A Code of Conduct for HIV and Health Professionals: Strengthening Human Rights Approaches to Health

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- [MAC AIDS Fund](https://www.mac.org)
- [MSD](https://www.msd.com)
# Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
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<td>ART</td>
<td>Antiretroviral Therapy</td>
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<tr>
<td>eMTCT</td>
<td>Elimination of Mother-to-Child Transmission (of HIV)</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>VHTC</td>
<td>Voluntary HIV Testing and Counselling</td>
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<td>IAS</td>
<td>International AIDS Society</td>
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<tr>
<td>ICESCR</td>
<td>International Covenant on Economic, Social and Cultural Rights</td>
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<td>ICCPR</td>
<td>International Covenant on Civil and Political Rights</td>
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<tr>
<td>ILO</td>
<td>International Labour Organization</td>
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<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<tr>
<td>NGO</td>
<td>Nongovernmental Organization</td>
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<tr>
<td>OST</td>
<td>Opioid Substitution Therapy</td>
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<tr>
<td>SRH</td>
<td>Sexual and Reproductive Health</td>
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<tr>
<td>TB</td>
<td>Tuberculosis</td>
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<tr>
<td>TRIPS</td>
<td>Trade-Related Aspects of Intellectual Property Rights</td>
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<tr>
<td>UN</td>
<td>United Nations</td>
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<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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<td>WHO</td>
<td>World Health Organization</td>
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As the AIDS response moves into a new phase of accelerated scale up of existing and new interventions with the hope of ending AIDS, earlier generations of HIV and health professionals are retiring. These professionals include decision makers (local, national and international), and policy and programme implementers; HIV activists, advocates, lawyers and members of the media; people involved in all aspects of health service delivery (doctors, nurses, midwives, pharmacists, dentists, support workers (including non-health staff), psychologists, lab technicians, scientific researchers, and public health and community health workers); people involved in non-governmental organizations such as community-based and civil society organizations, including networks of people living with HIV and key populations; and social, political and academic researchers. Scaling up AIDS responses will also require an increased number of professionals in all these sectors, who will need pre- or in-service training in order to maintain and increase their capacity and knowledge, to increase their skills to undertake task-shifting or service integration, and to assist them in carrying out their duties in non-discriminatory and non-stigmatizing ways.

A Code of Conduct for HIV and Health Professionals: Strengthening Human Rights Approaches to Health (Code of Conduct or Code) is a timely effort to harness the experiences gained through the AIDS response over the previous decades to ensure that the lessons learned inform both current and future HIV and health professionals of the importance of advocating for human rights-based approaches as well as for ensuring implementation of such approaches in their day-to-day work.

The aim of the Code of Conduct is to accelerate access to comprehensive HIV prevention, testing, treatment, care and support for all people living with HIV, key populations and those affected by HIV/AIDS, as well as to promote prevention and treatment adherence and retention in care, by using human rights as a framework and HIV and health professionals as the means to achieve this aim. Its objective is to empower HIV and health professionals to implement human rights-based AIDS responses that are effective in preventing HIV transmission and reducing the impact of HIV and AIDS by improving their knowledge of and commitment to international human rights obligations, including the rights of HIV and health professionals.

The Code, which builds upon existing professional codes across sectors, provides HIV and health professionals with guidance on:

- The development of supportive and enabling workplace policies and capacity building programmes, as well as the development, implementation and evaluation of human rights-based policies, programmes and services.
- The allocation of resources and development of policies, programmes, and services based on “Know your Epidemic, Know your Response.”
- Advocacy for supportive laws, policies and practices.

The Code consists of nine guiding principles:

1. Know your Human Rights Responsibilities
2. Respect Dignity
3. Benefit from Scientific Progress
4. Access to Justice
5. Know your Epidemic, Know your Response
6. Meaningful Participation
7. Education
8. Monitoring and Evaluation
9. Accountability

The chapter relating to each guiding principle consists of the principle itself and outlines its relevance for HIV and health professionals. Background information on international instruments underpinning the Code is provided in Annex 1 with additional references provided in the References section.
Good practice examples will be collated and disseminated by the International AIDS Society (IAS) as part of the process of rollout of the Code.

By signing and adopting the Code, HIV and health professionals recognize their daily responsibility toward stigmatized populations, both to prevent human rights violations and to acquire additional knowledge of international norms. The value of the Code lies in its implementation and signatories commit to working towards the realization of all the guiding principles as part of their work. As with most codes of conduct, this Code is intended to be self-policing and relies on the individual commitment of each signatory.

HIV and health professionals must also do everything possible to assist in achieving the Millennium Development Goals by the end of 2015 as well as the development goals to be set for the years post-2015. While the AIDS response has achieved many important gains towards universal access to health services, this work remains unfinished. More must be done in order to secure the well-being, dignity and rights of all people, especially those most vulnerable to HIV. It is hoped that this Code of Conduct will reinforce the commitment of HIV and health professionals to these important goals.
HIV infections have fallen by 33% since 2001 with an estimated 2.3 million people being newly infected in 2012. These falling numbers are the result of sustained political commitment and action. Building upon this positive trend, AIDS responses are being scaled up in line with international commitments and national strategic plan targets to levels that require extensive engagement of new and existing service providers (see Box 1). Scaling up AIDS responses requires an increased number of HIV and health professionals, who will need to be adequately trained prior to their service, or receive in-service training in the case of existing HIV and health professionals, in order to maintain and increase capacity and knowledge, to increase skills when undertaking task-shifting or service integration, and to assist all HIV and health professionals in approaching their duties in a non-discriminatory and non-stigmatizing manner.

Furthermore, as earlier generations of HIV professionals are retiring, the Code is a timely effort to harness the experiences gained through the AIDS response over the previous decades to ensure that the lessons learned inform both current and future HIV and health professionals of the importance of advocating for human rights-based approaches as well as for ensuring implementation of such approaches in their day-to-day work.

**Who is the Code for?**
The Code of Conduct for HIV and Health Professionals is for any individual working (or volunteering) in the AIDS response, including:

- Decision-makers (local, national and international), and policy and programme implementers
- HIV activists, advocates, lawyers and members of the media
- People involved in all aspects of health service delivery (doctors, nurses, midwives, pharmacists, dentists, support workers (including non-health staff), psychologists, lab technicians, scientific researchers, and public health and community health workers)
- People involved in non-governmental organizations such as community-based and civil society organizations, including networks of people living with HIV and key populations
- Social, political and academic researchers.

**Why do we need a Code of Conduct for HIV and Health Professionals?**
Globally, the number of people newly infected with HIV and of those dying of AIDS-related causes continues to fall. In 2012, there were an estimated 35.3 million people living with HIV. Since the start of the epidemic, around 75 million people have become infected with HIV, of whom an estimated 36 million have died of AIDS-related illnesses, with deaths falling by 30% since the peak in 2005. Worldwide, new HIV infections have fallen by 33% since 2001 with an estimated 2.3 million people being newly infected in 2012.

**Box 1: Scaling up AIDS responses**

Voluntary HIV testing and counselling (VHTC) is the entry point for people to access prevention, treatment, care and support services. Scaled up VHTC is currently taking place with tens of millions of people regularly undergoing VHTC.

Prevention: To be optimally effective, prevention efforts should include strategic combinations of behavioural, biomedical and structural programming and approaches that focus on rapid scale-up in geographic settings and among populations at greatest risk of acquiring...
and transmitting HIV. Vulnerable populations should be meaningfully involved at every stage of the design, development, and implementation of such programmes to increase the ownership and chances of success. Progress towards meeting prevention related targets by 2015 has been variable:

- **Reduce sexual transmission of HIV by 50% by 2015.** The annual number of new HIV infections among adults and adolescents decreased by 50% or more in 26 countries between 2001 and 2012. However, other countries are not on track to halve sexual HIV transmission.

- **Halve the transmission of HIV among people who inject drugs by 2015.** Although people who inject drugs account for an estimated 0.2–0.5% of the world’s population, they make up approximately 5–10% of all people living with HIV. The world is not on track to meet this target, and as recent evidence suggests, little change has occurred in the HIV burden among this population. HIV prevention coverage for people who inject drugs remains low:
  - Only two of 32 reporting countries provided the recommended minimum of at least 200 sterile syringes per year for each person who injects drugs
  - Among 35 countries providing data in 2013, all but four reached less than 10% of opioid users with evidence-based opioid substitution therapy (OST).

- **Eliminate HIV infections among children and reduce maternal deaths.** As a result of sustained progress, it may be possible to reach at least 90% of pregnant women living with HIV with antiretroviral interventions by 2015. Antiretroviral coverage among pregnant women living with HIV reached 62% in 2012, and the number of children newly infected with HIV in 2012 was 35% lower than in 2009 (prong 3) (according to the Elimination of Mother-to-Child Transmission (eMTCT) Global Plan baseline). However, achieving the global goal will require similar scale-up of other prevention strategies, including primary HIV prevention for women (prong 1) and access to contraception and other family planning services (prong 2).

