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2017 Social Forum*

Report of the Co-Chair-Rapporteurs

Summary

In accordance with Human Rights Council resolution 32/27, the Social Forum was held in Geneva from 2 to 4 October 2017. Participants considered the promotion and protection of human rights in the context of the HIV epidemic and other communicable diseases and epidemics. The present report contains a summary of the discussions, conclusions and recommendations of the Forum.

* The annex to the present report is being issued in the language of submission only.

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I. Introduction

1. The Human Rights Council, in its resolution 32/27, reaffirmed the Social Forum as a unique space for interactive dialogue between the United Nations human rights machinery and various stakeholders, including civil society and grass-roots organizations.[1]

2. The 2017 Social Forum was held in Geneva from 2 to 4 October. It focused on the promotion and protection of human rights in the context of the HIV epidemic and other communicable diseases and epidemics. The President of the Council appointed the Ambassador and Permanent Representative of Brazil to the United Nations Office at Geneva, Maria Nazareth Farani Azevêdo, and the Ambassador and Permanent Representative of Belarus to the United Nations Office at Geneva, Yury Ambrazevich, as the Co-Chair-Rapporteurs of the Forum.

3. The programme of work was prepared under the guidance of the Co-Chair-Rapporteurs, with inputs from relevant stakeholders, including United Nations agencies and non-governmental organizations (NGOs). The present report contains a summary of the proceedings, conclusions and recommendations of the Forum. The list of participants is contained in the annex to the present report.

II. Opening of the Social Forum[2]

4. The meeting was opened by the Co-Chair-Rapporteurs of the Social Forum. Ms. Farani Azevêdo emphasized that it was essential to strengthen health systems and promote universal health coverage in order to provide long-term sustainable responses to future epidemics. To be effective, those responses must include not only technical and financial support, but also be firmly anchored in a human rights perspective. Realizing the right to health entailed ensuring equal access to medicines and health-care services and addressing social, economic and environmental determinants of health. Poverty, lack of sanitation, air pollution, unsafe water and inappropriate waste disposal and management perpetuated the transmission of vector-borne and infectious diseases and enabled the outbreak of epidemics. Discrimination resulting from harmful social practices or restrictive legal norms were major obstacles to the right to health. Those challenges required a multisectoral approach. The interdependence between the human rights and the development frameworks had been reaffirmed by the 2030 Agenda. The 2017 programme of the Social Forum was aimed at building bridges between the Sustainable Development Goals and human rights obligations and norms.

5. Mr. Ambrazevich stated that the promotion and protection of human rights in the context of the AIDS epidemic and other communicable diseases and epidemics were directly related to the complex challenges of finding the most effective ways to combat those diseases. Each State needed to carry out careful analyses of systems and mechanisms for ensuring a balance of interests of all stakeholders in that issue, particularly in the light of the emergence of new challenges. To achieve the Sustainable Development Goals relating to health, global progress should be made in economic, social and cultural rights. That also required national dialogue between all interested parties, as well as effective and action-oriented governance, adequate policy space, international cooperation, assistance mechanisms, and national and international partnerships.

6. The Vice-President of the Human Rights Council, Mouayed Saleh, drew attention to the resolutions adopted by the Council on issues related to physical and mental health, and to the fact that health was an important element of the 2030 Agenda. Recent outbreaks of Zika, cholera and severe acute respiratory syndrome (SARS) had illustrated that a

[1] For further details on the Social Forum, see www.ohchr.org/EN/issues/poverty/sforum/pages/sforumindex.aspx.

[2] The full texts of the statements and presentations submitted to the Secretariat are available at www.ohchr.org/EN/Issues/Poverty/SForum/Pages/SForum2017Statements.aspx.

comprehensive approach to public health challenges required broader social measures, including tackling stigma and discrimination. Epidemics had also made clear that the right to the highest attainable standard of physical and mental health enjoyed a symbiotic relationship with other human rights. Health could only be improved when other human rights were upheld.

7. The United Nations High Commissioner for Human Rights said that the human rights principles of non-discrimination, participation and accountability were essential to achieving more sustainable, inclusive and effective health systems. Recent outbreaks of Ebola, Zika and cholera had highlighted the importance of basic infrastructure for the enjoyment of the right to health, the need to uphold the right to comprehensive sexual and reproductive health services and the need for special protection for health facilities during armed conflicts. Focusing on the health of adolescents and supporting health workers as human rights defenders made societies more sustainable. The 2030 Agenda provided an opportunity to accelerate efforts to integrate all human rights, including the right to development, and public health considerations into policies at every level.

III. Summary of proceedings

A. Keynote speakers and general statements

8. The Executive Director of the Joint United Nations Programme on HIV/AIDS (UNAIDS), Michel Sidibé, recalled that almost 40 years before the establishment of the Social Forum, people living with HIV had challenged indifference and created, championed and led a transformative movement from a focus on disease to a people-centred approach. Activists had broken the "conspiracy of silence", which had helped change the trajectory of the epidemic and make treatment more affordable. That progress in the HIV response had been made possible by adopting an approach grounded in human rights. While 20 million people were currently on antiretroviral therapy and AIDS-related deaths had dropped sharply, millions still awaited treatment. Moreover, global solidarity and shared responsibility were being questioned, and civil society space was shrinking. Stigma and discrimination discouraged people from accessing prevention services, especially in the cases of transgender and gay persons and people who injected drugs. A transformative global agenda, powerful scientific and medical tools, strong and binding global human rights frameworks, and programmes that worked to advance health all imposed a moral and a legal responsibility to act.

9. The Director-General of the World Health Organization (WHO), Tedros Adhanom Ghebreyesus, spoke about the importance of achieving universal health coverage to address impending health challenges. Universal health coverage improved everyone's health, reduced poverty, created jobs, drove inclusive economic growth, promoted gender equality and protected people against epidemics. However, social barriers prevented many people from getting the care they needed, and included discrimination against adolescents, refugees, sex workers, drug users, people in prison, the poor and people with minority sexual orientation. Robust health systems should provide the services people said they needed, not those that providers decided they needed. Civil society organizations, community groups, Governments, United Nations agencies and for-profit companies should work together to fulfil the political mandate of the Sustainable Development Goals to improve health outcomes and transform health systems.

10. An advocacy officer at AfricAid Zimbabwe, Loyce Maturu, shared her experience as a young person living with HIV and tuberculosis. Living with HIV was difficult due to stigma, obstacles in access to care and lack of confidentiality in health facilities. There was a need for evidence-based, differentiated care models and to ensure that there were AIDS-free generations. Investment was required in peer-led interventions and comprehensive sexual and reproductive health education. Young people living with HIV needed not only treatment but also interventions that supported and motivated them to stay on treatment and remain healthy. The fight against HIV could be won only by believing in the voices of affected populations and by making them partners and decision makers.

