



**HARM REDUCTION
INTERNATIONAL**

HANDOVER DIALOGUES

UN Special Rapporteur on the Right to Health

A discussion paper on

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

Introduction

A wealth of literature and jurisprudence demonstrates that criminalisation of drug use, sex work, consensual same-sex relations, and HIV transmission not only has a negative impact upon public health but amounts to a violation of the right to the highest attainable standard of physical and mental health.

The evidence demonstrating the negative impact of criminalisation on health is clear and robust. Systematic reviews of evidence have found that criminalisation of drug use (including street-level policing and incarceration) has a negative effect on HIV prevention and treatment, for example by increasing syringe sharing.¹ Criminal penalties related to sex work also negatively impact health, for example by reducing workers' ability to negotiate condom use, putting workers at risk of physical and sexual violence and extortion. This also pushes people engaged in sex work into isolated locations, which disrupts peer support networks and health and social service access.² The criminalisation of same-sex relations drives LGBT people away from health services and puts them at risk of harassment, extortion, and sexual and physical violence.³ Finally, the criminalisation of HIV non-disclosure, potential or perceived exposure, and non-intentional transmission (HIV criminalisation) deters testing by introducing the fear of prosecution and undermines relationships with health and social service providers.⁴ This is compounded by broad definitions of culpability that include recklessness and negligence as well as intention.⁵ In an acutely contemporary echo of decades of such criminalisation, we are now witnessing the same risks and harms playing out, following efforts to criminalise or penalise exposure to COVID-19.⁶

Marginalised and minority groups are particularly affected by criminalisation and co-occurring and mutually reinforcing structural health inequalities, including those based on race, class, nationality, and gender. For example, transgender people engaged in sex work or who have experience of migration or drug use, face particularly negative health outcomes related to criminalisation due to their layered vulnerabilities.⁷ HIV criminalisation presents greater risks for women. Women may have less negotiating power in the context of HIV prevention, as well as being more at risk of prosecution when HIV exposure is criminalised. Women living with HIV (who are more likely to know their HIV status than men) may face a double threat of criminal prosecution and intimate partner violence. All of this deters disclosure of HIV status further, and therefore puts women at greater risk of prosecution and negative health outcomes.⁸

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Criminalisation's impact on the right to health goes beyond direct impacts on physical health and access to healthcare. It has health consequences that transcend individuals and cross generations. For example, people with a history of incarceration may be restricted to low-paying or low-status employment, and may be limited in their ability to access social assistance.⁹ Research shows the intergenerational negative impact of the incarceration of parents on families, including consequences for social inclusion, educational attainment, housing status, and, ultimately, health.¹⁰ These effects are concentrated in social groups that are more likely to experience incarceration, reinforcing pre-existing health inequalities related to race, nationality, and socio-economic class.

Criminal frameworks disempower criminalised groups and undermine their ability to organise. This reduces the health-promoting potential of solidarity and mutual support. For example, when sex work is criminalised, workers have less power to negotiate a safer work environment and wages.¹¹ It also undermines the mental health promotion that can be fostered through mutual support networks.¹² Community empowerment-based responses that enable sex workers to take collective ownership of programmes have reduced HIV transmission and increased condom use, but criminalisation of sex work prevents such activities.¹³

Though developments are slow and incremental, the overall trend worldwide over the course of the past three decades is towards decriminalisation. This is evidenced by organisations mapping national or sub-national policies, such as [Release](#), [Talking Drugs](#) and the [International Drug Policy Consortium](#) (on drugs), the [Institute of Development Studies](#) (on sex work), the [HIV Justice Network](#) (on HIV criminalisation), and the [International LGBTI Association](#) (on same-sex relations).¹⁴ This mapping also demonstrates the diversity of what is termed decriminalisation, and the extent to which different conceptualisations of decriminalisation can mitigate the harms described above. For example, in some cases reforms amount only to depenalisation, removing punitive measures while maintaining elements of prohibition and mandatory rehabilitation or probation.¹⁵ The term decriminalisation can also include regimes that impose administrative sanctions, such as fines or the removal of licenses, which can be as burdensome as custodial sentences.¹⁶ With regard to sex work, some jurisdictions, such as Sweden, have decriminalised the actions of sex workers while continuing to criminalise their clients. However, a systematic review has found that any criminalisation of sex work is associated with barriers to health.¹⁷