**Treatment:** As the number of people receiving antiretroviral therapy rose by 1.6 million to an estimated 9.7 million in 2012 in low and middle-income countries, the world was nearly two-thirds of the way (64%) toward the 2015 target of reaching 15 million people living with HIV with treatment. In addition, new WHO ART guidelines (released in June 2013), recommend earlier initiation of ART and the use of simplified, more durable regimens, aiming to maximize the therapeutic and preventive benefits of ART, while at the same time increasing the number of people eligible for ART from roughly 15 million to 26 million.

**Key Populations:** There are signs that the relative HIV burden among key populations (namely men who have sex with men, people in detention settings, people who inject drugs, sex workers and transgender people) is increasing over time. Long believed to represent a relatively modest share of infections in generalized epidemics, it is now clear that key populations account for a substantial share of new infections in every part of the world. However, the world has yet to come to grips with the HIV-related needs of key populations. Countries allocate minimal resources for HIV programmes for key populations, stigmatizing attitudes of health care providers deter members of key populations from accessing testing, treatment

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1. See next page
and prevention services, and many countries have punitive laws against key populations, including in sub-Saharan Africa where every country has laws criminalizing at least one key population group.

Service Delivery: At the same time, and partly in response to scale up (as well as cost effectiveness), service modalities are evolving with an emphasis on shifting services from "specialized" to primary care settings. This includes service integration (i.e. HIV and Tuberculosis (TB), eMTCT and maternal and child health, sexual and reproductive health (SRH) and HIV, HIV and chronic care (including mental health) and integrated HIV treatment), task-shifting, and a renewed emphasis on community-based service delivery to reach people in rural areas, as well as other hard-to-reach populations.

What is the Code of Conduct?
The International Guidelines on HIV/AIDS and Human Rights recommends that States should ensure a healthy partnership between governments and the private sector in order to develop codes of conduct regarding HIV issues that translate human rights principles into codes of professional responsibility and practice, with accompanying mechanisms to implement and enforce these codes.

The aim of A Code of Conduct for HIV and Health Professionals: Strengthening Human Rights Approaches to Health (Code of Conduct or Code) is to accelerate access to comprehensive HIV prevention, testing, treatment, care and support for all people living with HIV, key populations and those affected by HIV/AIDS, as well as to promote prevention and treatment adherence and retention in care, by using human rights as a framework and HIV and health professionals as the means to achieve this aim. It builds on existing professional Codes, including the International Council of Nurses Code of Ethics for Nurses, the World Medical Association International Code of Medical Ethics and the Sphere Project Humanitarian Charter and Minimum Standards in Humanitarian Response.

The objective is to empower HIV and health professionals to implement human rights-based AIDS responses that are effective in preventing HIV transmission and reducing the impact of HIV and AIDS by improving their knowledge of and commitment to international human rights obligations, including the rights of HIV and health professionals.

The Code of Conduct provides HIV and health professionals with guidance on:
- The development of supportive and enabling workplace policies and capacity building programmes, as well as the development, implementation and evaluation of human rights-based policies, programmes and services.
- The allocation of resources and develop-

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1 The terms ‘key populations’, ‘key affected populations’ or ‘key populations at higher risk of HIV exposure’ refer to those most likely to be exposed to or to transmit HIV – their engagement is critical to a successful AIDS response i.e. they are key to the epidemic and key to the response. In all countries, key populations include people living with HIV. In most settings, men who have sex with men, transgender persons, people who use drugs, sex workers and their clients, people in closed settings such as prisons or detention centres, and HIV-negative partners of HIV-positive individuals are at higher risk of HIV exposure than the general population. In addition, there is a strong link between various kinds of mobility, such as internal and external migration, and a heightened risk of HIV exposure, depending on the reason for mobility and the extent to which people are outside their social context and norms. Each country should define the specific populations that are key to their epidemic and response based on the epidemiological and social context.
ment of policies, programmes, and services based on “Know your Epidemic, Know your Response.”

- Advocacy for supportive laws, policies and practices.

As such the expected outcomes are:

- A knowledgeable workforce of HIV and health professionals with a better understanding of human rights and non-discrimination principles, and a strong respect for dignity, social justice, meaningful participation, accountability, and the rights to health and to benefit from scientific progress.
- Increased commitment by HIV and health professionals to promote and protect human rights through their work.
- A change in practices and conduct of some HIV and health professionals to a human rights-based approach.
- Increased accountability of HIV and health professionals and their organizations.

The Code consists of nine guiding principles, under the following headings:

- Guiding Principle 1: Know your Human Rights Responsibilities
- Guiding Principle 2: Respect Dignity
- Guiding Principle 3: Benefit from Scientific Progress
- Guiding Principle 4: Access to Justice
- Guiding Principle 5: Know your Epidemic, Know your Response
- Guiding Principle 6: Meaningful Participation
- Guiding Principle 7: Education
- Guiding Principle 8: Monitoring and Evaluation
- Guiding Principle 9: Accountability

The chapters relating to each guiding principle consist of:

- the guiding principle itself
- an explanation of the relevance of the principle for HIV and health professionals.

Background information on international instruments underpinning the Code is provided in Annex 1 with additional references provided in the References section.

**Signing on to the Code of Conduct**

By signing and adopting the Code, HIV and health professionals recognize their daily responsibility toward stigmatized populations, both to prevent human rights violations and to acquire additional knowledge of international norms. They are endorsing all of the guiding principles enclosed within and committing to follow them to the best of their ability.

**Accountability**

Given the diversity of HIV and health professionals and of the work that they do the application of the guiding principles and the monitoring of progress will vary greatly depending on the context. Accordingly, the proposed approach to accountability is a flexible one.

Many HIV and health professionals will already have in place or work in organizations with systems for accreditation, quality assurance, monitoring or evaluation. Such systems can be utilized or modified wherever possible to measure performance in implementing the Code, including improved accountability to the guiding principles. Further, as noted previously, many HIV and health professionals working as doctors, nurses, members of the media, lawyers, etc. have a specific code of ethics to which they are accountable.
Guiding Principle 1: Know your Human Rights Responsibilities

This principle aims to ensure a supportive work and living environment for HIV and health professionals and clients through increased knowledge and understanding of human rights obligations.

Why is it relevant to HIV and health professionals?
Every HIV and health professional and the people whom they serve has the right to live and work in a safe environment, free from discrimination and stigma. HIV and health professionals must always remember their responsibility and ethical obligation to serve all clients fairly.

Non-supportive environments can have a range of negative impacts:

- HIV-related stigma and discrimination can create barriers to prevention, testing, treatment, care, and support for people living with HIV and key populations; it can increase fear and internal stigma and create emotional distress. For example, women living with HIV face heightened human rights violations through forced and coerced abortion or sterilization as well as denial of basic services (health, legal, education, employment, etc.). Transgender people and men who have sex with men are often denied access to services such as condoms and lubricants, and face discrimination, detention or even death if they seek treatment for a medical issue related to their sexual practices. People who inject drugs and sex workers face frequent harassment and abuses by police authorities, including the confiscation of condoms and clean needles and syringes, as well as detention. All these abuses create an environment of fear, resulting in lack of access to health services on the part of key populations.

- Breaches of informed consent and confidentiality can occur. This is especially true in contexts where providers may be required by law to report clients who may belong or be perceived to belong to a key population.

- For HIV and health professionals living with HIV, stigma and discrimination in health care settings can reduce access to services (including VHTC; prevention information and commodities; and treatment and care for HIV, opportunistic infections and co-morbidities) and threaten their employment.

- HIV and health professionals, irrespective of whether or not they are HIV-positive, may be stigmatized by their colleagues or by the community as a result of working with people living with HIV and/or face persecution, criminal investigation, arrest and sentencing for working with key populations.

Apart from negatively impacting the lives of the HIV and health professionals involved, such misguided policies and practices also discourage other activists and professionals from engaging in this vital work, and thereby deprive societies of some of their most valuable and vital resources in the AIDS response.

While the need to reduce stigma and discrimination is widely recognized, action at the scale needed to create a positive impact has yet to take place. For example, while anti-discrimination and confidentiality laws and policies exist in many countries, gaps exist between protective instruments and the lived experience of people living with HIV and key populations.

Although there are multiple interrelated drivers of HIV-related stigma and discrimination (includ-
ing structural and cultural facilitators) research consistently highlights three causes of HIV-related stigma irrespective of setting, namely:

- Lack of awareness and knowledge of HIV-related stigma and discrimination and their consequences
- Fear of acquiring HIV through everyday contact with HIV-positive people
- Linking people living with HIV with behaviours considered improper or immoral.

All three are immediately actionable through interventions.

HIV and health professionals, whatever their level and field of engagement, can play a pivotal role in breaking down barriers and contributing to achieving universal access to prevention, treatment, care and support services through a human rights framework. HIV and health professionals can also play a key role in preventing and addressing stigma, including self-stigma, and promoting treatment adherence and retention in care.

