



## A Joint Civil Society Analysis of the 2016 Political Declaration: On the Fast-Track to Accelerate the Fight against HIV and to End the AIDS Epidemic by 2030

### 1. Introduction

The 2016 United Nations Political Declaration on HIV and AIDS should have been a critical milestone. It was the opportunity for governments to elaborate how they intended to meet the ambitious target of ending the AIDS epidemic by 2030 that they committed to as part of the Sustainable Development Goals just last year.

In order to achieve this goal, governments should have agreed to a Political Declaration that encompassed ambitious treatment, prevention, care and support and financing targets and recognized the central role of communities in the HIV response, while also advancing the human rights and fundamental freedoms of people living with and affected by HIV. Some of those goals were achieved. However, the Declaration failed to explicitly recognize the human rights and fundamental freedoms of key populations affected by HIV—sex workers, people who use drugs, prisoners, gay men and other men who have sex with men, and transgender persons—and the strategies that most effectively meet their needs.

This joint analysis was prepared to reflect on both the progress and shortfalls in the political declaration; the challenges posed by a hostile group of countries towards the participation of civil society and meaningful advancements on the human rights of key populations; and the steps that we, as a community, must take to ensure accountability for the implementation of this declaration and other key actions that must be taken to make progress.

It provides:

- An overview of the political process of negotiation and the barriers to progress posed by a small group of hostile countries;
- An overview of the mobilization of civil society throughout the process of negotiating the declaration;
- An overview of the anatomy of the political declaration;
- A summary of the key advances and shortfalls in the political declaration;
- A snapshot of how the 2016 declaration compares to prior HIV political declarations; and
- In-depth analyses of the commitments on human rights; people living with HIV; key populations; women and girls; children; adolescents and young people; Combating stigma and discrimination and the inappropriate use of criminal law against people living with HIV; comprehensive prevention; sexual and reproductive health and rights; HIV and HIV-related treatment targets;

intellectual property rights and access to medicines; financing the response; sovereignty; civil society and community engagement; and accountability, follow up and next steps.

Civil society stakeholders, including representatives of people living with HIV, gay men and other men who have sex with men, transgender people, people who use drugs, sex workers, indigenous people, and women and young people mobilized and engaged in highly strategic advocacy throughout the negotiation of the political declaration and at the High Level Meeting itself. Our experience with prior political declarations, however, has demonstrated that securing renewed commitments to expanding and sustaining HIV responses is only the first step. The ambitious goal of putting 15 million people on treatment by 2015, agreed to in 2011, was only achieved through the concerted advocacy by civil society to follow up on the Declaration's promises and translate global targets into real action. The implementation of this Political Declaration will be the same. Activists will need to hold decision-makers to account to both deliver on the targets set in the Declaration, and to go beyond it to address the human rights and HIV prevention and treatment needs of key populations, women and young people, in order to achieve the progress we need.

## **2. The Political Process**

At the 2011 High Level Meeting on HIV/AIDS, many governments said it would be the UN's last. Targets were set with an end date of 2015, to coincide with the end of the Millennium Development Goals, including the goal to being to halt and reverse the AIDS epidemic and governments declined to commit to a further meeting to review progress and take additional action.

In the face of waning political commitment to address HIV and fully fund the response, civil society mobilized to ensure that HIV remained on the global political agenda. The adoption of the target to end the AIDS epidemic as a public health threat by 2030 as part of the global Sustainable Development Goals meant that governments needed to elaborate on how they intended to meet that target. After concerted pressure from civil society, governments agreed in 2015 that a new High Level Meeting on HIV/AIDS was necessary.

Ambassadors Mwaba Kasese-Bota from Zambia and Jürg Lauber from Switzerland were appointed by the President of the General Assembly in October 2015 to shepherd governments through the process. From the beginning there were clear political divides among governments about the type of meeting that was required and the role that civil society should play in it. In December 2015, after protracted negotiations governments agreed to a 2016 High-Level Meeting that would aim to engage diverse civil society groups and result in a new forward-looking political declaration. But there was a catch: a small number of regressive governments, including China, Russia, Indonesia and a number of other states, secured agreement that any country would be able to anonymously veto the participation of any civil society group that did not already have consultative status with the UN's Economic and Social Council (ECOSOC).

In April 2016, the co-facilitators held a round of consultation with governments and two-day civil society hearing to solicit views about what the declaration should encompass. With the support of UNAIDS, the co-facilitators produced a zero draft on April 18, 2016 that was bold and ambitious and met many of civil society's demands.

Over the next six weeks, governments engaged in intense political negotiations that exposed deep divides between governments about the strategies that are necessary to effectively address HIV. These

divides spanned a range of issues including the central importance of committing to respecting, protecting and fulfilling human rights of people living with and affected by HIV, rather than blaming those who are most affected; the role of comprehensive sexuality education in giving adolescents and young people the tools to negotiate safer sex and protect themselves from HIV; the need to respect, protect and fulfill sexual and reproductive rights; and the importance of removing barriers to access to medicines that arise as a result of trade-related aspects of intellectual property rights, among others. Towards the end of the negotiations, with the positions of governments well-entrenched and little agreement about many of the key contentious issues, the co-facilitators decided to release a final draft under “silence procedure,” which assumes consensus unless a government breaks the silence.

This final declaration included many important and ambitious commitments, however much of the promising language in the initial draft of the declaration had been stripped and weakened. Civil society mobilized an effort to try to get progressive governments to break the silence in order to press for stronger commitments, particularly on the health and human rights of key populations. Our efforts were ultimately unsuccessful.

After requesting an extension of the initial deadline, Russia broke the silence in an attempt to further weaken language on harm reduction. In the final negotiations that were held on the eve of the high level meeting in response to the broken silence, Russia was persuaded to back down. The Political Declaration was adopted on the first morning of the High Level Meeting.

Sadly, the inclusion of outdated counterproductive moralistic prejudice won out against the proven track record of evidence and rights based approaches to the HIV epidemic. For example, one the one hand, the declaration recognizes that key populations, namely, men who have sex with men, transgender\* persons, people who inject drug users, sex workers and prisoners, need support, for the first time naming transgender people in a UN resolution. However, instead of going further to fully address these communities’ needs, it instead allows UN member states to define their own epidemics and responses in accordance with national laws, setting a disturbing precedent for governments to ignore evidence indisputably and consistently showing gay men, sex workers, people who use drugs, and transgender people to be nearly everywhere disproportionately affected by HIV.

Further, as the MSMGF states in their round-up of the HLM, “While the Political Declaration sets ambitious goals to accelerate HIV prevention and treatment targets to deliver treatment to 30 million people by 2020 and end AIDS by 2030, the document’s failure to adequately include, define, and commit to programming for gay and bisexual men and other men who have sex with men, sex workers, people who use drugs, and transgender people seriously undermines any potential to meet the Declaration’s ambitious targets to end AIDS.”<sup>1</sup>

### **3. Civil Society Mobilization and Advocacy on the Political Declaration**

During the lead up to and at the High Level Meeting on HIV, there was unprecedented civil society mobilization and work in collaboration across a broad range of issues. This included the establishment of a stakeholder task force, primarily composed of people living with HIV, representatives of key populations and other civil society stakeholders; virtual coordination among a wide-ranging group of NGOs across the globe; agreement about [ten key priorities](#) for the political declaration; a coordinated “lobby week” during the middle of the informal negotiations process to demonstrate the collective

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<sup>1</sup> Read more: <http://msmgf.org/moving-high-level-failure-next-steps/#ixzz4DfD6p7hl>

strength of HIV-related civil society groups; a rapid [civil society response](#) to the political declaration; and a large-scale mobilization during the HLM itself. While many civil society groups considered the final document to fall far from the mark, the civil society mobilization process is an important achievement.

When a small group of member states took action to block the participation of twenty-two organizations representing key populations, especially transgender people, people who use drugs, and men who have sex with men, civil society mounted a critical response. This included a sign-on letter, extensive social and traditional media efforts, and negotiations with the office of the President of the General Assembly (OPGA) in an effort to get governments to back down. In particular, the Stakeholders Task Force worked with the OPGA to ensure maximum access and some exclusions were reversed. However a number of organizations remained excluded. Civil society organized a side event to give a platform to representatives of these organizations, included them in the delegations of other organizations with ECOSOC status, and ensured that some of them had the opportunity to intervene in the discussions during panel sessions at the High Level meeting. Future advocacy must include preventing non-transparent processes that permit Member States to oppose the inclusion of organizations who have views that they do not agree with, particularly those based outside their borders.

#### **4. Anatomy of the Political Declaration**

The outcomes of UN high level meetings, like UN resolutions, have a common format: first, there is a preambular section, followed by an “operational” section and concluding with recommendations.

The ***preambular section*** of the 2016 Political Declaration places the Political Declaration in the context of previous relevant UN treaties, agreements and resolutions. It sets out the main principles for the Declaration, and states, in general terms, the Declaration's points of reference.

