FWLD is an organization which is working on law and policy intervention focusing on human rights issues. Organization is working on protection and promotion of human rights through its advocacy and legal and policy interventions. along with working for enabling women, children and other marginalized and disadvantages group of the society including HIV and MARPs by using laws as instruments of social change for equality and to encourage them to participate in the development process.

FWLD in collaboration with National Centre for AIDS and STD Control (NCASC) and the POLICY Project Nepal conducted a study on "HIV/AIDS and Human Rights: A Legislative Audit" in accordance with the UN International Guidelines on HIV/AIDS and Human Rights. The purpose of the study was to identify the gap between international obligations and national practices in addressing HIV and AIDS issues. Based on the findings of the study, separate model umbrella legislation "HIV and AIDS (Prevention, Control and Treatment) Bill" in collaboration with HIV and AIDS and MARPs group and other stake holders. Apart from this, FWLD is also working on issue of HIV and WIPR, HIV and VAW, HIV and Trafficking and other related issues. FWLD also filed PIL cases at Supreme Court and recorded various milestone on gender issue and HIV issue separately. FWLD also providing free legal aid services to HIV infected and affected person and MARPs group through its Legal Aid Cell on Stigma and Discrimination.

Issues that forwarded by Commission

Laws and practices that effectively criminalize people living with HIV and vulnerable to HIV;

a. **Rape offender with HIV will be punished more**: No 3A, Chapter on Rape, Country Code 1963 state that any person commits rape with any women having adequate information of being HIV positive, shall be punished with additional one years along with punishment stated on 3 No and 3 A No. (Proposed Rape law (of the Criminal Code, 2010 also have same proposition).

b. **Homosexual may punished under Unnatural sexual**: No 1 & 4, Chapter on Bestiality Country Code 1963 state that unnatural sexual intercourse as an offence providing imprisonment up to one year for such act. However there is not any definition of "unnatural sexual", however there is undefined understanding that homosexual activities also fall on this provision.

c. **Drugs users may imprison for their drugs use**: Under Narcotic drugs Control Act, drugs users can be punished with sentence if they are found guilty of using drugs. Section 4 of the Act provides to consume any kind of narcotic drugs including cannabis. Further, consume of cannabis shall be punished with an imprisonment for a term up to one month and for other narcotic drugs it will be up to one years.

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2. Section 14 (1)(a); (e) (h) of Narcotic drugs Control Act.
However if he or she shall undergone for treatment to get rif off from drug, such punishment may not be imposed on the

**d. Sex workers and homosexual being harassed by Administration:** Even there is not any law which criminalized sex work, and homosexual, they are being tortured and prosecuted in that ground justifying maintaining peace in public places and they are arrested from massage centers, hotel and lodges or restaurants. The Some Public (Offence and Punishment) Act 2027 (1970) has prohibited the acts of violating peace by using obscene words, language, gestures or acts of demonstrating obscenity in public places.

**Laws and practices that mitigate or sustain violence and discrimination as lived by women; Law that mitigate violence and discrimination**

**a. Right against violence and exploitation:** Interim Constitution of Nepal has guaranteed rights against violence and exploitation. Article 20 of the Constitution reserved special rights related with women which include not to be discriminated against in any way on the basis of gender and right against physical, mental or other form of violence against any woman and it also such act punishable by law. Further Article 29 also protect right against exploitation which include not to make subject of any exploitation in the name of custom, tradition and practice, or in any other way. This Article also prohibits to make be subjected to human trafficking, slavery or bonded labour which may also many time increase risk of HIV. Further this article also prohibits any kind of forced labour. In Nepal, there are many instance that women are been forced to work as sex work or other harmful practices.

**b. Law against Domestic Violence:** Domestic Violence Control Act 2008 of Nepal is one specific laws which is enacted to control violence related with domestic relationship. This Act has aim to control and punish all kind of domestic violence related offences which may occur any person. major specialty of the Act is delegate various duties to local authorities and local policy to handle issues strictly, victim can directly file case at the court, system of shelter and interim protection including compensation is well covered. However, due to lack of implementation strategy, this Act is not much being effective to curb the violator or perpetrator.

**c. Confidentiality Guideline of SC.** Writ petition filed by Sapana Pradhan Malla on behalf of FWLD, Supreme Court issued directive order to Government of Nepal to make a law including the rights and duties of the concerned parties and maintain the level of privacy as prescribed in some special type of lawsuits in which victim women or children or HIV/AIDS infected persons are involved as a party to the case right from the time of registration of the case in the police office or its direct registration in a law court or in other bodies till disposal of the case.

At the same time, Supreme Court also issued guideline on The Procedural Guidelines for Protecting the Privacy of the Parties in the Proceedings of Special Types of Cases, 2064 (2007) for the interim period till to enactment of law.

**d. Punishment for force sex work:** Trafficking in person and Transportation (Control) Act, 2064 has prohibited for causing to be engaged in prostitution by receiving or not receiving any kind of benefit and make punishment up to Further this Act also enlisted various act as a crime which was committed

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1. Proviso of Section 14 (1)(a); (e) (h) of Narcotic drugs Control Act.
2. Section 4 (d) of the Trafficking in Person Act 2007 only criminalized client of sex worker with imprisonment up to 3 months.
4. Writ No 3561 of 2063 BS, Decision Date 2064/9/10 BS, SCB ( Special Issue) Magh.
5. Section 4(b) of the Trafficking in person and Transportation (Control) Act, 2064” (2007 A.D.).
with the propose of causing to be engaged in prostitution or exploitation of any human being including women. 

**e. Additional imprisonment for unnatural sexual with girl child:** No. 9 A of Chapter on Rape of Country Code, any unnatural sexual intercourse with any minor is deemed to be considered as an offence of rape and punishable with imprisonment of up to additional one year, in addition to the punishment set forth for an offence of rape.

Laws and practices that sustain violence and discrimination as lived by women

FWLD continuously auditing Nepalese laws and regulation and reviewing various discriminatory provisions against women. As per updated on 2009, there are still..... discriminatory provisions, some of key finding are below:-

a. **Laws still discriminate Women on Citizenship Rights:** Interim Constitution of Nepal provides equal right to mother to transfer citizenship for her child. However practice is discriminatory. Administration never provide citizenship to citizens through mother such person. More over, Constitution directly discriminate women to provide citizenship to her spouse as it allow woman of foreign nationality who is married to a Nepali citizen may acquire naturalized citizenship.

b. **Bigamy still allowed for husband:** Chapter on Marriage of the Country Code still allow men for bigamy on certain conditions. This is also one of the major cause of violence against women particularly domestic violence.

c. **Married women are not entitled to get share:** Chapter of Share Partition of the Country Code does not provide married daughter to inheritance properties as like unmarried daughter. Article 1 of the CEDAW strictly prohibits to discriminate between women even in any status.

d. **Punishment On Marital rape discriminatory:** Prevailing laws on marital rape only provide 3-6 month imprisonment while other rape offender use to get minimum 5 years imprisonment. In Meera Dhungana's case, Supreme Court also asked government to review this law.

e. **Harmful practices:** In Dil Bahadur Bishwokarma's case, Supreme Court of Nepal issued directive order to Government to make laws to eradicate harmful social practice i.e. Chaupadi. However, after 5 year of court’s order, there is still same practices is continued.

Laws and practices that facilitate or impede HIV-related treatment access;

i) **Laws and practices that facilitate HIV-related treatment access:**

a. **Right to basic health services:** Interim Constitution has ensured that right to basic health services free of cost from the State as provided by law. as per this constitutional guarantees, Government also implemented various plan and policies which also cover HIV and related treatment including Nepal Health Sector Plans, periodic National HIV Strategies and supporting documents etc.

b. **Draft HIV Bill’s provision on treatment, care and support system:** Draft HIV Bill has various

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8 Section 4(2) read as: - (2) Any person who commits the following act shall be deemed to have committed transportation of person:-

3) taking a person to a foreign country with the purpose of selling or buying,

(b) taking by separating from the house, place or person of abode or having control over or keeping with him/her or harboring or taking from one place to another place within Nepal or to a foreign country or handing over to somebody a person by enticement, allurement, misrepresentation, fraud, deception, force, coercion, abduction, taking hostage, taking benefit of vulnerability, making unconscious, abusing post or power or alluring, causing fear, giving threat or coercing the parent or guardian, with the propose of causing to be engaged in prostitution or exploitation.

9 No. 9A of the Chapter on Rape of the Country Code, 1963.


12 No. 1B of the Chapter on Share partition of the Country Code, 1963.

13 Writ No. 064-0035 of 2063 BS, Decision date 2065/3/26 BS

14 Writ No. 3303 of 2061 BS, Decision date 2062/1/19 BS

provision which guarantees treatment facilities, health promotion and protecting materials.

ii) Laws and practices that impede HIV-related treatment access:

a. HIV infected may put in isolation: Contentious Disease Control Act 2020 (1963) has provision which state that if any person or group of persons is suspected or likely to be suffering from an infectious disease Government can issue any order to be applicable to such person or group of people requiring them to be referred to a hospital or other separate places to inspect or control spread of infectious disease.\(^\text{16}\)

b. HIV infected may put in isolation in Prison: Prison Act It is also provided that the infected person may be kept separately in any place or hospital and he may be controlled to walk and travel\(^\text{17}\). Since this Act has not made clear that which diseases are included in the definition of infectious diseases, it is not clear whether persons suffering from HIV/AIDS may be segregated and kept separate under the order.

c. Hotel Room may not available for HIV infected: The Hotel Management and Liquor Sales and Distribution (Control) Act: This law has provided that must be accommodated only to persons who are not infected by any disease, thus, persons suffering from infectious diseases are discriminated against.\(^\text{18}\)

iii) Issues of law and HIV pertaining to children.

a. Right against Exploitation: The Interim Constitution of Nepal, 2007\(^\text{19}\) has safeguarding the children from any kind of exploitation including physical and mental or be engaged in any other hazardous work. This Article also provides right to receive special privileges to all helpless, orphaned or mentally retarded children.

b. Right to have basic Health and Social Security: Interim Constitution also provides children to get basic health and security\(^\text{20}\). Further, this Article also provides rights to be nurtured to all children of the country. Children Act 2048 (1990) also provide obligation to parent to make arrangements of Child and to provide health care facilities also with education, sports and recreation facilities to the Child according to the economic status of their family further this Act also has provision to make state obliged arrange proper health care to the pregnant mothers and the mothers who have recently given birth to a Child.

c. Consensual sex with minor is Punishable: The Chapter on Rape of the Country Code has provided that a sexual intercourse with any girl below the age of sixteen whether with or without her consent shall be deemed to be a rape\(^\text{21}\). Further this Chapter also criminalized any kind of unnatural sex with minor and arranges imprisonment of up to additional one year, in addition to the punishment referred at prevailing laws and also Court can issue order offender to make reasonable compensation to such minor.\(^\text{22}\)

d. Protection from immoral acts: Children Act also prohibit to use or involve children in immoral acts and should take or cause to be taken photograph with an intention of involving them in immoral profession or publication of such photographs\(^\text{23}\). The Act also provides for punishment for a person who commits such an act and compensation to the child.\(^\text{24}\)

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16 Section 2 (3) of the Infectious Diseases Control Act, 2020 (1963).
17 Section 6(1)(e) of the Prison Act, 2019 (1962)
18 Section 5(1)(b) of the Hotel Management and Liquor Sales and Distribution (Control) Act, 2023 (1967)
23 Section 16(1) of the Children’s Act, 2048 (1991)
e. **Child Marriage is strictly prohibited:** Country Code strictly prohibit marriage of any person below 18 and provide imprisonment up to three years\(^{25}\).

Apart from these laws, there are many policies which have provisions related to children and HIV issue.

National HIV Strategy 2006-2011 have following provision: under Strategy 5.4 of pediatric care which Including Orphan and vulnerable children also provide activities to improved access of children living with HIV/AIDS to quality care, support and treatment and ensure that at least 15% of people receiving ARVs are children. It also has strategy to strengthen capacity of government and partners to provide pediatric ART services and improved access to and management of drugs and diagnostic supplies, including pediatric formulations and early infant diagnosis. This Strategy also has activities for social safety net to support OVC established. Apart from this, this strategy also one strategy expands and strengthens prevention of mother to child transmission program.

**Positive initiatives:**

**Progress of HIV Bill:** After National Auditing of law and polices from HIV and AIDS and Human Rights perspective based on international human rights instrument along with UN guideline, FWLD, with support of various NGO and stakeholders drafted HIV BILL on 2003 AD. Since then, all concerned stakeholders are continuously advocating for enactment of the same. At the end Bill has been taken by HIV and STI Control Board of Government of Nepal. This board has improved with incorporation of detailed institutional mechanism. The Bill is now in final stage at Ministry of Health to register the Bill at Parliament.

**Forum of APLF in Parliament:** 5 leaders of Asia Pacific leaders Forum are now in the parliament of Nepal. They also formed a informal caucus for necessary discussion on HIV and related issue and also working as policy leaders on the issue.

**Parliamentarian those are APLF leader:**

1) Hon'ble Sharad Singh Bhandari
2) Hon'ble Sapana Pradhan Malla
3) Hon'ble Rajendra Khetan
4) Hon'ble Gagan Thapa

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**Public-Criminalisation of MSM**

The Pacific Sexual Diversity Network (PSDN) was formed in 2007. The network reaches across the Pacific region and is comprised of organisations and projects working with MSM and transgender people, especially in relation to HIV/AIDS. It coordinates regional communication, capacity development of men-who-have-sex-with-men (MSM) and transgender organisations, and advocacy and representation on behalf of Pacific MSM and transgender people. Currently, the network has members in Samoa, Fiji, Papua New Guinea, Tonga, Vanuatu and the Cook Islands.

The PSDN thanks the Global Commission on HIV and the Law for this opportunity to contribute to current debates in the Pacific context. It is true that much work must be done if we are to prevent the spread of HIV and address the health, legal and social issues facing Pacific MSM and transgenders. Please note that we are happy for this to be a public submission.

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The criminalisation of consenting adult homosexual activity is recognised as compromising HIV prevention, care and support among MSM and transgenders, as well as undermining effective national HIV/AIDS responses generally. International guidelines identify the existence of sodomy laws as an impediment to HIV/AIDS education and prevention work. The Pacific Regional Strategy for HIV and other STIs 2009-2013 recognises that confronting HIV/AIDS requires affirming and inclusive legislative frameworks.

Two of the key challenges to addressing HIV/AIDS in the Pacific region identified by the strategy (the need to deal with vulnerable groups, and the need to address stigma and discrimination), are exacerbated by criminalising MSM and transgender people. The existence of criminal laws fuels epidemics among MSM, transgender and other vulnerable groups in a number of ways. First, it prevents people who are part of these groups from accessing the necessary sexual health and other HIV-related support services, for fear of imprisonment and other forms of criminal punishment. Second, it sends a strong message to society that stigma and discrimination is condoned by the state. At the very least, this restricts health services from engaging with MSM and transgenders, and at worst leads to higher rates of public and private violence being committed against MSM and transgenders. Last, being labelled a criminal from behaviour can have a detrimental impact on self-esteem and mental health of some MSM and transgenders. In some cases, this may lead to some people placing themselves at greater risk of being infected with HIV, by not feeling confident enough to insist on the use of condoms during sex for example.

Throughout the Pacific, all countries retain colonial era laws that criminalise consenting homosexual activity and threaten sexual minorities with imprisonment for periods of years. The exceptions to this rule are the Federated States of Micronesia, Vanuatu and the Marshall Islands, all of which have no specific legislation in this area, and the French-speaking territories where homosexuality is decriminalised.

These laws not only make providing effective HIV prevention, testing, care and support to MSM and transgenders more difficult. They also undermine the ability of MSM and transgenders to raise grievances with the police or through the legal system. They make MSM and transgenders legitimate targets of violence, harassment and blackmail with no recourse through the law.

In some Pacific countries, there is a degree of recognition that local culture is contradicted by laws that criminalise consenting adult homosexual activity. In Samoa for example, indications from authorities suggest that these laws are unlikely to be enforced as they conflict with Samoan recognition of fa'afafine as an accepted part of the community. However, even the existence of these laws institutionalises the illegality and exclusion of MSM and transgenders and endorses discrimination against them. The inconsistency between traditional values and colonial era laws is present in a number of Pacific countries.

In other countries, more pronounced legal contradictions exist, often because of relative progress in law reform. In 1998 Fiji became one of the few countries in the world to recognise in their constitution the rights of sexual minorities to live without discrimination. However, Fiji’s laws criminalising consenting homosexual activities remain in place, in part due to the concerted campaign launched by the Methodist Church in that country which included calls by the Church for sexual minorities to be put to death and public rallies against same sex marriage even though no such call had been made.

When the Pacific Sexual Diversity Network or PSDN was formed in 2007, The Tonga Leitis’ Association(TLA), Fiji and Samoa were the founding members of the Pacific Sexual Diversity Network. This year’s Miss Air NZ Galaxy in Tonga was significant, as it is the year the Tongan Leiti’s Association launches their Strategic Plan for 2010 – 2015. The TLA’s Strategic Plan is based on recommendations from the PSDN’s advocacy report. This plan testifies a vision, which is; together we will achieve a Kingdom without STI’s and discrimination. This is an interesting vision as STI’s and discrimination are very much part of Tonga’s society today. Discrimination is not only against the leiti community, but against the education and promotion of awareness regarding STI’s and
people living with STI’s or HIV and AIDS. This discrimination may be partly ignorance, that is, that some members of Tonga’s society are ignorant enough to assume that STI’s and HIV and AIDS will not make its way into their lives.

As the TLA Patron mentioned in her Speech at this year’s Miss Galaxy “This is far from reality, the Kingdom should come to terms with the fact, that it doesn’t matter who you are, what sexuality you are or how old and healthy you are, everyone is at risk of contracting STI’s and HIV and AIDS. The strategic Plan being launched tonight has set goals that the TLA want to achieve, and in order to achieve these goals they have weighed out the strengths and weaknesses and their opportunities and threats. All these factors have been brought about, to make the TLA’s vision a reality”.

Decriminalising consenting adult homosexual sex activities is not the only example of law reform that is needed in the Pacific. Including MSM, transgender people and other sexual minorities within anti-discrimination laws is also urgently needed. These additional measures are especially important because of the high levels of violence, stigma and discrimination against sexual and gender minorities in the Pacific.

There is also specific local laws in place in some countries, such as Samoa, that criminalise dressing in the clothing of the opposite sex. These laws, devised in the colonial era to prevent confusion for Europeans, create obvious problems for fa’aafafine, many of whom live and dress as women regardless, and should be repealed.

In closing, the PSDN thanks the Global Commission on HIV and the Law for this opportunity and stresses the need for clear non-discrimination policies which compel governments in the Pacific to provide equal access to government-provided services.

3 China

Yunnan University Legal Aid Center

The Legal Aid Center at Yunnan University commenced operation in October 2009. This submission provides information on some key lessons learned from the first year of the Center’s operation. The Center is the only organization in Yunnan to provide free legal services to people living with HIV and their partners and families as well as to people at risk of HIV, including sex workers, injecting drug users and men who have sex with men (MSM). The goals of the Center are to reduce discrimination and improve the enabling HIV legal and policy environment through the provision of high quality HIV legal services and capacity building.

In the first year of its operation, the Center developed links with local community organizations and government departments (e.g. Yunnan Bureau for Legal Aid Management, Yunnan Provincial Bureau for HIV/AIDS Prevention and Control). Since opening, the Center has provided legal counseling to 139 clients (269 client contacts). The Center organized 360 outreach activities, which comprised group legal information sessions and one-to-one counseling aimed to increase the target groups’ awareness and knowledge of HIV-related legal issues. The Center held a series of legal trainings for peer educators and pro bono lawyers and established access to clients through outreach sites. The Center delivered HIV law training for 30 peer educators and linked with Yunnan Lawyer’s Association to establish the first Pro Bono Lawyer’s Network, which comprises 124 lawyers. The Center delivered HIV law training for pro bono lawyers and law students from Kunming for the first time.

The Center is funded by International Development Law Organization (IDLO) and receives technical support from IDLO and USAID | Health Policy Initiative in the Greater Mekong Region-China implemented by RTI International.

Key lessons:
- People living with HIV and most at risk populations require access to specialist legal aid services for a broad range of issues. Demand for the Center’s services had included in relation to property issues, personal injury, labor issues, privacy, marriage and family issues, inheritance and minimum living standards security.
- Services can be provided through a variety of mechanisms including face-to-face consultation with lawyers and peer counselors, outreach at community sites and telephone advice.

- Fear of disclosure is a major concern of clients. Many are not willing to protect their rights through legal means because they worry about exposing their status to the public. Although few HIV cases are taken to court, the availability of legal information and advice has many practical benefits for clients.

- An enabling legal environment for HIV responses requires investment in legal advice and representation services; training of judges, lawyers and police on HIV and the law; and review and reform of laws and policies.

- The evidence about client’s needs gathered from provision of legal services can inform government policy. In addition to detailed confidential client files, anonymous data can be recorded on an electronic file register to inform advocacy and research efforts.

**Legal issues for drug users**

- According to the Anti-Drug Law, people who are identified as current users of illicit drugs are usually detained for two years, and the detention can be further extended up to one year. As this is a form of administrative detention, if the person concerned does not agree with the decision, she/he may initiate an administrative review or bring an administrative suit. Otherwise this kind of cases is not brought before a court and they have no right to access a lawyer once they are detained.

- Drug users are highly stigmatized and face difficulties obtaining regular work. Some people receiving methadone therapy (MMT) need to ask for a leave to attend their clinic regularly. It is very difficult for them to give an appropriate excuse for going to the clinic at the same time every day. Once they tell their employer they have used drugs, their employers will dismiss them.

- Sometimes police detain IDUs for drug tests near methadone clinics. This discourages drug users from attending for methadone treatment.

- Drug users face discrimination in access to hotel accommodation. Since the police have established a Nationwide IDUs Control System, when monitored IDUs check in to a hotel with their ID card, the police will be alerted. Police than inquire about the IDUs or ask them to receive urine test. This traumatizes those who stay abstinent for years and who are receiving MMT, and discourage them to mainstream into the society.

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I heard of the Legal Aid Center when I was in Changpo Drug Rehabilitation Center. I really doubted whether the Center would help drug users like me. After leaving the Rehabilitation Center, I wanted to receive methadone maintenance therapy, but it was impossible because I could not submit relevant documents. I contacted the Center, and to my surprise, they contacted a methadone clinic for me and even accompanied me to the community where I live to seek their support. As a result of their efforts, which went on for about a week, I finally got registered at a methadone program. My mother was very happy about this. We all felt grateful for the Center’s help.

—Comment from a Center Client

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**Legal issues for MSM**

Once they disclose their identity or their identity is disclosed by others, they will be discriminated against by various communities. The common legal issue for MSM is division of property after breaking up. Their relationship is not protected by the Marriage Law as a couple. Therefore they will have serious problems on
division of property when breaking up.

**Legal issues for sex workers**

In China, prostitution is illegal. Therefore when sex workers’ rights are violated, they will not protect their right in the law courts. For example, if a sex worker is beaten by her client because of a dispute, usually she dares not call the police. Because even though the clients might be punished and she may be compensate for her loss, afterwards the police would impose fines upon her or send her for re-education through labor. Sex workers are unable to do anything if the clients do not pay for them after they provided the service.

Marriage and child rearing: If a man finds out that his wife used to be sex worker after they get married, usually the man will ask for a divorce and not pay for child rearing.

**Employment discrimination laws: Xiao Wu’s case**

On 12 November 2010, Xiao Wu lost a discrimination claim against the education department that denied him employment because of his HIV-positive status. The case was decided by Anqing Yingjiang District People's Court, Anhui province. This was China’s first HIV discrimination court case. The Court found the municipal education department’s hiring process was legal because it abided by the *Standards for Civil Servant Recruitment Medical Testing*. These national Standards prohibit a person suffering from a sexually transmitted disease from working as a civil servant. The decision will be appealed. Xiao Wu is represented by an NGO, the Beijing Yi Renping Center.

The case it highlights the discriminatory nature of recruitment medical testing *for all civil servants in China* as well as teachers.

In upholding the legality of these discriminatory standards, the decision undermines the effectiveness of the Employment Promotion Law, the law enacted in 2008 that purported to make discrimination on the grounds of HIV unlawful throughout China.

The case also has social implications. The outcome will lead to ongoing and further systemic discrimination. The decision feeds into widespread myths about HIV, based on unfounded fears about HIV risk and fitness for work. That is, the case provides legal support for the incorrect view that HIV disease can be transmitted casually. It may also provide support for the view that people living with HIV inevitably become unfit to work due to illness. This disregards the benefits of antiretroviral treatments in preventing progression of HIV disease.

Although national press coverage has been largely critical of the court’s decision the widespread media on the court’s findings have lent legitimacy to institutionalized prejudice and discrimination.

While the case is not finalized and is currently under appeal the publicity surrounding it has major implications for the national HIV response. It will discourage people with an HIV-related complaint from coming forward and using the court system or any other mechanism for redress and gives encouragement to employers and others (for example landlords or hospitals) who practice or allow discriminatory practices.

This decision will negatively impact on HIV programs and activities seeking to work with most-at-risk populations. Most barriers to HIV prevention, treatment and support in China are linked to stigma and discrimination. For example, people are fearful of getting tested for HIV as a positive result may quickly become known by employers, family members and neighbors. Once the result is known, people are at severe risk of loss of employment, housing, denial of health care and being isolated by family and community. This is well known among people living with HIV and others who are at risk. The court’s decision further entrenches this fear and means that those most at risk will now be less willing to come forward for prevention and treatment services.
Yunnan University Legal Aid Center provided advice to Xiao Wu, and is in contact with the Xiao Wu’s lawyers (Yi Renping Center). The Center has also been in contact with Yi Renping Center over a similar case in Szechuan province, which has yet to come before the courts. The two Centers have agreed to collaborate. Yunnan University Legal Aid Center has also briefed international organizations working in Yunnan about the implications of the case.

**Key lesson**

Xiao Wu’s case has highlighted the need for stronger legal protections from discrimination in employment. The lack of meaningful legal protections from discrimination is disempowering for people living with HIV and harmful to the HIV response.

| 4 | Asia-Pacific | International Drug Policy Consortium |

The International Drug Policy Consortium is a network of civil society organisations and other professional networks that come together to advocate for more humane, just and effective drug policies. We work in several regions of the world to promote drug laws, policies and practices that comply with human rights and public health principles, and in particular that create an ‘enabling environment’ for effective HIV prevention, treatment and care. We have extensive experience of working with civil society and policy makers in the Asia/Pacific region, and agree that harsh drug control laws and their enforcement are a significant barrier to the scaling up of HIV prevention, treatment and care programmes in the region.

Injecting drug use is a key driver of the HIV epidemic in Asia as a whole. An estimated 4.5 million people inject drugs in Asia and UNAIDS estimates that around 16% of these are living with HIV, although prevalence is much higher in some countries (Burma/Myanmar has around 38% prevalence, Thailand has between 30% and 50% prevalence)¹.

Laws and practices relating to the control of the illicit drug trade are highly punitive in this region and governments are still committed to make ASEAN drug-free by 2015². This goal underpins a zero-tolerance approach to drug use which manifests itself in a harsh legislative environment that criminalises people who use drugs and reinforces stigma and discrimination towards an already vulnerable and marginalised population group. This repressive approach does not prioritise the health of people who use drugs and presents significant structural barriers to evidence-based harm reduction and drug treatment programmes. There have been some trends in the region to move towards harm reduction in an effort to address HIV in people who inject drugs as can be seen in China and Malaysia, however there are still counterproductive laws and practices which undermine these efforts.

We ask that the Commission considers the following issues in relation to addressing punitive laws and practices that effectively criminalise the lives of people who use drugs in South East Asia³ and calls on governments to address these issues as a matter of urgency.

**The impact of criminalising drug use on HIV prevention, treatment and care for people who use drugs**

**Sentencing and prisons:**
Drug use is heavily criminalised in nearly all countries of the region with the exception of Vietnam which decriminalised in 2009⁴. This level of criminalisation goes beyond the requirements set out in the current UN Conventions on Drug Control. The 1988 Convention does not require punishment for drug consumption while allowing considerable flexibility to Parties when addressing possession for personal use and other offences of a minor nature, explicitly mentioning the possibility of diversion towards treatment and rehabilitation instead of
prison sentences\textsuperscript{5}.

Across Asia, 68% of countries in the region have exceeded the maximum capacity of their prison systems while a total of 28% of countries in Asia have exceeded the maximum prison capacity by more 150% or more\textsuperscript{6}. In Thailand for example it is estimated that there are around 170,000 people in prison and a further 44,000 held in pre-trial detention\textsuperscript{7}. There are estimates that between 60% to 80% of those incarcerated in Thailand are serving time for non-violent drug related offences\textsuperscript{8}.

The criminalisation of drug use and the disproportionate levels of sentencing for drug use offences, results in a high number of people who use drugs, particularly people who inject drugs, being incarcerated in overcrowded prison settings. Prisons are a high-risk setting for HIV transmission. HIV infection rates tend to be higher in prisons than national averages while there is very poor coverage of HIV prevention services, including harm reduction interventions such as needle and syringe programmes (NSP) and opioid substitution therapy (OST)\textsuperscript{9}. The importance and effectiveness of providing HIV prevention, treatment and care in prisons is well documented\textsuperscript{10}.

The high-level of criminalisation places a heavy burden on judicial and penitentiary systems and diverts valuable resources away from effective drug treatment and HIV prevention efforts. Discussions around decriminalisation of drug use and the possession for personal use are very nascent in South East Asia. Advocacy efforts have focused more strongly on the provision of harm reduction services particularly for people who inject drugs and on the issue of compulsory centres for drug users (CCDUs). The capacity of civil society organisations and representatives of affected populations to also challenge unsupportive legislative frameworks needs to be strengthened.

**Diversion and drug treatment:**

There has been a trend in the region to start to recognise that people who use drugs should be treated as ‘patients not criminals’\textsuperscript{11}. Unfortunately in efforts to divert people who use drugs away from the criminal justice system and provide alternatives to incarceration, many governments in South East Asia have adopted a compulsory drug ‘treatment’ model that is more akin to detention and involves very little in the way of evidence-based treatment.

These compulsory detention centres are strongly associated with the arbitrary arrest of people suspected of drug use, who are often detained for unspecified periods sometimes without trial or due process. In many cases the centres are run by security or military forces (such as in Thailand)\textsuperscript{12} without any appropriately trained medical staff. Detainees are subject to forced detoxification, forced labour, military style exercises and other types of ‘punishment’ in the name of rehabilitation. In fact, the human rights violations which are committed in these centres are well documented\textsuperscript{13}. HIV risk in these centres is extremely high due to the lack of harm reduction services (or in most cases any type of health care provision). Governments in the region are becoming increasingly aware that these compulsory detention centres are not an appropriate model but yet seem reluctant to dismantle such centres.

There are some recent efforts by UNODC, UNAIDS and UNESCAP to engage both civil society and regional governments on this issue to seek a way forward. These efforts should be supported by the Commission and in particular holding governments accountable for the contradictory legal and policy contexts in which such centres operate.

**Policies and practices that undermine harm reduction in the community:**

There have been some efforts in the region to scale up the provision of HIV prevention services for people who inject drugs, some form of NSP is available in fifteen countries and OST is available in twelve countries of the
region. Coverage across the region is very poor overall and far below what is required to have an impact on HIV prevalence amongst people who inject drugs.

In addition to poor coverage of such services, the criminalisation of people who use drugs encourages policies and practices that severely hamper access to such services. IDPC has received reports of police harassment to both clients and staff of drop-in centres where NSP and OST are provided in Thailand, Burma/Myanmar, Malaysia, Cambodia and China. This discourages people who use drugs from accessing such services for fear of arrest, persecution and forced treatment. There are a number of initiatives in the region to sensitize law enforcement towards harm reduction practices but progress is slow as the legal framework remains unchanged.

A further issue that has been raised repeatedly in relation to policies that undermine effective HIV prevention via harm reduction services is the requirement for ‘drug user registration’ which is supported by legislation. This requirement is mandatory in many countries of the region.

China, Thailand and Burma/Myanmar all have drug user registration systems whereby information captured often when a person accesses healthcare related to their drug use (OST or NSP). The fear of being placed on registries that are shared with law enforcement and other authorities is a serious impediment to accessing services.

Other legislative barriers relate to the provision of NSP, for example in Thailand and Vietnam, NSPs can only operate underground, unregistered or quasi-legally as legislation prohibits their implementation and in Malaysia and Myanmar the possession of needles and syringes is still a criminal offence. In some countries OST, such as methadone and buprenorphine, are still scheduled as illegal despite being on the WHO List of Essential Medicines and strong evidence to show the efficacy of OST as an effective HIV prevention intervention.

Recommendations:

- The Commission should call on policy makers in the region to treat their citizens who use drugs as ‘patients not criminals’, and focus on their social inclusion and reintegration.
- The Commission should encourage the reform of drug laws and policies to ensure that their enforcement does not undermine HIV prevention, treatment and care for people who use drugs. This includes the harmonisation of public health and drug control laws and policies. The Commission should also encourage dialogue and collaboration between responsible government agencies.
- The Commission should stimulate a regional discussion on the decriminalisation of drug use and possession for personal use.
- The Commission should emphasise the importance of appropriate diversion mechanisms for people who use drugs who come into contact with the criminal justice system and also reinforce the critical importance of providing humane, evidence-based drug treatment for those who require it.
- The Commission should call on governments in the region to prevent human rights abuses in the name of drug treatment, including arbitrary deprivation of liberty, torture, cruel, inhuman and degrading treatment, and violations of the right to health.
- The Commission should support the mobilisation of resources to support drug law reform advocacy and harm reduction implementation. Injecting drug use is the key vector for HIV transmission in South East Asia and investments in HIV prevention should be proportional to the needs and risks across the region.

2 According the ‘ACCORD Plan of Action’.
3 For the purposes of this submission, South East Asia will comprise Thailand, Malaysia, Burma/Myanmar, China, Vietnam, Laos and Cambodia.
4 This has still been problematic. Drug use is no longer a criminal offence but is still considered a ‘social evil’ that constitutes an administrative offense. In such cases, access to due process is virtually non-existent. Those caught or suspected of drug use are no longer subject to criminal justice procedures but in many cases are detained in compulsory centres for drug users (CCDUs) often without access to drug treatment, harm reduction and HIV services.
6 ICPS. 2010, Current situation of Prison Overcrowding.
Dear Honorable Commissioners:

I am writing to you today as the Director at AIDS Access Foundation and on behalf of the Thai civil society groups, fighting against the abuse of intellectual property (IP) laws that create barriers to HIV-related treatment access. I have been personally involved in the treatment access campaign for HIV anti-retrovirals (ARVs) in Thailand for over ten years. In that time, Thailand has been a global leader in lawfully using domestic and international IP and trade laws to gain access to more affordable, quality ARVs.

The Thai government accomplished lowering the price of ARVs in part by issuing seven compulsory licenses (CLs) in 2007 and 2008, including for efavirenz and lopinavir/ritonavir. After these CLs were issued, the prices for the ARVs dropped by 50% and 70%. Moreover, the number of Thais living with HIV/AIDS who had access to treatment increased from 6,000 in 2003 to over 160,000 in 2009. More Thais with HIV were also able to afford treatment because ARVs were also included on the Thai Essential Medicines List, meaning that all the Thais covered by the universal healthcare scheme are entitled to ARV treatment for free. Therefore, the CLs issued by the Thai government significantly decreased the prices of ARVs in Thailand (but also globally), and greatly expanded access to ARV treatment for Thais living with HIV/AIDS.

CLs are a legal mechanism that WTO members are allowed to use under the Trade Related Aspects of Intellectual Property Rights (TRIPs) agreement, which governs international IP standards including for patents. Despite the legality of CLs, several pharmaceutical companies and developed countries targeted Thailand for retaliation because of these CLs. One such country has been the United States. In 2007, the United States Trade Representative’s (USTR) put Thailand on its Special 301 Report Priority Watch List (PWL), in part because of the CLs the Thai government issued. Since its inception in 1988, the “Special 301” adjudication of foreign intellectual property law standards has been used to promote policies restricting access to affordable medications around the world. The program requires the USTR to publish a list of countries that deny “adequate and effective protection of intellectual property” and permits the unilateral imposition of trade sanctions against such countries, even in the absence of violation of any trade agreement.

There are many notable examples of the use of the Special 301 program to sanction countries for access to medicines policies that do not violate international trade commitments, including that of Thailand. Moreover,
being listed on the PWL has indeed increased the barriers to accessing medicines in Thailand. For example, in reaction to the listing of Thailand on the Priority Watch List, the new Thai Public Health Minister Chaiya Sasomsab in February 2008 called for a review of the policy that led to the granting of compulsory licenses for the four cancer medications issued in January 2008. Minister Sasomsab cited Thailand’s listing on the USTR Priority Watch List as a main reason for the review of the compulsory licensing review. The compulsory license review order by Minister Sasomsab caused a postponement in the delivery of two million tablets of heart disease drug clopidogrel. The compulsory license for clopidogrel was issued on January 25, 2007, and the Ministry of Public Health delegated the Government Pharmaceutical Organization to commence the importation process on February 12, 2007. In June 2007 the Thai Government Pharmaceutical Organization (GPO) Board approved the importation of two million tablets of clopidogrel from the generic drug manufacturer Kalida. With the review initiated by Minister Sasomsab, Kalida postponed delivery to the GPO because it feared that the original drug maker might sue it if it exported clopidogrel to Thailand. The GPO did not receive this shipment of clopidogrel from Kalida until June 18, 2008 - when the first consignment of 575,000 tablets arrived in Thailand. Minister Sasomsab’s compulsory license review caused a one-year delay in the receipt of the two million tablets of clopidogrel from Kalida, resulting in damages around 248,378,550 baht per month as calculated based on the number of patients who need clopidogrel and the difference in the costs between original and generic clopidogrel.

Moreover, the Thai Ministry of Commerce also made several internal policy suggestions about how to get Thailand off the Priority Watch List. The Commerce Ministry suggested that no new compulsory licenses should be issued, that efforts to amend intellectual property laws (including the Thai Patent Act), by introducing IP rules stricter than the World Trade Organization’s requirements, should be sped up, and that more punitive measures and actions should be taken against IP infringing activities. These efforts by the Thai government to get off the Priority Watch List will lead to greater barriers to accessing medicines.

Therefore, to draw attention to and help combat the negative impact the USTR Special 301 Report has on access to lifesaving medicines here in Thailand, Thai civil society activists came together to submit a complaint to the UN Special Rapporteur on the Right to Health. The complaint requests that the Special Rapporteur respond to information documenting violations of the international right to health by the United States through the operation of its Special 301 program and related trade policies with Thailand. By listing Thailand on its Special 301 Priority Watch List, the United States has used this report and other trade negotiations, Generalized System of Preferences, foreign aid, technical assistance and diplomatic pressure to promote intellectual property and pharmaceutical regulations that restrict access to affordable medications in Thailand. These policies are continuing in the present administration, and cause grave and needless suffering in Thailand. UN Human Rights officials have frequently affirmed that promoting access to medicines in poor countries is a human rights duty of all countries, including of donors and trade partners, and have reviewed country compliance with these mandates in human rights review proceedings. Thus, I am submitting a copy of this complaint for your review and consideration to learn more about the impact of the Special 301 program on access to medicines in Thailand.

I would like to personally thank the Global Commission on HIV and the Law for this opportunity to submit information on our efforts here in Thailand to battle IP laws to gain access to more affordable treatment for HIV/AIDS. Furthermore, I would also welcome the opportunity to discuss this complaint and our other advocacy work on behalf of Thais living with HIV/AIDS in person during your Asia-Pacific Regional Dialogue in Bangkok. Please feel to contact me at nimit@aidsaccess.com if you have any further questions.

| 6 | Thailand | Thai Network of People Living with HIV/AIDS; AIDS Access Foundation; Foundation for AIDS Rights; Thai NGO Coalition on AIDS; Friends of Kidney-Failure Patients Club; Cancer Patient Network; Foundation for Consumers; The Rural Pharmacist Foundation; The |
ALLEGATION LETTER

UNITED NATIONS SPECIAL RAPPORTEUR ON THE RIGHT TO HEALTH

IN THE MATTER OF USE OF THE “SPECIAL 301” PROGRAM, SECTION 182 OF THE TRADE ACT OF 1974, TO LIMIT ACCESS TO MEDICINES IN VIOLATION OF THE INTERNATIONAL RIGHT TO HEALTH

1. In accordance with resolution 2002/31, we, the undersigned Thai organizations, submit this allegation letter to request that the Special Rapporteur respond to the enclosed information documenting violations of the international right to health by the United States through the operation of its “Special 301” program and related trade policies with Thailand.