Specifically, stigma and discrimination can be significantly reduced by combining a range of complementary interventions such as:

- The implementation of workplace policies which expressly prohibit discrimination in employment and in the exercise of professional responsibilities
- The provision of comprehensive care, including wellness programmes and provision of treatment to improve the quality of life
- Appropriate training of HIV and health professionals at all levels in order to increase understanding of HIV and AIDS and to help reduce negative and discriminatory attitudes towards colleagues, people living with HIV and other key populations. Training should include:
  - Knowledge and understanding of human rights principles, including their own ‘right to health’ (HIV prevention and treatment, universal precautions and compensation for work-related infection), equality of access to HIV-related services, including VHTC, confidentiality of HIV-related information, prohibition of mandatory HIV testing for employment or mandatory disclosure of HIV status, and discrimination based on actual or perceived serostatus.
  - Inter-personal skills to help HIV and health professionals understand the impact of HIV and the burden of stigma, and provide them with the tools to communicate with clients, colleagues and others in a respectful and non-discriminatory manner.
  - Techniques to manage stress and avoid burnout such as through the provision of appropriate staffing levels, work rotation, promotion and personal development, early recognition of stress, development of communication skills, appropriate supervision and staff support groups.
  - Awareness of existing legislation and regulations that protect the rights of HIV and health professionals and clients regardless of HIV status.

In relation to awareness of legislation and regulation, the International Guidelines on HIV/AIDS and Human Rights, Guideline 3, outlines that Public Health Legislation should address the following:

- HIV testing of individuals should only be performed with the specific informed consent of that individual
- Pre-and post-test counselling must be provided in all cases
• The implementation of universal infection control precautions in health-care, and
• Health-care workers should undergo a minimum training in ethics and/or human rights in order to be licensed to practice.

• Information relative to the HIV status of an individual must be protected from unauthorized collection, use, or disclosure in health-care and other settings
• The use of HIV-related information requires informed consent
• Health-care professionals should decide, on the basis of each individual case and ethical considerations, whether to inform their patients’ sexual partners of the HIV status of their patient.
VHTC and access prevention services and they are the point of contact for providing ongoing care for people living with HIV. As such, respecting people’s dignity is critical for the provision of appropriate and acceptable services. The lack of respect towards a person seeking HIV services will discourage not only that person but others from accessing HIV services. Providing services with dignity and respect for diversity is closely tied to HIV and health professionals’ duties to make the care of clients their first concern and to provide non-discriminatory services.

Why it is relevant to HIV and health professionals?
As described in the ILO and WHO guidelines on health services and HIV/AIDS:

“Stigma and discrimination by health care workers towards other health care workers, towards patients or by employees towards health care workers – are a serious issue in many health care settings, undermining the provision of care as well as programmes for prevention. They take a variety of forms and can result in treatment being delayed, inappropriate or withheld, and in breaches of confidentiality, inappropriate and unethical behaviour and the use of excessive precautions.”

HIV and health professionals are generally the first point of interaction when people undergo VHTC and access prevention services and they are the point of contact for providing ongoing care for people living with HIV. As such, respecting people’s dignity is critical for the provision of appropriate and acceptable services. The lack of respect towards a person seeking HIV services will discourage not only that person but others from accessing HIV services. Providing services with dignity and respect for diversity is closely tied to HIV and health professionals’ duties to make the care of clients their first concern and to provide non-discriminatory services.

With respect to equity (i.e. health promotion and access), the particular needs of people living with HIV and key populations must be effectively addressed by HIV and health professionals with prevention, treatment, care and support services tailored to their specific needs. For example:

- VHTC services for sex workers should be delivered in a manner that does not endanger...
In terms of confidentiality, HIV and health professionals have ethical (i.e. under existing professional codes) and legal responsibilities to protect the privacy of people in care. Clients have a right to expect that HIV and health professionals will hold information about them in confidence, especially when clients disclose personal information such as their sexual orientation, behaviour or drug use, which may be outside of the law. In such cases, the healthcare provider must always protect the confidentiality of the client. Failure to maintain confidentiality may cause harms such as discrimination, harassment, violence or arrest. In case of dual loyalty, the healthcare provider must always weigh on the side of the client. When there is a clear indication that a third party may be harmed by the actions of a client, the ethical principle of confidentiality may conflict with the ethical principle to ‘do no harm’. The healthcare provider must weigh the potential harms and benefits to the parties involved in order to decide how to proceed. Further, the community has an interest in maintaining privacy so that people will feel safe and comfortable in using HIV prevention and care services.

Informed consent is an essential process to be undertaken by HIV and health professionals for gaining permission from the client or guardian before conducting a healthcare intervention or clinical research on a client. The goal is to ensure that the person is involved in a transparent decision-making process, in which full disclosure, understanding, decision-making capacity and voluntariness are all respected.
Critical to this new approach is the right to health, which is vested in all people. Every country in the world has ratified at least one treaty that recognizes this right, more specifically understood in international law as the right to the “highest attainable standard of physical and mental health.” More than 100 countries protect the right to health in their national constitutions. Access to medicines, and particularly to essential medicines, has been recognized as a core component of the right to the highest attainable standard of health, which also requires that medicines be available in sufficient quantity, accessible (including economically), acceptable (including medically), and of good quality.

In relation to the right to health, HIV and health professionals should realize that the State is accountable for the availability, accessibility, acceptability and quality of healthcare. HIV and health professionals must also be aware of the role that his or her professional association should play as a spokesperson as well as advocate with the State and political processes.

For HIV and health professionals, the right to benefit from scientific progress has three crucial advocacy components:

1. Future medicines and medical technologies, when developed, should be made available.
2. More immediately, universal access to existing drugs, commodities and supplies.
3. HIV-related research and new technologies are designed and implemented for the benefit of people living with and affected by HIV, and key populations.
**Guiding Principle 4: Access to Justice**

This principle urges HIV and health professionals to advocate for the development and effective implementation of legislative and policy frameworks that protect human rights, in particular for the reform or removal of punitive and non-supportive laws, policies and practices, where they exist.

### Why is it relevant to HIV and health professionals?

In many countries, there are legal impediments to service provision and uptake by specific populations, including:

- Criminalization of HIV non-disclosure, exposure and transmission (Box 2);
- Punitive laws directed at key populations (Box 2); and
- Age of consent laws or marital status-related restrictions on people’s access to services, including HIV prevention (i.e. condoms and harm reduction (e.g. clean needles and syringes and OST)), sexual and reproductive health, and VHTC.  

When faced with an issue of dual-loyalty (if the law in one’s jurisdiction is in conflict with the ethical obligation to serve all clients fairly), it is important for all HIV and health professionals to prioritize their core obligations (i.e. to treat all clients with dignity and in a non-discriminatory way). HIV

### Box 2: Punitive Laws

**Criminalization of HIV non-disclosure, exposure and transmission:** As of 2013, 63 countries have, in at least one jurisdiction, HIV-specific provisions that allow for the prosecution of HIV non-disclosure, exposure and/or transmission by people living with HIV. In other countries, prosecutions for HIV non-disclosure, exposure or transmission have been based on general criminal law offences such as sexual assault, grievous bodily harm, criminal nuisance, manslaughter or attempted homicide.

**Criminalization of same-sex acts:** Seventy-seven countries currently criminalize same-sex relations, with some jurisdictions permitting imposition of the death penalty for convictions under such laws. This is in the face of scientific evidence that homosexuality is a normal variation of human sexual behaviour.

**Criminalization of people who inject drugs:** The international drug control regime is constituted principally of three Conventions with the primary goal of improving the health and welfare of mankind. Despite their references to health, and even drug treatment, the Conventions embody a criminal rather than public health approach to drug use. Virtually all countries are parties to these Conventions, and have adopted drug laws consistent with them, though national drug laws and policies vary considerably. Punitive laws pertaining to drug use include imposition of harsh penalties for possession of small amounts of drugs for personal use, criminalization of drug dependence, detention in compulsory drug detention and rehabilitation centres, and bans on OST and needle and syringe programmes.

**Criminalization of sex work:** Most countries have laws in place that criminalize some aspect of sex work, and sex workers are often vulnerable to police harassment and mistreatment.
and health professionals must never participate in any form of judgment, discrimination, abuse, coercion or punishment in their work. All HIV and health professionals have a responsibility to advocate for the alignment of HIV-related policies, laws and regulations with human rights principles. Achieving such an alignment will improve service availability, accessibility, acceptability, and quality.

