

Eliminating discrimination in health care

Stepping stone towards ending the AIDS epidemic



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Summary

There have been enormous advances in the AIDS response during the past decade. New HIV infections have decreased since 2000,¹ society is one step closer to eliminating HIV infections among children,² more people living with HIV know their status and are receiving HIV treatment,³ and AIDS-related deaths are declining (1).⁴ Global commitment, clear goals, resources, innovation and, not least, communities made this happen.

However, these achievements have been unequal across locations, regions and populations. Throughout the world, stigma, discrimination, exclusion and inequality—including unequal power and gender relations—continue to make women and girls, young people, people with disabilities, key populations and other affected groups⁵ vulnerable to the epidemic, and hinder their access to HIV prevention, treatment and care services. Stigma and discrimination in all their manifestations isolate people from services that they are entitled to receive and from institutions that are mandated to serve them; on average, one in eight people living with HIV report being denied health services (1). Intersectional or compounded stigma and discrimination—that is, stigma and discrimination that are fuelled by multiple factors—further exacerbate barriers to health services. In one analysis from Swaziland, nearly 62% of men who have sex with men surveyed said that they feared seeking health care as a

1 There were 2.1 million [1.8 million–2.4 million] new infections in 2015—down from 3.2 million [2.9 million–3.5 million] in 2000.

2 In 2015, 150 000 [110 000–190 000] children acquired HIV—50% fewer than in 2010.

3 At the end of 2015, 60% [56–65%] of people living with HIV knew their status. As of June 2016, 18.2 million [16.1 million–19.0 million] people living with HIV were accessing antiretroviral therapy, up from 15.8 million in June 2015.

4 The rapid scale-up of life-saving treatment has contributed to reducing AIDS-related deaths by 45% since 2005.

5 UNAIDS considers gay men and other men who have sex with men, sex workers, transgender people and people who inject drugs as the four main key population groups, but it acknowledges that prisoners and other incarcerated people also are particularly vulnerable to HIV and frequently lack adequate access to services.

result of their same-sex conduct, and those who face discrimination in health-care settings report a greater fear of seeking health care than those who have not experienced discrimination (2). Third-party authorization requirements remain an important barrier for adolescents and young people in accessing HIV testing in 58 countries, and sexual and reproductive health services in 72 countries (3). In 2015, 2.1 million people were newly infected with HIV and 1.1 million people died from AIDS-related causes worldwide. Key populations are particularly affected by the epidemic (see below for more examples) (4).

In 2015, countries agreed to the Sustainable Development Goals (SDGs), which in SDG 3, have the important target of ending the epidemics of AIDS, tuberculosis and malaria, and combating hepatitis, by 2030.⁶ Other SDGs are also critically important in reaching this goal, including those on achieving gender equality, employment and decent work for all, and reducing inequalities. The 2016 Political Declaration on Ending AIDS, adopted by Member States at the United Nations General Assembly High-Level Meeting on Ending AIDS, reinforced that, in reaching all of the SDG goals, no one must be left behind and that discrimination, including in health care, must be eliminated (5). Zero discrimination is at the heart of the UNAIDS vision, and one of the targets of the Fast-Track strategy of UNAIDS (6). Fast-Track focuses on addressing discrimination in health-care, workplace and education settings, and is key to achieving the 10 commitments reflected in the 2016 Political Declaration on Ending AIDS.⁷

Working towards implementing Fast-Track, UNAIDS and the World Health Organization (WHO)

launched *the Agenda for Zero discrimination in health care* on 1 March 2016, which brings together all stakeholders for joint efforts towards a world where everyone, everywhere, is able to receive the health care they need with no discrimination (7). This means tackling discrimination in its many forms by removing punitive laws, policies and practices that undermine key populations and other vulnerable groups, or block their access to good-quality health-care services. At the same time, it is important to ensure that health-care workers, in their workplace, are enjoying their labour rights free from stigma and discrimination, and are in a protective environment that allows them to exercise their roles, rights and responsibilities, and to protect themselves from occupational exposure. By continuing to put people first and ensuring that no one is left behind in the AIDS response, ending the AIDS epidemic in every region, in every country, and in every community and population is possible.

