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Venue: Executive Board Room, WHO, Geneva

Agenda item 5

Report by the NGO representative

**Sexual and Reproductive Health and Rights of People Most Affected by
HIV: The Right to Development**

Additional documents for this item: None

Action required at this meeting - the Programme Coordinating Board is invited to:

See decisions in paragraphs below

85. *Recall* United Nations General Assembly Resolutions, in particular, the 2030 Agenda for Sustainable Development (2030 Agenda)¹ that: commit to promote and protect the full range of human rights, including those rights essential for the achievement of sexual and reproductive health; ensure non-discrimination for people living with HIV, key populations such as sex workers, gay men and other men who have sex with men, transgender people, and people who inject drugs; and those most affected by HIV, including women and girls in all their diversity, adolescents and young people, migrants, people who have been incarcerated, people living with disabilities, and indigenous peoples; also *recall* UNAIDS Strategy 2016-2021 that urges the Joint Programme to fully meet sexual and reproductive health and rights needs to prevent HIV infection²; *affirm* the right to development as a universal and inalienable human right for every person and all peoples; and, emphasize the need to fully implement the Declaration on the Right to Development;
86. *Urge* Member States to recognize the inextricable linkages between sexual and reproductive health and rights, HIV and AIDS, the right to the highest attainable standard of health, and the right to development for people living with HIV, other key populations and those most affected by HIV, including women and girls in all their diversity;
87. *Call* on Member States to support the right to the highest attainable standard of sexual and reproductive health for people living with HIV, other key populations and those most-affected by HIV, including young women and adolescent girls, through i) ensuring access to non-discriminatory comprehensive sexuality education, and quality, integrated sexual and reproductive health services; ii) preventing and addressing gender-based and sexual violence in all its forms; iii) removing laws and policies that are discriminatory and/or create barriers to accessing education and services for key populations, including age-related barriers; and, iv) instituting laws and policies that include rights protections based on sexual orientation and gender identity and expression;
88. *Request* the Joint Programme, specifically the World Bank, in broad consultation with civil society, to produce a cost analysis report to i) evaluate the impacts of non-recognition and non-inclusion of sexual and reproductive health and rights of people living with HIV, other key populations and those most affected by HIV in the context of the Right to Development, particularly in relation to addressing poverty; and ii) estimate the *benefits* of addressing sexual and reproductive health and rights of key populations and those most-affected by HIV in the context of the Right to Development;
89. *Urge* UNAIDS and other partners to increase the existing funds and provide technical assistance to strengthen civil society and community-level capacity, in line with the call in the UNAIDS Fast-Track Report (2014), Lancet Commission's Report (2015), and the UNAIDS 2016-2021 Strategy. These funds should be allocated for:
- a. advocacy work to respect, protect and fulfil the sexual and reproductive health and rights related to the right to development of key populations and those most affected by HIV, including through the meaningful engagement in policy- and programme-development fora;

¹ *Transforming our world: the 2030 Agenda for Sustainable Development.*

<https://sustainabledevelopment.un.org/post2015/transformingourworld>

² Key Result Areas 5 and 8, *On the Fast-Track to End AIDS, 2016-2021 Strategy*, UNAIDS, 2015.

- b. support to community-based and -driven responses that promote and protect sexual and reproductive health and rights and address barriers to claiming and realizing sexual and reproductive health and rights faced by key populations and those most affected by HIV, including providing rights literacy and access to legal support; and
- c. capacity-building for key populations and those most affected by HIV at global, regional and national levels, which includes building platforms for sharing knowledge and good practice models among communities and civil society.

BACKGROUND AND CONTEXT

1. **“Sexual and Reproductive Health and Rights of People Most Affected by HIV: The Right to Development”** is the focus of the 2016 NGO Report to the Program Coordinating Board (PCB) of UNAIDS. It will be presented at the 38th meeting of the UNAIDS PCB (28 June – 30 June 2016).
2. The report is situated within the context of the implementation of the 2030 Agenda for Sustainable Development (2030 Agenda)³ comprising 17 Sustainable Development Goals (SDGs), agreed by the United Nations General Assembly in September 2015, and the UNAIDS Strategy 2016-2021.⁴ It reviews the international commitments that describe and underpin the right to development, and specifies what the right to development might be for populations most affected by HIV. The report argues that sexual and reproductive health and rights (SRHR) are an integral part of and a prerequisite for the full realization of the right to development, including achievement of the SDGs on Health (SDG3), Gender Equality (SDG5), Reducing Inequalities (SDG10), and Promoting Peaceful and Inclusive Societies (SDG16), among others.⁵ It describes barriers to SRHR experienced by people living with and most-affected by HIV; how these have contributed to the failure to fully meet Millennium Development Goal (MDG) Targets 6A and 6B;⁶ and how denial or fulfillment of SRHR impacts the right to development for these populations. Finally it recommends decision points (DPs) for action to the UNAIDS PCB.
3. The NGO report to the Programme Coordinating Board reflects a review of the literature and the findings of consultations carried out by the NGO Delegation to the UNAIDS Programme Coordinating Board. Various methods, such as face-to-face interviews, group discussions, consultations, and email and telephone interviews, were used. Consultations were held in all five PCB regions, with 69 informants who self-identify as members of key populations, or who represent key population groups from a total of 27 countries. An independent consultant was contracted to write the report. A second consultation was contracted to review and revise the report in the light of the uptake of the UNAIDS 2016-2021 Strategy, the PCB having approved the request of the NGO Delegation to defer presentation of the report to the June 2016 PCB meeting. The production of the report was coordinated by a Working Group of the NGO Delegation, and reviewed by 14 community experts. Consultation participants and reviewers are listed in Annex 1. The voices of key populations are reflected in the report by way of direct quotes obtained through the consultation, from paragraph 27 onwards.

³ *Transforming our world: the 2030 Agenda for Sustainable Development*.

<https://sustainabledevelopment.un.org/post2015/transformingourworld>

⁴ *On the Fast-Track to End AIDS, 2016-2021 Strategy*, UNAIDS, 2015.

⁵ *Ibid*, pp8-9 and 26-27. The ten targets and eight results areas of the UNAIDS 2016-2021 Strategy are situated firmly within, and align with key AIDS-related SDGs: SDG3 – Good health and wellbeing; SDG5 – Gender equality; SDG10 – Reduced inequalities; SDG16 – Peace, justice and strong institutions, and SDG17 – Partnerships for the goals. The strategy further draws linkages between and highlights opportunities for cross-sectoral collaboration towards shared goals to (SDG1) End poverty; (SDG2) End hunger; (SDG4) Ensure quality education; (SDG8) Promote economic growth; and, (SDG11) Make cities safe.

⁶ <http://www.un.org/millenniumgoals/aids.shtml>

UNDERSTANDING THE LINKAGES BETWEEN SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS (SRHR), HIV, KEY POPULATIONS, AND THE RIGHT TO DEVELOPMENT

4. The UNAIDS Strategy 2016-2021, “On the Fast-Track to End AIDS”, recognizes that to halt the AIDS epidemic there is a need to make progress on realizing all human rights, including sexual and reproductive health and rights, for all people – including children, women, young people, men who have sex with men, people who use drugs, sex workers and their clients, transgender people and migrants. The Strategy equally places at the centre of the response the “knowledge, rights and power” of all people to: make and benefit from choices about their healthcare; access to quality information and services, including sexual and reproductive health (SRH) services; and live their lives free from violence, discrimination and poverty, and with dignity and equality.⁷
5. SRHR and HIV are inextricably linked: HIV is largely sexually transmitted, or transmitted from mother to child; some sexually transmitted infections (STIs) increase HIV risk; and, intimate partner and sexual violence increases the risk of acquiring HIV. HIV acquisition and disclosure also negatively impact on people’s ability to protect and fulfill their SRHR, and can result in stigma and discrimination, denial of or coercion into SRH services, and gender-based violence, including within services (for example forced or coerced abortion or sterilization of women living with HIV). The protection and promotion of SRHR, including the ability to make decisions on when, how and with whom to have sex and to marry and whether or not to have children, or how many children to have, is central to preventing HIV acquisition and to ensuring the health and longevity of those living with HIV. This agency rests on the ability to access and utilize a full range of SRHR information, services and commodities.
6. The term “key populations”⁸ describes the people most affected by HIV, whose agency in relation to SRHR is most compromised, due to rights violations. These include – and further entrench: stigma and discrimination; criminalization; issues of economic and social exclusion; gender and age inequality; gender based violence (GBV) and sexual violence; involuntary medical interventions, including forced and mandatory medical testing and interventions, involuntary sterilization and abortion and, lack of access to comprehensive sexuality education. Barriers (and facilitators) to the realization of SRHR for key populations can be related to: individual knowledge and behavior, including for example, decision-making within the intimate realm and control over private resources; factors at the services level, including accessibility, acceptability, affordability, and quality of services; cultural and gender norms, especially regarding sex and sexuality, including religious beliefs and traditional practices; and national laws, policies and resource allocations which affect the availability and accessibility of information, commodities, and services.

⁷ UNAIDS Strategy 2016 – 2021, op. cit., p3-4 and p7

⁸ *Getting to Zero, 2011-2015 Strategy*, UNAIDS 2010, footnote n. 41 defines key populations, or key populations at higher risk, as “groups of people who are more likely to be exposed to HIV or to transmit it and whose engagement is critical to a successful HIV response. In all countries, key populations include people living with HIV. In most settings, men who have sex with men, transgender people, people who inject drugs and sex workers and their clients are at higher risk of exposure to HIV than other groups. However, each country should define the specific populations that are key to their epidemic and response based on the epidemiological and social context.” The same definition is used in the 2016-2021 strategy. This classification is adopted throughout the NGO report, unless otherwise specified.

7. The 2030 Agenda includes commitments to respect, protect and fulfill human rights, to 'leave no-one behind' and to ensure universal access to SRH. Key components of achieving these aspirations, and thereby the "indivisible goals"⁹ of the SDG framework, remain to be specified and operationalized. These include ensuring access to comprehensive sexuality education; recognizing the specific barriers to SRH services and commodities experienced by key populations affected by HIV; and the actions necessary to remedy these, including protection of sexual rights;
8. Sexual rights describe rights already recognized in international and regional human rights documents, other consensus documents and national law, which are necessary for the realization of sexual (and reproductive) health.¹⁰ These include the rights to: life, liberty and security of the person; equality and non-discrimination; freedom from torture or cruel, inhumane or degrading treatment; privacy; the highest attainable standard of health and social security; enter into marriage with the consent of the intending spouses; find a family and decide the number and spacing of one's children; information and education; freedom of opinion and expression;; and right to access justice and legal remedies. These are inalienable rights, co-equal and intrinsically connected to other human rights including the right to development.¹¹
9. Equally, the right to development establishes the right of all persons and peoples to participate in, contribute to, and enjoy all forms of development, and ensure the protection of all other rights. Addressing the SRHR of key populations most affected by HIV enables this participation, contribution and enjoyment by i) enabling health, ii) ensuring non-discrimination and freedom of expression iii) promoting agency and decision making in relation to SRH among other areas; and, iv) ensuring protection from violence. Therefore, claiming and exercising SRHR is a key milestone towards the enjoyment of the entitlements conferred by the right to development – and claiming and exercising the right to development increases the agency of key populations in relation to their SRHR.

⁹ UNAIDS Strategy 2016-2021, op.cit., p25.