Laws, policies, social norms and community attitudes and perceptions shape the environment in which the AIDS response happens, and change is often a long-term process. Advocacy efforts by HIV and health professionals may be focused at local, national and international levels, with the aim of creating and sustaining an environment in which laws and public policy protect and promote the rights of people living with HIV and key and vulnerable populations. Such an environment would have the effect of increasing access to prevention, treatment, support and care services, while reducing the vulnerability of key populations. HIV and health professionals should work toward reducing their own stigmatizing attitudes as well as those of their colleagues, and should acquire the tools necessary to ensure clients’ rights to dignity (respect for diversity, equity, informed consent and confidentiality), access to prevention and care services, and non-discrimination. This process can be assisted by sensitization programmes and trainings.
For HIV and health professionals providing prevention programmes and services, ‘know your epidemic, know your response’ requires them to:

- Investigate, understand and respond to local epidemiological realities, including in settings in which there are limited or no epidemiological data available.
- Confront their own misconceptions and prejudices towards various populations and behaviours so as to analyze and respond to the epidemic realities on the ground when designing, implementing, monitoring and evaluating programmes and services.
- Understand and respond to the political, legal, socio-cultural, and economic context in which HIV prevention programmes and services are provided.

**Why is it relevant to HIV and health professionals?**

Knowing your epidemic is the basis for knowing your response, which provides countries and communities with an opportunity to critically assess who is and who should be participating in HIV prevention. As such it is the foundation for the combination prevention approach which seeks to achieve maximum impact on HIV prevention by combining behavioural, biomedical, and structural strategies that are human rights-based and evidence-informed, in the context of a well-researched and understood local epidemic. To be equipped as such is an ethical obligation of all HIV and health professionals.

Further it enables countries to “match and prioritize response” by identifying, selecting and funding those HIV prevention measures that are most appropriate and effective in relation to the specific epidemic scenario(s) and settings. Matching and prioritizing the response entails identifying those populations most-at-risk and vulnerable, gauging the extent to which new HIV infections are occurring within these populations, and the extent to which they are consulted and engaged in tailoring the response to their communities.

**Guiding Principle 5:**

**Know your Epidemic, Know your Response**
**Guiding Principle 6: Meaningful Participation**

This principle urges HIV and health professionals to meaningfully involve people living with HIV and key populations (specifically men who have sex with men, people in detention settings, people who inject drugs, sex workers and transgender people), at every stage of the design, development, implementation and monitoring of policies, programmes and services to strengthen client-centred care.

**Why it is relevant to HIV and health professionals?**

In order to enhance the quality and effectiveness of the AIDS response, it is imperative to realize the rights of people living with HIV and key populations, including their right to self-determination and participation in decision-making processes that affect their lives. It is important to respect people’s abilities to address their own needs. This principle should be woven into the very fabric of every level of the AIDS response, as it supports personal development of vulnerable populations by reducing social isolation and self-stigma and by creating support networks through peer connections.

Involving people living with HIV and key populations also ensures that policies, programmes and services are grounded in their lived realities, thus enhancing their effectiveness. Such policies, programmes and services are more likely to:

- Respond to the needs and priorities of other people living with HIV and key populations
- Be more open and non-judgemental
- Be seen as acceptable and credible
- Increase access and demand to programmes and services
- Make sure that your organization’s human and financial resources are directed towards the most relevant and realistic interventions
- Sustain funding and resources
- Create peer support networks within communities
- Challenge negative attitudes about people living with HIV and key populations by signalling their contributions and value as community members
- Mainstream HIV in other sectors and building partnerships at the local level to improve coordination, enhance impact and avoid duplication

At the service delivery level, participation requires shared responsibility between HIV and health professionals and the concerned person or guardian in making decisions about health care. For this to occur, effective communication and trust are both crucial.

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*This principle refers to the Greater Involvement of People Living with HIV (GIPA), a principle rather than a project or programme that aims to realize the rights and responsibilities of people living with HIV, including their right to self-determination and participation in decision-making processes that affect their lives. In these efforts, GIPA also aims to enhance the quality and effectiveness of the AIDS response. UNAIDS (2007). The Greater Involvement of People Living with HIV (GIPA). Policy Brief. [http://data.unaids.org/pub/Report/2007/jc1299-policybrief-gipa_en.pdf](http://data.unaids.org/pub/Report/2007/jc1299-policybrief-gipa_en.pdf)*
At the organizational level, useful questions to be answered by HIV and health professionals in assessing the involvement of people living with HIV and key populations include:

1. Does your organization advocate for people living with HIV and key populations and allow them to participate in decision-making and policy-making bodies, in order to ensure that their input is valued?

2. Does your organization advocate for a broad range of people living with HIV and key populations to be meaningfully involved in the design, implementation and evaluation of HIV interventions and research?

3. Does your organizational environment foster a safe and non-discriminatory environment in which the contributions of people living with HIV and key populations are valued?
While the primary HIV transmission mode is associated with individual behaviours, health professionals providing care to HIV-positive people can be at risk of HIV infection. All HIV and health professionals have the right to safe and healthy working conditions. Where a possibility of transmission exists in the workplace, such as in health-care settings, HIV and health professionals must be properly trained in universal precautions for the avoidance of bloodborne viruses and be supplied with the means to implement such procedures. They must also address fears of physical contact with people living with HIV and key populations, which could lead to inadequate health care. Information on the modes of HIV transmission and other infectious diseases, the level of occupational risk, and addressing fear of physical contact with people living with HIV and key populations provide a platform for continuous learning. An expanded, well-trained, adequately resourced and secure HIV and health professional workforce is essential to scaling up HIV prevention, treatment, care and support services for individuals and communities who need them. It is imperative that HIV and health professionals continue to acquire correct information on the modes of HIV transmission and on the level of occupational risk they and their colleagues face.

Guiding Principle 7: Education

This principle seeks to integrate education on human rights and the right to health, including international HIV-related human rights obligations, into professional education, the workplace, programmes and services.

Why it is relevant to HIV and health professionals?
Capacity building for HIV and health professionals on human rights and responsibilities is crucial for ensuring service availability, accessibility, acceptability and quality, including the delivery of non-discriminatory programmes and services. Focusing on human rights education for all HIV and HIV professionals, including non-health professionals such as media and politicians, is essential for effective future policy design. For example, human rights-based media can be of great assistance in public awareness raising, creating a culture of a human rights approach as the norm, and in reducing stigma and discrimination. Decision makers can work to design a health system based on human rights principles to provide a supportive environment for delivering integrated client-centred services. Further, people living with HIV and key populations should be meaningfully involved in the design and delivery of pre-service and in service training, specifically addressing stigma and discrimination as well as the importance of meaningful participation and respect for dignity (i.e. respect diversity, equity, informed consent, confidentiality).
Guiding Principle 8:
Monitoring and Evaluation

This principle invites HIV and health professionals to undertake periodic self-evaluations, both at the individual and organizational levels, in order to determine their level of adherence to human rights and basic standards of care.

**Definitions**

**Monitoring** is the continuous oversight of the implementation of an activity, intervention, project or programme. It seeks to establish if inputs (resources invested), processes (activities undertaken and their quality) and outputs (direct deliverables) are proceeding according to plan. It includes the regular collection and analysis of data to assist timely decision-making, ensure accountability and provide the basis for evaluations and learning.

**Evaluation** is a process that aims to determine as systematically and objectively as possible, the relevance, effectiveness, efficiency, merits (value-added), sustainability and/or impact of an intervention, project or programme. It aims to provide valuable management information, judge the value and merits of an intervention, and draw lessons for future actions and decision making.

Why it is relevant to HIV and health professionals?

It is impossible to know whether the Code’s principles have been understood and adopted without appropriate monitoring and evaluation, and the resulting ability to draw and share lessons learned. Such quality assurance mechanisms:

- Provide the necessary checks and balances to protect both service users and HIV and health professionals.
- Support ongoing improvements in the quality of services.
- Can contribute to ensuring that programmes make a sustainable contribution to overall health systems strengthening.

In the context of the Code, monitoring and evaluation (M&E) is required in two areas:

1. Implementation of an overarching human rights approach
2. Implementation of policies, programmes and service delivery.

Often HIV and health professionals and their organizations implement programmes and activities that bear directly on the human rights of people, including those living with HIV and key populations, but may not be framed or thought about as human rights activities. This is sometimes the case with activities designed to reduce stigma and discrimination, remove barriers that restrict people living with HIV and key populations from accessing needed services and resources, or empower communities to claim their rights.

At the organizational level, a human rights and HIV self-assessment can help an organization assess the degree to which your organization is successfully implementing a human rights approach into their work. For HIV and health professionals, it is important to agree on clear roles and responsibilities, which can be done through adherence to this Code, and hold one another accountable for results through adherence to timelines, target outcomes, transparent reporting and real-time assessment of results. A useful tool, which can be adapted for this purpose or used at the organizational level, is the NGO Code of Good Conduct: Self-Assessment Checklist: Human Rights and HIV.
This principle aims to ensure that HIV and health professionals are directly answerable to the community and clients served, including through establishing and/or advocating for governance structures which support ongoing accountability.