This report briefly describes and defines the challenges and impacts of discrimination in health-care settings. Such discrimination affects people seeking access to HIV prevention, testing, treatment, care and support measures, as well as health-care workers in their workplace. International human rights standards provide the rationale for catalysing global action to eliminate such discrimination. This report aims to serve as a reference for policy-makers and other key stakeholders engaged in shaping policies and programmes to regulate health care, and eliminate discrimination and other structural barriers to achieving healthy lives for all.

6 Sustainable Development Goals were adopted in September 2015 (<http://www.un.org/sustainabledevelopment/sustainable-development-goals/>).

7 The Fast-Track commitments are drawn from the 2016 Political Declaration on Ending AIDS, which was adopted by Member States at the 2016 UN General Assembly High-Level Meeting on Ending AIDS, and the UNAIDS 2016–2021 Strategy.

The challenge of discrimination in health-care settings

People across the globe face barriers to accessing quality health care. The reasons vary between countries and between the communities within them. However, some barriers are present across the board. They include various forms of discrimination that are faced by certain populations. Key populations and other vulnerable groups continue to face stigma, discrimination, criminalization and ill-treatment based on their actual or perceived health status, race, socioeconomic status, age, sex, sexual orientation, or gender identity and expression. Such discrimination and other human rights violations are pervasive in health-care settings, affecting the health of these marginalized populations. Workers in health-care settings can also face discrimination from their co-workers and employers.

Discrimination is rarely linked solely to one characteristic of a person. It is often fuelled by multiple factors, referred to as intersectional, multiple or compounded discrimination.⁸ Too often, people at higher risk of HIV infection face multiple forms of discrimination. Under international human rights law, states have a duty to take measures to address all forms of discrimination, including ensuring the right to access health care on a

⁸ See, for example, United Nations Committee on Economic, Social and Cultural Rights, General Comment No. 22, The right to sexual and reproductive health; 2016 (E/C.12/GC/22); Convention on the Rights of Persons with Disabilities, Preamble and Article 6; 2006 (A/RES/61/106); UN Committee on the Elimination of all Forms of Discrimination Against Women, General Comment 25, Temporary special measures; 2004.

non-discriminatory basis.⁹ The United Nations Committee on Economic, Social and Cultural Rights has noted that all health facilities must be accessible to everyone, without discrimination—this includes ensuring physical and economic accessibility to the most vulnerable populations.¹⁰

The goal of healthy lives for all, and the targets of universal health coverage and ending AIDS, tuberculosis, malaria, hepatitis and other communicable

diseases are contingent on addressing stigma and discrimination in health care. The lessons learned through the implementation of human rights programmes as part of the HIV response can serve as critical entry points to more broadly address intersectional discrimination in health care. These lessons include the meaningful involvement of affected communities, whose participation has been crucial in responding to the HIV epidemic.

⁹ See, for example, United Nations Committee on Economic, Social and Cultural Rights, General Comment 14: the right to the highest attainable standard of health; 2000; United Nations Committee on Economic, Social and Cultural Rights, General Comment 22: the right to sexual and reproductive health; 2016.

¹⁰ See, for example, United Nations Committee on Economic, Social and Cultural Rights, General Comment 14: the right to the highest attainable standard of health; 2000.

Understanding discrimination and human rights obligations to eliminate discrimination

Laws and policies regulating health care need to be firmly grounded in human rights principles. Programmes for their implementation should develop human rights competencies of health-care workers and stronger accountability, and should empower clients. Understanding the content and meaning of discrimination is essential for designing better programmes to eliminate discrimination in health-care settings and ensure accountability.

Defining stigma

Stigma as a harmful societal phenomenon has been defined as a process that begins when a specific trait or group is labelled and linked to negative stereotypes, leading to status loss and discrimination for those carrying the trait (8). HIV-related stigma refers to negative beliefs, feelings and attitudes towards people living with HIV, groups associated with people living with HIV (e.g. the families of people living with HIV) and other key populations at higher risk of HIV infection, such as people who inject drugs, sex workers, men who have sex with men and transgender people (9).