¹⁰ *Defining sexual health*. http://www.who.int/reproductivehealth/topics/sexual_health/sh_definitions/en/

¹¹ The International Planned Parenthood Federation (IPPF) and the World Association of Sexual Health (WAS) provide further explanation to the content of sexual rights based on the WHO working definition, recognizing sexual rights as a set of entitlements related to sexuality that emanate from the rights to freedom, equality, privacy, autonomy, integrity and dignity of all people. See: *Sexual Rights: An IPPF Declaration*.

<http://www.ippf.org/resource/Sexual-Rights-IPPF-declaration>; and *Declaration of Sexual Rights*.

http://www.worldsexology.org/wp-content/uploads/2013/08/declaration_of_sexual_rights_sep03_2014.pdf.

THE RIGHT TO DEVELOPMENT HAS HUMAN RIGHTS – INCLUDING SRHR – AT ITS CORE

10. **The Right to Development – An inalienable human right to which every person is entitled.** The Declaration on the Right to Development (RTD) was adopted in December 1986 by the United Nations General Assembly (GA).¹² This right is also recognized in international instruments and covenants¹³, regional charters, including the African Charter on Human and Peoples' Rights, the Arab Charter on Human Rights, African Youth Charter, Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, and the Charter of the Organization of American States, and the Association of Southeast Asian Nations (ASEAN) Human Rights Declaration and re-affirmed in other global summits.¹⁴ In the Declaration, the General Assembly recognized that:

Development is a comprehensive economic, social, cultural and political process, which aims at the constant improvement of the well-being of the entire population and of all individuals on the basis of their active, free and meaningful participation in development and in the fair distribution of benefits resulting therefrom.

11. The United Nations recognizes the following basic principles about human rights, including the right to development:¹⁵

- No hierarchy of rights. All human rights are equal and interdependent.
- The right to development belongs not with Governments, States, or regions, but with human beings—that is, individuals and peoples: as with all human rights, the rights holders are human beings.
- Human rights are universal; the right to development belongs to all people, everywhere.

12. The 2030 Agenda is explicitly grounded in human rights, resolves to protect and realize the human rights of all people, and envisages a world where human rights are universally respected. The right to development is an inalienable human right by virtue of which “every human person and all peoples are entitled to participate in, contribute to, and enjoy economic, social, cultural and political development, in which all human rights and fundamental freedoms can be fully realized.”¹⁶ This includes a number of constituent elements, such as people-centered development, a human rights-based approach, equity, participation, non-discrimination and self-determination.¹⁷ States and governments, as “duty bearers”, have a responsibility to ensure that human rights are protected and promoted at all times.

¹² *Declaration on the Right to Development*, (A/RES/41/128), 1986.

¹³ These are : the Universal Declaration of Human Rights, International Covenant on Economic, Social and Cultural Rights, International Covenant on Civil and Political Rights, Convention on the Rights of Persons with Disabilities, International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families,

¹⁴ These are: the 1992 Rio Declaration on Environment and Development, the 1993 Vienna Declaration and Programme of Action, the Millennium Declaration in 2000, the 2002 Monterrey Consensus, the 2005 World Summit Outcome Document and the 2007 Declaration on the Rights of Indigenous Peoples.

¹⁵ N. Pillay, *Development is a Human Right For All*. Online at <http://www.ohchr.org/EN/Issues/Development/Pages/IntroductionStatement.aspx>.

¹⁶ *Declaration on the Right to Development*, Articles 1.1 and 1.2, (A/RES/41/128), 1986.

¹⁷ Pillay, op. cit.

13. Key and vulnerable populations, including women and girls in all their diversity, remain central to the UNAIDS 2016-2021 Strategy. The Strategy creates an opportunity and mandate to focus on key populations and those most affected by HIV as being in particular need of having the protections articulated in the SDGs specified and enacted, including their right to development and those rights pertaining to their SRH. In doing so, UNAIDS recognizes that the realization of the SRHR of key populations affected by HIV accelerates the potential of every human person to participate in, contribute to and enjoy economic, social, cultural and political development, and that advancing and sustaining development in all its forms requires the fulfillment of the human rights of all. Thus the right to development depends upon the promotion and fulfillment of all human rights, including SRHR, and vice versa.

MDGS (2000 TO 2015) TO SDGS (2015 TO 2030): PROGRESS TOWARD INCLUSION OF SRHR IN GLOBAL HEALTH AND DEVELOPMENT AGENDAS

14. The Millennium Development Goals (MDGs) were drawn up in 2000 and expected to be achieved by 2015. They included a specific focus on combating HIV, malaria and other diseases (MDG 6), improving maternal health and reduction in maternal mortality rates (MDG 5), and promoting gender equality and empowerment of women (MDG 3). Under MDG 6, Target 6A aimed to “halt AIDS and begin to reverse its spread by 2015,” while Target 6B aimed to “achieve universal access to HIV treatment for all those who need it by 2010.”¹⁸ While considerable progress towards these targets has been made, the continued high rates of HIV prevalence and acquisition, especially among adolescent girls and young women and other key populations (especially gay men and other men who have sex with men, transgender women, sex workers and people who use drugs), reflects the on-going challenges to these populations’ ability to claim and realize SRHR. Multiple layers of stigma, discrimination and marginalization faced by these groups – including misuse of criminal law such as criminalization of sex work, consensual same sex sexual activity, cross-dressing, gender-based and sexual violence and denial of SRHR or forced interventions, – also create barriers to accessing HIV treatment and care.
15. In 2000, there were no specific targets that focused on SRH, despite a growing consensus about its importance, as evidenced by global conferences and international platforms for action. The International Conference on Population and Development (ICPD) in 1994, allied sexual health with the “new comprehensive concept of reproductive health.” Exclusion of SRH from the MDGs was partially remedied in 2007 by the inclusion of a target (MDG 5B) on achieving universal access to reproductive health by 2015.¹⁹ The modified targets did not specifically mention sexual health, however.
16. In the past decade and a half, dramatic developments have occurred in the global understanding of sexuality and sexual health, and much of this is attributed to learning from the field of HIV, social mobilization and sexual behaviour research.²⁰
17. Sexual health encompasses some aspects of reproductive health, such as contraception and abortion, but many aspects of sexual health – including sexual pleasure, intimacy, and

¹⁸ Goal 6: *Combat HIV/AIDS, Malaria and Other Diseases*, <http://www.un.org/millenniumgoals/aids.shtml>

¹⁹ *Vision 2020*, IPPF, April 2013.

²⁰ *Advancing Sexual Health through Human Rights: The Role of Law*, Kismodi et al. *Global Public Health*, 2015, Vol.10 No. 2: 252-267.

the sexual health consequences of violence and female genital mutilation, as well as the complexities of sexual dysfunction – are not directly associated with reproduction.²¹ Sexual health encompasses the early years of life, preceding one's capacity to reproduce, extends well beyond the reproductive years, and is inclusive of those who are unable to, or choose not to have children. However, a broader definition of sexual health as it relates to sexuality and to overall well-being has not been generally accepted.²² The focus of reproductive health is selective, honing in on disease prevention, child and maternal mortality, and family planning, rather than on health more broadly as a "condition of physical, emotional and social well-being, and not merely the absence of disease and infirmity."²³

18. Following global consultations held by the Open Working Group (OWG) and the Intergovernmental Negotiations convened by the United Nations Secretary General and the General Assembly from 2013 to 2015, the United Nations Summit held on 25-27 September 2015 formally adopted the 17 SDGs of the 2030 Agenda, superseding the eight MDGs (see Annex 3). The new goals are contained in the Outcome Document, "Transforming Our World: The 2030 Agenda for Sustainable Development."²⁴ A broader, more holistic and specific agenda for health is specified in the SDGs, with the inclusion of SRH-related targets. **Goal 3** focuses on health, "**Ensure Healthy Lives and Promote Well-being for all at all ages.**" Closely related, **Goal 5** addresses gender, "**Achieve gender equality and empower all women and girls**". Both goals contain the Universal Access target on SRH, with Goal 5 recognizing reproductive rights, albeit within the framework of ICPD and the Beijing Platform of Action.²⁵
19. Of the nine targets under Goal 3 (Health), Targets 3 and 7 are of specific interest.²⁶ Target 3 states, "by 2030 end the epidemics of AIDS, tuberculosis, malaria, and neglected tropical diseases, and combat hepatitis, water-borne diseases and other communicable diseases." Target 7 states, "by 2030 achieve universal access to sexual and reproductive health care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes."
20. Under Goal 5 (Gender Equality and Empowerment of Women and Girls), Target 6 aims to "ensure universal access to sexual and reproductive health and reproductive rights agreed in accordance with the Programme of Action of the ICPD and the Beijing Platform for Action and the outcome documents of their review conferences."
21. Goal 10 on reducing inequality is also of particular relevance to achieving SRHR for populations most affected by HIV and fulfilling the right to development. Target 2 states "by 2030 empower and promote the social, economic and political inclusion of all, irrespective of

²¹ *Defining sexual health Report of a technical consultation on sexual health 28-31 January 2002, Geneva, WHO*

²² WHO has no official definition of sexual health. See paragraph 25 for further discussion on sexual health.

²³ <http://www.who.int/about/definition/en/print.html>

²⁴ *Health in the Sustainable Development Goals: Ready for a Paradigm Shift?*, Buse K and Hawkes S. *Globalization and Health*, 2015; 11:13, 2015.

²⁵ The omission of sexual rights in the SDGs, and the lack of consensus on sexual and reproductive rights more broadly, may be due to a scarce understanding of the concepts of sexual health and its principles, such as sexuality and autonomy. There has traditionally been a narrow focus on negative outcomes of sexuality and sexual behaviour, such as disease, mortality and violence. In the 1994 ICPD, sexual health was subsumed under RH and this may be a reason why discussions of sex and sexuality that go beyond reproduction have been given less attention.

²⁶ *Report of the Open Working Group of the General Assembly on Sustainable Development Goals.* <http://undocs.org/A/68/970>.

age, sex, disability, race, ethnicity, origin, religion, economic or other status;” while Target 3 focuses on removing discriminatory laws to ensure equal opportunities and reduce inequalities of outcome in all areas of development, in line with the right to development.

22. Aside from these, targets under Goals 1, 2, 4, 6, 8, 11, 16 and 17 have implications for, and are indirectly related to both health and HIV. These goals cover poverty, hunger, quality education, water and sanitation, decent work and safe housing conditions, peace and access to justice, and implementation of the framework respectively.²⁷
23. United Nations Special Rapporteurs have criticized the inadequate recognition given to the right to attain the “highest attainable standard of physical and mental health” (the specific wording of the right to health) and in particular, the full range of SRHR, and the lack of specification of the importance of comprehensive sexuality education in the SDGs. They note that SRH services should not only be “universal” but also accessible, affordable, adequate and of good quality.²⁸

SEXUAL HEALTH, SEXUAL RIGHTS AND THE CENTRAL ROLE OF SEXUALITY IN RELATION TO HIV

“[Sexual health] is a state of physical, emotional, mental and social well-being 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. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.” (WHO working definition of sexual health)^{29, 30}

24. Sexual health cannot be defined, understood or made operational without a broad consideration of sexuality, which underlies important behaviours and outcomes related to sexual health. Again, according to WHO: *“Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors.”*³¹

²⁷ The UNAIDS 2016-2021 Strategy (pp26-27) elaborates linkages between each of these areas, as well as health and gender equality, and identifies opportunities for cross-sectoral collaboration to address these.