The ***operational section*** outlines specific commitments. It is divided into 11 of sections, as follows:

- 2011-2016: Reflecting on unprecedented achievements and acknowledging those left behind:
- 2016 – 2021: Global leadership: uniting to Fast-Track the HIV and AIDS response
- Front-loading and diversifying resources are critical to Fast-Track the AIDS response
- Ensuring access to testing and treatment in the fight against HIV and AIDS
- Pursuing transformative AIDS responses to contribute to Gender Equality and the Empowerment of All Women and Girls
- Ensuring access to high-quality HIV services, commodities and prevention, while expanding coverage, diversifying approaches and intensifying efforts to fight HIV and end the AIDS epidemic
- Promoting laws, policies and practices to enable access to services and end HIV-related stigma and discrimination;
- Engaging and supporting people living with, at risk of, and affected by HIV as well as other relevant stakeholders in the AIDS response
- Leveraging regional leadership and institutions is essential to more effective AIDS responses
- Enhancing governance, monitoring and accountability will deliver results for and with people
- Follow-up: accelerating progress

#### **5. Key advances and shortfalls**

The 2016 Declaration contains both encouraging aspects and causes for extreme concern. Key gains include new pediatric targets, strong gains for women and girls, and some good language on access to

medicines. It is the first globally negotiated document that refers to transgender people. It builds upon past commitments to address the needs of people who use drugs through harm reduction services. These are important achievements. However, the document is unconscionably weak on key populations including MSM, transgender people and sex workers. And many of the gains are accompanied by gaps. For example, despite the inclusion of two references to harm reduction, opioid substitution therapy (OST) was not included.

Areas of advancement include:

- Strong references to the need to advance human rights for all without distinction of any kind;
- increased attention to adolescents and young people;
- more specific and explicit to address HIV among children;
- stronger commitments to address HIV among women and girls, including recognition of the connection between gender-based violence and HIV (with an important list naming a variety of forms of violence);
- recognition of the need to protect reproductive rights and ensure access to sexual and reproductive health services;
- explicit positive reference to harm reduction as an important HIV strategy;
- specific references to rights to privacy, confidentiality, informed consent and commitments to address discrimination and violence against people living with and affected by HIV in health-care settings;
- consistent attention to stigma and discrimination as significant challenges to effective HIV responses;
- commitment of 6% funding for CSOs;
- a call to meet replenishment goals for the Global Fund to Fight AIDS, TB and Malaria;
- an explicit reference to the importance of broad stakeholder participation including civil society, women's, youth groups, feminists, human rights defenders, national human rights institutions; and
- recognition of the need to use existing TRIPS flexibilities to their fullest and to ensure that intellectual property provisions in trade agreements do not undermine existing flexibilities; and an accountability process that is linked to the 2030 Agenda review process.

However, an unfortunate number of commitments fall far short of those required to meet the 2020 vision. Most concerning is the fact that the Political Declaration highlights victimization and blame instead of rights and agency. For example, the use of the term "people at risk" can and often does function to obfuscate the truth about which communities need to be addressed and leaves the door open for HIV responses that are driven by ideology rather than informed by evidence and rights-based obligations. In addition, caveats in the political declaration, such as the recognition of the sovereign right of countries to implement the declaration in line with their own national laws, policies and contexts, open the door for governments to deviate from normative guidance for evidence-based HIV prevention and treatment approaches established by the World Health Organization (WHO) and other UN agencies.

A progressive and forward-looking agenda to end the HIV epidemic must:

- address the needs and rights of key populations (including men who have sex with men, transgender people, sex workers, people who use drugs, and prisoners);
- articulate a bold commitment to address persistent and multiple forms of discrimination and human rights abuses, including those based on real or perceived sexuality, sexual orientation or gender identity;

- assert a commitment to reform and remove punitive laws and policies, including the criminalization of people living with and affected by HIV;
- declare a strong commitment to promote comprehensive sexuality education for children, adolescents and young people, including those from key populations;
- affirm the promotion of medically assisted therapy, and, in particular, opioid substitution therapy; and
- commit to accountability measured in human rights-based and time-bound targets.

## **How the 2016 Political Declaration Compares to the 2001, 2006 and 2011**

In a number of areas, 2016 the Political Declaration contains stronger and/or more explicit language than previous HIV Political Declarations. For example, it names transgender people for the first time in a UN General Assembly agreement.

There were also gains in the area of gender equality and women and girls, such as the urgency of creating enabling environments for education, empowerment and the fulfillment of the human rights and fundamental freedoms for women and girls, and a call for explicit attention to adolescent girls and young women in sub-Saharan Africa. The declaration specifically calls for attention to “gender-based, sexual, domestic and intimate partner violence, by i.a. eliminating sexual exploitation of women, girls and boys, trafficking in persons, femicide, abuse, rape in every and all circumstances, and other forms of sexual violence, discriminatory laws and harmful social norms that perpetuate the unequal status of women and girls, as well as harmful practices such as child, early and forced marriage, forced pregnancy, forced sterilization, in particular of women living with HIV, forced and coerced abortion and female genital mutilation” (61(h)). This is groundbreaking. It is also the first time that intimate partner violence has been recognized in a UN General Assembly agreement. Other innovations in the 2016 PD was the inclusion of “gender equality and positive gender norms” and addressing harmful gender norms (61(o)) and encouraging the uptake of laws to criminalize violence against women and girls (61 (i) and (k)) and “gender-responsive preventive, protective and prosecutorial measures and services” (61(i)).

Recognizing that the document fell far short of the kinds of commitments required to end the epidemic as it exists across diverse countries and communities, the explicit references to key populations was a step forward, even if it was far too minimal. The term “key populations” is stronger than the 2011 PD’s “populations that are key to the epidemic.” Unfortunately, the fact that key populations are mentioned almost exclusively in relation to their likelihood of infection is inherently stigmatizing. This one-sided and incomplete reference prompted advocates in panel sessions and protests to ask, “How many more of us have to die before you are ready to act?”

In another step forward, the 2016 declaration uses the term “people who use drugs” as well as “people who inject drugs”, acknowledging that in some settings amphetamine-type substances are associated with HIV infection. Paragraph 43 includes reference to harm reduction interventions, later specified to include needle and syringe programmes (62(d)) and treatment for drug dependence (60(e)). However, advocates were disappointed with the reference to “medication assisted therapy” (62(d)) rather than OST, owing to the delegation from the Russian Federation where OST is criminalized. On the other hand, there is a call for attention to restrictive laws that pose obstacles to PWUD accessing to services (43). No targets were included for HIV services for PWUD or PWID, an unfortunate missed opportunity. However, member states were encouraged to use “WHO, UNODC and UNAIDS Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users” (43).

With regard to migrants and mobile populations, it was significant that references were included for taking steps to “reduce stigma, discrimination and violence”, while the importance of ensuring access to prevention, treatment care and support was reiterated (63(g)). “[A]ccess to tailored HIV comprehensive prevention services for all ... migrants” is another significant inclusion for 2016 (62(e)).

While CSO were disappointed with the limitation of commitments to national legislation and policies, paragraph 4, on sovereignty and is identical to the language from 2011. The inclusion of “international human rights” in paragraph 4 is used to limit rights protections rather than expand them, and was insisted upon by Member States that did not want to affirm rights related to sexual orientation and gender identity, and the right to development.

## 6. The Issues in Depth

### a. Human Rights<sup>2</sup>

The three Political Declarations (2016, 2011, and 2006) and the Declaration of Commitment (2001) all contain language on human rights to some degree, including many of the same concepts, such as access to medicines as integral to the right to the highest attainable standard of health<sup>3</sup>, the full realization of human rights as an essential element in the global HIV response<sup>4</sup>, and recognition of the particular needs of women and girls.<sup>5</sup>

The 2016 Political Declaration saw significant improvements in the human rights language, especially in comparison to the 2011 Political Declaration, which contained contradictory formulations in different parts of the document. For example, even though both the 2016 and 2011 Political Declarations contain sovereignty paragraphs – unlike the previous Political Declaration (2006) and Declaration of Commitment (2001) – the placement was higher in the 2011 version (¶ 2) than in 2016 (¶ 4). Both sovereignty paragraphs come before the paragraphs reaffirming commitments to human rights, but in 2016 the human rights paragraph immediately follows (¶ 5) and is an expansive listing of human rights instruments, as opposed to in 2011 when the reaffirmation of human rights did not come until paragraph 38, mentioned only the Universal Declaration of Human Rights by name, and included a reference to “cultural, ethical and religious values” as well as “the vital role of the family.” In contrast, the 2016 Political Declaration contains no mention of the importance of the family or cultural, ethical or religious values in the context of human rights. Moreover, the 2016 Political Declaration calls for protecting, respecting, and fulfilling human rights rather than only promoting or protecting them as had been done in previous Declarations.

In addition, the 2016 Political Declaration expanded upon the human rights language found in the previous documents, including recognizing the right to development (¶ 7); expanding the categories of people for whom human rights are a key concern, including children in child-headed households (¶ 40), and people living with disabilities, especially women and girls (¶¶ 45 and 62(h)); and it reframed the HIV epidemic as a human rights challenge, in addition to a development and health challenge (¶ 33) for the first time since the 2001 Declaration of Commitment.

Finally, the 2016 Political Declaration also clearly stated the need for health systems and services to be based on human rights principles (¶¶ 60 (d), 61 (l), 62 (a), 62 and (h)). It also noted that the human rights of young people and people living with, at risk of, and affected by HIV, are “insufficiently addressed” partly as a result of inadequate integration of health services, legal services, and social protection (¶ 47).

A noticeable weakness in the 2016 Political Declaration is the lack of call for attention to the human rights of key populations, for whom there is no explicit call for action the way that other groups receive attention. Paragraph 63(b) calls for strengthened measures for preventing crimes and violence against “people living with, at risk of, and affected by HIV,” including key populations without naming them. Similarly paragraph 63(c), outlines commitments to creating “enabling legal, social and policy frameworks” and promoting and protecting human rights for “people living with, at risk of, and affected

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<sup>2</sup> Prepared by the International Women’s Health Coalition.