Defining discrimination

As defined by international human rights law, discrimination includes any act or behaviour that has the intention or effect of impairing the enjoyment of fundamental human rights by all people on an equal footing, including their right to access health care. The right to non-discrimination implies that people are treated with respect for their human dignity, autonomy, privacy and confidentiality, and that their freedom from coercion

and abuse is guaranteed on an equal basis, including in relation to health care.¹¹

HIV-related discrimination refers to unfair and unjust treatment (by act or omission) of an individual based on their real or perceived HIV status, or the fact that they belong to a segment of the population that is perceived to be at greater risk of, or more vulnerable to, HIV infection. It encompasses unjust treatment of key populations and vulnerable groups, such as sex workers, people who inject drugs, women, men who have sex with men, transgender people, people in prisons and other closed settings, young people, migrants, refugees and internally displaced people. HIV-related discrimination is usually based on stigmatizing attitudes and beliefs about populations, behaviours, practices, sex, illness and death (10). HIV-related discrimination can be compounded with other forms of discrimination, including discrimination based on race, sex, socioeconomic status, sexual orientation, gender, identity or national origin (11).

The International Covenant on Economic, Social and Cultural Rights, which guarantees the right to health among other rights (see Annex), is one of many treaties that sets out prohibited grounds of discrimination. The Committee that interprets rights and monitors state compliance with the covenant, and other treaty monitoring bodies, have also established various prohibited grounds for discrimination, including HIV status, gender, disability, sexual orientation and age (12,

13, 14, 15). Also, the supervisory bodies in the International Labour Organization have adopted numerous international labour standards, founded on international human rights instruments that apply to HIV. Specifically, Recommendation No. 200 enumerates key fundamental human rights that are applicable to all workplaces in all sectors, including the right to not be discriminated against based on real or perceived HIV status, sexual orientation or for belonging to populations perceived to be at greater risk of, or more vulnerable to, HIV (16). (See Annex for details.)

Discrimination can be direct or indirect. Both direct and indirect forms of differential treatment because of discrimination are prohibited (17). Direct discrimination occurs when an individual is treated less favourably, through either acts or omissions, than another person in a similar situation for a reason related to a prohibited ground. For example, an HIV-positive person may be discriminated against in employment by not being hired, or through concerns about their ability to perform their job duties, because of their real or perceived HIV status. Living with HIV generally does not affect a person's ability to perform job duties, particularly considering the effects of sustainable antiretroviral treatment.

Indirect discrimination refers to laws, policies or practices that appear neutral at face value, but have a disproportionate impact on specific groups of people. For example, requiring a permanent

¹¹ See, for example, United Nations Committee on Economic, Social and Cultural Rights, General Comment No. 20: Non-discrimination in economic, social and cultural rights; 2009 (E/C.12/GC/20); United Nations Committee on Economic, Social and Cultural Rights, General Comment No. 22, The right to sexual and reproductive health; 2016 (E/C.12/GC/22).

address or registration in a specific locality to obtain health benefits may indirectly affect migrants.

Although addressing discrimination is critical, it does not always ensure equality. It is not enough to guarantee treatment that is identical; there must be an enabling environment to achieve equality of results (substantive equality). Biological differences, as well as socially and culturally constructed differences, must be taken into account; the underlying causes of discrimination must be addressed to guarantee discrimination-free health-care settings (18). For example, efforts to eliminate forced sterilization of women living with HIV must reassert the illegal nature of such sterilization and the biological low odds of mother-to-child transmission of HIV, as well as challenge the underlying stereotypes that consider women living with HIV not worthy of parenting.

Drivers and facilitators (19, 20) leading to discrimination include HIV-related stigma that results from fear of HIV, prejudice and stereotypes; punitive laws targeting people living with HIV and other key populations; other legal and regulatory barriers to accessing services; gaps in institutional policies and means of protection for health-care workers; and lack of information and rights literacy.

