbank.org/INTHIVAIDS/Resources/375798-1103037153392/GFWBReportFinalVersion.pdf**The World Bank’s Global HIV/AIDS Program of Action**, 2006.

The latest (December 2005) statistical update from UNAIDS confirms that, despite progress in a small but growing number of countries, the AIDS epidemic continues to outstrip global efforts to contain it. While spending on AIDS has gone up sharply in recent years, it is still woefully inadequate if the massive requirements for treatment as well as prevention and mitigation are to be met. Thus, it is especially important that resources currently available are well-utilized and that the collective international effort is coherent and well-coordinated.

NIS countries mentioned: Georgia, Azerbaijan, Ukraine, Moldova, Armenia, Kazakhstan, Kyrgyzstan

56

data.unaids.org/UNA-docs/ImplementRecommend_24Aug05_en.pdfImplementation of the Global Task Team **Recommendations Update** Paper 25 August 2005 (based on their Final report of June 2005)

Relevant keyword: sexual health and rights, sex work, men having sex with men, marginalized groups

NIS countries mentioned: Kazakhstan, Ukraine

57

http://www.unaids.org/epi/2005/doc/EPIupdate2005_pdf_en/epi-update2005_en.pdf**Global Summary of the AIDS Epidemic, 2005****Relevant keyword:** men who have sex with men, MSM, homosexual, homophobia, transgender, sex work**NIS countries mentioned:** Moldova, Ukraine, Azerbaijan, Armenia, Kazakhstan, Kyrgyzstan

58

www.odi.org.uk/PPPG/politics_and_rights/publications/kb_JRSMed_globalfund.pdf**The Global Fund at Five:** what’s next for universal access for HIV/AIDS, TB and Malaria. Journal of the Royal Society of Medicine. Volume 99, October 2006**Relevant keyword:** marginalized populations

59

www.arha.org.au/index/UNFPA%20Global%20pop%20policy%20statetment%20Dec%2006.pdf**UNFPA Global Population Policy update** Issue #67, 13 December 2006 Bangkok meeting pledges to attain at least 10 per cent of development assistance budgets for reproductive health**Relevant keyword:** vulnerable populations, marginalized populations

60

data.unaids.org/Publications/IRC-pub02/JC868-ActionGuide_en.pdf**Action Guide for United Nations Country Teams** Implementing the Declaration of Commitment on HIV/AIDS adopted at the United Nations General Assembly Special Session on HIV/AIDS, 25–27 June 2001**Relevant keyword:** men having sex with men, sex work, vulnerable groups

61

http://www.ceehrn.org/old_site/index.php?ItemId=16783**The Central and Eastern Europe's Harm Reduction Network** links to a variety of CEEHRN resources**Relevant keyword:** sexual and reproductive health and rights, sexual orientation, MSM, etc

62

www.icaso.org/ungass/advocacyeng.pdf**Advocacy Guide to the Declaration of Commitment on HIV/AIDS****United Nations General Assembly Special Session on HIV/AIDS****June 2001**

ICASO have produced this advocacy guide to particularly draw attention to how the Declaration impacts on LGBT populations.

Relevant keyword: gay, men who have sex with men, vulnerable groups

63

siteresources.worldbank.org/INTHIVAIDS/Resources/375798-1127498796401/GHAPAFinal.pdf**The World Bank's Global HIV/AIDS Program of Action 2005****Relevant keyword:** at risk groups, bisexual, MSM, marginalized groups, vulnerable groups, sex work, sexual and reproductive health**NIS countries mentioned:** Georgia, Azerbaijan, Armenia, Kazakhstan, Kyrgyzstan, Moldova, Ukraine

64

International statementsftp.who.int/gb/pdf_files/WHA54/ea5415.pdf

World Health Organization 54th World Health Assembly A54/15 Provisional agenda item 13.6, 9 April 2001

HIV/AIDS Report by the Secretariat**Relevant keyword:** sex work, sexual and reproductive health, vulnerable groups, men having sex with men

65

www.casy.org/engdocs/UNReport_N0529509.pdfUnited Nations A/59/765 General Assembly, 4 April 2005, Fifty-ninth session Agenda item 43. **Follow-up to the outcome of the twenty-sixth special session: implementation of the Declaration of Commitment****Relevant keyword:** marginalized populations, marginalized groups, sex work, sexual and reproductive health, vulnerable groups, men having sex with men

