



# HANDOVER DIALOGUES

UN Special Rapporteur on the Right to Health

## Notes from Dialogue

# *Re-thinking criminalization: drugs, sex work, same-sex relations, and HIV*

### **Panellists:**

Judy Chang, Executive Director of the International Network of People Who Use Drugs  
Lucas Ramón Mendos, Research Coordinator at the International LGBT Association (ILGA)  
Natalia Isaieva, Director of Legalife, Ukraine  
Charles Hawthorne, National Harm Reduction Coalition, California  
Edwin J. Bernard, Global Coordinator of the HIV Justice Worldwide Coalition

**Special Rapporteurs:** Tlaleng Mofokeng (current), Dainius Pūras (former)

### **Moderators:**

Naomi Burke-Shyne, Executive Director of Harm Reduction International  
Dr Adrian Jjuuko, Executive Director of the Human Rights Awareness and Promotion Forum, Uganda

**Organising partners:** Harm Reduction International, together with Lawyering on the Margins Network, Human Rights Monitoring Institute, and the Human Rights Center at the University of Essex.

**Dainius Pūras:** When I started in the role of the mandate, I wondered whether I could really add to my predecessors' work on decriminalisation. But I soon realised that these issues are ever present in public health; criminalisation of same sex relations and gender identity, sex work, HIV, and use of drugs, have a serious negative impact on individual and community well-being, including on children and adolescents. Public health issues are not resolved through detention and deprivation of liberty. So in the end, I had to address these topics, and I wrote thematic reports on various aspects of criminalisation, my country missions included visits to detention facilities, and I also wrote open letters on the subject. In one of these letters I drew attention to an argument used in support of the War against Drugs, which promotes a zero tolerance approach, often in the name of protecting children. However, history and evidence shows that the negative impact of repressive drug policies on children's health and healthy development often outweighs the protective element behind such policies. The theme of children is also quite painfully used again to criminalise LGBTI people, when same sex relationships are conflated with paedophilia.

However, there are champions who are moving forward the agenda on drug use, and also the rights of LGBTI people. When we compare these movements to the early AIDS and human rights movement, people might comment that this is different because there is no remedy we can present to policy makers as you can with public health epidemics. But the answer is, yes, there is a scientific evidence-based treatment—you just have to stop criminalizing and discriminating key populations if you want to stop this epidemic.

**Tlaleng Mofokeng:** It was the frustration of working as a medical doctor that brought me to human rights. A lot of the patients I used to see were unfairly bearing the brunt of failures in the system or unbalanced power dynamics within the health sector and definitely within the consultations with their health providers. Many of them were living in contexts that did not lead to positive health outcomes. As their doctor, I was just giving them a Band-Aid but not really getting to the root cause of their health problems. At the height of the HIV response in South Africa many health systems strengthening activities were about testing, treating, and collecting data. Even with global health programming and funding and philanthropic aid, there was little commitment to the underlying issues, to the root causes of illness. And that was very, very frustrating and prompted my move into policy.

In health, the issue of criminalization is a very obvious big problem, along with stigma and discrimination. Sex workers, who understand about safer sex tools, and want access to them, would be ridiculed and stigmatized in the health facility if they took a whole box of condoms rather than one or two. Younger people, too, know about their rights, about the importance of STI screening, and using contraception. But they too face discrimination because of their age.

Dainius has written a report about the medical and nursing education curricula being devoid of human rights perspectives. So health workers are not providing care that promotes and protects people's rights and particularly the rights to autonomy and bodily integrity.

Neither are health services comprehensive, nor modern contraception available. So my patients have a difficult time navigating life, because by being criminalized, they cannot go and report poor treatment, whether this is experienced in the health or any other sector. As a result, their humanity is not seen. They are not respected, protected, or treated with dignity because of the work they do. I realised if I wanted to succeed as a medical doctor, I had to go beyond diagnostics and treatments and become an activist.