Why it is relevant to HIV and health professionals?
Accountability of HIV professionals includes a duty to make the care of clients their first concern and to provide services safely and effectively. Maintaining a high level of professional competence and conduct is essential for good care. Specifically:
• Making decisions about health care is the shared responsibility of the HIV or health professional and the client or guardian.
• Relationships based on openness, trust and good communication will enable HIV and health professionals to work in partnership with the client or guardian.
• HIV and health professionals have ethical and legal responsibilities to protect the privacy of people receiving care. Clients have a right to expect that HIV and health professionals will hold information about them in confidence.
• HIV and health professionals need to obtain informed consent for the care that they provide from the client or guardian. Good practice involves genuine efforts on the part of HIV and health professionals to understand the cultural needs and contexts of different clients to obtain good health outcomes. HIV and health professionals need to be aware that some clients, including members of key populations, have additional needs and modify their approach appropriately.
• When adverse events occur, HIV and health professionals have a responsibility to be open and honest in communication with the client or guardian to review what has occurred.
• Maintaining and developing HIV and health professional’s knowledge, skills and professional behaviour are core aspects of good practice.

HIV and health professionals do not work in a vacuum and must therefore be subject to transparent governance and be accountable to the communities and clients served. Accountability, transparency and effective stewardship of resources are crucial. This is vital to credibility with both communities and agencies providing resources. Further, it is essential that HIV and health professionals protect and maintain the right to independently determine priorities in line with the needs and aspirations of the communities and clients served.

HIV and health professionals also have an interest and responsibility to ensure that their organization has governance structures which are accountable. These are crucial to effective AIDS responses and for the integrity of organizations. Accountable organizations must have clear written policies which address the following points:
• Definition of roles and responsibilities of the governing body, both individually and jointly, including strategic planning, financial probity and oversight of quality assurance, including codes of conduct
• Appointment and termination of members of the governing body
• Identification and mitigation of conflicts of interest
• Accountability and reporting arrangements both internally and to government, donors and partners, and communities served.
Guiding Principle 1:  
Know your Human Rights Responsibilities

The formulation, adoption and enforcement of the principles of universal human rights were formally recognized with the signing of the Charter of the United Nations (UN) in 1945, the Universal Declaration of Human Rights in 1948, the International Covenant on Economic, Social and Cultural Rights (ICESCR) and International Covenant on Civil and Political Rights (ICCPR) in 1966. Within this internationally agreed framework, all human beings enjoy these human rights without distinction. Articles 2 of the ICCPR and ICESCR specifically guarantee that the rights recognized therein are respected “without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status”.

‘Other status’ has been consistently interpreted by a range of UN bodies, including the Commission on Human Rights, the Committee on the Rights of the Child, the Committee on Economic, Social and Cultural Rights, and the Sub-Commission on Prevention of Discrimination and Protection of Minorities as prohibiting discrimination on the basis of HIV status, actual or presumed. The existence of a general prohibition of discrimination against people living with HIV is further reflected in a number of international and regional instruments. Since 2001, the UN General Assembly has produced Political Declarations on HIV/AIDS, in which States have expressed their commitment to adopt and enforce legislation and other measures aimed at eliminating all forms of discrimination against people living with HIV.

The ILO HIV and AIDS Recommendation, 2010 (No. 200), the first international labour standard on HIV and AIDS and the world of work, establishes a human rights framework for the development and application of workplace HIV policies and programmes. This recommendation specifically prohibits discrimination or stigmatization of workers based on real or perceived HIV status and provides guidance on promotion of equality of opportunity and treatment, as well as access to treatment and care. It has already been cited as a source of law in a number of cases before regional (European Court of Human Rights) and national courts (Brazil, Kenya and South Africa).

Guiding Principle 2:  
Respect Dignity

The Universal Declaration of Human Rights, Article 1 states that: “All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.”

Diversity: Respect for diversity is about behaviours and attitudes. It is founded on the values of equality, respect and opportunity for all. It goes beyond legal rights to encompass issues such as a secure sense of belonging and a feeling of being accepted and welcome. In addition, certain human rights principles, including non-discrimination (see Guiding Principle 1) and the right to participation (see Guiding Principle 6) are central to respect for diversity.

Equity in health is an ethical value grounded in the principle of distributive justice and is consistent with human rights principles. As such, it requires equal opportunity for all population groups to be healthy. This implies that resourc-
es are distributed and processes are designed in ways most likely to move toward equalizing the health outcomes of disadvantaged social groups. At its core, it involves the distribution and design not only of health care resources and programmes, but of all resources, policies, and programmes that play a role in shaping health, many of which are outside the immediate control of the health sector. 

Confidentiality and Informed Consent: Article 17 of the ICCPR provides that “No one shall be subjected to arbitrary or unlawful interference with his privacy.” The right to privacy encompasses the respect of physical privacy, including the obligation to seek informed consent to VHTC and the privacy of the results. With regards to VHTC, WHO has defined five key components that must be respected and adhered to by all VHTC services: consent, confidentiality, counselling, correct test results, and connection/linkage to prevention, care and treatment. The ILO HIV and AIDS Recommendation, 2010 (No. 200) provides among its general principles that workers, their families and their dependants should enjoy protection of their privacy, including confidentiality related to HIV and AIDS, in particular with regard to their own HIV status. Furthermore, VHTC should be genuinely voluntary, not required for employment and results should be confidential.

The international prohibition contained in ICCPR Article 7, and supported by the International Guidelines on HIV/AIDS and Human Rights, on submitting a person to medical and scientific experimentation without his or her free consent, must be specifically underlined. Informed consent is a process by which an individual is provided with enough information about a trial or intervention to make an independent decision whether or not to participate.

Guiding Principle 3: Benefit from Scientific Progress

The International Covenant on Economic, Social and Cultural Rights, Article 15 1(b) stipulates that “The States Parties to the present Covenant recognize the right of everyone to enjoy the benefits of scientific progress and its applications”, which is also affirmed in the International Guidelines on HIV/AIDS and Human Rights and the Universal Declaration on Bioethics and Human Rights. The latter, in Article 15, recognizes multiple forms of benefit-sharing, including “special and sustainable assistance to, and acknowledgement of, the persons and groups that have taken part in the research, access to quality health care, provision of new diagnostic and therapeutic modalities or products stemming from research, support for health services, access to scientific and technological knowledge, and capacity building facilities for research purposes.”

The ILO HIV and AIDS Recommendation, 2010 (No. 200) states that all persons covered by this recommendation, including workers living with HIV and their families and their dependants, should be entitled to health services. These services should include access to free or affordable:

a) Voluntary counselling and testing
b) Antiretroviral treatment and adherence education, information and support
c) Proper nutrition consistent with treatment
d) Treatment for opportunistic infections and sexually transmitted infections, and any other HIV-related illnesses, in particular tuberculosis
e) Support and prevention programmes for persons living with HIV, including psychosocial support.

There have been increased commitments at the international, regional and national levels towards the full realization of all human rights relat-
ed to HIV, including improved access to health services for people living with HIV. Key among these are the Declaration of Commitment on HIV/AIDS, the Millennium Development Goals, General Comment 14 of the Committee on Economic, Social and Cultural Rights, and the Commission on Human Rights resolutions on the right to the highest attainable standard of health and access to medication.

Guiding Principle 4: Access to Justice
In the 2011 UN General Assembly Political Declarations on HIV/AIDS, States committed “to review, as appropriate, laws and policies that adversely affect the successful, effective and equitable delivery of HIV prevention, treatment, care and support programmes to people living with and affected by HIV, and to consider their review in accordance with relevant national review frameworks and time frames.”

The International Guidelines on HIV/AIDS and Human Rights contains specific guidelines on the criminalization of HIV non-disclosure, exposure and transmission, punitive laws directed at key populations and discriminative laws to protect people living with HIV.

Guiding Principle 5: Know your Epidemic, Know your Response
Know your epidemic, know your response is not a legal obligation; however, the 2011 Political Declaration on HIV and AIDS notes that “many national HIV-prevention strategies inadequately focus on populations that epidemiological evidence shows are at higher risk of infection, specifically men who have sex with men, people who inject drugs and sex workers,” and commits States “to ensure that financial resources for prevention are allocated for evidence-based prevention measures that reflect the specific nature of each country’s epidemic by focusing on geographic locations, social networks and populations vulnerable to HIV infection, according to the extent to which they account for new infections in each setting.”

Guiding Principle 6: Meaningful Participation
The right to participation (in the conduct of public affairs) derives from Article 25 of the ICPR along with General Comment 25, which states inter alia that: “Every citizen shall have the right and the opportunity ... to take part in the conduct of public affairs (including) all aspects of public administration, and the formulation and implementation of policy.”