<sup>3</sup> 2001: paragraph 15. 2006: paragraph 12. 2011: paragraph 32. 2016: paragraph 37.

<sup>4</sup> 2001: paragraph 16. 2006: paragraph 11. 2011: paragraph 39. 2016: paragraph 7.

<sup>5</sup> 2001: paragraphs 59, 60, and 61. 2006: paragraph 31. 2011: paragraph 81. 2016: paragraphs 61(a), 61(b), and 61 (d).



by HIV,” without an explicit reference to key populations or a call for specific human rights protections that would protect and empower them.

#### **b. People Living with HIV**

The Greater Involvement of People with HIV/AIDS - the GIPA principle - was formalized during the Paris AIDS Summit Declaration of 1994 and articulates the central role that people living with HIV can play in both the delivery of HIV education, support and services and the design and implementation of local, national and international policies and programmes. The principle also calls on governments to develop and support structures, policies and programmes to facilitate the greater involvement of positive people in decision-making bodies.

Just as with the 2011 Political Declaration, paragraphs 21 and 64 (a) – (b) of the 2016 Political Declaration echo, in part, the GIPA principle and asserts the need to involve people living with HIV as relevant stakeholders in the AIDS response.

Quite significantly, the Declaration in paragraph 64(a), calls on member states to increase the investment for the work of civil society to at least 6% of all global AIDS resources in order to build their capacity to frontline service delivery and community driven responses. Additionally, the Declaration explicitly recognizes the critical role that civil society plays in community based monitoring, advocacy and mobilization as essential accountability mechanisms that hold key stakeholders into account, advance law and policy reform and reduce stigma and discrimination.

However disappointingly, the current Declaration stops short of explicitly calling on the meaningful participation of people living with HIV, and specifically key populations living with HIV, in all decision-making bodies shaping and implementing local, national and global HIV responses. This omission is a major concern.

The evidence is clear that the leadership of people living with HIV and key populations in program design, implementation and monitoring vastly improves the effectiveness, quality and accessibility of such programmes. The results of failing to ensure the meaningful participation of key populations are also clear: despite the unprecedented gains experienced since 2011 in increasing access to HIV services, HIV prevalence among members of key populations remains worryingly high. Among key populations, late diagnosis, high HIV-related mortality, significant ongoing gaps in access to quality HIV treatment, care and support services, rampant stigma and discrimination, the lack of widespread harm reduction programming as well as obstacles retaining people in care and achieving viral suppression remain major challenges worldwide. Further, the willingness and capacity of many member states to create or sustain critical programming for key affected populations remains extremely questionable.

Moving forward, civil society organizations will need to push countries to adhere to the GIPA principle and ensure that people living with HIV and key populations are at the center of designing HIV responses.

#### **c. Key Populations**

This is the first negotiated document that uses the term “key populations”. The 2011 Political Declaration referred to MSM, sex workers and PWID as “populations that are key” to the epidemic response. The expansion of the term to include prisoners and transgender people reflects new

epidemiological data from prisoners and the breakout of transgender people from MSM (as transgender people were categorized in UN data until late 2012).

The zero draft referred to key populations throughout, but ultimately only two references were retained after tense negotiations. Both the term key populations and this expansion of the term were controversial during negotiations. Some member states sought to use stigmatizing language positioning particular groups as vectors of disease or responsible for infection by behaving counter to social, cultural and religious norms. Some of these objections to the term were counter to their own public health programmes and even their country statements during the HLM. Others positions changed during the final overtime negotiations with the arrival of more members of their delegations.

The remaining references to key populations include epidemiological information that in broad context explained why key populations are in fact *key*. However, without the broader context and inclusion of key populations throughout the declaration, the remaining references could be interpreted in stigmatizing ways or used to justify discrimination against key populations.

- Gay and other MSM, Sex Workers, and Transgender People<sup>6</sup>

In every country in the world, gay and bisexual men and other men who have sex with men, sex workers, people who use drugs, and transgender people (and, in particular, transgender women) shoulder disproportionate HIV incidence and prevalence, lack equitable access to HIV services, are criminalized, and face unrelenting stigma, discrimination and violence. No country can end its epidemic unless it effectively addresses HIV in all four of these key populations – whether in Africa or anywhere else in the world.

However, the needs and rights of key populations, as noted above, are bypassed in setting priorities for the global HIV response. The zero draft, as noted above, was promising in this regard, with several explicit provisions about gay and other men who have sex with men, transgender people and sex workers. These included the naming of key populations, calls for programming specifically for key populations, and calls to address punitive legal and policy frameworks, including laws and policies that criminalize same-sex behavior.

For example, Paragraph 7 recognizes that *“there are multiple and diverse epidemics and that in order to achieve the prevention and UNAIDS 90-90-90 treatment targets by 2020 and to end the AIDS epidemic by 2030 that AIDS responses need to achieve greater efficiency and focus on evidence, the geographic locations, populations at higher risk of infection...taking into account national context...”* The caveat, *“Taking into account national context”* is a phrase that conservative UN delegations pushed to insert in the final text to weaken emphasis on global epidemiological evidence, particularly worldwide data indicating a need to specifically address the HIV epidemic among gay and bisexual men and other men who have sex with men, sex workers, people who use drugs, and transgender people. This falls far short of the need for all HIV response plans related to the 90-90-90 treatment targets and ending AIDS by 2030 to explicitly name and set prevention, treatment, and support targets for key populations.

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<sup>6</sup> Prepared by MSMGF, the Platform, NSWP, GATE, and IRGT, noting the collaboration between MSMGF, NSWP, GATE, IRGT, and the Global Platform to Fast-Track the HIV and Human Rights Responses Among Gay and Bisexual Men and Other Men Who Have Sex with Men (*The Platform*) to examine specific paragraphs from the Political Declaration of relevance to the needs and priorities of key populations, and identify entry points and barriers for those advocates seeking to move on from the high-level failure of the UN Political Declaration. A full Political Declaration analysis report prepared by MSMGF and the Platform can be downloaded as a PDF [here](#).

It is important to note that the term sex work was coined to emphasize the income generation aspects rather than the sexual aspects of selling sex, and has been used in epidemiological literature for over two decades. However, during the negotiations, Iceland proposed using “people who sell sex” instead of “sex worker”, and asked whether minors could be included in data as sex workers. UNAIDS explained in a technical briefing that epidemiological data about key populations referred to adults, and so alternative language was not necessary. Iceland continued to propose its alternative, and stated during the HLM that prostitution is a form of violence against women. This was not the stance taken by the EU and Nordic states, which supported the inclusion and listing of key populations including sex workers. The zero draft contained a promising discussion that accurately specified that the HIV epidemic is concentrated among key populations in *all* world regions, including in Asia and the Pacific, Latin America and the Caribbean, the Middle East and North Africa, Eastern Europe and Central Asia, and cities in North America and Western Europe. The final declaration (¶ 19) strips all references to concentrated HIV epidemics among gay and bisexual men and other men who have sex with men, sex workers, people who inject drugs and transgender women in these regions. In addition, the final declaration makes no mention of disproportionate HIV burden among key populations in sub-Saharan Africa.

Paragraph 44 explicitly names key populations, with a specific citing of each key population. It further states the epidemiological evidence for elevated HIV burden. However, it seriously weakens country-level implementation by including the phrase “emphasizing that each country should define the specific populations that are key to its epidemic and response...” This language gives countries license to relinquish their responsibilities to address the HIV- and human rights-related needs of gay and bisexual men and other men who have sex with men, sex workers, people who use drugs, and transgender people. It also gives governments the power to invoke national sovereignty clauses in contexts where key populations frequently face State-sanctioned stigma, discrimination and violence. In light of consistent calls for evidence-informed responses, states should be called to repeal national regulations incompatible with human rights standards, including those that have a strong impact on key populations (such as the criminalization of sex work and same-sex relationships, restrictive gender identity laws, etc.), rather than creating extra space for ideologically driven HIV plans and programmes.

Paragraph 61 includes a strong and positive call to achieve gender equality and the empowerment of women and girls, and to “*respect, promote and protect their human rights, education and health, including their sexual and reproductive health.*” However, none of these explicitly mention the need to address the HIV epidemic among transgender women and female sex workers, who are globally far more likely to be living with HIV than the general population. In addition, none of these mention the critical links between homophobia, transphobia, whorephobia, and gender inequities in the global HIV response.

Next steps for advocacy therefore must include working for the best possible outcomes and countering any adverse effects, including by promoting the inclusion of members of key populations in the design and implementation of programs, community-based programming, and working to end stigma and discrimination and violence against key populations.

Future steps include advocating for non-stigmatizing language addressing sex workers, and work to reduce stigma and discrimination against sex workers including among diplomats and policy makers as well as in health care settings and national and local settings, and efforts to eliminate violence against sex workers.