11. The Director-General of the World Trade Organization (WTO), Roberto Azevêdo, described the contributions of WTO to the realization of the right to health. Innovation was vital for new treatments as diseases evolved, but to benefit those in need of treatment, effective and equitable access to medicines was necessary. The Agreement on Trade-Related Aspects of Intellectual Property Rights (the TRIPS Agreement) provided exceptions and limitations and was to be implemented in a manner conducive to social and economic welfare. The 2001 Doha Declaration on the TRIPS Agreement and Public Health had marked a major milestone in increasing access to medicines. It had led to the amendment of WTO trade rules to allow for generic medicines to be produced under compulsory licences for export to countries with limited or no pharmaceutical production capacity for treating affected populations. WTO had also taken measures to reduce the costs of and delays in shipping medicines internationally and to cut tariffs on medicines. There could be no higher calling for the international community than to work together to fulfil the right to health. WTO, working jointly with others, would continue to ensure that trade supported the fulfilment of that right.

12. Following the presentations, representatives of Bahrain, Cabo Verde (on behalf of the Community of Portuguese-speaking Countries), Egypt, Ghana, the Islamic Republic of Iran, Mexico, Panama, the Philippines, Portugal, South Africa, the Association of World Citizens, the Elizabeth Glaser Pediatric AIDS Foundation, the Global Forum on MSM & HIV, the Stop AIDS Alliance and the World Social Forum took the floor. They underlined the need to address challenges faced by specific groups, such as children, adolescents, women, migrants, refugees, persons deprived of liberty, sex workers and lesbian, gay, bisexual, transgender and intersex persons. Those challenges included discrimination, criminalization of vulnerable groups, the shrinking of civic space, barriers to access to medicines and unaffordable prices, and a lack of funding for health and other policies addressing the social determinants of health. Overcoming those challenges was a collective endeavour that should build on the 2030 Agenda commitments. Proposals for addressing those challenges included the adoption of universal health-care systems, the collection of disaggregated data in a manner respectful of key populations, the inclusion and participation of civil society and youth in policymaking and implementation, increasing investments in community-led programmes and decriminalizing drug use and behaviours common among affected populations. Some speakers encouraged countries to include HIV-related human rights issues in their universal periodic review reports and recommendations, their reports to human rights treaty bodies and their voluntary national reviews on the Sustainable Development Goals.

B. Setting the scene: implementing health related Sustainable Development Goals through a human rights perspective

13. The Chair of the Committee on Economic, Social and Cultural Rights, Virginia Bras Gomes, said that while the policies, targets and indicators that had been adopted for the fulfilment of the Sustainable Development Goals would, in principle, lead to the realization of rights, that realization did not depend only on policies. It was the human rights framework that could strengthen the fulfilment of the Goals. If States complied with their non-discrimination and equality obligations, the 2030 Agenda commitment to leave no one behind would be achieved. Fulfilment of the right to access to information and education campaigns could prevent the spread of sexually transmitted infections. The right to health required the availability of an adequate number of functioning health-care facilities, services and goods and the promotion of social determinants of good health, such as environmental safety, economic development and gender equity. The targets and indicators in Sustainable Development Goals 3, on ensuring healthy lives, and 5, on gender equality, could contribute to realizing the right to health of people affected by AIDS and other diseases.

14. A Portuguese Parliamentarian, Ricardo Baptista Leite, recalled that the decriminalization of drug use in Portugal in 2000 had contributed not only to decreasing crime, but also to the decrease in drug consumption and the prevalence of infectious diseases, especially HIV and viral hepatitis. A parliamentary resolution developed by an

all-party group on HIV in collaboration with civil society, health-care workers and health industries had become the backbone of health policy on HIV in Portugal. In the same spirit of consensus among stakeholders, Portugal had been able to secure a financially sustainable strategy on hepatitis medication, ensuring access for all patients. The quality of life of people living with HIV should be as important an objective as biomedical targets relating to treatment. Parliamentarians could play an active role in responding to epidemics by approving national budgets, changing policies and building bridges between people and Government. He called for support for the work of "Unite", a global network of parliamentarians that focused on combating AIDS, hepatitis and tuberculosis.

15. The Vice-President of Helen Keller International, Joseph Amon, emphasized that rigorous and routine monitoring was a means of accountability, which was a key human rights principle. While specific indicators and regular reporting constituted an important tool to promote the right to health for all, indicators did not always tell the whole story. National averages could hide significant inequalities between regions, age groups and among most at risk populations. Data could also be inaccurate. True accountability required both disaggregation of data and broad participation with communities to validate what was presented. The Sustainable Development Goals called for an end to the epidemic of neglected tropical diseases, which mainly affected people living in poverty, in sub-standard housing and without adequate water and sanitation. The success of health programmes stemmed not only from scientific advances but also from the promotion and protection of human rights, including the right to health, education, non-discrimination, freedom from violence, access to justice, gender equality and participation. The health sector had an important role to play, but could not address human rights abuses and social determinants of vulnerability alone.

16. A representative of the World Social Forum, Armando de Negri, said that the Forum facilitated discussion of alternative proposals for inclusive globalization that fostered the people's well-being and radical democracy based on social justice. It had established a thematic forum on social rights related to health and social security, which was aimed at promoting health systems based on the universality, integrity and equality of all human rights, including the right to development. A new balance of power was needed internationally, which could be achieved only through correlations of power in national Governments, parliaments, the judiciary and the media that favoured solidarity instead of individualistic and fragmented political thinking. To reverse the concentration of wealth, democracy should be strengthened and political power distributed fairly. Otherwise, the Sustainable Development Goals would be overcome by the wealth-concentrating dynamics of capitalism, impeding the realization of economic and social rights and a life of dignity for all.

17. During the interactive dialogue, representatives of Brazil, Chile, Ecuador, Portugal, the Global Forum on MSM & HIV, the Institute for Planetary Synthesis and the People's Health Movement took the floor. Participants considered that the Sustainable Development Goals and human rights, including the right to health, were mutually reinforcing endeavours, and recalled the importance of accountability, participation, non-discrimination and international solidarity in order to implement the Goals. Some speakers recalled the importance of disaggregating data when reporting, welcoming indicator 3.3.1 of the Goals. Participants also called for a multi-stakeholder approach to the implementation of the Goals and for the preservation and promotion of civil society space in relation to health programmes. Some speakers recommended preventive approaches to health that addressed the social determinants of health and better accountability mechanisms to address discrimination in health systems. The panellists were asked about the meaning and operationalization of universal health coverage (target 3.8 of the Goals) from a human rights perspective and about the roles of stakeholders, including parliamentarians and treaty bodies.

18. In response, Mr. Baptista Leite acknowledged the importance of disaggregating data, but stressed that Governments should not be excused from acting due to the absence of data. He argued that data related to the Sustainable Development Goals should be produced at the local level for a central registry. He underscored that universal health coverage could ensure better health outcomes and lower costs by preventing more serious health problems.

Mr. de Negri called for an institutional architecture that enabled the participation of patients and affected populations in social policies and in the implementation of the Sustainable Development Goals. He argued that the Goals were the object of a "battle of ideas", with concepts such as universal health coverage still open for interpretation, which could leave many behind. Ms. Bras Gomes emphasized the role of disaggregated data in identifying discriminatory practices and ensuring that no one was left behind economically and in terms of policies and rights. Human rights treaties required that national action plans encompass accessibility, availability and affordability, particular in implementing Goal 3. Mr. Amon stressed the need to ensure a people-centred approach to health and direct engagement with local communities, to ensure that rights were respected in the fight to end all epidemics. He called for strengthened cooperation between civil society and Governments.