The idea that personal experiences should shape the AIDS response was first voiced by people living with HIV in Denver in 1983. The Greater Involvement of People Living with AIDS Principle was formalized at the 1994 Paris AIDS Summit when 42 countries agreed to “support a greater involvement of people living with HIV at all...levels...and to...stimulate the creation of supportive political, legal and social environments.” Similar sentiments are included in the International Guidelines on HIV/AIDS and Human Rights, and since 2001, UN General Assembly Declarations on HIV and AIDS have been unanimously adopted by States, affirming support for the greater involvement of people living with HIV. The ILO HIV and AIDS Recommendation, 2010 (No. 200) provides that the implementation of policies and programmes on HIV and AIDS should be based on cooperation and trust among employers, workers and their representatives, and governments, with the active involvement of persons living with HIV.
Guiding Principle 7: Education

The 2011 Political Declaration on HIV and AIDS commits states to strategies that promote and protect human rights, including programmes aimed at eliminating stigma and discrimination against people living with and affected by HIV, including their families, by sensitizing the police and judges and healthcare workers on non-discrimination, confidentiality and informed consent. In terms of HIV and the workplace, the ILO HIV and AIDS Recommendation, 2010 (No. 200) provides specific guidance on occupational safety and health as well as education, training and access to information.

The International Guidelines on HIV/AIDS and Human Rights include a number of Guidelines which have training implications for a range of HIV and health professionals.

Guideline 3: Public Health Legislation which covers:

- HIV testing of individuals should only be performed with the specific informed consent of that individual.
- Pre-and post-test counselling be provided in all cases.
- Information relative to the HIV status of an individual be protected from unauthorized collection, use or disclosure in the healthcare and other settings and that the use of HIV-related information requires informed consent.
- Health-care professionals decide, on the basis of each individual case and ethical considerations, whether to inform their patients’ sexual partners of the HIV status of their patient.
- The implementation of universal infection control precautions in health-care.
- Health-care workers undergo a minimum amount of ethics and/or human rights training in order to be licensed to practice.

Guideline 8: Women, Children and Other Vulnerable Groups states that persons employed by child care agencies, including adoption and foster-care homes, receive training in the area of HIV-related children’s issues in order to deal effectively with the special needs of HIV-affected children including protection from mandatory testing, discrimination and abandonment.

Guideline 9: Changing Discriminatory Attitudes through Education, Training and the Media includes:

- Supporting HIV-related human rights/ethics training/workshops for Government officials, the police, prison staff, politicians, as well as village, community and religious leaders and professionals.
- Targeted training, peer education and information exchange for people living with HIV staff and volunteers of community-based and AIDS service organizations as well as for leaders of vulnerable groups as a means of raising their awareness of human rights and of the means to enforce these rights.
Guiding Principle 8: Monitoring and Evaluation
With regards to the M&E of the implementation of a human rights approach, the International Guidelines on HIV/AIDS and Human Rights, Guideline 1, stipulates that States should ensure monitoring and enforcement mechanisms to guarantee the protection of HIV-related human rights, including those of people living with HIV, their families and communities. Furthermore:

“Standard-setting and promotion of HIV-related human rights standards alone are insufficient to address human rights abuses in the context of HIV. Effective mechanisms must be established at the national and community levels to monitor and enforce HIV-related human rights. Monitoring is necessary to collect information, formulate and revise policy, and establish priorities for change and benchmarks for performance measurement. Monitoring should be both positive and negative, i.e. reporting on good practice to provide models for others to emulate, as well as identifying abuses. The non-governmental sector can provide an important means of monitoring human rights abuses, if resourced to do so, since it frequently has closer contact with communities. Training is to develop skills so as to be able to analyse and report findings at a level of quality which is credible for States and international human rights bodies.”

Guiding Principle 9: Accountability
The International Guidelines on HIV/AIDS and Human Rights, Guideline 10, highlights the need for human rights principles to be translated into codes of professional responsibility and practice, with accompanying mechanisms to implement and enforce these codes. Furthermore:

“States should require or encourage professional groups, particularly health-care professionals, (...) to develop and enforce their own codes of conduct addressing human rights issues in the context of HIV. Relevant issues would include confidentiality, informed consent to testing, the duty to treat, the duty to ensure safe workplaces, reducing vulnerability and discrimination and practical remedies for breaches/misconduct.”

With regards to M&E of the implementation of policies, programmes and service delivery, the 2011 Political Declaration on HIV and AIDS underscores the need for effective evidence-based operational monitoring and evaluation and mutual accountability mechanisms between all stakeholders to support multisectoral national strategic plans for HIV and AIDS.
Guiding principle 1: Know your Human Rights Responsibilities
United Nations General Assembly. 2011 High-Level Political Declaration on HIV/AIDS.


WHO and United Nations Development Programme (2013). The Time Has Come" Enhancing HIV, STI and other sexual health services for MSM and transgender people in Asia and the Pacific: Training package for health providers to reduce stigma in health care settings.
http://www.thetimehascome.info/


http://www.hsph.harvard.edu/population/aids/southafrica.aids.00.doc

http://www.hsph.harvard.edu/population/aids/malaysia.aids.01.pdf

Guiding Principle 2: Respect Dignity
http://www.ilo.org/wcmsp5/groups/public/@ed_protect/@protrav/@ilo_aids/documents/publi-
cation/wcms_116240.pdf

Guiding Principle 3: Benefit from Scientific Progress.


Guiding Principle 4: Access to Justice

http://www.unaids.org/en/media/unaids/contentassets/documents/document/2012/KeyScien-
tificMedicalLegalIssuesCriminalisationHIV_final.pdf


Guiding Principle 5: Know your Epidemic, Know your Response

Guiding Principle 6: Meaningful Participation


Guiding Principle 7: Education
Guiding Principle 8: Monitoring and Evaluation

Guiding Principle 9: Accountability
Pharmacy Board of Australia (2012). Code of conduct for registered health practitioners.


http://www.hsph.harvard.edu/population/aids/southafrica.aids.00.doc

http://www.hsph.harvard.edu/population/aids/malaysia.aids.01.pdf

NGO Code of Good Conduct: Self-Assessment Checklist: Governance
http://www.hivcode.org/silo/files/final-governance-.pdf
Endnotes

To know your epidemic requires that countries identify the key drivers of the epidemic focusing on the relationship between the epidemiology of HIV infection and the behaviours and social conditions that impede their ability to access and use HIV information and services. Knowing your epidemic is the basis for knowing your response which provides countries with an opportunity to critically assess who is and who should be participating in HIV prevention. Knowing your epidemic and response enables countries to “match and prioritize your response” by identifying, selecting and funding those HIV prevention measures that are most appropriate and effective for the country in relation to its specific epidemic scenario(s) and settings.


Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez (2013). A/HRC/22/53.


Para 20b

Para 20c

Para 20f

Para 20g. Public health legislation should authorize, but not require, that health-care professionals decide, on the basis of each individual case and ethical considerations, whether to inform their patients’ sexual partners of the HIV status of their patient. Such a decision should only be made in accordance with the following criteria:

(i) The HIV-positive person in question has been thoroughly counselled;
(ii) Counselling of the HIV-positive person has failed to achieve appropriate behavioural changes;
(iii) The HIV-positive person has refused to notify, or consent to the notification of his/her partner(s);
(iv) A real risk of HIV transmission to the partner(s) exists;
(v) The HIV-positive person is given reasonable advance notice;
(vi) The identity of the HIV-positive person is concealed from the partner(s), if this is possible in practice; and
(vii) Follow-up is provided to ensure support to those involved, as necessary.

Para 20i

Para 20j


See Committee on Economic, Social and Cultural Rights, the right to the highest attainable standard of health. 11/08/2000. E/C.12/2000/4, CESC General Comment 14, 2000. While the General Comment refers frequently to a right to “essential” medicines, but refers several times to essential medicines without explicitly limiting the concept to an existing list, e.g. the WHO’s EDL. See id. at 4, 7, 16. A recent Human Rights Council resolution expresses the clear, emerging view of states that the right to medicines is broader than a right to medicines considered “essential,” although essential medicines are worthy of particular priority. See Access to medicines in the context of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, A/HRC/23/L.10/Rev.1 (June 11, 2013).

Affordability is crucial and may require delinking research and development costs from product prices, as proposed by the World Health Organization in its global strategy and plan of action on public health, innovation and intellectual property. See resolutions WHA 61.21 and 63.28.

Committee on Economic, Social and Cultural Rights, General Comment 14, Right to Health Factsheet No. 31.


International Policy:

• International Council for Science (ICSU). Universality of Science statement includes gender identity and sexual orientation. September 2011


National and Regional Policies:

• Brazil: Conselho Federal de Psicologia, Brazil, Resolution 1/99: Establishes professional conduct standards for psychologists with regard to Sexual Orientation (PDF, 58KB). March 22, 1999

• Quebec, Canada: Position on sexual orientation change efforts, Les interventions qui visent à changer l’orientation sexuelle, by l’Ordre des psychologues du Québec. Nov. 23, 2012

• Costa Rica: Position statement on sexual orientation change efforts, La homosexualidad no es una enfermedad, by the Colegio Profesional de Psicólogos de Costa Rica. Feb. 25, 2013

• Hong Kong SAR:
  • Position Paper for Psychologists Working with Lesbians, Gays, and Bisexual (LGB) Individuals; Background Paper. August 2012.
  • Position Statement of the Hong Kong College of Psychiatrists on Sexual Orientation. Nov. 15, 2011.