Even where protective laws exist, few people living with, at risk of or affected by HIV are able to seek redress when their rights are violated. This lack of access to justice is exacerbated for people belonging to vulnerable groups, such as women living with HIV, sex workers and people who inject drugs. Structural barriers that obstruct access

to justice include lack of access to education, illiteracy, lack of awareness, lack of economic or bargaining power, and gender bias. Such lack of accountability leads to impunity for the perpetrators of discrimination. The right to an effective remedy is a human right in itself, and its denial exacerbates human rights abuses and jeopardizes health.

Obligations to respect, protect and fulfil human rights

Under international human rights law, states that have ratified international human rights treaties (see Annex) have an obligation to respect, protect and fulfil human rights. This includes taking proactive measures in all areas of human rights, including non-discrimination and sexual and reproductive rights in health-care settings and the workplace:

- *The obligation to respect* requires states to refrain from interfering directly or indirectly with the enjoyment of human rights. For example, states have an obligation under international law to refrain from limiting access to antiretroviral therapies, condoms and contraceptives. They are also obliged to refrain from withholding, censoring or misrepresenting health information—for example, stating that use of condoms does not prevent the spread of HIV and other sexually transmitted infections.
- *The obligation to protect* requires states to prevent third parties from interfering with the realization of human rights. This includes the obligation to investigate and punish practices by health-care providers and others such as coerced

or forced sterilization of women living with HIV, forced termination of pregnancies in women living with HIV, or refusal to provide services to individuals belonging to key populations.

- *The obligation to fulfil* requires states to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures to enable full enjoyment of rights; they must promote human rights. For example, states must pass laws that prohibit discrimination against key populations including in health-care settings and workplaces. They must ensure that health-care providers are trained so that services are provided in a manner that is compliant with human rights—for example, services must be provided in a way that is non-discriminatory, and respects the dignity and autonomy of clients. States must also ensure the adequate allocation

of budgetary resources to implement laws and policies that protect against discrimination, and to effectively address human rights barriers in their national AIDS responses.

States have an immediate legal obligation to address discrimination in health care and the workplace, even if there are severe resource constraints. Vulnerable members of society must be protected, and many measures, such as most strategies and programmes designed to eliminate health-related discrimination, can be pursued with minimum resource implications. This might involve the adoption, modification or abrogation of legislation, or the dissemination of information, including through education programmes for the health workforce (21, 22).¹²

¹² See also International Labour Conference, HIV and AIDS Recommendation No. 200; 2010. This recommendation establishes key human rights principles for the prevention of HIV transmission and mitigation of the HIV epidemic's impact on the world of work.

Health and human rights impact of discrimination in health-care settings, including health-care workplaces

Discrimination in health care does not only relate to denial of health-care services. Examples of discrimination in health-care settings also include the provision of misinformation, requiring third-party authorizations for provision of services, lack of privacy, breach of confidentiality, mandatory HIV testing or screening, and providing treatment without informed consent (23, 24, 25). HIV-related discrimination, more specifically, can take many forms, including mandatory HIV testing without consent or appropriate counselling (26, 27, 28); forced or coerced sterilization of women living with HIV (29); health providers minimizing contact with, or care of, patients living with HIV (30); delayed or denied treatment (31, 32); demands for additional payment for infection control (33, 34, 35); isolation of patients living with HIV (36); denial of maternal health services (37); and violation of patients' privacy and confidentiality, including disclosure of patients' HIV status to family members or hospital employees without authorization (38, 39).

In addition to violating the right to freedom from discrimination, the above policies and practices have been consistently found by national and international bodies to violate other human rights obligations in international treaties, and in national laws and constitutions. These include the rights to: life; health; privacy and confidentiality; and freedom from violence, torture and other ill-treatment.

While these are human rights abuses and harmful in and of themselves, they also negatively affect health by isolating people from the very institutions that are mandated to serve them and that they have a right to access. As well as specific HIV-related

stigma and discrimination, discrimination in health care more broadly undermines people's access to prevention, treatment and care services, and the quality of health care delivered. It may also reduce adherence to treatment regimes, by discouraging continued access to care (40, 41, 42). In a 2013 systematic review of both qualitative and quantitative studies conducted among 26 715 HIV-positive people living in 32 countries worldwide, HIV-related stigma was found to compromise adherence to antiretroviral therapy, primarily by undermining social support and adaptive coping (43).