2. The alleged victims in this matter are the Thai people in need of medicines. This allegation letter is submitted by Thai Network of People Living with HIV/AIDS, AIDS Access Foundation, and Foundation for AIDS Rights, organizations of Thai-based AIDS and human rights activists, people living with HIV/AIDS, public health experts, fair trade advocates and concerned individuals who campaign against policies that deny treatment for HIV.

3. By listing Thailand on its Special 301 Priority Watch List, the United States has used this report and other trade negotiations, Generalized System of Preferences, foreign aid, technical assistance and diplomatic pressure to promote intellectual property and pharmaceutical regulations that restrict access to affordable medications in Thailand. These policies are continuing in the present administration, and cause grave and needless suffering in Thailand. UN Human Rights officials have frequently affirmed that promoting access to medicines in poor countries is a human rights duty of all countries, including of donors and trade partners, and have reviewed country compliance with these mandates in human rights review proceedings.

THE U.S. LISTS THAILAND ON ITS SPECIAL 301 PRIORITY WATCH LIST

4. Despite the Doha declaration, clear human rights duties and the demands of global health, the U.S. has used, and continues to use, its “Special 301” program to pressure Thailand to give up TRIPS flexibilities.

5. One of the central tools used by the U.S. to promote “TRIPS-plus” policies on access to medicines has been the “Special 301” program. The program requires USTR to publish a list of countries that deny “adequate and effective protection of intellectual property” and permits the unilateral imposition of trade sanctions against such countries, even in the absence of violation of any trade agreement. The USTR has listed Thailand on its “Special 301” program Watch List since 2001, and Thailand was elevated to the Priority Watch List starting in 2007 because it lawfully exercised its right to issue compulsory licenses.

6. On November 29, 2006, the Thai Ministry of Health issued a non-commercial, government use compulsory license for the first-line HIV/AIDS antiretroviral (ARV) efavirenz. In January 2007, the Thai government issued two more government use compulsory licenses for the ARV lopinavir/ritonavir, and for the heart medication clopidogrel. Finally, in January 2008, the Thai government issued government use compulsory licenses for four cancer medications: docetexel, letrozole, erltinib, and imatinib.

7. On March 20, 2007, The USTR downgraded Thailand to its “Special 301” Report Priority Watch List. The USTR cited the following reasons for the downgrade: “In addition to these longstanding concerns with deficient IPR protection in Thailand, in late 2006 and early 2007, there were further indications of a weakening respect for patents, as the Thai Government announced decisions to issue compulsory licenses for several patented pharmaceutical products. While the United States acknowledges a country’s ability to issue such licenses in accordance with WTO rules, the lack of transparency and due process exhibited in Thailand represents a serious concern.”
8. In March 2007, Abbott Laboratories Ltd., the patent owner of AIDS drug Kaletra (generic name: lopinavir/ritonavir), reacted to the Thai government’s compulsory licensing policy by withdrawing their drug registration application in Thailand for seven drugs, including Aluvia (a new heat-resistant version of Kaletra), and medicines for treating hypertension, kidney disease, etc. Ralph L. Boyce, who was later the U.S. Ambassador to Thailand, wrote a cable to support Abbott’s action, even he was aware of the adverse health consequences of the drug registration withdrawal.

9. On July 20, 2007, Ralph L. Boyce, the U.S. Ambassador to Thailand, authored a letter to GEN Surayud Chulanont, the Prime Minister of Thailand, opposing the legal and legitimate action taken by the Thai Ministry of Public Health to issue compulsory licenses to address the country’s public health threats. In the letter, the Ambassador claimed that “While all WTO members have the ability to make appropriate use of flexibilities to address urgent situations, these decisions should not be made lightly and only as a last resort.” In this letter, Ambassador Boyce also requested the Thai Ministry of Public Health to involve the patent-owner companies in the decision-making process in an open and transparent manner.

THE U.S. PRESSES THAILAND TO RESTRICT ACCESS TO MEDICINES THROUGH “TRIPS-PLUS” TRADE PRESSURE

10. In reaction to the listing of Thailand on the Priority Watch List, the new Thai Public Health Minister Chaiya Sasomsab in February 2008 called for a review of the policy that lead to the granting of compulsory licenses for the four cancer medications issued in January 2008. Minister Sasomsab cited Thailand’s listing on the USTR Priority Watch List as a main reason for the review of the compulsory licensing review.

11. Minister Sasomsab also cited concerns that the US would further downgrade Thailand by listing it as a Priority Foreign Country when calling for a review of the cancer drug compulsory licenses. The Priority Foreign Country listing is the last and most severe category under the “Special 301” program, with the US subjecting countries in this category to trade sanctions. The Pharmaceutical Research and Manufacturers of America (PhRMA) called for Thailand to be labeled a Priority Foreign Country in its submission on Thailand’s intellectual property rights protection and enforcement to the USTR in February 2009.

12. The compulsory license review order by Minister Sasomsab caused a postponement in the delivery of two million tablets of clopidogrel. The compulsory license for clopidogrel was issued on January 25, 2007, and the Ministry of Public Health delegated the Government Pharmaceutical Organization to commence the importation process on February 12, 2007. In June 2007 the Thai Government Pharmaceutical Organization (GPO) Board approved the importation of two million tablets of clopidogrel from the generic drug manufacturer Kalida. With the review initiated by Minister Sasomsab, Kalida postponed delivery to the GPO because it feared that the original drug maker might sue it if it exported clopidogrel to Thailand. The GPO did not receive this shipment of clopidogrel from Kalida until June 18, 2008 -- when the first consignment of 575,000 tablets arrived in Thailand.

13. Minister Sasomsab’s compulsory license review caused a one-year delay in the receipt of the two million tablets of clopidogrel from Kalida, resulting in damages around 248,378,550 baht per month as calculated based on the number of patients who need clopidogrel and the difference in the costs between original and generic clopidogrel. A recent study revealed that clopidogrel increased life expectancy by 0.55 QALYs as compared with aspirin. In addition, in post-stroke patients, clopidogrel increased life expectancy by 0.17 QALYs as compared with aspirin. Clopidogrel provides a substantial increase in quality-adjusted life expectancy, with the delay in receiving clopidogrel also affecting the life expectancy of the patients along with their quality of life.

14. The Thai Ministry of Commerce also made several internal policy suggestions about how to get Thailand off the Priority Watch List. The Commerce Ministry suggested that no new compulsory licenses should be issued, that efforts to amend intellectual property laws (including the Thai Patent Act) should be sped up, and that more punitive measures and actions should be taken against IP infringing activities. These efforts by the Thai
government to get off the Priority Watch List will lead to greater barriers to accessing medicines.

CONCLUSION
15. The Special Rapporteur for the Right to Health should call on the U.S. to account for its use of Special 301 program and other elements of its foreign policy that encourage and coerce Thailand to adopt intellectual property norms that restrict access to medicines, including access to antiretroviral medicines for people living with HIV/AIDS. The Special Rapporteur should encourage the U.S. to use its trade and foreign assistance programs to promote full use of TRIPS flexibilities and to otherwise revise its foreign policies to promote access to medicines. The Special Rapporteur should call on the U.S. to provide a procedure for the appeal of human rights issues within the Special 301 report, to reverse its unlawful unilateral threats of trade sanctions via Special 301, and to reconsider and reverse the many decisions it has made that violate the right to health of Thai poor people and poor people around the world.

2 Ralph L. Boyce’s cable
3 Letter of Ralph L. Boyce to the Thai Prime Minister
5 Complaint letter by Saree Aongsomwang
7 Letter from Phuangrat Aswaphisit, Department of Intellectual Property, to all agencies in the Ministry of Commerce.

The paper seeks to share the HIV/AIDS response specifically on how the law is improving the lives of People Living with HIV/AIDS and how these people have been discriminated in West New Britain Province, the paper will address some case studies how the communities and families are responding to the fight of stigma and discrimination as of 2010 and on the other hand, the case studies where People Living with HIV/AIDS have been discriminated, neglected from their families.

Limited evidence available suggests that the main factors contributing to HIV transmission in West New Britain are: Heterosexual, unprotected sex, multiple sexual partners, and High levels of untreated sexually transmitted infections. West New Britain is growing rapidly in terms of business and population. This has brought increasing wealth and benefits to the province, but has also optimized social conditions for increased rates of HIV transmission. Papua New Guinea’ s national HIV prevalence among adults aged 15 – 49years is 0.9%, estimated number of people living with HIV at the end of 2009 is 34,100 with (31,000 adults & 3,100 children) number of newly infected people in 2009 is 3,200 1,300 deaths estimated in 2009 from HIV – related illness & AIDS. HIV prevalence is highest in Highlands & Southern Regions (1.02% & 1.17%, respectively) with lower estimates in Momase & New Guinea Islands (0.63% & 0.61%, respectively)

The central role of the West New Britain Provincial AIDS Committee Secretariat (WNB PACS) is to coordinate HIV/AIDS activities in the province, compile and analyze data in order to “guide and know the epidemic” to share this information with the National AIDS Council (NAC), District AIDS Committee (DAC) and local stakeholders and partners, and to use this information to effectively coordinate evidence-based interventions that can be monitored and evaluated for effectiveness. However, the ability of the WNB PAC to deliver on this mandate over the past years has been severely constrained by number of factors.

A variety of HIV/AIDS prevention and education activities including fighting stigma and discrimination are being undertaken throughout the province, a more to limited extent, counseling, care and treatment and testing activities. The main actors are Kimbe General Hospital, Oil Palm Industry Corporation (OPIC), Hargy Oil Palm Limited, New Britain Palm Oil Limited, Catholic Health Services, Anglican Church, Provincial Health, Prisoners of
Hope Lakiemata, Friends and Children’s Foundation, Shepherd Ministry of Hope and several other active and committed local volunteers.

The Independent State of Papua New Guinea has a law on HIV/AIDS; “HIV/AIDS Management and Prevention Act 2003” certified on 20th August 2003. Most of the rural population and which is the majority in West New Britain have not yet put the law into practice. A few years ago there have been number of reported cases on People Living with HIV and AIDS being discriminated, neglected from their families and in public especially in the rural areas because of their HIV positive status, this is a worsening situation paving a barrier to address stigma and discrimination in the fight of HIV/AIDS in the province. However by 2009, some of the companies like Hargy Palm Oil Company among others have formalized and endorsed their company HIV/AIDS Work Policy protecting the HIV positive work force.

Today some companies in the province have got a functioning HIV/AIDS Work Policy. There is also one of the active Community Based Organizations by the names; Friends and Children’s Foundation (FCF). FCF is located and operates in Mosa Local Level Government, dealing with Campaigning against stigma and discrimination and advocating for people living with HIV & AIDS to enjoy their full human rights and enjoyment of their lives, tracking their sexual networks and conduct community education on HIV/AIDS prevention, stigma and discrimination. On 5th October 2010, FCF introduced the HIV/AIDS Management and Prevention ACT 2003 at Mosa Local Level Government and conducted awareness on this law for the first time. Since this event which was participated by a big crowd from all over the location, paved a strong stepping stone for this community and beyond to understanding and recognize the law, over 14 People Living with HIV/AIDS have so far approached FCF to join in responding to fight of sigma and discrimination.

The paper will put in details the HIV/AIDS response activities by the stakeholders in the province, a number of stakeholders are addressing the law to reduce sigma and discrimination and disseminate the law targeting the most rural and remote areas in the province. As the focus for the West New Britain Provincial Committee Secretariat targeting to roll out a number of trainings on Basic Information to HIV/AIDS, counseling and testing including establishing District AIDS Committees to spearhead and coordinate HIV/AIDS activities at the district level.

INTRODUCTION: Who, What & Where

Friends for Progress, the welfare organization which I am a co-founder of has set up a centre to promote HIV&AIDS/STIs information and prevention. We work extensively with sex workers (female & male) as well as transgendered community in Pakistan (pop: 172 million). We have established two centres (1) in the Red Light area of Lahore and (2) in F-10, Markaz, Islamabad, which provide legal counseling and support services to emotionally vulnerable people, particularly victims of rape, incest and sexual violence.

THE WORK WE DO

In both centres we have a lawyer (volunteer on part time basis) and female Psychologist (full time) who provide basic information to sex workers, transgendered community and general public on (i) legal rights of a victim of sexual abuse / violence, (ii) contraception and (iii) reproductive health. In addition free condoms are also available on demand (courtesy of the local administration).
FUTURE PLANS

We plan to launch a toll-free phone HELP-LINE in 05 local languages which would provide (i) basic legal advice to victims of Sexual Abuse / Violence, (ii) HIV / STIs, (iii) Psychological counseling and (iv) how to report a rape and where to seek help from. This Help-line will be advertised briefly on television and for a longer period on Radio, keeping in view the prohibitive costs of TV advertising.

EXPERIENCE(s)

Our experience of working with vulnerable individuals during the last five years has exposed a fatal synergy between the pandemics of Violence against Women (VAW) and HIV&AIDS. Women who are HIV-positive tend to have a higher degree of exposure to violence. And women in violent situations experience heightened vulnerability to HIV transmission.

The individual stories are heart wrenching. In the displacement following the 2005 catastrophic earthquake in Pakistan, Shazia (28 years) was gang-raped by a group of looters. She reported the rape to her husband but he felt powerless to help her due to his own injuries and poverty. A few months after the rape, Shazia began to feel ill, and discovered first that she was pregnant and then that she was HIV-positive. Her husband abandoned her and her twin sons.

Gullakhta (32 years) an illegal immigrant from Afghanistan living on the outskirts of Peshawar also underlines the link between violence and HIV&AIDS as she describes her treatment at the hands of an abusive husband who had 2 other wives: “He would beat me to the point that he was too ashamed to take me to the doctor. He forced me to have sex with him and beat me if I refused. This went for all his [wives]. Even when he was HIV-positive he still wanted sex. He refused to use a condom.”

Despite the abundant nature of such of chilling stories from across Pakistan, most HIV & AIDS prevention strategies fail to integrate effective measures to address violence as a crucial transmission channel for the AIDS virus.

As we help build the justification for linking VAW and HIV prevention programs, our rights-based approach compels us to include the voices of those most affected by the twin pandemics in both the analysis of the problem and the debate on solutions. Our research on this issue will help women like Shazia and Gullakhta make their case in the halls of power and within their own communities. And to do so we will have to strengthen the research base that helps policy makers, Judiciary, donors and public health officials understand the connection between VAW and HIV&AIDS.

LOCAL SITUATION

Pakistan is a low incidence yet very high risk country given the rampant nature of poverty, unemployment, gender inequity and illiteracy. The realization is only beginning to emerge that the HIV is now a predominately female disease and that its spread is being accelerated by the very high level of violence against women in countries such as Pakistan.

In Pakistan almost 20 percent of women report that their first sexual experience was forced or coerced and, globally, the United Nations estimates that a third of women experience abuse. Sexual violence against women which is common in Pakistan and regularly emerges in the media tends to increases exposure to infection. In addition, inequality prevents women from negotiating whether to have sex, who they marry, or whether their spouse is faithful to them. Pakistan is largely a male dominated society, it is almost impossible for a woman to insist that her husband use a condom without inciting violence.

Sex workers face a wide range of human rights abuses in Pakistan, frequently as a result of the laws, policies, and practices of the government. Officials charged with enforcing prostitution laws routinely extort bribes,
confessions, testimony, and other “favors” from sex workers. Such problems are exacerbated when police and security forces are required to meet quotas for arrests and criminal convictions. Sex workers often receive harsh punishments such as incarceration and flogging for committing prostitution-related offenses inscribed in national legislation. In the worst cases, police beat, detain, rape, and torture sex workers, and face little or no accountability for their actions because of sex workers’ relative powerlessness and social marginalization.

ADVOCACY EXPERIENCES

The case of 27 year old Natasha a sex worker from the famous Heera Mandi red-light district of Lahore, got significant media attention in 2007 after the gang rape she suffered at the hands of local police. She was arrested after her pimp did not pay enough protection money to corrupt police authorities—and kept in illegal confinement for 11 days where she was forced to consume pain-killers, then the policemen would rape her, one after the other. She was also made to dance naked for them, she explained.

Her case was advocated by us and a legal counsel arranged, however, as all forensic evidence was destroyed by the police and no witnesses came forth, all the accused policemen who were initially suspended and arrested were released on bail and resumed duty. Eventually, under pressure from the police she retracted her statement and despite our best efforts we could not get her interested in resuming the trial. She said: “I am too poor to challenge the police, they will do the same thing [and] nothing will happen [because] I cannot afford to keep going to court and face the risk of being killed.” This is not a singular incident in terms of its nature or severity and such cases of police torture and high handedness are unfortunately quite common in Pakistan.

BUILDING A LONG TERM STRATEGY

In our recent presentation at ‘Pakistan Human Rights Forum’, we stressed on policy makers and civil society that Police must be made to be accountable to communities and protect and serve all individuals, including sex workers. But participants noted that police are often the primary perpetrators of abuse. In Pakistan, the police go beyond their mandate of law enforcement to impose their own conceptions of morality, such as the idea that women shouldn’t be in control of their sexual behavior. Participants discussed risks confronted by NGOs that try to work with police. Some are co-opted into informing on sex worker communities or facilitating enforcement of prostitution law. Or conversely, NGO staff may be attacked or arrested for the work they carry out with and on behalf of sex workers and other marginalized groups. Participants stressed that the strategies used to address policing tactics must vary according to local realities. For example, lawyers may be useful in some places to contest police abuse. However, laws and courts are irrelevant in many places, and collective action may be the best way to restrain police. Others stressed that pragmatic reforms work best, such as working against police corruption by advocating for better police training, internal accountability and higher police salaries.

In my opinion the rights situation in Pakistan for those suffering with HIV and vulnerable to HIV is far from ideal. Significant efforts are needed to educate the public and reform legislation to improve the rights of marginalized segments of society that are most vulnerable to exploitation and HIV infection.

9  Thailand  PT Foundation

Background
Malaysia has a concentrated epidemic. Up to 2009, almost 87,000 cases of HIV were recorded – the vast majority are from the most at risk populations ie. Drug user (22% prevalence rate), female sex workers (10.5%), male to female transgender persons (9.8%), and MSM (3.9%).
Hence these populations are highly vulnerable to HIV. While the Malaysian government provide some funding for HIV prevention work to these communities, the biggest challenges are the disenabling environment of which structural barriers such as government legislation, policy, guidelines and culture. This report attempts to list out some of the main barriers.

A. MSM Population

Laws restricting HIV prevention work:

a) Malaysia Penal Code 377

377A. Carnal intercourse against the order of nature.
Any person who has sexual connection with another person by the introduction of the penis into the anus or mouth of the other person is said to commit carnal intercourse against the order of nature.

377B. Committing carnal intercourse against the order of nature
Whoever voluntarily commits carnal intercourse against the order of nature shall be punished with imprisonment for a term which may extend to twenty years, and shall also be liable to whipping.

377D Gross Indecency
Any person who, in public or private, commits, or abets the commission of, or procures or attempts to procure the commission by any person of, any act of gross indecency with another person, shall be punished with imprisonment for a term which may extend to two years.

b) Local council by-laws

All local councils require all entertainment and recreation businesses to be licensed and needs to be renewed annually.

Implications for HIV prevention work for MSM:

1. The MSM population is highly invisible and underground. Many do not identify with being gay or homosexual due to the illegality of the act. They remain difficult to reach with HIV education.

2. There is no HIV prevention messaging in the local media for MSM – condom advertising are not allowed in all print and AV media.

3. The Government controlled media does not allow any positive portrayal of homosexuality in local film broadcasting – all homosexual and transgender characters must be shown to either die, repent or punished for their homosexuality or transgenderism.

4. The oppressive state leads to the mushrooming of an underground network of venues that cater to gay men and other MSM especially in cities like Kuala Lumpur and Penang. Such venues operate under the guise of clubs, saunas, and massage centers. However as such venues require annual renewal of their business licensing, the enforcement officers use the presence of safe sex posters, condoms and lubricants as indicative that these sites are used for illegal and immoral uses, and are threatened with closure, and/or invite harassment / extortion of the venue operators. This goes on almost every month. Recalcitrant operators will also have their venues raided often under the guise of narcotics or vice operations. In such raids, the media, religious officers, the police and the local council are present to create optimum impact on the ground and in the media. These operations together with the business licensing laws prevent NGOs like PT Foundation to conduct effective HIV prevention work where this is most needed.

B. Female Sex Workers
Laws restricting HIV prevention work:

Section 27 B of the Minor Offences Act (Civil Law)
Every Prostitute behaving in an indecent manner in or near any public road or any place of public resort shall be deemed to be an idle and disorderly person and shall be liable to a fine not exceeding RM 100 or to imprisonment for a term not exceeding one month or to both.

Section 29 Act 1977 (Syariah Criminal Offences)
Any person who, contrary to Islamic Law, acts or behaves in an indecent manner in any public place shall be guilty of an offence and shall on conviction be liable to a fine of RM 1000 or to imprisonment for a term not exceeding 6 months or both.

Section 21 (Syariah Criminal Offences)
Any woman who prostitutes herself shall be guilty of an offence and shall be liable to a fine of not exceeding RM 5000 or to imprisonment for a term not exceeding three years or to whipping not exceeding six strokes or to any combination thereof.

Implications for HIV prevention work for SW:
- Hampers HIV responses
- Hinder dissemination of CORRECT information to key population
- Create further Stigma and Discrimination
- Reduces self confidence

Investigate by Police and Religious enforcement hamper HIV/AIDS prevention work targeting Female sex workers (FSW) in Malaysia. We have tracked many cases since September 2007 until November 2010 involving both the police and religious enforcement officers. Out of the many cases, only a few cases were brought to court with legal assistance and won. Many are still on trial. Most are not reported; PT Foundation only know after the FSW were released from detention or prison or paid their fine after being pressured to plead guilty.

Feedback received from the outreach workers and the clients stating that raids by the authorities (Religion department, Police, City Counsel etc) happened almost day and night at the SW area (street base and brothel base) in Kuala Lumpur

There are some complaints from FSW that they were threatened by authorities of having condoms with them and due to this they put the blame on the outreach workers. Some of them are reluctant to get or asked condoms from the outreach workers. In Malaysia media(newspaper and television) showing a negative role such as advertise condom as a evidence where condom were found in any operation done by the authorities and put the blame on the person without doing any investigation or clarification on the person.

C. Transgender Persons

Raids done by Police and Religious enforcement hamper HIV/AIDS prevention work targeting TG sex workers in Malaysia. Since January 2010 until November, we received 22 cases of TG has been arrested by Religious authorities and referred to LAC. Out of 22 cases, 7 had challenged the case, 1 has won the case and others still on trial. However, there are unreported cases which the program was informed after the TG was being jailed or paid their fine after pleaded guilty.

In Malaysia, cross dressing is illegal due to syarie’ law, however some of the syarie’ law are not uniformed in other states. This law however creates social stigma and discrimination against TG for many years till now. The penalty for this law is very much heavier (up to RM1000.00 and 6 months jail) than the civil law (fine for only RM25.00)
Feedback received from the outreach workers and the clients stating that raids by the authorities (JAWI, Police, DBKL etc) happened almost everyday and night at the SW venues and recently more frequently, not only in KL but in other states i.e. Malacca and Negri Sembilan. There were also complaints of assault done by enforcement officers verbally and physically.

Some of the TG community scared to go out to work and some operate home based moved to other areas or states and this cause more difficulty to reach out for them. And also some TG sex workers changed their working shift in the morning (from 2am onwards) to avoid raid.

There are some complaints from TG sex workers that they were threatened by authorities of having condoms with them and due to this they put the blame on the outreach workers. Some of them are reluctant to get or asked condoms from the outreach workers.

<table>
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<th>10</th>
<th>Myanmar</th>
<th>Individual</th>
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My name is X. I am 39 years old. I had used drugs especially heroin in the age of 12 or 13 years. The beginning of Psychiatric hospitalization had been started in 1988. The hospital had start examined for HIV in the year of 1989. In 1990 I had my bloods examination result which HIV positive had been clearly described on that year. My mother had passed away with car accident on that year too. I had been sentenced in jail two times for using heroin. In 1993 first time with 3 years penalty and 3 years penalty with hard labour for the second time in the year of 1996. There are no regular basic health care services in prisons. It is very hard to get medical check for a prisoner. Unless his (or) her family brings along cash and medicines on every visit regularly from beginning to the end of the sentence, the prisoner cannot take care himself. Otherwise the prisoner will be cared by nobody. There are no proper treatments, medical necessaries for orphans in prisons. If someone who cannot be able to get support from his (or) her family, it is simply hard get recover once getting ill. The prisons’ staff do not have any knowledge of caring the prisoners for the sake of health. Nobody can say precisely that how HIV, HVB, HVC, TB, STI and dysenteries diseases are spreading and infected, what is the status of each virus existing, what are the infection levels of those virus in prisons in Myanmar. There is no any health statistics in prisons. There are so many sorts of people in prisons. Some of them are bad and some of them have good livings in their live. Prisoners can have tattoos on their skin with unclean needles and it is very dangerous. Some have sexual harassment without any condom. It is not possible to get a single condom in prisons.

While I was in Insein prison, there was a one room filled with many kids whom were just teenagers. So it was completely questionable. Some of them had been detained in Youth Rehabilitation Camp for more than 5 (or) 4 times before they were in the prison, before they were in the prison. Many of them might be infected without being known by HIV, HVC, STI (sexually transmitted infections) and so on. They had definitely be infected if they had been sexually abused unfortunately.

Someday those kids will be out of the prison and they may get married, they will have sexual relationship with other people, they may have pregnancies. It is very very awful for human society. We are responsible to stop those disgusting circumstances.

A man could not be recognized as before after he came back from the prison. Everybody looked down on me. Narcotic drugs addicted people still not be recognized as patients in our country. We are recognized as criminal people in our surrounding and watched by the surveillant all the time.

The pessimistic make us not to do good things. Our ways of thinking become bad, sometime getting worse. But we are not bad people. This is a problem for the addicted. After taken penalties for addicting drugs, by not knowing anything, we reach the outer bound of human society gradually. So we are HIV positive that we have no place to stay then no where to go. In our country, there is still a penalty from 3 months to 6 months, if
somebody is found with a syringe. That opposes to Harm Reduction Proceeding. Obviously rather still away from accepting the drugs addicted as patients. The addicted are very hard to get ART medicine in our country.

By experiencing this, we are pleased to attend any workshop respectfully relative to HIV. Hopefully we will have much knowledge which might be useful for our living.

I have been taking ART medicine since 2007, hence I have been working for Civil Society as a volunteer. For I could not have enough time for own business and have been known as HIV positive, I had to close my fashion shop. It is very hard to stand for if anyone is found with HIV positive, no matter he/she is business man/woman (or) government servant (or) company staff. He/She will have treated by his/her colleagues not warmly and untruly. If he (or) she is doing any kinds of business, it is quite embarrassed and it is too much troublesome, it will be fed up with disturbance completely.

Please let me tell you my own story. I had a younger brother. He and I together had opened a fashion shop at one of the well-known markets called “Mingalar Mon” in Yangon city. He had been a profession JD player in Yangon. Our business had been quite good for many young guys and girls from musical society had bought from us because of him. Unfortunately he had been found with HIV virus in his blood. Once it had been known in public and people had moved their faces slowly on us and our business had been going down. By the time, people had not even known me as a HIV carried person. Then he passed away so soon and I was left in the fashion shop. After his funeral, my business was total going down by not knowing that I was a HIV patient in my surrounding. There were many days I could not be able to sell any outfit, not even a pant, a shirt. In spite of my family have been already known me as HIV positive for 20 years and they have treated me very warmly, finally I had to close my shop with debts.

That is my own experience and true story. There are so many people have livings like me, Some of them are in government organizations Some are in private area and etc. Some of the public staff have to give up, once they are found out HIV positive, their jobs by asking, and so do private companies’ staff. I mean not every organization and company. Some of them have understanding for suffering, offer their sympathies and do charity works for unhealthy and abnormal staff. But there might be very few societies in our country.

If someone has to give up his career for he is HIV positive, his (or) her abilities, skills and, experience will be useless. It is really dangerous for human resources, losing man power and losing experties. Nowadays, most of the countries have the knowledge that if you just stay together with a HIV carrier in your office (or) home, it is not able to infect. But it still have discriminations in public and private areas.

In our country, some of the NGOs’ and UN organizations’ staff still discriminate the HIV patients whose are drugs addicted. The staff are working for the organizations those currently developing rehabilitation for people living with HIV. The patients are not allowed to do everything as other people, so they dare not doing anything, in the end they lost themselves. It is too much dreadful for our society. If the patients have some useful knowledge and technical know-how, it will be sorrowfully lost.

I cannot imagine that it is possible for people living with HIV to access life-sustainable treatment. Is there a place where lawfully protects the human rights and dignity of all?

My mother unit is SWIFTS. I am one of the leaders of Swifts. Swifts was organized by 5clients of M.M.T on 6.8.2007. Now swifts is caring members of [20] people and reserved members of [40] people. Swifts carried out HIV care and prevention, awareness. Networking, advocacy, Harm Reduction coordinate with Burnet Institute, Alliance,UNODC,UNDP, harp, MANA, Myanmar positive group and national NGO Network, National Drug User Network  Myanmar.

We have found Myanmar Drug User Network was organized together with 8 groups of SHG on 14. 3.2008. I am
the one of the member of steering committee MDN + (Myanmar Drugs User Network). I am one of the volunteer Editor of MDN+(Myanmar Drugs User Network) News journals. Writing on introduction Myanmar Drugs User Network and Editorial. Writing Harm Reduction Periodical of Method one, ATS, Heroin. We just changed the name of our organization from Myanmar Drug User Network to Myanmar Drug User Group. We have found National Drugs User Network Myanmar since 2009.

I have volunteered for National Drug User Network Myanmar as Yangon area representative. I attended to HIV/ AIDS Pattayar Community Mobilization Regional forum in Thailand and ATS Harm Reduction Seminar in Kuming as a representative of SWIFTS.

Those are the reason that I would like to get some knowledge that protect and promote the human rights of people living with and most vulnerable to HIV. That is why I am so enthusiastic to attend the workshop entitled with Global Commission on HIV and the LAW.

If my submission is selected I will be so graceful to co-operate. I am looking forward to hear you kind consideration.

11  India  TASOSS - CHAHA – MMSSS

“The Law – Worthwhile /Worthless – PLHAs”

Issues Faced by the PLHA:-

- When a PLHA passess away his/her family is drifting for their livelihood as the relatives discriminate them and they are also driven out of their house. Though the PLHAs family has the legal right to access their constitutional rights of legacy they are forbidden their basic legal rights in their family.
- In availing from the Govt. schemes like widow pension, tailoring machine, pregnant women fund and else the document like ration cards, voters Id etc are missing from the side of PLHAs as their in-laws have it and refuse to entrust these manuscript to the PLHIVs family who are suppose to possess them.
- Stigma in society is adding together the burdens of the PLHAs in spite of being humans they are disregarded in humanitarian aspects.
- The PLHAs children are refused admission in school in spite of been bright students their edification is spoiled
- The employment prospects are not obtainable by the PLHAs and hence their livelihood sustainability is affected.

Recommendations:-

- Free legal aid for the PLHAs to ensure the basic rights for the PLHAs to inherit their properties.
- Prioritizing the PLHAs in regard to the documents in case they are taken away by their family and it must be arrange for the alternative documents by the Government authorities.
- Prioritize the PLHAs in the Govt.schemes and employment opportunities.

CASE STUDY
NAME: Vijay  
AGE: 8  
PARENTS: Prakash and Bhagyam

Surya (CAA) is one of the children registered with CHAHA. They are residing at Cumbam at Theni district in a rental house. His father was infected by HIV/AIDS and died. His mother is a handicap and so she is not able to work else where. She is vending flowers in small scale from her house. With their meager earnings they lead their life.

In this stage as soon as their house owner knew that this is a PLHAs family they were driven out of the house and their belongings were thrown away on the road. Their neighbours also hated them and used abusive words on them. CHAHA lend its helping hands to uplift the family. They were arranged for a rental house and Rs 300 was paid for them as the house rental charges by CHAHA and later they were linked to the stake holder. The new house owner not informed about their infection.

The child’s mother was offered a job in a neighboring NGO . She was with her son in a congested house. In this state she applied to the Government for a housing patta. She submitted the document she had but the authorities lost the application with the documents produced by Annaki. In the very beginning her in-laws family had the documents like patta, ration card and else. They refused to give it to them. The Government authorities negligence and as the PLHAs are not having any priority in the Government allotment are adding factors for the PLHAs. Now Annakilli has applied for the second time to get a housing patta. This time CHAHA team is on their follow-up and Bhagyam was told that she will be getting it within 6 months.

Note: Names and place are changed for confidentiality

CASE STUDY

NAME: Vanaja  
AGE : 13  
PARENTS: Selvam and Rahini

Geetha is a CAA residing at Periyakulam in Theni district. When her parents were working in the brick chamber her father was often getting sick and lost weight. He was treated in the Government hospital nearby. When he was tested it was found he was infected by HIV/AIDS. Though he was not able to work he was in a critical situation to carry on working in the brick chamber as he had some debts with the management. He was referred to the neighbouring NGO for the medical care. His health was poor and not able to work. So their source of income was affected. The child was supported by the CHAHA. As the child’s father failed to continue the course of medicine he his health dropped to worst and finally he died.

The family was taken care by CHAHA. After 6 months of Selvam’s death one day the child was alone at home. Her mother was out to attend a house warming function of their relative. At that time a stranger entered their home and tried to abuse the child. As Vanaja shouted the people around gathered and the rapist was handed over to the police. In the beginning the police were not in an interest t to file the case on the accuser. The child’s mother was threatened to withdraw the case. After the CHAHA team’s intervention from the NGOs side the case was filed forwarded to the. Even at the court the prosecutor threatened the child’s mother to withdraw the case. These happened because they are PLHIV and they have no hold up and also the negligence of the authorities. The case is now followed by another like minded NGO through our linkage effort. The CHAHA team was in a close watch on the child’s medical report so as to avoid malpractice in the reports.

Note: Names and place are changed for confidentiality
The Law on HIV / AIDS of prevention and control and the fact
My name is X and I have been living with HIV for 17 years and is one of the first positive person had participated in the GIPA program (Greater Involvement of people living with HIV / AIDS) in Viet Nam. Here is a story I met stigma and discrimination when information about my HIV status is disclosed

After graduating from the technical mining college, I was working for Coal company in Quang Ninh province. At that time, the Law on HIV / AIDS has not yet launched, the only ordinance on HIV/AIDS of prevention and control. In 2001, I and my former manager, we went to Hanoi capital for HIV testing and we'll get results together according to doctor’s appointment. His results is negative and I was called into the consultancy room of doctor but there is no consultation whatsoever

A few days later, so many colleagues in our company already know I have HIV, they looked at me with eyes so strange and elusive. My former manager advised memy. “You should write a letter of resignation,” but I definitely did not write, he appointed me this work to other many time, not suitable to toward professional and my health. Do not stand the pressure I had to write an application for leave. With the for 3 new working years, so the amount of severance allowance is too little, I could not avoid the difficult both physical constraints, and crystal than.Besides, I also take away the stigma by the family, relatives, friends and social communities. People do not want to meet me and do not want to eating together. Even relatives do not want to me come to thier home.

After that time, participation in social activities such as media and peer counseling. I was fortunate to meet Mr. David Stephen - Former Resident Advisor of Health Policy Initiative project Vietnam (HPI), the old stage. I was sent for some training courses and recruitment into the project with program staff positions. One of my job is doing is related to the operation of legal aid for people living with HIV / AIDS

Law on HIV / AIDS are the comments of people living with HIV / AIDS and the National Assembly passed and enacted, with effect from January 1, 2007 this is a change breakthrough for people living with HIV / AIDS in Viet Nam and is a good tool to reduce stigma and discrimination against people living with HIV / AIDS

Thanks to the Law on HIV / AIDS many people with HIV/AIDS do not lose a job like before. However, in reality the Law on HIV/AIDS of prevention and control does not always go to life also does not have any people have a knowledge of this law. Although they understood the Law of HIV/AIDS of prevention and control, but still sack people with HIV for an other reason. To live and work far form the home, for this reason I have to rent a house, we have repeatedly been expeled from home by master of house because of HIV. Also very difficult to apply the Law on HIV / AIDS for similar cases. Moreover, no sanctions can punish them.

Rationale
Sex work in the Philippines is both illegal and criminalized. The Philippine government condemns any kind of economic activity involving sexual intercourse for money or profit and provides serious sanctions to people who engage in this kind of work. Heavily influenced by the “moral teachings” of the Roman Catholic Church, the State’s position against sex work is reflected through laws that remain enforced in the country today – the Anti
Vagrancy Law (Article 202) and the Anti-Trafficking Law (RA 9208).

The Anti-Vagrancy Law, signed into law in 1935, criminalizes prostitutes, who are defined as “women who, for money or profit, habitually indulge in sexual intercourse or lascivious conduct”. The Anti-Trafficking Law, a more recent law signed in 2003, criminalizes both the client and the pimp who, under this law, are known as the “trafficker”. In contrast to the Anti-Vagrancy Law, the Anti-Trafficking Law defines trafficked persons as victims and they are therefore, not penalized. Because both laws criminalize sex work, many sex workers are forced to operate underground in order to escape arrests. Further, they become vulnerable to exploitation, abuse, harassment and extortion.

The abuses and harassment are also experienced by HIV outreach workers and peer educators who reach out to both establishment-based and street-based sex workers. Trained volunteer street-based peer educators who happen to be sex workers themselves, are vulnerable to arrests especially those who are unable to show identification. Likewise, outreach workers who frequent street-based sex workers to provide HIV education services are suspected as either traffickers or pimps.

Quezon City has an active local AIDS council (also called the Quezon City STD/AIDS Council or QCSAC), which operates under the mandate of Quezon City Ordinance 1053, otherwise known as the Quezon City AIDS Prevention and Control Ordinance. Passed in May 4, 2001, it implements measures for the prevention and control of STIs, including HIV/AIDS in the city. Among its salient provisions is requiring the availability of information materials on STI including HIV/AIDS and prophylactics such as condoms in all entertainment establishments. However, the Quezon City Health Department has expressed that this specific provision is very difficult to enforce because condoms are used as evidence of prostitution by law enforcement agencies when they conduct raid and arrests among entertainment establishments.

Thus, while the local AIDS ordinance in Quezon City clearly requires entertainment establishments to make condoms and information materials on STIs including HIV/AIDS available in their establishments, the frequency of raids and use of condoms as evidence of prostitution in establishments sow fear among the owners to not display condoms in their premises.

Action for Health Initiatives (ACHIEVE), Inc.,

Our organization, Action for Health Initiatives (ACHIEVE), Inc., sees the enforcement of laws concerning sex work/prostitution as disabling factors in sex workers’ access to HIV prevention information and services. ACHIEVE, Inc. is an NGO engaged in the development and implementation of programs and projects addressing migration, health, gender, sexuality, reproductive health, and HIV and AIDS issues. Our main community partners are people living with HIV (PLHIV), migrant workers and their families, women (including sex workers) and young people.

The Project

With funding support from the Levi Strauss Foundation, we were able to implement a project entitled, “Reducing HIV-related Stigma and Discrimination through Policy Review, Advocacy and Media Competency”. The project commenced in November 2009 and is concluding in December 2010. One of the key components of the project is a policy review of RA 9208 and Article 202 and their impact on HIV prevention efforts among sex workers, especially in Quezon City.

After conducting a literature review, ACHIEVE gathered primary data through focus group discussions and group interviews with establishment-based and street-based sex workers. Key informant interviews were done with key stakeholders, such as city health officials, entertainment establishment owners, and NGOs working on HIV issues. ACHIEVE also interviewed law enforcement officers and authorities such as the head of the Philippine
National Police Women and Children Protection Center Chief and division chiefs of the different police stations in the city.