66

www.aids-kampagne.de/english/pdf/2006_aidsdeclaration_en.pdfUnited Nations A/60/736, **24 March 2006** Sixtieth session**Follow-up to the outcome of the twenty-sixth special session: implementation of the Declaration****Relevant keyword:** vulnerable and at risk groups, sexual health, men who have sex with men

67

data.unaids.org/pub/InformationNote/2006/20060324_HLM_GA_A60737_en.pdfUnited Nations A/60/737 **24 March 2006** Sixtieth session Agenda item 45

Follow-up to the outcome of the twenty-sixth special session: implementation of the Declaration of Commitment on HIV/AIDS

Scaling up HIV prevention, treatment, care and support**Relevant keyword:** sexual and reproductive health, vulnerable groups, vulnerable populations, men who have sex with men, homosexual

68

hrw.org/backgrounder/hivaids/ungass0806/appendix.pdf

United Nations A/RES/60/262 General Assembly

15 June 2006 Sixtieth session Agenda item 45

Resolution adopted by the General Assembly

60/262. Political Declaration on HIV/AIDS

Relevant keyword: sexual and reproductive health

69

www.unece.org/commission/2005/E_ECE_1424e.pdf

United Nations Economic Commission for Europe

Sixtieth session (22-25 February 2004) (Provisional agenda item 8)

Achieving the internationally agreed Goals, including those contained in the Millennium Declaration, as well as implementing the outcomes of the major United Nations conferences and summits

NIS countries mentioned: Eastern Europe and Central Asia

Discrimination

70

data.unaids.org/Publications/IRC-pub01/JC295-Protocol_en.pdf

UNAIDS 2005 **Protocol for the identification of discrimination against people living with HIV**

Relevant keyword: marginalized, sex work, men having sex with men, most-at risk

Language

71

data.unaids.org/pub//InformationNote/2006/EditorsNotes_en.pdf

UNAIDS **Notes for Editors** 2006

This fairly extensive guide gives an overview of UNAIDS most recent usage of terms in an accessible glossary form. UNAIDS have produced this document in response to a great demand from a variety of public sources who are creating print or data about HIV/AIDS in the belief that “As language shapes beliefs and may influence behaviours, considered use of appropriate language has the power to strengthen the response to AIDS”.

72

unesdoc.unesco.org/images/0014/001447/144725e.pdf

UNESCO **Guidelines on Language and Content** in HIV- and AIDS -

Related Materials

The complexity of HIV and AIDS, and the fact that what makes them exceptional is the stigma attached – a real impediment to prevention – makes the way we describe, discuss and portray HIV and AIDS instrumental to our success in effectively responding to the pandemic. This publication provides guidelines for a harmonized use of language and content in HIV- and AIDS-related materials that reflect an approach to the epidemic which is comprehensive and inclusive, sensitive to the needs and issues of the whole population, but with focused attention on especially vulnerable populations.

73

www.unesco.org/webworld/publications/media_aids/chapter_1.pdf

ABC of AIDS

Produced by the PANOS Institute in London, this 24pp document offers a glossary of terms to do with HIV/AIDS.

74

www.ifj-asia.org/files/IFJ%20media%20guide%20FINAL%20low%20res.pdf

IFJ media guide

This guide, produced by the International Federation of Journalists, is designed to both inform and assist journalists in their coverage of HIV/AIDS issues – it encompasses a ‘train the trainer’ element (informing those interested on educating others on the issues)

75

www.unaids.org/DocOrder/OrderForm.aspx

UN PDFs and document reference guide: Order Form

This is the entire extensive list of UNAIDS publications, divided into Corporate Publications and Best Practice Collection. All reference numbers and titles are given, as well as the languages that documents are available in, to the hundreds of titles in this resource.

76

Armenia

http://www.who.int/hiv/HIVCP_ARM.pdf

WHO, 2005, **Summary Country Profile for HIV/AIDS Treatment Scale-up**

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http://www.unaids.org/unaids_resources/UNGASS/2005-Country-Progress-Reports/2006_country_progress_report_armenia_en.pdf

Armenia. **Country UNGASS Report, January 2003 – December 2005**

78

http://www.undp.am/docs/cpd/undp_armenia_cpd.pdf

Country Program Document for the Republic of Armenia (2005-2009)

79

<http://www.undp.am/?page=AWP9>

UNDP goal: Responding to HIV/AIDS Service Line 5.2: Development planning, implementation and HIV/AIDS responses. Also has links to other AWP3 on human rights.