• Philippines:
  • Statement of the Psychological Association of the Philippines on Non-Discrimination Based on Sexual Orientation, Gender Identity and Expression. Oct. 8, 2011;
  • Statement of the National Association for Filipino Psychology (Pambansang Samahan sa Sikolohiyang Pilipino) on Discrimination Based on Sexual Orientation, Gender Identity and Expression in Tagalog. March 22, 2013

• South Africa: Sexual and Gender Diversity Position Statement: Introduction, Rationale and Context. Psychological Society of South Africa. September 2013


• United States: American Psychological Association policy statements related to LGBT concerns.


United Nations entities call on States to close compulsory drug detention and rehabilitation centres and implement voluntary, evidence-informed and rights-based health and social services in the community.

The continued existence of compulsory drug detention and rehabilitation centres, where people who are suspected of using drugs or being dependent on drugs, people who have engaged in sex work, or children who have been victims of sexual exploitation are detained without due process in the name of “treatment” or “rehabilitation”, is a serious concern. Compulsory drug detention and rehabilitation centres raise human rights issues and threaten the health of detainees, in-
including through increased vulnerability to HIV and tuberculosis (TB) infection.

Joint statement on compulsory drug detention and rehabilitation centres


Study of HIV incidence by modes of transmission refers to an epidemiological model developed by UNAIDS to help countries calculate HIV incidence by mode of transmission in the short term. The model incorporates biological and behavioural inputs, such as HIV and sexually transmitted infection prevalence, risk behaviours, and transmission probabilities. Review and analysis of available epidemiological and programmatic data, along with assessment of a country’s current resource allocation against the findings of the modes of transmission modelling, facilitate an analysis of the likely effectiveness of the existing response for decision makers to consider. This process is sometimes referred to as ‘Know your Epidemic’ and ‘Know your Response’ or ‘Tailor your Response’.


The United Nations Commission on Human Rights (the predecessor of the Human Rights Council) has, for example, repeatedly confirmed that the term “other status” should be interpreted to cover health status, including HIV/AIDS. See, e.g., The protection of human rights in the context of human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS), UN Commission on Human Rights Resolution 1995/44, 3 March 1995; and, more recently, Human Rights Resolution 2005/84, 21 April 2005.

The reference to ‘other status’ contained in Article 2 of the Convention on the Rights of the Child has been interpreted to include HIV/AIDS status of the child or his/her parent(s). Committee on the Rights of the Child, General Comment No. 3 “HIV/AIDS and the Rights of the Child”, CRC/GC/2003/3 (2003), para. 9.

The Committee on Economic, Social and Cultural Rights’ General Comment on non-discrimination expressly included health among “other status” grounds referred to in Article 2, ICESCR. The Committee emphasised the need for a flexible approach to the interpretation of ‘other status’ “in order to capture other forms of differential treatment that cannot be reasonably and objectively justified and are of a comparable nature to the expressly recognized grounds in Article 2, paragraph 2.” Health status, which also covers HIV status, is included by the Committee as among the additional grounds that are “commonly recognized” and that “reflect the experience of social groups that are vulnerable and have suffered and continue to suffer marginalization.” Paragraph 27. When discussing examples of prohibited discrimination on grounds of health, the Committee explicitly refers to HIV-related discriminatory rights restrictions in such areas as education, employment, health care, travel, social security, housing and asylum, see Paragraph 33.


The existence of an obligation to protect against discrimination on grounds of HIV status is also recognised in the International Guidelines on HIV and Human Rights, adopted by the OHCHR.

The Joint ILO/WHO guidelines on health services and HIV/AIDS, 2005 and the ILO Recommendation concerning HIV and AIDS and the World of Work, 2010, (No. 200) emphasize that there should be no discrimination on the basis of real or perceived HIV status, specifically:
The Joint ILO/WHO guidelines state: stigma and discrimination by health care workers towards other health care workers, towards patients or by employees towards health care workers - are a serious issue in many health care settings, undermining the provision of care as well as programmes for prevention. They take a variety of forms and can result in treatment being delayed, inappropriate or withheld, and in breaches of confidentiality, inappropriate and unethical behaviour and the use of excessive precautions. ILO/WHO (2005). Joint ILO/WHO Guidelines on Health Services and HIV/AIDS. Para 25.


Recommendation concerning HIV and AIDS and the World of Work, 2010, (No. 200) states: There should be no discrimination against or stigmatization of workers…; and further: real or perceived HIV status should not be a ground of discrimination preventing recruitment or employment, or the pursuit of equal opportunities”. Recommendation concerning HIV and AIDS and the World of Work, 2010, (No. 200), IV National policies and programmes, Discrimination and promotion of equality of opportunity and treatment, paragraphs 3 (c) and 10.


UN General Assembly (2006). Political Declaration on HIV/AIDS. A/RES/60/262, see para 29.


55 Article 3 (c) there should be no discrimination against or stigmatization of workers, in particular jobseekers and job applicants, on the grounds of real or perceived HIV status or the fact that they belong to regions of the world or segments of the population perceived to be at greater risk of or more vulnerable to HIV infection.

56 Articles:

10. Real or perceived HIV status should not be a ground of discrimination preventing the recruitment or continued employment, or the pursuit of equal opportunities consistent with the provisions of the Discrimination (Employment and Occupation) Convention, 1958.

11. Real or perceived HIV status should not be a cause for termination of employment. Temporary absence from work because of illness or caregiving duties related to HIV or AIDS should be treated in the same way as absences for other health reasons, taking into account the Termination of Employment Convention, 1982.

12. When existing measures against discrimination in the workplace are inadequate for effective protection against discrimination in relation to HIV and AIDS, Members should adapt these measures or put new ones in place, and provide for their effective and transparent implementation.

13. Persons with HIV-related illness should not be denied the possibility of continuing to carry out their work, with reasonable accommodation if necessary, for as long as they are medically fit to do so. Measures to redeploy such persons to work reasonably adapted to their abilities, to find other work through training or to facilitate their return to work should be encouraged, taking into consideration the relevant International Labour Organization and United Nations instruments.

14. Measures should be taken in or through the workplace to reduce the transmission of HIV and alleviate its impact by:

(a) ensuring respect for human rights and fundamental freedoms;
(b) ensuring gender equality and the empowerment of women;
(c) ensuring actions to prevent and prohibit violence and harassment in the workplace;
(d) promoting the active participation of both women and men in the response to HIV and AIDS;
(e) promoting the involvement and empowerment of all workers regardless of their sexual orientation and whether or not they belong to a vulnerable group;
(f) promoting the protection of sexual and reproductive health and sexual and reproductive rights of women and men; and
(g) ensuring the effective confidentiality of personal data, including medical data.

57 Article 3. There should be no discrimination against workers or their dependants based on real or perceived HIV status in access to social security systems and occupational insurance schemes, or in relation to benefits under such schemes, including for health care and disability, and death and survivors’ benefits.

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


"In terms of consent, people being tested for HIV must give informed consent to be tested. They must be informed of the process for VHTC, the services that will be available depending on the results, and their right to refuse testing. Mandatory or compulsory (coerced) testing is never appropriate, regardless of where that coercion comes from: health-care providers, partners, family members, employers, or others


Articles:
24. Testing must be genuinely voluntary and free of any coercion and testing programmes must respect international guidelines on confidentiality, counselling and consent.
25. HIV testing or other forms of screening for HIV should not be required of workers, including migrant workers, job-seekers and job applicants.
26. The results of HIV testing should be confidential and not endanger access to jobs, tenure, job security or opportunities for advancement.

ICCPR Article 7: No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation.
Guideline 5: States should enact or strengthen anti-discrimination and other protective laws that protect vulnerable groups, people living with HIV and people with disabilities from discrimination in both the public and private sectors, ensure privacy and confidentiality and ethics in research involving human subjects, emphasize education and conciliation, and provide for speedy and effective administrative and civil remedies.

The right to enjoy the benefits of scientific progress and its applications is important in the context of HIV in view of the rapid and continuing advances regarding testing, treatment therapies and the development of a vaccine. More basic scientific advances which are relevant to HIV concern the safety of the blood supply from HIV infection and the use of universal precautions which prevent the transmission of HIV in various settings, including that of health care. In this connection, however, developing countries experience severe resource constraints which limit not only the availability of such scientific benefits but also the availability of basic pain prophylaxis and antibiotics for the treatment of HIV-related conditions. Furthermore, disadvantaged and/or marginalized groups within societies may have no or limited access to available HIV-related treatments or to participation in clinical and vaccine development trials. Of deep concern is the need to share equitably among States and among all groups within States basic drugs and treatment, as well as the more expensive and complicated treatment therapies, where possible.