Negative attitudes and discriminatory behaviour from providers are wrong in and of themselves, and can also deter people from accessing services, including testing, sharing information with staff, and adhering to treatment. In Thailand, 88% of health-care workers surveyed in 2013 reported negative attitudes towards people living with HIV, and 23% of respondents observed discriminatory practices by staff in their health facility in the 12 months preceding the survey. These practices included staff members being unwilling to care for people living with HIV or providing them with a poorer quality of care compared with other patients (44). Based on the People Living with HIV Stigma Index aggregated data from 50 countries, one in eight people living with HIV report being denied health care (45).

As noted above, health-care workers who are themselves living with HIV are also affected by HIV-related stigma and discriminatory practices,

including routine mandatory HIV testing as a precondition of employment, and workplace discrimination and stigma within their own profession (46, 47). In addition, an absence of enabling working environments for health-care workers puts them at risk—it is estimated that more than 50 000 cases of hepatitis and 1000 cases of HIV occur in health-care workers globally every year because of needle-stick injuries (48). Inability to access personal protective equipment for compliance with universal precautions and lack of knowledge about the modes of HIV transmission exacerbate fear, and drive stigma and discrimination. It is important to address such drivers of discrimination and empower health-care workers, including through ensuring that their labour rights are fully respected, protected and promoted.

Key populations and other vulnerable groups are often under-served and encounter significant barriers to realizing their health-related rights. For example, access to HIV and/or sexual and reproductive health information and services may be largely unavailable, or of inferior quality, for these populations, affecting their quality of health. Reasons might include physical or geographic barriers, absent or wrong information, and discriminatory practices (49). For example, indigenous women, women belonging to other minority groups, women with disabilities, women living with HIV and transgender people have been subject to coerced or forced sterilization (50, 51, 52). Such practices not only reflect intersectional or compounded forms of discrimination, they also violate other rights, including the right to determine

the number, spacing and timing of children, the rights to privacy and health, and the right to be free from inhumane and degrading treatment. They are also recognized forms of violence against women (53).

International human rights law requires that special attention is given to populations living in situations of vulnerability and disadvantage. Aligned with this principle, the 2030 Agenda for Sustainable Development includes commitments to leave no one behind and to start by addressing the needs of populations that are hardest to reach first.¹³ UNAIDS has identified the following populations that are specifically vulnerable to discrimination and, hence, left behind in the response to AIDS to date: adolescents and young women, prisoners, migrants, people with disabilities, people who inject drugs, sex workers, gay men and other men who have sex with men, transgender people, children and pregnant women living with HIV, displaced people, people with disabilities, people aged 50 or older, and people living with HIV themselves.

Laws, policies and practices that discriminate against these key populations create an environment that contributes to discrimination in health care and has a negative impact on health (54). For example:

- An estimated 12 million people worldwide inject drugs, and one in ten of them are living with HIV. People who inject drugs are almost universally criminalized for their drug use or through the

lifestyle adopted to maintain their drug use (55). Antiretroviral therapy coverage rates among people who use drugs are lower than for people who do not use drugs, as is access to health services more generally (56).

- Sex workers are 10 times more likely to acquire HIV than adults in the general population. Sex work is criminalized or otherwise made illegal in 116 countries. In some parts of the world, sex workers may be arrested for carrying condoms, which are considered evidence of engaging in illegal sexual activity (57). Criminalization increases vulnerability to HIV by fuelling stigma and discrimination; limiting access to HIV and sexual health services, condoms and harm reduction services; and adversely affecting the self-esteem of sex workers and their ability to make informed choices about their health (58).
- Globally, gay men and other men who have sex with men are 24 times more likely to acquire HIV than the general population. Same-sex sexual practices are criminalized in 73 countries and territories (59). Reports show the link between criminalization and limitations on access to health care. Recent studies in assessing the impact of criminalization of same-sex relations found that men who have sex with men reported greater fear in seeking health care and greater avoidance of health care after the implementation of such laws (60). Studies

have documented serious disruptions in the availability of, and access to, HIV and other health services following widely publicized prosecutions of gay men and other men who have sex with men (61).