C. Leaving no one behind: discrimination and the realization of the right to health

19. The Interim Executive Director of the Global Fund to Fight AIDS, Tuberculosis and Malaria, Marijke Wijnrocks, said that the Fund had made it a strategic objective to increase investments in programmes to remove human rights-related barriers to health services. The programmes attacked stigma and discrimination, taught people about their health-related rights, provided legal support, reduced harmful gender norms and gender-based violence, improved the attitudes and practices of health-care workers and the police, and made laws and regulations protective of health. The Fund had made it a requirement that all countries include those programmes in their grant proposals. Civil society, Governments, the United Nations system, other technical partners and donors should help promote more effective programmes for removing human rights-based barriers to health. She hoped they would all join in the move from human rights principles to human rights programmes supporting people to be effective players in determining their own health and well-being.

20. The Chair of the Committee on the Protection of the Rights of Persons Living with HIV and Those at Risk, Vulnerable to and Affected by HIV of the African Commission on Human and Peoples' Rights, Soyata Maiga, described the Commission's efforts to integrate HIV and health in its work and mandates. Addressing those issues was critical, as Africa was particularly affected by HIV and many countries had laws and policies that represented barriers to effective HIV responses. The Committee she chaired had been established in 2010 with a broad mandate that included conducting fact-finding activities on the situation of persons living with HIV and those at risk, and engaging States, civil society and others on the measures needed to advance human rights in response to HIV. The Commission took steps to protect the human rights of persons living with HIV and those at risk by receiving communications concerning human rights violations; issuing urgent appeals, general recommendations and thematic studies; and adopting resolutions on health, HIV and human rights. She recommended that all stakeholders integrate a human rights-based approach to drawing up and implementing plans, policies and programmes to combat HIV.

21. A member of the Regional Steering Committee of the Asia Pacific Transgender Network, Phylesha Brown-Acton, presented data illustrating the challenges and barriers faced by transgender people in accessing transgender-competent general or mental health care. Transgender women were 49 times more likely to be affected by HIV than the general population. There was a need for transgender-positive interpretations of human rights law and jurisprudence, a strong commitment to enforcement of international obligations, and space for transgender voices. The lack of acknowledgement of indigenous specific terminologies for transgender identities in declarations, systems, mechanisms and processes resulted in them being referred to in demeaning and dehumanizing ways. Ignoring indigenous terminology impeded effective country responses and the achievement of fast-track targets. Moreover, the lack of data on indigenous and transgender peoples resulted in them being left behind.

22. A representative of the Zero TB Initiative, Ulaanbaatar, Batbayar Ochirbat, said that tuberculosis patients in Mongolia experienced discrimination in terms of access to medicines, diagnosis and treatment. The poor availability, poor quality and high prices of

medicines were significant problems. The health sector was one of the most corrupt in the country, which undermined the credibility of the data it produced and the quality of treatment provided. The fight against corruption, underfunding, and the lack of political will and commitment were cumulative challenges that needed to be faced in order to fight diseases effectively. Since the capacity of Governments in the global South was low, NGOs should lead the fight against discrimination and efforts to combat tuberculosis and HIV in a cost-effective manner. NGOs in Mongolia had succeeded in reducing the cost and improving the quality of drugs. He welcomed the partnerships WHO and the Global Fund to Fight AIDS, Tuberculosis and Malaria had set up with local communities to identify and remedy discriminatory practices against children with tuberculosis.

23. During the interactive dialogue, representatives of Panama, Ukraine, the Domino Foundation and the International Federation of Anti-Leprosy Associations took the floor. The issues they raised included violations of the right to health of people who used drugs, minorities and persons living with HIV in Crimea; the need to access high-quality health services for all persons; the close link between mental health, HIV and treatment adherence patterns; the specific needs of specific groups; discrimination against people affected by neglected tropical diseases, including leprosy; and the importance of not leaving behind indigenous peoples and people living in rural communities.

D. Role of civil society in the context of epidemics

24. The Executive Director of the Global Network of People living with HIV, Laurel Sprague, said that people living with HIV lived at the intersection of a health condition and social prejudice. They had created the principle of Greater Involvement of People Living with or Affected by HIV/AIDS, which had resulted in their increased representation in various policymaking bodies at all levels. Ending AIDS required a real right to health; the right to non-discriminatory employment and education for people living with HIV; putting a stop to gender-based violence, discriminatory gender norms and laws, arbitrary arrests based on lesbian, gay, bisexual and transgender identity, drug use, sex work or HIV status; and addressing poverty and the other social determinants of health that made some people and communities more vulnerable to HIV than others. Ending AIDS without ending prejudices and social hierarchies would be a failure.

25. The Strategic Initiatives Advisor to the Board of African Men for Sexual Health and Rights, Kene Esom, recommended breaking the silos that continued to divide human rights and public health work both in national ministries and in international organizations. Funding for community work on health was either for public health interventions or human rights interventions, which restricted the allocation of funds to one area or the other. However, the distinction between them was blurred in the case of many organizations that supported marginalized groups affected by communicable diseases. Other challenges included the shrinking of civil society space through reprisals or restrictive NGO regulations, and the denial of due process. Health-care workers often did not know about the work of the Human Rights Council to prevent and prohibit reprisals, and did not therefore benefit from it. Stigma, discrimination and persecution also impeded the delivery of quality health services that left no one behind.

26. The Regional Director for Latin America and the Caribbean at the Centre for Reproductive Rights in Colombia, Catalina Martínez Coral, described how the 2016 Zika outbreak in Latin America had disproportionately affected pregnant women due to the increase in the number of abortions and of babies born with microcephaly. Many countries had ignored reproductive rights and reacted by recommending the postponement of pregnancy. That recommendation was unworkable in a region where 55 per cent of pregnancies were unplanned, the availability of contraception was limited and sexual violence was widespread. The region also had legislation criminalizing with harsh sentences most if not all cases of abortion. She recommended that States recognize women’s rights to make an informed decision about their bodies and family planning, provide access to contraception and safe abortions, update health workers in rural areas about the virus and provide good quality free maternal health services. She recommended

that international organizations keep putting pressure on States to adopt systemic human rights-based responses to public health crises.

27. The representative of Brazil delivered the statement of the Director of the department for sexually transmitted infection, HIV/AIDS and viral hepatitis of the Brazilian Ministry of Health, Adele Benzaken, explaining how health policies, particularly the management of the HIV/AIDS epidemic, had been democratized and highlighting the importance of community participation in ensuring effective strategies to fight epidemics and realize human rights.

28. During the interactive dialogue, representatives of Islamic Republic of Iran, WHO, the Association for Human Rights in Kurdistan of Iran-Geneva, the Global Forum on MSM & HIV, the University College of Social Work at Geneva, the Stop TB Partnership, the UNAIDS Global Reference Group on HIV/AIDS and Human Rights, the World Social Forum and the Zero TB Initiative, Ulaanbaatar took the floor. Speakers addressed challenges faced by specific groups, including drug users, ethnic minorities and adolescents. The overlapping of those conditions aggravated marginalization in access to health. Speakers also referred to the challenges faced in accessing medicines due to high costs, and the shrinking civic space in countries where epidemics were widespread. One participant emphasized the importance of finding ways to ensure that the economy addressed social needs, including by maintaining universal health and social assistance systems. Another participant emphasized the adverse impact of unilateral coercive measures and sanctions on the enjoyment of the right to health in the countries affected by those measures. Participants inquired about the role of civil society in collecting disaggregated data concerning diseases and the role of the Office of the United Nations High Commissioner for Human Rights (OHCHR) in promoting the right to health in the context of communicable diseases. The representative of OHCHR described its permanent cooperation with UNAIDS through, for example, publications on HIV and human rights aimed at different readerships.