Results from the data gathering were collated, analyzed and presented in a consultative dialogue between and among the Quezon City Health Department, the Quezon City Police Department and the association of entertainment establishment owners. The three parties aired their perspectives on the issues and resolved to cooperate with each other in order to address the policy conflicts arising from the enforcement of RA 9208 and Article 202. A second dialogue was held with national stakeholders in the HIV response, such as the Philippine National Police (PNP), the Department of Health, nongovernment organizations, sex worker peer educator, and UNAIDS.

Results

The first dialogue/roundtable discussion resulted to a clarification between the police and the Quezon City Health department that condoms cannot be used as ‘sole’ evidence of prostitution. It was also agreed on that there is a need to orient and inform entertainment establishment owners of the procedures and protocols of raids. Lastly, it was recognized that HIV education efforts should be sustained among the police force, as well as a dissemination of the City HIV/AIDS ordinance. Six months after the dialogue was done, the Quezon City Health Department has noted that the number of raids among entertainment establishments has significantly reduced.

The second dialogue/roundtable discussion resulted to a decision to come up with a Memorandum of Agreement (MOA) between the police and the city health department. The MOA is envisaged to serve as a guideline for the aforementioned parties to properly coordinate and cooperate on the city’s public health initiatives on STI prevention, including HIV/AIDS, without compromising enforcement of police mandates on prostitution and trafficking. The law enforcers also reiterated the need for the City Health department to provide HIV awareness, including policy/legal briefing, among their ranks in order to reduce unlawful raids and arrests using condoms as evidence for prostitution.

While the focus of the project is on sex workers in general, ACHIEVE recognized that men who have sex with men (MSM) are also affected by the problem, for reasons that a significant number of entertainment establishments cater to them. Thus, MSM patrons and clients are also often subjected to unwarranted raids and arrests. In the first dialogue, a police inspector/representative from the Philippine National Police revealed that the police perceive male-to-male sex as transactional sex, hence a form of prostitution, which is deemed illegal. Further, they also held the position that being gay is enough reason to get arrested. The second dialogue clarified a number of these misconceptions and beliefs.

Next Steps

In 2011, ACHIEVE will assist in the drafting of the MOA in Quezon City, in close coordination with the Quezon City Health Department, Quezon City Police Department and UNAIDS. We have also committed to undertake the necessary actions in order to achieve the formal adoption and signing of the MOA.

ACHIEVE was also given an extension grant by Levi Strauss Foundation to replicate the activities (policy review and dialogue) conducted in Quezon City in two other major cities, in order to gather more evidence on how enforcement of national laws on trafficking and prostitution hinder or affect HIV prevention services among sex workers in other localities. The project is envisaging the enactment of a national policy addressing these conflicts so that sex workers will no longer be denied access to HIV prevention services and information, not just in selected cities, but throughout the country.

14 Vietnam Adamzone Can Tho
A case study of violations of the human rights of transgender people in Viet Nam

Sex between homosexual people in Viet Nam is legally accepted. It seems that men who have sex with men and transgender people are equally treated under the law. However, the recent rape of a transsexual person has created debate among lawmakers and activists and demonstrated that the rights of transgender people are not yet fully respected, protected and fulfilled. The legal acceptance of sexual acts does not always translate into equal treatment and justice.

According to the Penal Code of Viet Nam, a person who commits rape will be punished by law. The Penal Code does not mention the sex of perpetrators and victims nor any differential treatment according to gender. However, in practice, only when victims are female and perpetrators are male will prosecution be initiated. It is commonly assumed by lawyers that only women are raped (and by men). This assumption arises from the belief that only women’s freedom and sexual inviolability should be protected. Male victims of either female or male perpetrators cannot bring their cases to court. i.e. the notion that women (and not men) have a sexual being that can be violated

On 24th August 2010, a transsexual person in Quang Binh province – who underwent male-to-female sex reassignment surgery in 2006 – was raped by three men. The transsexual person reported the rape to the local police. As a result, three men were arrested and admitted their crime.

When prosecution was initiated, it was discovered that on paper the transsexual person was classed as male, despite her female body. She remains a man because the law in Viet Nam does not allow her to register her new sex. Decree 88/2008/ND-CP, issued on 5th August 2008, stipulated eligibility for sex reassignment based on the unclear structure of genitals and chromosomes which determine biological body of a person. Decree 88/2008/ND-CP forbids sex reassignment according to an individual’s perception of their identity or their desire to change sex. As a result, transgender people cannot undertake sex reassignment surgery in Viet Nam. If they have such surgery outside Viet Nam, they cannot register their identity or renew their personal identity papers.

The agency in charge of criminal procedures in Dong Hoi city submitted the case to the higher level in Quang Binh province. At the outset, both the police and the provincial people’s procuracy agency agreed to initiate prosecution. However, following discovery of the identity of the victim, there have been contradictory opinions about whether or not the case could be prosecuted.

People who are against the case argue that in law the transsexual person is still a man. As mentioned above, rape victims must be female and therefore the transsexual person cannot sue the perpetrators.

Arguments for the case include the following:

- According to an Appeal Court Judge of the People’s Supreme Court in Ho Chi Minh City, it is possible to sue the three perpetrators since there is enough legal justification to conclude that their behaviour constituted rape. The three men are adult, capable of responsibility for their crime and they are male. They had sexual intercourse with the victim against her wishes. The victim has a female body and therefore she was the object of the rape.

- A high-level controller of Appeal Court No.3 argues that the rapes committed by the three men were undertaken in the belief that the victim was female. A Criminal Court judge of the People’s Supreme Court in Ho Chi Minh City added that the agency in charge of criminal procedures could invite medical doctors to check and confirm whether the victim was a (biological) female when she was raped.

- Another opinion is that the three men could be prosecuted for committing violence, humiliation and attacking sexual dignity and honour. However, others argue that these acts are not equivalent to rape because they have
different aims.

In the end, no legal procedure took place to protect the victim because she was still considered male.

**Recommendations:**

1. Decree 88/2008/ND-CP on sex reassignment should be revised to allow transgender people to have sex reassignment surgery based on their perception of their identity. Relevant health procedures should be developed to ensure that transgender people receive proper counseling, operations and treatment.

At the moment, due to the high cost of surgery in Thailand, many transgender people undertake illegal hormone treatments and surgery which expose them to health risks. Because of social stigma which leads to poor access to health care, including HIV information and services, transgender people are at high risk of HIV infection. Revising Decree 88/2008/ND-CP will help transgender people to fully live lives that they want, as well as access more health care services, including HIV prevention and treatment.

2. Following this revision, other legal documents need to be changed to allow transsexual people to officially register their new identity. This will entitle them to the human rights that all others enjoy, such as the right to inherit, to travel, to register property and to be equally and legally protected from violence and crime such as that experience by the woman in this case.

3. The interpretation of the law should be revised for law-enforcement institutions and individuals. While the Penal Code does not specify any difference between male and female perpetrators and victims, the Code has been interpreted and enforced in a very gender-biased way. All men and women should be equally protected and treated in law and by enforcers of the law.

Improving the law-enforcement process will require significant efforts to raise awareness about gender and issues of power relations. This case study has attracted a lot of discussion and debate among different groups of people in Viet Nam, and further advocacy activities should be conducted to encourage the revision of the law.

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**EXPERIENCE SHARING ON HIV/AIDS LEGAL AID PROJECT IN VIETNAM**

**1. Background**

In May 2006, the Viet Nam National Assembly passed a new Law on HIV/AIDS Prevention and Control. The new law contains a range of provisions dealing with the rights and responsibilities of people living with HIV/AIDS (PLHA), employers, health care workers, and others, in relation to discrimination, confidentiality, and access to services. However, HIV/AIDS-related stigma and discrimination remain serious problems.\(^1\)\(^2\) Thus, there is an ongoing need for expanded and improved legal services for those who suffer from such discrimination. In January 2009, Health Policy Initiative Vietnam (HPI), a USAID/PEPFAR funded program, took over (from Constella Futures/HPI) the support of the existing national hotline and five legal clinics staffed by lawyers and HIV-positive peer counselors in Ha Noi, Quang Ninh, Hai Phong, An Giang and Ho Chi Minh City to provide legal assistance to people subjected to HIV/AIDS-related discrimination in health services, education, employment, family relations, and other spheres of life.

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2. Project Goal, Objectives and Activities in Year 2 (October 2009-September 2010)

Project Goal: To contribute to the reduction of HIV/AIDS-related stigma and discrimination against PLHA by offering quality legal aid to adults and children facing HIV stigma and discrimination.

Project Objectives:
- Objective 1: To improve lawyers’ knowledge of HIV/AIDS laws and policies; the HIV epidemic in Viet Nam - including HIV prevention, treatment, care and support programs - and the impact of the epidemic on individuals and communities.
- Objective 2: Provide PLHA with information related to law and policy on HIV/AIDS, especially the rights and the obligations of PLHA.
- Objective 3: Provide legal counseling and assistance to PLHA, people affected by HIV/AIDS and most-at-risk population (MARP) through a national hotline and 5 legal clinics in Quang Ninh, Hai Phong, Hanoi, An Giang and HCMC.

Project Activities:
- Strengthen staff capacity by providing ongoing training on the operational procedures and legal assistance skills to lawyers and HIV-positive peer counselors;
- Improve promotion of legal clinic services through wide distribution of standard-format posters, name cards and leaflets with success stories;
- Improve screening to increase numbers of clients seen who are in need of actual HIV/AIDS legal services as opposed to general HIV/AIDS information and referrals;
- Upgrade facilities in the legal clinics to ensure private and convenient counseling places for clients;
- Build and maintain referral networks;
- Carry out ongoing monitoring and quality assurance.

3. Project Results in Year 2 (October 2009-September 2010)

- The lawyers and PLHA counselors from 5 legal clinics and hotline attended a refresher training in Ha Noi during May 31- June 2, where they were updated with new HIV/AIDS related policies and regulations and shared experiences and lessons learnt on providing legal counseling and assistance to clients. In addition, they were trained to improve data monitoring on clients accessing legal clinics and hotline.
- Improving promotion of HIV/AIDS legal services: HPI staff worked with the 5 legal clinics and national hotline to design the standard-format posters, name cards and leaflets with success stories, which are being made widely available to HIV/AIDS services providers and potential clients as a concrete evidence of the assistance and support they can receive from these services. HPI worked closely with the legal clinics and hotline to increase coordination with HIV/AIDS service providers and PLHA groups. HPI also supported innovative measures such as registering the HIV/AIDS legal services in 1080 telephone directory in HCMC and spreading the information on HIV/AIDS legal clinics to 06 center releasees in all the districts of HCMC through the email network of the Provincial AIDS Committee’s Transitional Program.
- The legal clinic in Ho Chi Minh City moved to the first floor of its building with larger space and more accessibility for clients. Other legal clinics such as Quang Ninh and An Giang created convenient and private places to provide legal counseling and assistance to clients.
- HPI facilitated the coordination between the legal clinics and Positive Prevention programs in Ho Chi Minh City and An Giang. When there were PP group discussions on HIV/AIDS legal topics, the lawyers and PLHA counselors came to share with the group members on the services they can receive from legal clinics. A similar approach will be applied in Ha Noi and Hai Phong. That coordination will also be linked with HPI activities on capacity building and legal status assistance for self-help and supported groups (SSGs) in the coming months.
- During regular visits, HPI staff discussed in detail with the lawyers and PLHA counselors the Legal Clinic operation procedures and the quality of legal services provided to clients. Successful cases in one province
were shared with others as lessons learnt to improve the service quality.

- The legal clinics updated the mapping of service providers in their local areas and assigned concrete responsibilities to each staff to cooperate with those sites to increase the numbers of legitimate clients accessing the legal services. They widely distributed promotional materials through health service providers, PLHA groups, and other settings and organizations.

- The number of client visits and new clients accessing the 5 legal clinics and hotline increased steadily during the past quarters; the figures in April - June 2010 increased by 55% and 58% as compared to April - June 2009, as shown in the below graph.

- The number of client visits and new clients accessing the 5 legal clinics and hotline increased steadily during Year 2; the figures in Quarter IV (1,189 and 1,168 clients) increased by 16.5% and 17.4% as compared to Quarter I (1,021 and 995 clients), as shown in the below graph:

![Number of Client Visits & New Clients Accessing the Legal Clinics and Hotline in Year 2](image)

- Table 1 below shows the services of the national hotline and 5 legal clinics during the project year 2 (October 2009 – Sept 2010). The legal issues brought by clients vary in quite a wide range, consisting those related to marriage and family relationships, social protection for OVC, the confidentiality and procedures of care, treatment and HIV testing; the rights of treatment for AIDS patients who are rehabilitation centers residents or inmates, workplace and schooling - related discrimination, etc.

Table 1. Services of 5 legal clinics and the national hotline in Year 2 (October 2009 – September 2010):

<table>
<thead>
<tr>
<th>Location</th>
<th>Client Visits</th>
<th>New Clients</th>
<th>Age &lt;18</th>
<th>Workpl.</th>
<th>Marriage/ family</th>
<th>Education</th>
<th>Social protection</th>
<th>VCT, care treatment</th>
<th>Civil, crimina l issues &amp;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hotline</td>
<td>1948</td>
<td>1946</td>
<td>0</td>
<td>4</td>
<td>44</td>
<td>17</td>
<td>38</td>
<td>24</td>
<td>733</td>
</tr>
<tr>
<td>Ha Noi</td>
<td>866</td>
<td>839</td>
<td>40</td>
<td>149</td>
<td>43</td>
<td>71</td>
<td>18</td>
<td>70</td>
<td>102</td>
</tr>
<tr>
<td>Quang Ninh</td>
<td>367</td>
<td>365</td>
<td>67</td>
<td>94</td>
<td>33</td>
<td>29</td>
<td>10</td>
<td>33</td>
<td>51</td>
</tr>
<tr>
<td>Hai Phong</td>
<td>330</td>
<td>322</td>
<td>46</td>
<td>39</td>
<td>18</td>
<td>47</td>
<td>15</td>
<td>82</td>
<td>41</td>
</tr>
<tr>
<td>HCMC</td>
<td>380</td>
<td>344</td>
<td>33</td>
<td>141</td>
<td>16</td>
<td>40</td>
<td>7</td>
<td>39</td>
<td>125</td>
</tr>
<tr>
<td>An Giang</td>
<td>474</td>
<td>456</td>
<td>58</td>
<td>166</td>
<td>11</td>
<td>55</td>
<td>9</td>
<td>58</td>
<td>216</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>4365</strong></td>
<td><strong>4272</strong></td>
<td><strong>244</strong></td>
<td><strong>589</strong></td>
<td><strong>125</strong></td>
<td><strong>286</strong></td>
<td><strong>76</strong></td>
<td><strong>320</strong></td>
<td><strong>559</strong></td>
</tr>
</tbody>
</table>

- The 5 clinics carried out 232 mobile legal outreach visits to PLHA groups, service providers, and other settings. HCMC, An Giang and Quang Ninh succeeded in organizing mobile legal dissemination to
rehabilitation centers and prisons. The legal clinic teams in other provinces will try to reach rehabilitation centers or prisons in their areas during the coming months.

4. Lessons learned:

- The participation of HIV positive counselors in the legal clinics and hotline has been an innovative and effective strategy in Vietnam. The counselors can easily reach and understand the needs of clients who are PLHA and MARPS; which makes legal service friendlier. All the counselors, who are members of PLHA self-support networks, can easily continue to follow up to support the clients after they receive the service from the legal clinics.
- The legal clinics can only reach more clients if the staffs actively plan and carry out more mobile trips to the community (especially PLHA groups) and rehabilitation centers or prisons. Far fewer clients would access the services if the staffs spend most of their time in the office. Besides, in most cases, the legal clinic teams recognized that multimedia is expensive and not very efficient in promoting the legal services.
- The quality of service and satisfaction of clients are higher where the lawyers and counselors actively contacted with local government agencies and community-based organizations during the legal assistance to clients, rather than just providing instructions to the clients then they will go to the relevant agencies by themselves.
- Efforts should be made on consolidating a strong networking and referral-linkage as well as quality assurance and improvement for the services provided to clients of the legal clinics and hotline.
- HPI needs to carry out continuous quality monitoring of legal clinic services through client satisfaction surveys and “mystery client” exercises.

16 Malaysia Individual

Paradigm shift: Punitive prohibition to harm reduction

In 2003, the Malaysian government announced that in view of the country’s losing battle against its ‘public enemy number one’ i.e. “dadah” (dangerous drugs) there should be a policy shift from ‘a punitive to a more rehabilitative approach’. This suggests that the Malaysian government are adopting a more pragmatic approach, despite having always maintained a zero tolerance drug policy, with the aim of achieving a drug free society in line with ASEAN’s common goal for a drug free ASEAN by 2015. To what extent have they taken on board the views of the NGOs, medical and other health professionals who are advocating a more pragmatic approach to reduce the harm caused by the government’s drug prohibition policy still remains to be seen.

Proponents of harm reduction contend that committing drug users to drug rehabilitation centres involves a substantial amount of government resources that does not bring any benefit to the problems of drug dependence.

With the lack of understanding of drug dependence and high levels of stigma, the relapse rate is very high – 90 to 100 per cent...Things could be changed more positively if they changed from being compulsory to harm reduction. The system was as costly as it was ineffective: With the current approach of putting drug users in centres, 146.9m US dollars will be required from 2006-2015.

Treatment should start from the point of arrest i.e (for suspected drug users who come into contact with the criminal justice system) by providing treatment for withdrawal symptoms whilst being detained for drug assessment. Not only would this be a process towards ‘an ongoing rehabilitation programme’ but as an external motivating factor for the drug users to successfully complete the treatment programme.

Recent years have seen a gradual shift in the drug policy towards this more pragmatic approach on treatment
for drug addiction. According to Dr. Christopher Lee Kwok Choong, government agencies are making positive efforts and advocating harm reduction programmes:

We are hopeful that the harm reduction programme, both the free methadone as well as the needle exchange programme which has a strong prevention element, will make a bigger impact and we can reach the target. It is the first time we are witnessing a strong collaboration between government, police, rehabilitation officers at Serenti (Puspen) and NGOs. Harm reduction is too new to make a significant impact but the pilot project was successful. The challenge is always in scaling up because it involves community acceptance. There must also be interphasing with law enforcement. The centres in Kuala Lumpur, Johor Baru and Penang have been running for two years and we are seeing an improved understanding with the police force."

Bollinger describes this ‘intermediary level of development’ as a ‘medicalisation paradigm’ in which ‘softer control strategies’ are being practiced within the objective of a drug-free society with the aim of raising the standard of public health and reducing harm to drug users. Furthermore, scientific research has shown that the traditional prohibitionist drug control policy is unsuccessful in that it has caused more harm than good to drug users.

Malaysia’s zero tolerance approach towards drug addiction has emphasised a ‘single treatment modality’ by which drug users are institutionalised for long periods rather than getting out-patient or community-based treatment. Such a regimented-style of treatment implemented by the government has been criticised by many quarters as ‘not an ideal approach’ in that ‘no single treatment will suffice for the different levels of addiction – novice, habitual, hardcore’. This can be illustrated by the low success rates of only 20 per cent recorded by Puspen centres.

The Malaysian government has for the past 27 years stood firmly against the harm reduction approach in dealing with drug addiction. However, due to the increase in the number of HIV/AIDS cases in Malaysia, the government have decided to move away from the ‘total abstinence’ to a more ‘moderate abstinence’ approach in combating drug addiction. This seems to suggest a general acceptance of a harm reduction approach as a way of reducing the health problems. The government’s ‘top-down multi-agency’ strategy for containing the spread of HIV/AIDS did not seem to work as incidence rates were high among drug users.

In 2006, the Ministry of Health initiated a six-month programme by which hypodermic needles and condoms were distributed to 1,200 IDUs in four cities. In February 2008, the Drug Service Centre, AADK set up a Methadone Maintenance Treatment (MMT) clinic at its centre. Although still at its induction phase, the clinic has thirty-four patients under its MMT programme. The clinic operates on a daily basis from 8 a.m. till 11 a.m. Dispensing of methadone to registered patients are done daily by a registered pharmacist.

In fact, as many as 600 private practitioners have volunteered to provide Drug Substitution Treatment (DST) at their clinics. It was reported recently that according to the National Drug Substitution Treatment (NDST) statistics, the number of patients (drug users) seeking DST have increased throughout the years since DST was introduced, with approximately 17,930 patients as at June 2008. The statistics also indicate that the programme was accepted by patients with the number of registered patients doubling from 6,184 to 13,174 during the same period. Nonetheless, although Malaysia has the highest rate of HIV infections related to injection drug use, information about the risks of HIV/AIDS and hepatitis infection and transmission is still lacking amongst drug users in Malaysia. As a consequence, these IDUs do not fall within the targeted group for receiving the antiretroviral treatment.

In light of the current trend towards a more pragmatic approach to the drug problem, it is hoped that Malaysia will continue to make further progress in order to achieve a drug free society by 2015. To cite Jelsma:
Drug use: a clear trend is underway towards acceptance of harm reduction measures. Across the globe we find examples of policy shifts taking place in the direction of decriminalisation of drug use, introduction of needle exchange and substitution programmes, expansion of drug consumption rooms and heroin prescription, and incorporation of harm reduction language in policy documents. There is no question about the direction policy trends are taking in this field.

Dear Honorable Commissioners:

I am writing to you as a volunteer attorney with the Foundation for Consumers, a Thai NGO that works on consumer advocacy issues. My work as a volunteer attorney includes researching how domestic and international intellectual property laws impact access to medicines here in Thailand for chronic diseases, such as cancer, heart disease, and HIV/AIDS. This research led me over the past year to delve further into the hidden epidemic of Thais living with HIV/AIDS who are also co-infected with the hepatitis C virus (HCV). Not only is there a general lack of awareness of HIV/HCV co-infection issues among activists, policymakers, and the medical profession, but there is also a lack of access to treatment for HCV.

Due to the civil society activism over the past ten years, developing countries like Thailand now have access to affordable, quality anti-retrovirals (ARVs) to treat people living with HIV/AIDS (PLHIV). The increase in access to ARVs has led to longer and better quality of life among PLHIV. As PLHIV live longer on ARVs, they are facing other chronic health problems, such as co-infection with hepatitis C virus (HCV). Some recent studies have documented that end-stage liver disease from HCV is the leading cause of non-AIDS deaths among PLHIV. Most people, including many experts, are unaware of this pending public health crisis because of the marginalized community it disproportionately impacts—injecting drug users (IDU). In fact, preliminary studies estimate that 90% of Thai IDU are living with HCV. These numbers most likely underestimate the severity of HIV and HCV among Thai IDU because of the lack of accurate data on IDU in Thailand and even fewer studies are assessing the prevalence of HCV co-infection. HCV disproportionately affects IDU because it is a blood-borne disease easily spread through shared injecting equipment. Furthermore, IDU face numerous legal, social, and other barriers when trying to access health care and treatment, including denial of treatment, discriminatory treatment, and lack of confidentiality when receiving treatment.
Unlike HIV/AIDS, HCV is a curable disease; yet a majority of people living with HCV are dying because they do not have access to treatment due to its high cost. The current standard of care is a three to twelve month course of treatment with a combination of two drugs—pegylated interferon and ribavirin. Ribavirin is a pill that must be taken twice daily, while pegylated interferon is an injection given once a week. Currently, there are generic forms of ribavirin available. However, the two versions of pegylated interferon currently available are still under patent by two pharmaceutical companies Roche (brand name Pegasys), and Schering-Plough/Merck (brand name Peglntron). Due to these patents, hepatitis C treatment is very expensive, usually costing around $30,000 USD for a 48-week course of treatment in Thailand. As a result, most health care systems are unable to provide or refuse to offer treatment to a majority of HCV patients.

Thus, to draw attention to the lack of access to treatment and diagnostics for HCV in Thailand, I researched, wrote, and published a policy brief detailing the barriers to access Thai IDU face, while providing policy recommendations to remove these barriers. The overall purpose of the policy paper is for use in education and advocacy campaigns. The first part of the paper provides a medical overview of HCV. The second section describes the standard treatment options for HCV and the availability of treatment for IDU in Thailand. The third part discusses the unique barriers Thais co-infected with HIV and HCV encounter when seeking treatment in Thailand. The fourth section explores how treating HCV/HIV co-infection is sound economic policy that should be instituted immediately by Thai policymakers. Finally, the paper concludes with recommendations for policymakers to follow to successfully reverse this raging epidemic. Therefore, I am submitting a copy of this policy brief for your review and consideration to learn more about the barriers Thai IDU face when trying to access treatment for HCV.

Thank you in advance for your time and consideration of my proposal submission. I greatly appreciate this opportunity to submit my research on HIV/HCV issues to the Global Commission on HIV and the Law. Moreover, I would also welcome the opportunity to discuss these issues in person during your Asia-Pacific Regional Dialogue in Bangkok. If you have any further questions about my submission, please feel free to contact me via email at noah.metheny@gmail.com, or by phone at +66874131911.
Introduction

Over the past decade, people living with HIV/AIDS (PLWHAs) in low and middle-income countries have gained greater access to antiretroviral treatment (ART), mainly due to treatment access campaigns waged by civil society advocates worldwide. The increase in access to ART has led to a longer and better quality of life among PLWHAs. As PLWHAs live longer on ART, they are facing other chronic health problems, such as co-infection with hepatitis C virus (HCV). End-stage liver disease from HCV causes premature and unnecessary deaths among PLWHAs, particularly among current and former injecting drug users (IDU), among whom HCV is highly prevalent. HCV disproportionately affects IDU because it is a blood-borne disease easily spread through shared injecting equipment. Moreover, IDU face numerous legal, social, and other barriers when trying to access health care and treatment, including denial of treatment, discriminatory treatment, and lack of confidentiality when receiving treatment.

The World Health Organization (WHO) estimates that three percent of the world's population - or 180 million people - have been infected with hepatitis C; each year, three to four million more become infected. In Southeast Asia, WHO estimates that 32.3 million people are infected with HCV. Moreover, as of 2008, almost five million of the world's 33.4 million PLWHAs live in Southeast Asia. It is also estimated that there are two to nine million IDU living in the Asia-Pacific Region, with an estimated 750,000 IDU who are living with HIV/AIDS. Unfortunately, there are few epidemiological studies on the prevalence of HIV and HCV co-infection in Asia.

However, these studies estimate a 60% to 90% rate of HCV co-infection among IDU living with HIV/AIDS in Asia.

The statistics on HIV and HCV among IDU in Thailand are staggering:

- 610,000 Thais are living with HIV/AIDS, with at least 5-10% contracting HIV from injecting drugs.
- At least half (50%) of injecting drug users in Thailand are living with HIV/AIDS.
- Up to 90% of injecting drug users in Thailand have contracted HCV.
These numbers most likely underestimate the severity of HIV and HCV among Thai IDU because of the lack of accurate data on IDU in Thailand and even fewer studies are assessing the prevalence of HCV co-infection. Nevertheless, existing statistics are troubling in light of Thailand's universal health care system, which purports to provide healthcare for all without discrimination. The 2007 Thai Constitution supports this policy, by explicitly stating that Thais "shall enjoy an equal right to receive standard public health service, and the indigent shall have the right to receive free medical treatment from State's infirmary."\textsuperscript{10} Clearly, policies are not effectively addressing HIV/HCV co-infection, a rapidly growing epidemic that is needlessly killing many IDU (since HCV can be treated and, in some cases, cured). \textit{Moreover, lack of access to clean injecting equipment for Thai IDU is leading to higher rates of HIV and HCV infection.} HIV/HCV co-infection among Thai IDU is a public health emergency being ignored by Thai policymakers.

The purpose of this policy paper is to offer a concise introduction to issues faced by Thai PWLHA co-infected with HCV, specifically focusing on people who inject drugs, to be used for education and advocacy campaigns. The first part of this paper will provide a medical overview of HCV. The second section describes the standard treatment options for HCV and the availability of treatment for IDU in Thailand. The third part of this paper discusses the unique barriers Thais co-infected with HIV and HCV encounter when seeking treatment in Thailand. The fourth section explores how treating HCV/HIV co-infection is sound economic policy that should be instituted immediately by Thai policymakers. Finally, this paper will conclude by offering recommendations for policymakers to follow to successfully reverse this raging epidemic.

\textbf{1. Medical Nature of HCV}

HCV is a blood-borne infection transmitted when infected blood from one person enters another person's bloodstream through any type of contact. The hepatitis C virus is smaller than HIV and, unlike HIV, can live outside the body for a long period of time, making it ten times more infectious than HIV. The most common mode of HCV transmission in Thailand is by injecting drugs with shared equipment.\textsuperscript{11} Thus, an estimated 90% of Thai IDU are infected with HCV.

The hepatitis C virus lives in blood and liver cells. HCV does not directly damage the liver; rather, the immune response to the virus causes scarring over time by walling off infected cells. Over time, liver scarring can worsen; serious damage impedes the liver's capacity to perform normal activities, such as filtering out bodily waste, metabolizing drugs, and regulating other crucial biological functions. The liver damage caused by HCV may take years, or even decades to develop.
There are two phases of HCV infection - acute and chronic. The acute phase of HCV infection lasts from the time a person is initially infected up to six months after infection. During the acute phase, approximately 45% of HIV-negative people and up to 20% of individuals living with HIV/AIDS are cured because their immune system successfully clears hepatitis C. However, these people remain at risk for re-infection, since clearing HCV does not provide immunity. The majority of individuals who do not clear HCV naturally progress to the chronic phase of HCV infection, meaning that HCV becomes a lifelong infection unless treated successfully.

Symptoms are rare during the acute phase of HCV, making it difficult to diagnose. Like HIV, people living with chronic HCV can experience no or few symptoms for years or even decades, while others experience non-specific symptoms such as depression and forgetfulness.

HCV is the world’s leading cause of liver disease. A majority of people living with HCV eventually develop some liver damage. Some people have mild-to-moderate liver scarring (called fibrosis), while about a quarter end up with serious liver scarring (called cirrhosis). People with cirrhosis are at risk for complications from HCV such as liver cancer and liver failure.

HIV can have a deleterious effect on hepatitis C from acute infection onward. PLWHAs have compromised immune systems, and are less likely to clear the hepatitis C virus during the acute phase than people who are HIV-negative. HCV progresses more rapidly in PLWHAs, and increases the risk for serious liver damage. In fact, end-stage liver disease is a growing cause of death among PLWHAs. In turn, HCV complicates a PLWA's treatment for HIV because it can triple the risk of ART-associated liver toxicity.

II. Treatment for HCV

A. Standard of Care and Treatment Options

The standard procedure for testing for HCV is a two-part process. First, a person is tested for antibodies to the hepatitis C virus (HCV antibody test.) A positive result means that a person has been infected with hepatitis C, but it cannot determine whether the person is chronically infected. People who have cleared the virus remain antibody-positive, so another test is needed to confirm or rule out chronic HCV. This is called a viral load test (or HCV RNA). If the hepatitis C virus is detected in a person’s bloodstream, it usually means that he or she is chronically infected.

Additional tests, such as liver enzyme levels, are used to monitor people with HCV. Genotypic testing is essential to determine duration of HCV treatment, which ranges from 3 to 12 months. There are at least six genotypes (different genetic versions) of the hepatitis C virus, but genotypes 1, 3 and 6 are the most common in Thailand.12 People with genotype 3 usually require only six months of treatment, but treatment may be longer for co-infected people.
HCV is a curable disease. The current standard of care is a three to twelve month course of treatment with a combination of two drugs - pegylated interferon (PEG-IFN) and ribavirin (RBV). Ribavirin is a pill that must be taken twice daily, while pegylated interferon is an injection given once a week. Ribavirin by itself is not effective to treat HCV, but becomes effective when used in combination with pegylated interferon. Interferon stimulates the immune system to fight viruses, and pegylation is simply a small molecule added to interferon, which makes it more effective by keeping it in the bloodstream longer. Patients undergoing this treatment often experience side effects, including flu-like symptoms (such as weakness and fatigue, appetite loss, aches and pains), anemia, depression, and anxiety.

Response to treatment depends on several factors, particularly HCV genotype. Overall, HCV treatment is successful for approximately 50% of cases. Response rates are highest in people with genotypes 2 and 3 -- more than 70% are cured. However, HCV treatment is less effective for patients co-infected with HIV. Treatment outcomes can be predicted by a hepatitis C viral load test after three months of treatment, so not everyone will require a complete course of treatment.

Currently, there are generic forms of ribavirin available. However, the two versions of pegylated interferon currently available are still under patent by two pharmaceutical companies: Roche (brand name Pegasys) and Schering-Plough (brand name PegIntron). Due to these patents, hepatitis C treatment is very expensive, usually costing around $30,000 USD for a 48-week course of treatment. Thus, most healthcare systems are unable to provide or refuse to offer treatment to a majority of HCV patients.

Currently, pharmaceutical companies worldwide are developing more than twenty experimental HCV drugs. These new drugs aim to eradicate HCV and are in, or getting ready to enter clinical trials. However, pegylated interferon and ribavirin may still be required with the new drugs, keeping HCV treatment prohibitively expensive.

**B. Treatment Availability in Thailand**

Even though Thailand has a universal healthcare system, it fails to provide adequate access to screening for, and diagnosis and treatment of HCV. Currently, HCV antibody tests in Thailand costs 200-300 baht (6-9 USD). The two-drug combination therapy of pegylated interferon and ribavirin costs 591,263 baht (17,828 USD) for a 48-week course. Moreover, the administration and monitoring cost for such a 48-week course is 503,693 baht (15,187.49 USD). Thus, the total cost for a 48-week course of pegylated interferon and ribavirin in Thailand is 1,094,956 baht (33,015.49 USD). Furthermore, pegylated interferon and ribavirin are not on the Thai National Essential Drugs List, meaning this treatment is not included in the Thai universal coverage scheme. Therefore, as in most other low and middle-income countries, the cost of treatment of HCV with pegylated interferon and ribavirin is very high and out of reach for most patients.
III. Barriers Faced by Thai IDU Who Are Co-Infected with HIV and HCV

Even if HCV screening, diagnostics and treatment were available in Thailand, Thai IDU co-infected with HIV and HCV would face many barriers when accessing healthcare. The social stigma around drug use pervades many aspects of Thai society, creating huge barriers that Thai IDU face when seeking health care and treatment. One of the biggest barriers in the healthcare setting is the prejudice and lack of experience among medical service providers, which leads to limited and inadequate care.\textsuperscript{19} For example, many Thai doctors would refuse treatment to IDU because they think that IDU cannot adhere to treatment regimens because of their past and/or current drug use. However, having a history of substance use or current use does not predict lack of adherence to medical treatment.\textsuperscript{20} In fact, there is no evidence to support this assumption. Studies show that active IDU can adhere to treatment regimens as effectively as non-users.\textsuperscript{21} Moreover, treatment adherence among IDU increases when they have access to other health and social services (harm reduction support, mental health care, etc.).\textsuperscript{22} Prejudiced or under-educated health care providers also think that illegal drug use decreases effectiveness of treatments. However, most studies indicate that HCV treatment outcomes among active IDU are similar to those of non-users.\textsuperscript{23} Therefore, treating Thai IDU should not be seen as an impossibility, but as a challenge that can be met through educating medical staff and providing support for patients.

IV. Screening and Treating HCV Is Sound Economic Policy

Access to treatment and healthcare is a right enshrined in the Thai Constitution; but it is a right being abrogated by Thai policymakers when it comes to treating Thai IDU co-infected with HIV/HCV. One of the major arguments against treating HCV is that the combination pegylated interferon and ribavirin treatment is too expensive. However, in the long-term, it is more costly (both economically and in terms of patient quality of life) to not treat HCV in Thailand. The main economic benefit to treating people with HCV is that it lowers the cost and amount of medical care need for IDU with HCV, including expensive treatment for severe liver disease. Moreover, successfully treating Thais with HCV prevents new infections, since people who have been cured cannot transmit HCV to others.

Two recent studies clearly illustrate that it is cost-effective in Thailand to treat people with HCV with pegylated interferon and ribavirin.\textsuperscript{24} Researchers reported that HCV treatment increased life expectancy; moreover, treatment is cost-effective for genotypes 1, 2, and 3. In particular, treating Thai HCV (genotype 2/3) patients (versus no treatment) was associated with a lifetime cost savings of 556,862 baht (16,784 USD). Therefore, it is not only the Thai government’s constitutional and moral duty to provide adequate treatment for Thai HCV patients, but it is also in its economic interest to do so.
He held the paper close to his face and carefully unfolded it. The tears came almost instantly.

“It says “reactive”. That means I’m HIV positive, doesn’t it? “, he sobbed quietly.

“I’m already a homosexual and now I’m HIV positive. What will become of me? What will other people say?” he asked, speaking in Filipino using the word “bading” for homosexual which in the vernacular is a softer translation of the word “fag”.

Now crying openly, he covered his face in shame.

This is the story of X, a 20 years old student who is gay.

X was one of the participants of a sexual health workshop that I conducted for his student organization. X and the other twenty or so participants all received a piece of small pink piece of paper that was no more than 2 inches wide.

On some papers, the word “non-reactive” was written. On other papers, the word “reactive” was written. This is the simulation exercise part of the workshop to demonstrate stigma and discrimination.
Yes, this was just a simulation exercise. But for many young people like X, being infected with HIV and scorned by a judgmental and self-righteously pious society is an all too possible reality.

Though he has openly declared his sexuality to his parents, X says they have not accepted him. His mother openly told him that she would not consider him her son unless he changed his ways. An ex boyfriend left X for a woman after saying that he was ashamed to have even been involved with a gay man.

He told me that on many occasions, he considered killing himself and ending his misery.

Even though it was a simulation exercise, it was too much for X. It was just too close to home.

HIV infection is a very real possibility many young people face in the Philippines.

Multiple partners and casual sex hook-ups through social networking sites are becoming more common, but condom use remains a dismally low 2.8% (source: National Demographic Health Survey 2008). According to a Reuters report, the Philippines has the lowest level of condom use in Asia.

The highly Catholic Church imposing the rules on morality has caused shame and self-censorship. Many young people don’t ask about sexual health because even asking – and a sign of curiosity / interest is shameful. The denial is taking its toll – this year has marked the unprecedented rise in HIV infections in the country. From January to October 2010, there were a noted 1,305 infections recorded by the HIV / AIDS Registry of the Department of Health. This is more double the number of infections that were recorded in 2009.

The sexual health workshop that I conduct is a trademark offer of Sex and Sensibilities, a website that I founded and manage.

The workshop is called The Triple-S Sexual Health workshop because it covers three aspects:

**Sexual health rights and STI prevention**

Sex education in the Philippines is not a standard part of school curricula. In many private Catholic schools, only natural family planning methods are taught and gender sensitivity and sexuality are not taught at all.

**Sexual Health Rights**

Though an AIDS Prevention and Control Law (Republic Act 8504) was passed as early as 1998 and was once labeled as a best practice in the region, not many people are aware of this law. This is evidenced by the fact that there is a provision in the law to advance the prevention of HIV though mass education and information, this is not being done.

**Stigma and Discrimination**

Currently, Sex and Sensibilities is the only organization that is offering this kind of workshop that is based on fact and statistics and combines interaction with a strong component on stigma and discrimination. At the end of the workshop, the speaker who conducts the stigma and discrimination portion reveals that he is living with HIV.

For many people attending the workshop, it is the first time for them to see someone who is living with HIV. Many register shock and don’t know how immediately how to react. Many have questions about what it is like and if one can continue living a normal life even while being HIV+.
I am not a lawyer. I am not a legislator.

I am a journalist and sexual health advocate. In my years writing about women’s issues and sexual health rights, I have seen first hand how people living with HIV recluse themselves and cut themselves off from friends and loved ones. It is borne out of fear of rejection, stigma and judgment.

For many like X, it is this stigma that causes him shame; that damages his self-esteem and his concept of his own self-worth.

The Triple S Sexual Health Workshop is my way of bringing out the concept of sexuality, condom use and stigma and discrimination and talking about it – openly. In the past year since we started doing the Triple S Sexual Health workshop, I have given talks to the transgender community, the medical students, to university students, to employees in call centers and yes, to nursing students like X.

The Triple S Sexual Health Workshop is my way of reaching out to the middle class youth who are not serviced by NGOs and development agencies because they already have their hands full attending to the two-thirds of the population who are living on less than USD1 a day.

The young, educated, middle class segment is not being given the proper information about sexual health. They are magically supposed “to know better”.