- HIV prevalence among migrants to Thailand from neighbouring countries is up to four times the rate of HIV prevalence found among the general population. In European countries, undocumented migrants face complex obstacles, such as the lack of access to health-care services or social protection, including through limited legal entitlements to health insurance, especially if they are undocumented. Restrictions on entry, stay and residence related to HIV status, while unnecessary, discriminatory and ineffective in protecting public health, still exist in at least 35 countries, territories and areas (62). Migration and the social exclusion often accompanying migrants, as well as barriers in accessing health care (including affordability issues), can place people in situations of heightened vulnerability to HIV (63).
- Globally, the chance of acquiring HIV is 49 times higher for transgender women than all adults of reproductive age. Most countries lack a human rights compliant legal framework for legal recognition of one's affirmed gender; thus, legal documentation often does not reflect one's gender identity. This results in people being denied or hindered from accessing basic services, including health care (64).

- Currently, approximately 50 000 cases of hepatitis and 1000 cases of HIV occur in health-care workers globally every year because of needle-stick injuries (65). Lack of enabling working environments for health-care workers puts them at risk. For example, lack of access to means of protection, albeit simple and low cost, exacerbates fear, and drives stigma and discrimination. Another example is having no access to training.
- Young women aged 15–24 years are at particularly high risk of HIV infection, accounting for 20% of new HIV infections among adults globally in 2015, despite accounting for just 11% of the adult population. In sub-Saharan Africa, young women accounted for 25% of new HIV infections among adults, and women accounted for 56% of new HIV infections among adults (66). Experiences of physical and emotional intimate partner violence in settings with male controlling behaviour and HIV prevalence above 5% have been strongly associated with HIV infection in women (67). In addition, barriers to health services, such as third-party authorization, deter many adolescents and young women from seeking sexual and reproductive health information and services. This can lead to more unsafe abortions, unwanted pregnancies and HIV infections (68). Studies show parental consent requirements hinder adolescent access to needed sexual and reproductive health services, but laws that protect confidentiality encourage adolescents to protect themselves (69).

¹³ Examples include sexual, racial and ethnic minorities, indigenous people, migrants, refugees and internally displaced persons, sex workers, children and adolescents, and persons with physical or mental disabilities—and particularly women belonging to these groups. Committee on Economic Social and Cultural Rights. General comment no. 14: The right to the highest attainable standard of health (article 12), paras. 18-27; 2000; Committee on the Elimination of Discrimination against Women. General recommendation no. 24: Women and health (article 12), para 6; 1999.

- A study in four countries found that women living with HIV were more likely to experience discrimination than men living with HIV (70). Discriminatory practices occur particularly in reproductive health-care settings. For example, pregnancy-related discrimination is frequently reported by women, including advice not to have children (71), inappropriate treatment or failure to provide care during labour (72), and forced or coerced sterilization of women living with HIV (73). This type of discrimination can have particularly profound effects on women's health and efforts to eliminate mother-to-child transmission of HIV, because women who have faced HIV-related stigma and discrimination are less likely to access pre- and post-natal treatment and care (74).

The Global Commission on HIV and the Law¹⁴ undertook extensive research, consultation, analysis and deliberation to examine links between legal environments and HIV responses. In its final report, *HIV and the law: risks, rights and health* (July 2012),

the commission found that women affected by HIV were routinely discriminated against in health-care settings. Recommendations from the report included:

- Removing legal barriers that impede women's access to sexual and reproductive health services.
- Ensuring that health-care workers provide women with full information on sexual and reproductive options, and secure informed consent for all matters relating to their health.
- Training health-care workers on informed consent, confidentiality and non-discrimination.
- Making accessible complaints and redress mechanisms available in health-care settings (75).

¹⁴ The commission is an independent body convened by the United Nations Development Programme on behalf of UNAIDS.