29. In response, Ms. Sprague said that affected populations had to claim their rights to affordable treatment and forge alliances in order to achieve a power balance with pharmaceutical companies. She called on the Human Rights Council to push for a framework that would enable access to affordable treatment. She also called on stakeholders to continue to push for and support space for civil society. Mr. Esom emphasized that the Sustainable Development Goals were an opportunity to adopt an intersectional approach to health and deliver social justice. He urged participants to join forces and set up communities to tackle an economy that sustains epidemics. He drew attention to the human rights of indigenous peoples, people in prisons and migrants. Ms. Martínez Coral called for the progressive realization of the right to access to medicines. Specific epidemics had provided lessons learned in terms of the need for comprehensive, differentiated and intersectoral responses to broad human rights challenges.

E. Communities leading programmes for health

30. The Director of the United Nations Children’s Fund (UNICEF) Liaison Office in Geneva, Marilena Viviani, said that adolescents were the only age group in which deaths due to AIDS were not decreasing. Adolescents required prevention through regular HIV testing that was easy to access, condoms, comprehensive sex education and high-quality targeted social welfare and protection services. However, stigma, discrimination, fear and ignorance undermined the success of those measures. New approaches based on the rights of the child were needed. Children’s freedom of expression included the freedom to seek and receive information or ideas, thus protecting the right to self-determination. Community-based organizations were the most effective and reliable sources of information for young people. UNICEF had therefore partnered with communities, as illustrated in its cash transfers in sub-Saharan African countries, including Malawi and Tanzania, and its delivery of health services to eastern Ukraine.

31. The General Secretary of the Swaziland Migrant Mineworkers Association, Vama Jele, explained how many migrant mineworkers were recruited while healthy and were

fired once they had been affected by tuberculosis, silicosis or HIV. They then returned to their homes and died or spread diseases in their communities, exacerbating poverty and vulnerability. Inadequate compensation for mineworkers' occupational diseases signalled a number of human rights violations, but due to illiteracy, many workers were unaware of their rights. The 2030 Agenda provided an opportunity to work beyond silos to integrate the right to health at all levels for the benefit of vulnerable migrant mineworkers and their families. He recommended tackling the challenges faced by that group, including through capacity-building in unions and occupational health associations, prevention of diseases and collection of disaggregated data, advocating for better labour laws and practices, and reporting abuses and human rights violations.

32. The Chair of the Board of the International Network of People who Use Drugs, Brun González Aguilar, explained that the legal prohibition and criminalization of drug use, as well as historical and cultural factors, had all caused devastating consequences to people who used drugs, including stigma, discrimination and other human rights violations. That had made people who used drugs more vulnerable to contamination with HIV and hepatitis C. The rights to education, freedom of religion, freedom of thought, privacy and self-determination were affected by prevalent anti-drug policies. He recommended harm reduction measures, including deconstructing stigmatizing notions and seeking more rational, humane, objective cultural and social approaches. He echoed the call made by the General Assembly at its Special Session on Drugs (in General Assembly resolution S-30/1) to promote and strengthen regional and international cooperation in developing and implementing innovative forward-thinking treatment-related initiatives. He added that fewer than 11 per cent of people who used drugs actually needed treatment; the majority of people who used legal and illegal drugs worldwide were non-problematic users.

33. During the interactive dialogue, representatives of UNAIDS, WHO, the People's Health Movement, Porn4PrEP and the World Social Forum took the floor. Participants emphasized the importance of sexual education for sex workers and pornography actors. They also spoke of the challenges faced by migrants, adolescents, women, drug users, mineworkers, and persons living with HIV and affected by other diseases. They called for child and social protection and labour policies to be strengthened as strategies to counter epidemics, bearing in mind problems of scale and the interdependence of rights.

34. In his final remarks, Mr. Jele said that when mineworkers and their families, including women, participated in programming, health, social and labour programmes were more successful. Mr. González said that harm reduction strategies were entirely developed by communities of people who used drugs, as few others considered them worth helping. He cited as good practices the harm and risk reduction programmes implemented by peers in Spain. Ms. Viviani stressed the importance of working in partnership to promote education and of conducting outreach to the most marginalized children. She called for health programmes at the community level to be strengthened and institutionalized.

F. Health-care workers on the front line

35. A representative of the International Committee of the Red Cross (ICRC), Esperanza Martinez, explained that in armed conflicts, health workers and services were especially protected by international humanitarian law and, in all cases, they were protected by human rights law. The increase in battles in urban contexts amplified the effects of indiscriminate attacks. Urban conflicts affected the social determinants of health and the rights to water, sanitation, food and health. Protracted conflicts made health systems unable to cope with crises at the times at which the need was most acute. The "Health Care in Danger" project highlighted the multifaceted violence suffered by health-care workers. ICRC provided practical guidelines on the rights and responsibilities of health-care personnel in conflict areas, including on the right to privacy and on engaging with arms carriers. In order to achieve the Sustainable Development Goals, there was a need to implement more preventive measures against violations of human rights and international humanitarian law.

36. The Permanent Representative of Thailand, Sek Wannamethee, explained that his country was the first in Asia to have eliminated mother-to-child transmission of HIV and

syphilis. Thailand offered free HIV testing and treatment for all, including migrant workers. Despite those achievements, stigma and discrimination remained barriers in the HIV response. The AIDS strategy in Thailand included specific targets to reduce HIV-related discrimination. The Government had an evidence-based approach to tackling discrimination. Levels of stigma and discrimination had been measured in health facilities through a survey. Based on the results, the country combated discrimination at the individual, health facility and community levels through participatory and active training of health workers. Lessons learned from the experience included acknowledging that HIV-related stigma and discrimination were common, the need to adopt an evidence-based approach to combat stigma, adapt global guidelines to local contexts, create multi-stakeholder partnerships, safe learning spaces and take a non-judgmental approach, and the need for technical assistance and capacity-building.

37. The Director of the Saint John of God Catholic Hospital in Lunsar, Sierra Leone, Brother Michael Musa Koroma, said that health workers and administrators were in a unique position to use human rights to improve health-care systems. Front-line health-care workers were often the only point of contact with the health system for millions of people and many of them provided culturally appropriate health care, counselling to prevent the spread of diseases and other health services. Their role in promoting human rights was undermined by a lack of resources and knowledge, personal and societal beliefs and attitudes and institutional norms. During the Ebola outbreak, hundreds of health workers had died. The quality of care for the sick had been undermined by discriminatory and disrespectful behaviours. Ebola suspects and their families had been quarantined without basic supplies. Communities had been scattered due to a lack of information and mistrust. The care given and the measures taken to protect the dignity of those affected by the crisis in the hospital in Lunsar provided lessons for the promotion of human rights in future crises.