As human rights activists we call on states to respect and protect the right to health as prescribed by General Comment 14, and we must also take into account historical injustices that have led to inequality. We must be honest about the role of colonization, the role of apartheid, the role of, for example, mineral extraction from the so-called Global South, enriching the high income countries in the Global North and how this links to the collapse of public health systems right now in the Global South. Then there are other bigger discussions we should be having at a global level about philanthropy and global health funding and financing that doesn't really bring solutions to the root causes of global health inequities.

I'm proposing that we have to be decolonial in our thinking, in how we design programs and research, and how we use data. Solutions have to be anti-racist because we know that racism reinforces and compounds other injustices. To achieve global health equity we need intersectional frameworks that understand and reflect the complexities of structural discrimination and power dynamics and show how these forces exert themselves onto an individual to make them further marginalized and vulnerable in certain situations, whether it's drug use, sex work, or in adolescent health.

We know the legal frameworks that we must work hard at changing—that continue to criminalize vulnerable people and reinforce inequality and injustice. We need to embed human rights in all policies. All health

workers need human rights training, because if they are not human rights centered in their approach, it doesn't matter what the legislation says, it doesn't matter what policy says, and it doesn't matter how much money goes into health programs: it will not yield the desired outcomes.

**Adrian Jjuuko:** Can you explain the key ways in which criminalization impacts the right to health?

**Judy Chang:** Criminalization across the key populations is rooted in imperialist and colonialist agendas. The legal architectures, which continue in the international drug control treaties, are driving rights violations around the world. The first right to health mandate holder, Paul Hunt, described the international drug control system as existing in a parallel universe to the human rights system. It is vital to point out these inconsistencies and tensions within international law because of their high cost on people who use drugs; criminalization drives people away from harm reduction and health services. We know that people fear arrest simply for possessing needles and syringes when attending health services. The current overdose epidemic, happening around the world, and particularly in North America, is because people cannot predict what is in their drug supply and are literally being poisoned to death. Criminalizing laws harm the people who call emergency services seeking help, which is a disincentive to helping friends or family who overdose. The severe lack of access to quality, affordable health care for people who use drugs is a direct consequence of criminalization.

It's very difficult for a criminalized group to argue for resources and political support. Funding for harm reduction is in crisis and worsening. People who use drugs, particularly women who use drugs, were disproportionately impacted by HIV, hepatitis, and tuberculosis. We won't make any fundamental headway unless we expose the links between criminalization, health, stigma, and discrimination.

COVID has spotlighted social and structural determinants of health, as well as the fault lines of inequity in society. In April 2021, the director of the US Centers for Disease Control declared racism as a serious public health threat. It has also been described as a twin pandemic. There is justification in rethinking the term "criminalization" because of its origins and the way it continues to be weaponized as a tool of racism.

We also need clearer definitions when talking about decriminalization of drugs, and to stop assuming there is only one model. This leads to a misunderstanding that "decriminalisation" anywhere equals progress. We know a number of countries that have removed drug use and possession from criminal laws and placed these matters into administrative sanctions and laws, with associated compulsory drug detention centers, exorbitant fines, criminal records, and prison time. We might assume that as long as we move drug-related activities under the mandate of health, they won't attract punishment. But this is not so.

Decriminalisation is not always a panacea. Without legalization of drugs, there will still be overdose deaths. People remain exposed to violence within a black market. People are still arrested for exceeding minimal quantities. So, decriminalisation should be seen as just a first step towards legalization, which is the goal.

**Charles Hawthorne:** Criminalization impacts on the right to health by re-prioritizing how we move throughout the world and the decisions that we make towards our health. For example, I live in Oakland, California, in an area where there is a large encampment of homeless people, and insufficient services and resources available to meet their needs. And when we interact with Oakland police, the way they see it is: "Well, we need to go and clear out this encampment." It's going to cost tens of thousands of dollars to clear out this encampment and it is much cheaper to just house the people living there. But, criminalization tells us that this isn't about getting people their services. This is about punishing people. How dare they use drugs! How dare they have sex! How dare they exist outside of this capitalist framework!