Accountability for eliminating discrimination in health care

As part of their human rights obligations, states should ensure accountability and redress, including monitoring of compliance with non-discrimination, in health-care settings. As part of such efforts for accountability, strong mechanisms and frameworks for monitoring and evaluation¹⁵ are important to monitor programme results, as well as to build and share the evidence base, including ensuring data collection and best practices to eliminate discrimination in health-care settings. The drivers and manifestations of stigma and discrimination in health care can be assessed using the experiences reported by people living with HIV through the People Living with HIV Stigma Index surveys (77) and experiences reported by key populations through, for example, integrated bio-behavioral surveillance surveys. Knowledge, attitudes and practices of health-care workers also need to be addressed regularly to inform programmes and strengthen accountability.

¹⁵ Several indicators have been globally endorsed to monitor progress towards zero discrimination. These can be found in the Indicator Registry (<http://www.indicatorregistry.org>), a central repository of information on indicators used to track the AIDS epidemic and the national and global response, by clicking on the link "stigma and discrimination" on the right side of the screen.

Window of opportunity for action

In September 2015, United Nations Member States adopted the 2030 Agenda for Sustainable Development (78). The agenda sets out a vision for sustainable development grounded in international human rights and—by ensuring healthy lives, building inclusive societies—it puts respect for equality and leaving no one behind at the center of its goals. Sustainable Development Goal 3 is premised largely on improving efforts to ensure universal health coverage, signalling a strong intent to address barriers to access to ensure improved access to services for everyone, everywhere. International human rights and fundamental freedoms apply to all human beings, irrespective of their behaviour or occupation is legal or not in a country.

The 2016 Political Declaration on Ending AIDS reaffirms "... the need for all countries to implement the commitments and pledges in the present Declaration consistent with ... international human rights" (79). State commitments have included ensuring that health services comply with human rights standards, and that all forms of violence, discrimination and coercive practices in health-care settings are eliminated and prohibited. With respect to HIV, this includes for all human beings to have equal access to HIV prevention, treatment, care and support free from stigma and discrimination.

In the 2016 Political Declaration on Ending AIDS, Member States committed to addressing discrimination in health care, education and the workplace. Recognizing that health-care settings are among the most common environments where people experience HIV-related stigma and

discrimination, the UNAIDS 2016–2021 *Strategy*, adopted in October 2015, has a clear target on eliminating HIV-related discrimination, with a particular focus on health care, workplace and educational settings. The *WHO global strategy for human resources for health: workforce 2030* (81) places similar priority on ending discrimination in health care.

Moving forward: a zero discrimination agenda

Joining efforts to address the challenge of discrimination in health-care settings, UNAIDS, together with WHO and the Global Health Workforce Alliance (GHWA) started the development of an Agenda for Zero Discrimination in Health Care (82), which arose out of a consultation held in November 2015. Participants included United Nations agencies, civil society, professional associations and governments. This consultation led to the recognition that eliminating HIV-related discrimination needs to be considered in the context of discrimination in health-care settings more broadly, and in the context of pervasive discrimination against key populations and how it affects the AIDS response. For example, without ending violence against women generally, and ending discrimination against women and girls in health-care settings, higher levels of unsafe abortion, unwanted pregnancies and HIV infection cannot be addressed. In addition, ensuring universal health coverage, with a skilled and motivated health workforce as a prerequisite, will also require eliminating discrimination in health care, including by and against health workers.

On 1 March 2016, UNAIDS, WHO and GHWA launched, with growing support from stakeholders from across the globe, the Agenda for Zero Discrimination in Health Care. The agenda prioritizes three critical areas for action:

- Political impact—increasing political commitment by mobilizing key constituencies to secure prioritization at all levels.

- Accountability—by promoting monitoring and evaluation frameworks to build evidence, monitor progress and ensure accountability.
- Implementation—fostering scale-up of implementation of effective actions to achieve health care that is free of discrimination.

The agenda provides a way forward on addressing this challenge. It calls on stakeholders to ensure protection of human rights and health by:

- Building capacities and competencies of the health-care workforce to provide services free from stigma and discrimination, including providing the health-care workforce with appropriate training and access to personal protective equipment.
- Supporting the building and sharing of the evidence base and best practices to eliminate discrimination in health-care settings.
- Investing in accountability and redress mechanisms.
- Strengthening mechanisms and frameworks for monitoring, evaluation and accountability for discrimination-free health care.
- Setting the standards for discrimination-free health care, including ensuring:
 - The removal of legal and policy barriers that impede discrimination-free health care, including—but not limited to—prohibiting mandatory testing and treatment and other coercive practices, and respecting patient privacy and confidentiality.