- Harm reduction/People who use drugs<sup>7</sup>

Paragraphs 43 and 62 (d) of the 'Political Declaration on HIV and AIDS: On the Fast-Track to Accelerate the Fight against HIV and to End the AIDS Epidemic by 2030' relate specifically to harm reduction:

*43: Note that some countries and regions have made significant progress in expanding health-related risk and harm reduction programs, in accordance with national legislation, as well as antiretroviral therapy and other relevant interventions that prevent the transmission of HIV, viral hepatitis and other bloodborne diseases associated with drug use, yet note the lack of global progress made in reducing transmission of HIV among people who use drugs, particularly those who inject drugs, and call attention to the insufficient coverage of such programs and substance use treatment programs that improve adherence to HIV drug treatment services, as appropriate in the context of national programs, the marginalization and discrimination against people who use drugs through the application of restrictive laws, particularly those who inject drugs which hamper access to HIV-related services, and in that regard, consider ensuring access to such interventions including in treatment and outreach services, prisons and other custodial settings, and promoting in that regard the use, as appropriate, of the WHO, UNODC and UNAIDS Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users, and note with concern that gender-based and age-based stigma and discrimination often act as additional barriers for women and for young people who use drugs, particularly those who inject drugs, to access services;*

*62 (d): Commit to saturate areas with high HIV incidence with a combination of tailored prevention interventions, including outreach via traditional and social media and peer-led mechanisms, male and female condom programming, voluntary medical male circumcision, and effective measures aimed at minimizing the adverse public health and social consequences of drug abuse, including appropriate medication assisted therapy programs, injecting equipment programs, pre-exposure prophylaxis for people at high risk of acquiring HIV, antiretroviral therapy, and other relevant interventions that prevent the transmission of HIV with particular focus on young people, particularly young women and girls, and encourage the financial and technical support of international partners as appropriate;*

While these were important references, there were also significant gaps. For instance, the 2011 Political Declaration included a specific target to reduce transmission of HIV among people who inject drugs (PWIDs) by 50 per cent by 2015. A new target to reduce HIV among PWIDs was not included in the 2016 Political Declaration despite calls from civil society.

The zero draft of the 2016 Political Declaration mentioned harm reduction three times (¶¶ 16, 30, 60d). Paragraph 30 specifically mentioned criminalization of PWIDs: '*Note the lack of global progress made in reducing transmission of HIV among people who inject drugs and call attention to the insufficient coverage of highly effective harm reduction programmes, the marginalization and criminalization of people who inject drugs which hamper access to HIV services, and note with concern that gender-based stigma and discrimination often act as additional barriers for women who inject drugs to access HIV services*'. Some elements of this paragraph were incorporated into paragraph 43.

The main point of contention for people who use drugs and the harm reduction sector was the insistence of China, Russia, India and Singapore to use language from the UN General Assembly Special Session on Drugs, adopted in April 2016, instead of the more progressive language on harm reduction

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<sup>7</sup> Prepared by Harm Reduction International

from the 2011 Political Declaration. During the final negotiations paragraph 62(d) was changed to include the UNGASS language, as China and others would only accept one reference to harm reduction. This UNGASS language, developed in a drug forum rather than a HIV one, does not specifically mention 'harm reduction' and refers to the vague concept of "medically assisted therapy" rather than specifically recognising opioid substitution therapy.

In the final hours of the Political Declaration negotiations Russia broke the silence to add a national sovereignty caveat to paragraph 62 (d). They were, ultimately, unsuccessful in this attempt and the paragraph remained unchanged.

While it is unfortunate that the insufficient UNGASS language was used, it is important that paragraph 43, with its explicit references harm reduction, remained in the final declaration. While it has the usual caveats to national legislation, it calls out the lack of progress in expanding services, uses the term "risk and harm reduction", mentions the need to remove restrictive laws and advocates a focus on prisons, women and young people. The 2016 Declaration is also the first to advocate for the provision of harm reduction in prisons and other custodial settings.

Key challenges going forward are the lack of sustainable funding for harm reduction and the absence of leadership from UN agencies, especially UNAIDS. The 2011 Political Declaration target to halve transmission of HIV among people who inject drugs by 2015 has been missed by 80%. This comes as no surprise given the fragility of support for harm reduction, both political and financial. Harm reduction programmes are grossly underfunded in many countries and recent shifts in donor priorities away from middle income countries with concentrated epidemics among PWID further threaten harm reduction. In their recent report, 'Do no harm,' UNAIDS state that USD 1.5 billion is required to "fast track" the HIV response among PWID.<sup>8</sup>

#### **d. Women and girls<sup>9</sup>**

The 2016 HLM Political Declaration contains several notable advances pertaining to women, adolescents, and girls living with HIV. An overarching theme throughout the Declaration is that of achieving gender equality and of empowering women and girls, and a deep understanding that structural inequalities greatly increase HIV vulnerabilities for women and girls. The Declaration specifically mentions women's equality and leadership as a way to overcome "unequal power relations in society between women and men . . . unequal legal, economic and social status, insufficient access to health-care services, including sexual and reproductive health, as well as all forms of discrimination and violence in the public and private spheres, including trafficking in persons, sexual violence, exploitation and harmful practices."

Sexual and reproductive health and reproductive rights, in addition to gender-based violence, are robustly discussed in the document; however, the document falls short of serving *all* women and girls in

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<sup>8</sup> On analysis, HRI has discovered that this figure relates to need only in low- and lower-middle income countries, excluding some three quarters of people who inject drugs. Along with other harm reduction, drug user and human rights organizations, HRI has written to Michel Sidibe to challenge UNAIDS' use of these figures and to demand that UNAIDS increases its leadership on harm reduction. Harm reduction advocates remain concerned about the need for increased funding for harm reduction. Last year we launched the 10 by 20 campaign, calling for 10 percent of resources currently spent in the war on drugs to be redirected to harm reduction by 2020. Recent research conducted by HRI and the Burnet Institute found that an annual investment of USD 2.5 billion until 2030 (amounting to a redirection of just 2.5%) could reduce new infections among PWID by 78% by 2030. An annual investment of USD 7.6 billion (or 7.5%) over the same time period would effectively end HIV globally among PWID by 2030. HRI will work to build support for a redirection of funding over the next few years, looking towards the 2019 high level meeting on drugs.

<sup>9</sup> Prepared by ICW/International Community of Women Living with HIV

all of their diversity, and, in particular, transgender women. It lacks comprehensive understanding and language around sexual orientation and gender identity, and does not name key populations of women critical to the success of the HIV response, namely women who use drugs, transgender women, women prisoners, and female and transgender sex workers.

Sexual and reproductive health as discussed in the Declaration includes women and girls' access to treatment, freedom from stigma, discrimination, and coercion, access to family planning, including abortion (see below for additional details). It includes an important commitment in paragraph 61 (f) to reduce the number of adolescent girls and young women, aged 15-24 years old, newly infected with HIV globally each year to below 100,000 by 2020. It makes critical commitments to address gender-based violence, and recognizes intimate partner violence for the first time in a UN general assembly document. In addition, harmful "cultural norms" and practices are identified as problematic. The document also specifically addresses stigma and discrimination, access to treatment, and other issues specific to pregnant, parenting, and breastfeeding women.

When compared with the Declarations from 2011/2006 and from 2001, women and girls have made significant gains, which will, hopefully, translate to an increased importance placed on better health and wellbeing outcomes. In the 2011 document, women were only mentioned 7 times, and girls were mentioned only twice. Gender equality served as an afterthought, and was not acknowledged as framework essential to ending the HIV epidemic. In addition, the language around sexual and reproductive health mentions the stigmatizing and victim-blaming concepts of abstinence and fidelity, while failing to mention abortion at all. Finally, gender based violence (GBV) is mentioned only twice, and GBV as a cause and consequence of HIV was not substantively connected to the HIV epidemic. In the 2001 Declaration, women are mentioned only once. Violence, abortion, and even the word "sexuality" do not appear at all. Therefore, the 2016 document has made some progressive, and commendable strides towards understanding the nuances of women's lives as they intersect with the HIV epidemic.

Looking forward, it is critical that governments engage women and girls in the processes of implementation of their HLM commitments, and are held accountable for their actions. In addition, governments and other stakeholders must:

- Create gender-responsive policies at the national level based on the HLM outcome document;
- Take a human rights-based approach to the HIV response in order to meet global targets for 90-90-90, "Ending AIDS," and the Sustainable Development Goals;
- Implement programming priorities and funding that recognize gender discrimination as a barrier to a successful HIV response;
- Recognize and invest in community engagement of women living with HIV as central to the success of the HIV response;
- Recognize that women and girls in all their diversity (women sex workers, women who use drugs, transgender women, lesbians, bisexuals and other women who have sex with women and women living with HIV) may face additional barriers to accessing health services and justice because of their gender, putting them at risk of multiple and overlapping forms of discrimination;
- Prioritize sexual and reproductive health and rights; and
- Recognize that gender-based violence, stigma, and discrimination are counter productive, and increase vulnerability to contracting HIV for everyone, especially women and girls.

It is essential that implementation of the commitments made at the HLM reflect the full diversity of women, including key populations. We must also recognize that although some women living with HIV are mothers, they are also independent human beings, deserving of full human rights including autonomy, sexual, reproductive and health rights and access to treatment, care, and support.

#### **e. Children<sup>10</sup>**

One of the most positive and surprising achievements in the political declaration was the inclusion of a specific target to get 1.6 million children on treatment by 2018, and recognition of the importance of ensuring that their viral load is suppressed. The target was backed by an enumeration of the many remaining challenges in getting and keeping HIV-positive children on treatment and specific political commitments to address these issues.

The commitment to ending new HIV infections among children to complete the work of the Elimination of Mother-to-Child Transmission (EMTCT) Global Plan is strong and combined with adopting innovative systems to track and provide comprehensive services to mother-infant pairs to eliminate preventable maternal mortality through lifelong treatment as well as a commitment to work towards WHO certification of EMTCT.