And so, when we are operating in a criminalized framework, that criminalized framework isn't just about getting arrested and fined. It's about a state of mind, a colonized mind. It's about how we are taught to perceive people who are poor, people who are vulnerable to structural harm, people who use drugs, people who do sex work, people of color, queer people, and trans people; our internal response is that they need to suffer because they are not operating in the world in the way they are supposed to.

Then, instead of trying to make it as easy as possible for them not to be in a difficult situation, resources are withdrawn from them, and this really concentrates the harm. This harm is concentrated in a few specific subgroups, reflecting global anti-blackness and global racism.

Work around intersectionality shows that the people who we're talking about are not from seven different population groups. There are lots of people in this world who are queer trans people who are living with HIV, who use drugs, who do sex work—they are not distinct groups. Criminalisation impacts on all these different overlapping identities, and there are some specific people, everywhere, who are bearing the largest brunt of those harms.

**Participant comment:** In response to Charles' comments about the costs of closing down an encampment, as well as those related to withdrawing services from people needing them, we can share a simple calculation of the criminalisation cost in comparison to harm reduction services provision in 29 countries in the Eastern Europe and Central Asia region: <https://harmreductioneurasia.org/criminalization-costs/>

**Adrian Jjuuko:** What is the relationship between race and criminalization. Do you see any relationships?

**Charles Hawthorne:** The truth is we don't know what race is. But we do know that there are global systems of blackness where, across the world, darker skinned people are always treated worse, are always put more in vulnerable situations, are given less empathy, less sympathy, and less care. We know that Indigenous people have had their land, their resources, their cultures, and their way of life taken from them, forcefully and often violently. And we know that when those when those systems of anti-blackness and colonization interact, people are uniquely vulnerable to harm. Criminalization adds another layer of vulnerability, because it provides a tool to "disappear" people.

It is also a tool of stigma. Stigma is a system that people of power employ in order to remove resources and power from one group in order to advance their own.

When you think about race and criminalization, things don't stay in any specific race, you can't create a policy that really only impacts one race, because there will be larger harms that occur across the community. But the good thing is, on the flip side, when we create policies that are pro Black, when we create policies that support people who are poor, that are supportive of people who use drugs and people who do sex work, those policies lift all of us up.

**Edwin J. Bernard:** HIV criminalization is the unjust use of criminal or other laws against people living with HIV (of which I'm one), primarily on the basis of our HIV positive status, although, as has already been mentioned, we live with HIV in a great range of diversities. So of course, there is an intersectional frame here.

All over the world, there are all kinds of broad and unscientific, HIV specific or general criminal laws, that are used against women and men living with HIV in all of our diversities. These include laws such as alleged nondisclosure of a health condition, or potential or perceived HIV exposure, or for unintentional

transmission. The HIV Justice Network did an analysis, using our global HIV criminalization database, and found about 50 countries that are actively prosecuting individuals under these laws for sexual acts that may or may not risk transmission, as well as for activities like spitting and biting and even breastfeeding. Another 60 countries in the world have HIV specific criminal laws on the books that they do not seem to be using at the moment, but they could be used at any time.

The overarching problem with HIV criminalization is that it moves the personal decision making of people living with HIV away from managing a health condition in an enabling and supportive way. Instead, it becomes a punitive sphere that involves investigations and prosecutions and often severe punishment. This represents a significant threat to the rights and well-being of all people living with HIV, and creates unnecessary additional barriers to HIV prevention and to testing, treatment, and care. As well as being deeply damaging for the people involved in these criminal cases, the impact goes far beyond the courtroom, particularly because of media coverage of HIV criminalization. It demonizes people living with HIV, and perpetuates stigmatizing misconceptions and ignorance about us and how HIV is transmitted. It also undermines messages of shared responsibility for HIV prevention.

**Adrian Jjuuko:** What lessons are there from HIV criminalization that might inform the response to COVID-19 and other disease outbreaks in the future?