- That health-care settings provide timely and quality nonjudgemental health care regardless of gender, gender identity or expression, sex, nationality, age, disability, ethnic origin, sexual orientation, religion, language, socioeconomic status, real or perceived HIV status or other health status, or whether someone is a sex worker, uses drugs, lives in prison or is a migrant worker.
 - That health-care providers actively inform people of their human rights.
 - The existence of effective grievance mechanisms and mechanisms of redress and accountability for discrimination and violations of the rights of both clients and health-care workers.
 - That health-care settings link key and vulnerable populations to additional service providers, peer support networks or community-based organizations, or legal services, when necessary.
- Supporting the empowerment of clients, workers and civil society to demand discrimination-free health care and workplaces, including the participation of affected communities in the development of policies and programmes that promote equality and non-discrimination in health-care settings and other workplaces.

Annex

International human rights and HIV: treaty obligations and political commitments

Human rights are inherent to all human beings. Human rights are universal, inalienable and apply equally to all people without any distinction or discrimination whatsoever. Human rights and fundamental freedoms are interrelated, interdependent and indivisible. They are expressed in instruments, such as treaties and conventions, which can be ratified by countries.

The following lists provide a selection of key human rights standards, resolutions and declarations that are of interest to the HIV response. This is not intended to be exhaustive—there are many other texts at both international and regional levels that may be equally important.

These international instruments include:

- Universal Declaration of Human Rights (1948).
- International Covenant on Civil and Political Rights (1966).
- International Covenant on Economic, Social and Cultural Rights (1966).
- Convention on the Elimination of All Forms of Discrimination Against Women (1979).
- Convention Against Torture (1984).

- Convention on the Rights of the Child (1989).
- Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (1990).
- Convention on the Rights of Persons with Disabilities (2006).

Non-discrimination is not tackled in isolation from other rights. The following rights are also particularly applicable to ensuring zero discrimination in health care and can be found in the instruments listed above:

- The right to life.
- The right to liberty and security of the person.
- The right to the highest attainable standard of physical and mental health.
- The right to equality.
- The right to freedom of movement.
- The right to seek and enjoy asylum.

- The right to privacy.
- The right to freedom of expression and opinion and the right to freely receive and impart information.
- The right to freedom of association.
- The right to marry and found a family.
- The right to work.
- The right to equal access to education.
- The right to an adequate standard of living.
- The right to social security, assistance and welfare.
- The right to benefit from scientific progress.
- The right to participate in public and cultural life.
- The right to an effective remedy.
- The right to be free from torture and other cruel, inhuman or degrading treatment or punishment.

United Nations General Assembly political declarations

The United Nations General Assembly has adopted four political declarations on HIV and AIDS, where Member States have made political commitments to address HIV and AIDS, as well the various drivers, including discrimination:

- 2001 Declaration of Commitment on HIV/AIDS.
- 2006 United Nations Political Declaration on HIV/AIDS.
- 2011 United Nations Political Declaration on HIV and AIDS.
- 2016 Political Declaration on Ending AIDS.

International Labour Organization documents

- International Labour Organization, HIV and AIDS Recommendation, Recommendation 200 (2010).
- Labour Inspection Convention, 1947 (No. 81).
- Equal Remuneration Convention, 1951 (No. 100).
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- Minimum Age Convention, 1973 (No. 138).
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- Occupational Safety and Health Convention, 1981 (No. 155).
- Workers with Family Responsibilities Convention, 1981 (No. 156).
- Termination of Employment Convention, 1982 (No. 158).
- Worst Forms of Child Labour Convention 1999 (No. 182).
- Maternity Protection Convention, 2000 (No. 183).
- Promotional Framework for Occupational Safety and Health Convention, 2006 (No. 187).
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