²⁸ The mandates of the Chairperson-Rapporteur of the Working Group on the issue of discrimination against women in law and in practice, the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, and the Committee on the Elimination of All Forms of Discrimination against Women. <http://www.ohchr.org/Documents/Issues/Women/WRGS/OpenLetter4Nov2014.pdf>.

²⁹ The definition of sexual health above has not been ratified by the World Health Assembly and is “offered as a contribution to further discussions” (WHO). See *Sexual health, human rights and the law*. http://apps.who.int/iris/bitstream/10665/175556/1/9789241564984_eng.pdf.

³⁰ *Defining sexual health; Report of a technical consultation on sexual health 28-31 January 2002, Geneva, WHO*; see also: http://www.who.int/reproductivehealth/topics/sexual_health/sh_definitions/en/

³¹ Cited in *Poverty and Sexuality*. http://www.who.int/reproductivehealth/topics/gender_rights/sexual_health/en/index.html.

25. Therefore, sexuality concerns more than sexual relations and behaviours; it is distinct from reproduction; it is at the core of personhood; the right to be one's own self, and about the very right to exist as a human being.³² It is also at the heart of realizing SRHR. **"Harold", a 27-year-old gay man living with HIV from the Philippines**, captures this succinctly: *"...the exercise of sexual and reproductive health and rights is not confined to the genitalia. It includes the overall psychosocial health of a person in the exercise of one's sexual orientation and gender identity and expression, as related to the realization of individuality and personhood.... To push for sexual and reproductive health and rights is to push for the realization of each one's personhood..."*
26. There is increasing recognition that sexual health cannot be achieved without the recognition, respect, protection and fulfilment of sexual rights and that meeting human rights obligations is essential for social justice, sustainable development and public health.³³ For example, the United Nations Economic Commission for Latin America and the Caribbean (UNECLAC), an intergovernmental commission of Latin American and Caribbean countries, reviewed 20 years of ICPD implementation and concluded in 2013 that states must *"promote policies that enable persons to exercise their sexual rights, which embrace the right to a safe and full sex life, as well as the right to take free, informed, voluntary and responsible decisions on their sexuality, sexual orientation and gender identity, without coercion, discrimination or violence, and that guarantee the right to information and the means necessary for their sexual health, and reproductive health."*³⁴ Sexual rights refer to the human rights necessary to protect all people's rights to fulfill and express their sexuality and enjoy sexual health, with due regard for the rights of others and within a framework of protection against discrimination.

PROTECTING THE SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS OF ADOLESCENTS AND YOUNG PEOPLE

Access to Quality Comprehensive Sexuality Education

27. Access to quality, accurate and up-to-date information and education are keys to achieving other rights, including SRHR. Often, health education in schools does not include all aspects of SRH, focusing on reproductive system biology and diseases.³⁵ Comprehensive Sexuality Education (CSE) includes information on sexual health, gender, human rights and sexuality as aspects of being human, that is accurate, appropriate in accordance with evolving capacities, scientifically-based, and covering non-discrimination, equality, tolerance, safety and respect for the rights of others.³⁶

³² Cited in *Poverty and Sexuality: What are the Connections?*

<http://www.globalequality.org/storage/documents/pdf/sida%20study%20of%20poverty%20and%20sexuality.pdf>.

³³ World Association for Sexual Health (WAS), 2014; WHO, 2010; International Planned Parenthood Federation (IPPF), 2008.

³⁴ Kismodi et al., op.cit.

³⁵ The *Vision 2020 Manifesto* of IPPF notes that CSE is sensitive to cultural contexts; recognizes where it exists, the significant sexualization of public spaces, media and social discourses, and conveys accurate information that respects the right of all people to information and education about their sexual and reproductive health.

³⁶ *Sexual Health, Human Rights and the Law*, WHO, June 2015.

“...When I was in high school, there was no Comprehensive Sexuality Education. I migrated to Beijing with no knowledge... [I was] ignorant about contraception. I got pregnant without planning for it and was very scared. There were two choices: to get married because of my pregnancy, or have an abortion. Either way I felt very lonely because I could not talk to my partner, or any providers about the solutions. In hospitals, they don't have counseling, only surgery. When the hospital doctor learned I was one month pregnant, he just told me to come back after a month for the surgery. Migrants don't have relatives in the cities where they work, and rely on their partners for support. Women migrants face a more difficult situation...If I had the education, then maybe I could have planned a better life...”

“Z.N.”, female migrant and rights activist, Beijing

28. In the case of adolescents and young people, the additional conditions of age of consent, and the perception of “suitability” and “age-appropriateness” (as determined, often in a subjective way, by health providers, teachers, parents, guardians) of sexuality-related information constitute further barriers—an irony, because this is when people precisely need information and services to protect themselves and others. The alternative for many adolescents and young people is to source the information from friends, peers, mass media or the Internet. This information may not always be accurate, appropriate or relevant to the context or may be misleading. Barriers to accessing accurate information, advice and services can be even greater for young women born with HIV who are becoming sexually active, as they are faced with prejudice concerning both their age and their HIV status in relation to their SRHR.

“I was born HIV-positive and both parents have passed away. I live with my aunt in Harare... She is supportive, especially on treatment adherence and other positive living aspects. Now that I've started dating, she tells me that I should not get into a relationship, forgetting that I have sexual feelings and am a sexual being. I have also faced challenges in accessing adequate information and services such as family planning. The service providers are very judgmental and don't seem to care about our well-being... they just say we should not do this or that but do not address my issues. In most cases when I have disclosed my HIV status to the service providers they would call me names or start castigating me, not recognising the good service I am doing to the community by not spreading the virus...”

“Mollyn”, 19, young woman college student living with HIV, Zimbabwe

29. The concept of “evolving capacities”, articulated in the Convention of the Rights of the Child (CRC)³⁷ is fundamental when providing sexuality information and youth-friendly services. This encourages a balance between autonomy and protection for adolescents.

“...I've always faced problems with health providers who saw me as “baby face” so I never had a chance to talk about sexual health and HIV. In schools, nobody talks about it and it's always complicated because most young people begin to have sex much sooner than people think, so it's important to educate people from childhood... When I wanted to buy condoms from the pharmacy, they would not sell me condoms because “I was too young to think about these things”, so even when I wanted to take responsibility, they would not let me...”

“Lucas”, 17, gay male, Paraguay

³⁷ Convention of the Rights of the Child (CRC), Articles 5 & 14, UNOHCHR.

Young Women and Adolescent Girls

30. Young women and adolescent girls continue to experience disproportionate rates of HIV acquisition, especially in sub-Saharan Africa, where every hour 34 young African women newly acquire HIV.³⁸ Awareness of one's rights – especially for adolescent girls and young women – is important for personal confidence and understanding, and can contribute to behaviour changes needed to prevent HIV or to live positively with HIV. Seven core conditions have been identified in a recent publication by UNAIDS and the African Union underpinning the exceptionally high rates of HIV acquisition among young women and adolescent girls. The first of these relates to “inadequate access to good-quality sexual and reproductive health information, commodities and services, in some measure due to age of consent to access;” while another relates to “lack of age appropriate comprehensive sexuality education.”³⁹

“...The Bethany project support group for young people living with HIV and AIDS teaches us to take our medication consistently and correctly, to be confident and assertive. I disclosed my HIV status to my boyfriend; he accepted me and we are prepared to marry. It is an advantage to be in a support group when you are HIV-positive because you learn a lot about sexual and reproductive health, adherence, nutrition and your rights. I now know that it is my right to have a child if I choose to, but I should do that in consultation with health staff at the clinic so that I can have an HIV-negative baby...”

“Primrose”, 22, young woman living with HIV, Zimbabwe

31. Other SRHR-related conditions driving HIV acquisition among young women include: low personal agency, meaning women are unable to make choices and take action on matters of their own health and well-being; harmful gender norms, including child, early and forced marriage, resulting in early pregnancy; transactional and unprotected age-disparate sex, often as a result of poverty, lack of opportunity or lack of material goods; intimate partner violence, which impacts on risk and health-seeking behaviour; and violence – including sexual violence – in conflict and post-conflict settings.⁴⁰

SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS AND WOMEN LIVING WITH HIV: VIOLENCE, COERCION AND PRESSURE COMMON PLACE

32. Everyday patterns of denial and discrimination regarding the SRHR of women living with HIV have been well documented.^{41 42 43} These include: pressure to have or not to have children; pressure to change infant feeding practices; disapproval for starting or continuing to have sexual relationships; inability to negotiate safer sex and fears and concerns about

³⁸ *Empower young women and adolescent girls : fast-tracking the end of the AIDS epidemic in Africa*, UNAIDS and African Union 2015 http://www.unaids.org/sites/default/files/media_asset/JC2746_en.pdf, p,13

³⁹ Ibid.

⁴⁰ Ibid,

⁴¹ *Sexual and reproductive health and rights: international community of women living with HIV/AIDS (ICW) and the global coalition on women and AIDS (GCWA).*

<http://webcache.googleusercontent.com/search?q=cache:3VLZZfYDwN8J:www.icw.org/files/SRHR-ICW%2520fact%2520sheet-06.doc+&cd=1&hl=en&ct=clnk&gl=th&client=safari>

⁴² *Building A Safe House on Firm Ground: Key Findings from a Global Survey of SRHR of Women living with HIV.* Salamander Trust, 2014.

⁴³ *Violations of Sexual and Reproductive Health and Rights of Women Living with HIV in Clinical and Community Settings in Uganda*, ICWEA, June 2015

disclosure; lack of access to treatment for STIs and reproductive tract infections; lack of sexual health screening, including pap smears; lack of prevention tools like female condoms and services to support safe conception; emergency contraception; PMTCT programs that reinforce the role of mothers merely as reproductive machines and vectors of transmission; pressure, coercion or force to terminate pregnancy, be sterilized, or take contraceptives in order to access treatment or other services; and/or, withholding of such services. Violence against women living with HIV is pervasive; existing and emerging data show that violence – structural, cultural and direct – is part of the experience of being an HIV-positive woman.⁴⁴ A definition of violence against women living with HIV has been proposed, as follows:

“Violence against positive women is any act, structure or process in which power is exerted in such a way as to cause physical, sexual, psychological, financial or legal harm to women living with HIV.”⁴⁵

33. Several key informants living with HIV shared their experiences. The case of **Stacey from the USA**, illustrates violations of reproductive rights, coercion and sterilization without consent:

“... In March, 2014, I gave birth to what I was told was a healthy baby boy. At the time the doctors kept informing me that my baby was ok. They waited 14 hours to deliver him even though they knew something was wrong. At the time I opted to have my tubes tied because I was told that he was fine and my fiancé and I decided that we weren't going to have any more children. The doctors misled me. Technically by law they were not supposed to perform a tubal ligation. They were supposed to wait 24 hours before doing so since my son was born prematurely. They ended up burning, double tying, and cutting my tubes without my consent. When I asked about a reversal, the doctor was insinuating that I shouldn't be having unprotected sex anyway since I'm HIV-positive. As for my son, K.J., he was not fine. They pulled the plug and never could give me a reason for his death.”