But “knowing better” connotes comparison. And I believe that before they can know any better, they need to know what their choices are.

And one of those choices is to exercise their right to live a life free from stigma and discrimination. It is already mandated by the law. It now simply needs to be respected by the rest of humanity.

I am a journalist by education and profession and now a sexual health advocate as a matter of choice and passion.

This is my story of fighting stigma and discrimination in my country, the Philippines.

20 India India HIV/AIDS Alliance

The International HIV/AIDS Alliance is a global partnership of nationally-based Linking Organisations (LOs), working to support community action on AIDS in developing countries. LOs financially and technically support community-based organisations (CBOs) to work across the spectrum of HIV interventions, with a particular focus on empowering those most vulnerable and marginalized communities key to the epidemic. The India HIV/AIDS Alliance comprises of a Secretariat in Delhi, five LOs1 and various other civil society partners. The India HIV/AIDS Alliance welcomes this opportunity to provide input to the Global Commission on HIV and the Law.

Programming experience from Alliance India and its partners clearly shows that punitive laws targeting key populations in particular continue to hinder evidence-based, effective HIV responses for these communities in India. Stigma and discrimination against key populations have resulted in legal frameworks that criminalise and support social exclusion and marginalization. Even where legal frameworks do not in themselves criminalise behaviours or individuals, stigma and discrimination against certain communities means they are ‘soft targets’ for law enforcement and continue to be subject to human rights violations and disempowerment.

While law reform therefore continues to be a critical component to ensuring the rights of key populations,
correct interpretation and application of laws, addressing stigma and discrimination and supporting systematic community mobilization and empowerment present necessary, complementary approaches. Without these, law reform in itself is not sufficient to ensure realization of the rights of key populations.

In the case of sex workers, the Immoral Traffic Prevention Act provides an unsupportive framework for the HIV response. While current legislation does not in itself criminalise sex workers per se, their vulnerability and stigma and discrimination against them result in law enforcement targeting sex workers themselves, even when solicitation as such cannot be proven. The fundamental concept of equating sex work with trafficking and considering all sex workers as victims stands in direct opposition with the need to empower sex workers and achieve recognition of their rights. In addition, sections of the Indian Penal Code are also invoked frequently against sex workers (including for instance sections on engaging in acts causing annoyance to the public, behaving indecently in public, etc).

Alliance India’s Andhra Pradesh (AIAP) regional office (reaching 50,000 female sex workers as lead state partner for the Avahan programme) reports that police raids in the name of the prevention of trafficking are targeting sex workers themselves who have little legal or social protection. Furthermore, the legal framework has resulted in the breakdown of the more structured brothel-based sex work, leading to a more mobile and less visible community of sex workers, making it more difficult to reach sex workers through outreach and clinic-based services. In order to address the violence and abuse experienced by sex workers through the hands of law enforcement officials, AIAP has been supporting a structure of community action groups (CAGs) and community action teams (CATs). CATs provide community representatives who provide support at hotspot level in responding to cases of violence and in sensitizing community members to their rights. CAG members in turn are responsible for advocating with and sensitizing law enforcement agencies, media, government departments and other key stakeholders at the project site level to prevent future incidents and to support correct interpretation of laws.

Similarly, SIAAP in Tamilu Nadu, one of Alliance India’s partners under its Pehchān project, has been working with sex workers, MSM, and transgender people to address police violence. SIAAP has been training community members on human rights, the law and the legal system in particular to equip them with the skills to negotiate with police officers in cases of arbitrary arrest and to seek redress. SIAAP also provides legal assistance, counseling and sensitizes police officers on the legal rights of the community. SIAAP emphasises that monitoring police practices at local level is essential to ensure sustained change to police practices on the ground. In 2004, SIAAP documented 39 specific cases of police violence against sex workers and submitted a report to the Secretary of Home in Tamil Nadu. Due to concerted advocacy and awareness-raising, the Secretary then issued a letter to all district police stations insisting that the rights of sex workers are upheld and that violence and unlawful imprisonments cease.

In July 2009, the Delhi High Court ruled that Section 377 of the Indian Penal Code as far as it pertains to consensual sex between adults is unconstitutional. While recognition of the rights of men who have sex with men (MSM) in the legal framework was a critical step, actually realization of rights of MSM in India still remains. Alliance India and its partners have recently started implementation of Pehchān, a community-based programme aiming to building the capacity of MSM-, TG- and hijra-led community organisations across 17 states to take a lead in the HIV response. Partners continue to report stigma, discrimination, violence and targeting by law enforcement officials. Partner organisations report the misuse of vagrancy laws (e.g. public nuisance sections in the India Penal Code) against men who have sex with men. Stigma and discrimination again emerges here as the underlying factor for the misuse of these laws against certain communities and individuals.

Furthermore, concerns have been raised by national community and civil society stakeholders regarding the National AIDS Control Organisation’s (NACO) introduction of target-based testing for the organisations implementing its ‘targeted interventions’. Achievement of targets for testing is linked to performance evaluation and future funding of implementing partners. Target-based testing could result in testing being involuntary in nature. Reportedly, implementing organisations have started resorting to coercive measures to achieve testing
targets, including making access to services conditional on HIV testing. Furthermore, implementing organisations have to collect individuals’ names and addresses to report their client base to the NACO. These kinds of practices not only violate the rights of MSM and other key populations, but also undermine the effectiveness and reach of the services provided.

Furthermore, the legacy of criminalization has also left a lasting impact at the level of the community with very few CBOs in place. Given the NACO’s strategy of supporting targeted interventions implemented (at least in part) by community organisations themselves, this has impeded scale up of appropriate services for MSM, TG and hijra communities in India. Community mobilization and investment in community systems and structures therefore constitutes a critical component of realizing the rights of these communities, not only for an improved HIV response, but also as an end in and of itself. In this regard, Alliance India’s Pehchān is making an important contribution by supporting 80 existing and 120 new CBOs to implement HIV-related interventions. Furthermore, while some interventions for MSM were being implemented before the law was reformed, the new recognition of rights and identities has facilitated a more comprehensive approach. This approach is based on the recognition that only when the underlying sources of vulnerability, exclusion and marginalization at the community and the individual level are addressed, will interventions have an impact on HIV outcomes. In this context, Pehchān will be implementing services that take a holistic approach to the needs of the community (supporting issues related to gender and sexual identity, mental and psychosocial support, rights literacy and support female partners) and will ensure appropriateness and access by working through community-led systems.

Realising the sexual and reproductive rights of adolescents in India faces significant challenges, including a legal framework that limits access to appropriate information and services. Alliance’s India’s experience through its CHAHA programme, a child-centered care and support programme supporting 64,000 children affected by AIDS, confirmed the widespread unmet sexual and reproductive health needs of adolescents. In particular, it highlighted the particular needs of adolescents living with HIV for SRH and HIV prevention services, which are largely unaddressed. Not only are existing SRH services mainly cater to married adolescents, but existing policy and legal frameworks limit access to services (such as VCT) through laws that requires legal guardians to provide consent and to information (such as through sexuality education in schools) through recent state-level bans.

Within this challenging context, providing information and services to adolescents from sexual minorities faces additional barriers due to the existing legal framework. Reaching adolescent males who are having sex with males is a challenge that continues despite the recent successful law reform. While age for consent is 16 for heterosexual sex, sex involving a man under 18 is considered pedophilia and is punishable under Indian law. Pehchān partners have however reported that a significant proportion of community members actually in need of services are under the age of 18. It is during adolescence and during the process of discovery of sexual and gender identity that they are most vulnerable due to the higher number of partners (mostly with peers), unprotected sexual encounters, coupled with low knowledge levels and no access to services. Limited access to services is not only due to the social pressures and stigma that prevent young MSM from accessing appropriate services, but also due to the legal framework that prevents service providers from providing services to under-18s. Community outreach to this age group would put staff and the organization at risk for legal consequences, and informal provision of services would mean that their needs, and the resources required, are not formally recognized.

The experience from Alliance India and its partner has highlighted that laws and their application to key populations continue to impede rights- and evidence-based, effective HIV responses. Community mobilization and community-led responses, in implementation and in advocacy and monitoring are necessary to ensure that communities whose rights are compromised by the law or by discriminating enforcement and practices realize their rights and receive effective HIV-related services and support.

1 MAMTA, LEPRA, PWDS, VMM, Humsafar Trust and partner SASO
2 Lawyers Collective, Key concerns, Presentation at the National Consultation on Sex Work, HIV and the Law, 5th November 2007, New Delhi
3 See for instance open letter to Mr K. Chandramouli, Secretary and Director General, National AIDS Control Organisation, Re: Concern over ‘anti-rights’
Drug Users in India are Hindered by existing enforcement of Law to Access HIV Related Services

Prelude

By misusing the provisions of various Acts, the Drug Users are been harassed and sometimes victimized by the police although the Constitution of India ensures right to information and equal access to justice for her citizens. The provisions of the law and fear of police harassment has reinforced the antisocial feelings and loss of faith in law among drug users. This is a major obstacle in accessing the Needle Syringe Exchange Services (NSES) provided by the Turning Point Foundation through Outreach and Drop In Centre, in Panipat, Haryana, India.

Organizational Background

Turning Point Foundation, a registered organization founded by a group of social and medical professionals along with ex-addicts to provide prevention, treatment and rehabilitative services to the drug users. TPF intervenes in issues related to Drug Abuse, HIV/AIDS and alternative systems of Medicines. The 40 bedded Drug de-addiction and rehabilitation centre in Delhi and harm reduction for program for Injecting Drug Users are some of its endeavors to achieve its goals. It partners with government of India, state governments, Bilateral, multilateral and private foundations along with individuals for the logistic and programmatic support.

As a part of its initiatives to prevent HIV transmission among Injecting Drug Abusers(IDUs) in the North Indian state of Haryana, it is running peer led Drug abuse prevention and support programme in Panipat. Being one of the India most highly IDU populated state; it has identified over 300 IDUs through. The peer led HIV/AIDS prevention through Needle Syringe Exchange Programme (NSEP) and abscess management, the project reaches the IDUs in their shooting sites through peer educators and outreach workers and also through Drop In Centre which has also Clinic for Abscess management and STI treatment.

Harm reduction among IDUs

All most all the identified IDUs are from the poorest sections of society and are isolated/disowned by the families and society. They look dirty and involved in odd jobs such as rag picking and some of them occasionally do petty stealing. From time to time, they are engage in begging to sustain their lives with drugs. They are in the age group of 15-45 years and live in streets. Most of the addicts are in high risk behavior groups and they do not have basic knowledge about HIV transmission. Due lack of awareness and other supportive services, they freely exchange needles while injecting. Many of them feel themselves as criminals and having hopeless feeling towards life.

Access to services and fear of law

It takes a lot of time and energy for the outreach workers and peer educators, about their vulnerability to HIV transmission and how needle syringes can prevent the infection of HIV.

Although after sometime, they get convinced about the need of the NSEP, many of them are afraid to seek support and avail services as they are in the fear being caught by police under NDPS Act.

Bad experiences of the IDUs

Many of them have the experience that they are been picked up police while sleeping in the pavement or rag
picking. Some of them shared that after being picked up, the police plant drugs on them or force them to consume drugs at police station and take them for medical check up.

Other times, they are been arbitrarily arrested by the police on the allegation of stealing in the area and consumption of drugs. They are been forced to do menial jobs in police stations and the quarters of the constables.

None of them are informed about their rights on arrest. All these arrests mostly by using several sections of Indian Penal Code and Narcotic Drugs and Psychotropic Substances Act, 1985 (NDPS Act).

Since they are socially isolated and government institutions are reluctant to help out, they do not get any legal aid, most of the time they plead guilty

Thus, they are been trapped in the vicious cycle of “vulnerability → arrest → plead guilty since no legal aid → imprisonment → increased vulnerability → release → arrest again → plead guilty again....

To come out of this cycle, there is a need for facilitating them for access to justice through legal awareness and timely legal aid. The initiatives for access to justice can avoid repeated arrests and victimization by the police and society.

**Constitutional Provisions before arrest**

The Preamble of Indian Constitution proclaims that the Constitution will secure to all its citizens justice, liberty and equality. Provides that no person on arrest can be detained in custody without being informed of the grounds of his arrest, or denied the right to consult or be defended by a legal practitioner. Every person who is arrested or detained is required to be produced before the nearest magistrate within 24 hours.

**Narcotic Drugs and Psychotropic Substances Act, 1985**

Basic Features of the Narcotic Drugs and Psychotropic Substances Act, 1985

The NDPS Act 1985 sets out the statutory framework for drug law enforcement in India.

The main elements of the control regime mandated by the Act are as follows:

The cultivation, production, manufacture, possession, sale, purchase, transportation, warehousing, consumption, inter-State movement, transshipment and import and export of narcotic drugs and psychotropic substances is prohibited, except for medical or scientific purposes and in accordance with the terms and conditions of any license, permit or authorization given by the Government. (Section 8)

All persons in India are prohibited from engaging in or controlling any trade whereby narcotic drugs or psychotropic substances are obtained (Section 12).

The Act, however, makes a distinction between possession for personal consumption and trafficking, the punishment for the former being limited to between six months and one year only. The application of this provision is subject to the following two qualifications: 1. The quantity of the drug involved in the offence should be a small quantity as specified by the Central Government.

2. The onus is on the accused to establish that the drug in question was meant for personal consumption and not for sale, distribution etc.

**The 1988 U.N. Convention** against Illicit Traffic in Narcotic Drugs and Psychotropic Substances to which India is a signatory, requires Parties to impose controls on the manufacture, internal distribution and import and export of chemicals which can be used in the illicit manufacture of narcotic drugs and psychotropic substances.
Other Laws in which Drug Users are Arrested

The below provisions in Indian Penal Code is been used, misused or abused by the law enforcers to arrest/harass the drug users.

Section 107 IPC defines abetment

And section 109 IPC provides the punishment for it.

107 Section 120A IPC defines criminal conspiracy to mean an agreement between two or more persons to do or cause to be done an illegal act or an act, which is not illegal by illegal means. Punishment is provided for in Section 120B IPC.

108 Section 40 IPC.

109 Section 34 IPC.

110 Section 292 IPC prohibits sale, distribution, circulation, exhibition of obscene material, pamphlets, writings, etc.

111 Section 292A IPC.

112 Section 293 IPC imposes a higher punishment if such objects are offered to young persons.

113 Section 294 IPC

Abuse of the Act by the Police

At the instance of an arrest of a Drug User, using the provisions in the Act “possession of drugs for personal consumption and trafficking” the police have lot of arbitrary power for interchange the charges from personal consumption and trafficking. The punishment for this two actions are makes a lot difference. Using this arbitrary power, police threaten the addicts and force them to pay bribes or do odd jobs without remuneration.

Rights of Drug Users

Based on the European Convention on Human Rights, Drug users have the three general rights to (a) consume drugs, (b) receive help for drug problems, and (c) be subject to fair drug laws and policies. Under these three headings, drug users have the specific rights (1) to ingest drugs and be intoxicated, (2) to possess and store drugs, (3) to share drugs with others, (4) to access quality drugs, (5) to access drug-taking equipment, (6) to access information about drugs, (7) to receive help for drug problems, (8) to be accurately described, (9) to be subject to reasonable drug laws, and (10) to social inclusion without discrimination. Drug users and non-users also have universal rights under the Human Rights Act.

Conclusions

The abuse of Law and some provisions of the NDPS Act and some penal provisions plays major obstacle in accessing the harm reduction and counselling services provided by voluntary organizations in India. There is need to amend the law and penal sessions after consulting with all the concerned people along with drug users, so no human rights violations will not happen in future also.

While arresting a Drug User, it is recommended that a senior police officer along with social worker should be present to avoid possible violations of human rights. Legal Awareness and free legal aid should be made available for the drug users.
IPPF’s ‘Criminalize Hate Not HIV’ campaign was launched at the International AIDS Conference in Vienna, July 2010 provides an opportunity for us all to become more conscious of the impact of criminalizing HIV transmission.

Some highlights include:

- **Behind Bars**: an international collection of interviews published online that exposes the effect criminal laws on HIV transmission on people’s working and private lives. The stories illustrate the personal and professional dilemmas faced by doctors, lawyers, parliamentarians, researchers, and advocates; among them a doctor who was forced to aid a police investigation against her ethical principles, a woman living with HIV who prosecuted her former partner and a lawyer who advocated in a HIV transmission case.
- **Criminalize Hate Not HIV**: A short conscious raising campaign film that will go live on World AIDS Day. It shows the humanness of sex, of relationships and of HIV. The people in the film are from many walks of life, are not professional actors, and many are living with HIV. It builds on IPPF’s Declaration of Sexual Rights and purposefully focuses on sex – irrespective of how, where, with whom and why people have sex.
- **New and useful resources** about the law, public health, and human rights in the context of HIV.

IPPF would like to submit the film as a public submission for the Asia-Pacific Regional Dialogue for the Global Commission of HIV and the Law. The Criminalize Hate Not HIV film is publicly available and can be viewed at [http://www.youtube.com/IPPFHIV](http://www.youtube.com/IPPFHIV).

We look forward to hearing from you and would be happy to provide further information or materials as needed. Please contact Anisa Ismail (aismail@ippfeseaor.org) for more information about the campaign in the Asia-Pacific region or Lucy Stackpool-Moore (lstackpoolmoore@ippf.org) for more information about the global campaign.

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**The Right to Choose a Place of Residence and the Right to Freedom of Movement**

The right to choose one’s place of residence and the right to freedom of movement is a constitutionally guaranteed human right in Sri Lanka. Yet for X this constitutional right meant nothing as residents of her village set fire to her home and forced her and her two young daughters to leave because of her HIV status.

In 2001, her husband who worked in Germany for many years, tested positive for HIV. Soon after that X also tested positive and since then X has battled to ensure her right to dignity and the rights of others living with HIV.

Violation of the right to choose her place of residence is among only one of the many violations that X experienced. After her husband tested positive, medical staff at a state run hospital where he underwent the test breached his right to privacy by sharing this information with other staff in the hospital who in turn shared it with the residents of the village in which X and her husband lived. The hostile reaction of the community forced X to leave the village in which they resided and return to ‘her’ village.

Her husband could not handle the marginalization, the shame and the stigma of his HIV status and committed
suicide. Burial of her husband’s body in his village was prevented by the residents and X was forced to bury her husband’s body in Colombo. It was after her husband’s death that her neighbours set fire to her house in which she resided with her two daughters and which caused X to flee yet again.

X’s two daughters were also subjected to discrimination. Soon after she tested positive, parents had removed their children from the school in which her daughters were studying forcing X in turn, to take her children out of school. ‘At that time I took it as their fate that even my children would be subjected to discrimination because of my HIV status. My greatest regret is that I did not teach my children that this need not be so’, says X. ‘I will not allow any other child to suffer the same fate as my children’, she said. ‘No child, whether they are HIV positive, or live with parents who are HIV positive, should face the discrimination that my children did’.

Since discovering that she is HIV positive X has begun speaking out against the discrimination that PLHIV face. She now heads the Positive Women’s Network, one of the few organizations that supports those living with HIV.

According to X although the constitution contains a right to equality and non-discrimination there are several areas in which PLHIV experience discrimination and exclusion. The health sector was one of those areas. Several of those who have sought support from the Positive Women’s Network have complained about the lack of confidentiality in the health sector; the marginalization they experience when they seek treatment; the unwillingness of medical staff to provide adequate information; and blood tests which are done without the consent of the patient. ‘It is my body, yet I did not get the information I was entitled to. They treated me like I didn’t own my own body’ says X in relation to her own experience.

X’s life story illustrates the need for a law and policy that will guarantee the rights of PLHIV. Such a policy will need to ensure that medical staff respect the right to privacy of PLHIV; provide adequate information both to those with HIV and to others; provide the necessary treatment and counseling to PLHIV; and do not engage in the testing of people without their express consent. Such a law and policy will also need to ensure more broadly that PLHIV are not subjected to discrimination as a result of their status and identify in clear terms the duties of hospitals, doctors, medical staff, the police, educational institutions and other stakeholders.

### Re: Violence through HIV Program in India

We write to you to express concern over recent practices introduced by the National AIDS Control Organization (NACO) on Targeted Interventions (TIs) for most at risk populations (MARPs) namely, female sex workers, men having sex with men and people who inject drugs that affect individual autonomy and confidentiality and also threaten the success of the National AIDS Control Programme (NACP).

**Prescription of targets for HIV testing of MARPs enrolled in TIs**

It has come to our knowledge that NACO has begun to follow a practice of target based HIV testing for MARPs, the achievement of which is linked to performance evaluation and future funding of the TI. While we recognize the importance of scaling up voluntary counselling and testing for HIV as well as the need for sound monitoring of the programme, it is our concern that where imposed as a target, HIV testing will take on an involuntary character, undermining the reach and effectiveness of the TI. Target based testing of MARPs has reportedly led to the following:

**Undue pressure on organisations running TIs**

Organizations implementing TIs have confirmed that the inability to meet testing targets leads to a negative
evaluation by the Technical Surveillance Unit (TSU) and/or State AIDS Control Society (SACS), triggering a series of adverse consequences. These include downgrading of performance rating, reduction in the size of population to be served under subsequent grants, decline in funding and even disqualification from running TIs. This despite the fact that the TI may be performing well on other indicators such as – coverage through outreach, referral to STI screening and delivery of condoms or sterile needles.

As a result, organizations operating TIs are reportedly resorting to coercive or compulsive methods to test MARPs in order to meet the prescribed testing targets. In some places, access to services provided by the TI has been made conditional upon undergoing HIV testing. Some projects are reportedly submitting inaccurate reports by entering one person’s HIV test result multiple times in the data base. Still others are reportedly organising ‘health camps’ to test persons with no reported high risk behaviour in order to fill in numbers of people tested for HIV. The priority of the intervention has evidently shifted from reducing HIV risks to increasing HIV testing.

Target driven testing encourages breach of rights of MARPs. Cuts in TI budgets for non-compliance with HIV testing targets diminish the strength and scale of prevention services for MARPs. Incorrect reporting and false data ultimately weakens the epidemiological vigour of the NACP.

**Impact on MARPs**

The success of TIs lies in their ability to reach out to MARPs in a non-judgmental and affirmative manner and instill confidence and self-respect in the community. This is done through practices that uphold rights and dignity of clients – whether they are sex workers, MSM, transgender or persons injecting drugs. NACP-III Operational Guidelines for TIs clearly require services to be delivered in a caring and welcoming environment. Any compulsion to get tested can lead MARPs to lose trust in service providers and feel alienated from services. Recently, drug users from North-East India strongly condemned a move to have 100% testing of target population annually, deeming it an attempt to make them “guinea pigs”. It is well known that MARPs are least likely to access health services if they are deemed coercive or unfriendly. The pressure to test for HIV is likely to drive MARPs away from TIs and other critical services.

**Bad public health strategy**

Given the concentrated nature of the HIV epidemic, India can ill-afford to weaken or undermine interventions for MARPs. It is important that we do not begin to carry out testing for testing sake. Testing to report, for example, that 80% of sex workers have undergone HIV screening does not in itself serve any purpose. For MARPs, the rationale for pursuing aggressive testing without assuring access to anti-retroviral treatment is indeed questionable.

Target driven involuntary testing is a marked departure from the rights based approach followed under the NACP over the last two decades. It is inconsistent with NACO’s successive policies on HIV testing including the National HIV Testing Policy, 1995, Guidelines for Voluntary Counselling and Testing, 2004 and Operational Guidelines for Integrated Counselling and Testing Centres, 2007 – all of which require HIV testing to be conducted with express, voluntary and informed consent of the client. These policies incorporate legal norms on patient’s consent espoused by Courts in India and abroad. NACO must respect law and policy standards both in letter and in spirit.

**Line listing of MARPs under the TIs**

Project staff in TIs are mandated to record the name, address and other contact information of MARPs and share this data with TSU/SACS. The practice is ostensibly to improve follow up as well as monitoring of the TI, at the cost of client confidentiality. Unauthorised disclosure of personal information is illegal, unless required by law or directed by a Court in large public interest.
We would like to reiterate that respecting client confidentiality is not only a legal requirement but also a good public health strategy, as it improves attendance at clinics, enables clients’ to reveal medical or related risks and facilitates correct diagnosis and treatment. Safeguarding privacy and confidentiality assumes greater importance for MARPs on account of the stigma and criminality associated with sex work and drug use. Organisation have confirmed that disclosure of personal information for line listing is causing many clients, especially MSM to drop out of TIs. This is indeed worrisome.

**Undue pressure on peers and outreach workers**

Outreach workers and peer educators are the backbone of TIs as they are the first, and often, the only point of contact between MARPs and HIV related services. As peers and community outreach workers are the ones who meet MARPs, the pressure to fulfill testing targets invariably falls on them. Fear of a cut in salary, loss of work and a negative performance assessment has reportedly resulted in peer staff pressurizing their contacts to get tested. Some peer educators, for example, have reported falling at the feet of their contacts or paying money to gain acquiescence for HIV testing. Though this may not amount to coercion, such methods vitiate consent to testing. Further, they are likely to create mistrust and unprofessionalism in programme delivery.

**Need for an Enabling Environment**

Instead of enforcing targets on MARPs, NACO must focus on the creating an enabling environment for HIV prevention and control. This would include *inter alia*:

**Removing factors that discourage testing**

There are many reasons that inhibit MARPs from seeking HIV counselling and testing. These include low self esteem, fear of loss of support from family/peers, loss of earnings especially for female and transgender sex workers, fear of incrimination for illicit sex/drug use, inflexibility of ICTC timings and insensitivity of counsellors. A genuine uptake of voluntary HIV counselling and testing by MARPs is possible only if individual and institutional barriers to testing are addressed.

**Promoting measures that encourage testing**

People seek test when the benefits of getting tested outweigh the potential risks of undergoing testing. Maintenance of confidentiality, protection against HIV related discrimination, ensuring free and timely treatment, removal of punitive laws are some of the means by which MARPs will come into the fold of HIV prevention and care. It is imperative that NACO pursue such strategies in earnest.

In the name of size validation the TSU members are going to brothel houses even in odd hours calling them to come out from their houses and to show their identity without respecting their privacy and confidentiality which has created fear and anxiety leading to exodus from the brothel. As sex work in brothel setting is not legal in our country this has created more problem than good for the HIV program besides we consider it more as violation of Human rights of sex workers,

We understand that it has not been the intention of NACO to introduce mandatory testing or breach confidentiality. Yet, target based testing and line listing of MARPs, is inadvertently diminishing our ability to reach out and protect the most vulnerable members of society. It is also eroding the soundness and efficiency of our carefully designed AIDS prevention strategy. We therefore request you to convene a meeting with civil society and community groups to address the concerns raised.
I would like to share my experience of working with the most marginalised transgender community in Delhi.

A large number of Kothis (feminised males) are thrown out of their homes. Often they are disowned by family members as they are thought to be a dishonour to the family. Most of them could not complete even secondary school as they are constantly teased, abused and ridiculed by peers and teachers alike, for their gender variant behaviour. With no support system whether social, emotional or financial, many transgender individuals from very young age start begging on traffic red lights in women's clothes. It is the strong identification with the opposite gender than that with the biological one that one identifies as transgender.

In this context, the Bombay Prevention of Begging Act, 1959, which is extended to the National Capital Region (NCR) of Delhi, comes into the picture. On a routine basis, a number of transgender individuals are arrested by mobile courts in Delhi on account of begging. The judgement is passed on the spot by a district magistrate in the mobile court itself which is usually a van. And in almost all cases the accused is said to have pleaded guilty. Then the individual is sent to a detention centre for a year which is under the Social Welfare Department. The detention centre has separate cells for men and women and the transgender are to live with men. Often, they are required to strip in front of the officials and wear the uniform given by the centre.

A number of transgender individuals who are availing services through our Project ‘Delhi Dost’ over the years have faced humiliation – the humiliation of being arrested for no fault, making them live with men and in men’s clothing, stripping in front of others, and being abused physically and sexually by others including inmates. They are thought by many to be just sex objects and not human beings. There is utter lack of sensitivity on the part of the law enforcement agencies regarding the individual needs of transgender persons.

In one of the recent cases, a transgender individual was arrested by a mobile court and a one year sentence was given out to her without providing any legal assistance. The sentence read that the client was ‘posing as eunuch’ for the last ten years, and he begs because he is a lazy person. This is the height of insensitivity. Can anyone pose as eunuch for ten years and willingly sleep under a flyover after being thrown out of one’s home in the young age of 13 years? A Petition has been filed to the court by the organisation in this regard.

The Bombay Prevention of Begging Act needs change. It is inhuman, vague and gives undue power to police and courts to abuse hapless people especially the most marginalised ones, in the name of law. It criminalises a community most vulnerable to HIV infection.

There needs to be a strong advocacy and sensitisation programme for people in power. With transgender individuals having no opportunities for income generation, utter lack of understanding of transgender issues by authorities, and pressure to behave and act like a ‘man’ to get even menial jobs deters the community to come forward. Such an environment further pushes them into serious vulnerable situations.

This hostile environment has to change. It can be done effectively through legal reform and laws that recognise the diversity of individuals, along with social change.

In addition to this I would like to share the recent announcement of the Delhi Government that says that Rs.1000/- monthly pension will be given to the 'Eunuch' under the welfare scheme that covers the disabled, and widows. Are the 'eunuchs' disabled? Isn't it further marginalising them and making them actually 'disable'? Instead of doling out such paltry money that serves no purpose there should be legal policies and programmes that make the community self dependent, empowered and mainstreamed. There can be seats reserved in educational institutions, public education on gender, curriculum on gender studies from the beginning of education etc.
Mandatory HIV Testing of Asian Migrant Workers

CARAM Asia, a regional network with over twenty-seven members spanning across Asia to the Middle East, has been working on the issues of health and HIV among Asian migrants for over ten years. In 2007, CARAM Asia released the report *State of Health of Migrants: Mandatory Testing*. The report, based on research conducted in sixteen origin and destination countries¹, looked at the policies and practices of mandatory health and HIV testing for migrant workers using direct input from key stakeholders and migrant workers themselves. Since the release of the report, CARAM and its members have been actively pursuing advocacy on the issue in a variety of venues and fora, at the national, regional and international levels, including participation on the UNAIDS Task Team on HIV Travel Restrictions. This submission is based primarily on the findings of CARAM Asia’s 2007 report.

Policies and practices of mandatory HIV testing and related deportation of Asian migrant workers effectively criminalizes people living with HIV. These archaic policies and practices ignore pragmatic HIV prevention interventions and widely available treatments in favor of punitive measures. The practice of mandatory HIV testing for migrant workers, besides being discriminatory, also contravenes international guidelines and national policies on HIV testing by disregarding the established best practices of providing consent, confidentiality, counseling and referral. This omission results in a missed opportunity for members of this marginalized group to access timely treatment or prevent transmission of HIV to their spouses. Although many developed countries in Asia and the Middle East rely on migrant workers to keep their economies functioning, they have instituted migration policies that use health as a primary criterion for permitting entry and stay of migrants for employment. The crux of these policies is that migrant workers coming from less developed countries must undergo mandatory or compulsory health testing as a screening process to identify those with any of up to twenty-two exclusionary health conditions including HIV. Migrants must undergo health screening that includes HIV testing in their country of origin during the work permit and visa application procedure. Those who pass must then undergo testing again upon arrival and semi-annually to renew their work permit in most destination countries. If one of the exclusionary conditions including HIV is found during pre-departure, the migrant is disallowed from traveling for work; if testing finds a health condition or HIV while the migrant is in the destination country, that person’s work permit and migration status is voided, and he or she may be summarily deported. In other words, mandatory HIV testing is not intended to benefit migrants’ health – it is a screening device that effectively criminalizes HIV positive migrants.

The following are key points identified in CARAM Asia’s report:

**Mandatory Testing is discriminatory and contradicts national laws on HIV testing**

The policies and practices of mandatory testing for HIV are discriminatory because migrant workers who come from developing countries are singled out for this testing and are refused employment if found to be HIV positive. National laws and policies that protect nationals against compulsory or mandatory HIV testing for employment exist in both origin and destination countries. Migrant workers, however, are commonly omitted from these protections. Origin countries willingly submit to destination countries’ demands for compulsory HIV testing, making their own policies irrelevant; while many destination countries that have policies to protect nationals from this practice also have policies that explicitly single out migrant workers for mandatory HIV testing.

**Standards of HIV testing are disregarded**

1. Reference is not visible in the text.
Most countries have national laws, policies or guidelines that establish the following conditions as standard practice for HIV testing: consent, provision of pre-test and post-test counselling, protection of confidentiality, and referral to proper services and treatment as available. Yet, due to various factors related to conducting large-scale testing of migrants and the association of the tests as a requirement for migration - these standard practices are simply disregarded. In Origin Countries In the pre-departure stage before migrants can get a visa or work permit, they first must undergo health testing. This is where the first violation of informed consent is committed. Prospective migrants feel obliged to sign whatever documents are required to go abroad even if they cannot read or understand them; while health officials, with the understanding that the health exam is compulsory, assume that there is implicit consent to HIV testing even though the list of conditions tested is not elaborated. In the end, few prospective migrants are aware they are being tested for HIV. Due to a combination of factors, including assumptions about migrants’ awareness of HIV, the volume of people testing and a lack of counselling skills by medical staff, prospective migrants do not receive any pre- and post-test counselling. Prospective migrants rarely see their reports and may only be notified of whether they can work abroad or not. Those deemed “unfit” – meaning that an exclusionary health condition was found – are commonly not even informed of the condition that has excluded them from receiving a work permit. Some countries are now providing migrants with HIV referral to other testing centres for confirmation and counselling when they test positive for HIV, but this is not a standard practice.

Part of the problem is that test results always go directly to the recruitment agency, which is responsible for informing prospective migrants of their eligibility status. Not only does this practice further eliminate any chance for meaningful counselling, it is a routine breech of confidentiality, especially when the health conditions found, including HIV, are listed. Rejection by a GAMCA 2 clinic is a systematic and categorical breech of confidentiality as migrants’ results are fed into a database that is shared with all other GAMCA centres, effectively banning a “permanently unfit” person, which includes those with HIV, from ever legally migrating to work in a Gulf Country again.

In Destination Countries

Those who are allowed to travel for work are tested again upon arrival and regularly throughout their stay in the destination country. Again, all standard practices for voluntary HIV testing are disregarded, and results go directly to employers. In destination countries, not only is the volume of migrants testing an issue, but there are also language and cultural barriers which negate any potential for meaningful consent or pre- and post-test counselling, if any attempts are even made.

Mandatory Testing leaves migrants vulnerable to unethical deportation

When an HIV result is found, some destination countries in Asia and the Middle East will treat the migrant like a criminal by immediately putting him or her in quarantine and/or deporting him or her without explanation. This unethical treatment obviates any chance for counselling and results in a terrible emotional shock. In most cases, migrants are deported without being made aware of what health condition was found that led to their deportation; in other cases, they are notified of their HIV status under the worst conditions.

Once returned home, a migrant may receive paltry financial compensation, and, on rare occasions, referral to HIV services. Generally though, the individual is simply left to return to his or her family, bewildered and devastated. For those with HIV, there are serious implications regarding spousal transmission as the returned migrant may not be aware of his or her status, may not know how to prevent transmission, or may be afraid of revealing his or her status for fear of the negative social impact.

Platforms where CARAM Asia has engaged on the issue of mandatory HIV testing of Asian migrant workers:

- Joint UN Initiative on Migration and AIDS (JUNIMA)
ASEAN Task Force on AIDS (ATFOA)
- IOM and WHO Pre-Colombo process (July 2010)
- High Level Multi-Stakeholder Dialogue on HIV Prevention, Treatment, Care and Support for Migrants in the ASEAN region (Feb. 2009)
- UNAIDS Task Team on HIV-Related Travel Restrictions (2008)

CARAM Asia’s report can be accessed at:

http://www.caramasia.org/index.php?option=com_content&task=view&id=592&Itemid=343

For more information, please contact: Brahm Press, Convener of the Task Force on Migration, Health and HIV for CARAM Asia, brahm.press@gmail.com +6689 850 1715 (Thailand)

1 Destination countries included: Bahrain, Dubai, the Hong Kong Special Administrative Region (China), Japan, the Republic of Korea, Malaysia and Thailand; Origin countries included: Bangladesh, Cambodia, India, Indonesia, Nepal, Pakistan, Philippines, Sri Lanka and Vietnam.

2 Gulf Country Council Approved Medical Centres Association CARAM Asia 8th Floor, Wisma MLS, 31 Jln Tuanku Abdul Rahman, 50100 Kuala Lumpur, Malaysia Tel: (603) 2697 0708, 2697 0219 www.caramasia.org

27 China

Domestic Violence Experienced by Women Living with HIV from the Case of Ms. X

I met Ms. X in July 2006 for the first time when she lived with the virus for five years. One scar under her left eyebrow turned my attention. Out of the guess that she fell and hit the place, I asked how she had the scar. To my surprise, she burst to tears and started to tell me her tragic story.

She was infected with HIV in the blood transfusion when she gave birth to the second child in 1995, and was tested positive during the hospital stay in the city’s TCM hospital in September 2002. Her family and she were greatly scared and disturbed at the news, but the stark reality was unchangeable. In the ensuing days, Ms. X was marginalized in the family and her life was reduced to discrimination and torture by her husband. From then on, no longer could she eat and live with her family. Instead, she lived on her own in a small room. She slept and ate, but no one would ever notice her existence, needless to say talk to her or ask about how she felt. She had to go to the hospital by herself when she got sick. Despite all these, she could not get away from the verbal and physical abuse by her husband.

In September 2002, Ms. X was abused by her husband for the first time. He vented his anger by shouting at and beating her out of an ungrounded reason, because he blamed her to use up the savings of the family for the disease. He said why not she took her life soon now that she had the disease, while flailing his fists on her. But Ms. X did not fight back, because she also hated herself deep down at her heart for the infection and dragging her family into this. Her ignorance was a result of the deeply seated traditional mentality among the Chinese women. She believed that she had to accept the torture unconditionally, because a woman is supposed to follow the orders of her husband. In the following years, she was abused verbally and physically again and again. In the worst case, she was hospitalized for eight days after passing out with injuries and bruises all over her body. The most recent abuse happened half a month before I met her. Half of her face was then bruised and some parts were bleeding. The scar stayed even until half a month later when I met her. When asked why she did not press charges against the hospital for compensation, she then told me the truth. Actually she won the case against the hospital in 2003, but the compensation of 90,000 RMB was all taken away by her husband. Worse was that a story entitled “Deadly Blood Transfusion” broadcast by CCVT’s Legal Report programme on June 29th, 2005 angered the local government. As a result, the court ignored her further claims, which cut the
financial source for her medical bills. Since then, her husband not only left her all on her own and turned a blind eye to her deteriorating conditions, but also vent his anger increasingly on her. When asked why she did not divorce her husband, Ms. X answered, “It is the fault of HIV.” How pathetic she is!

Ms. X is a victim of the serious domestic violence after she was infected with HIV. Her shocking story is only one among the many women living with HIV subject to domestic violence. Her case reflects the low status of women living with HIV in the family and their tragic and thought-provoking experience as the most vulnerable group.

The Chinese government holds a consistent and clear-cut position towards the HIV issue. The national leadership visited AIDS patients in the hospital and the government has released the “Four Free and One Care” policy to protect the rights and interests of PLHIVs. But in the meanwhile, it is undeniable that some local governments do not make the most of the resources they have to care for these people. Instead, they abuse their power by withholding the information of these people to the outside world and cracking down upon PLHIVs for the sake of flawless government performance. It can be inferred from the Ms. X’s case that once the interests of the local government are in jeopardy, the rights and interests of PLHIVs will not be protected. This is the rule of man over the rule of law. In China, with a lack of supervision on the local government, it will be particularly difficult for the vulnerable groups such as PLHIVs to have their rights honoured from the competence departments. Worse still, rather than a well developed set of laws to protect their rights, the national government merely has released a few administrative regulations to address relevant issues. This had made it extremely challenging for PLHIV infected through blood transfusion to receive the compensation and protect their right to employment. The living status of them can be well imagined with such lack of applicable laws. Many of them had to give up the legal action to have their rights honoured, because the court refused to accept their cases. Legal assistance and aid are of particular importance for these most vulnerable people like Ms. X, who do not know where to turn for help, but ignorantly regard the virus as the scourge of their life.