38. A representative of the International Federation of Medical Students' Associations, Frederike Booke, spoke about the links between human rights protection and access to and utilization of health services, emphasizing the vicious circle of human rights violations suffered by persons living with communicable diseases. To break the circle, the Association had engaged in projects aimed at addressing discrimination in health care. In 2017, it had adopted the Declaration of Commitment to Eliminate Discrimination in Healthcare and a memorandum of understanding with youth-led organizations to increase medical students' awareness and knowledge of the importance of fighting discrimination. Together with partners, including local communities, the Association planned to develop an advocacy brief on non-stigmatization of health care and a guidance note on building more inclusive medical curricula.

39. During the interactive dialogue, representatives of Spain, UNAIDS, the Association Miraisme International, the Centre for Reproductive Rights, the International Disability and Development Consortium, the People's Health Movement and the World Social Forum took the floor. Participants praised the work and initiatives of front-line health workers and students. Some asked questions about human rights in armed conflicts regarding data and information on maternal health and reproductive rights. Others raised issues relating to institutional involvement in non-discrimination initiatives, effectiveness of accountability policies and training on the treatment of persons with disabilities. One participant inquired how health workers in countries without health systems could be helped and how to foster international solidarity to establish such systems.

40. Mr. Wannamethee described the tools Thailand had to measure stigma and discrimination, and the country's goal to reduce 90 per cent of stigmatization by 2030. Global guidelines needed to be commensurate with local realities and all stakeholders should participate in designing training materials. Brother Koroma called for training and respect for front-line health workers' rights. Accountability required infrastructure, faith-based health institutions should complement the work of Governments, and the cultures of local communities should be respected. Ms. Booke said that the opinions of persons with disabilities and young health workers should be taken into account when designing programmes to fight communicable diseases. Ms. Martinez called for reproductive health to be embedded in overall primary health-care services, for community participation in health

care to be strengthened, and for parties to conflicts to respect commitments concerning access to health care. She stressed that data systems in conflict settings were fragile and required new partnerships.

G. Building synergies for health: engaging diverse partners

41. UNAIDS International Goodwill Ambassador and Chair of The Foundation for AIDS Research, Kenneth Cole, praised the achievements that had been made since the first awareness campaigns on HIV/AIDS in 1985, but reiterated that there was still much to be done. Empowering those with the least resources was crucial to advancing the fight against AIDS. It was important to connect and leverage resources beyond silos for making progress with regard to the human rights, including the right to health, of people living with HIV. For example, the Foundation's efforts to help find a cure for AIDS by 2020 would be an important contribution to the efforts of UNAIDS to end AIDS by 2030.

42. A senior human rights lawyer from the DLA Piper global law firm, Emily Christie, spoke of the role private law firms played in assisting affected populations to access justice, which was essential in order to achieve universal access to health care. In 2016, around 130 law firms had contributed some 2.5 million hours of pro bono legal support worldwide. Her firm had been working with partners to create enabling and protective legal environments and challenging harmful laws through law reform, legislative drafting and public interest litigation. It had also worked on strengthening civil society and communities, assisting them to engage with human rights monitoring mechanisms, supporting access to legal services and providing training on health-related rights. It had assisted commercial clients to integrate human rights in their operations. Pro bono work could effectively contribute to achieving health, human rights and justice for all when undertaken in partnership with experts in the field, civil society groups, governments, NGOs and United Nations organizations.

43. A representative of the Belarusian Association of UNESCO Clubs, Dzmitry Subtselny, described Belarusian programmes to combat HIV, which included access to treatment, measures to protect the confidentiality of patients' status and specific training for health workers. Many members of vulnerable groups, such as people who used drugs, sex workers and men who had sex with men, avoided treatment due to concerns regarding the disclosure of their status. Civil society organizations acted on harm reduction, online educational work on HIV-related issues, and carried out advocacy on protecting the human rights of vulnerable groups. They also planned to monitor the quality of health-related services to the affected population and the degree to which those services respected human rights. Those activities were possible thanks to financial and technical support from the United Nations system to Governments and civil society in middle-income countries.

44. A member of the Moldovan Council for the Prevention of Torture, Svetlana Doltu, said that the main health issues in the penitentiary system of Moldova were drug dependency, viral hepatitis, HIV/AIDS and multidrug resistant tuberculosis, and combinations thereof. Despite the challenges it faced, the Republic of Moldova complied with the United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules) and provided the prison population with the same health-care standards as the rest of the population without discrimination based on their status. Treatment to prisoners affected by communicable diseases was provided in close partnership with NGOs, including by engaging former prisoners. The Council for the Prevention of Torture worked to improve prison conditions, addressing the social determinants of health and the provision of HIV prevention services. While challenges remained in addressing prisoners' health issues in Moldova, much had been achieved thanks to the work of many partners, including international organizations that had provided technical and financial support.

45. During the interactive dialogue, the moderator and representatives of the African Commission on Human and Peoples' Rights and the Global Human Rights Clinic took the floor. They asked about the role of business and sports communities, children, medical doctors, confessional groups, law students and women's organizations. Participants also

asked about harm reduction policies, legal protection and assistance in Africa, and access to mental health services for persons living with communicable diseases.

46. Mr. Cole argued that businesses would understand that what was good for their community was good for them. Ms. Christie called for efforts to build social justice and include legal ethics in legal curricula, and for affirmative action to be taken in law schools for groups subject to discrimination. It was important to deal with the legal, social, physical and mental needs of populations. Mr. Subtselny referred to a health programme supported by UNESCO on reproductive education for parents, and to the role of peers and role models in education. Ms. Doltu said that a system of part-time medical work in prisons could contribute to better health services in prisons. She called for more data to be collected on the social impact of epidemics affecting women. All panellists called for more steps to be taken to raise awareness of the positive impact of harm reduction policies in reducing infections. They also called for the decriminalization of drugs and for efforts to put an end to the stigmatization of drug users and other vulnerable populations.

H. International cooperation for global responses and national implementation

47. The Permanent Representative of Switzerland, Valentin Zellweger, described his country's contributions to the fight against HIV and other communicable diseases at the international and bilateral levels in a manner that broke silos. The UNAIDS governance structure, which included civil society as members of the UNAIDS Programme Coordinating Board, made a big difference as speaking directly with affected communities allowed for an understanding of the implications of the policies and programmes on the ground. Evidence demonstrated that a human rights and gender-based approach was more effective. The six elements Switzerland considered crucial in the response to HIV were: establishing a balance between prevention and treatment; placing gender equality and human rights at the centre of the response; taking an evidence-based approach; aiming to contribute to health systems and the achievement of universal health coverage; addressing the underlying determinants of HIV; and taking a multi-stakeholder approach.

48. The Executive Director of Partners in Population and Development, Joe Thomas, said that involving vulnerable populations in developing responses and South-South cooperation were ways of translating the key principles of the 2030 Agenda into action to end HIV and other communicable diseases. There was a need to incorporate constantly evolving data and evidence about differential vulnerability experiences. He echoed the United Nations Secretary-General's call for more support to South-South efforts towards achieving internationally agreed development goals. The full realization of Sustainable Development Goals 3, 5, 16 and 17 was intertwined with protecting and promoting human rights. He described Partners in Population and Development's governance and mandate on South-South cooperation, including on sexual and reproductive health, and its potential for improving HIV response in low- and middle-income countries.