“Yvette”, a 26-year-old woman living with HIV, originally from Guinea-Bissau and now living in Belgium, shares a dilemma experienced by married women living with HIV, and the interplay of various power dynamics, biases of health workers and restrictive laws that undermine autonomy and choice: *“...When my doctor told me I was HIV-positive he also recommended I tell my husband. There was no discussion about possible consequences, and I don't think he understood what those would be in my situation. When I told my husband, he left me. Health care workers have discouraged me from getting pregnant. When you are pregnant and HIV-positive, health care workers suggest you get an abortion. I am still young, in my 20s, and would like to have children.”*

While **“Nadege”, 25, from Rwanda**, relates: *“I was 16 when they tested me for HIV, and was immediately put on treatment. Fortunately the clinic was close to where I lived and it had funding. I kept on losing my loved ones - my mother, brother and three aunts, two girls from my high school and four others from our neighborhood. They did not have access to the same treatment*

⁴⁴ Salamander Trust 2014 op. cit., findings from this Survey showed that 89% of women living with HIV who answered questions on violence, had experienced one or more forms of violence before, since or because of their HIV diagnosis

⁴⁵ *Violence against women living with HIV/AIDS – a background paper*. Hale F and Vasquez M, Development Connections, ICW Global and UN Women, 2011, p.13

that I had. Young people need to have a chance of living a brighter and happier future with full rights as citizens, with love, consideration and support. Without this, many young people drop out of school due to illnesses and many more lives will be lost. Stigma is high in the health service centers. Many health personnel have negative attitudes towards HIV-positive people. This can result to non- or limited drug adherence, and no information being shared about family planning and dating. We are denied our sexual rights due to our HIV+ status, as if we do not have feelings....”

SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS OF KEY POPULATIONS

34. In July 2014, WHO launched the Consolidated Guidelines on HIV prevention, diagnosis, treatment and care for key populations.⁴⁶ Unlike the UNAIDS definition of “key populations”, people living with HIV are not specifically listed as part of this population, though they are specified in many sections of the guidelines. Aside from HIV-specific and general health sector interventions, “critical enablers” – law and policies, stigma and discrimination, community empowerment and reduction of violence – are emphasized.
35. In a major shift, which aligns the concepts of reproductive health and sexual health, the SRH interventions in the above guidelines acknowledge the importance of pleasurable sexual lives and choices, as well as options related to reproductive health and rights. On pages 19 and 78 (4.6.2) the guidelines specify: *“Members of key populations, regardless of whether or not they are living with HIV, should be able to experience full, pleasurable sexual lives and have access to a range of reproductive options. Screening, diagnosis and treatment of STDs should be offered routinely as part of a comprehensive HIV package; women from key populations should enjoy the same reproductive health rights as all other women; it is important that they have access to family planning and other reproductive health services, including reproductive tract cancer prevention, screening and treatment; abortion laws and services should protect the health and human rights of all women including those from key populations.”*

Gay men and other men who have sex with men

36. Globally, gay men and other men who have sex with men are 19 times more likely to be living with HIV than the general population, and this continues to rise in many parts of the world.⁴⁷ Sexuality remains central among the issues gay men and other men who have sex with men face, as discussed in the previous sections. Stigma and discrimination due to the non-recognition of their sexuality pushes many men who have sex with men underground and keeps them from accessing HIV and SRH services that they need. Currently, 78 countries criminalize same-sex sexual practices, and in seven of these countries, same-sex practices are punishable by death.⁴⁸ UN Agencies, such as OHCHR, UNDP, UNAIDS, WHO, recommends that countries review, repeal or institute a moratorium on the application of

⁴⁶ *Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care in Key Populations*. WHO, July 2014. WHO specifies these key populations as: men having sex with men, people in prisons and closed settings, people who inject drugs, sex workers and transgender people. Vulnerable populations are groups of people who are particularly vulnerable to HIV infection in certain situations or contexts, such as adolescents (particularly adolescent girls in sub-Saharan Africa), orphans, street children, people with disabilities and migrant and mobile workers.

⁴⁷ *Gap Report*, UNAIDS, 2014, p. 20.

⁴⁸ *Ibid*, p.12.

laws that criminalize same-sex sexual behavior as a critical enabler in turning the tide of the HIV epidemic among this particular key population.⁴⁹

37. Where same-sex activities are criminalized or persecuted, gay and other men who have sex with men live in fear, which undermines the right to health and even the right to life. “**Balo**”, a gay man in Nigeria with HIV, states: “...We have been living in fear since the Government of Nigeria enacted a law criminalizing same-sex relationship. Many of us that are openly gay have seen increasing threats. I sometimes experience hostile attitudes from health care workers in the ARV clinics although I have never been refused treatment. Similarly, in Liberia, “**Sail**” says: *Laws criminalizing same-sex activities among consenting adults drive LGBTI underground, affecting their ability to seek sexual and reproductive health services ... We need to take a closer look at the impact of the recent wave of homophobia in Africa and the grave danger it poses to the gains we have achieved in the last three decades....*”

Transgender Persons

38. Transgender people, specifically transgender women, have the highest rates of HIV globally among key populations, being 49 times more likely to acquire HIV than the general population, according to UNAIDS.⁵⁰ Further, in many settings, transgender women are still included under the “MSM” umbrella, which fails to comprehensively address all their needs. In recognition of the need to further specifically address HIV prevention and care among transgender people, WHO with partners developed a policy brief in July 2015.^{51 52} While framing interventions specific for transgender people within the guidance documents for key populations, the technical brief also discusses other specific transgender health and rights issues. These include discrimination, violence, and stigma that transgender people face in their daily life, how human rights may be often violated, and how health services may be denied or how health, including SRH problems, go unrecognized because of their gender identity and expression. These limit the agency of transgender women and other transgender people to access knowledge and enact decisions which promote their health in general and sexual and reproductive health and well-being specifically, including HIV prevention, or living positively with HIV, among other areas of decision making and agency. They should have access to transition related services specific to transgender people including hormone therapy and different types of gender affirmation surgery. WHO recommends that countries work towards legal recognition of transgender people and non-conforming gender identities, citing supportive legislation from Nepal, India, Argentina, Malta and Uruguay.⁵³
39. The major concerns of transgender people in general and transgender women in particular expressed during the consultations for this NGO report include non-recognition, discrimination at work and general health services, and violence, both from health authorities and police.

⁴⁹ Inter-Agency Statement on LGBT, UNDP HIV and the Law Commission, WHO (2014) Consolidated Key Pops Guidelines, Ibid, p.8.

⁵⁰ UNAIDS Strategy 2016-2021, op.cit., p.29

⁵¹ *Transgender People and HIV– A Policy Brief*. WHO, 2015.

⁵² Sexual Health, Human Rights and the Law. WHO 2015

⁵³ Ibid p.8

“...We often have trouble obtaining basic legal documents and rights. The fact that we are trans has complicated our experiences with getting jobs or in everyday human interactions...We are not counted, we are looked down as third grade citizens, we have no choices...”

“Poloumi”, 50, Muslim transgender person living with HIV, India

Ari, a 26-year-old gay African-American/Indigenous man living with HIV from the USA

notes: *“...Hate crimes keep happening, especially to trans women. The attitudes of the police toward young people who are gay or lesbian or transgender are a big issue; they are supposed to protect, but they aggravate the situation. People have left the state. They are afraid because of legislation (Religious Restoration Act) that gives medical personnel the right to refuse to treat you, even in emergency situations, if they believe that you are LGBT, and if homosexuality goes against their religious beliefs.”*

40. Transgender people need a similar range of SRH services, including breast cervical and other cancer screening, abortion/post abortion care services, maternal and child health (MCH) and prevention of vertical transmission for transgender men who may get pregnant, intentionally or not. Health providers should be sensitized on the need for comfortable examinations of the breasts, genitals and anal areas, and should be able to address issues related to GBV, including providing psychosocial support and referrals. In the same manner, uniformed personnel also need to be sensitized and trained on transgender sex work issues, to protect and promote rights, prevent violations and punish those responsible should they occur.

Sex Workers

41. Aside from HIV prevention interventions such as condoms and lubricants, sex workers need STI treatments, family planning information and services, contraception, abortion services and post-abortion care, and protection from violence. Sex workers are often viewed solely in the context of sex work and not as parents and partners. They also need antenatal services, MCH services and programmes to prevent vertical transmission for sex workers living with HIV who choose to have children.⁵⁴ However, their fertility choices are often disregarded because they do not fit into gendered cultural stereotypes regarding ‘appropriate’ motherhood.

“I was 19, new to sex work, and got pregnant... I didn’t know what to do and was afraid and ashamed. One of my friends told me about a clinic doing abortions, but the doctor asked to bring my husband.... So I went to another clinic and told them that my boyfriend made me pregnant and left me.... I did not have the money to pay for the abortion.... When I went for delivery, doctors, nurses and even cleaners asked where the father was. After delivery, the nurse said I delivered a dead baby, I did not even see the body.”

“Farzana”, 19, sex worker, Bangladesh

42. Male, female and transgender sex workers experience high rates of substance use, such as alcohol, amphetamine-type stimulants and various “party drugs.” Harm reduction interventions should also be incorporated into the services available. The UNAIDS Guidance Note on HIV and Sex Work (2012) recommends States to move away from

⁵⁴ *Experiences with pregnancy among FSW in Ethiopia: a link-up exploratory study..* The Link-Up Project, OSSA, Miz-Hasab Research Center Ethiopia, Population Council, April 2015.

criminalizing sex work or activities associated with it, in particular, “decriminalization of sex work should include removing criminal laws and penalties for purchase and sale of sex, management of sex workers and brothels, and other activities related to sex work to the degree that states retain non-criminal administrative law or regulations concerning sex work, these should be applied in ways that do not violate sex workers’ rights or dignity and that ensure their enjoyment of due process of law”⁵⁵ ..

People who inject drugs

43. People who inject drugs are another key population whose SRHR and general health needs are neglected. Criminalization of, and negative societal attitudes regarding, drug use contribute to stigma and discrimination against people who inject drugs. This includes denial of or failure to recognize the SRH needs and rights of people who inject drugs (including those living with HIV), including the potential desire for intimate relationships and to have children and families.⁵⁶ People who inject drugs who are women, pregnant or with children, sell sex, are incarcerated or are living with HIV tend to face even harsher stigma and discrimination. Negative social attitudes mean that proven harm reduction interventions such as needle and syringe programmes, opiate substitution, or overdose prevention education may be less of a priority compared to ineffective, but popular, abstinence-based or ‘rehabilitation’ interventions. In many countries, drug use remains under the realm of law enforcers, rather than being considered a health concern.

44. A supportive health care provider can make a difference. In the case of “**Svetlana**”, a **pregnant 32-year-old Russian woman who uses drugs**: *“Doctor N.A. treated me very well. Thanks to him I gave birth. I didn’t have all the documents and he took responsibility for me. The hospital doctors knew that I am addicted. Dr. N. A. took care of me; he worried about me. He scolded the medical personnel harshly if they did something wrong. I now have two children and I didn’t abort the second because I was lucky with the doctor....”*

Incarcerated Populations (People in prisons and other closed settings)

45. Incarceration is associated with increased risk behaviours and lack of HIV services in these settings. People in prisons should have access to the same array and quality of health services, including SRH and HIV-related services and rights, as other people who are not confined. Specific situations experienced in confinement (such as tattooing and unclean needles, drug use, sexual violence, overcrowding, etc.) may add to the risk of acquiring and spreading HIV, STIs, Hepatitis and Tuberculosis.⁵⁷ Lack of adequate prison health and follow up services, once people are released, complicate the situation further. The SRH and HIV-related needs and rights of people in prison may also be ignored. In particular, the rights to privacy, confidentiality, and dignity are often compromised in the context of accessing SRH and HIV services in prison.