We as the legal professionals should therefore stand out and deliver our support. The women living with HIV should foster legal awareness and know how to take advantage of the laws to keep domestic violence at bay. The other people who need help are the family members and relatives of the PLHIVs, who are both victims themselves and perpetrators of the domestic violence. They are in mental pain because of the infection of their family members on the one hand, and vent their anger upon their positive family members by way of abuse on the other. Therefore, the psychological counselling and legal aid to these abusive family members should also turn our attention. We should make them understand that they are supposed to care for their positive family members and that they can resort to legal means to protect the rights and interests for their positive family members.

Let’s settle the issues through law and put an end to the tragedies like Ms. X’s.

28 Nepal Blue Diamond Society (Care, Support and Hospice Centre)

**Share your experience of how the law impacts or life or the lives of those you work with?**

Homosexuality is a taboo issue in Nepal. Being as a transgender PLWHA means facing double stigma and discrimination. 1st due to their sexuality and 2nd due to their HIV status. Transgender people live as a criminal because there is not any space in the society, lack of job opportunities and lack of equal rights result they became sex worker. Being a transgender sex worker in our country is not easy to survive their life. They face harassment, rape and abuse through security personnel day by day. There are many cases we have recorded for eg once a night 14 police rape one transgender turn by turn very badly without using condom. Due to lack of law towards transgender and related to HIV we cannot case the file to against them and most of the transgender PLWHA and transgender sex worker are facing this kind of harassment daily and seen highly in these days. We have heard only women trafficking but there are many people in our hospice those who are infected and
trafficked by their boyfriend and their family members. There is only law towards women those who are trafficked but transgender not any law. So we cannot case any file to against them.

**Share your experience with your commission?**

The Care, Support and Hospice function brought home the great human costs of the discrimination and lack of education and information that the LGBTI population experience, so I took leadership to advocate for the rights for those living with HIV. While the national focus is still not adequate, we were the ones to make sure that MSM, MSW and Transgender people were included as high risk groups in the national HIV/AIDS work plans. Our sensitization included various educational efforts, street drama, television, radio and the press and direct interactions with government. It was necessary even to advocate with health care providers, hospitals, clinics, where sexual minorities experienced discrimination. While there was often resistance, we also saw the fruits of objective scientific and human educational explanations to those who succumbed to fear and prejudice. Our initiatives promoted World AIDS Day, Condom Day, HIV education through street festivals and education about sexuality and human development and continue as important health contributions. Our efforts aim also to reach society and families. One aspect of these efforts will hopefully to prevent continuation of the degree of migration to India for sex-work that results from family and social rejection, preventing education and employment by LGBTI populations.

The advances we have made through BDS and formation of those autonomous groups thus far show us how great the needs are in the areas already served. In those districts where there is absolutely no program for equal rights, educational about sexual minorities or for the realities of HIV/AIDS that they face and that impact the population at large, the needs are total. I lead our various training programs. How to effectively educate and advocate for our equal rights, to empower ourselves for equality enabling dignified lives and contributions to society, are key components of my work, based upon what I have experienced and witnessed.

**Share your work and your perspective with the commission?**

Since the founding of Nepal’s Blue Diamond Society (BDS) --- for the equal rights for lesbian, gay, bisexual, transgender and intersex (LGBTI) individuals, and their needs in the face of the HIV/AIDS pandemic --- I have been a part of the BDS team. BDS had made incredible progress as a truly grassroots organization working for the benefit of the communities which we serve and for the country as a whole.

I was Outreach Educator from 2001, promoting rights, awareness and sexual health, especially where they were so much needed in the men-who-have-sex with men (MSM), male sex worker (MSW) and transgender (TG) populations. We were and continue to be the only focused advocates in these areas. I initiated awareness programs with peer meetings, programs for police, the military and legal communities, and public forums such as television.

From 2005 I led our BDS Care, Support and Hospice Center for the populations we serve - the only such facility in the country. Our communities were rejected or ill-served by many HIV/AIDS education and care programs, in addition to suffering the rejection by families and society. We provide treatment and care, and initiatives for positive and safe healthy and responsible living for those infected.

I am very proud and grateful to have represented our work in international conferences, workshops and trainings, including: XV International AIDS Conference (Bangkok 2004); XVII International AIDS Conference (Mexico City, 2008); Nepal’s 3rd National AIDS Conference (2008), where my poster abstract “Inclusive Democracy in Nepal Must Provide Care to MSMS/TGs” was presented.

Each training, workshop and conference experience has been very worthwhile in expanding my knowledge and effectiveness in my work. I learn also from other participants, and also feel very rewarded when they share that our experience and methods provide good education for them. Such is the world family of those confronting
We Demand A Patients’ Rights Charter For India

Bhimavva Golar

My name is Bhimavva. I am a sex worker, and a social worker at VAMP, SANGRAM. It’s extremely important to have a law for patients’ rights.

Laxmi Shinde

My name is Laxmi Shinde. I am a sex worker, and I am associated with Veshya Anyay Mukti Parishad (VAMP) since the last seven years. I myself am an HIV positive woman, and I have seen a lot of women like me going to the civil hospital and getting discriminated and stigmatized at the hands of many doctors. In 2008, I used to get a lot of pain in my back, because of which I had gone to the civil hospital. After the sonography test, it was found that I have water in my tubes, because of which I should undergo Pap smear diagnosis. When I went to the doctor and told him that I am HIV positive, the doctor told someone in English not to touch me, and send me back only with pills. Then I fought a lot with that doctor, and asked him that if I had not told him that I was HIV positive, would he have given me proper treatment?? At this the doctor replied, “I am the doctor, not you; we would do whatever we think is correct”.

Bhimavva Golar

If it is an HIV positive patient, rooms next to the toilets are allocated to them. They don’t even take proper care of them. Are we not humans?? We also need proper diagnosis.

Kiran Deshmukh

My name is Kiran, I work with SANGRAM. I myself had gone to the civil hospital for treatment. The stitches of an earlier caesarean section had opened up and I also had a large hernia. We went for a Sonography, which they did and they told me it was Normal. Disbelieving this we went to a private hospital for Sonography, where it was discovered that I still had an open caesarean section and a large hernia. We took the same report to the civil hospital, and showed it to the doctors. But they still refused to perform the operation. They will only provide treatment at their own will, and will not pay attention if we do not pressurize them.

Pandurang Kavathe

My name is Pandurang Kavathe, and I am the son of a sex worker. I work at SANGRAM, MUSKAN and VAMP as an outreach worker. I had contracted STD once, therefore I went to the civil hospital. The doctor was reading a book there, and despite my calling him thrice he did not respond at all. Finally I screamed aloud for him, at which he gave me a cold nosed stare and asked me about my problem. I gave him the necessary information, at which he asked me to sit inside while himself going out for a while. After two three minutes, he returned with two-three doctors, and now all of them were laughing at me. I was made to sit like a puppet as every doctor came to gaze at me and go back. I was being turned into a practical joke, as if some alien has come to the hospital and everyone else is coming to stare at it. A man who has come clad in a sari. Because of all this, there has to be a law for all the patients like us: patients’ rights: so that doctors do not mock at us, so that they understand our problem, giving us the necessary medicines and treatment.
Seema Patil

My name is Seema Patil. I have been associated with SANGRAM since twelve years. We work for HIV/AIDS and Violence. When we were working with the rural population, we found there was no proper treatment and care for the PLWHA, and they were discriminated and stigmatized. Pregnant women go to the Primary health centers (PHC), Rural hospitals (RH) and Civil hospitals for delivery, but whenever an HIV positive woman goes to PHC for delivery, the doctor and the sisters refer her to the rural hospital just because of her status. When she goes to the rural hospital, they make excuses and tell her she needs a caesarean, which is done only in the civil hospital. But the distance between the rural hospitals and civil hospitals is often so huge that women have to undergo immense pain and trauma, and many women deliver en route.

Kamlabai Pani

My name is Kamlabai Pani. I am a sex worker and I am talking on behalf of VAMP and SANGRAM. When we go to civil hospital, we are stigmatized. Some doctors behave in a manner that they don’t even touch us. We do not get proper medicines. They ask us where we have come from, and if we say we have come from our area (brothel area), they discriminate against us. As not literate persons we are made to run helter-skelter. Are we not humans?? Therefore, there has to be some law for patients rights, there should be no discrimination. The doctors and sisters should at least talk to us properly. We also have desires and rights and we deserve better treatment.

Meena Seshu

Hello. My name is Meena Seshu, and I work with SANGRAM, which is a rural Health and Human Rights organization in Maharashtra, India, And SANGRAM works with VAMP, which is a collective of sex workers in the region, MUSKAN which is a collective of Kothis and Jogappas in the region and SANGRAM PLUS which is a PLWA organization. In 2004, all of us had come together and decided that we needed to start a Patients’ Rights movement because the Civil hospital and the public hospitals or Private doctors were refusing to treat even simple opportunistic infections for people living with HIV. This resulted in a people's tribunal in June 2004 where representatives came up and spoke about stigma, discrimination, lack of access to treatment: medical treatment. This was presented to the local government in Sangli. We, also, at that meeting/tribunal decided the end of it was that we would actually apply for Patients’ Rights Charter for the country, and accordingly we had commissioned a Supreme Court laywer to write one and submit it to the National Human Rights Commission by a network called Action Plus of 15 organizations in the country working on Sexuality, Reproductive rights, Sexual health and Reproductive health and rights This was done in 2006, we have yet to hear from the NHRC. We would like to appeal to the Global Commission to initiate a process where the Patients’ Rights Movement of this country can actually look forward to a Patients' Rights Charter, such that patients will not be treated and discriminated against.

Made by Sangli Talkies, The Community Video Unit  SANGRAM

| 30 | Vietnam | Center for Consulting on Legal and Policy on Health, HIV/AIDS |

“Successfully protect and guarantee rights of PLHIV according to the Law on HIV/AIDS prevention and control”

The Law on HIV is an important legal protection instrument for people living with HIV (PLHIV). Despite the existence of the Law on HIV, PLHIV continue to suffer from stigma and discrimination in the community, as well as the violation of their rights and legal benefits. Furthermore, they often do not know how to protect
themselves. This situation can make them feel hopeless. It is on the basis of this law that the Center for Consulting on Legal and Policy on Health, HIV/AIDS (CCLPHH) protects rights of PLHIV. The Center has provided free counseling for 6,695 clients and direct legal support for 1,894 people living with or affected by HIV/AIDS. There are many areas where the rights of people living with or affected by HIV/AIDS are often violated including education and training, labour and employment; HIV testing, treatment and healthcare; privacy related to HIV status; freedom from stigma and discrimination; administrative sanction (forced drug treatment, rehabilitation); violation of penal code (sex work, illegal drug use, theft, intentional HIV transmission); divorce and marriage; inheritance; medical insurance; birth, marriage and death records; social support beneficiaries., etc. Below is a story on how the Law on HIV is used by the Centre to protect the right to education of a child living with HIV.

- ‘Huong is a 9-year old girl who lost both her parents to AIDS. She is HIV positive and depends on her grandfather for care. Despite having a clear legal right to access education without discrimination, the local school board submitted to pressure from students’ parents and refused to admit her as a student. After trying repeatedly to negotiate on her behalf, and receiving only refusals, Huong’s grandfather sought assistance. Based on the available information, the CCLHP confirmed Huong’s story and determined that the girl’s right to education, as protected by the Law on HIV/AIDS Prevention and Control, had not been respected. The CCLPHH used steps to successfully advocate for Huong’s enrolment in her local primary school as follows:

1. Assess the situation

Based on the available information, the Center confirmed Huong’s story and determined that the girl’s right to education, as protected by the Law on HIV/AIDS Prevention and Control, had not been respected. The Center appointed lawyers to support Huong and to work with the school board to handle her case.

2. Identify relevant laws and policies

Law on Child Protection, Care and Education

- Article 4: ‘Children, whether female or male, born in or out of wedlock, biological or adopted, born to one or both marital spouses; irrespective of their nationality, belief, religion, social background and position as well as the political opinions of their parents or guardians, have the right to enjoy protection, care, education, and all other rights prescribed by law.’

- Article 16.1: ‘Children have the right to study’

- Article 28 stipulates the responsibilities of the child’s family, the State, school and other educational establishments to ensure the child’s right to study.

- Article 53: ‘Children living with HIV are not to be discriminated against but are to be supported with enabling conditions for medical treatment and care by their families or child-support establishments.’

Education Law

- Article 10 stipulates the right and responsibility of all citizens to pursue an education.

Law on HIV/AIDS Prevention and Control

- Article 3.4 stipulates that the principles of HIV prevention and control include: ‘Elimination of stigma and discrimination against HIV-infected people and their family members...’

- Article 4.1 safeguards the rights of people living with HIV to: have general education, vocational training and work.
Article 8.3 includes ‘stigmatizing and discriminating against HIV-infected people’ among those acts which are prohibited.

Article 15.2a: ‘Educational establishments are forbidden to refuse admittance to a student or learner on the grounds that such person is infected with HIV.’

Article 17.1d stipulates the responsibility of commune People’s Committees to broadcast messages calling on community members to oppose HIV-related stigma and discrimination.


According to this Directive, educational establishments must protect the right of people living with or affected by HIV to have a general education and vocational training, to work and to live as integrated members of the community. It is illegal for an educational establishment to request that a student, learner or candidate have an HIV test or produce an HIV test result.

3. Identify main stakeholders

At this stage lawyers identified the stakeholders (agencies, individuals, etc) that had the responsibility to protect Huong’s right to education, including: Provincial Centre for HIV/AIDS Prevention and Control, District People’s Committee, District Education Department, District Committee of Care and Education, Commune People’s Committee, Headmaster of the local primary school, Commune village mayor. Then the Center drafted a work plan that detailed the specific actions they would use to obtain their collaboration in resolving the case.

4. Support client to protect rights

On the strength of the above laws and policies, Center lawyers met with Huong’s grandfather. They explained to him what Huong’s rights and responsibilities were, according to Vietnamese law, and they discussed the responsibilities of Huong’s school board and other relevant bodies. Lawyers emphasized the right of people living with HIV, including children, to access education.

According to Vietnamese law and discussed the responsibilities of Huong’s school board and other relevant bodies. Lawyers emphasized the right of people living with HIV, including children, to access education. Center’s lawyers assisted him to compose and mail the letters. The letters highlighted Huong’s rights vis-à-vis Vietnamese law, and called upon the recipients to protect Huong’s right to attend school.

Next, Center’s lawyers accompanied Huong’s grandfather to visit the offices of the provincial Centre for HIV/AIDS Prevention and Control, the commune People’s Committee, the local social union and the board of the commune primary school. In meeting with these agencies, Center’s lawyers re-stated the information that Huong’s grandfather had given in his letters of complaint: Vietnamese law recognises Huong’s right to education, that right has not been respected, and it is the responsibility of the relevant agencies to step in and protect Huong’s right.

As a result of these meetings, the lawyers requested the commune People’s Committee to instruct the commune village mayor to initiate an anti-discrimination media campaign. The lawyers also worked with the provincial Centre for HIV/AIDS Prevention and Control to spread messages to the teachers of the primary school and to the people in the commune. Advocacy messages included information on HIV, the *Law on HIV/AIDS Prevention and Control* and the rights of people living with HIV. Messages targeted educators, school officials, community members and the parents of other pupils in the school, and emphasised the illegality of discriminating against PLHIV and barring PLHIV from attending school. Thus, in the 2009-2010 school year, Huong was permitted to enrol in grade one. In order to help her make up for lost time, Center lawyers sought
and obtained the school headmaster’s agreement to assign a teacher to tutor Huong during the summer holiday.

But Huong only could go to school in short time, because of stigma and discrimination from teachers, her classmates and parents of pupils in the school, the younger brother of her grandfather wrote a letter to the headmaster board to let her stay at home as the suggestion of the school. Once again, she’s illiterate. In the new school year 2010-2011, the Center continues supporting her to go to school. Center consults and guides her grandfather writing letters and all requirement procedures to relevant authorities and unions to support Huong goes to school.

Over all difficulties Huong was accepted to go to school again. But all parents in school opposed and did not take their children go to school. Only Huong in the school so teachers and head master board required Huong should not go to school. The Center convinced the school and Huong’s family continue her studying at school.

After 4 days, the parents of other pupils started bring their children to go to school. Now Huong can studying with other children. She’s 10 years old and the eldest pupil in the class but she’s very happy to be with other pupils and no longer have to stand outside the gate and look inside to wish a day she can go to school.

Huong studies very hard and she’s good at school. Her grandfather has just informed us that the teachers and headmaster gave her a warm coat for her good results at school.

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### Improving the drug rehabilitation system in Vietnam: a two-track strategy

#### Issues

Vietnam’s current drug “rehabilitation” system prescribes commitment for up to 2 years in a “06 center” for detoxification, moral education, and labor plus up to two years of post-detoxification management either in a center or in the community. The current system provides little or no evidence-based treatment and only very limited HIV/AIDS services. HIV prevalence among 06 center residents is ~50% and relapse rates among releasees from centers are 70-90%. The current system represents a moral and punitive approach to a medical and psychosocial problem.

#### Description

Health Policy Initiative Vietnam, a USAID/PEPFAR-funded project, is taking a two-track strategy: 1) Build evidence to advocate for fundamental systemic change; and 2) because systemic change is unlikely to occur soon, work for evidence-based improvements to benefit the thousands of individuals who are subjected to the current system. To build evidence for systemic change, we recommend the first full-scale evaluation of the efficacy and cost-effectiveness of the current center-based system and emerging community-based alternatives. To improve the current system, we work to incorporate in new legal documents (implementing decrees and circulars under the revised Drug Control Law; administration law, methadone decree) provisions that will send fewer people to centers for shorter periods, and expand evidence-based treatment, including methadone and addiction counseling, and deliver more comprehensive HIV/AIDS services in 06 centers and community settings.

#### Lessons learned

Strong ideological, political and economic interests support maintenance of the current system, but some key government officials as well as emerging civil society groups, and international organizations are committed to working for, positive change.
Next steps

HPI will continue to pursue both systemic change, though development of the evidence base and, in collaboration with key stakeholders and the Vietnamese government, change in the current system through focused drafting, review, and revision of decrees, circulars, and other legal documents.

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**Filling the Gaps in policy and legal framework on HIV/AIDS, drugs, and sex work**

**Issues**

The HIV/AIDS law continues to call for a “close combination” between HIV/AIDS prevention and control and the prevention and control of drug use and sex work. This is problematic as the government’s approaches to these problems are different – drug and sex work control emphasizes law enforcement and confinement of violators and HIV/AIDS prevention emphasizes community-based harm reduction measures. As a result, the activities and strategies on the ground of health, police, drug and prostitution prevention officials may come into conflict.

**Description**

The preferable nexus between the legal systems on HIV, drug and sex work control is the implementation of harm reduction interventions for injecting drug users and sex workers. However, there are still difficulties in implementation of harm reduction intervention because of inconsistencies in the legal framework on HIV / AIDS, drug and prostitution control.

The Law on HIV/AIDS requires implementation of harm reduction interventions including provision of condom and clean needles and syringes for injecting drug users and sex workers and substitution treatment of opiate addiction for injecting drug users. However, under the provisions of the Law on drug control2000, the “producing, storing, transporting, buying and selling means and tools for use in the illegal production and/or use of narcotic substances” (Clause 4, Article 3) are defined as illegal and prohibited acts. This law also stipulates that “Drug addicts aged full 18 years or older, who have been placed under the family- or community- based detoxification or educated time and again in communes, wards, district, towns, but kept on addicting or had no fixed residence places, must be put into compulsory detoxification establishments”(Clause 1, Article 28). In an effort to harmonize with the Law on HIV/AIDS, the revised Law on drug control in 2008 prescribes “Intervention method to reduce the harm of drug addiction means a method to reduce harmful consequences of a drug addict’s use of drugs caused to himself/herself and his family and community” and “the Government shall specify intervention methods to reduce the harm of drug addiction and organize their implementation”. However, such intervention methods have not yet been specified, causing confusion and conflict between health, police and drug control officials in implementation of harm reduction intervention in HIV/AIDS.

The Ordinance on prostitution prevention forbids acts of purchase and sale of sex services and prescribes that “Prostitutes shall, depending on the nature and seriousness of their violations, be administratively sanctioned, applied with the measure of education in communes, wards or townships or sent into medical treatment establishments” (Clause 1, Article 23). The Ordinance and implementing decree also mention material evidence and means used to buy and sell sex, giving rise to confusion and consideration of condom possession as evidence in many cases against alleged sex workers.

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**Next steps**
HPI will continue to work with government agencies and other stakeholders in the drafting review, and revision of legal documents to harmonize the policy and legal framework on HIV/AIDS, drugs and sex work.

### China

#### Individual

**The First Legal Relief Case for Employment Discrimination against PLHIV in Sichuan Province**

The plaintiff under the alias of Xiao Jun, is from Yanyuan County, Liangshan Prefecture of Sichuan Province. He graduated from music education department of Xichang Education College. In June 2010, he entered the exam for the music teacher position of primary schools in Yanbian County and took the written test on August 9th.

On August 20th, Xiao Jun was qualified for the interview as the second place in the written exam for primary school music teachers. After passing the interview on the 23rd, he took the physical examination in the Panzhihua Fifth People’s Hospital on August 25th. According to the requirements of **Notice of Public Recruitment of the Yanbian County Public Institution Staff in 2010**, the General Physical Examination Criteria for Recruitment of Public Servants (Trial) will be applied to the physical examination.

After the physical examination, Xiao Jun, who was attending the pre-job training for the teaching position, was asked by the county education bureau for a second test. He was eventually verbally notified that he would not be hired because he was tested positive in the HIV test of the physical exam.

I represented Xiao Jun’s case and submitted the indictment to Yanbian County Court, Panzhihua City of Sichuan Province on October 20th. According to Xiao Jun’s claim, the Education Bureau’s refusal to hire him was illegal, it should hire him and apologize for the breach of the confidentiality on his HIV status.

As a matter of fact, there are strict regulations in the Chinese law on the compulsory HIV test, where it is only allowed in certain exceptional circumstances. Xiao Jun applied for a teaching position of the county, which should not require a compulsory test. The action of Yanbian County’s Education Bureau was a serious infringement upon Xiao Jun’s human rights.

On the other hand, the second test on September 9th still showed positive. Worse still, Xiao Jun discovered that his status was exposed by the Education Bureau during his negotiations with the department. Xiao Jun said, “I was at a meeting called by the county’s HR Bureau and Education Bureau with Discipline Inspection Commission, Public Security Bureau and Health Bureau. One said it to my face that I could not be hired because I had AIDS.” After the meeting, the news that he had HIV was spread among the government departments of the county and even arrived at his hometown. This grave breach of Xian Jun’s privacy sent Xiao Jun’s life into great trouble, due to the extensive and deeply-seated discrimination of the public. Some parents said during the media interview, “It’s ok for myself to shake hands with and even hug the PLHIVs, but it is absolutely unacceptable for the teacher of my children to be HIV positive.” The majority of the parents believed that despite their sympathy for PLHIVs, they would be worried if an HIV positive person taught their children. Some parents said, “It is not discrimination but worry.”

Moreover, according to Article 33 and 34 in the Chinese Constitution and relevant laws, citizens have equal rights to employment, which cannot be violated by any organizations or individuals. Article Three and 12 of the Labour Law provide that labourers have equal rights to employment and they should not be discriminated in their job seeking. The Law on Promotion of Employment implemented from January 1st, 2008 stipulates that “employers should not refuse to hire the pathogen carriers during its recruitment process.” All these legal articles manifest that PLHIVs are entitled for equal employment as others.
According to Article 16 of Law on the Prevention and Control of Infectious Diseases, “Any organizations or individuals should not discriminate against patients of infection disease, pathogen carriers and suspected patients of infection disease.” It is also specified in Article Three of HIV Prevention and Control Regulations that “no organizations or individuals should discriminate against people living with HIV, AIDS patients and their family members. People living with HIV, AIDS patients and their family members should enjoy equal rights to marriage, employment, medical services and education as others, which are protected by the law.” That is to say no organizations or individuals should discriminate against PLHIVs, whose legitimate rights to employment are protected by law.

Counter to all such legal provisions, the action of Yanbian County’s Education Bureau has posed substantive discrimination against Xiao Jun’s right to employment.

The right of PLHIVs to employment has a significant bearing upon their survival. Therefore it is a meaningful attempt to protect their employment rights by legal action and relief, but such approach may take time to show effect.

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### 34 China

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<th><strong>Asia Pacific Council of AIDS Service Organizations (APCASO)</strong></th>
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**To Insure, Or Not to Insure? Advocating for the rights of PLHIV in China**

When the Insurance Association of China issued a new document in July 2009 requiring that insurance companies include people living with HIV (PLHIV) and passive drug takers into their liabilities in insurance contracts, it was a defining moment not only for the PTAP project in China but also for community-centred advocacy. PTAP is short for Prevention and Treatment Advocacy Project, an ambitious 5-year global project implemented in China (Yunnan) and India (Tamil Nadu) by the Asia Pacific Council of AIDS Service Organizations (APCASO) from 2005 to early 2010.

Getting to this announcement was not easy for PTAP China’s fledging coalition of lawyers, HIV activists, academicians, media professionals and community supporters. But they succeeded in protecting the rights of PLHIV and reducing stigma and discrimination through (1) having a catalyst for change (a PLHIV), (2) devising a smart advocacy strategy, (3) building the right coalition and (4) maintaining the momentum.

This is their story.

**Background**

Legal advocacy was one of five key programme strategies for PTAP. It began in December 2007 with a training workshop for more than 30 legal professionals from Yunnan province, in southwest China. A few months later in 2008, the aptly-named “Yunnan Righteous Law Firm” signed on as the key provider of legal aid to PLHIV including free counselling and legal representations. PTAP implementing organization in China was the Yunnan Daytop Drug Abuse Treatment and Rehabilitation Center based in Kunming.

On 4 February 2008, Mr Lee, a PLHIV, bought two accidental insurance policies from Pin An Insurance Company. But he found out by chance that HIV was one of the liability-exempt clauses, in the same category as some hazardous illnesses. Mr Lee was very unhappy because he felt his rights were violated. With assistance from the Righteous Law Firm, Mr Lee brought a lawsuit against Pin An Insurance Company on 15 May 2008 at the Kunming Wuhua District Court.

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1 Not his real name.
If you get thrown out, try again

The lawsuit went through a long and difficult course: the Wuhua District Court took 10 months to reach a verdict and rejected the case in June 2009. The court said that it was an important, difficult but important case. One month later, in July 2009 Mr Lee appealed to the Kunming Intermediate Court.

Objectives

The objectives of this legal advocacy campaign were to:

1. Advocate Ping An Insurance Company to delete the discriminatory clause in its personal insurance contract;
2. Advocate the China Insurance Regulatory Committee to perform its supervising and monitoring duties against discriminatory contracts written by any insurance company;
3. Increase PLHIV's awareness of using the law to protect their rights; and
4. Increase the general public's awareness on stigma and discrimination faced by PLHIV in China.

Building a coalition

A coalition was formed, comprising:

- PLHIV networks and NGOs that work on HIV and AIDS;
- Legal professionals;
- Media;
- Academicians;
- Public supporters;
- UNAIDS; other bilateral and donors;
- Ministry of Health (MOH) and other relevant government organizations.

Advocacy activities: Maintaining the Momentum

The coalition devised a strategy that ensured that their legal ‘battle’ to protect the rights of PLHIV from discrimination by the insurance industry was put in the news and the public consciousness. Among the key advocacy activities were:

- **Open Letter** to industry ‘watchdog’ : On 20 June 2008, with assistance from PTAP, Mr.Lee sent an open letter to China Insurance Regulatory Commission (CIRC);
- **Response**: 15 August 2008: CIRC replied to Mr.Lee saying that they would take his suggestion into serious consideration.
- **Community survey**: From July to August 2008, Daytop conducted a survey with 500 college students and 500 community people. 80% of the informants considered the clause as discriminatory and support Mr. Lee to
use the legal tool to protect his legal right; the survey results were widely shared with PLHIV groups, GOs, NGOs and media.

- Legal advocacy workshop for coalition members: 18 June 2009, Daytop organized a legal advocacy workshop in Beijing with participants from PLHIV groups, legal professionals, media, MOH, UNAIDS etc.

- Press conference: 9 July 2009: Using the media to inform the public of the rejection of Mr Lee’s case and subsequent appeal to a higher court.

- National and international media: The public’s interest in this case was helped by the wide coverage by national press and TV as well as Voice of America’s Chinese programme.

- Media advocacy: PTAP’s radio programme for PLHIV (initiated in 2007 and called “May the trees of life be forever green”) broadcasted the activities of this case and through interviews and phone call-ins, kept the information alive on the air waves.

Achievements

Aside from the announcement by The Insurance Association of China in July 2009 requiring all insurance companies to include PLHIV into their liabilities in insurance contracts, other outcomes were equally important:

1. This advocacy campaign has inspired PLHIVs in China (and other countries) to be aware of and use legal tools to protect their rights.

2. Involvement of PLHIV and other HIV affected communities was crucial in actions that impact on their rights and lives.

3. Public opinion could be swayed and support given when people realize that PLHIVs were unjustly discriminated against in what was a simple act of buying insurance protection.

4. Provision of legal service and advocacy can contribute to policy change. In July 2009, a legal center specialising in HIV was established in Yunnan.

5. Involvement of legal professionals and the media was significant in bringing about change in both the law and the public opinion.

As a result of its innovative methods and persistent advocacy for reducing stigma and discrimination and protecting the rights of PLHIV and key affected communities, PTAP China received many awards from national, provincial and international bodies. One of the most high-profile awards was the “Positive Commitment to Community Mobilisation” Award from the International Treatment Prevention Coalition (ITPC) China at November 2009.

India

Bharatiya Muslim Mahila Andolan (All India Muslim women’s Rights movement)

RE: Laws and Policies that Mitigate and Sustain Violence and Discrimination lived by Women

Background

According to 2001 Census carried out in India, 18.4 per cent of Indian population comprises minority
communities of which Muslims constitute 13.4 per cent. Muslims in India experience widespread illiteracy, low income, irregular employment, a high incidence of poverty and marginalization. The documented evidence by various agencies reveals that in areas like education, work participation, health, income Muslims are found to be faring much lower than other communities. The rise of communal and conservative forces has made matters worse. Muslim women suffer from multiple marginalizations owing to poverty, lack of education, inequality and lack of opportunities. The issue of marginalization and injustice is compounded by the fact that it is a minority community and is deeply influenced by conservative, religious patriarchal forces on one hand and exists in extreme poverty and marginalization on the other. Moreover rising communalism and fundamentalism has resulted in increased insecurity and sense of alienation within the community.

Muslims have the lowest literacy rate with 59.1% the national average being 64.8%. Despite common belief, Muslim parents are not averse to mainstream education or to send their children to affordable Government schools. However, the access to government schools for children of Muslim parents is limited. The participation of Muslims in the professional and managerial cadre is low. There is a clear and significant inverse association between the proportion of the Muslim population and the availability of educational infrastructure in small villages. Muslim concentration villages are not well served with pucca approach roads and local bus stops. Substantially larger proportion of Muslim households in the urban areas is in the less than Rs. 500 expenditure bracket. The presence of Muslims has been found to be only 3% in the Indian Administrative Service, 1.8% in the Indian Foreign Service and 4% in the Indian Police Service. Representation of Muslims is very low in the Universities and in Banks. Their share in police [constable positions] is only 6%, in health 4.4%, in transport 6.5%.

Though India recognizes the prevalence of exclusion based on social group and emphasizes the need for inclusive growth the gap between the promise and reality continues. Indian minorities and particularly the largest among them, the Muslims, who have been historically disadvantaged and vulnerable in spite of the Constitutional safeguards, continue to live in poverty and backwardness.

**HIV/AIDS in Muslim Communities in India**

The true impact of HIV/AIDS on Muslims in India is unknown. The reliability of available HIV/AIDS prevalence in Indian Muslim communities is low because many communities do not report their statistics or under-report due to the stigma associated with the infection. Further, the Indian government does not disaggregate data by religion.

Even though Muslim communities (like many other communities) are home to many behaviors involved in the spread of HIV/AIDS, such as extra-marital sex, intravenous drug use, men having sex with men, the socio-cultural stigma that enshrouds the infection has virtually denied prevention mechanisms and public health education into these communities. Lack of information and education about HIV increases vulnerability to contracting HIV. Patriarchy makes women unable to negotiate sex, economic dependency, and violence are marginalized even within the Muslim community. This gender based inequality is furthered by a parallel legal system on personal law that often governs the lives of these women.

**Muslim women And Marginalization in India**

Studies show that 60% of Muslim women are illiterate. Less than 17% of the Muslim girls completed the minimum of 8 years of schooling and less than 10% finished their higher secondary. 26% of the educated Muslim women have illiterate husbands. Hardly any Muslim woman is aware of or able to access welfare programmes and facilities that government provides. The community is perceived as uneducated, parochial, rigid, extremely religious and conservative. These perceptions only get more entrenched because of increasing social, economic, physical ghettoisation of the community.

Staying in a ghettoized environment has its own accompanying problems. The community gets physically and emotionally alienated from the rest of the society. They stay, educate, work and die within the same physical environment. To the outside world a Muslim ghetto comes across as a dangerous, dirty place to be avoided.
the state these ghettos do not exist. The experience of Bharatiya Muslim Mahila Andolan (BMMA – the Muslim women’s rights movement) shows that for the state structures Muslim ghettos do not exist. Essential services are almost absent. The PDS or food grain distribution system is faulty as shops contain poor quality grains or no grains at all. There is rampant corruption in this system. Needless to say women who are found in the lowest rung of the family pyramid are the first to struggle to get food in the house and the last to consume, if anything remains. Absence of good quality and cheap food is the first hurdle. The Muslim family living in a ghettoized slum cannot afford to consume food grains available in the open market.

After food accessibility comes the turn of health services. Muslim ghettos are crowded with semi-qualified doctors doing private practice. The community has no choice but to go to them as government health services are absent. Government primary health centres are missing in these communities. There is no facility for women especially for their reproductive health problems.

To add to these issues is the fact that Muslim women are a minority within a minority with constraints on her mobility and access to public amenities. She is most vulnerable to infections like TB and other respiratory illnesses given cramped ghettoized and dense living conditions. Due to cultural constraints women in general and Muslim women in particular do not give adequate importance to their reproductive health. Many suffer from ailments linked to their reproductive health and due to shame attached to reproductive and sexual health complications. Women do not report issues with their sexual and reproductive health even within the family. Due to absence of cheap and accessible health care, she herself becomes the reason for ignoring her health concerns.

The all pervasive patriarchal values are still prevalent which exposes women to domestic violence. A Muslim woman is vulnerable because she is a woman, she is a Muslim woman and she is a poor Muslim woman. The three axis of gender, religion and class impact her status. Tremendous marginalization, socio economic backwardness and extremely poor status within the family negate her entire being. There are just too many layers of oppression for her to deal with, just too many fronts on which she has to wage a battle, nay, war. In this labyrinth of marginalisations, her health is her last concern. Needless to say there is very little data on what constitutes the health concerns of Muslim women, let alone HIV. In the absence of data, no policy document or law can be made. In the absence of food and the related nutrition deprivations if a woman is HIV positive it is difficult to adhere to medications and care for her health and well-being.

Post Independence there has been an absence of progressive and liberal leadership within the Muslim community. Not only it has not raised the legal concerns of Muslim women, it has not even raised the concerns of their educational and economic backwardness. The BMMA seeks to work to

Today one of the major challenges for the BMMA is to raise the legal concerns of Muslim women and decrease a Muslim woman’s experience of discrimination and violence sustained by the legal system. In the context of health, it is this perpetual discrimination that renders women vulnerable to contracting STIs and HIV.

**India’s Personal Law System Violates Muslim Women’s Rights under Domestic and International Law and Makes Women Vulnerable to HIV**

Indian law consists of a uniform system of criminal and commercial law that applies to all citizens regardless of their religious affiliations. However, the same is not true of personal law or law that governs issues of matrimony, divorce, child custody, adoption, guardianship and inheritance. Therefore, each religious community has their own set of personal laws that applies to their religion (i.e., Hindu, Christian, Muslim, Parsi or Zoroastrian, and a secular law that applies to those who do not fit into any religious category). Despite these

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separate religious personal laws, India is still considered a secular state. Secularism in India is not defined as a separation between religion and state, but as a neutral involvement in religion by the state.  

Muslim personal law (“MPL”) is an important part of Islamic law (Shar’ia) and is applied in almost all predominantly Islamic countries, as well as Islamic communities in secular states like India. When MPL is not enforced by state courts, its principles are often still formally observed by Muslims as a matter of religious obligation. In disenfranchised communities, MPL has become the symbol of Islamic identity, since it was the only aspect of Shar’ia that resisted colonialism and various forms of secularization of states and institutions. Importantly, the same version of MPL principles do not apply everywhere in the Muslim world due to differences in schools of Islamic jurisprudence (Fiqh) that prevail in different Islamic countries and communities. Muslim law as practiced in India is not codified, as a result of which each sect and sub-sector of the community follows its own version of Muslim law which needless to say are extremely patriarchal, anti-Islamic and anti-Constitutional. Meager amounts, polygamy, oral unilateral divorce, low maintenance are some of the legal issues which confront Muslim women in India. These personal laws serve to ground the inequalities face by Muslim women in India and impact women’s vulnerability to contracting HIV.

Muslim personal laws are arbitrated in Shariah courts by Qazis/Muftis [religious clerics] and jamaats [sect arbitration councils]. These bodies are readily accessible and have closer contacts with the community unlike the secular court structures, which are expensive, inaccessible and time consuming. In turn, communities actively engage in this legal infrastructure. Though accessible they are dominated by men who arbitrate and settle disputes, which more often than not go against the interest of the women. These individuals and institutions have adopted a very patriarchal, conservative and anti-women interpretations of the religious texts and some of the more parochial groups do not recognize the Indian Constitution and the secular legal machinery. Muslim women do approach the family court and other localized State run legal structures but as said earlier the time and money required to pursue the case is beyond the reach of many women especially so of the Muslim women.

Specific laws enshrined in Muslim personal law make women more vulnerable to contracting HIV and increase exposure to violence and ongoing subordination. The areas of legal reform that BMMA activists are concerned with that also increase women’s susceptibility to HIV/AIDS include: Talaq, Khul, Polygamy, Nikahnama. Together these laws leave women powerless in the context of relationships and vulnerable to ongoing violence given an inability to leave partners and an economic dependency on men.

**Talaq**: Talaq is an established fact under traditional Shar’ia law that gives a husband the unilateral right to extra-judicially terminate the marriage contract without cause. Most Muslim women activists argue that the continuing use of triple-talaq as a customary practice needs to be reformed. Activists argue that if a man wishes to divorce his wife, he should do so in a phased matter, where the couple waits for a month between each talaq in order to see if the relationship can be reconciled. Only after the problems cannot be reconciled, should the husband be able to utter the third and irrevocable talaq. If a woman wants to divorce it is alarmingly difficult to do so if her husband refuses. Patriarchal male clerics and the ulema indicate that making it easier

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4 There are 57 Organization of Islamic Conference (OIC) member countries (see http://www.oic-oci.org).

5 Hamid, Abdul Ghafur & Sein, Khin Maung, *supra*.

6 *Id.*

7 Sylvia Vatuk, *supra* at 507.

8 Triple-talaq is male-initiated, extra-judicial, instantaneous divorce where the husband says the talaq three times.

9 In 2002, the Supreme Court of India—in the case of Shamim Ara v. State of U.P. and Anr.—ruled that an irrevocable talaq can only be given for ‘a reasonable cause’ and must be preceded by ‘an attempt of reconciliation’ by relatives from each side. See http://www.supremecourtonline.com/cases/7383.html (October 1, 2002). Despite this decision, triple talaqs continue in Muslim communities.