Decriminalisation is not a 'silver bullet' that addresses the barriers to health for affected populations, especially if it is not implemented using human rights-based approaches. It must be accompanied by efforts to empower, and de-stigmatise, previously criminalised populations, because even after legislative change, de facto criminalisation, stigma, and discrimination continue. For example, in China and Vietnam, drug use is primarily considered an administrative infraction rather than a criminal offence but widespread use of compulsory drug detention centres continues.¹⁸ There are similar concerns around the use of drug courts, primarily in the Americas.¹⁹ Even in Portugal, globally praised for its drug decriminalisation programmes, people who use drugs continue to face stigma, fines, and 'dissuasion committees'.²⁰ Decriminalisation must be full and inclusive, and must be accompanied by efforts to address the negative health and social consequences of criminalisation.²¹

Interventions under previous Special Rapporteurs

- *Incarceration impacts on health across generations*

Decriminalisation has been a consistent recommendation in the reports of several Special Rapporteurs. In his open letter to the UN Office on Drugs and Crime during the 2016 UN General Assembly Special Session on the Drug Problem, Dainius Pūras highlighted the ineffectiveness of criminalisation in "delivering health benefits or deterring drug use [as] now well established by evidence-based research."²² He emphasised that

incarceration driven by criminalisation has lifelong health consequences “for the entire family related to criminal records, including barriers to access to social services and employment.”²³

Reporting in 2017 on people deprived of liberty, Pūras wrote in relation to drugs, sex work, same-sex relations, and HIV status that “punitive legal frameworks and public policies that make incarceration likelier hinder the realisation of the right to health.”²⁴ He referred to prison itself as “a determinant of poor health as a result of poor conditions of detention, the provision of health care under surveillance and/or a lack of access to health care.” In his report on the right to mental health in 2018, he wrote that criminalisation is a “structural factor that consistently puts some groups in a vulnerable situation” and has a “corrosive [psychosocial] impact.”²⁵ During the COVID-19 pandemic in 2020, he emphasised that people who use drugs face unique needs and risks and must be recognised as a high-risk group in the context of the pandemic.²⁶

- ***Law reform needed over transgender identities and same-sex relations***

Calls to move away from criminalisation of drug use, sex work, consensual same-sex relations, and transgender identities have also been made by other special procedure mandate-holders. For example, in his report to the UN General Assembly in 2017, the UN Independent Expert on protection against violence and discrimination based on sexual orientation and gender identity recommended that states reform laws, policies and practices that criminalise transgender and consensual same-sex relations.²⁷

- ***Compulsory treatment is a human rights violation***

In 2010, the second Special Rapporteur on the right to health, Anand Grover, reported that criminalisation of sex work, same-sex relations, and HIV transmission negatively impacts the right to health, and that “decriminalisation is necessary in response”.²⁸ In the same year, he observed that the “excessively punitive regime” of drug control had “not achieved its stated public health goals”, and that “harm reduction and decriminalisation would improve the health of people who use drugs and the general population.”²⁹ In particular, he emphasised that some of the “most egregious violations of the right to health” have occurred in the context of compulsory treatment for drug dependence, a form of treatment which amounts to the denial of medically appropriate health care and “disregards the need for informed consent.”³⁰

- ***Denial of access to harm reduction services is cruel, inhuman and degrading treatment***

Existing policies and practices make people who use drugs and people living with HIV vulnerable to imprisonment. In his 2009 report, UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment highlighted his concern on denial of access to treatment, including to harm reduction and HIV services in prison constitute a form of cruel, inhuman and degrading treatment.³¹ He added that “drug dependence should be treated like any other health care condition”.

National politics vs human rights?

Decriminalisation of drug use, sex work, same-sex relations, and HIV transmission is now recommended by most UN bodies. This includes Special Rapporteurs on health and other special procedures,³² as well as the UN Common Position on Drugs, endorsed by the Chief Executives Board for Co-ordination which represents all 31 UN agencies including the UN Office on Drugs and Crime, the World Health Organization, and the UN Development Programme.³³ The latest Global AIDS Strategy, adopted in March 2021, emphasises the importance of decriminalisation in addressing HIV and includes targets for its implementation.³⁴

Despite this high-level call for change, significant political and institutional support remains for law enforcement and the criminal justice system to address drug use, sex work, same-sex relations, and HIV transmission. To understand why the human rights imperative of decriminalisation has not translated into national-level reform requires an interrogation of the social dynamics that shape criminalisation.³⁵ Criminalisation has been used as a proxy to target and disempower Black, Brown and Indigenous people, people living in poverty, people with experience of migration, and people experiencing mental health issues.³⁶ For example, in the United Kingdom, Black people are disproportionately stopped for drug-related searches, and in the United States, they receive disproportionately long custodial sentences.³⁷ In the United Kingdom and South Africa, research shows that undocumented migration status robs women engaged in sex work of recourse to the law when they are exploited,³⁸ while in Canada, indigenous women are more likely to be street-based sex workers, putting them at a greater risk of violence. Current statistics also show that indigenous women are overrepresented in HIV new infections.³⁹ The criminalisation of drugs and sex work also exacerbates the persecution of people living in poverty, particularly people living in informal settlements or experiencing homelessness, as documented in Australia, Brazil and Chile.⁴⁰ Importantly, this targeting applies most acutely to those with intersecting vulnerabilities, whether those who belong to more than one criminalised community or those who come from otherwise vulnerable or marginalised groups.