49. The Executive Director of the South Centre, Vicente Paolo Yu, recalled that international human rights instruments pointed to States' duty to cooperate with each other. The realization of the right to health and achievement of Sustainable Development Goal 3 required international cooperation on addressing barriers to access to medicines, research and development of medicines, provision of health services and emergency humanitarian assistance during pandemics. It was important to maintain policy space, flexibilities and coherence in issues related to intellectual property to enable developing countries to cope with new epidemics. Coping capacity was further affected by international economic, social and environmental challenges. In order to further international cooperation, he proposed that research and development for new drug discovery should be publicly funded and that any new drugs discovered under that model should be patent-free or have public interest patents. In addition, North-South cooperation remained essential, particularly in the development of infrastructure for the delivery of public health services. Moreover, strengthened South-South cooperation would foster the exchange of expert skills, training, technology and capacity in delivering public health services.

50. During the interactive dialogue, the moderator and representatives of Ecuador, Nigeria, UNAIDS and the World Social Forum took the floor. They raised points related to examples of local good practices on key populations' access to health, taking into account local expertise and experience to provide inputs when planning global policies, and questions on how to bring big business to the table and negotiate in a context of power asymmetries at the global level. Some participants mentioned legal issues such as law as a determinant of health, and the importance of imposing the duty to grant access to basic medicines.

51. Mr. Zellweger described the transition of drug policies to harm reduction, a practice promoted by Switzerland in its foreign cooperation. Laws that were based on human rights and the promotion of gender equality were determinants of health. Evidence-based policies should be applied, even when they ran contrary to certain cultural behaviours. Mr. Thomas reflected on plurilateral and bilateral dialogue by emphasizing the work of Partners in Population and Development to facilitate the sharing of information to solve issues related to health, access to medicines and ageing populations. Mr. Yu considered that law could shape society, making it a determinant of health, for good or for bad. In developing countries, any changes in laws required in order to qualify for aid should be implemented in full respect of rights, local officials and the role of the State. He called for the implementation of the right to development. Panellists welcomed the Sustainable Development Goals and related recent agreements as major achievements on international cooperation, and called for further cooperation to implement them.

I. Access to medicines, diagnosis, vaccines and treatment in the context of the right to health

52. The Chief Executive Officer of the World Hepatitis Alliance, Raquel Peck, argued that the development of lifesaving medicines for hepatitis C had created hope for those affected by that condition. However, extremely high medicine costs had left many behind; indeed, only 1.5 million out of the 75 million who were infected had received treatment. She gave some specific examples of advocacy by communities that had expanded the right to access to medicines. NOhep was a global movement that aimed at the elimination of hepatitis by empowering communities. Eliminating hepatitis went beyond the right to health; it required steps to be taken to reduce inequalities, address poverty and tackle stigma and discrimination. As technical solutions existed, no one should be dying from that epidemic.

53. The Intellectual Property and Access to Medicines Lead at the International Treatment Preparedness Coalition, Othoman Mellouk, praised the decision of the Government of Malaysia to issue the first compulsory licence under trade-related intellectual property rights (TRIPS) flexibilities for sofosbuvir, an expensive drug for treating hepatitis C. That had been the result of actions by local civil society organizations. Many middle-income countries were excluded from licences and prices arrangements and had lower treatment coverage rates than lower-income countries. Civil society organizations and communities had challenged big pharmaceutical companies despite the power asymmetries. Developed countries were, on behalf of big pharmaceutical companies, pushing for restrictive intellectual property demands in bilateral and plurilateral trade treaties, with potentially adverse effects for the world's poor. He called for stronger international and national rights frameworks for a paradigm shift on the right to access medicines.

54. Senior Researcher for the Global Health Unit of the University Medical Centre Groningen, Ellen ´t Hoen, said that the distinction between communicable and non-communicable diseases was artificial, as one group often caused diseases under the other group. The right to health implied that States had the duty to ensure the availability, accessibility, acceptability and good quality of medicines. Intellectual property norms should be interpreted in a manner supportive of States' human rights obligations. States had a duty to use TRIPS flexibilities when it was necessary to ensure the right to access to medicines. Echoing the United Nations High-level Panel on Access to Medicines, she called for a coalition of like-minded countries to exert pressure for a global agreement on

health technologies, including a binding convention delinking research and development costs from end prices of medicines and promoting transparency on costs of production.

55. The Medical Innovation and Access Policy Adviser for the Médecins Sans Frontières Access Campaign, Elena Villanueva-Olivo, spoke about the Médecins Sans Frontières Access Campaign to raise awareness about the need to improve medical tools in crises. The Ebola outbreak in West Africa, during which there had been a lack of effective diagnostics, treatments and vaccines, had illustrated the failure of the research and development system to prioritize, develop and produce affordable drugs and vaccines. She mentioned initiatives to prevent new gaps and failures, such as the WHO Research and Development Blueprint and the Coalition for Epidemic Preparedness Innovations. She expressed concern that Northern philanthropists and Governments, which funded nearly all research and development, prioritized the protection of their own populations and economic interests over the essential health needs of poor populations.

56. During the interactive dialogue, representatives of Belarus, Botswana, Brazil, Chile, Ecuador, the Bolivarian Republic of Venezuela, OHCHR, the Asia Pacific Transgender Network, the Elizabeth Glaser Pediatric AIDS Foundation, the Medicines Transparency Alliance Mongolia and the PrEP Impact Trial took the floor. Many participants raised issues concerning economic barriers to access to medicines, including the fact that market and economic considerations took precedence over human rights. They also highlighted the lack of transparency on pricing, "commercial" determinants of health, the devastating impacts of epidemics on the economies of developing countries, and neglected tropical diseases. Participants commented on international partnerships and partnerships between Governments and civil society. A number of participants inquired about discrimination within and among nations in access to medicines, diagnosis, pre-exposure prophylaxis and resources, with specific reference to children, transgender women, and men who had sex with men. Some mentioned the relationship between universal health coverage and access to medicines.

57. Ms. Villanueva-Olivo said that access to medicines was necessary for universal health coverage. Advocacy was then needed to ensure that WHO had a strong role in promoting access to medicine and support for the adoption of TRIPS flexibilities. Ms. Peck emphasized the need for global and domestic funding mechanisms, including for access to vaccines. She reiterated the importance of partnerships with communities. Mr. Mellouk argued that recognizing law as a determinant of health referred both to the text and the implementation of laws. TRIPS flexibilities should be available in a non-discriminatory manner and without yielding to pharmaceutical companies biased choices. Ms. ´t Hoen argued that access to new essential medicines also affected developed countries. For universal health coverage to be viable, it was necessary to deal with patents, market and data exclusivities, including by delinking research and development from the market logic and improving transparency in pricing.

J. The way forward

58. The director of the Thematic Engagement, Special Procedures and Right to Development Division of OHCHR highlighted the 2030 Agenda and its call to leave no one behind as key for discussions on human rights related to health. Stigmatization, criminalization and discrimination worsened epidemics. Civil society's role was crucial, but it was often under attack and its space was shrinking. States should foster civil society's legal, policy and financial enabling environment. The human rights-based approach to access to medicines was the best way to promote policy coherence in that area. Echoing the call made by the High-level Working Group on the Health and Human Rights of Women, Children and Adolescents for policy shifts, she recalled the importance of the protection of rights through and to health, of the role of health workers in defending human rights and their empowerment and protection, and of improved participation of all stakeholders, including communities and parliamentarians, in leaving no one behind in the advancement of health related human rights.