Generally, the political declaration contains a strong commitment to responses that consider that children, as well as their families and caregivers should benefit from HIV-sensitive social protection programmes. Further, this commitment includes strengthening child protection systems to protect vulnerable children from abuse and sexual violence.

There are moderately strong commitments to support the needs of caregivers, including addressing the disproportionate burden of caring for people living with HIV that falls on women and girls. There was an unexpected recognition in the Declaration for the need to support the development of children to their full potential especially through equal access to early child development services.

In comparison with previous HIV Political Declarations, the 2016 Political Declaration has the strongest language for children living with and affected by HIV. The 43 references far exceeded the previous declarations: 2001 (9), 2006 (14) and 2011 (24). This in part reflects the increasing recognition that issues related to children need to be disaggregated from those for adults and referred to separately. It also represents increased recognition of the breadth of issues affecting children needing to be addressed.

There were a number of points of contention during the negotiations. There was disappointment that UNAIDS and the OPGA failed to include organizations representing children in the Stakeholder Task Force. It was acknowledged that Children and Youth are two distinct population groups. *Youth* begins at the age of 15 and extends well into adulthood, sometimes to age 35. The concerns of youth are critical and there is some overlap with older adolescent issues, but naturally there are many additional and different priorities from those of children whose age bracket starts at birth. It is important that in the future, civil society organizations representing children are considered as a specific category. The other challenge was the need to repeatedly remind negotiators that children required separate prevention and treatment targets and specific mention within commitments for the broader population.

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<sup>1010</sup> The Coalition for Children Affected by AIDS advocated on five main issues related to children, adolescents and their caregivers and the outcomes were between very strong, on paediatric treatment, to moderately strong on support for caregivers.

The advocacy challenge moving forward is ensuring that the commitments are implemented by governments, in particular the very ambitious target to get 1.6 million children on treatment by 2018. The encouraging step was the launch of the “Start Free, Stay Free, AIDS-Free” initiative at the HLM as a means of completing the work of the EMTCT Global Plan, achieving the ambitious targets for both adolescent prevention and pediatric treatment by 2020. However, as the needs of children affected by AIDS, seem to perpetually ‘fall off the radar’, strong and effective advocacy will be needed to achieve these commitments.

#### **f. Adolescents and Young People<sup>11</sup>**

Previous Political Declarations contained only a few references to adolescents and youth, and usually alongside children, not recognizing, as noted above, the important differences and their implication for effective HIV responses. In 2006, the terms appeared a total of three times, in the context of increasing their capacity to protect themselves and the provision of youth-specific education and health services. In 2011, they appeared a total of six times, in the same contexts as before, but with the addition of the need for increased financial, social, and national support. In contrast, the 2016 Political Declaration addresses adolescents, youth and young people consistently throughout the text, drawing attention to their specific needs, recognizing them as the subjects and holders of rights, and setting specific targets and commitments for them.

The 2016 Declaration recognizes AIDS as the leading cause of death among adolescent girls globally, and in particular notes the risk to adolescent girls, especially in sub-Saharan African. It expresses grave concern that young people represent more than one third of all new HIV infections and that AIDS-related illnesses are the second leading cause of death among all adolescents globally. It briefly notes the important role that youth groups and youth-led organizations in civil society play, but does not recognize the extent to which adolescent key populations contribute to addressing HIV on a global scale.

Critically, the Declaration identifies a number of areas in which limited access for adolescents and youth contribute to their high risk, including quality education, sexual and reproductive health-care services, comprehensive information and education, legal barriers and gender inequality. It therefore includes critical commitments to eliminate gender inequalities and gender-based abuse and violence; review and reform legislation that may create barriers, reinforce stigma and discrimination, or restrict access to services among adolescents; ensure access to quality education for adolescent girls and young women, and promote laws and policies that ensure adolescents the enjoyment of all human rights and fundamental freedoms. However, despite recognizing them as rights-holders, the Declaration fails to explicitly recognize the sexual and reproductive rights of adolescents.

The Declaration details the essential elements of scientifically accurate comprehensive education and information that adolescents and young people need on sexual and reproductive health in order to enable them to protect themselves from HIV infection. Importantly, it recognizes the importance of integrating human rights, power, and gender equality and women’s empowerment into such programmes. Also, it is in the section on HIV services and prevention rather than the gender section, which is important since CSE is relevant to everyone, including young people in key populations, and not just adolescent girls and young women, as the paragraph notes.

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<sup>11</sup> Prepared by IPPF/WHR



In a significant step forward, the 2016 Political Declaration did not contain language promoting abstinence and fidelity or language about the importance of families or cultural values in HIV education programmes as in the 2001 (¶¶ 25, 38, 63), 2006 (¶ 25), and 2011 political declarations (¶¶ 25, 38 and 45) as had been done in 2011 (¶¶ 25, 43) or in 2001 (¶ 63). Though paragraph 62(c) does mention culture and parents, it requires only that the education be “relevant to cultural contexts” and that parents, legal guardians, caregivers, and others, be involved in “full partnership” with young people. These are very important distinctions from 2011 because they maintain the focus on young people and the accurate, non-judgmental education that they need in order to make empowering decisions for themselves and their lives.

Unfortunately it falls short of calling for comprehensive sexuality education, despite strong evidence presented by UNAIDS, the Secretary General’s Report, and the Lancet on its critical role in preventing HIV. While this language is a step-forward from previous declarations, it fails to set the standard needed.

The Declaration also contains commitments for 2020 to reduce the number of adolescent girls and young women, aged 15-24 years old, newly infected with HIV globally each year to below 100,000; reduce the number of new infections in children and young adolescents (under 15) by 95%; and ensure that at least 81% of the number of children and young adolescents (under 15) are on treatment. These concrete commitments are critical for future work holding governments accountable at the national level.

**g. Combating stigma and discrimination and the inappropriate use of criminal law against people living with HIV**

The current Declaration calls much needed attention towards addressing the scourges of stigma and discrimination as significant challenges to effective global HIV responses. Notably, subparagraphs 62(J) references the “need to eliminate barriers, including stigma and discrimination in healthcare settings.” Further in subparagraph 63(c) the Declaration calls on member states to commit to “intensifying national efforts to create enabling legal, social and policy frameworks in each national context in order to eliminate stigma, discrimination and violence related to HIV, including by linking service providers in health-care, workplace, educational and other settings, and promote access to HIV prevention, treatment, care and support and non-discriminatory access to education, health-care, employment and social services, provide legal protections for people living with, at risk of, and affected by HIV.”

Finally, in recognition of the fact that stigma and discrimination are drivers of the epidemic, the Declaration in Subparagraphs 63(b) explicit calls on member states “to strengthen measures at the international, regional, national, and local and community levels to prevent crimes and violence against, and victimization of, people living with, at risk of, and affected by HIV and foster social development and inclusiveness, integrate such measures into overall law enforcement efforts and comprehensive HIV policies and programmes...[and] review and reform, as needed, legislation that may create barriers or reinforce stigma and discrimination, such as, age of consent laws, laws related to HIV non-disclosure, exposure and transmission...”

In sum, the current Declaration represents one small step forward but two large steps back in advancing the rights and wellbeing of people living with HIV. Significant advancement has been made by member states in recognizing the contributions and need for further investment in the work of communities and civil society as key enablers of an effective response to HIV. Additionally, the current Declaration

proactively demands that member states address the widespread and multifaceted manner that HIV positive people experience stigma, discrimination and violence, particularly in relation to healthcare settings, employment, education and social services. However, we cannot ignore the fact that this Declaration undermines its gains by turning a blind eye to the needs of sex workers, people who use drugs, prisoners, gay men and men who have sex with men, and transgender persons living in political environments that perpetuate socially and legally sanctioned discrimination and violence, including misogyny, homophobia and transphobia.

Moving forward, advocates must urge member states to hold one another accountable on any attempts to suppress human rights, and with civil society and key population groups acting as community watchdogs, to ensure that such outright violation of rights and expressions against people living with HIV and key populations are acknowledged, recorded and rectified.

#### **h. Comprehensive Prevention<sup>12</sup>**

As in all other previous Declarations, the 2016 Political Declaration reaffirmed that comprehensive prevention must be the cornerstone of all HIV response<sup>13</sup> It further includes calls for tailored comprehensive HIV prevention services for women and adolescent girls, migrants, and key populations (¶ 62(c)), as well as naming specific types of interventions, including male and female condom programming, voluntary medical male circumcision, pre-exposure prophylaxis, and harm reduction though in this paragraph – paragraph 62 (d) – it uses the UNGASS on Drugs language rather than naming harm reduction explicitly. The 2016 Political Declaration also calls for specific prevention targets including ensuring that comprehensive prevention services reach 90% of people in need of them, that 3 million people access pre-exposure prophylaxis, that 25 million young men are voluntarily medically circumcised, and that no less than a quarter of AIDS spending globally is spent on prevention (¶¶ 62 (f) and 62 (g)).