10 *Id.* at 503.
for woman to initiate divorce would cause an unacceptable divorce rate that would breakdown Muslim family structure.\textsuperscript{11}

**Polygamy:** Although the instances of polygamy in India are low, it is sanctioned in the *Qur’an* under very limited circumstances.\textsuperscript{12} Restrictions on polygamy are high on the agenda of BMMA activists, as the *ulema* and AIMPLB have done very little to restrict this practice in their communities.\textsuperscript{13} Activists indicate that in the case of polygamous relationships, the husband should be required to obtain his wife’s permission prior to marrying again. Studies from Sub Saharan Africa demonstrate that polygamy has shown to increase women’s vulnerability to contracting HIV.\textsuperscript{14}

**Nikahnama:** Over the past two decades, Muslim women activists have been trying to bring awareness to women’s rights under the *nikahnama*, or marriage contract. *Shar’ia* permits a woman to specify conditions under which she will give her assent to marriage in the *nikahnama* (i.e., she will be allowed to continue her education, she opposes her husband from taking another wife). The *nikahnama* allows women to require their husband to agree to the stipulations set forth in the contract. In case of his failure to comply, she can dissolve the marriage herself by *talaq-e-tafwid*, or delegated divorce.\textsuperscript{15}

With the extremely low literacy and education rates of Indian Muslim women, especially in rural communities, negotiating a gender-just *nikahnama* is difficult. Without the active cooperation of the *ulema* and patriarchal factions within Muslim communities, reforms to the *nikahnama* are elusive. This inability of women to negotiate their marriage contract often results in an inability of women to divorce, leaving women in relationships where they are without power or ability to negotiate condom use and vulnerable to contracting HIV.

These laws and policies provide the foundation for the ongoing vulnerability of women to poverty, violence, oppression, and HIV/AIDS.

**Conclusion**

Poverty, marginalization, and gender inequalities combined with patriarchal norms and laws render Muslim women vulnerable to contracting HIV while acting to sustain violence and discrimination against women and girls. An effective response to HIV must take on these legal and structural inequalities in order to reach marginalized and underserved populations. *The BMMA thanks the Commission for the opportunity to begin to bring the issues facing Indian Muslim women to light in the context of HIV/AIDS and hopes that addressing the laws impacting the health and well being of Muslim women will be a priority in the work of the Commission.*

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This is submitted by the Asia Pacific Coalition On Male Sexual Health (APCOM) at the unanimous request of participants of the ‘Action Planning Meeting on Men who have sex with men and Transgender populations Multi---City HIV Initiative’, held in Hong Kong, China, 7---9 December 2010.

This meeting brought together 10 participants from Health and Community sectors from each of six mega---cities in which HIV incidence among the key affected population groups, men who have sex with men (MSM)

\textsuperscript{11} Id.
\textsuperscript{12} Kirti Singh, Sumaiya Musharraf, Maimoona Mollah, *supra* at 168.
\textsuperscript{13} Id.
and transgender people (TG), is either increasing rapidly or only just stabilizing having reached saturation levels, along with regional partners including resource people from Singapore and Hong Kong.

The cities are:

- Bangkok, Thailand
- Chengdu, People’s Republic of China
- Ho Chi Minh City, Vietnam
- Jakarta, Indonesia
- Manila, The Philippines
- Yangon, Myanmar

**The evidence on which this submission is based**

The submission is based on findings from three recent stages of the process of developing more effective actions in prevention and treatment in all of the six cities.

These are:

- A “Six Cities Scan and Analysis”, in which the qualitative research method of Appreciative Enquiry was used to collate information about programs in each city through workshops, interviews and preparation of reports by City Consultants each working in their own cities. An in---depth analysis of the city scans, updated and informed during the Hong Kong meeting, will be available shortly. This process was coordinated by Scott Berry, of the AIDS Projects Management Group, and supported by UNDP.

- A “Synthesis of Lessons Learned in Six Cities”, in which the information from the cities scans was reduced to a six page background report of lessons learned. This synthesis was prepared by Bruce Parnell and supported by USAID | Health Policy Initiative in the Greater Mekong Region and China, implemented by RTI International and Burnet Institute.

- The “Action Planning Meeting”, in which delegations from each of the six cities came together To consider the findings from the other cities, including the resource reports from Hong Kong and Singapore, challenge one another, and then develop Action Plans for new approaches to HIV prevention, treatment, care and support for MSM and TG in their city, which will occur within the next 12 months, during 2011. This meeting was facilitated by Peter Mok and Paul Causey, consultants, and supported by USAID through FHI.

**What does this evidence tell us?**

The evidence included here is extracted from the Background Report --- Synthesis of Lessons Learned in Six Cities and discussed extensively during the 3---day meeting in Hong Kong.

**Stigma and discrimination**

The City Scans show that stigma And discrimination prevent public discussion of HIV. They affect individuals’ self esteem and their ability to speak openly to health service providers or even peer educators. They limit what can occur in prevention and they limit access to treatment services.

Transgender initiatives in all Six City Scans report far more problems with stigma, discrimination and human
rights abuses. They report that transgender people have few places to turn To for assistance and may be turned away from mainstream welfare, medical, legal and other services.

People living with HIV (PLHIV) also experience stigma and discrimination, which doubles the burden when the PLHIV is also a MSM or transgender person. This results in people living with HIV being afraid to disclose their HIV status among friends and sexual networks, or even to their families. Rejection, isolation and loneliness are the result.

Laws and Policing

Every one of the City Scans noted problems arising from laws and police practices. The most common example is that condoms are used as “evidence that sex work is taking place” or “evidence that this venue allows people to have sex”. This was not reported in Yangon or Chengdu, but both of these cities did report at the meeting that Other policing problems occur on a regular basis. Many laws about other issues are used to stop prevention of HIV. These include laws about sex between men which are legal in five of the six cities, but rarely “approved of” by local police. Laws about sex work are often vague, leaving some police to consider that all male—–to—–male sex is a form of sex work, or that the mere presence of condoms means that sex work is happening.

Laws and Regulations on “pubic scandals”, “social evils” or “social order” are used to stop HIV education and prevention activities. Pornography laws are invoked to prohibit the distribution of information and educational materials. Laws about vagrancy and loitering are used As a way forcing people to provide money or sexual favors to police.

The lack of safe and private spaces for men to meet in some cities means they have to meet in lanes or parks.

Four questions which all six cities are now considering

1. Is it legal to use condoms Anywhere other than at home?

2. Is it legal to produce and disseminate explicit information on how safe sex can occur between men?

3. Are there safe places where men can go to meet, or to have safe sex outside their homes but away from the public gaze?

4. Are the city police Aware of the answers to these questions, And do they act on them, properly?

The Action Planning Meeting participants agreed that if the answer to any single one of these Questions is “No” then HIV prevention will fail.

How do changes come about?

The City Scans noted some progress has been made that brought positive changes. Building An enabling environment for prevention and treatment requires developing supportive law practice. There have been discussion forums with police and other city officials, training sessions for police on HIV, health and welfare, police invitations to community meetings and entertainment events, and a toolkit on HIV for police. Understanding often comes from allowing space for the police and public security officers to talk about the issues from their own perspective. However, these discussions do not occur in all of the six cities, and none of the cities had Senior Police in their city delegation at the Action Planning Meeting, even though it had been strongly suggested by the Initiative’s Steering Committee. This would be standard practice in many HIV initiatives affecting people who inject drugs, sex workers or the clients of sex workers. The City scans identified this as an essential component of processes to improve access to prevention or treatment amongst men who have sex with men or transgender populations, at least in each of these six cities.
Laws against discrimination

There are laws in some countries to stop discrimination against people on the basis of whether they have HIV, or appear to be in a risk group. Some cities promote discussion about these laws amongst police and city officials, to ensure they are well understood. Most do not. Generally, city police do not act in ways that indicate they understand these laws or have any desire to enforce them.

Devolution of laws to local administrations

In some cities, decisions on laws about sex work or public morality are taken at a city level. Some local policies were reported to be out of line with national laws, constitutions or AIDS strategies.

What do we now recommend to the Commission?

1. This submission recommends that the Global Commission on HIV and the Law – Asia---Pacific Regional Dialogue does not confine its final Recommendations to only changes in national laws and policies.

2. The Global Commission could also make suggestions on:
   - How national laws and policies can be better disseminated to provinces and Cities
   - How police and other community members, including mass media, Can be encouraged to act in accord with good laws and policies
   - How police can more effectively ensure community safety for all citizens, including safety against transmission of HIV and other communicable diseases.

3. We recognize that there are no simple solutions to how these concerns can be addressed. Some ideas were developed at the Action Planning Meeting and will be available in the forthcoming report on the meeting as well as in the Six Cities Scan and Analysis. But we note that it would help if the Global Commission made strong statements of advocacy directed to governments, at all levels, donors and development and technical Partners including UNAIDS and it’s cosponsoring UN agencies, that they should support further development of these initiatives. This could include assistance with advocacy; encouragement of collaboration between police, community and health sectors; funding for sensitivity training and development of peer support and exchanges between police of different cities and countries; and evaluation of the impact of these types of advocacy initiatives.

Respectfully submitted on behalf of the Asia Pacific Coalition on Male Sexual Health and its 10 sub---regional and regional member networks, and participants of the ‘Action Planning Meeting on Men who have sex with men and Transgender populations Multi---City HIV Initiative’.

Endeavour towards Transformed Life

LEPRA Society is a non-profit organisation established in 1989. Engaged in health and development activities to help the weaker sections of the society and to ameliorate their conditions and to uplift their quality of life. Its mission is to restore health, hope and dignity of people affected by leprosy, tuberculosis, malaria and HIV/AIDS and other allied diseases and conditions caused by them. As a Sub-Recipient, LEPRA working in association with
India HIV/AIDS Alliance, (Principal-Recipient), with the funding from Round 6 of Global Fund to Fight Against AIDS. Tuberculosis and Malaria [GFATM] is implementing a child centered home and community based care and support program. This Global Fund Round 6 project titled “CHAHA” (meaning ‘a wish’ in Hindi) was launched in June 2007 with the goal of reducing HIV related morbidity and mortality in adults and children and to address the impact of HIV on children. CHAHA is all about working with the children, families and communities to overcome their isolation, exclusion and impoverishment. The overall purpose of the project is to improve care and support services to children living with mV/AIDS & children affected by HIV/AIDS & enable interventions which keep them with their parents or extended families.

The face of HIV/AIDS in India evolved the grim and dire situation for women and children living with and is addendum to their vulnerability. In India there is no law or statute that specifically addresses the issues that are raised in the HIV context. In the dearth of proper law towards safeguarding the rights of people living with and affected by HIV/AIDS the situation become more verse. According to the sentinel surveillance of National AIDS Control Organization in 2007 the overall HIV prevalence in India is estimated as 0.36%, which contributes to 2.5 million people living with it. Moreover about 4 out of 10 people living with HIV are women. Also NACO estimated that about 70,000 children below 15 yrs of age are HIV positive. Children with their deceased parents have to shoulder the onus of their siblings and themselves, Poverty, illiteracy, inadequacy of services, information and legal rights with invariable gender inequality makes the situation of women and children more vulnerable.

This paper sets out to discover how absence of laws and policies for people and children living with HIV/AIDS is bane to their life and denies access to their rights and freedom. The abstract employed a qualitative, primary data collection method and literature review. The case study recorded during the field visit also establishes the method of information collection. Data analysis integrates the project information collected on quarterly basis through program monitoring reports.

The working experience with the children living with and affected by HTV/AIDS through CHAHA gave a profound insight towards debatable fact that still AIDS is often seen as someone else’s problem and people living with HTV are highly stigmatized. The women and children living with HIV faced violent attacks, been rejected by the families and communities, spouses and even few have been denied of last rites. Moreover children living with HIV have been ostracized to continue their education once their status is revealed. The fact extracted and analyzed while working in the 5 districts of Andhra Pradesh (viz. Ranga reddy, Nalgonda, Krishna, Nizamabad and Hyderabad) under CHAHA project covering 5825 children wherein 12% of them are living with HTV and 36% of the children are double orphans. Also out of 1808 women headed families with their deceased husband 50% of them have been thrown out from their in-law’s houses and were abandoned their share in the family property. Remarkable numbers of the children have been observed to migrate from their home town and are leading a banished life.

The need for legislation on HIV has led to a unique draft of HIV/AJDS Bill in 2006 which is yet to be approved from the parliament. The Bill embodied principles of human rights and seeks to establish a humane and egalitarian legal regime to support India’s prevention treatment, care and support efforts vis-a-vis the epidemic. It committed to address the issues of discrimination in employment healthcare, and education, informed consent for testing, confidentiality and access to treatment. Ultimately, the vision of thebi11stocreateastrategy to tackle the HIV epidemic where every person is a stakeholder, every voice is included and no one is left behind. It hopes to strengthen our public health system and help the epidemic emerge from the underground, so that HIV/AIDS is no longer a synonym for fear, neglect, discrimination and violence but for empowerment, compassion, united action and triumph.

The Policy Framework for Children and AIDS 2007 is a comprehensive policy covering a broader and holistic agenda, spanning both medical and socioeconomic dimension of the HIV/AIDS epidemics as it affects children. The policy framework also recognizes the futility of trying to differentiate between children in distress and affirms the need for universal approach addressing the children subjected to social exclusion, neglect and abuse
including those affected by HIV/AIDS. Though it was not operationalized fully and reached to the periphery.

National Consultation Meeting on "National Policy for Children" was held in June, 2010 to Develop a holistic policy framework which will replace few prior futile and redundant policies not in-line with the Human Rights Commission. In spite of consultation and recommendations made nationally with the involvement of various stakeholders and departments, the final shape of the policy framework is yet to be given.

The evidences from the field, reels out the paradoxical fact that though the bill on HIV/AIDS with the benign motive of mainstreaming people living and affected by AIDS in the community was little instrumental for safeguarding their rights. In the absence of proper law and guidelines for the execution of the National policy, the importance of the policy framework was hardly realized and the grim situation of the women and children remained same. Moreover women and children are unable to internalize the violence against them; rather they think that they are destined to suffer. This is mainly due to lack of information about appropriate law and services and had to lead a life without any baton. It is also hard for them to file a complaint against any heinous act, as in lieu of it the confidential status will be disclosed and will add up to their further exploitation on the hands of police, local leaders and relatives.

A case study recorded from Rangareddy district of Andhra Pradesh exarnplate the violation of human rights. Laxmi, 28 years old woman staying with a girl child and her husband in Tandur mandal. Her husband, Ramchandraiah, went to Dubai for mason work and after he returned, their life plummeted into the depths of darkness. He became sick and soon his health situation further deteriorated. He went to hospital where he got tested and was diagnosed as HIY positive. Meanwhile, Laxmi also became ill un-expectedly and was also diagnosed as HIV positive. Happy days faded away from her life and she witnessed the death of her husband. The lady was ostracized from the house, her husband’s property and even was not allowed to perform the last rituals for her husband. She pleaded but all in vain. She had nobody to help her; stayed with her only child in a small hut in the same village. Her neighbor found her staying at the brink of the village and called on meeting with her family members. Laxmi was banished out from the village. She stood helpless.

If there would have been appropriate law in place to safeguard the rights of Laxmi, many such and many more Laxmi(s) would not have suffered and deprived of their rights.

Different measures need to be taken to combat violation of rights of people living with and affected by HIV/AIDS. There should be an appropriate and adequate policy formulation with the greater involvement of people living with and affected by HIV/AIDS. The holistic and integrated approaches should be streamlined in the policy framework to ensure social security of PLHIV. The involvement of positive networks and peer support groups should be ensured for handling and advocating all kinds of violations of their rights.

1 NACO Sentinel Surveillance Report 2006
2 HIV Prevention Bill Summary 2006
3 'Policy Framework for Children and AIDS' India, 3 ISI July 2007

Around the world, governments commit flagrant and widespread human rights violations against people who use drugs, often in the name of "treating" them for drug dependence. Suspected drug users are subject to arbitrary, prolonged detention and, once inside treatment centers, abuses that may rise to the level of torture. In many countries, military and police force people who use drugs into treatment without any medical
assessment, and then rely on chains and locked doors to keep them there. Drug users who voluntarily seek medical help are sometimes unaware of the nature or duration of the treatment they will receive. In fact, treatment can include detention for months or years without judicial oversight, beatings, isolation, and addition of drug users’ names to government registries that deprive them of basic social protections and subject them to future police surveillance and violence.

Mechanisms to force people who use drugs into treatment, and the methods of treatment used, are rarely documented. United Nations or national assessments of drug dependence treatment frequently report numbers of those treated without additional detail about the nature or quality of what constitutes “treatment.” The accounts below, drawn from published literature and from those who have passed through treatment in Asia and the former Soviet Union, detail the range of abuses practiced in the name of drug dependence treatment, and suggest the need for reform on grounds of health and human rights.

Arbitrary Deprivations of Liberty and Denial of Due Process

A common way for people to enter drug treatment is involuntarily through the criminal justice system. People suspected of using drugs, whether actual drug users or those simply swept up in police or military raids, are frequently detained for treatment on the basis of mere police suspicion or a single positive urine test. They are remanded to treatment for months or years without medical assessment or right of appeal. Even those who enter treatment voluntarily find themselves confined for years at a time without due process.

- Malaysia’s drug treatment system makes no distinction between occasional drug users and those actually dependent on drugs.1 Anyone can be detained for up to two weeks and forcibly tested by police on suspicion of drug use. Those testing positive, even in the absence of possession, can be flogged and interned for up to two years in a compulsory drug treatment center.2
- In Cambodia, drug users and others are picked up in police raids and confined in treatment and rehabilitation centers run by military staff with no training in addiction or counseling. Drug users, people with mental disabilities, sex workers, and the homeless are sometimes confined together. There is no judicial supervision or process for appeal, though detainees report being able to bribe their way out of internment.3 There is no clear criteria for release, which may depend on being able to recite the Cambodian national drug laws from memory.4
- Drug users in Vietnam can be committed by family members or community focal points that keep lists of known drug users, and there is no due process to appeal commitment or extension of internment.5 In response to high rates of return to drug use (as high as 95 percent by those leaving the centers) the government in some cities has extended terms of detention to as long as six years, including labor in facilities built near the treatment centers.7,8 Between 50,000 to 100,000 drug users are now interned in Vietnam’s compulsory rehabilitation centers.9,10
- As many as 350,000 people are in China’s reeducation through labor and compulsory detoxification centers, which have recently been renamed, but which continue to intern people upon suspicion of drug use or a positive test for illicit substances.11 The involuntary nature of treatment is revealed by one 2004 study, which found that nearly 10 percent of those apprehended by the police on suspicion of drug use swallowed nails, metal filings, or ground glass in order to obtain a medical exemption and escape internment.12

Abuses in Confinement

What is referred to as “treatment” in many centers in fact includes painful, unmedicated withdrawal, beatings, military drills, verbal abuse, and sometimes scientific experimentation without informed consent. Forced labor, without pay or at extremely low wages, at times in total silence, is used as “rehabilitation,” with detainees punished if work quotas are not met. These abuses violate the right to be free from torture, cruel, inhuman, or degrading treatment and punishment; the right to health; and other fundamental human rights.

Physical and Mental Abuse
People formerly detained in Malaysian government treatment centers describe being kicked, punched, made to crawl through animal excrement, “act like a whale” by drinking and spitting out dirty water, and being abused and caned by a religious leader while being told that they are “worse than an animal.” Overcrowding forces as many as 40 inmates to sleep in one cell.13

- In Vietnam, detainees are punished for failing to meet work quotas by being denied baths for a month, beaten with clubs, and being chained and forced to stand on their toes for more than 24 hours. Some internees report being put in isolation for up to a week in a cell so small that they are forced to sleep, urinate, and defecate in a standing position. Several people interviewed after completing compulsory treatment said they felt “lower than animals” after serving such sentences.14

- In Guangxi province, China, a recent study found reports of sexual abuse of female inmates by guards. Inmates received mandatory HIV tests but were not told the results. Guards reportedly used the data to know which inmates they could sleep with without using a condom.15

- In Nagaland, India, drug users have been crammed into thorn-tree cages in a sitting position.16 In Punjab, drug treatment patients are routinely tortured, and in some cases have been beaten to death.17

- Drug users in Nepal recount that being taken for treatment has included suspension by the arms or legs for hours, beatings on the soles of the feet, threat of rape, and verbal abuse that includes assertions that they do not belong in the “new Nepal.”18

- In Cambodia, former detainees report being locked in cement facilities where they are forced to withdraw “cold turkey,” and not allowed to use the toilet despite the diarrhea that is commonly associated with such withdrawal, subjected to sexual violence and beatings with batons and boards, and compelled to confess to unsolved criminal cases. Detainees also describe shortages of food so severe that some eat grass and leaves.19

- In Russia, drug users in some facilities are chained to their beds and offered “flogging therapy.”20

- In South Africa, unregistered treatment centers are allowed to operate without government regulation or medical oversight. Former residents of one center report being kicked and beaten if they did not maintain sufficient speed during physical training, which consisted of carrying boulders on their bare backs, rolling long distances on hot pavement, or running while carrying as much as 25 liters of water and then being forced to drink it all, pausing only to vomit.21 Despite the reported deaths of two teenage patients, the center still in operation.22,23,24 Methods used at other centers in South Africa include stranding patients in remote areas for three days, or prohibiting them from talking to, looking at, writing messages to, or touching another person while in treatment.25

### Non-evidence based and experimental treatment

- Malaysia’s drug treatment centers are commonly run by ex-army personnel, and there are few trained paramedics or counselors.26 Treatment is largely military-style discipline and drills in the hot sun. Methadone, a proven treatment for opioid dependence, is unavailable in most centers.27 Condoms are also unavailable in many centers, despite accounts of sexual behavior among residents and between residents and guards.28

- Antiretroviral treatment is not available in most of Vietnam’s treatment centers, although HIV prevalence is reported at 75 percent.29 Some centers conduct mandatory HIV testing without informing those tested of their results.30 Treatment of tuberculosis and other opportunistic infections is also unavailable, except through bribes, and there is no access to sterile injection equipment despite documented drug use in many centers.31

- Those interned in China’s centers are often offered little treatment other than mandated chants such as “drugs are bad, I am bad,” long hours of forced labor, and military-style drills.32 Private and voluntary treatment methods include partial lobotomy through the insertion of heated needles clamped in place for up to a week to destroy brain tissue thought to be connected to cravings.33 The technique is a variation of a Russian technique in which very cold, rather than heated, rods were used to destroy brain tissue.34 This
surgery is one for which families save and pay significant money, despite reports of adverse effects and widespread condemnation of such procedures as experimental and unethical.

- One treatment center in India runs on the motto “changed when chained,” and shackles participants’ legs together and loosens links the longer they remain drug free.35 Some centers administer drugs that have been discontinued in Europe due to their adverse effects, while treatment with methadone or buprenorphine, both on WHO’s list of essential medicines, is often not available.36

- Throughout Eastern Europe and Central Asia, “narcologists” charged with treating drug and alcohol addiction administer hypnoid therapies used in Soviet times, where patients have ampoules or substances injected under the skin and are told that they will explode and poison them if they drink or use drugs, or where patients are shown films with subliminal anti-addiction messages.37 Prescription of methadone or buprenorphine, either for maintenance or detoxification, is illegal in Russia.

Forced Labor

- Human rights groups assert that drug treatment centers in Vietnam are in reality forced labor camps, with inmates required to work long hours under extremely harsh conditions38 at far below market wages. Tasks included carrying heavy buckets of water and excrement, hauling clay on their shoulders,39 or making trinkets for market sale. Those who fail to meet work quotas are isolated and punished severely.40

- One study in China found that detained IDUs reported working from 7 a.m. to 2 a.m., seven days a week, performing unpaid factory labor, with the threat of punishment, including beatings, if production quotas were not met.41

“The Special Rapporteur wishes to recall that, from a human rights perspective, drug dependence should be treated like any other health care condition. Consequently, he would like to reiterate that denial of medical treatment and/or absence of access to medical care in custodial situations may constitute cruel, inhuman or degrading treatment or punishment and is therefore prohibited under international human rights law. Equally, subjecting persons to treatment or testing without their consent may constitute a violation of the right to physical integrity. He would also like to stress that, in this regard, States have a positive obligation to ensure the same access to prevention and treatment in places of detention as outside.”

— Manfred Nowak, Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment (Geneva, January 14, 2009)

The Limits of Equivalence: Ethical Dilemmas in Providing Care in Drug Detention Centers

ABSTRACT

This article considers the phenomenon of detention centers as a purported means of drug treatment, common throughout much of Asia. It describes the growth of the drug detention center model over the past decade – a system where people suspected of using drugs are rounded up on suspicion of drug use or a positive urine screening, and sent to closed settings without due process or means of appeal. Inside, detainees receive no effective drug treatment, little medical care, and insufficient food. Indeed, they are more likely to face what amounts to torture, cruel, inhuman, and degrading treatment. In some countries, they are forced to work or face severe punishment. This article explores the ethical dilemmas inherent in providing care within an abusive system. For organizations offering health education, food, or even lifesaving medical care inside drug detention centers, what are the limits of providing ethical care, without risking legitimizing the system or building its capacity to detain more people? We explore how organizations might weigh the risks and benefits of their engagement.
INTRODUCTION

A significant amount of attention in prison health has been devoted to the principle of equivalence (UNAIDS et al, 2006; UNGA, 1990; WHO, 1993) – namely the need to provide treatment and prevention of HIV and other medical conditions in state custodial settings when they are available in the surrounding community. Less analysis has been applied to pretrial detention centers generally, a gap this issue seeks to fill. Most limited of all – and most ethically thorny – is consideration of medical care in detention settings that are themselves arbitrary and abusive, or illegal. This article explores the case of detention centers for people who use drugs, common in much of Asia.

As with those detained on grounds of threatening national security or immigrating illegally, detainees in drug detention centers are often held in systems that international law regards as arbitrary – that is, without right of appeal, due process, or clear standards for internment or release. In some cases, these detentions are contrary to processes required by national law (Human Rights Watch, 2010a); in others, terms of detention violate multiple international human rights norms and international standards (Human Rights Watch, 2010b). People who use drugs, particularly people who inject drugs, are disproportionately infected with HIV and hepatitis C virus (HCV), with the Joint United Nations Programme on HIV/AIDS (UNAIDS) estimating that a third of new HIV infections outside sub-Saharan Africa are among people who inject drugs (UNGA, 2006); 50%-95% of people who inject drugs may be HCV-infected (EHRN, 2007). Detainees are vulnerable to the same range of health challenges as prisoners, including tuberculosis, with HIV-positive individuals suffering more extreme health consequences of multiple transmissible diseases. In addition, while high-risk behaviors such as drug use and unprotected sex continue in detention centers, means of protection such as sterile injection equipment and condoms are unavailable (Thomson, 2010; Human Rights Watch, 2010b; Wolfe & Saucier, 2010).

The question thus confronting health and penal system professionals is what is the ethical response when detention centers themselves are the biggest obstacle to HIV prevention, treatment and realization of rights? How do we weigh whether our involvement inadvertently supports an abusive system – either by making its continued operation financially feasible, by lending legitimacy, or by building its capacity? One argument may be that the principle of equivalence applies – that is, that detainees are entitled to the same services as those in the community. A counterargument holds that illegality of the detention centers is the most salient fact, and that the provision of some or all services in such settings risks their legitimization. A third, pragmatic view focuses on available resources, and suggests that these should be devoted to actions to close the centers or divert people from detention as the most effective disease prevention measure, and one enhancing the likelihood of treatment.

THE RISE OF THE DRUG DETENTION CENTER MODEL

Drug detention centers are sometimes called compulsory treatment centers, drug rehabilitation centers, or reeducation through labor centers. These are closed settings where people suspected of illicit drug use or those who test positive in urine screenings are sent for detoxification, treatment, and rehabilitation. Today such detention centers for people who use illicit drugs exist in some 11 countries throughout Asia, including China, Vietnam, Cambodia, Thailand, Laos, and Malaysia (Mathers et al., 2010). More than an estimated 400,000 people are detained annually (Mathers et al., 2010). Though there are differences by country and sometimes even by province within a country, the centers are variations on a similar model.

Detention is extrajudicial and most often involuntary. People suspected of using drugs, whether they actually use drugs or are simply swept up in police or military raids are frequently detained for treatment on the basis of mere police suspicion or a single positive urine test. For example, in Cambodia, people who use drugs are picked up by police, sometimes along with people with mental disabilities, sex workers, and the homeless. One former detainee in Cambodia describes the process of his detention: “I got arrested when I was walking with a group of friends. I was told the reason I was arrested was that I was walking with too many people at the same time (12
people). I didn’t go to court or face a trial. I was told that I was a yama [methamphetamine] user and therefore required treatment” (Thomson, 2010). There is no judicial supervision or process for appeal. Some detainees report being able to bribe their way out of internment (International Harm Reduction Development Program, 2009a). In other cases, people suspected of using drugs may be committed upon the request of a family member or the report of a neighbor. People who use drugs in Vietnam report that even those who enter so-called rehabilitation centers voluntarily find themselves unable to leave and are instead confined for years at a time without due process, with severe beatings and other punishments meted out to those attempting escape (International Harm Reduction Development Program, 2009b; personal communication with Saucier & Wolfe, 2010).

Terms of release are similarly arbitrary: In Cambodia, for example, detainees are sometimes required to recite the Cambodian national drug laws from memory prior to release (International Harm Reduction Development Program, 2009a). In Vietnam, drug detention terms have been extended to two years of “rehabilitation” plus two years of “post rehabilitation management” for most detainees, which in practice is more of the same. In China, detention has also been lengthened to up to two years (Human Rights Watch, 2010b). These extended sentences are a response to relapse rates that even by official estimates range between 60% and 100% (WHO WPRO, 2009). Rather than questioning the method, authorities decided more of it was needed.

Despite lack of evidence of effectiveness, the center model has grown exponentially. In 2004, there were 35 drug detention centers in Thailand; currently there are 84. Similarly, in Cambodia the number of centers grew from zero to 14 in eight years; and in Laos from zero to eight in 10 years (Thomson, 2010). While some people who use heroin and other drugs are also detained in these centers, in most countries they are predominantly filled with people who use methamphetamine (Thomson, 2010). In China and Vietnam, heroin remains the drug that is used predominantly, and most people are detained for using or being suspected of using it. Today China detains some 330,000 people in drug detention centers (Mathers, 2010); Vietnam detains approximately 60,000 of the 135,000 people estimated to use drugs in the country (Mathers, 2010). High relapse rates mean multiple terms in the centers, since repeat offenders are often sent back for more of the same.

Drug detention centers are predominantly managed by either the military or law enforcement, with the regimens implemented there based upon a military “boot camp” type model. Detainees are subjected to early morning wake-ups and physical exercises, and are often indoctrinated with anti-drug rhetoric. In many cases, detainees report inadequate food and shelter. A former detainee in Laos described the living situation in the center where he was held as follows: “There is not enough water for drinking, showering, and washing. The toilets are filthy, and there are bags with shit lying around. We all eat and sleep in the same room, so that’s dirty too. Each room is about seven by five meters, and there are about 35 to 40 people in each room” (Thomson, 2010). A World Health Organization (WHO) report found high rates of skin infections and beriberi amongst detainees in Laos (Thomson, 2010). Qualified health sector personnel are rarely involved in any aspects of drug treatment in the centers. Detainees report degrading treatment and severe physical, mental, and sexual abuse. One detainee in Laos described his experience: “They would attack anyone who tried to be strong or tried to escape. Ten men or so would beat them, kick them. The guards would use their shoes to beat them. I also saw guards make people jump up and down like a frog until they were exhausted, became weak, and fell down” (Thomson, 2010).

In Vietnam and China, so-called rehabilitation centers are in reality forced labor camps where slavery is enforced by violent punishments or torture. Detainees are expected to work long hours without adequate workplace safety provisions, producing goods for private companies (Human Rights Watch, 2010b; International Harm Reduction Development Program, 2009b). Detainees have production quotas, and report beatings and other harsh punishments if daily quotas are not met. One former detainee in China described the situation: “We work until dinner time. After downing a few mouthfuls of food, we rush back to the workshop, trying to take advantage of the little time we have left. But no matter how much we hurry, there is still a large majority of ‘crooked pears’ [people who fail to meet their production quota] suffering physical injury by the end of the
workday at 9 p.m. After recording how many did not finish their tasks or produced low quality goods, the Big Brothers [more senior detainees tasked by center authorities with disciplining other detainees] stand at the doors of the workshop, raise long hoes, and take turns viciously beating the ‘crooked pears” (International Harm Reduction Development Program, in press).

These punitive approaches are justified in terms of social rehabilitation of those regarded as having profound disorders of consumption and production – people who use drugs are often described both in terms of their inability to stop using drugs and their failure to contribute productively to society (Wolfe, 2007). The detention center model, however, does not constitute effective drug treatment, and is not based in evidence (Mathers, 2010). Further, because of its compulsory and long-term nature, as well as the abuses represented by forced labor, beating, and arbitrary detention, it is at odds with internationally recognized principles. The United Nations Office on Drugs and Crime and the WHO stress that drug treatment must be evidence-informed and respect human rights; neither forced labor nor detention are recognized as scientific methods for treating drug dependence (WHO & UNODC, 2008). Involuntary treatment is justifiable only in emergency short-term situations when the person is an imminent threat to themselves or others (UNODC, 2010).

**Health Implications of Compulsory Detention as a Response to Drug Use**

Some portion of detainees continues to inject drugs in detention centers, but sterile syringes and other injecting equipment are unavailable (Thomson, 2010; Human Rights Watch, 2010b, Wolfe & Saucier, 2010). Detainees are thus at increased risk for diseases like HIV and hepatitis C, as well as abscesses, endocarditis, or septicemia. For methamphetamine users who are the largest share of detainees in Thailand, Cambodia, and Laos, drug use outside the centers was predominantly via inhalation; once inside a detention center, however, exposure to bloodborne viruses and other infectious diseases may increase (Thomson, 2010). Despite high rates of HIV and tuberculosis, medical treatment for these infections remains largely unavailable (Wolfe & Saucier, 2010). In Southeast Asia, other prevalent behaviors increasing disease risk include tattooing and penile modifications without sterile needles or blades, unprotected sex and rape (Thomson, 2010). While data is not collected by center staff, detention in these facilities – as with incarceration of people who use drugs in prison systems – is likely associated with a host of negative health outcomes, including sexually transmitted infections and blood-borne viruses such as syphilis, herpes, HIV, HCV, and hepatitis B virus (HBV).

**PROVISION OF PREVENTION AND TREATMENT INSIDE THE DRUG DETENTION CENTERS**

Some nongovernmental organizations have attempted to provide care and services to detainees in the centers. This can range from providing food to detainees, providing antiretroviral treatment or medications for other infections, educating detainees about disease prevention (though provision of prevention paraphernalia such as sterile syringes or condoms is generally prohibited), and engaging in capacity building with center staff. Taken at face value, these activities answer basic needs of those in detention, in keeping with the principle of equivalency. Further, nongovernmental organizations and former detainees point to the importance of showing those detained that they have not been forgotten.

The ethical complications of work to provide treatment and prevention inside the centers, however, become apparent when center administrators or governments seek to use engagement by health professionals to legitimize their approach. Agreement signing ceremonies are prominently displayed on websites; in some centers in Vietnam, directors are purported to have certificates hanging on their walls from a US-based group that engaged in capacity building. In 2008, many were alarmed when a large US-funded health organization sent an announcement saying that they were going to help make a notoriously abusive drug detention center in Cambodia a “Center of Excellence.”

This same center was widely viewed by most health and human rights organizations as beyond redemption. Additional complications arise when considering testimony by former detainees noting that testing and
treatment are complicated by the involuntary nature of the centers, particularly those using the forced labor system. In one interview, for example, a recently released detainee noted that HIV-positive detainees were offered antiretroviral treatment, but only if they agreed to remain working in the detention center for an additional year. Others note that those who participate in HIV testing or who go to peer education sessions are motivated to do so primarily because they are given time off from punishing work regimens (personal communication with Saucier & Wolfe, 2010).

ETHICAL CONSIDERATIONS FOR HEALTH RELATED ORGANIZATIONS WORKING WITH DRUG DETENTION CENTERS

The care of the sick and the promotion of health are activities that are recognized as ethical activities. We expect good people to do these things, and we believe that human beings need and deserve these social goods. However, ethics also requires the consideration of burdens as well as benefits. An activity ceases to be ethically sound when it harms more than it helps. When health related resources – including the application of knowledge, as well as personnel, supplies, and funds – are used in ways that perpetuate known harms or that direct limited resources toward the perpetuation of a system that is fundamentally unjust, these resources are supporting interests other than the interests of those who suffer. At some point, these resources are no longer serving health-related ends: we see this starkly in situations in which medical knowledge and skills are applied to interrogation practices that amount to torture. The goal of providing effective health-related services to persons who are in drug detention centers is an ethically sound goal with respect to the treatment of persons. However, attempting to provide these services in this setting presents an ethical dilemma – a situation in which no option is clearly right, and that can be resolved only by determining which option is less wrong than the others. It would be naïve to imagine that there is a “no harm” option in a setting in which human rights violations are known or suspected to be occurring. It would be incorrect to assume that doing something in this setting – in this case, undertaking health-related goals – is better than doing “nothing.” Does progress toward these goals constitute a real benefit to persons in need of care, or are any incremental benefits undermined by the harms that are unavoidable in and integral to this setting?

Following the ethical maxim “ought implies can,” health related organizations working with drug detention centers have a moral obligation to determine whether they can accomplish health-related goals in such settings, or whether such efforts merely perpetuate inhumane systems, misuse resources that could support better systems, and compromise the moral integrity of personnel on the ground. Personnel may aim to use their knowledge to help detainees, but find themselves experiencing moral distress (the perception that they are powerless to prevent harm or improve conditions) or forced into complicity with neglect and abuse. In health care and public health, the bioethics principles of autonomy, non-maleficence, beneficence, and justice are well-established as touchstones for analyzing the goals and consequences of activities that aim to relieve suffering or promote the health of individuals and populations, with the recognition that these principles exist in tension with one another. Organizations working with drug detention centers should also seek to do no harm, to do good, to honor the rights of individuals, and to promote fairness, including the rule of law and equitable access to health-related goods. They should also seek to avoid futility – the delivery of burdens without benefit, as when an intervention constitutes “doing to” rather than “doing for” a person or population by prolonging but not alleviating their suffering.

The British Medical Association (2001) and the World Medical Association (2009) have published ethics guidelines for medical professionals providing care to patients in prisons and others who are detained. There is international consensus that prisoners and other detainees retain “fundamental rights and freedoms subject to the restrictions that are unavoidable in a closed environment” (Cohen & Amon, 2008). As persons in closed systems depend on the system for medical care – they cannot simply leave to obtain care elsewhere – medical professionals in these systems violate their own ethical principles if they provide or participate in providing substandard care to prisoners and detainees when the standard of care could be met. Current medical standards of care require medication assisted treatment for detainees with opioid dependence. Therefore,
failure to provide this care, “poses serious ethical problems for health care providers, violating basic principles of beneficence and non-maleficence” (Cohen & Amon, 2008). This ethical consensus also addresses arbitrary detention and forced labor. Although international law “permits convicted criminals to be required to work as part of their punishment,” this does not extend to people in drug detention centers who have not been convicted of a crime in a court of law (Cohen & Amon, 2008). Drug detention centers that operate outside the rule of law are further compromised by their lack of accountability and transparency. These centers should not be viewed as badly functioning but legitimate systems, akin to health care centers in which the quality of care is poor, or prisons where conditions are bad. Rather, they are illegitimate systems in which the involvement of health-related organizations may have a legitimizing effect even though opportunities for reform through legal channels may be limited or nonexistent.

Organizations working with drug detention centers must also weigh their desire to help individuals in these centers with concerns about promoting justice and human rights in the particular countries in which the centers are located (Public Health Leadership Society, 2002). Major humanitarian-aid organizations have clear policies and processes for how they organize and provide various forms of lifesaving assistance in regions in which human rights violations are present or suspected, and what circumstances will prompt them to reassess whether or not they should continue a mission. These rules may cover situations in which a humanitarian-aid organization enters a closed system, such as a prison or a detention facility, both to provide care and to bear witness to conditions, including human rights violations. Organizations whose missions are focused on building or strengthening local capacities rather than on the direct provision of lifesaving aid also need ethically sound policies and processes to follow, whether they are considering starting, continuing, or stopping operations. For example, the goal of promoting the health of people who inject drugs in a developing country may be better served by strengthening medical education, providing psychosocial support, or increasing access to antiretroviral drugs, rather than by working with closed systems that undermine the health of this population through harsh conditions and by limiting detainees’ ability to benefit from services provided only outside of detention centers.