59. The Director of the Rights, Gender, Prevention and Community Mobilization Department at UNAIDS presented five themes the Forum had reiterated from previous discussions. First, discrimination affected different groups and people in different ways, hampering access to public goods and services. Second, the voices of the most affected people should be included in policy design and implementation, including by having civil society on the boards of international agencies. Third, communicable and non-communicable diseases were all avoidable and had as a common denominator inequality and inequity in access to health services. Fourth, access to medicines should be ensured at affordable sustainable prices, by, for example, tackling the monopoly of intellectual property through TRIPS flexibility and price delinking mechanisms. Fifth, collection of disaggregated data could decrease the invisibility of inequity in access to services of specific populations.

60. The Director of the AIDS and Rights Alliance for Southern Africa, Michaela Clayton, noted that although there were many commonalities in the kinds of discrimination experienced in the health field, it was important to name the grounds of discrimination in the context of each health condition and explicitly name the key populations affected. In addition to challenges, many examples of good practice had been shared during the Social Forum and it was now time to act. Action should include scaling up people-centred programmes, funding human rights interventions, increasing access to justice and removing barriers to civil society participation. To ensure marginalized communities had access to services, the involvement of Ministries of Health was not enough; Ministries of Justice, of the Interior and of Security should also be engaged. She called for an increased role for OHCHR in health and for WHO in human rights. She also called for the issues of stigma and discrimination to be discussed at the World Health Assembly.

61. Concluding remarks were made by representatives of OHCHR, WHO, AfricAid, the African Commission on Human and Peoples' Rights, the Asia Pacific Transgender Network, the Belarusian Association of UNESCO Clubs, the Global Forum on MSM & HIV, the Coordinating Committee of the International Conference on AIDS, the International Federation of Medical Students' Associations, the People's Health Movement, the Stop TB partnership, Swaziland Migrant Mineworkers Association and the World Social Forum. Participants mentioned groups facing specific challenges and offering opportunities, including health-care workers and students, migrant workers and undocumented migrants, refugees, people who used drugs, indigenous peoples, rural communities and the urban poor, children, adolescents transgender people, men who had sex with men, and sex workers. Empowering those groups was essential to ensure access and adherence to treatment. That could be done by focusing on general social needs as common denominators between the different groups. Those groups should also participate in collecting disaggregated data. Participants called for multi-stakeholder and multisectoral alliances. International human rights systems could be instrumental for promoting accountability in delivering the right to health. States should actively engage in international negotiations and cooperation to promote human rights in health, such as at the high-level meeting on tuberculosis to be convened by the General Assembly in 2018. Specific social policies should be provided to all. States should review counter-terrorism and other norms that attacked civil society space and funding. Many participants called for preventive approaches and more human rights education and awareness on the part of different stakeholders.

IV. Conclusions and recommendations

62. The following conclusions and recommendations emerged from the 2017 Social Forum.

A. Conclusions

63. **The high level of engagement at the Social Forum demonstrated that human rights in the context of health and communicable diseases was an important topic on the agenda of different international organizations, Governments, organized civil**

society, communities and the private sector. Fulfilling the right to health was considered one of the highest challenges faced by the international community. It was recognized that upholding human rights, including the right to health, was essential to broader efforts to promote peace and development. However, from the discussions, it had become clear that stigma, discrimination, misuse of criminal laws and other human rights violations continued to act as barriers to effective responses to HIV and other communicable diseases and epidemics and that often, human rights were not adequately integrated into health responses. In many countries and regions throughout the world, the populations most affected by HIV were made more vulnerable by laws that criminalized same-sex sexual relations, sex work, drug use, HIV non-disclosure, exposure or transmission. Addressing such laws had been highlighted as imperative in order to respond to HIV and advance health for all.

64. **The 2030 Agenda and the Sustainable Development Goals offered a framework for multisectoral action to realize human rights in the context of HIV and other communicable diseases and epidemics. The Sustainable Development Goals, with their promise of leaving no one behind, called for the meaningful participation of civil society and communities in health responses, including at decision-making tables. The 2030 Agenda for Sustainable Development also called for universal health-care coverage, access to quality essential health-care services and access to safe, effective, quality and affordable medicines and vaccines.**

65. **Stigma, discrimination, marginalization and criminalization worsened epidemics, undermined prevention efforts and hindered access to lifesaving public services and goods by key populations and groups in vulnerable situations. Several groups faced specific challenges, including migrants, refugees, persons with disabilities, indigenous peoples, poor populations, children, adolescents, women, transgender people, men who had sex with men, people who used drugs, people deprived of their liberty and sex workers. Many speakers emphasized the importance of collecting data about the impact of epidemics among those populations, of disaggregating data and of ensuring the participation of affected communities and civil society in data collection and analysis efforts, and in the political debates and decisions informed by that analysis.**

66. **Participants noted that the economic, social, legal and "commercial" determinants of health included poverty, substandard housing, inadequate water and sanitation, a lack of social security, gender inequality, a lack of access to health-care services and safe, effective, quality and affordable medicines, the marginalization of certain groups and the criminalization of certain behaviours, such as sex between consenting adults of the same sex, drug use or sex work.**

67. **It was recognized that civil society and affected community organizations were crucial actors in the protection of human rights in the context of communicable diseases. However, in many countries they were under pressure and their space was shrinking due to restrictive laws and policies and a lack of funding. Their in-depth knowledge of the challenges faced in particular regions and by particular groups risked being ignored in the design of global and local strategies against epidemics and other diseases.**

68. **Health-care workers were on the front line of the fight against epidemics and other diseases, often working under poor working conditions, lacking appropriate resources and protection against infection. Appropriate training and information, including human rights education and training, could empower health workers and students preparing for health-related careers to promote and protect the human rights of patients and communities and to provide discrimination-free care.**

69. **Diverse partners across sectors need to be mobilized in order to address the many human rights challenges in the context of communicable diseases. There were many encouraging examples of good practices, programmes and initiatives implemented by national, international and regional human rights mechanisms and institutions, governmental bodies, civil society and affected community organizations,**

Parliamentarians, the private sector, law firms, faith-based institutions, celebrities, national mechanisms on the prevention of torture and others.