In some ways the 2016 Political Declaration is an improvement over previous Declarations since it does not contain references to local “ethics and cultural values” nor does it promote “responsible sexual behavior, including abstinence and fidelity” as the 2011 and 2006 Political Declarations did (¶¶ 59 and 59(c) and ¶¶ 22 and 26 (without abstinence and fidelity), respectively). However, as noted above, the inability to name key populations more explicitly in the 2016 Political Declaration is a significant weakness. Thus, even though paragraph 62 (e) calls for comprehensive prevention services for key populations, as well as women and girls and migrants, paragraph 62 (g) on financial resources for prevention is more circumspect calling for money to be spent: “on geographic locations, social networks and populations that are at higher risk of HIV infection according to the extent to which they account for new infections in each setting, in order to ensure that resources for HIV prevention are spent as cost-effectively as possible and to ensure that particular attention is paid to those populations at highest risk, depending on local circumstances.” Civil society had also been advocating for a strong emphasis on ‘combination prevention’ as a key strategy to address comprehensive prevention efforts, in line with UNAIDS and PEPFAR strategies. Unfortunately, while earlier drafts contained a strong focus on combination prevention, this language was practically entirely removed from the final draft.

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<sup>12</sup> Prepared by IWHC

<sup>13</sup> 2016: paragraph 62 (a). 2011: paragraph 27. 2006: paragraph 22. 2001: paragraph 17.

### **i. Sexual and Reproductive Health and Rights<sup>14</sup>**

The 2016 Political Declaration contains the strongest, most progressive language yet on sexuality and sexual and reproductive health and rights of all of the Declarations so far. But there are still significant gaps, including the continued failures to recognize the right of adolescent girls to control their own sexuality, to recognize sexual rights, and to name comprehensive sexuality education (CSE).

To date, the Political Declarations have only recognized the right of women and girls to control their sexuality, based on paragraph 96 from the 1995 Beijing Platform of Action, as critical to the AIDS response. The Political Declarations of 2016, 2011, and 2006, contain a paragraph (61(c), 53, and 30, respectively) that has remained virtually unchanged and which draws from paragraph 59 of the 2001 Declaration of Commitment. Each paragraph recognizes women’s human rights “to have control over, and decide freely and responsibly on, matters related to their sexuality” in order to protect themselves from HIV infection. During the negotiations there was an attempt by some member states to expand recognition of this right to adolescent girls; however it was removed from the final text by the co-facilitators despite the fact that there was broad consensus on this issue.

This Declaration, and prior ones, fall short in recognizing the human rights of other groups to have control over and decide freely on matters related to their sexuality, despite the fact that this right underpins effective HIV responses among gay men and other men who have sex with men, sex workers, transgender people, people who use drugs and adolescents and young people

Since 2006, the Political Declarations have mentioned the need for better integration of HIV and other health services, including sexual and reproductive health services.<sup>15</sup> In 2016, significant progress was made in naming the key services that women and girls, especially who have experienced violence, need, including emergency contraception and other forms of modern contraception, safe abortion, pre- and post-exposure prophylaxis, diagnosis and treatment for sexually transmitted infections, and women-initiated prevention commodities.<sup>16</sup>

The 2016 Political Declaration also detailed violations of sexual and reproductive rights for the first time, including child, early and forced marriage, forced pregnancy, forced sterilization, in particular of women living with HIV, forced and coerced abortion, and female genital mutilation. It committed to end all forms of violence against women, including gender-based, sexual, domestic and intimate partner violence (¶ 61 (h)). Importantly, the 2016 Political Declaration also notes “that the lack of protection and promotion of the human rights of all women and their sexual and reproductive health and reproductive rights... and insufficient access to the highest attainable standard of physical and mental health, aggravates the impact of the epidemic especially amongst women and girls...” (¶ 61 (b)). This is the first time that reproductive rights have been recognized in an HIV Declaration.

### **j. HIV and HIV-related Treatment Targets<sup>17</sup>**

The Political Declaration’s paragraphs 60 (a)-(h) outline member states’ commitments to “ensuring access to testing and treatment in the fight against HIV and AIDS”. These paragraphs of the adopted document include important commitments on expanding access to HIV treatment and achieving viral

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<sup>14</sup> Prepared by IWHC

<sup>15</sup> 2011: paragraph 98. 2006: paragraphs 21 and 34.

<sup>16</sup> Listing based on paragraphs 61 (j) and 61 (l).

<sup>17</sup> Prepared by HealthGAP, StopAIDS UK and the International HIV/AIDS Alliance

suppression, expanding access to voluntary, confidential, evidence-based and community-based testing, expanding access to community-led service delivery, combating mother-to-child transmission, and addressing Tuberculosis and Hepatitis C co-infection. Most importantly, this area of the document reflects important progress, as compared with previous Declarations, towards the inclusion of clear numerical targets in addition to broader policy commitments, to which member states can be held accountable.

In 2011, activists fought for the inclusion of a hard target of putting 15 million people living with HIV on treatment by 2015 in the Political Declaration on HIV/AIDS being negotiated at that time, arguing that its inclusion would be critical for setting the tone for the global AIDS response. We were right. The “15x15” goal was used by activists to exert pressure on decision-makers, to increase funding for the response and to shift towards evidence-based policy and programmes. By the end of 2015, the target was not only achieved, but exceeded.

Drawing on this experience, civil society once again successfully fought for the inclusion of hard targets in the 2016 Political Declaration on HIV and AIDS. Principally, The Declaration commits member states to a bold new target of reaching 30 million people on treatment by 2020 (¶ 60 (a)). This is both an ambitious and winnable goal, if politicians take action to deliver on the right to health for people with HIV. Additionally, the paragraph commits to achieving the 90-90-90 treatment targets by 2020 - 90% of people living with HIV know their status, 90% of people living with HIV who know their status are receiving treatment, and 90% of people on treatment have suppressed viral loads. These targets are grounded in an analysis of the current state of the response, recent scientific evidence, and epidemiological modeling of the epidemic. As was the case in 2011, civil society activists advocated strongly for the inclusion of “30 million on treatment by 2020” in the Declaration. The inclusion of these treatment targets will encourage countries to make use of the new evidence in HIV treatment science, delivering access to treatment and viral load monitoring for all people living with HIV, regardless of their clinical status.

If achieved, the target will reflect a near doubling of the number of people living with HIV who have access to treatment. Delivering on these treatment targets is crucial to curbing the AIDS epidemic by 2030. The Declaration does well to commit not only to achieving increased treatment coverage targets, but to achieving effective treatment coverage resulting in viral suppression and dramatically reduced rates of HIV transmission. If the world fails to achieve these targets, we risk undoing the achievements made in reduction in HIV prevalence, and deaths due to AIDS.

Along with robust treatment targets, the declaration includes commitments to using multiple strategies and modalities to provide HIV testing for the millions of people who do not know their status, and to provide the appropriate pre-test information, counseling, and follow-up to facilitate linkage to treatment and care, including viral load monitoring (¶ 60 (b)). The fulfillment of these commitments is a necessary factor in the achievement of the 2020 treatment targets.

The 2016 Declaration moves beyond the 2011 commitments with the addition of treatment targets focused on HIV co-infections, which pose a dangerous threat to people living with HIV, and to public health across the world. The Declaration commits to reducing TB-related deaths among people living with HIV by 75% by 2020, and to both fund and implement the TB 90-90-90 targets to reach 90% of all people who need TB treatment, including 90% of populations at high risk, and achieve 90% treatment success (¶ 60 (g)). The document also commits to reducing the high rates of HIV and Hepatitis B and C co-infection, by making efforts to reduce new cases of chronic viral Hepatitis B and C infections by 30%

in 2020, by treating 5 million people living with Hepatitis B, and 3 million people living with chronic Hepatitis C infection (¶ 60 (h)).

Another welcome addition to the 2016 Declaration is the commitment to expand community-led service delivery to cover at least 30% of all service delivery by 2030 (¶ 60 (d)). Increases in community-led service delivery will bring services closer to the people who need them and increase service uptake and effectiveness

However, the Declaration does not adequately acknowledge that achieving these targets on treatment and testing will require the overcoming social, financial, political and health systems barriers to access health care and affordable medicines, and the elimination of the discrimination and bigotry that fuel the epidemic and prevent people from accessing the services they need. In particular, scaling up treatment to reach marginalized and criminalized populations will require a dramatic shift—elimination of ‘business as usual’ in service delivery. This is of particular concern, given the inadequate attention to marginalized populations, including men who have sex with men, people who inject drugs, sex workers, and transgender persons, in the Declaration. Achieving the targets will also require the expansion of generic production of medicines and access to these affordable medicines through the elimination of intellectual property barriers, and an increase in financing for the response from both donor and domestic sources. These issues are addressed in detail in other sections of this document.

#### **k. Intellectual Property and Access to Medicines<sup>18</sup>**

In the Political Declaration’s paragraphs 60(i)–(n), member states discuss how to ensure future access to safe, affordable and efficacious HIV-related medicines, including generic medicines, diagnostics and related health technologies. These provisions were heavily disputed between the US and other rich countries acting as proxies for the innovator pharmaceutical industry on the one side, and people living with HIV and their allies on the other. In a context of increasingly scarce resources for scale-up in access to HIV-related treatment and care, enhancing the affordability of medicines and other health technologies is critical. While the 2016 Political Declaration affirms the right of member states to interpret and implement the World Trade Organization (WTO) Trade-Related Aspects of Intellectual Property Rights (TRIPS) in such a way that places public health above commercial interests, the declaration fails to acknowledge that this right is currently under threat around the world. The result is a Political Declaration that fails to take the kind of visionary and action-oriented approach needed to address the high prices of medicines.