“...My husband and I were arrested in 2013; he had eight grams of methadone. I was pregnant and sentenced for six years... For 53 days, I was not given the medicine that I took for HIV. I

⁵⁵ http://www.unaids.org/sites/default/files/media_asset/JC2306_UNAIDS-guidance-note-HIV-sex-work_en_0.pdf

⁵⁶ *Advancing Sexual and Reproductive health and Human Rights of Injecting Drug Users living with HIV.*

International Network of People who use Drugs (INPUD) and GNP+, 2010.

⁵⁷ *Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care in Key Populations*, op. cit., p. 5.

had enough therapy for one month and after it ran out, I didn't have medicine. When I went into labour, I was taken to the nearest maternity ward in a convoy. I hadn't stopped bleeding and I was brought back to the colony. Now, in the colony, I have other problems in my uterus that may need an operation, but until I am released they won't do it, and it is unclear what the outcome will be...."

"Catherine", a 34-year-old Russian woman living with HIV

Migrants and Mobile Populations

46. Migrants also face specific challenges with respect to access to various health and social services, including HIV and SRH services, owing to language and cultural barriers, lack of identity cards, residency or registration papers, and lack of knowledge about the health services, health insurance and social security systems. These difficulties are further exacerbated by cultural and gender stereotyping, racism, xenophobia, gender inequality, homophobia or/and transphobia.

"People think that HIV is an African problem and we are carriers, and they think we are just here to get medication. Living with HIV is one thing, but also being black. You're treated totally different if you are a white person living with HIV, than if you're black. You try and find a job and they don't even give you a chance..."

"Winnie" 45, Ugandan migrant woman living with HIV, London

47. Migrants who are on antiretroviral therapy (ART) may rely on networks and personal friends to continue adherence. For example, **"Rodrigo", a 20-year-old gay man with HIV, who lives in Argentina, near the border with Paraguay:** *"I went to Paraguay to visit my family. I ran out of medicine there. Some friends in Asuncion gave me some of my prescribed medicines. This wasn't thanks to the government or anything, but it saved me from running out of medication..."*

Indigenous Peoples (and Ethnic Minorities) with HIV

48. Another population that may be vulnerable in some countries are Indigenous Peoples. While few efforts have been funded for systematic research on the needs of Indigenous Peoples related to HIV, there are reports of barriers to access health services, including SRH and HIV-related services, and of human rights violations within health settings. In particular, reports of SRHR violations among indigenous women are beginning to be well-documented.

"Indigenous peoples globally are facing a renewed threat to their survival post-colonisation. Incidences of violations to indigenous women living with HIV, and to their sexual and reproductive health rights, are rising. This is a noted common theme for all indigenous populations throughout the world. Six years ago, I was coerced into being sterilized. I've spoken to other indigenous women in Asia Pacific who have been "talked into" having a hysterectomy, coerced into not having children via contraception, or have had children taken away because of their HIV status."

Marama Pala, Maori, International Indigenous Working Group on HIV/AIDS

People with Disabilities

49. People with disabilities are often isolated and excluded from various services, formal education systems and community life. They may be easily subject to exploitation, abuse and violence, and are often unable to complain. They are not expected to have SRH needs and desires, or these are rigidly controlled through forced sterilization, abortion and/or use of long-acting contraception. As a result, people with disabilities have been systematically overlooked in HIV and SRHR programming, and few attempts are made to address the barriers they face in accessing services and information. This contravenes provisions of the Convention on the Rights of People with Disabilities (CRPD).⁵⁸

“Being blind and HIV-positive does not mean being useless, but sometimes I feel I am because of the way some nurses treat me.... making comments on how someone with a disability could get HIV, as if I deserved it because I had sex even with my condition. Being blind doesn’t mean I am asexual. I have children, and have feelings just like any normal human being.”

“Berlita”, a 30-year-old HIV-positive blind woman, Zimbabwe

“...Some people just look at you and think of you as somebody they should take advantage of. Some men think that they are doing you a favour when they have sex with you. Several people wanted to take advantage of me sexually. Many of us do not have the courage to say no to sex or have the confidence to discuss their experiences. Whenever HIV programmes are organized, there are no provisions for sign language interpreters.”

“Loveth”, woman living with disability, Nigeria

Older people and coming to terms with HIV: the next frontier?

50. As the epidemic enters its fourth decade, a number of people have lived with HIV as a chronic and persistent condition for decades. Older people living with HIV experience other SRH changes, such as increased risk of reproductive tract cancers, while also having needs for pleasure, companionship and intimacy. Older women also experience SRH changes brought on by menopause.⁵⁹ A whole “life cycle” approach to SRHR, from the pre-pubertal, to the reproductive, and post-menopausal years, should be adopted, including greater recognition of the risk of acquiring HIV and other STIs among post-menopausal women for whom the focus of ‘protection’ has been on preventing unwanted pregnancies. As a recent consultation on the SRH and human rights of women living with HIV has highlighted, further research into the geriatric years, including post-menopausal years, of people living with HIV is needed.

“There are huge gaps in clinical care, practice, policy and research for women especially those of us living with HIV in menopause and post-menopause, because then the ‘threat’ of mother-to-child-transmission is not present”⁶⁰

Belonging to several key populations and affected communities at the same time is a reality for many of the respondents as discrimination is exacerbated.

⁵⁸ Article 25 of the CRPD states: provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes.

⁵⁹ Salamander Trust 2014, op. cit., p. 13, 52-53.

⁶⁰ Ibid, p.13

51. Many of those who self-identify with multiple key population groups may have inter-locking concerns and “overlapping” risks. As one respondent stated, “...Where there is overlap, where one is LGBT, at the same time, PLHIV, an injecting drug user (IDU) and an IP (Indigenous Person), the exercise of sexual and reproductive rights is constrained; one remains silent or denies his identity to avoid discrimination and being judged. But in denying realities, one may not get the right services. In school, one puts up a façade to be accepted. The expression of identity is denied due to fear of rejection. Add HIV-status to that. Add being an IDU. The answer is obvious. Can living a life full of denial be considered a life lived with meaning?”

“Harold”, a 27-year-old gay man who lives with HIV, and is also an indigenous person who occasionally injects, Philippines

52. The burdens on sexual, mental and psychosocial health imposed by knowledge of one’s HIV status can be formidable, even in situations where people on treatment are aware of the very negligible risks of transmission. In the words of “**Maria**”, **35, who lives with HIV in Portugal**: “...I had a boyfriend for five years. He knew my HIV status and did not want to use a condom. We ended the relationship because I was so afraid of transmitting HIV. So, I am single since 2005. To have a sexual life is complicated. All the time I am aware of living with HIV, concerned if I have an infection, adhering to my treatment and so on. I cannot fully relax. It’s a huge responsibility. I would rather be alone, than to think that there might be a possibility of transmitting the infection to someone.”

INTEGRATION OF SRH AND HIV SERVICES REMAINS A CHALLENGE

53. Approaches to addressing the linkages between HIV and SRHR for key populations include research, advocacy, Comprehensive Sexuality Education, community mobilization, movement building, human rights monitoring, challenging gender norms and service integration, among others,⁶¹ and tailoring these interventions for women and men from diverse backgrounds and contexts. However, while integration of HIV and SRH services provides a promising approach to addressing some of the barriers faced by key populations in accessing services, translation of the principle into practice remains a challenge. The main components of SRH and HIV services and their linkages were described in 2004 (see Annex 4).⁶² Integration refers to different kinds of SRH and HIV services or operational programmes that join together to ensure and maximize collective outcomes. Efforts to make linkages with practical examples of integrated services exist, but need to be further reproduced, taken to scale and made more efficient.⁶³ The example below also highlights the potential benefit of, but current lack of integration of, services tailored to the needs of sex workers in Myanmar:

⁶¹ See for example, *Community Innovation*, ATHENA and UNAIDS 2011, http://www.athenanetwork.org/assets/files/Community%20Innovation/UNAIDS%20and%20ATHENA_Community%20innovation.pdf

⁶² Sexual and Reproductive Health and HIV: A Framework for Priority Linkages. WHO, UNFPA, UNAIDS, IPPF. 2005

⁶³ *Thematic Segment: Sexual and Reproductive Health (SRH) services with HIV interventions in practice Background Paper*. https://www.unfpa.org/sites/default/files/resource-pdf/SRH_background_paper.pdf.

“...I entered sex work a year ago, not knowing much about STIs or pregnancy. It is a challenge to use condoms every time. Some clients don't want to, sometimes they are not available.... One day I felt pain during urination and itching in my genitals. It got worse and a few days later, I had a discharge with blood and an unpleasant smell. It was so bad that I had to stop working. A friend took me to an NGO clinic, where I had an HIV test. I had two problems: I was pregnant, and had syphilis. The doctor could treat me for syphilis but said he could not deal with pregnancy. The medicine worked, the pain and discharge ended, but the pregnancy remained. I wanted an abortion, but did not have the money; luckily, a client helped out. Post-abortion, I felt serious stomach pain, bled for a week, and could not work. I went to an NGO, but they don't provide treatment related to abortion, so there was no help. We need safe abortion and also care after abortion....”

Tazin, 19, sex worker, Myanmar

54. Approaches to integration may include referrals and/or “one-stop” facilities, as well as mobile/outreach clinics, peer education and youth-led services that provide a range of SRH and HIV information, services, interventions and referrals for various populations in different contexts, including young people and adolescents. For example, these may include: information to make informed decisions on sex and sexual relationships; promoting intergenerational dialogue; safer sex promotion to prevent STIs, HIV and unintended pregnancy; HIV testing and counseling, post-exposure prophylaxis (PEP), Pre-Exposure Prophylaxis (PrEP), human papillomavirus (HPV) vaccination, cervical cancer screening and treatment, including anal and penile cancer screening in treating HPV particularly for those living with HIV; family planning; emergency contraception; safe abortion and post-abortion care; protecting and enhancing fertility; HIV treatment; prevention of vertical HIV transmission; maternal and child health; voluntary male medical circumcision (VMMC); prevention, diagnosis and treatment of SRH-related cancers; and, preventing and addressing GBV.⁶⁴ WHO also recommends the use of PrEP as another HIV prevention option for sex workers, within a set of comprehensive HIV prevention interventions, as well as for populations who have a yearly HIV infection rate (incidence) higher than 3% and among serodiscordant couples.⁶⁵
55. The SDGs do not explicitly promote an integration agenda. Furthermore, the 2030 Agenda does not define the full scope of “sexual and reproductive health care services”.⁶⁶ This could be interpreted according to ICPD, WHO or other global and regional bodies and platforms, or else left to Member States and various ministries to interpret. However, the Agenda does not include specific reference to Comprehensive Sexuality Education, and does not articulate linkages between SRH and HIV. The UNAIDS 2016-2021 Strategy, in accordance with Decision 5.4 of the 36th PCB, calls for multisectorality of the AIDS response in the SDGs, and articulates linkages not only between HIV and SRHR, but also in relation to a range of other areas, as shown (see paragraphs 21-24 above). The Strategy is also explicit in calling for integrated SRH and HIV service delivery and policies which support the same (see paragraph 73 below).⁶⁷

⁶⁴ Modified from *Integration of HIV and Sexual and Reproductive Health and Rights: Good Practice Guide*. [http://www.aidsalliance.org/assets/000/000/416/507-Good-Practice-Guide-Integration-of-HIV-and-Sexual-and-Reproductive-Health-and-Rights-\(Black-_-White\)_original.pdf?1405586797..](http://www.aidsalliance.org/assets/000/000/416/507-Good-Practice-Guide-Integration-of-HIV-and-Sexual-and-Reproductive-Health-and-Rights-(Black-_-White)_original.pdf?1405586797..)