A human rights-led approach to decriminalisation requires that states do not simply replace criminalisation with medicalisation. For example, the response to the crisis (or even “epidemic”) of opioid overdose in the United States has included a medicalised response that increases state control and pathologizes and disempowers people who use opioids.⁴¹ Practices that raise human rights concerns include the supervision of consumption of opioid agonist therapy, ‘diversion’ schemes that redirect people from the criminal justice system to the medical system, and the rise of medical technologies such as long-acting opioid antagonists which, when implemented via criminal justice systems, increase the risk of loss of bodily autonomy for periods of weeks or months.⁴²

The present experiences of people who use drugs echo a long history of pathologizing non-heteronormative behaviours and identities worldwide, which continues both formally and informally, for example in the form of “conversion therapy” for LGBT persons.⁴³

Using human rights mechanisms to challenge criminalisation

Criminalisation, stigma, and discrimination, violate the rights of marginalised and minority groups, and negatively impact the physical, mental, spiritual, and social health of these groups. Efforts to promote health should not only guarantee access to health services, but also respect and protect freedom, bodily autonomy, and dignity.⁴⁴

International human rights acknowledge people as rights-holders, and states as duty-bearers. This means states are under an obligation to protect and promote all human rights, including the right to health of people who use drugs, sex workers, LGBT people, and people living with HIV. Human rights have monitoring and evaluation mechanisms through which states can be held accountable for these obligations.

Human rights mechanisms at international, regional, and national levels can be used to draw attention to violations and to promote change. For example, over the last two Universal Periodic Review cycles (from 2006 to 2017), 50% of states received a total of 346 recommendations concerning HIV and human rights. Of these, 91% were accepted, and more than 50% of those have been at least partially implemented.⁴⁵

However, over the same period, no recommendations were made on the harms of criminalisation of HIV transmission, and only 37 were made about people who use drugs, sex workers, and LGBT people.⁴⁶ In a small number of cases, UPR recommendations resulted in changes to criminalisation, including the decriminalisation of homosexuality in Palau (in 2014) and in the Seychelles (in 2016).⁴⁷

Human rights obligations have been used to challenge criminalisation in states. For example, the 2016 decriminalisation of same-sex relations in Belize came after a Supreme Court ruling that criminalisation violated constitutional rights to dignity, privacy, freedom of expression, and freedom from discrimination.⁴⁸ In 2019, the Constitutional Court of Colombia removed the section of the criminal code that criminalises HIV and hepatitis B transmission, ruling that the law violated the principles of equality and non-discrimination, as it singled out people living with HIV, stigmatising them and limiting their rights.⁴⁹ In December 2020, Bhutan decriminalised consensual same-sex relations by amending its Penal Code to clarify that homosexuality between adults shall not be considered unnatural sex. One reason for this amendment was that the criminalisation of same-sex relations represents a barrier to accessing to HIV treatment for the LGBT community.⁵⁰

- *Role of civil society*

A strong and united civil society strengthens the use of human rights mechanisms. The decriminalisation of sex work in New Zealand in 2003 is an example of successful cross-community mobilisation that brought together sex worker activists, Christian associations, feminist organisations, AIDS foundations, and supportive members of parliament.⁵¹ It is vital that efforts to use human rights mechanisms to overcome oppression advance the principle of by-and-for leadership. That is, human rights advocacy for marginalised groups must be led and carried out by the group itself for its greater good.

Collaboration between local, national, and international civil society is also valuable. Decriminalisation challenges and opportunities have been experienced throughout the world, providing civil society everywhere with lessons to draw on, including through the Concluding Observations of the Treaty Bodies and the country reports of the special procedures. Indeed, in the example above from Belize, the court decision decriminalising same-sex sexual conduct referred explicitly to rulings elsewhere, including in South Africa, the United States, and the European Court of Human Rights.⁵²

Finally, de jure and de facto decriminalisation should not be the end goal when re-thinking criminalisation. Decriminalisation reforms law and law enforcement practices, but human rights approaches require the empowerment of people who use drugs, sex workers, LGBT persons, and people living with HIV to claim their right to health entitlements.⁵³

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