Those involved in constructing the zero draft of the Declaration, including UNAIDS, largely adopted a cautious non-confrontational approach. Notably, they avoided directly confronting the growing threat of higher priced HIV medicines and other health technologies, which are protected by an array of patent and data monopolies that are being intensified in the post-TRIPS era. Instead, the drafters looked to past circumlocutions that referenced the problem, but failed to outline a real course of action. Building on this weak base, and in the face of rich country opposition to more robust approaches, the Declaration ultimately fails to challenge the intellectual property and trade regime that threatens universal access to medicines for HIV and related opportunistic infections—most especially in middle-income countries.

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<sup>18</sup> Prepared by HealthGAP, StopAIDS UK and the International HIV/AIDS Alliance

On the plus side, the Declaration reaffirms that the WTO Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) should be interpreted and implemented in a manner supportive of public health so as to promote access to medicines for all (¶ 60(j)); that domestic law reform should optimize the allow the use in full of TRIPS-compliant flexibilities, (¶ 60(l)(a)); that intellectual property provisions in trade agreement should not undermine TRIPS flexibilities (¶ 60(l)(a)); and that generic competition should be promoted (¶ 60(l)(b)).

However, there are unfortunate qualifiers on virtually all of these now well-established principles. For example, member states (under influence of the Pharma lobby) insisted that the Declaration include a statement “recognizing the importance of the intellectual property rights regime in contributing to a more effective AIDS response.” This qualifier is highly contested in the access to treatment movement, where astronomical monopoly prices have resulted in the unnecessary deaths of millions of people living with HIV. To the contrary, at present there are multiple IP-related obstacles to the development of optimized medicines, new pediatric and fixed-dose combinations, and easier-to-use and more robust diagnostics—all challenges that the Declaration fails to identify solutions for.

The Declaration puts no real pressure on countries to adopt, use, and protect TRIPS flexibilities – instead they are urged merely to remove IP obstacles “as deemed appropriate”—a standard directly at odds with countries’ human rights obligations to progressively realize the right to health and of access to medicines by proactively removing access barriers. In addition, the Declaration places no duty on rich country trading partners to cease seeking TRIPS-plus measures that strengthen and lengthen pharmaceutical company monopolies and to roll back any existing TRIPS-plus provisions while simultaneously ceasing other pro-IP trade and diplomatic pressure.

While the Declaration does encourage the use of voluntary measures, including truly new mechanisms such as prizes, open-source sharing of patents, and patent pools benefiting all developing countries, it also mentions voluntary measures that have proven to be inadequate or even counterproductive in the past such as private-public partnerships and tiered pricing (¶ 60(l)(c)). The Declaration also calls for the early adoption of proposed Article 31bis of the TRIPS Agreement, which inaptly addresses the vexing problem of facilitating use of compulsory licenses by countries that lack sufficient manufacturing capacity to make medicines locally (¶ 60(l)(c)). Unfortunately, the overly cumbersome mechanism created has been used only once in the past 13 years and thus the mechanism should be modified not adopted.

In one of the most heavily contested provisions, the Declaration notes the establishment of the UN Secretary-General’s High-Level Panel on Access to Medicines (¶ 60(i)), but makes no real mention of numerous recent proposals to require government funding of research and development and to delink the system for incentivizing appropriately targeted research from the system for manufacturing and distributing generic-priced medicines.

Finally, the Declaration abstractly addresses other regulations, policies and practices that limit legitimate trade in medicines, including regulatory policy and supply chain management, (¶ 60(k)), but does not urge global, regional, and national regulatory reform addressing registration, inspections, and quality assurance throughout the supply chain that would help ensure speedier and more consistent access to safer medicines and diagnostics.

In sum, the access to medicines provisions in the Declaration lack vision, clarity, and actionability. They barely name the real problems of escalating monopoly power and place few if any enforceable

obligations on countries to take action to ensure access to affordable medicines. In an era of needlessly scarce resources for scale-up to achieve the goal of 30 million people on treatment by 2020, let alone ending AIDS by 2030, enhanced affordability of better-adapted medicines and other health technologies is vitally important. Intellectual property barriers must be dismantled, not papered over.

### **I. Financing the Response<sup>19</sup>**

Global civil society organizations advocated for member states to commit to meeting the UNAIDS financial target of \$26.2 billion needed to achieve the fast-track targets and for the Global Fund Replenishment target of \$13 billion. The final Political Declaration delivered this.

In paragraph 59 (b) States agree to ‘Commit to increasing and fully funding the AIDS response from all sources, including from innovative financing, and reaching overall financial investments in developing countries of at least US\$ 26 billion/year by 2020, as estimated by UNAIDS’.

And in paragraph 59 (p): ‘Commit to mobilizing resource needs of US\$ 13 billion for the Global Fund’s Fifth Replenishment’.

The \$13 billion replenishment target for the Global Fund was not specified in the zero draft of the Political Declaration. Securing a commitment in the declaration from member states to reaching the figure of \$26 billion of UNAIDS’ estimated need globally by 2020 was important, but a key question remains for many civil society organizations regarding whether this amount is what it was considered realistic to raise rather than what is actually needed to meet the 2020 AIDS targets.

Ending the AIDS epidemic is a shared responsibility, requiring increases in both international and domestic investment in the global AIDS response. It is essential there is a global commitment to this shared responsibility and that the resources required to reach Fast-Track Targets are urgently scaled up, as noted in paragraph 59 (c).

CSOs were pleased that the contentious and, for many, unrealistic UNAIDS figures related to the level of funding needed to be raised by low, lower middle and upper middle income countries were not included in the declaration.

Domestic resourcing has steadily increased over recent years to the point where domestic resourcing for AIDS makes up more than half of global HIV resources. However, nobody contests that most low- and middle-income countries can and must do more to finance their own responses. The declaration rightly highlights the centrality of domestic investment in the HIV response for achieving sustainable development (¶ 59 (e)). At the same time, overall donor funding for the response has flat lined. The declaration states that the fulfillment of all ODA commitments remain crucial’ and calls on developed countries to deliver their 0.7% commitments (¶ 59 (h)).

Of particular concern for civil society, recent reductions in donor funding for middle-income countries, particularly upper middle income countries, is threatening the HIV response in these countries, especially among key populations and where civil society organizations play a key role in implementation. At present, 105 countries are considered middle-income, but many are characterized by high-levels of inequality. They are home to more than 75 per cent of the world’s poor and 58% of all

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<sup>19</sup> Prepared by HealthGAP, StopAIDS UK and the International HIV/AIDS Alliance

people living with HIV globally. By 2020, this proportion is expected to rise to 70%. From a global health perspective, the largest share of disease burden is now concentrated in middle-income rather than low-income countries, a reality that GNI per capita alone cannot capture. As a result, there is increasing concern that funding policies based on income classification alone overlook important dimensions of development, such as poverty, inequality, and health.

Up to the penultimate draft of the declaration there was strong text proposed in the declaration (CARICOM 49 *bis*2) regarding the particular challenges facing middle income countries and the importance of ensuring transitions away from donor funding that sustain rather than undermine gains made in the national response. However, it was disappointing that this important text was deleted in the final draft and the remaining paragraph 49 simply references but does not list ‘the specific challenges facing the middle-income countries’.

Even with significant increase in the domestic financing, civil society faces challenges in accessing money from national governments due to government suspicion or lack of funding mechanisms in place to channel funds. Community-based organizations struggle to access domestic government funding for HIV service delivery let alone to continue more contentious work in advocacy, policy analysis, protecting human rights, and budget monitoring. The declaration recognizes the critical role of civil society in the HIV response and commits to ‘expanding community-led service delivery to cover at least 30% of all service delivery by 2030, and through investment in human resources for health, as well as in the necessary equipment, tools and medicines’ (¶ 60 (d)). Specifically, the declaration also calls ‘for increased and sustained investment in the advocacy and leadership role, involvement and empowerment of people living with, at risk of, and affected by HIV...’ (¶ 64 (d)).

Donors have a key role to play in low-income and middle-income countries providing catalytic and strategic resources to support the Civil Society Organizations and Key Populations groups working at the community level. National mechanisms to sustain and scale up human rights, key populations and prevention programmes must be in place before donors leave a country. As mentioned in the section above, there was little or no recognition in the declaration of the challenge and critical importance of managing successful and sustainable transitions away from donor funding.

Toward the future, key issues for advocacy and any next steps, it will be important to push for a clearer definition of more realistic investment needs in the AIDS response in terms of what is needed rather than what is possible. Moving forward also means agreeing on a better way to identify priority investments that do not solely rely upon the World Bank income level classifications. Effective “fast tracking” also depends upon maintaining some strategic donor investment in middle-income countries and continued support of the Global Fund and other multilateral funding mechanisms in those countries. Without this, CSOs will struggle to survive and ensure that the gains that have been made in addressing HIV, particularly among key populations, are protected. In light of this, it is crucial that donors engage in a responsible transition and exit, including investing in sustainability.

Moving forward, HLM Political Declaration language must be translated into advocacy messages to be used by CSO supporting the full replenishment of the Global Fund and the incremental investment of domestic funding in middle-income countries. This also includes promoting a deeper global and regional discussion on how local key population groups and other civil society organizations engaged on advocacy, policy and human rights will continue when donors exit.



### **m. Civil Society and Community Engagement<sup>20</sup>**

The importance of a sufficient investment in the community-led HIV response is addressed in the political declaration. Many Member States supported targets to scale up the community-based response as key to achieving the fast track targets. So the language on the role of communities in the AIDS response which was part of the zero draft was retained in the adopted Political Declaration.