⁶⁵ *Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care in Key Populations*. WHO, July 2014, pp. 44-48; *Policy Brief on Transgender People and HIV*, WHO, July 2015, p. 21-22.

⁶⁶ Paragraph 26 of the 2030 Agenda includes: “We are committed to ensuring universal access to sexual and reproductive health-care services, including for family planning, information and education.”

⁶⁷ UNAIDS Strategy 2016 – 2021, op. cit., p. 81

SEXUAL AND REPRODUCTIVE HEALTH, HUMAN RIGHTS, HIV AND THE LAW

56. The HIV epidemic is not merely a major public health issue—it has been described as a “crisis of law, human rights, and social justice.”⁶⁸ Punitive laws, discriminatory and brutal policing and denial of access to justice to people living with or vulnerable to HIV fuels the epidemic and increases risks by limiting access to services and driving people underground. In 2012, the Global Commission on HIV and the Law made comprehensive recommendations for legal and policy reform rooted in both public health evidence and human rights standards.
57. In June 2015, a WHO report on Sexual Health and the Law concluded that States have obligations to bring their laws and regulations that affect sexual health into alignment with human rights laws and standards.⁶⁹ Removing barriers in access to SRH information and services, and putting in place laws and regulations that aim to support and promote SRH, are actions that are also in line with WHO’s global reproductive health strategy adopted by the World Health Assembly in 2004.
58. Recently, Amnesty International approved a policy to advocate for decriminalization of sex work. The policy is based on human rights and harm reduction principles: namely, consensual sexual conduct between adults (excluding acts that involve coercion, deception, threats, or violence) is entitled to protection from state interference, and the criminalization of sex work is more likely than not to reinforce discrimination and increase the likelihood of being subjected to harassment, violence, ill-treatment by police, denial of due process and exclusion from various public benefits.⁷⁰ The policy has been lauded by communities of sex workers, various civil society organizations (CSOs) and non-government organizations (NGOs) working with sex workers, and the United Nations.
59. Punitive laws, such as those that criminalize same-sex sexual activity among consenting adults, cross-dressing, voluntary sex work, drug use, transmission of HIV and the non-disclosure of HIV status, are considered counterproductive⁷¹ and a violation of human rights.⁷² They also create an environment where discrimination and stigma are further institutionalized and entrenched.
60. Laws can also contribute to an enabling environment. Decriminalization and elimination of legal barriers have resulted in positive health effects and reducing vulnerability to HIV,⁷³ including through reducing violence and improving access to SRH services by key populations.⁷⁴ These laws are often based on sound public health, as well as human rights principles. Estonia has enacted anti-discrimination legislation, leading to increased information and access to HIV prevention, treatment and care, as described below:

⁶⁸ *HIV and the Law: Risks, Rights, and Health. Report of the Global Commission on HIV and the Law*, UNDP, July 2012.

⁶⁹ *Sexual Health, Human Rights and the Law*, WHO, June 2015.

⁷⁰ *Summary: proposed policy on sex work*. <https://docs.google.com/viewer?a=v&pid=sites&srcid=YW1uZXN0eS5vcmcuYXV8YWlhLWFjdGl2aXN0LXBvcnRhbnRneDoxNWMyZThjMDI5MzJmZmMy>.

⁷¹ Global Commission on HIV and the Law, op.cit.

⁷² UNAIDS 2016-2021 Strategy, op.cit., p. 64

⁷³ Ibid.

⁷⁴ Global Commission on HIV and the Law, op. cit.; *Sexual Health, Human Rights and the Law*, WHO, 2015.

Estonia: Showing the Way for Respect for SRHR

Estonia has strengthened its commitment to fighting HIV, and currently spends the third highest amount per capita in Europe on HIV prevention (\$4.93, behind Luxembourg and Greece who spend \$5.00). It has a more liberal and tolerant attitude towards people of diverse Sexual Orientation and Gender Identity and Expression (SOGIE) and remains the only ex-Soviet country to recognize same-sex relationships. It recently adopted a same-sex cohabitation bill. Meanwhile, in countries with repressive policies on SOGIE and sexual and reproductive rights, gay men and other men who have sex with men are increasingly forced to resort to clandestine networks of casual sexual partners, which in turn may lead to an increase in HIV infection rates. Gay men and other men who have sex with men are often reluctant to visit sexual health clinics in such countries, due to stigma, discrimination or violence. Estonia's favourable political and social climate enables gay men and other men who have sex with men to learn of their HIV status and for those who test HIV-positive to seek treatment, care, and support. This information and access to treatment and care is crucial to ensuring an effective HIV response; recent estimates place the HIV prevalence among gay men and other men who have sex with men in Estonia at 2.5 per cent, compared to Ukraine (21 per cent) Russian Federation (18 per cent,) Uzbekistan (6.8 per cent), Moldova (4.8 per cent) and Georgia (3.7 per cent).

ROLES OF CSOS, NGOS AND NETWORKS IN REALIZING RIGHTS OF KEY POPULATIONS

61. According to the UNAIDS-Lancet Commission, “activism and advocacy are the defining features of the response to HIV.” The Commission report notes the roles played by activists and people living with HIV and cites these actions as “global public goods” deserving of investments.⁷⁵ Furthermore, CSOs' involvement has strengthened participation of key populations, improved access to health, education, and justice services and facilitated redress and remedies.

62. However, activism and advocacy in countries with repressive policies can put lives of activists at risk. In the case of “**A.E.**”, **a teacher and lecturer from Russia**:

“Under pressure from a campaign 'Against the propaganda of sexual perversions', he was fired from his work at the school due to his participation in several LGBT activities, and threatened with violence. In 2015, during an LGBT demonstration, he was attacked. A TV programme, 'Special Correspondent: Poisonous Export', accused him of being an agent of the US embassy, recruited to lead LGBT demonstrations in Russia. After this, A.E. decided to leave the country. LGBT people and their supporters face a difficult situation in Russia....”

63. Several informants cite the role played by CSOs, particularly in providing essential information and services. Participation of key populations in all aspects and stages of programme and project development, implementation and evaluation builds capacity, confidence and empowerment. This is the essence of meaningful involvement of key populations.

⁷⁵ *Defeating AIDS – Advancing Global Health*, Piot P et al. Report of the UNAIDS-Lancet Commission, June 2015. [http://dx.doi.org/10.1016/S0140-6736\(15\)60658-](http://dx.doi.org/10.1016/S0140-6736(15)60658-)

“ ...We address SRHR issues for sex workers, making sure there is no stigma and discrimination in health centres, and ensuring sex worker health and dignity. We, peer educators, promote and distribute condoms especially to our clients so that we remain in business. Recognition of sex work programmes by governments and companies will go a long way in terms of support to Wellness programmes in workplaces. We are responsible sex workers who have rights too...”

“Lydia”, Sex Worker Peer Educator, Mozambique

“...Working with other NGOs on different issues, collaborating with our expertise, they accept us as professionals and not judging us, boosts our morale and improves our abilities...”

“K.C.”, Transgender person and drop-In Center Coordinator, Pakistan

64. CSOs and networks provide much needed strategic technical support, build coalitions and movements, facilitate engagement with other key actors and allies who may not necessarily be HIV-focused and strengthen service delivery and demand creation, rights awareness, and integration efforts, among others. The case of the European Harm Reduction Network (EHRN) and its work with the National Harm Reduction Network on country reporting on the Convention to Eliminate Discrimination Against Women (CEDAW) illustrates this (see Annex 5).

ISSUES IN FINANCING THE SRHR RESPONSE

65. Investments in the provision of SRH services – including in civil society to mobilize demand for, provision, and utilization of services at the community level – are critical to well-being, resilience and prosperity, and have proven to be cost-effective and cost-saving.⁷⁶

Underfunding of rights-based SRH programmes is thought to be a contributing factor as to why goals related to achieving universal access to SRH services (1994 ICPD) remain unachieved, and why MDG 5 on maternal health is one of those left farthest behind.⁷⁷ Costs are passed on to the consumer. According to the High Level Task Force (HLTF) for ICPD, the bulk of domestic spending on Health SRHR packages (up to 62 percent, as of 2011, the latest year for which data was available) comes from out-of-pocket expenditures, with alarming implications for equitable access.

66. Funding (Official Development Assistance or ODA) for health has tended to favour biomedical approaches to HIV and AIDS. This has led to imbalances relative to SRHR funding, and engendered vertical as well as parallel funding streams for what are actually inter-related priorities: family planning, maternal health, and HIV and AIDS, among others.⁷⁸

67. The HLTF for ICPD stresses that the solution is not to diminish support for HIV, but to increase support for all the inter-related dimensions of SRHR. Advocacy and political will are needed to secure adequate domestic funding in all countries, and for donor countries to

⁷⁶ *Policy Considerations for Financing Sexual and Reproductive Health and Rights in the Post-2015 Era*, High Level Task Force (HLTF) for ICPD, February 2015.

⁷⁷ Ibid.

⁷⁸ Ibid.

have 0.7 percent of GNI allocated to ODA, a commitment that is yet to be met. The HLTF recommends several strategies for financing SRHR in the Post-2015 era.⁷⁹

68. In many countries, resources allocated for HIV prevention are not always based on evidence. In Asia and the Pacific, of US\$186 million invested in prevention activities by 15 reporting countries, only 36 percent of this amount was directed towards gay and other men who have sex with men, people who inject drugs, transgender people and sex workers.⁸⁰ This is the case despite evidence that the epidemics are concentrated in these populations⁸¹. Currently, external donors provide the bulk of resources for key populations. In 2014, 67 countries reported that they relied solely on international donors for financing programmes for men who have sex with men.⁸² There is no assurance that governments will continue such programmes after external funding ceases. There also appears to be insufficient attention to efficiency, or to planning for future transitions in funding.⁸³ Furthermore, only about one percent of current global resources for HIV support community mobilization and community systems strengthening. UNAIDS estimates that this will need to increase to four percent if current HIV prevention and treatment targets are to be met by 2030.⁸⁴
69. As economies progress, the march towards “middle income” status of many countries will result in shrinking ODA, and additional restrictions on development financing. This results in higher levels of out-of-pocket expenditures for health care. In Latin America and the Caribbean, from 2010-2013, close to 70 percent of health costs are paid for by patients compared to 45 percent for the rest of the world.⁸⁵ The high health care costs and the large proportion that has to be paid out-of-pocket can leave the poor behind, and push those just above the poverty line into poverty. A slight increase in national income takes years to transform the new revenues into larger health expenditure.⁸⁶ A redefined income classification is needed to protect countries whose public health might suffer when they reach middle-income status.⁸⁷
70. The impact of austerity measures in many countries with financial crises leads to more out-of-pocket expenditures and additional burdens:

⁷⁹ Ibid, pages 3-10. The recommendations include: development of national financing action plans for SRHR; improve tracking of financial resource flows for SRHR; reduce fragmentation of donor funding streams; improve efficient use of available resources; increase mobilization of domestic public revenue for health including SRHR (consider various taxation regimens); remove financial barriers to accessing SRHR; mobilize new innovative sources of financing; regulate private sector financing for SRH service provision, and strengthen monitoring and accountability for financial commitments to SRHR.

⁸⁰ *Gap Report*, UNAIDS, 2014, p. 75.

⁸¹ UNAIDS Strategy 2016 – 2021, op. cit., p88-89

⁸² *How AIDS Changed Everything: 15 years, 15 Lessons of Hope from the AIDS Response to MDG6*, UNAIDS, 2015, p.192, 213.