As the outcomes of health-promotion efforts are unlikely to be apparent immediately – another way in which development aid differs from emergency medical care – these organizations must determine how they will collect evidence to assess whether they are doing more good than harm, how they will assess the reliability of this evidence, and how much evidence should constitute a threshold for reassessing a situation and potentially changing course (Slim, 2002). They must also weigh the moral consequences of agreeing to work in a situation in which they do not have full access to the population they seek to benefit. Should they trust data collected under coercive circumstances? Can a health-related mission be reconciled with rules that limit workers’ ability to observe the real conditions under which detainees live, including the abuse they may suffer?

Avishai Margalit’s (2005) distinction between compromises and rotten compromises offers a useful lens for analyzing the ethical dilemmas arising from continued engagement with drug detention centers. A compromise is an agreement in which the sides to the agreement “make mutual concessions” (Margalit, 2005). A rotten compromise is:

“...an agreement that establishes or maintains a political order based on systematic cruelty and humiliation as its permanent features: Needless to say, usually the party that suffers this cruelty is not a party to the agreement. By humiliation I mean dehumanization – treating humans as nonhumans. By cruelty I mean a pattern of behavior that willfully causes pain and distress” (Margalit, 2005).

Although one should avoid rotten compromises whenever possible, if “a compromise prevents worse cruelty and humiliation,” it may be a “morally justified tradeoff” (Margalit, 2005). Picture a drug detention center that people who inject drugs are forced to enter, without a mechanism for appeal, because officials want to separate them from the rest of society. The center does not provide adequate health care and other basic resources to the detainees, who are wholly dependent on the center for their survival. The center mandates forced labor,
and allows guards to abuse detainees physically and psychologically. It would be reasonable to conclude that these centers are characterized by systematic cruelty and humiliation and that providing support for health-related programs in these centers represents a rotten compromise and should be avoided. If, however, these programs were demonstrably capable of promoting detainees’ health and welfare, to the extent that withdrawing program support would impair detainees’ health and welfare, it is possible that the rotten compromise is morally justified on humanitarian grounds.

CONCLUSION

In systems where rights abuses are rampant and the terms of detention are arbitrary, illegal, and clearly at odds with their purported aims of treatment or rehabilitation, it is not the principle of equivalence but Margalit’s “rotten compromise” standard that is most relevant. Avoiding the rotten compromise, and honest ethical assessment, requires the leaders of health-related organizations to avoid thinking in better-than-nothing terms when considering engagement with drug detention centers. In situations where systematic cruelty and humiliation are already present, this standard demands evidence of how programs can promote health under these conditions, and also how or whether non-engagement will make conditions much worse. All health-related resources are limited resources – might the resources in this instance be better served by efforts to keep individuals out of detention centers in the first instance? If one argues that urgent medical needs of detainees are paramount, how does one gauge which services are urgent and thus require delivery inside institutions? Is HIV prevention education delivered inside centers that prohibit needles and condoms justified, or might HIV prevention to detainees immediately upon release be as effective and less morally suspect? If food is insufficient and those too tired to work are dragged from their beds and beaten, is initiation of antiretroviral treatment really appropriate? Does it matter if such services are delivered by center staff, who may benefit from or divert resources meant for patients, or by outsiders? Does it matter if center administrators use the collaboration for public relations purposes? While these questions may seem to burden providers with too many intangibles, in fact those unwilling to consider them are likely inappropriate for work inside drug detention centers. Ethics demands that organizations and their donors question whether investing limited resources in these settings will result in benefits to detainees, or to the inhumane systems in which these individuals are caught.

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40 New Zealand INA (Māori, Indigenous & South Pacific) HIV/AIDS Foundation
Marama Pala, an executive director from New Zealand, discovered that her former partner was HIV positive when she saw him on the front page of a newspaper article entitled 'Face of Fear'.

"The High Court Trial was awful for me, he was found guilty by jury and sentenced to seven years imprisonment, on his release he was deported. During the trial he had large numbers of supporters trying to keep him in the country for his daughter. I was made the villain because I put him in jail and forced him out of the country."

I was infected on 23 July 1993 by an African Man in New Zealand – Peter Mwai. I found out that he had HIV from a newspaper article with his face on the front page saying 'FACE OF FEAR'.

The article below described how he had infected women with HIV and if anyone had had contact with this man to ring the police. I did, and then was asked that, if I should I test positive, would I help them stop this man from infected any other women? I said yes, and then I was tested shortly after.

After a two week wait the test came back positive and charges were laid.

The police had evidence that he was told he had HIV in June by an infectious diseases clinician. I was infected in July, and fell within the time frame to charge him. Whereas the other women he infected didn’t, but five other women could charge him with reckless endangerment.

I had asked him to wear a condom, he refused. I did not insist, because I had very little knowledge about HIV, I thought he was too healthy-looking and he had already shown me a picture of his baby daughter who was healthy too.

HIV transmission is currently not the subject of a specific ‘law’ in New Zealand, but there is legislation from 1969 about intentionally infecting someone with a disease. Peter Mwai was originally charged with this, but the police could not prove ‘intent’ and the charge was lessened to Grievous Bodily Harm, as well as the reckless endangerment charges.

There was a High Court Trial - that was awful for me. He was found guilty by jury and sentenced to seven years imprisonment, on his release he was deported, and subsequently died of TB in Uganda. During the trial and his release time he had large numbers of supporters trying to keep him in the country for his daughter. I was made to feel like the villain because I put him in jail and forced him out of the country.
The New Zealand AIDS Foundation (NZAF) is New Zealand’s leading HIV prevention and professional support organisation. The NZAF is a registered charity that grew out of gay community initiatives responding to the threat of HIV in the 1980s. Today the NZAF brings history, passion, commitment, expertise and diversity to meet the emerging trends of the HIV epidemic and the changing needs of the communities we serve.

The NZAF would like to thank the Global Commission on HIV and the Law for the opportunity to be part of this important discussion. We have maintained a keen interest in both the establishment and the early activity of the Global Commission and we are excited by this initiative.
The NZAF recognises that legal environments which advance human rights, gender equality, and social justice goals are fundamental for both the prevention of HIV and the maximisation of the health and well-being of people living with HIV. In New Zealand, we can be proud of a number of key pieces of legislation which are recognised as having been central in reducing the impact of HIV in our country. Such a legislative environment is to be both recognised and celebrated for contributing, at least partly, to the comparatively low HIV incidence rates in New Zealand.

It is salient in this submission to comment on the key pieces of New Zealand legislation which have meaningfully improved the lives of those marginal groups most at risk of HIV infection. The NZAF asserts that the decriminalisation of marginal populations at risk of HIV infection is a crucial first step in the fight against HIV. In the New Zealand context we have achieved decriminalisation for men-who-have-sex-with-men (MSM), intravenous drug users (IDUs) and sex workers.

First, the Homosexual Law Reform Bill (1986) decriminalised consensual sex between men aged 16 years and older by removing the provisions of the Crimes Act (1961) that criminalised this behaviour. Second, the Misuse of Drugs Amendment Act (1987) decriminalised the sale of needles and syringes to IDUs provided their sale was part of the established Needle Exchange Programme. Third, the Prostitution Law Reform Act (2003) decriminalised prostitution in New Zealand. Such legislative reform is consistent with international guidelines on HIV and the law and has empowered marginal populations at risk of HIV infection in New Zealand to access HIV prevention and support initiatives without fear of criminalisation.

As well as decriminalising the population groups most at risk of HIV transmission, New Zealand law also prohibits discrimination on a wide variety of HIV relevant grounds. For example, discrimination against somebody because of their perceived or actual sexual orientation is unlawful under the Human Rights Act (1993). The impacts of HIV stigma and discrimination are widely accepted and such legislation helps to minimise related harm to effective HIV and AIDS responses.

While New Zealand has much to be proud of in the context of HIV and the law, there is always the risk of legislative reform that would return those most at risk of HIV transmission to the status of criminals. The 2010 Manukau City Council (Regulation of Prostitution in Specified Places) Bill is an example of such potentially harmful reform. The Bill passed its first reading in Parliament by 82 votes to 36 and if enacted into law will allow Auckland Council to criminalise street-based sex workers (and their clients) in areas of the city where sex work ‘causes a nuisance or serious offence to ordinary members of the public’. Not only is this Bill contrary to the Prostitution Law Reform Act (2003) but it is also likely to be in breach of the New Zealand Bill of Rights Act (1990). It is inconsistent with international guidelines on HIV and the law and could place the health and safety of both street-based sex workers and their clients at greater risk. The current level of government support for this Bill is of serious concern and illustrates that a major step backwards in the context of HIV and law could occur at any time.

Finally, it is in our capacity as a partner in a current Secretariat of the Pacific Community funded project in the Pacific that it is relevant for the NZAF to comment on HIV and the law in the Pacific context. The NZAF is seriously concerned that colonial era laws criminalising homosexual activity persist throughout the Pacific. These laws make it difficult not only to provide effective HIV prevention, testing and support services throughout the Pacific but they also undermine the ability of marginalised populations such as MSM to access the legal system. The NZAF reiterates that decriminalisation of at risk populations is a crucial first step in the fight against HIV and we urge the Global Commission to make focused efforts in this context.

Thank you again for the opportunity to participate in this call for submissions on HIV and the law. We wish the Global Commission every success for the Asia-Pacific Regional Dialogue in February 2011.
NZPC is an organisation comprising past and present sex workers, formed in 1987. NZPC advocates for the human rights, health and well-being of all sex workers. NZPC is committed to working for the empowerment of sex workers, so that sex workers may have control over all aspects of their work and lives. NZPC has contracted to the Ministry of Health since 1988 to provide HIV related services to sex workers. Our work in this area is predominantly about prevention and community support for sex workers who are living with HIV.

We wish to make some brief comments related to sex workers and barriers that effectively criminalise people living with HIV and those who are vulnerable to HIV.

**Background to laws affecting sex work in New Zealand**

In 2003 New Zealand repealed laws that criminalised many sex work related activities, such as brothel keeping, soliciting, living on the earnings, and procuring. The aims of the 2003 sex work laws are contained in the Prostitution Reform Act and are:

To decriminalise prostitution and to create a framework that—

(a) Safeguards the human rights of sex workers and protects them from exploitation:
(b) Promotes the welfare and occupational health and safety of sex workers:
(c) is conducive to public health:
(d) Prohibits the use in prostitution of persons under 18 years of age:
(e) Implements certain other related reforms.

There are many positives in the law as it facilitates in occupational safety and health practices being strengthened. This newly decriminalised environment enables sex workers to explicitly promote safer sex practices to their clients, and to share ideas and strategies amongst themselves related to sex work and HIV prevention awareness. There are strong connections to service providers, including sex worker managed peer based outreach services, and sexual and reproductive health clinics. Mandatory testing is not required, and sex workers with HIV are able to continue working as sex workers. Decriminalisation has enabled sex workers to create stable working environments in sectors, which were prior to the law reform, vulnerable to being disrupted by law enforcement activities.

It is important that sex workers are not forced by authorities to relocate to unfamiliar places, as this can result in undermining significant relationships that sex workers may have with services and neighbourhoods, which in turn can assist in contributing to a wider environment which is conducive to HIV prevention and support.

NZPC has concerns regarding the illegal status of migrant sex workers. The Prostitution Reform Act prohibits sex workers from other countries coming to New Zealand to work as sex workers. This inequality in immigration status means that those migrant sex workers are working in environments that cannot always be legitimately supported by the aims of the Prostitution Reform Act. While these migrant sex workers may access sex worker focused services, and are accessed by peer based outreach services, they are sometimes disadvantaged in the context of wider health services. It is unlikely they would disclose that they are sex workers as this may result in deportation.

Sex workers are not protected by anti-discrimination laws in the context of their sex work, and stigma is an undermining factor in relation to their well being. Street based sex workers wear the brunt of this stigma, and in particular, those street based sex workers who are transgendered. Since the Prostitution Reform Act decriminalised street based sex work, there have been concerted attempts to overturn this part of the
legislation, and recriminalise these sex workers. The Police in some regions have ignored the rights of these sex workers and harass them, and even attempted to collection DNA samples from them with no reason. Neighbourhood watch groups have made claims that these sex workers are “spreading” HIV.

However, in other regions the police have welcomed the decriminalisation of sex work and relate in a more reasonable way to street based sex workers and negotiate with them about providing police patrols with the intention of not disrupting sex workers and their clients but will contribute to enhancing their safety.

While decriminalisation has certainly supported sex workers in reporting violence, and assisted in occupational safety and health, and health promotion, we believe it is also very important to address stigma and discrimination by way of policy and law if possible, as well as through destigmatisation programmes.

Respecting and assisting sex workers to realise their rights in the context of sex work is a critical and most important HIV intervention. Initiatives which seek to ‘rescue’ sex workers from sex work are mostly an unwelcome intrusion into the lives of sex workers and may cause significant harm and additional stress in the context of HIV. Finally, we would like to say that sex workers need to be consulted in a meaningful way, and involved in determining those laws and policies which will bring effective change to the negative impacts related to HIV.

NZPC bases the above opinions on evidence based research completed by the Prostitution Law Review Committee, a committee charged with reviewing the Prostitution Reform Act with members appointed by the minister of Justice, research completed by Otago University, Christchurch School of Medicine, and the Crime and justice Research Centre at Victoria University of Wellington. In addition, NZPC has more than 23 years experience of providing HIV services to sex workers.

References:


The Japanese government enacted “Act for prevention of AIDS”, in 1989, which was very discriminatory and included entry restriction for people living with HIV/AIDS. This law was not based on the scientific basis and human rights standpoint, and it depended on quarantine policy. This law caused more discrimination against people living with HIV/AIDS and HIV/AIDS itself.

10 years after, Act Concerning Prevention of Infection of Infectious Diseases and Patients with Infectious Diseases, was enacted in 1999. This new law got rid of quarantine policy from the Japanese policy. And then Prevention Policy from infectious diseases was enacted and it emphasizes on respect for human rights of people living with HIV/AIDS.

Generally speaking, in Japan although we enjoy high standard of medical service, human rights has not be achieved and is regarded as negligible. This inclination leads a lot of problems in the field of protection of PLWHA and marginalized people. Inside and outside of the medical service, there are a lot of discrimination against women, minority people and people living with HIV/AIDS and they are violated their human rights inside and outside of hospital and by medical personnel, mass media and authorities. What is worse, most Japanese people are not interested in HIV/AIDS issue. As the Japanese society is very conservative, sex education can be hard to do.

**Violence against women**

During the past decade, the Japanese government has tackled the violence against women, especially domestic violence issue, enacting the DV prevention law. However, the law is insufficient and doesn’t cover the other forms of violence against women, such as sexual assault, child abuse and prostitution, which I know is controversy. Our organization has been struggle for comprehensive anti-sexual assault act.

Although the total number of people living with HIV is small, about 17,000 for now, we have a risk that the number will be rapidly increasing. In that case, the existing law and system will not work for prevention from the heterosexual infection with HIV. A lot of offenders of sexual assault remains impunity, as our criminal law and criminal justice has many flaws, especially offenders of marital rapes are rarely punished. Also unmarried couples are not covered by the DV prevention law, so young women are at the risk of the infection through heterosexual sexual violence. Another issue is inclination that men are reluctant to use condom when they have a sex with their wives or girlfriends, for example the contraceptive prevalence is only about 50%.

**Violence and discrimination on the ground of sexual orientation and gender identity**

There is no law to protect sexual minority, except for Law concerning special rules regarding sex status of a person with gender identity disorder. Although we don’t have criminal law which punishes the homosexual act. Laws do not prohibit discrimination on the ground of sexual orientation and gender identity and some law protect only married couple. For example, basically, the above mentioned DV protection law does not cover the homosexual couples, so the victims of the DV in the lesbian or gay couple can not seek help and can not help staying with the offender, with high risk of homosexual infection. It is very difficult for sexual minority to file a complaint against offender, as police cannot understand the issue of same sex couple and transgender and sometimes despise them.

Sexual minority people suffer from many forms of discrimination in the Japanese society, including school, workplace, and their community, which prevents them from the access to the care and prevention and medical service.

**People who work in sex industry**

Some people insist that prostitution should be recognized as a work, but there are a lot of exploitation and violence that happen there. Many women and sexual minority people are controlled as a commodity. A few groups support prostitutes and provide information on HIV/AIDS and how to protect themselves for them, but the discussion around how to protect health and rights of those who work for sex industry, how to keep the dignity of women from discrimination and degrading and how to achieve both of them have not completed. The Japanese law on prostitution enacted in 1956 and it never punish clients of prostitution and punishes women who work for prostitution industry in some cases, as this law was aimed to restrain vicious brokers and
managers and to keep social morality. Under this law, health and rights of those who work for sex industry are not protected.

**Non-Japanese people**
The Japanese national health insurance system does not cover the non-Japanese people who don’t have permanent residence status. Non-Japanese people are discriminated on the ground of status of residence, but also crack down of illegal immigrants keeps non-Japanese people away from access to medical services, including HIV/AIDS medical and prevention service.

**Drug user**
In Japan, the Ministry of Justice prohibits illegal drug and the Ministry of Health, Labour and Welfare obeys the policy of the Ministry of Justice, so harm reduction approach is hard to be introduced in Japan. This may make injection drug users hard to access to necessary medical services as they are afraid of being arrested and punished.

**People living with HIV/AIDS**
While medical service and social welfare standard is almost good and groups of people living with HIV/AIDS are well-organized and do good advocacy and support activities, there still are many discrimination against people living with HIV/AIDS and a lot of human rights invasion cases have been reported and fully participation of PLWHA has not been achieved in various area.

**Universal access**
Due to the above mentioned reasons, universal access has not been achieved in Japan. Some people have to delay the access to HIV test and treatment due to social indifference and prejudice, and some have difficulty in accessing to the services due to the barrier of language.

| 44 | Thailand | Individual |

Honorable Commissioners,

I am writing as a person living with HIV and as a person with many years of experience with illicit drug use.

I am certain that I was infected with both HIV and hepatitis C during my imprisonment for drug use in Chiang Mai men’s prison in the 1990s, where at least 10 other prisoners and I shared homemade injecting equipment fashioned out of a pen barrel and needle, to inject heroin every day for the six months I was there.

There was, and is still, no clean injecting equipment available in Thai prisons, or opiate substitution therapy nor sterile tattooing equipment. When I was in prison, no condoms were distributed, though both consensual and non-consensual sex acts occurred. Chiang Mai in the late 1980s and early 1990s was the epicenter of Thailand’s HIV epidemic. Many of those who died were people who inject drugs (PWID), who never did and still do not enjoy government-supported HIV prevention methods for PWID, such as keeping people out of detention and prison, providing clean injecting equipment to injectors, and providing opiate substitution therapy to opiate dependents, which are all proven methods for preventing HIV and other blood-borne viruses.

My testimony is to implore you to highlight the burning issue of the criminalization of people who use drugs and subsequent vulnerability to exploitation, stigmatization and discrimination, HIV/other blood-borne viruses, especially hepatitis C (HCV), and numerous egregious human rights violations including extra-judicial execution, which has been documented in my own country (see “Not Enough Graves: The War on Drugs, HIV/AIDS, and Violations of Human Rights,” [http://www.hrw.org/en/reports/2004/07/07/not-enough-graves-0](http://www.hrw.org/en/reports/2004/07/07/not-enough-graves-0)).
The failure to address drug use as a health issue rather than solely a law enforcement concern has and continues to sentence people who use drugs (PWUD) to unnecessary illness and death. My own experience of arbitrary arrest and incarceration reflects a situation still commonly experienced by my drug-using peers. I was arrested in an area where drugs were sold, though I had no drugs on me at the time. The police took me to the police station and tried to charge me with “drug possession,” but I refused to sign. Then, they slapped me in the head. They waited for me to suffer heroin withdrawal symptoms and showed me some heroin. They asked me if I wanted it. Of course, I said yes, and I signed the confession. I spent the next six months in prison, where I was able to inject heroin every day. There were drugs, but no clean needles or syringes. The irony of this has not been lost on my peers and me. This is why we have spent the past ten years focused on organizing against these injustices and promoting the conscientization of people who use drugs as well as policymakers, to ensure these abuses stop.

I founded my organization, the Thai AIDS Treatment Action Group (TTAG), to respond to the treatment access crisis for highly marginalized populations: despite a national policy of universal HIV treatment coverage, the result of a successful advocacy campaign I participated in with many civil society and PWLHA partners, society’s criminalized, stigmatized and subsequently most marginalized still lack access to the highest standards of prevention and treatment services and care. TTAG works mostly with people who use drugs, people in prison, and people recently released from prison. These 3 groups clearly suffer from rights violations that perpetuate their marginality and vulnerability to HIV, and I beseech you to highlight these as a priority in your work in my region, where people who use drugs are often the majority of people in prison and other closed settings. Denial of HIV/AIDS medicines and treatment is common, despite a “medical criteria only” eligibility requirement on the books; negative attitudes of health care providers compounded by their lack of awareness about treating people who use drugs with antiretroviral therapy and other related issues leads to outright denial of life-saving ART medication or an order to “quit drugs” before becoming eligible for ART (documented by my organization with Human Rights Watch: “Deadly Denial: Barriers to HIV/AIDS Treatment for People Who Use Drugs in Thailand,” (HRW/TTAG, 2007), http://www.hrw.org/en/reports/2007/11/28/deadly-denial. Such disconnects between laws and policies on the books and real-life practices are the crux of the problem of rights violations and discrimination against people who use drugs.

Despite locally-generated evidence plus the overwhelming availability of international evidence in support of harm reduction policy and programming as an effective approach in addressing HIV and other vulnerabilities among people who use drugs, the Thai government has refused over the past 10 years to incorporate the full range of harm reduction services necessary for an effective response. However, the Thai Drug Users’ Network (TDN), of which I am a co-founder, was successful in a grant to the Global Fund to Fight AIDS, TB and Malaria (GFATM) for a community-driven harm reduction program in Thailand in 2003, and in 2008, Population Services International received endorsement from the Thai government to manage the harm reduction component of a Round 8 GFATM grant, now in its 2nd year of implementation (and of which we are currently a sub-recipient). Yet these projects were and are severely compromised by the lack of an enabling legal environment in which to carry out our activities. Specifically, our ability to fully provide the range of harm reduction services to make an appropriate impact is diminished by the lack of overt endorsement by the Ministry of Public Health, a continual police presence in and around our harm reduction drop-in center (DIC), the constant harassment and arrest of our DIC participants and outreach workers, discrimination in the health care setting at all levels including at “Voluntary Counseling and Testing” sites and hospitals where HIV care is provided.

People who use drugs are constantly rotating in and out of detention, prison, and compulsory drug detention centers (CDDCs), or dying of HIV, TB, or other diseases detected too late. Until people who use drugs are decriminalized, their well-founded fear of identification as a person who uses drugs will compromise their ability to get the health and social services they need, including social welfare benefits, clean injecting equipment, methadone maintenance therapy, tailored HIV treatment information and services, appropriate ART regimens, and community-based, voluntary, evidence-based drug treatment options, and even jobs,
housing, access to community loan schemes, and successful reintegration into the community.

I also propose that you work to close “compulsory drug detention centers (CDDCs)” where many drug users are held, yet where the oversight of the courts and justice system do not extend, and where as a result violations of basic human rights are the norm. Failing to successfully “treat” drug users, and resembling military boot camps where they are often housed, these Thai drug “rehabilitation centers” are just an extra-judicial measure to detain people who use drugs, yet detainees enjoy fewer rights than even people in prison.

I am certain that Thailand will not successfully address the HIV crisis until it can effectively solve HIV among people in prison, people who use drugs, and other highly marginalized groups such as ethnic groups and migrant populations who are disproportionately imprisoned. Without addressing the human rights conditions that increase vulnerability of these groups, HIV will continue to thrive. Maintaining laws and policies that criminalize and stigmatize people suffering from a health condition, as with people dependent on drugs, is tantamount to commuting a death sentence, and promotes cruel, inhuman, degrading behavior such as the type I myself suffered at the hands of the police during my forced confession. I hope you too will recognize and work to redress this deplorable situation.

Key documents to improve your awareness and understanding of the legal, policy and rights environment influencing HIV risk among people who use drugs in Thailand:


Abstract
Being a young people based in global south our identities and my risk perception brought us into the world of development and activism. We started working with HIV/AIDS intervention program in early 1999 with an understanding that discriminated populations probably have among the most valuable insights on HIV/AIDS. Young people make up about 50% of the new infections that is over 6000 every day. Yet, we find ourselves discriminated against and excluded from most decision-making processes. We, young people, have indeed again and again shown our strong capacities and commitment to stop HIV/ AIDS – but sadly only when we are invited to the table. We and other discriminated populations have a right to be there, a right too often denied. We, the members of populations discriminated against, are not vulnerable. Indeed, we are strong, capacitated and share a strong commitment to contribute to the fight against HIV and AIDS. The reason people are vulnerable to HIV and AIDS is not because they are young, or homosexuals, or sex workers or injecting drug users. We are not somehow extra vulnerable to the virus. Yet, we carry the heaviest burden of the pandemic, because society repeatedly denies us access to sexuality education, commodities for contraception and decision-making when it comes to HIV and AIDS-programme.

On the issue of rights, a lot of debate focused on the need to strike a balance between the autonomy and universality of rights and the contexts that surround the realization of these rights. We should begin to name sexual rights without shame, as what is unnamed is more likely to be unsupported, ignored or misunderstood.

**Confronting Hegemony: Young people and sexual rights**

Sex, sexuality and sexual rights, to this day, continue to be controversial and much contended topics. The controversy becomes even more convoluted and the contention greater, however, when the discourse specifically focuses on young people's sex, sexuality and sexual rights.

**Double standards in sexual rights recognition**

The issues of sexuality and sexual rights have been debated upon and fought over at various levels – personal and collective, local and global. At the international level, individuals and groups promoting sexual rights have gained significant ground despite opposition from conservatives. There is no explicit mention of sexual rights in international consensus documents, but in 1995, the international community in Beijing managed to recognise the existence of sexual rights without using the term. The Beijing Platform for Action', (outcome document of the 1995 Fourth World Conference on Women), is regarded as setting forth the definition of sexual rights by providing that women's human rights include the right to “have control over and decide freely and responsibly on matters related to their sexuality....” For sexual rights activists, this is a significant battle won, as international commitments (in theory, and ideally, at least) guide national laws and policies. The victory is incomplete though – commitment to recognise and respect sexual rights has failed to extend to young people.

At the crux of such failure is the compulsion of some adults to control, if not deny, young people’s sexualities, as reflected in the existence of several layers of double standards when it comes to young people and sex. The first layer is age-based, the general rule being: it is inappropriate for young people to have sex. The second layer is based on marital status: young women may have sex as long as they are married. The next one discriminates between men and women: young men having sex before or even outside marriage is often tolerated, if not encouraged. And so on and so forth.

The layers of double standards do not end in the social prescriptions regarding young people’s sexual conduct, or more appropriately, non-conduct. The layers apply to the selective recognition of which of the sexual and reproductive health rights are accorded to young people. For example, many adolescent and youth sexual/reproductive health (AYSRH) policies and programs recognise young people's rights to, and address their need for sexual and reproductive health information and education, but not services. If their need for sexual and reproductive health services is at all addressed, it is often limited, and does not include providing access to a full range of contraceptive options. Most of the time, safe abortion services are unavailable to young women;
when provisions for safe abortion services do exist, young people’s rights to confidentiality and privacy are often violated. Also, despite an almost universal recognition of young people's right to be free from sexual violence and diseases, recognition of this same right is somewhat grey when it comes to lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ) youth. Additionally, U.S. abstinence-only policies respect and promote young people's right to say no sex, but not their right to enjoy it.

Sadly in the end, it is young people who bear the consequences of these double standards: despite the dangers of early pregnancy, almost 15 million adolescent women become pregnant every year; one out of every four women undergoing unsafe abortion is an adolescent; one in two new persons living with HIV is a young person; and countless LGBTIQ youth are forced to hide their sexual identity for fear of discrimination and threats to their health and lives.

Ways Forward

Young people’s sexual responsibility and health can never be achieved by censorship of their sexual rights. Providing young people access to complete and fact-based sexuality information and education enables them to make informed and responsible decisions. Giving youth access to non-judgmental, non-discriminatory, safe and quality sexual health services, meanwhile empowers them to act on these decisions.

If policymakers, programme planners and implementers are sincere about their intent to address young people’s sexual and reproductive health needs, they should first come to terms with accepting young people as sexual beings and respect young people’s sexual rights. Youth sexual health needs may sometimes be different from those of adults, but they are just as legitimate. Next, adult stake-holders should recognise that as much as young people share many similar issues and concerns, there is vast diversity among them. Differences between the needs of young women and young men, heterosexual and LGBTIQ youth, rich and economically-disadvantaged youth, older youth and younger youth, among others, should therefore be reflected in any law, policy or programme affecting them.

Health service providers should confront their own prejudices against young people. Aside from the inaccessibility and lack of affordability of youth sexual and reproductive health services, discriminatory and condescending attitudes of health personnel, requirements of parental or spousal consent and betrayal of young patients' confidence discourage young people from seeking sexual and reproductive health care. Personal beliefs and morals should not be imposed when providing services to any client, regardless of the client’s age or marital status.

The international community should promote more progressive frameworks on AYSRH and support explicit language promoting youth sexual rights in international documents. They should also allocate funds to ensure that the progressive frameworks are translated into actions at both the local and global levels.

Critical to making youth policies and programmes work, however, is ensuring the meaningful participation and perspectives of young people in their planning, making, implementing, review and monitoring. However, the difference between meaningful participation and just any participation can never be over emphasized. Meaningful youth participation is not just about having young people in AYSRH organisations and networks, or having young people sit in meetings, roundtables or conferences. Meaningful youth participation entails respect for young people’s competencies and decision-making abilities and incorporation of their perspectives and opinions in any decision that has to do with them, at all levels and in every possible way.

Controlling young people’s sexualities is characteristically patriarchal, denial of it is condescending; both insult young people as they do not respect their capacity to make responsible decisions regarding their own sexualities and sexual lives, nor their capacity to bear the consequences of their sexual decisions. While intending to protect young people from the possible unpleasant consequences of sex, adults obsess on the
negative and deny young people their right to experience positive sexuality, including sexual pleasure and responsible sexual expression.

Young people’s rights are human rights. Their sexual and reproductive rights are a part of these rights. Young people cannot, and should not, wait to be accorded full recognition of and respect for their rights when they reach adulthood. Their rights have to be fulfilled now.

For a long time, adults have monopolised the definition of the parameters of young people’s rights. Young people are speaking up and reclaiming their own rights. The Network of Asia Pacific Youth (NAPY), for one, calls for respecting, promoting and fulfilling young people’s sexual rights. NAPY believes that same as adults, young people have the right to:

1. be free from all forms of discrimination on the basis of their age, gender, sexual orientation, refugee status, disability, class, caste, race, education, language, ethnicity, religion, political ideology, marital status, HIV status, occupation and physical appearance;
2. have freedom and autonomy to choose and express their individualities, sexualities and sexual orientation;
3. have a safe and satisfying sex life;
4. make informed choices and decisions on matters affecting their sexuality, health and lives;
5. privacy and confidentiality when accessing sexual and reproductive health services;
6. be free and protected from violations of their sexual and reproductive health and rights. Lack of access to sexual and reproductive health information, education and services including safe abortion services, contraception and protection from reproductive tract infections/sexually transmitted infections/HIV/AIDS is a violation of their sexual and reproductive rights;
7. choose if, when and who to marry; if and when to have children and how many; and end marriage;
8. bodily integrity, and to be free from sexual violence, physical, sexual and emotional abuse, domestic violence, unsafe abortion, forced migration, prostitution, trafficking, as well as forced and early marriage;
9. meaningfully participate at all levels of decision-making about matters that concern their lives;
10. and Have their realities and perspectives reflected in laws, policies and programs affecting them.

The Organization

The Network of Asia Pacific Youth (NAPY) is a member-based network of young people aged 15-30. It works towards the promotion, protection and advancement of young people's rights, especially their sexual and reproductive health rights (SRHR) and ensuring their meaningful participation and perspectives at all levels of decision-making.

NAPY was officially formed at the Asia Pacific Youth Workshop on Sexual and Reproductive Health and Rights in 2000. It had its seeds at a gathering of Asia Pacific women in September 1999 and gained momentum from the Youth Coalition on ICPD +5.

Background

Fifteen years after the ICPD and Beijing conferences, the lack of supportive policies and legal/regulatory barriers continue to hamper young people’s access to SRH services including HIV services. In the Asia Pacific, countries still fall short in comprehensive SRH programmes, supportive Sexuality education and lack of youth friendly HIV prevention program aimed at youth (e.g. nationwide IEC programmes for adolescents, provision of services to unmarried youth). Meanwhile, the region’s youth face an increasing range of Sexual and

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1 Data from ARROW project “ICPD Ten Years On: Monitoring and Advocacy on Sexual and Reproductive Health and Rights” and ARROWs for Change, Vol. 11 (February 2005).
reproductive health risks. Six million adolescents give birth yearly and HIV/AIDS infection of young people reached 1.8 million in 2001\(^2\).

Young people’s SRHR remains a difficult and sensitive issue in many countries. There is still a denial of young people’s sexuality and discrimination based on marital status, gender and parental or spousal consent. Growing fundamentalism and conservatism, persisting patriarchy and anti-choice donor policies present further obstacles.

As a result, NAPY advocates for the participation of young people in decision-making to ensure youth policies and programmes represent their own experiences and realities. The greater involvement and regional networking of young people from the Asia Pacific is crucial as they make up the majority of the world’s youth population. NAPY believes that advocating for the rights and empowerment of young women is necessary for social, economic, political and cultural development.

LEGAL AND JUDICIAL PREJUDICE AGAINST SEAFARERS WITH HIV AND HIV-AIDS IN THE PHILIPPINES

The Philippines is the number one supplier of international seafarers, who number some 370,000¹ of the world total of more than a million. Filipino land-based and sea-based overseas Filipino workers (OFW for brevity) are the main pillars of the tottering economy. They are also most vulnerable to HIV infection. One of every 4 reported HIV positive Filipino is an overseas Filipino worker, numbering 1,501 out of the total 5,729 based on the National AIDS Registry of the Department of Health as of October 2010.² They are also the ones who are victims of legal, judicial and systemic prejudice and discrimination.

The discrimination is obvious in all levels, from pre-employment, to actual employment, to termination and even up to the death of the person with HIV and HIV-AIDS. Even the heirs of the deceased OFW are discriminated and prejudiced in law and in the courts.

Prior to employment, all seafarers working abroad must be covered by a standard contract issued by the Philippine Overseas Employment Administration (POEA for brevity). This POEA contract imposes an obligation to all seafarers to admit and disclose his medical condition in a Pre-Employment Medical Examination (PEME).

According to the contract: “A seafarer who knowingly conceals and does not disclose past medical condition, disability and history in the pre-employment medical examination constitutes fraudulent misrepresentation and shall disqualify him from any compensation and benefits. This may also be a valid ground for termination of employment and imposition of the appropriate administrative and legal sanctions.”³

This requirement is clearly against the privacy provision of the Philippine AIDS Prevention and Control Act of 1998. The declaration of policies of the said law provides that “The State shall extend to every person suspected or known to be infected with HIV/AIDS full protection of his/her human right and civil liberties. Towards this end, the right of privacy of individuals with HIV shall be guaranteed; discrimination, in all its forms and subtleties, against individuals with HIV or persons perceived or suspected of having HIV shall be considered inimical to individual and national interest; and provisions of basic health and social services for individuals with HIV shall be assured.”⁴ (Emphasis supplied).

What is wrong is that any person who admits to being HIV positive is denied employment even if he or she is otherwise “fit to work”. This prejudice was revealed by an HIV positive seafarer, “Raffy”, an engine officer⁵ in his testimony delivered before a seminar that was held by ISAC on HIV/AIDS last December 3, 2010.⁶ “Raffy” who is fit to work, was refused employment by his agency and principal just because he is HIV positive. Seafarers who are fit to work but who are HIV positive are not employed anymore. This is in violation of the ILO Code of Practice that states that HIV infection is not a cause for termination of employment, for as long as medically fit in available, appropriate work.⁷

This discrimination against persons with HIV and HIV-AIDS is also prevalent in the highest court of the land, the Court of Appeals and even in the Supreme Court. In one case a seafarer who was HIV positive but was otherwise fit to work sustained a full blown HIV-AIDS illness while working on board and subsequently died of opportunistic infections two years after medical repatriation. The heirs sued for death benefits but the Court of

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¹ 2009 data of Philippine Overseas Employment Administration (POEA).
³ POEA Standard Employment Contract for seafarers. Sec. 20, E.
⁴ Declaration of Policies, Sec. 2 (b), Statements (2), (3) and (4), Republic Act 8504, Philippine AIDS Prevention and Control Act of 1998.
⁵ Not his real name, the Seafarer is a volunteer of ACHIEVE, a Philippine non-governmental organization.
⁷ Presentation by Jesus Macasil, JR., ILO SRO Manila, in the same conference of ISAC.
Appeals denied this because at the time of boarding, he was already HIV positive. The hiers appealed to the Supreme Court, which in a year 2010 decision affirmed the Court of Appeals ruling, stating that AIDS is not listed as an occupational disease and is not work-related. The Supreme Court held that AIDS is a preexisting illness that the seaman did not disclose during his PEME. Since he died of AIDS related infections, he was deprived any contractual death benefit. The widow, and orphans of the dead seafarer were ordered by the high court to return all the death benefits that they have already received.

The confusion arose from the court’s error of equating AIDS as an illness to the HIV positive status of a healthy carrier. Medical experts agree that a person who is HIV positive may not have HIV-AIDS. The ILO Code of Conduct and the Philippine AIDS Prevention and Control Act of 1998 emphasize that persons who are HIV positive who are healthy carriers may not be deprived employment. Yet the Philippine courts cannot see this distinction. This emboldens the manning agents and the shipowners to trample on the labor rights of their HIV positive employees who are fit to work.

Right now, mandatory testing for HIV and HIV/AIDS, though prohibited by the said Philippine AIDS law is being surreptitiously practiced by many shipowners who employ Filipino seafarers. Those who are HIV positive but who are fit to work are automatically deprived employment.\(^8\) Seafarers who are HIV positive and who sustain illness or full blown HIV AIDS on board are deprived of their medical benefits, disability benefits and even death benefits if they die.

To end this dark age of prejudice in the Philippines, there must be a thorough going legal reform and education on all levels. Beginning from a repeal of the POEA Standard Employment Contract, to a repeal of the Labor Laws and Social Legislations Laws, the whole legal system must be overhauled. There should also be a massive and urgent education of magistrates, justices and judges on all levels on the labor and human rights and struggle of persons with HIV and HIV-AIDS. This may be a tortuous uphill battle but it can only be won if we all unite and start the fight, now!

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**Sex Work in Papua New Guinea**

We are from Friends Frangipani – the national sex workers organization in Papua New Guinea. We are doing a lot of peer education on sex workers sexual health and a lot of advocacy on sex workers human rights in our country.

Sex Work is criminalized in PNG. The laws on sex Work are ---

*Section 55 of the Summary Offences Act 1977* which states

- a) A person who knowingly lives wholly or in part on the earnings of prostitution is guilty of an offence.

This law has been used to arrest sex workers, as in the case of a police raid at the Three Mile Guest House in Port Moresby in 2004

In addition, section 56 and 57 of the *Summary Offences Act* and section 231 of the *Criminal Code Act 174* cover criminal offences which can be used against people who own or manage premises upon which sex work take place.

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\(^8\) Testimony of ‘Raffy’ see note 6 supra.
Friends Frangipani would like to offer the following submission, which is a short summary of how the laws affect our lives as sex workers. This information has been put together through consultation with sex workers over the past 2 years.

**Stigma and Discrimination**

The general public call us names like “AIDS carriers”, and exclude us from community activities. We face discrimination in all areas of the public including workplaces if we have other jobs. Sex workers are subject to violence from the general community, who do not view us as deserving of protection.

Sex workers are often rejected by family and peers, and for transgender and HIV positive sex workers, the stigma can be even more intense.

The effects of stigma and discrimination are that sex workers are less likely to access the services they need, are less likely to seek justice after abuse, and are less able to participate in family and community life. Sex workers may also internalize this stigma and isolate themselves, or view themselves as undeserving of access to health and justice. Stigma and discrimination have a big impact on sex workers’ lives and can destroy efforts made toward HIV prevention and care.

If sex workers were not criminals we feel there would be less ground for stigma and discrimination.