Guideline 3: States should review and reform public health laws to ensure that they adequately address public health issues raised by HIV, that their provisions applicable to casually transmitted diseases are not inappropriately applied to HIV and that they are consistent with international human rights obligations.


Guideline 4: States should review and reform criminal laws and correctional systems to ensure that they are consistent with international human rights obligations and are not misused in the context of HIV or targeted against vulnerable groups.


Guideline 5: States should enact or strengthen anti-discrimination and other protective laws that protect vulnerable groups, people living with HIV and people with disabilities from discrimination in both the public and private sectors, ensure privacy and confidentiality and ethics in research involving human subjects, emphasize education and conciliation, and provide for speedy and effective administrative and civil remedies.


Note that many national HIV-prevention strategies inadequately focus on populations that epidemiological evidence shows are at higher risk, specifically men who have sex with men, people who inject drugs and sex workers, and further note, however, that each country should define the specific populations that are key to its epidemic and response, based on the epidemiological and national context.

UN General Assembly (2011). Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS. A/RES/65/277, see para 78.

Commit to ensure that financial resources for prevention are targeted to evidence-based prevention measures that reflect the specific nature of each country’s epidemic by focusing on geographic locations, social networks and populations vulnerable to HIV infection, according to the extent to which they account for new infections in each setting, in order to ensure that resources for HIV prevention are spent as cost-effectively as possible and to ensure that particular attention is paid to women and girls, young people, orphans and vulnerable children, migrants and people affected by humanitarian emergencies, prisoners, indigenous people and people with disabilities, depending on local circumstances.

UN General Assembly (2011). Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS. A/RES/65/277, paras 40, 44 and 57, see para 60.

Every citizen shall have the right and the opportunity, without any of the distinctions mentioned in article 2 and without unreasonable restrictions: (a) To take part in the conduct of public affairs, directly or through freely chosen representatives; http://www.ohchr.org/en/professionalinterest/pages/ccpr.aspx

General Comment No. 25: The right to participate in public affairs, voting rights and the right of equal access to public service (Art. 25); 12/07/1996. CCPR/C/21/Rev.1/Add.7, General Comment No. 25. (General Comments).


Guideline 2: States should ensure, through political and financial support, that community consultation occurs in all phases of HIV policy design, programme implementation and evaluation and that community organizations are enabled to carry out their activities, including in the field of ethics, law and human rights, effectively.


UN General Assembly (2011). Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS.
Commit to national HIV and AIDS strategies that promote and protect human rights, including programmes aimed at eliminating stigma and discrimination against people living with and affected by HIV, including their families, by sensitizing the police and judges, training health-care workers in non-discrimination, confidentiality and informed consent, supporting national human rights learning campaigns, legal literacy and legal services, as well as monitoring the impact of the legal environment on HIV prevention, treatment, care and support.

UN General Assembly (2011). Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS. A/RES/65/277, see para 80

Articles:

32. When there is a possibility of exposure to HIV at work, workers should receive education and training on modes of transmission and measures to prevent exposure and infection. Members should take measures to ensure that prevention, safety and health are provided for in accordance with relevant standards.

33. Awareness-raising measures should emphasize that HIV is not transmitted by casual physical contact and that the presence of a person living with HIV should not be considered a workplace hazard.

40. Training, safety instructions and any necessary guidance in the workplace related to HIV and AIDS should be provided in a clear and accessible form for all workers and, in particular, for migrant workers, newly engaged or inexperienced workers, young workers and persons in training, including interns and apprentices. Training, instructions and guidance should be sensitive to gender and cultural concerns and adapted to the characteristics of the workforce, taking into account the risk factors for the workforce.

41. Up to date scientific and socio-economic information and, where appropriate, education and training on HIV and AIDS should be available to employers, managers and workers’ representatives, in order to assist them in taking appropriate measures in the workplace.

42. Workers, including interns, trainees and volunteers should receive awareness raising information and appropriate training in HIV infection control procedures in the context of workplace accidents and first aid. Workers whose occupations put them at risk of exposure to human blood, blood products and other body fluids should receive additional training in exposure prevention, exposure registration procedures and post-exposure prophylaxis.


Para 20b

Para 20c

Para 20f

Para 20 g. Public health legislation should authorize, but not require, that health-care professionals decide, on the basis of each individual case and ethical considerations, whether to inform their patients’ sexual partners of the HIV status of their patient. Such a decision should only be made in accordance with the following criteria:

(i) The HIV-positive person in question has been thoroughly counselled;
(ii) Counselling of the HIV-positive person has failed to achieve appropriate behavioural changes;
(iii) The HIV-positive person has refused to notify, or consent to the notification of his/her partner(s);
(iv) A real risk of HIV transmission to the partner(s) exists;
(v) The HIV-positive person is given reasonable advance notice;
(vi) The identity of the HIV-positive person is concealed from the partner(s), if this is possible in practice; and
(vii) Follow-up is provided to ensure support to those involved, as necessary.
Commit to having effective evidence-based operational monitoring and evaluation and mutual accountability mechanisms between all stakeholders to support multisectoral national strategic plans for HIV and AIDS to fulfil the commitments in the present Declaration, with the active involvement of people living with, affected by and vulnerable to HIV, and other relevant civil society and private sector stakeholders.


Strengthening human rights approaches through a Code of Conduct for HIV professionals was developed by Doupe A., HIV and Legal Consultant, with the assistance of Dr Kurian M., Senior Manager, Policy & Advocacy, International AIDS Society, and under the supervision of a technical working group comprising: Dr Albers E R., International Network of People who Use Drugs; Amon J., Human Rights Watch; Baggaley R., World Health Organization; Bernard E., HIV Justice Network; Dr. Chan R., Action for AIDS Singapore and Member of IAS Governing Council; Clayton M., AIDS and Rights Alliance for Southern Africa; Collins C., UNAIDS; Dr. Day M., Caribbean Drug and Alcohol Research Institute; Delorme C., World Medical Association; Dvoriak S., Ukrainian Institute on Public Health Policy; Grover A., United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health; Kerr A., International HIV/AIDS Alliance; Kusano Y., International Council of Nurses; Lee M., Asia Pacific Coalition of AIDS Service Organizations; MacInnis R., Futures Group; Morgan Thomas R., Global Network of Sex Work Projects; Moses-Burton SM., Global Network of People living with HIV; Dr. Ndugulile F., Member of IAS Governing Council; Nyagiro T., International Federation of Red Cross and Red Crescent Societies; Nyblade L., Futures Group; Nygren-Krug H., Joint United Nations Programme on HIV/AIDS; Paxton S., ICW Global; Raff N., Global Forum MSM and HIV; Rahman F., Malaysian AIDS Council; Prof. Salomon H., Member of IAS Governing Council; Stangl A., Stigma Action Network; Sundararaj M., Global Forum MSM and HIV; Torriente A., International Labour Organization; Prof. de Wit J, Centre for Social Research in Health, University of New South Wales, Australia; and Dr. Zuniga J M., International Association of Providers of AIDS Care.

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A Code of Conduct for HIV and Health Professionals: Strengthening Human Rights Approaches to Health

Human rights are a fundamental part of clinical best practice guidelines and of public health practice. Human rights require HIV and health professionals to look within and act practically, concretely, and immediately – as both individuals and organizational members – to realize the right to health. This pledge serves both as a reminder and a call to action to me, as a HIV or health professional, to remain proactively engaged and ever vigilant in protecting and promoting the rights of people living with HIV, key populations and those affected by HIV/AIDS.

I pledge to fulfil, to the best of my ability, the following principles:

• I will learn more about HIV-related human rights obligations and integrate this knowledge into my profession, workplace, programmes and services.
• I will always prioritize the human rights of those who seek health services. I will endeavour to provide services with dignity by respecting diversity, equity, confidentiality and informed consent. My first obligation is to treat all clients fairly.
• I will protect and promote the right of everyone to benefit from scientific progress and new knowledge, and to access drugs, commodities and supplies as well as the results of clinical trials and research.
• I will advocate for the development and effective implementation of legislative and policy frameworks that protect human rights. I will advocate for the repeal, reform or removal of punitive and discriminatory laws, policies and practices.
• I will advocate for the design, development and implementation of HIV policies and programmes that promote an environment which protects human rights.
• I will meaningfully involve people living with HIV and key populations at every stage of the design, development and implementation of policies, programmes and services, in order to strengthen client-centred care.
• I endeavour to continuously gain knowledge regarding modes of transmission and populations at risk, resource tracking, and programmatic gaps in order to inform programme planning.
• I will undertake to continuously review my adherence to human rights values and basic standards of care, both at the individual and organizational levels.
• I will be answerable to the communities and clients whom I serve, and will establish and advocate for governance structures that support ongoing accountability.

By signing and adopting the Code I endorse all of the above guiding principles.

To sign on to the Pledge and to download the full code go to: http://hivhumanrightscode.org