⁸³ Ibid.

⁸⁴ *Fast-Track: Ending the AIDS Epidemic by 2030*, UNAIDS, 2014, p. 21.

⁸⁵ *Money Matters in Middle-Income Countries: Funding Sexual and Reproductive Health in Latin America and the Caribbean*, IPPF, 2015.

⁸⁶ *Countries beware: climbing up the income ladder can seriously damage your health.*

<http://www.msf.org/article/countries-beware-climbing-income-ladder-can-seriously-damage-your-health>.

⁸⁷ *Defeating AIDS-Advancing Global Health*. Lancet Commissions Report, June 25, 2015.

[http://dx.doi.org/10.1016/S0140-6736\(15\)60658-4](http://dx.doi.org/10.1016/S0140-6736(15)60658-4). P. 24

“...Countries that are living under austerity measures like Greece, Spain and Portugal are now imposing fees for treatments. Health in Portugal was universal and free (for the ones with chronic diseases and low income). Nowadays it has changed, imposing more vulnerabilities to those most vulnerable....”

Woman living with HIV activist, SERES, Portugal

71. The UNAIDS–Lancet Commission Report and the UNAIDS “Fast-Track” report both urge a ramping up and more efficient AIDS efforts, noting that the next five years (2016-2020) present a window of opportunity to “fast-track” the AIDS response and end AIDS as a public health problem by 2030; failing to do so, and to continue at current efforts, will increase the number of deaths and new HIV infections by 2020.⁸⁸ “Smart” and “selective” integration of HIV services into the general health services – beyond the usual RH and MCH facilities – is proposed by the Commission, with the caveat that no single approach to integration will work in all contexts. The 2016-2021 UNAIDS Strategy highlights the need to invest in integration efforts that sit at the intersection of a number of SDGs. These include integration of HIV services with SRH, MNC, STIs and non-communicable diseases (NCDs), as well as with TB, hepatitis, mental health and other health issues as well as procurement. The Strategy also promotes integration of food and nutrition with HIV and TB services, and TB, HIV and hepatitis with harm reduction services for people who use drugs.⁸⁹
72. As noted, other interrelated aspects of SRHR and HIV within the 2030 Agenda go beyond the scope of the health sector; hence more multi-sectoral approaches are needed to support SRHR. This includes Comprehensive Sexuality Education (Education sector) and combating discrimination against key populations (Law and Justice sector), to name just a few.⁹⁰

THE LINKS BETWEEN SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS, HIV, DEVELOPMENT AND POVERTY-COMING FULL CIRCLE

73. Sexuality, gender, and the economy are interconnected. Denial of sexual rights can contribute to poverty and inequality, not only in terms of income, but also lack of choices and opportunities. People with non-conforming sexualities may be excluded from social and economic participation, or included on adverse terms. People who do not fit gender stereotypes, people living with HIV, divorcees, widows, single women, sex workers, LGBT people and others may face family pressure, bullying in schools, discrimination by health services, rejection by employers and stigma from communities on which they depend to take part in informal economies.⁹¹
74. In 2005, African Health Ministers recognized that African countries were not likely to achieve the MDGs without significant improvements in SRHR, which is crucial in addressing MDG 1 on poverty reduction. They adopted the Continental Policy Framework on Sexual and Reproductive Health and Rights, also known as the “Maputo Plan of Action.”⁹² This was endorsed by Heads of State of the African Union in January 2006.

⁸⁸ Ibid.

⁸⁹ UNAIDS 2016-2021 Strategy, op.cit., p. 80

⁹⁰ See para 23 above

⁹¹ *Poverty and Sexuality: What are the Connections?*

<http://www.globalequality.org/storage/documents/pdf/sida%20study%20of%20poverty%20and%20sexuality.pdf..>

⁹² *Maputo Plan of Action for the Operationalization of the Continental Policy Framework for Sexual and Reproductive Health and Rights, 2007-2010*, African Union Commission, 2006.

75. With “Ending Poverty in all its forms” as the very first of the SDGs, there is an urgent imperative to address the main concerns of key populations: (a) stigma and discrimination in work and community life that limits one’s options and choices; (b) lack of access to comprehensive SRHR information and services specific for key populations and people living with HIV; and, (c) criminalization of consensual same sex activity between consenting people, HIV exposure, non-disclosure and transmission, drug use and sex work, and lack of protection in the law of people with diverse sexualities, and non-conforming gender identities and expression. These are all critical factors that can affect individual and community vulnerability to all forms of poverty, ill-health, and HIV and AIDS. **And this time, if sustainable development is to be achieved, key populations, people living with, and those most affected by HIV cannot be left behind once more.**

CONCLUSIONS

76. Sexual and reproductive health and rights are human rights, inextricably linked to the right to development and to the SDGs in relation to health, HIV, gender equality and beyond.
77. Stigma remains a formidable obstacle to addressing needs and fulfilling rights of key populations. Discrimination based on sex, age, health status, including HIV, marital status, gender identity and expression, sexual orientation, ethnic identity, race, drug use, migration or legal status, sexual behaviours, disability status, as well as norms and attitudes around what is considered locally “appropriate”, causes further marginalization. Identification with two or more key population groups creates multiple layers of stigma and discrimination that are yet harder to overcome. Self-exclusion and self-stigma also need to be addressed.
78. Existing services for SRH and HIV do not appear fully integrated and fail to meet the needs of key populations, including for adolescent girls and young women, in a comprehensive way. The major focus of SRH services remains on family planning, condoms and MCH whereas SRH priorities for key populations (including young people and adolescents from key populations) include Comprehensive Sexuality Education, youth-friendly services, safe abortions and post-abortion care, GBV services, PrEP and PEP, child-care services and VMMC.
79. Other priorities for key populations include enhancing knowledge, agency and power to make healthy decisions relating to SRHR and HIV, and meaningful engagement and enjoyment in full benefits of the 2030 development agenda, through: decriminalization, transforming gender norms and ending gender-based violence, meaningful participation and being treated fairly and equitably. For transgender persons, recognition of legal status and acknowledgment of specific reproductive and sexual health needs are of paramount importance. The range of barriers to universal access to HIV prevention, care and treatment services for all key populations need to be urgently addressed. Other emerging health issues and concerns related to new and emerging HIV prevention options (PrEP, treatment as prevention), substance use, and early sexual behavior, such as HPV vaccination and cervical cancer screening, also need to be addressed.
80. Other vulnerable groups, such as migrants and mobile populations, people living with disabilities and Indigenous Peoples living with HIV, also have specific SRH needs, and appropriate rights-based interventions are needed. Ageing populations develop specific health concerns – including SRH concerns – and these will become more prominent as people with HIV live longer.

81. Structural factors such as poverty, gender-based violence and workplace discrimination also need to be addressed generally, as well as in particular for key populations and those most affected by HIV.
82. CSE is neglected and restricted when most needed; there is little or no inclusion of sexual rights, sexuality and SOGIE in the discussions. CSE has to be accurate, scientifically based, inclusive, and must take into account the evolving capacities of adolescent and young people from key populations, and be relevant to them.
83. CSOs and networks play a significant role in creating an enabling environment and in advocacy for key populations and their meaningful involvement in responding effectively to the needs of those communities.
84. Financing for the HIV response, if continuing at current trends, will be inadequate to reach the SDGs; it needs to be “fast-tracked.” Recommendations of the HLTF for ICPD for SRH funding need to be implemented. Funding for critical enablers, such as law and policy reform, in accordance with recommendations from the Global Commission on HIV and the Law, needs to be earmarked as well as sustained.

RECOMMENDATIONS

Based on the findings of the 2015 NGO Report, The UNAIDS Programme Coordinating Board is requested to:

85. *Recall* United Nations General Assembly Resolutions, in particular, the 2030 Agenda for Sustainable Development (2030 Agenda)⁹³ that: commit to promote and protect the full range of human rights, including those rights essential for the achievement of sexual and reproductive health; ensure non-discrimination for people living with HIV, key populations such as sex workers, gay men and other men who have sex with men, transgender people, and people who inject drugs; and those most affected by HIV, including women and girls in all their diversity, adolescents and young people, migrants, people who have been incarcerated, people living with disabilities, and indigenous peoples; also *recall* UNAIDS Strategy 2016-2021 that urges the Joint Programme to fully meet sexual and reproductive health and rights needs to prevent HIV infection⁹⁴; affirm the right to development as a universal and inalienable human right for every person and all peoples; and, emphasize the need to fully implement the Declaration on the Right to Development;
86. *Urge* Member States to recognize the inextricable linkages between sexual and reproductive health and rights, HIV and AIDS, the right to the highest attainable standard of health, and the right to development for key populations and those most affected by HIV, including women and girls in all their diversity;
87. *Call on* Member States to support the right to the highest attainable standard of sexual and reproductive health for key populations and those most affected by HIV, including young women and adolescent girls, through i) ensuring access to non-discriminatory comprehensive sexuality education, and quality, integrated sexual and reproductive health services; ii) preventing and addressing gender-based and sexual violence in all its forms; iii) removing laws and policies that are discriminatory and/or create barriers to accessing

⁹³ *Transforming our world: the 2030 Agenda for Sustainable Development*.
<https://sustainabledevelopment.un.org/post2015/transformingourworld>

⁹⁴ Key Result Areas 5 and 8, *On the Fast-Track to End AIDS, 2016-2021 Strategy*, UNAIDS, 2015.

education and services for key populations, including age-related barriers; and iv) instituting laws and policies which include rights protections based on sexual orientation and gender identity and expression;

88. *Request* the Joint Programme, specifically the World Bank, in broad consultation with civil society, to produce a cost analysis report to i) evaluate the impacts of non-recognition and non-inclusion of the sexual and reproductive health and rights of key populations and those most affected by HIV in the context of the Right to Development, particularly in relation to addressing poverty; and ii) estimate the benefits of addressing sexual and reproductive health and rights of key populations and those most affected by HIV in the context of the Right to Development.
89. *Urge* UNAIDS and other partners to increase the existing funds and provide technical assistance to strengthen civil society and community-level capacity, in line with the call in the UNAIDS Fast-Track Report (2014),⁹⁵ Lancet Commission's Report (2015),⁹⁶ and the UNAIDS 2016-2021 Strategy⁹⁷ These funds should be allocated for:
- a. advocacy work to respect, protect and fulfil the sexual and reproductive health and rights related to the right to development of key populations and those most affected by HIV, including through the meaningful engagement in policy- and programme-development fora;
 - b. support to community-based and -driven responses that promote and protect sexual and reproductive health and rights and address barriers to claiming and realizing sexual and reproductive health and rights faced by key populations and those most affected by HIV, including providing rights literacy and access to legal support; and
 - c. capacity-building for key populations and those most affected by HIV at global, regional and national levels, which includes building platforms for sharing knowledge and good practice models among communities and civil society.

[Annexes follow]

⁹⁵ The *Fast-Track: Ending The AIDS Epidemic by 2030*, UNAIDS 2014, indicates that existing funds available to people living with HIV, key population networks and communities must be scaled up from 1% to 4% in order to end AIDS by 2030.

⁹⁶ According to *Defeating AIDS – advancing global health*, The Lancet, Vol. 386, No. 9989, 2015, technical assistance should: “reinforce and renew the leadership and engagement of people living with HIV, strengthening and expanding their decision-making roles in policy design, implementation, and evaluation, and invest in activism as a global public good; promote more inclusive, coherent, and accountable AIDS and health governance; and establish a multi-stakeholder, multi-sector platform to address determinants of health.”