**Edwin J. Bernard:** Our experience with HIV criminalization has taught us that laws, especially hastily drafted laws, are likely to be influenced by moral panic and fear, and not guided by the best available scientific evidence, especially when the science is complex and evolving. Unlike HIV, we know the coronavirus can be transmitted easily by casual contact, but like HIV, an incontestable proof of who exposed or infected whom is not possible. So principles of legal and judicial fairness are extremely unlikely to be upheld when a case goes to trial. But just like with the HIV pandemic, lawmakers want to be seen to be doing something and what they know is how to pass laws. So we've been shocked, but really not surprised, to see policymakers turn to criminalization in their attempt to tackle COVID-19.

Laws have a negative impact on public health and human rights. Just as with HIV criminalization, people will avoid being tested to remain ignorant of their coronavirus status. And just with HIV criminalization, singling out people with coronavirus for severe penalties is stigmatizing and makes people living with or even suspected to have coronavirus appear less human than those who aren't infected. Just like with HIV criminalization, it's the most vulnerable, the poor, those already criminalized, and those who are disproportionately policed and prosecuted who will face the long arm of the law. We must keep human rights central to our responses to both of these public health crises, HIV and COVID. They've emerged and are perpetuated by these stigmatizing climates of fear and blame. Communicable diseases are public health issues, not criminal issues. Public health measures that are respectful of human rights, that focus on the empowering of communities, are much more effective than punishment and imprisonment.

**Natalia Isaieva:** When there are different laws that criminalize and persecute different groups of people who do not live or behave according to the norm, it affects the whole society. Because there is more to people than the one part of their life which is considered criminal. Criminalising sex work denies our right to unite with colleagues, to create unions, to create safe conditions of work, to turn to different governmental bodies and fight for our rights, for our rights to health care. I want my rights to be respected. The impact on health is large, because, for example, sex workers never disclose the whole truth about their lives to doctors, because this would result in compromised health services at the medical center.

We see by the experience in New Zealand that legalisation of sex work in 2003 did not lead to more sex workers, and children are not choosing this profession. So I think all choices have to be based on evidence, because otherwise even more harm is going to be done.

**Lucas Ramón Mendos:** I will comment on four key impacts from criminalization of consensual same sex sexual acts.

Firstly, there are at least 68 countries that criminalize consensual same sex sexual acts. ILGA conducted research into the enforcement of these laws and found at least 34 of these countries actively enforce these provisions, proving these are not dormant laws that exist only on the books. This means that people are being arrested, prosecuted, and incarcerated for consensual same sex sexual activity today in all of these countries. And in nearly all of these countries, there is no legal recognition of gender identity which means in most cases, trans women will be incarcerated in male facilities, which increases the risk of sexual violence, intimidation, and harassment. Governments in most of these countries do not provide condoms in prison because that runs counter to their criminalisation of same sex activity. So that's a major issue that intersects with HIV as well as other health concerns.

Secondly, LGBTQ people in these countries have limited access to health care, because of stigma and criminalization. They fear being outed by hostile healthcare professionals, and they face discrimination, violence, and harassment in healthcare environments. LGBTQ people living with HIV, and trans people requiring gender-affirming care, are two vulnerable groups within LGBTQ people.

Thirdly, access to information on sexual health is also a huge concern. Laws that criminalise consensual same sex sexual activity act as a major obstacle to the distribution and dissemination of factual, unbiased information which would help people engage in sexual activity in a safe way.

Finally I want to raise the issue of living in constant fear of being harassed by police and incarcerated under these laws. So the stress contributes to poor mental health.

**Adrian Jjuuko:** We are seeing that even where there's decriminalization, LGBT groups and individuals are targeted, and violated, even without punitive laws. Are LGBT people fighting back?