The political declaration, in paragraph 29, recognizes the *role that community organizations play, including those led by and run by people living with HIV, in supporting and sustaining national and local HIV and AIDS responses, reaching all people living with HIV, delivering prevention, treatment, care and support services and strengthening health systems, in particular the primary healthcare approach.* And welcome the leadership and commitment from stakeholders including civil society.

The inclusion of specific targets for community-led service delivery and for community mobilization in a UN document is a key win. For example, it includes three strong calls for member states to increase funding for civil society, service delivery and advocacy:

For example, in paragraph 22 *“Commend subregional, regional and global financing institutions, including the Global Fund to Fight AIDS, Tuberculosis and Malaria, for the vital role they play in mobilizing funding for country and regional AIDS responses including for civil society and in improving the predictability of financing over the long term.”*

The political declaration includes the commitment *to build people-centered systems for health by strengthening health and social systems. Expand community-led service delivery to cover at least 30% of all service delivery by 2030* in it paragraph 60 (d) and states the importance to support community systems (¶ 14). For example, community based testing is included in paragraph 60 (b).

The political declaration also calls for increased investment in advocacy in paragraph 64(a): *Call for increased and sustained investment in the advocacy and leadership role, involvement and empowerment of people living with, at risk of, and affected by HIV, women and children, bearing in mind roles and responsibilities of parents, young people, especially young women and girls, local leaders, community-based organizations, indigenous communities and civil society more generally as part of a broader effort to ensure at least 6% of all global AIDS resources are allocated for social enablers including advocacy, community and political mobilization, community monitoring, public communication, outreach programmes to increase access to rapid tests and diagnosis, as well as human rights programmes such as law and policy reform, and stigma and discrimination reduction.*

Apart from that, the political declaration commits to support capacity strengthening for CSOs in its paragraphs 60(d) and 61(n) referring to conflict settings, and commitment to engage CSOs in accountability mechanisms. However, while the political declaration refers to meaningful (¶ 21) and active (¶ 70) involvement of people living with HIV, there is no mention to the GIPA principle in the political declaration. There is one mention to community engagement in paragraph 60 (h) in the context of responses to hepatitis B and C: *“taking into account the linkages to and lessons learnt from the AIDS response such as the promotion and protection of human rights, reduction of stigma and discrimination, community engagement.”*

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<sup>20</sup> Prepared by ICASO and the International HIV/AIDS Alliance

Unfortunately, paragraph 60 (e) on universal health coverage does not include any reference to community-led health care, despite all the advocacy efforts to influence the universal health coverage agenda on this key issue. The universal health coverage debate is still very much focused on health care delivered through the public health system and does not address the need to invest in community-delivered care. This is a critical issue to advocate for in the implementation of policies in-country.

The Declaration reflects the vital role of communities and the increasing evidence about the importance of community-based services, advocacy and mobilization for the sustainability of the HIV response. However, while the community response is much better reflected in this Declaration than in previous ones, there is still a huge gap in funding for capacity building of community-based organizations, both in their roles of service providers and as advocates. This is especially critical issue in middle-income countries, when donors pull out and there is no domestic funding for the community response. Many organizations have already had to discontinue their services because of lack of funding. Community-based organizations must be adequately supported, provided with resources, and engaged with on a basis of equality and non-discrimination.

Future advocacy must include efforts to ensure accountability for the commitments on resourcing community-based services and community advocacy, both in the AIDS response and as part of universal health coverage. It is imperative to ensure that resources are allocated and spent in ways that reach affected communities and reflect genuine community needs, particularly among key populations, women and girls, and young people.

In particular, work will be needed to:

- Make countries accountable on their financial commitments to community responses, including for service delivery and advocacy, both at the international and national level.
- Ensure donors, recipient countries and UN agencies develop plans for responsible donor transition in middle-income countries, and ensure countries build national mechanisms to fund communities and human rights interventions.
- Increase engagement in the universal health coverage global debates. The move towards universal health coverage is an opportunity to ensure that parts of the AIDS response are integrated to ensure sustainability. Investment in and support of the community response to reach certain groups and the promotion of human rights should be a critical component of universal health coverage policies and programmes if universal health coverage is to be truly realized. The universal health coverage and HIV movements could provide an inclusive and equitable model for coordinated action in the next era of global health. The HIV movement has a significant body of evidence demonstrating the critical role of and the need to invest in community systems alongside public health systems. But also the engagement of UNAIDS and the HIV sector in this debate is a way to ensure that universal health coverage packages include the entire range of HIV services, including HIV prevention, treatment, care, harm reduction and human rights programming.
- Follow up UNAIDS PCB Thematic Segment on “the Role of Communities in ending AIDS by 2030” that took place 30 June 2016. The decision points will be adopted in December 2016.
- International partners (UNAIDS, WHO, WB, Global Fund among others) should work together to provide global standards on community responses for the SDG era to improve the health of all populations. This must include the interface between community work and other formal systems to build resilient and sustainable systems for health.

## **n. Sovereignty<sup>21</sup>**

Civil society advocates opposed language on sovereignty because it undermines States' obligations to implement the commitments in this declaration and, ultimately, effective HIV responses. Paragraph 4 is identical to sovereignty language from 2011, which states:

“Reaffirm the sovereign rights of Member States, as enshrined in the Charter of the United Nations, and the need for all countries to implement the commitments and pledges in the present Declaration consistent with national laws, national development priorities and international human rights”.

Sovereignty was not mentioned in 2006 or 2001. Paragraph 59 (i) also mentions sovereignty in reference to south-south cooperation (in line with national sovereignty). However, sovereignty is referenced obliquely in multiple paragraphs.

As discussed above, caveats in paragraph 42 that emphasize “that each country should define the specific populations that are key to its epidemic and response based on the local epidemiological context” risks undermining efforts to reach the very people and communities specified in this paragraph. Key populations have been neglected by national programmes, and this is reflected in the “slow progress in reducing new infections” and this paragraph opens the door to continued neglect.

Similar caveats are used to limit the scope of harm reduction programmes. Paragraph 43 refers to harm reduction and treatment for people who use drugs, but this is qualified “as appropriate in the context of national programmes”. Given that some harm reduction services are criminalized in some countries, this allows countries to continue to deny the provision of highly effective and evidence-based services to those who need them. In the final hours of the negotiations, Russia attempted to introduce a similar sovereignty clause in paragraph 62(d), which was ultimately unsuccessful.

Other paragraphs with similarly limiting language are: Paragraph 61(j) refers to “safe abortion where such services are permitted by national law”; Paragraph 57 that reads: “Commit to differentiate AIDS responses, based on country ownership and leadership, local priorities, drivers, vulnerabilities, aggravating factors, the populations that are affected and strategic information and evidence, and to set ambitious quantitative targets, where appropriate depending on epidemiological and social context, tailored to national circumstances in support of these goals”.

References to country ownership and national circumstances are two-edged, because countries that use evidence to determine their responses will benefit, but those that neglect particular groups - especially marginalized groups and key populations - may suffer a rebounding epidemic at great human cost.

Paragraph 63 refers to reviewing and reforming legislation that creates barriers to access “as needed”, offering wiggle room to those that are not committed to legal reform.

Sovereignty is a perennial issue during negotiations at the UN, particularly when issues related to sexual and reproductive health and rights, harm reduction, sex work, sexual orientation and gender identity are discussed. National-level advocacy, including for policy change, will be critical to hold governments to account for implementing the commitments in this Declaration.

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<sup>21</sup> Prepared by ICASO

#### **o. Accountability, Follow-up, and Next Steps<sup>22</sup>**

The Political Declaration provides extensive guidance on monitoring, accountability and follow up. This is more extensive than in previous years where, in 2011 for example, there were only two brief paragraphs on monitoring and accountability.

The 2016 Declaration specifies the need for an annual report on progress for the General Assembly. This is a repeat of 2006 and 2011. We should note though that the 2006 declaration went further than the 2011 and 2016 declarations by specifying two additional 'comprehensive reviews' of the 2006 commitments in 2008 and 2011. The 2016 document also requests that a date is set for the next HLM on AIDS to review progress against this declaration, no later than the 75<sup>th</sup> session of the General Assembly (2021). This differs from earlier declarations which did not specify a time for the next HLM.

The 2016 Declaration contains far less specific information on the operationalization of national and regional follow up. It is addressed only in paragraph 75. In contrast, the 2001 Declaration of Commitment had three paragraphs on national and three on regional follow up.

The 2016 Declaration does commit to 'effective evidence based operational mutual accountability mechanisms that are transparent and inclusive' (¶ 70). The strong emphasis on the importance of evidence gathering is good particularly considering the low quality of data about key populations. However, the main challenge is that key populations are not specified in the accountability or follow up sections of the declaration. Children and women and girls are the only populations that are specified.

A key outcome of the document therefore is the explicit emphasis on the importance of accurate data (¶ 71). The paragraph highlights collecting 'characteristics relevant in a national context' and to allocate resource by population to fill critical evidence gaps. The document also commits (¶ 75) to encourage the use of regional commissions to support reviews of national efforts and periodic reviews against progress made to combat HIV. It does not say that these reviews should be measured specifically against the Declaration itself.

A general weakness of these sections is that there is only a brief mention of the active involvement of people living with and affected by HIV. This would have been strengthened by explicitly linking this to the GIPA principles.

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<sup>22</sup> Prepared by StopAIDS UK