80

http://www.unssc.org/web1/programmes/rcs/cca_undaf_training_material/tot06/January26/Joint%20Programmes/Armenia%20Joint%20Programme%20Lessons%20Learned.pdf

Lessons learned in joint Program implementation staff working paper no.2 capacity building for HIV. **Armenia, Capacity building for HIV/AIDS**

81

http://hra.am/file/report1_9_2002.pdf

Human Rights in Armenia (1 January 2002 – 1 September 2002)

This report is prepared on the basis of materials from internet site Human Rights in Armenia – www.hra.am)

82

Azerbaijan

<http://www.un-az.org/doc/2004/2.php>

Progress in Reform – 6 part paper on Azerbaijan

83

http://www.unaids.org/en/Regions_Countries/Countries/azerbaijan.asp

Azerbaijan Country situation analysis, 2006. UNAIDS 2005

84

http://www.gender-az.org/shablon_en.shtml?doc/en/development/law/01

List of International Women's Human Rights Treaties, ratified by Azerbaijan. Azerbaijan Gender Information Centre

85

http://www.un-az.org/undp/AIDS/fs-rehabilitation_blood_transfusion2.php

HIV United Nations Development Program **Project Fact Sheet, Azerbaijan**

86

<http://www.un-az.org/UNDP/>

UNDP in Azerbaijan – portal page

87

http://www.un-az.org/undp/DOC/May_11_2005DCPAZE1.pdf

UNDP Country Program for the Republic of Azerbaijan (2005-2009)

Georgia

88

http://data.unaids.org/pub/Report/2006/2006_country_progress_report_georgia_en.pdf

2006 UNGASS `Country Report Georgia

89

<http://www.undp.org.ge/>

UNDP in Georgia, **Mission statement, etc**

90

Kazakhstan

http://www.unaids.org/en/Regions_Countries/Countries/kazakhstan.asp

Kazakhstan Country situation analysis, 2006

91

<http://www.undp.kz/>

UNDP in Kazakhstan – in relation to Millennium Development Goals

92

http://www.who.int/hiv/HIVCP_KAZ.pdf

WHO, 2005, **Summary Country Profile for HIV/AIDS Treatment Scale-up**

Kyrgyzstan

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http://data.unaids.org/pub/Report/2006/2006_country_progress_report_kyrgyzstan_en.pdf

Follow-up to the UNGASS Declaration of Commitment on HIV/AIDS. Country Report Kyrgyz Republic Reporting Period: 2003-2004

94

<http://www.prsp-watch.de/index.php?page=countries/kyrgyz-republic.php>

PRSP-Watch – much factual data and commentary on human rights

95

www.undp.org/execbrd/word/DCPKGZ1.doc

Draft country Program document for Kyrgyzstan (2005-2010) 14 - 23 June 2004, Geneva DCPKGZ1

96

<http://www.un.org.kg/>

The United Nations in Kyrgyzstan **Joint Programming and Activities**

97

http://www.who.int/3by5/support/june2005_kgz.pdf

WHO, 2005, **Summary Country Profile for HIV/AIDS Treatment Scale-up**

Moldova

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http://data.unaids.org/pub/Report/2006/2006_country_progress_report_moldova_en.pdf

Declaration of Commitment of the United Nations General Assembly Special Session (UNGASS) Progress report 2003-2005 for Moldova

99

<http://www.theglobalfund.org/programs/countrysite.aspx?countryid=MOL&lang=>

The Global Fund in Moldova – portal

100

<http://www.un.md/>

UNDP in Moldova – in regards to HIV/AIDS

101

Ukraine

http://data.unaids.org/pub/Report/2006/2006_country_progress_report_ukraine_en.pdf

National Report on the Follow-up to the UNGASS Declaration of Commitment on HIV/AIDS, Ukraine Reporting Period: January 2003 – December 2005

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<http://www.undp.org.ua/>

UNDP in Ukraine – re;/HIV/AIDS

103

http://www.ungasshiv.org/index.php/en/ungass/shadow_reports_2006/public_health_watch/ukraine_preliminary_findings

Shadow report on HIV/AIDS work in Ukraine - draft. This is an accredited NGO's (Public Health Watch) report on the situation 'on the ground'. This webpage allows you to link to other shadow reports (although there are none others present for Moldova, Armenia, Georgia, Azerbaijan, Kyrgyzstan or Kazakhstan)