**Lucas Ramón Mendos:** When countries move on to decriminalization, this does not resolve all of the problems overnight; rather than an arriving point, it is more like the point of departure towards equality. So obstacles that exist on the books are removed, and then we must move forward to seeing change in lived reality for people on the ground. The bad news is that beyond the criminalization of consensual same sex, sexual acts, states have engaged in what we call malicious creativity, to draft laws that are vague and open, that are used by law enforcement to go against LGBT people and other vulnerable groups. We see laws that speak to debauchery, to acts against morality, indecent acts, lewd acts; so you can just put whatever you want into those vague concepts. Once you decriminalize consensual, same sex, sexual acts, then there's a plethora of laws that you also need to deal with in terms of legal issues.

There's also the issue of how you train law enforcers and I welcome the discussion about bringing a human rights framework to the education of professionals.

Although decriminalization should be our number one priority, evidence from other countries suggests that perhaps making progress around non-discrimination and protection against violence could make a greater contribution to the quest for equality.

**Adrian Jjuuko:** What opportunities are there for advocates from and for different community groups to come together to make a case for decriminalization? What are the opportunities for broad based decriminalization?

**Lucas Ramón Mendos:** As Charles said, we are not just watertight compartments and we will definitely benefit from strategies that are multifaceted. We see this clearly in many countries with laws that criminalize consensual same sex sexual acts. They may also have laws that prevent organizations from gaining official status if they are explicit about advocating for sexual and gender diversity when this is seen as criminal conduct. We have learned ways around these barriers by watching organizations working on health and HIV issues achieve registration in various countries. This enables them to receive funds, to gain a voice and to advocate formally.

**Natalia Isaieva:** We have also experienced this in the European region, where groups representing sex workers are unable to register their organizations because the occupation is not legally recognized and it is criminalized. Some organizations that are unable to get registered have gone to court. We look to allies in other countries to seek their support to help us to decriminalize our lives.

**Edwin J. Bernard:** I think Dr Mofokeng's frame of bodily autonomy and integrity is key. For all of us, and for the right to health for people living with HIV, we want the right to access affordable, lifelong HIV treatment. One of the things that has been transformative, is the understanding that people who have access to the treatment can achieve an undetectable viral load. This has led to the U=U Campaign, which has helped to limit the use of criminal law against people living with HIV. But of course, access to viral load testing isn't universal. Our analysis has found that the likelihood of prosecution under HIV criminalization laws correlates to the same groups of people that experience discrimination on the basis of race and ethnicity and migrant status, gender or gender identity, sexual orientation, people in prisons, people who are homeless, and people with disabilities, including mental health issues. All of us who are discriminated against and marginalized are less likely to have access to the very healthcare that would actually render us un-infectious.

The answer is solidarity. It's the bodily autonomy frame, it's the human rights frame. We can't just use science to end HIV criminalization.

**Judy Chang:** Solidarity is, as Edwin has just said, the key to achieving political and social change. We work with other global key population led networks, to push the decriminalization agenda, particularly within HIV political spaces and forums. There is now a target of less than 10% of countries criminalizing drug use and possession, sex work, HIV transmission, non-disclosure, exposure, sexual orientation, and gender identity.

**Anand Grover:** When I took up the mandate, I realized that criminalization was a very important issue to address. And in a sense, we were fortunate that HIV programs allowed us to take up this issue—HIV itself provided a shelter, in the context of which we could take up issues of criminalization of sex work, same sex relations, drug use, and HIV. That shelter is now no longer available, because HIV is seen as an ordinary issue. So, the paradigm in the past was harm reduction, and that led to addressing decriminalisation of sex work, drug use, and same sex relations. Now, without the protective umbrella of HIV reduction, we have to tackle the issues about whether drug use, and sex work, should be decriminalised head on, which is more difficult. It can only be achieved by confronting our adversaries. The UN system is not radical, and it always tries to accommodate the states' point of view.