70. **Much had been done in terms of international cooperation. However, to maintain the momentum created by the adoption of the Sustainable Development Goals, it was necessary to advance North-South and South-South cooperation in addressing human rights in the context of communicable diseases, and to ensure meaningful civil society and community engagement at all levels. Joint efforts for realizing economic, social and cultural rights, as well as the right to development, could contribute to the social and economic determinants of health.**

71. **Access to safe, effective, quality and affordable medicines, vaccines, treatment and diagnosis was a necessary condition for the full enjoyment of the right to health in the context of communicable diseases.**

B. Recommendations

72. **A number of priority areas for action had emerged from the discussions during the 2017 Social Forum to better promote and protect human rights in the context of HIV and other communicable diseases and epidemics. All stakeholders should better coordinate health and human rights-related work in a manner that breaks silos. At the international level, OHCHR, UNAIDS, WHO, WTO and other organizations should increase their cooperation to address human rights issues in the context of HIV and other communicable diseases and epidemics. At the national level, different governmental bodies should adopt common understandings to protect the human rights of especially affected groups by including their needs in national plans and policies.**

73. **The Sustainable Development Goals and the human rights framework should be seen as mutually reinforcing. Human rights should guide the implementation of health-related Sustainable Development Goals and in addressing communicable diseases. Countries should report on human rights in the context of HIV and other communicable diseases and epidemics during their universal periodic reviews and in their other periodic human rights reports, as well as in their voluntary national reviews on the Sustainable Development Goals. In implementing target 3.8 of the Goals on achieving universal health-care coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all, States should consider the development and strengthening of universal health-care systems and policies on access to medicines and vaccines, including through international cooperation.**

74. **To address epidemics from a human rights perspective, States should adopt, strengthen and implement evidence-based policies and programmes to tackle stigma, discrimination and criminalization of key populations. Stakeholders should collect data on how epidemics are having an impact on different populations in order to leave no one behind. Data should be disaggregated by, inter alia, age, sex, race, gender, urban/rural, social and legal status. Affected communities and civil society should meaningfully participate in data collection and analysis. States should take into account empirical evidence demonstrating positive outcomes of experiences related to the decriminalization of drug use and harm reduction projects and programmes in formulating national policies.**

75. **States and other stakeholders should protect the rights of marginalized communities to and through health. In doing so, power imbalances should be corrected by including the voices of those communities in policy design and implementation and data collection. They should be empowered through the joint struggle for and provision of more general social needs, such as quality education, health literacy, sufficient amounts of safe and nutritious food, access to safe drinking water and sanitation, employment and effective access to justice.**

76. **States and other stakeholders should cooperate with civil society organizations and affected communities and foster their role in ending epidemics and achieving the Sustainable Development Goals by protecting and expanding civic space. That should be done by providing an enabling legal, policy and financial environment for civil society organizations and affected communities. States should review policies that restrict civil society space and funding. States should also review and reform laws that may contribute to stigma and discrimination, including criminal and other laws that have been shown to have a negative impact on public health. International agencies should consider the voices of the most affected people in their decision-making processes.**

77. **States and other stakeholders should increase efforts to address discrimination in health-care settings. Health-care workers should be empowered and recognized as agents who can promote and protect the human rights of patients and communities. Their human rights, including their labour rights, should also be protected. In order to ensure that health workers have the necessary capacity to provide discrimination-free health-care, issues related to human rights, non-discrimination, free and informed consent, confidentiality and privacy should be integrated into pre- and in-service training curricula for health workers. Best practices on such training and education programmes and materials should be shared.**

78. **Multi-stakeholder and multisectoral alliances should be built. Diverse partners should focus on their strengths and potential to contribute to the promotion of human rights in the context of communicable diseases. The private sector, including businesses and law firms, should engage in empowering communities by providing them with resources and building capacity. Parliamentarians should bridge the gap between communities and governments and unite in alliances to promote good practices across countries. In some contexts, new partners, such as grass-roots movements, national preventive mechanisms against torture and even arms carriers in conflicts, have unique access to otherwise unreachable vulnerable groups and should promote and protect their rights.**

79. **North-South and South-South cooperation should continue to focus on establishing the infrastructure needed to develop health systems, and to foster partnerships with civil society in countries where health systems are already in place in order to exchange expertise to address similar problems.**

80. **States should take into account human rights obligations in global health in multilateral and regional discussions and decisions. International and regional human rights mechanisms are encouraged to promote human rights and accountability in health, particularly in the context of HIV and other communicable diseases and epidemics. Good practices and lessons learned from such work should be shared between the different human rights and health mechanisms.**

81. **A human rights-based approach to access to safe, effective, quality and affordable medicines and vaccines is crucial to the fulfilment of the right to health and should be taken into account in the context of policies related to intellectual property rights and relevant international agreements on the matter.**

Annex

List of participants

States Members of the Human Rights Council

Albania, Belgium, Botswana, China, Cuba, Ecuador, France, Georgia, Ghana, India, Indonesia, Iraq, Mexico, Morocco, Netherlands, Nigeria, Panama, Portugal, Qatar, Slovenia, South Africa, Switzerland, Venezuela (Bolivarian Republic of).

States Members of the United Nations

Algeria, Angola, Argentina, Austria, Azerbaijan, Bahrain, Belarus, Brazil, Cabo Verde, Chile, Costa Rica, Cyprus, Czechia, Egypt, Guatemala, Iran (Islamic Republic of), Israel, Italy, Jordan, Kazakhstan, Myanmar, Nicaragua, Nigeria (National Agency for the Control of AIDS), Norway, Pakistan, Peru, Republic of Moldova (Council for the Prevention of Torture), Senegal, Serbia, Spain, Sweden, Thailand, Trinidad and Tobago, Ukraine, Zimbabwe.

Non-Member States represented by observers

Holy See

Intergovernmental organizations

African Commission on Human and Peoples' Rights, Community of Portuguese-speaking Countries, International Development Law Organization, Gulf Cooperation Council, Organization of Islamic Cooperation, Partners in Population and Development, South Centre, World Trade Organization.

United Nations

Joint United Nations Programme on HIV/AIDS, Office of the United Nations High Commissioner for Human Rights, Stop TB Partnership, United Nations Children's Fund (UNICEF), United Nations Educational, Scientific and Cultural Organization, United Nations Office for Project Services, United Nations Population Fund, World Health Organization.

Non-governmental organizations and others

AfricAid, AIDES, AIDS and Rights Alliance for Southern Africa, AIDS Foundation, African Men for Sexual Health and Rights, Asia Pacific Transgender Network, Asian-Eurasian Human Rights Forum, Association DREPAVIE, Association Miraisme International, Association for Human Rights in Kurdistan of Iran-Geneva, Association of World Citizens, Belarusian Association of UNESCO Clubs, Caissa, Centre for Reproductive Rights, African Commission of Health and Human Rights Promoters, Company of the Daughters of Charity of St. Vincent de Paul, DLA Piper law firm, Domino Foundation, Elizabeth Glaser Pediatric AIDS Foundation, Global Forum on MSM & HIV, Global Human Rights Clinic, Global Human Rights Group, Global Network of People living with HIV, Harm Reduction International, Health Development Center AFI, Helen Keller International, Institute for Planetary Synthesis, International Aids Conference Coordinating Committee, International AIDS Alliance, International Committee of the Red Cross, International Disability and Development Consortium, International Federation of

Anti-Leprosy Associations, International Federation of Medical Students' Associations, International HIV/AIDS Alliance, International Investment Center, International Network of People who Use Drugs, International Treatment Preparedness Coalition, OCAPROCE International, Partnership Network International, Médecins Sans Frontières Access Campaign, People's Health Movement, Swaziland Migrant Mineworkers Association, Porn4PrEP, Saint John of God Catholic Hospital, Sierra Leone, The Foundation for AIDS Research, Transparency Alliance-Mongolia, UNAIDS Global Reference Group on HIV/AIDS and Human Rights, VIVAT International, World Hepatitis Alliance, World Social Forum, Zero TB Initiative, Ulaanbaatar.

Academic institutions

Global Health Law Groningen Research Centre, University College of Social Work, Fribourg, Switzerland, University College of Social Work, Geneva, Switzerland.