⁹⁷ *On the Fast-Track to End AIDS, 2016-2021 Strategy*, UNAIDS 2015, see pp 48-49; the Strategy describes civil society engagement as a “global public good, [which] requires legal and social space as well as financial resources [...] to ensure its effectiveness.” (p.49), and identifies as a core action to reinforce the global partnership for sustainable development “Scale up investment and support for civil society and community groups to enhance and sustain their essential roles in providing services, advancing human rights, advocacy and accountability” (p.73)

ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ASEAN	Association of Southeast Asian Nations
CEDAW	Convention to Eliminate Discrimination Against Women
CRC	Convention on the Rights of the Child
CRPD	Convention on the Rights of People with Disabilities
CSE	Comprehensive Sexuality Education
CSO	Civil Society Organization
EHRN	European Harm Reduction Network
GBV	Gender-Based Violence
HIV	Human Immunodeficiency Virus
HLTF	High Level Task Force
ICPD	International Conference on Population and Development
IPPF	International Planned Parenthood Federation
IP	Indigenous Peoples/Indigenous Person
LGBT	Lesbian, Gay, Bisexual and Transgender
MCH	Maternal and Child Health
MDG	Millennium Development Goals
MSM	Men who have Sex with Men
NHS	National Health Service
NGO	Non-Governmental Organization
ODA	Official Development Assistance
OWG	Open Working Group
PCB	Programme Coordinating Board
PEP	Post-Exposure Prophylaxis
PrEP	Pre-Exposure Prophylaxis
PMCTC	Prevention of Mother to Child Transmission
PLHIV	People (Person) Living with HIV
RTI	Reproductive Tract Infections
SERES	Seres Como Viver con HIV (an NGO in Portugal)
SDG	Sustainable Development Goals
SOGIE	Sexual Orientation and Gender Identity and Expression
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infections
TasP	Treatment as Prevention
TB	Tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
UNFPA	United Nations Population Fund
UNGA	United Nations General Assembly
USA	United States of America
VMMC	Voluntary Male Medical Circumcision
WHO	World Health Organization

ANNEXES LIST

1. List of Participants and Organizations in the Consultation
2. Key Informants, Reviewers, and Experts from Civil Society
3. Sustainable Development Goals, Post-2015
4. Framework for SRH and HIV Integration and Linkages
5. Case Study: NGO Networking and Advocacy: The Eurasian Harm Reduction Network (EHRN)

1. List of Participants and Organizations in the Consultations

No.	REGION/COUNTRY	NAME
Asia and the Pacific		
1	Bangladesh	Farzhana, HARC
2	Bangladesh	Joti Akter, HARC
3	Bangladesh	Minu, HARC
4	Bangladesh	Ms. Riya, HARC
5	Bangladesh	Rohima Begum, HARC
6	Bangladesh	Sultana, HARC
7	China	Neil
8	China	Z.N., YouthLead
9	Fiji	Samuela Rabuku, MENFiji
10	India	Poloumi
11	Myanmar	Aye Aye Khaing, AMA
12	Myanmar	Kay Zin, AMA
13	Myanmar	May Thu Tun, AMA
14	Myanmar	Moe Moe, AMA
15	Myanmar	Myat Su, AMA
16	Myanmar	Tazin, AMA
17	Myanmar	That Htar Swe, AMA
18	Pakistan	'KC', Parwaz Male Health Society
19	Philippines	Harold
Latin America and Caribbean		
20	Argentina	Rodrigo
21	Brazil	Enrique Martins
22	Brazil	Oseias Cerqueira
23	Jamaica	Anon
24	Mexico	Raul Montes
25	Paraguay	Lucas
Africa		
26	Liberia	Naso
27	Liberia	Sail
28	Mozambique	Lydia
29	Nigeria	Balo

30	Nigeria	Bibiana
31	Nigeria	Bolu
32	Nigeria	Funmi
33	Nigeria	KCC
34	Nigeria	Laitan
35	Nigeria	Loveth
36	Nigeria	Morili
37	Nigeria	Sade
38	Nigeria	Sarah
39	Rwanda	Nadege
40	South Africa	Thembi
41	Zimbabwe	Berlita
42	Zimbabwe	Mollyn
43	Zimbabwe	Primrose
Europe		
44	Belgium	Grace
45	Belgium	Yvette
46	Italy	Mario
47	Portugal	Anon
48	Portugal	Anselmo
49	Portugal	Maria
50	Russia	A.E.
51	Russia	Catherine
52	Russia	Marina
53	Russia	Olga
54	Russia	Svetlana
55	Tajikistan	Alyona
56	UK	Anon
57	UK	Betty
58	UK	Lucy
59	UK	Winnie
60	Ukraine	Shakhnoza
North America		
61	United States	Ari
62	United States	GM
63	United States	Housing Works
64	United States	JF
65	United States	LVH
66	United States	Nina
67	United States	Reesii
68	United States	Stacy
69	United States	TM

2. Key Informants, Reviewers, and Experts from Civil Society

No.	NAME/ORGANIZATION
-----	-------------------

1	Nukshinaro Ao, Asian Network of People Who Use Drugs (ANPUD), India
2	Mabel Bianco, Fundación para Estudio e Investigación de la Mujer (FEIM), Argentina
3	Jennifer Bushee, Global Network of People Living with HIV (GNP+), The Netherlands
4	Eurasian Harm Reduction Network (EHRN), Ukraine
5	Greg Gray, International HIV/AIDS Alliance Link-Up Project, Myanmar
6	Marielle Hart, Stop AIDS Alliance, USA
7	Cornelia Jervis, Global Network of People Living with HIV (GNP+), The Netherlands
8	Musah Lumumba, Uganda Youth Coalition on Adolescent Sexual Reproductive Health Rights and HIV/AIDS (CYSRA-Uganda), Uganda
9	Alessandra Nilo, Gestos, Brazil
10	Luisa Orza, ATHENA, UK
11	Marama Pala, International Indigenous Working Group on HIV/AIDS, New Zealand
12	Arushi Singh, India
13	Maria Sundin, International Reference Group on Trans* and Gender Variant and HIV/AIDS issues, Sweden
14	Jennifer Vanyur, Planned Parenthood Federation of America, USA

3. Post-2015 Sustainable Development Goals

<p>Post-2015 Sustainable development goals⁹⁸</p> <p>Goal 1. End poverty in all its forms everywhere</p> <p>Goal 2. End hunger, achieve food security and improved nutrition and promote sustainable agriculture</p> <p>Goal 3. Ensure healthy lives and promote well-being for all at all ages</p> <p>Goal 4. Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all</p> <p>Goal 5. Achieve gender equality and empower all women and girls</p> <p>Goal 6. Ensure availability and sustainable management of water and sanitation for all</p> <p>Goal 7. Ensure access to affordable, reliable, sustainable and modern energy for all</p> <p>Goal 8. Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all</p> <p>Goal 9. Build resilient infrastructure, promote inclusive and sustainable industrialization and foster innovation</p> <p>Goal 10. Reduce inequality within and among countries</p>

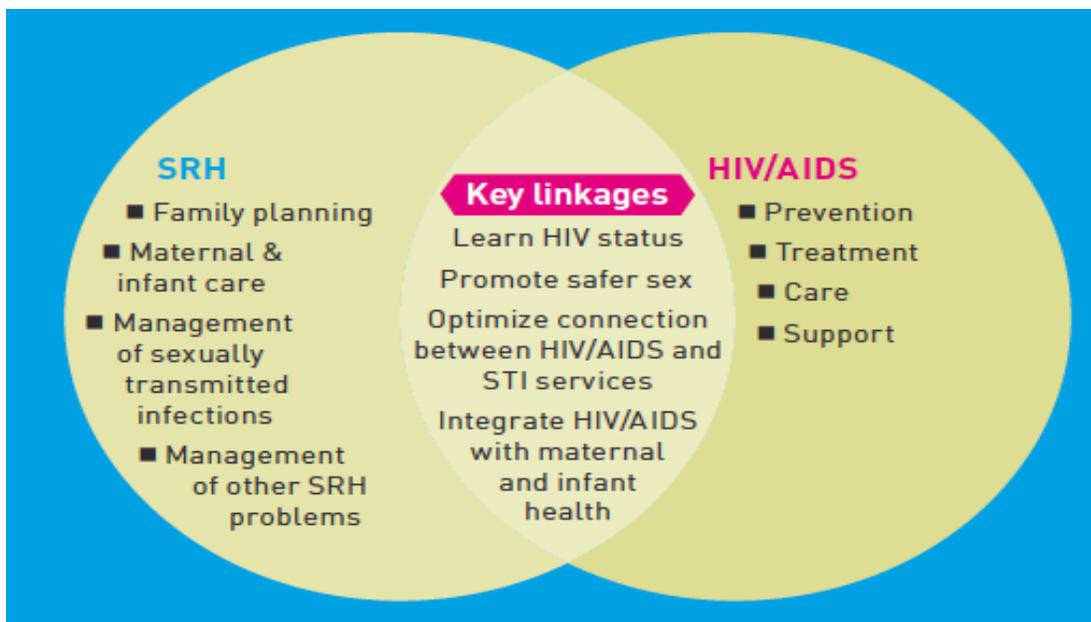
⁹⁸ Synthesis report, op. cit., p.14; Open Working Group Proposal for Sustainable Development Goals, <http://undocs.org/A/68/970>

Goal 11. Make cities and human settlements inclusive, safe, resilient and sustainable
Goal 12. Ensure sustainable consumption and production patterns
Goal 13. Take urgent action to combat climate change and its impacts*
Goal 14. Conserve and sustainably use the oceans, seas and marine resources for sustainable development
Goal 15. Protect, restore and promote sustainable use of terrestrial ecosystems, sustainably manage forests, combat desertification, and halt and reverse land degradation and halt biodiversity loss
Goal 16. Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels
Goal 17. Strengthen the means of implementation and revitalize the global partnership for sustainable development

* Acknowledging that the United Nations Framework Convention on Climate Change is the primary international, intergovernmental forum for negotiating the global response to climate change.

4. Framework for SRH and HIV Integration and Linkages

SRH and HIV/AIDS: A Framework for Priority Linkages. WHO, UNFPA, IPPF, UNAIDS (2005)



5. Case Study: NGO Networking and Advocacy: The Eurasian Harm Reduction Network (EHRN)

Collaboration among and between country level and Regional Harm Reduction Networks: Georgia and the Eurasian Harm Reduction Network (EHRN)

In 2014, the Georgian Harm Reduction Network and the EHRN jointly submitted a report to the 58th session of the Committee of the Elimination of Discrimination against Women (CEDAW), the global United Nations body that monitors the implementation of the Convention. EHRN initiated the process, got the national network on board, and built their capacity to engage with the UN and learn about how advocacy is done at the UN level. Working with experts, conducting briefing sessions at various stages of the reporting process, and engagement with other national, regional and global bodies were also done. As a result, the CEDAW committee considered the joint submission, specifically recommending the state party do the following:

1. Ensure access of adolescent girls and young women to SRH sexual services by eliminating prejudices, training medical personnel and enhancing obstetric health facilities;
2. Conduct more research on women who use drugs, including pregnant women;
3. Provide gender-sensitive and evidence-based drug treatment services to reduce harmful effects for women who use drugs, including those in detention.

As a result, the Ministry of Health in Georgia is intensifying efforts and developing guidelines for treatment of pregnant women who use drugs.

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