The second point is that historically, many countries including India and Uganda had not criminalized any of these behaviours until colonisation, when, in India, the British introduced them. And this was replicated through all Commonwealth countries. So the cruel irony is that alcohol, which is a big killer, is legal, but cannabis, which is actually beneficial for so many reasons, is criminalized. These laws are a cultural imperialist imposition, and they have to be removed. Another irony is that much of the West is actually removing these laws, but in India and Uganda we are enforcing them as if they are part of our cultures. And we have to take this head on, because it's plainly wrong to put people in prison. There have been a number of judgments that claim drug use kills so many people. These kinds of myths are perpetuated in jurisprudence, which is

completely wrong. We must fight this, all these issues of criminalization, we have to say criminalization is the wrong strategy and it is better to have a reformative approach. Otherwise, we will be having the same meeting after the next rapporteur takes the mandate! I don't want to see that.

**Participant comment:** There is one issue on which we need to have a strong position from a human rights perspective—the issue of using law on “drug propaganda” against sharing life-saving harm reduction information. Together with Russian organisations we asked about the mandate’s position on this last year. It is now even more repressive, and criminal punishment has been introduced for drug policy discussion and harm reduction information sharing: I am attaching a link to our request for information here: [https://harmreductioneurasia.org/wp-content/uploads/2020/06/Drug-propaganda-submission-to-specRaporters\\_Russia\\_ENG\\_18\\_06\\_2020.pdf](https://harmreductioneurasia.org/wp-content/uploads/2020/06/Drug-propaganda-submission-to-specRaporters_Russia_ENG_18_06_2020.pdf)

**Tlaleng Mofokeng:** Ultimately, what binds us all is our dedication to human rights. When we think about the right to health, one of the recurring questions for me is, whose lives matter? Many of us have been in crisis for a very long time. This is now compounded by COVID-19 but because the pandemic knows no borders, we have seen a global response. But a lot of people such as queer people, gender diverse persons, people of African descent, people with disabilities, migrant communities, have all had to live under crushing weight of prejudice and systemic exclusions for many years, centuries.

In terms of the health-related issues around drug use: I have been really clear and resolute around language use, that when you are saying it's a war on drugs, you are ultimately declaring war on people, and it's usually a war on people's human rights. Any policing will mirror the colonial and slavery types of policing and lead to more prejudice and more exclusion and pushing people further to the margins. How we name things, and the lens through which we look at issues, determines how we respond to them. So the reframing of 'the war on drugs' to harm reduction results in very different discussions.

If we think about the right to healthy work and environmental conditions, we can see how many of the issues we've spoken about today relate to that. Having access to health-related education and information is important because in many parts of the world there is a low health literacy rate, which stops people from partaking in the formal education system and the formal economy. They are then excluded from social, political, economic, and health participation.

I think it's very important as we as we look forward, as we try to survive one of the world's worst crises, to realize that all of us are trying to do our best in a very difficult time and that our mental health is under great stress. Many of us don't take care of our own mental health as we deal with what seem to be more pressing issues. But we need to take care of ourselves in the different ways that we can with the very limited resources that we have, to be able to do this work of defending human rights.

It's very hard, I'll be honest, navigating and balancing our different roles, but it is important in the work that we do, to really develop an understanding of intersectionality. We must recognize intersectional discrimination, because it is important to look at discrimination not only through a race lens. In South Africa when apartheid ended, we thought there would be freedom for everybody. But a lot of the population is still left out of the economy, especially along gender lines. So when you're thinking about underlying determinants of health, we really have look not just at equality, but also equity. The right to health exists along with other rights, to dignity, bodily integrity, safety, and security. I will take this work forward, examining these issues through a lens and an expertise on sexual and reproductive health rights.

But really, it's about working together; all of us across different areas. The way we've worked in the past, in different silos, needs to end because it doesn't really work. We have to share our strategies and our wins, but



be honest about where we are not doing well, and strategize and if we have to go back to the drawing board, we must not think of this as a sign of failure. Sometimes we have to change and be agile.

My vision, my wish, my dream, is that we achieve democratization in the global health architecture. The right to health must find expression in policy, in legal frameworks, but also in practice, because so much happens in practice. Health workers themselves need to be supported in providing services and care that's dignified, that's of quality. They must be included in global policy making and have a seat at these high level tables because they are an integral part of realizing the right to health of everyone.