**Access to services**

Because sex workers are seen as criminals we do not get fair treatment from service providers: if they know we are sex workers often they do not want to know about our problems. For example, some sex workers (in the Highlands area) report being denied access to maternity services – including during labour.

Services which “target” sex workers very often have little or no respect for our confidentiality, both as sex workers and potentially as people living with HIV. They often treat us as disease carriers.

While there is a law in place to protect breaches of confidentiality about HIV status (the *HIV AIDS Management and Prevention ACT 2003*), it would not be used by sex workers because our criminal status means we are very unlikely to receive access to justice in such matters.

Transgender sex workers receive “double stigma” from service providers who do not understand their needs and wants. This leads to transgender sex workers isolating themselves and not accessing sexual health information or services, including HIV testing and treatment (ART).

**Fear in Moving Around**

The cities in PNG are generally very unsafe after dark – the country has very high levels of crime, particularly against women and MSM and transgendered individuals.

Because we can be arrested for doing sex work, or abused and subject to bribery by police, as well as abused and stigmatized by the General public, we are forced to work at night which is very unsafe. This is compounded by the fact that most sex work takes place out of doors, due in part to the laws against operating sex work premises *.

So we hide because we do not want the police or general community to know we are sex workers, but doing sex work in hidden ways makes us vulnerable to violence and sexual assault by clients or raskols (street criminals).
Violence and sexual assault are contributing factors to HIV.

Condoms

Police have used condoms as evidence that people are sex workers. The general public think that if someone is using a condom they are HIV positive. This leads to sex workers being afraid to carry condoms and afraid to access and use condoms.

Clients also have a negative attitude towards condoms and Do not want to use them. Sex workers often have difficulty negotiating condom use (with some reporting abuse or violence from clients just for trying to use condoms).

The ABC campaign is the dominant message about sexual health protection in PNG. The message to Abstain, Be Faithful, Use a Condom is a “put--off” for many sex workers In seeking condoms and Health information – as sex workers, we cannot “abstain” or “be faithful!”

It might also be a “put---off” for some clients as it might make them feel guilty about having sex With a condom.

Problems with police

Although the laws against sex work are not often used, the police very often target sex workers as victims for bribery, violence and sexual assault under the threat of arrest. For example, police abuse Their powers by forcing sex workers to have sex with them without condoms, threaten sex workers, demand bribes and refuse to make reports on any crimes committed against us. Many sex workers fear the police: they give us more problems instead of protection. Because we have to hide from the police we do our sex work in hidden, unsafe areas.

Further, some sex workers who have been arrested but not convicted still carry criminal records, which hinder them from participating in society and finding additional or alternative income.

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Sangama is a sexuality minorities human rights organization for individuals oppressed due to their sexual preference. Sexuality minorities include, but are not limited to, hijras, kothis, doubledecker, jogappas, lesbians, bisexuals, homosexuals, gays, Female-to-male/male-to-female transsexuals and other transgenders. We aim to help live their lives with self acceptance, self respect and dignity. We especially emphasize the concerns of sexuality minorities from poor and/or non-English speaking backgrounds and sexuality minority sex workers, who otherwise have little to no access to information and resources.

Sangama aims to bring sexuality, sexual preference and gender identity into the realm of public discourse and link it to gender, human rights development and other social movements. We campaign for the changes in the existing laws, which discriminate against sexuality minorities, including sex workers and People Living with HIV/AIDS (PLHA). We work with family members, friends, co-workers and partners of sexuality minorities. We work at multiple levels of advocacy, documentation, lobbying for policy changes with the government, crisis intervention etc. For the past ten years we have been involved in several cases of police atrocities against our community. We will cite two cases, to show the extent of victimization by the police as there are just too many that we have handled in the past to mention here.
On 20th Oct, 2008 at 11 A.M the police caught five hijras near a traffic signal in the Girinagar police station limits and took them to the police station. The Assistant Commissioner of Police [ACP], H.T Ramesh beat one of them with his lathi, broke her bangles and made her bleed. Another hijra was forced to clean the floor of the police station. The police then charged them with false cases under section 341[wrongful restraint] and 384 [extortion] of the Indian Penal Code. There were gross violations of legal protocols during this entire incident. The hijras were not only brutally assaulted and humiliated, but no medical assistance was given to the injured persons involved. The crisis intervention team consisting of five members who went to Girinagar police station were also attacked by the police. The male bodied people in the team were physically abused. The police asked offensive questions and taunted the crisis intervention team [which consisted of sexuality minority activists who are also part of the community] about their gender identities. “Take off all your clothes; let me see what you’ve got there?”, “Are you a man or woman”? The team was verbally abused in this manner. The crisis intervention team itself was charged with false cases under Section 143 [unlawful assembly], 145 [joining unlawful assembly ordered to be dispersed] and 353 [obstructing government officials in performing their duty] of the IPC. Later, six delegates who went to have a dialogue with the police were also verbally, physically and sexually abused by the police. The police at the station claimed that they had orders from their seniors to round up all the hijras in the city and book them under extortion cases. At 7.45 P.M on the same day, when a group of protesters gathered outside the police station to raise their voices against the police excesses, they were lathi charged, cameras were broken so as to make sure there was no evidence of the incident, and 31 activists were taken into custody and booked under false cases.

Later, a lot of mobilisation was done to garner support for the community against this kind of police repression. An overwhelming number of community members stormed the streets at rallies held against the Banashankari police officials. Rallies were held at Delhi, Calicut, Dharwad, Ramnagara, Kumabakonam, Dhoddaballapura, Hyderabad etc. Some of our demands during our campaign against the Banashankari case was -

- To dismiss the guilty officials including H.T Ramesh[ACP] and M Shivashankara Murthi [PI] and prosecute them for their crimes.
- Stop police violence against hijras and sex workers
- Protect the rights of the hijra community for their traditional livelihood options including sex work and blessings or provide them with reasonable options.
- Make sure transgenders have access to education, employment. Health, housing, sex change procedures, savings and credit facilities.
- HIV prevention programme initiated by the Health Ministry should be backed and supported by the Home Ministry.

Another serious case that had a major campaign for, was during the sexual assault of Kokila, a 21 year old hijra on 18th June, 2004. Kokila was raped by a gang of ten goondas [all men] at the grounds near Madras road at around 8 P.M on June 18th. The police instead of punishing the perpetrators, dragged Kokila to the police station. She was then humiliated by not being allowed to wear her trousers and was made to stand naked for the next 7 hours. She was handcuffed to a window and was beaten with lathis and and kicked with bootlegs by the policemen. They tortured her by burning her nipples and chapdi [vaginal portion of hijras]. This continued till 1 A.M and then she was taken to two hamams [bathhouses run by hijras] in Krishnarajapuram and Garudacharpalya. They conducted illegal searches there and also abused her by making her wear men’s clothes and threatened to shave off her hair. At around 3 A.M she was taken to Chandni’s [a hijra human rights activist] house and after much negotiation, they left her behind there. The next day, with the help of several organisations she filed a complaint about the incident. A lot of pressure had to be put amongst the high ranking officers of the police force to even get the complaint registered. We organised an indefinite hunger strike from 23rd June 2004 in front of Gandhi statue near Cubbon park to seek justice for Kokila.

These two cases show how the law becomes the tool used to oppress and harass sexuality minority communities by the very same law enforcers who are supposed to “protect” us. Even now, the hijra community faces a lot of discrimination and are victimised by the police. Since sex work is illegal, it becomes easy for the...
police and other authorities to harass and abuse sex workers and hijras on a daily basis. One of our consistent demands has been to decriminalise sex work, to make sure that a system is in place whereby this can be considered a legitimate profession that one can do as a means of livelihood. This can be done only by structural changes in policy and increasing awareness and sensitising society through consistent campaigns.

One significant victory in terms of policy changes has been a recent government order passed on September 20th, 2010 recognises transgenders as a category within the Backward classes commission.

- Including the transgenders under the Backward Classes.
- Pension facilities for above 40 years transgenders.
- Constructing houses for transgenders under the slum board.
- Providing BPL cards under Food and Civil department.
- Free medical assistance under Health and Family Welfare department. Under Yeshaswini scheme, health insurance will be given to transgender people.
- Providing Rs 20,000 for individuals to start some self employment ventures. Group of 5 transgender individuals will be provided 1 lakh rupees for self employment ventures.
- Vocational training will be given by Women and Child Welfare Department.
- Inclusion of transgenders under the voter list under the Revenue Department.
- 1% Reservation in all State colleges for transgenders.

We requested the government to set up a proper assessment system to certify the transgenders. We suggest that psychiatrists who are aware of the transgender issues community from NIMHANS, government medical colleges and district mental health programmes to be part of this process to ensure that non transgenders don’t take away the benefits provided under these schemes. We request the government to make separate funds allocation for the welfare of transgenders. Karnataka State Aids Prevention Society [KSAPS] has recently given orders to CBOs and NGOs working with transgender communities to provide a list of all details of hijras. Since some of them are not willing to make their identities public, we condemn this order as we find it to be a violation of confidentiality clauses making it a human rights violation. This also excludes many transgenders including the jogappas, kothis, FTM etc. We welcome this progressive decision made by the Karnataka State government to recognize transgenders as a separate category as Backward Classes in Karnataka. We celebrate the fact that Karnataka is the first state to recognize all categories including Jogappas, hijras, FTM, MTF, kothis, Mangalamukhis. We hope this will be followed by more steps to provide support to transgender rights.

Sex workers and sexual minorities are two of the most marginalized sections of our society due to criminal and civil laws and social prejudice. This makes them highly vulnerable to HIV infection. KSAPS (Karnataka State AIDS Prevention Society), the main governmental institution to address issues of HIV in Karnataka state doesn’t seem to treat these communities as human beings. KSAPS routinely violates the human rights of sex workers and sexual minorities. The Karnataka Sex Workers Union [an organisation that works closely with Sangama] had a protest against the functioning of KSAPS during their World Aids Day function at Chithrakala Parishad on Dec 1st, 2010. Sex workers, PLHIV activists and other community members waved black flags and held red umbrellas[ the symbol of sex workers] as a marker of protest and put forward our demands. Our demands were-

**Stop line-listing in targeted interventions:** KSAPS forces all NGOs (Non Governmental Organizations) and CBOs (Community Based Organizations) implementing HIV prevention projects among sex workers and sexual minorities to maintain a line-list of all the people they are reaching out to. This line-list contains a lot of personal information including the name, address and other contact information. This information is often collected without concerned peoples’ consent. This information is taken by KSAPS and with Technical Support Unit. This violates the right to privacy and confidentiality of people. This is illegal and a gross violation of human rights. Any leakage of this information will put people’s lives in danger and expose them to greater stigma and discrimination.
Stop forced HIV testing: While we support practices that encourage people to go early for voluntary HIV testing, we are completely opposed to coercive practices of KSAPS in this regard. KSAPS fixes unreasonably high targets for the HIV prevention programs among sex workers and sexual minorities and links its continued funding to the achievement of these targets. This results in project staff forcing sex workers and sexual minorities into HIV testing – sometimes people are not even aware that their blood is tested for HIV, some times people are tested without the mandatory pre-test and post-test counselling, sometimes same person is tested multiple times and result is shown as that of different people, sometimes non-sex workers are tested and their results shown as that of sex workers and non-sexual minorities tested and shown as sexual minorities, sometimes poor people are given money/sarees/watches to go for testing. This is completely against the national policy of HIV testing which makes voluntary testing along with pre-test and post-test counselling mandatory.

Stop breaking confidentiality of people living with HIV: National policy on testing makes it mandatory to keep a person’s HIV status confidential. But most of the the HIV testing centres in Karnataka seem to break the confidentiality of the HIV status of sex workers and sexual minorities by handing over this information to the NGOs and CBOs running HIV prevention programs. Many times the HIV status of people is known to all project staff. This is a criminal offense. These unethical and illegal practices are pushing sex workers and sexual minorities underground and away from HIV projects. These practices not only increase the risk of HIV to sex workers and sexual minorities but also to the whole society in general as most people in the society are linked sexually.

These are just some of the challenges and issues that our community faces that we have highlighted. Many more issues need to be discussed and we hope the Global Commission on HIV and the Law will have constructive discussions and will join us in the struggle to fight for our rights locally as well as internationally.

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Australian Federation of AIDS Organisations (AFAO)

About AFAO

The Australian Federation of AIDS Organisations (AFAO) is the national federation for the HIV community response. AFAO’s members are the AIDS Councils in each state and territory; the National Association of People Living with HIV/AIDS (NAPWA); the Australian Injecting and Illicit Drug Users League (AIVL); the Anwerenekenhe Aboriginal and Torres Strait Islander HIV/AIDS Alliance (ANA); and Scarlet Alliance, Australian Sex Workers Association. AFAO advocates for its member organisations, promotes medical and social research into HIV and its effects, develops and formulates policy on HIV/AIDS issues, and provides HIV policy advice to Commonwealth, State and Territory Governments.

Background

In this submission we outline Australia’s public health response to HIV, and the significant part that gay law reform and policy advocacy has played in the success of that response. From early in the epidemic, the Australian response to HIV has been characterised by a progressive law reform and policy agenda that aims to support the public health response. This multi-faceted response has prioritised education and the engagement of marginalised communities affected by HIV, over punitive legal sanctions that entrench marginalisation.

NAPWA has provided a submission to the Commission regarding the impact of criminal laws applying to the sexual transmission of HIV, and the interaction of these laws with Australia’s public health laws. AFAO supports and endorses NAPWA’s submission, and we recommend that AFAO’s and NAPWA’s submissions be considered together.

Cornerstones of Australia’s successful HIV response
Australia’s HIV response is recognised globally as a success, and HIV prevalence rates in Australia have consistently been among the world’s lowest – both generally and for the most at-risk populations. In 2009 the number of new HIV diagnoses in Australia was 1,050. The number of diagnoses has remained relatively stable in Australia over the last four years at about 1,000 per annum.¹

Fundamental to Australia’s success in responding to HIV has been the creation of an ‘enabling environment’, i.e., the construction of a supportive legal and policy framework which complements HIV education campaigns and other public health measures, by enabling and encouraging healthy behaviours within populations most at-risk of HIV. The two areas of particular focus for law reform given the early and continuing prevalence of HIV among gay men in Australia, have been the decriminalisation of homosexuality, and the creation of anti-discrimination laws specifically addressing discrimination against gay, lesbian, bisexual, transgender and intersex (GLBTI) people.

HIV/AIDS devastated the Australian gay community from the early 1980s. Due to the need to focus on the development of services for people with HIV/AIDS and their carers, there was much debate within the gay community about whether advocacy to reform Australian state/territory laws that criminalised sex between men, and advocacy for the introduction of anti-discrimination protections, should be put on hold or delayed while the community focussed on more obvious and immediate treatment, care and support issues. By 1991, when the first National HIV/AIDS Strategy was launched, it had become accepted wisdom that laws regulating or penalising homosexual behaviour were counter-productive, given that such laws potentially drive communities of homosexually-active men underground and away from testing, counselling and support services. Accordingly, the first HIV strategy adopted the view that the issues are inseparable². Ensuing advocacy efforts on the part of the community sector resulted in the repeal of laws criminalising homosexual behaviour across Australia and since Tasmania’s decriminalisation of homosexuality in 1997, all Australian jurisdictions have been free of such laws.

Reform of Australian federal and state/territory laws that discriminate against GLBTI people is ongoing. In 2008 the Australian Government introduced legislation to remove discrimination affecting same-sex couples and their children from a swathe of Commonwealth statutes, however, federal marriage law continues to preclude same sex marriage. Community based health GLBTI organisations continue to advocate for the introduction of specific Commonwealth anti-discrimination legislation covering sexual orientation and gender identity.

Anti-discrimination protections are provided by state and territory anti-discrimination laws, under which gay, lesbian, bisexual, transgender and intersex people have generally reasonable levels of protection from discrimination.

The HIV Partnership

The driving force behind Australia’s successful HIV response and its capacity to ensure that public health responses continue to be supported by an enabling legal environment, is the collaborative partnership between federal and state/territory governments, affected communities, health professionals and research bodies - often referred to as the ‘HIV partnership’. This partnership has driven the creation and implementation of targeted HIV programs under the six national HIV strategies developed to date. The Sixth National HIV Strategy, launched in May 2010, clearly identifies priority action areas which include exploring options for more

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innovative prevention programs targeting gay men, as well as how best to address emerging issues such as the increasing rates of injecting among Aboriginal and Torres Strait Islander communities. Complementing these actions targeting specific affected communities are over-arching Priority Areas for Action in respect of human rights, legislation and anti-discrimination. These complementary and mutually reinforcing activities under the National HIV Strategy will ensure that due regard is had to human rights and discrimination issues faced by gay men, Aboriginal and Torres Strait Islanders and injecting drug users in the development and implementation of HIV prevention, care and support initiatives targeting these communities.

**HIV Partnership viability – political, financial and social support**

The collaborative HIV partnership, so crucial to Australia’s successful HIV response – past and ongoing - could not have developed, let alone thrived, in an environment which continued to criminalise homosexuality.

Crucial protagonists in the Australian HIV partnership have been the state and territory AIDS Councils. It is important to recognise that these organisations would not have been able to work as equals in partnership with governments on policies and programs targeting the gay community if homosexuality had not been decriminalised. Decriminalisation has allowed genuine government engagement at all levels, which has in turn ensured essential political support for potentially controversial initiatives.

From a resourcing viewpoint, the activities of state and territory AIDS Councils are dependent upon state and territory government funding. In countries where homosexuality is criminalised, such activities are vulnerable to political attack and fail to attract funding. Without stable, adequate funding, secured by the partnership, Australia would not have been able to develop its highly effective HIV prevention, care and management resources and programs for which it is renowned. Gay law reform has thus been pivotal to the success of Australia’s HIV response.

**Effective community health education**

State and territory AIDS Councils have had much success in developing and implementing HIV prevention, care and support resources and campaigns. However, from time to time these resources and campaigns have generated controversy as they often refer to intimate sexual behaviours and employ explicit language and images. Over the years this has at times led to government censorship, even in environments where homosexuality was already decriminalised. Among campaigns banned was the Victorian AIDS Council’s 1990 ‘When you say yes, say yes to safe sex’ campaign which featured two young men kissing, and the Queensland AIDS Council’s ‘Bubble Boy’ campaign - due to its being perceived as inappropriate.

It is noteworthy that even in a more advanced ‘enabling’ legal environment where homosexuality has been decriminalised, such campaigns may viewed as inappropriate by government authorities and this resistance can undermine the effectiveness of targeted health promotion campaigns. When reflecting on the HIV/AIDS response in Queensland prior to the decriminalisation of homosexuality there in 1990, the then head of the Queensland AIDS Council, Bill Rutkin, stated that:

> [t]here can be no serious doubt that lives have been lost in Queensland because of the laws...If there had been State government support for education and behavioural change programs for gay men then, from November 1984, it would not be unreasonable to claim that 25 per cent of the cases of AIDS we now have wouldn't have occurred.

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4 Leach T, op cit., p. 27.

Collaboration with police

Decriminalisation of homosexuality in Australia has facilitated important collaboration between police forces and state/territory AIDS councils and their member organisations. Such collaboration was impossible prior to decriminalisation, and represents a fundamental shift in perceptions on the part of both the police force and the gay community. For example, the NSW Police Force has for some years been actively engaged with the NSW AIDS council, ACON, and has supported GLBTI community engagement in encouraging the reporting of incidents of violence, crime and anti-social behaviour towards or involving members of the community. The police force expressly commits itself to providing high quality, professional policing services for the GLBTI community; and to building and maintaining effective community partnerships, including attending community events such as Fair Day and Mardi Gras.6

Efforts to develop the NSW GLBTI community’s trust in the police are an integral part of the NSW HIV response, facilitating the reporting of homophobic violence. Such collaboration with the police is undeniably an important element in breaking down structural barriers to HIV services for members of marginalised communities who historically have had cause to mistrust or fear the police. Establishing such trust in the police in a context where homosexuality is criminalised is impossible.

Schools

With the decriminalisation of homosexuality, and the more progressive environment that has ensued, Australian senior schools have been able to develop educational programs dealing with safe sex, including homosexual sex, and in relation to sexuality and gender identity. For example, Western Australia’s Department of Education provides resources for addressing, among other issues, discrimination regarding gender-identity and homosexuality.7 Initiatives in both these areas have significant public health impacts for communities at risk of HIV.

Conclusion

Australia’s partnership approach to responding to HIV has ensured that public health and law reform initiatives are complementary and mutually supportive. The recognition of the need to engage affected communities in policy development, and address human rights issues they face, has underpinned the success of Australia’s HIV response and has been enshrined in the various National HIV Strategies. The effective targeting of HIV prevention, care and support initiatives to the gay community is a case in point; Australia would not have been able to so successfully address the HIV epidemic among gay men without gay law reform.

49 China

Criminalization and De-criminalization of MSM in China

“Ji Jian” (anal intercourse, which means “chicken raping” in Chinese literally, as the sexual intercourse and defecation of chickens share one orifice. The term is therefore used to refer to anal intercourse between men) and sodomy reflect one fundamental difference in the perception upon MSM in the east and west. In the context of China, the law penalizes MSM out of a secular moral ground, where as in the west, the penalty upon MSM by law is underpinned by religion. Therefore, it is easy to throw light to the traditional laissez-faire

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attitude of the law in China towards homosexuality for a long stretch of time. Even after the homosexuality was
criminalized, the penalty was much less strict with that in the west. Under the legal framework of China, be it
the legal professionals or ordinary people, practically no one takes anal intercourse as a serious issue when it is
decriminalized and criminalized.

The statement that “the crime of hooliganism abolished by the penal code of China in 1997 signifies the
decriminalization of homosexuality in China” prevails in the MSM community. However, it is an “innovative
misinterpretation”. The true reason why the crime of hooliganism was abolished is that it is an all-catch ing
offence. Too many “hooligan behaviours” were included, such as “dissemination of obscene articles”, and
“heterosexual promiscuity”. The charges associated with MSM incorporated “practicing anal intercourse to
infants, forcefully practicing anal intercourse to the children, or practicing multiple anal intercourses by the
means of violence or coercion where the circumstances are grave”. The principle of “penalty fits the crime” was
established in the new penal code in 1997, which means that penalty should not be measured and exercised
without a specific crime. The crime of hooliganism according to such principle was therefore so vague that it
was abolished, which also moved the crimes associated with MSM out of the penal code. However, such
abolition, believed by many as the decriminalization of homosexuality in China, does not involve the
decriminalization of male-on-male rape. As a matter of fact, the male-on-male sexual violence has up to now
become an utter legal vacuum in China. Despite many media reports, there has been a lack of applicable laws
for such cases. Only the crimes without a victim have been decriminalized, which happened in many western
countries for MSM, but is irrelevant to the victims of sexual assault.

The legislators actually did not mean to put things right for homosexuality, though champions of the gay rights
are willing to interpret in that way. This happened because first, the abolition of hooliganism crime deprived
the ground for the criminal and other penalties upon anal intercourse, which made “decriminalization” an
“unintended consequence”. Secondly, although the hooliganism crime did not mainly target MSM, the police
kept cracking down and harassing MSM by abusing such offence. For a long period of time in the past, a myth
was circulated in the MSM community that one should never tell police that he had anal sex when he is
confronted. Otherwise, he will be detained. Such myth even carried after the abolition of hooliganism crime.

After the release of the new penal code in 1997, some MSM were still scared to be penalized for having anal
sex, which was the mental or even physical repercussion by the abused power. Third, the MSM community in
China simply followed suit at such a milestone event in the global context when the whole west was talking
about the decriminalization of homosexuality.

Since homosexuality vanished from the Chinese penal code, new “criminalized” cases have emerged in recent
years, which focused on two areas. One was the male-male sex trade that turned the authority’s attention and
the other was the male orgy penalized as “organized promiscuity crime”. Both sensational cases happened in
Nanjing, capital city of Jiangsu Province in China.

The first organized male-on-male prostitution case in Jiangsu province in 2003 made headlines in numerous
media. The local court, not sure of which offence to convict, submitted the case to the Supreme Court and
Standing Committee of National People’s Congress (China’s legislative body). Eventually, the penalty was meted
out as per the heterosexual sex trade, where the accused were sentenced to an eight-year imprisonment with a
fine of 60,000 RMB (around 9,000 USD). The case provoked debate in the media and among the academics.
Some believed that it was against the principle of penalty fits the crime. However, a large lot of similar cases
later were convicted.

Recently, another sensational case happened in Nanjing. In November, 2009, police from Yueyahu Station found
several half-naked young men when patrolling at a hotel. All of them admitted that they were gay men ready to
have sex in the hotel room during the questioning of the police. The police identified from them Mr. Liang,
organizer of many similar activities, and further found another score of people. Upon investigation, police
believed that the behaviours of these people had public promiscuity and four of them had committed the crime
of public promiscuity. In October of 2010, Baixia District Court of Nanjing sentenced three of the four men to a fixed term imprisonment with a reprieve and one to criminal detention with reprieve. It was learned that two of the four men accused were university graduates and the other two had Master’s Degree, and that all of them had decent jobs in the eyes of the public. They claimed that some of them went to the orgy to relieve their work stress and others out of curiosity.

From the aforementioned two cases, it was an unexpected consequence to the legislator that the abolition of the hooliganism crime led to the decriminalization of homosexuality. Nevertheless, the authority never turned a blind eye to the sexual indulgence of homosexuals. Instead, it made steady progress in the criminalization of male-on-male sex trade and orgy. What is preposterous is the lack of applicable laws for the male-on-male sexual violence, compared with the criminalized male-on-male sexual trade and orgy which should be decriminalized for the absence of victims. These together with the recent crackdown of the police on gay saunas and public cruising parks all suggest a worse environment for Chinese MSM after the so-called decriminalization in 1997.

| 50 | Thailand | Asia Pacific Network of People Living With HIV (APN+) |

**HIV, Free Trade and access to life saving medicines**

Currently, there are 15 million of People living with HIV (PLHIV) in low and middle-income countries in need of Antiretroviral treatment. However, only 36% of these PLHIV (5.6 million) are Able to access the treatment they need. Despite the dramatic measures the world has taken towards HIV, these figures came up after more than 25 years of global response.

The efforts to improve treatment coverage are challenged on several fronts, including the reduction in global aid funding. However, the impacts of the Free Trade Agreement negotiations between developed and developing countries on access to Treatment have often been overlooked. Specifically, the ways in which these trade agreements greatly jeopardize the production of generic ARV drugs, which Has played a critical and vital role in improving treatment Access for PLHIV in resource limited settings.

At the moment that this submission is written, European Union and India is under negotiation process to sign A Free Trade Agreement to enhance trade relationship between the two countries. The pool level of transparency throughout this negotiation process left no space for civil society to Monitor or be involved. Civil society groups from all around the world have not been able to receive any official information regarding the Agreement documents. In essence, negotiations about people’s lives are taking place behind closed doors.

However, through the leaked text of this negotiation, the civil society groups have been able to analyze the agreement and have been taken aback by the extent of “trading” this negotiation will reached.

India has been called as the pharmacy of the developing world. The Indian generic ARV production has supplied to more than 90% of PLHIV in low & middle-income countries in the world. The Indian generic ARV production Provided ARV drugs to almost all the region in the world, including Africa, where the HIV epidemic hits the hardest.

It is estimated that, if the generic ARV production and supply by India disrupted at the same time, without any other countries to compensate its production and supply capacity, then within 5 – 8 years, we will start to see at least 5.5 million PLHIV dying in the developing world. In other words, Indian generic drugs have served as
I would like to make a submission before the Global Commission on HIV and Law, based on the story of a widow.

A case of property denial, justice denial, and physical harassment

I would like to make a submission before the Global Commission on HIV and Law, based on the story of a widow.

Problematic Clauses

There are at least 6 problematic clauses in the text agreement that experts have analyzed and predict significant issues to affordable generic ARV production in India

1) DATA EXCLUSIVITY, as it will not permit the placing of affordable versions of new formulations, pediatric doses and combinations of “off-‐patent” medicines on the market.

2) PATENT TERM EXTENSION, as it will extend patent life beyond 20 years.

3) INVESTMENT RULES, as it will enable foreign companies to take Indian government to foreign courts over domestic health policies like tobacco warnings and measures to reduce prices of medicines.

4) BORDER MEASURES, as it will deny medicines to patients in other developing countries with custom officials seizing generic medicines in transit.

5) INJUNCTIONS, as it undermines the independence of the Indian judiciary to protect right to health of patients over pharma profits.

6) OTHER IP ENFORCEMENT MEASURES, as it puts third parties like treatment providers at risk of police actions and court cases.

The impacts of such trade agreement on not just India and other developing countries cannot be underestimated. As such, protests against the agreement have risen in different regions in India and the world. The Indians called the agreement “trading away our lives”; the Nepalese condemned the EU effort to take benefit from developing countries and enrich their pharmaceutical company; the Indonesians called the agreement “a genocide”; the Latvians marched and critics their leaders for agreeing to such agreement; the Thais stood up and shouted “EU! Go away!” to stop EU to take their medicines away.

The EU stated “nothing the agreement would stop India to produce cheap generic medicines” and also further stated that it is fully committed to promoting and facilitating access to medicines while negotiating free trade agreements that have provisions mentioned above. Over the last few years, generic ARVs that have been shipped from India or Brasil to African countries that transited in European countries have been ceased without proper clarification or trial process. All these have been “justified” on the grounds that production of generic medications infringes the Patent rights of the big pharmaceutical companies, yet, overlooking the fact that those generic medications have all been produced legally within their production countries. Boarder measures such as this greatly endangers the lives of millions of people around the world, who relies on those medications to sustain their health and lives.

Laws are developed and implemented to ensure that people are protected from behaviors and situations that which endanger their lives and their rights, including their rights to health. While countries have the responsibilities to ensure economic development of its states through measure such as FTA, at the same time, when such economic policies put human lives at stake, such polices cease to be for the benefit of its people.

| 51 | India | Individual |
living with HIV. This happened at a place called *Uralikanchan*, just 30 kilometres away from Pune City. Padma (Name changed) got married in 2005 and she used to stay with her in-laws. Though it was a joint family, all three brothers with their wives were staying just next to each other in separate units. In other words, it was a single unit with four sub-units. Three brothers were staying in three units and father and mother in the fourth unit.

Her husband died in 2007 and during that time the entire family including Padma came to know her HIV status as well as her husband’s. Since then, she was not allowed to go out of the house. For few months, husband’s elder brother used to give her grocery. However, he stopped this support after some time and she was not allowed to go out too. Even for drinking water she had to wait for hours as they are not allowing her to take the water from the tap. After some time, she somehow managed to get out, and started working in a farm for her survival. But then, the elder brother told the farmer that she is having “AIDS” so they should not keep her on job. After she lost the job, the family were pressurising her to leave that place. She could not find a place at her mother’s house, as they too came to know about her status and were not willing to keep her in the house. One Anganwadi worker guided her to the Integrated Counselling and Testing Centre (ICTC) where she got retested and her result came positive.

All her in-laws continued forcing her to leave the house. They even tried to bring pressure through *gram panchayat* who asked her to leave the place. Since she was not having any other shelter or a source of income, she refused to vacate the house. All in-laws and family members intensified their fight with her when she lodged a complaint at the local police station. Unfortunately, the complaint was not accepted. In addition, the police called her brother in-law and told that she had gone to lodge a complaint. Late evening on that same day, they beat her up for going to the police station. When she ran to the police station, the entire family ran to the police station and pulled her out from there. Then they took out all her clothes in the middle of the road. There were more than 100 people in the crowd and no one including police came to save her. She was beaten-up on the road naked.

The next day, anganwadi worker called to the office of the Network of Maharashtra by People living with HIV (NMP+). With the help of this anganwadi worker, we were able to speak to Padma who explained everything to us. Being in the outskirts, it took two hours for NMP+ members to reach her place. After meeting the anganwadi worker, NMP+ members went to the house. But her in-laws did not allow them to enter the house. We came to know that she ran away somewhere. She did not come back to that house as she was very scared. Out Reach Worker went to the police station, but since there was no official complaint made, they did not answer properly to any questions.

We are not able to locate her, and we still do not know what happened to her. She is missing and we do not have any official complaint against all this discrimination. The story remains unnoticed and undocumented. This is something that happened in 2009. Even amidst news about success of the AIDS programme in terms of decrease in national HIV prevalence, several questions remain:

- How effective is the money being spent on awareness generation and ensuring enabling environment?
- How many such cases would be there of which we have not even heard of?
- When will law protect women like Padma?

**Are you an academic, researcher, or human rights advocate who has been working on Intellectual Property Rights (IPR) in the context of HIV-related treatment access? Please share your work and the perspective.**

**EU India FTA protest - Delhi police beat up ITPC- India PLHIV members and threaten MSF Access Campaigner**

In my association with the International Treatment Preparedness Council in India (ITPC-India), I was involved in a peaceful protest march in Delhi. The Delhi Network of People living with HIV (DNP+), and Medecins Sans Frontiers’ (MSF) Access Campaign were some of the other organisations who collaborated for this march.
Through this protest, we wanted to bring attention to our concerns regarding the proposed Free Trade Agreement (FTA) between European Union (EU) and India.

We had been raising such issues in the past too. However, Intellectual Property (IP) provisions that affect access to affordable medicines continue to be part of the FTA negotiations between India and EU despite several appeals to the European Commission (EC) and the Indian Government. Amidst these concerns, there were public remarks that both sides wanted to conclude the FTA negotiations by the end of 2010. Thus we decided to have this protest in front of the Commerce Ministry to strengthen our demand to the EC and the Indian government not to include such harmful provisions in the bilateral trade agreement.

When the demonstration was about to end, members of ITPC-India and DNP+ picked up the arthīs (symbolic coffins) to cross the road. At this point, Delhi Police started to push, slap and lathi-charge (beat-up with batons) us. Several people were hurt and dragged, including a person living with HIV who is co-infected with spinal TB. The police beat him up with batons and he was hit on his back several times.

Several protestors started running to escape the police brutality but were chased and roughed up. Later we came to know that one Assistant Sub Inspector of Police in the Tughlaq Police was the one who ordered the offensive and instructed the police persons to forcibly pick up several members of the protesting group including People living with HIV. We were dragged and pushed into vans despite the fact that we stated our willingness to get arrested peacefully.

DNP+ followed up with members who were hurt and facilitated medical aid. After several hours in the Tughlaq Police station, following the intervention of Lawyers Collective, other lawyers and organisations, and Parliamentarians, all five of us were released. The police were asking us to sign a letter stating that we regret the inconvenience caused. But we refused!

A video footage is available on youtube at http://www.youtube.com/watch?v=KdUCGHXOY0M

We sincerely hope that the Global Commission on HIV and Law will look into these issues of Human Rights violations faced by people living with HIV.

| 52 | Fiji Islands | Individual |

My name is X and 31 year old Fijian transgender and also a sex worker. I am publicly open about being transgender and a sex worker. And also I have an active connection with sex worker and transgender advocacy networks at a global, regional or national level. I believe in human equality regardless of age, race, skin color, gender, sexual preference, occupation, HIV status etc. I believe that everyone is entitled to freedom and security. I am a human rights activist and I am the Ambassador for Transgender people in Fiji after winning the Adi Senikau Pageant title (the Fiji national transgender pageant) here in August 2010.

Living as a transgender in Fiji has not been easy. I have been discriminated and abused for being transgendered. Growing up in a village setting with strong religious views, I was often physically and verbally and sexually abused. I had a hard time in school, on the playground and even at home where I thought I should be protected, just because I was feminine. I couldn’t take anymore so I decided to run away to the city where I met up with other transgenders who are older and sex workers and they took me under their wings. Meeting these transgender friends was the best thing that ever happened to me. I take my hat off to them. They introduced me into doing sex work in order from to survive. I thought life was going to pleasant but little did I know that working the streets was even worse where we get picked up by the police and taken to the police station where we are told to strip off in front a group of police officers and sometimes we are told to touch each other in the genitals while they laugh their hearts out. Sometimes I am punched, slapped and kicked around when I question as why I am being picked up. With the ongoing abuse by the police I moved to another town to live and work
but the story was the same every town I go to. One time I was picked up by 2 police officers and taken to a beach side where they beat me up before raping me and left me there to make my way back into the town. While working the streets I contracted genitals warts and one of my transgender friends told me to go to a government run STI clinic. I was so happy to go there but as soon as I entered the clinic the woman at the reception made faces and went through the door behind her and came back to serve me after a while. While she was serving me there were some medical students were popping their heads out of the door behind her and made fun of me calling names and passing rude remarks. When the doctor was attending to me, to my surprise the called the medical students into the room to see what I have contracted without my consent. I was so embarrassed and I didn’t want to access that clinic ever or any other clinic for that matter. After 2 years, a friend told me that a transgender and sex worker friendly clinic has been opened. I accessed it and my experience there was totally different to the last clinic I went to.

After years on the street, I was invited to attend a self esteem workshop by a local NGO. I attended the workshop and learned a lot from it and started talking with the Director of the NGO. I asked her if I could come and do some voluntary work with her NGO to which she agreed. While doing this voluntary work, I learned about my human rights and I got empowered. I reached out to members of my community and shared what I have learnt about human rights and try to empower members of my community as most of them are not well educated. I started working for one of the projects of the NGO called Equal Ground Pasifik (EGP) which does advocacy on LGBT rights. While working for EGP, I have organized pride events like social gatherings, dance fundraising events, clean up campaigns and attended a couple of national and regional workshops on human rights and also HIV/AIDS awareness. I also worked as a peer educator where I often go out to the street and distribute condoms and sometimes accompany those transgenders who don’t feel comfortable accessing the clinic on their own. Unfortunately Equal Grounds Pacific has been shut down in 2005.

After winning the Adi Senikau Pageant (national transgender pageant) I became the Ambassador for Transgender people in Fiji. I have worked with the Coordinator of Fiji Transgender Empowerment Network in running consultation workshops for transgenders in the Western, Northern and Central division in Fiji.

At the moment I am the Coordinator for the Survival Advocacy Network a network made up of transgender and female sex workers where I advocate on Human Rights addressing issues in Stigma and discrimination, challengers on Human right abuses and the negative portrayal towards sex workers in the context of Human Rights. In my work have facilitated Empowerment and Human Rights workshops and organized social gatherings where our community members get together.

It is difficult to talk about sex workers as a single ‘group’, because those involved in the sex industry come from a diverse range of backgrounds and cultures, and can differ greatly in the lives that they lead. In the same way, the levels of risk that they face in terms of HIV infection can be vastly different, depending on whether they work from a brothel or ‘on the street’, and whether they have access to condoms, amongst other factors. For instance, many face a very different level of risk to that of an impoverished girl who is being forced to sell sex on the street. Despite this diversity, sex workers often share several common factors in their lives, regardless of their background. Some of these factors can increase the risk that they will be exposed to HIV. Sex workers are generally stigmatized, marginalized and criminalized by the societies in which they live, and in various ways, these factors can contribute to their vulnerability to HIV. At present in Fiji under the new Crime Decree, Prostitution is a crime although there is some protection against violence and if the law is used correctly sex workers can operate safely. However the police are ignorant of the new law and continue to harass and charge sex workers. The lack of understand by the police leaves sex workers open to abuse, violence and rape, and in such an environment it is easier for HIV transmission to occur as police often incorrectly use condoms as evidence of soliciting.

In addition, the stigma that sex workers face can make it hard for them to access health, legal, and social services. They may either be afraid to seek out these services for fear of discrimination or be physically blocked
from accessing them – for instance, if a nurse refuses to treat them after finding out about their profession. Without access to these services, sex workers may face a higher risk of HIV infection, and be more likely to pass on HIV if they do become infected. If you want sex workers to be able to support the national strategic plan to prevent the spreading of HIV and other STI’s then we require your support in decriminalizing sex work. Thus enabling us to work in a safe and non-violent work place just as any other worker in any profession is entitled to.

I commit to my responsibilities and have a strong commitment to supporting human rights and community response to HIV. I make sure that I do my best in everything I do. I love networking with people and sharing and generating information, building capacity and building solidarity within the networks that I am part of. I am a good facilitator and love learning new things.

In the Pacific Region, specific vulnerabilities faced by many HIV positive people include lack of access to education, employment, and healthcare; as well as insufficient viable options for and obstacles to their ability to make positive decisions concerning their health and well-being. To add to the challenge, the social environment in the Pacific is one which emphasizes communal rights over individual human rights. While the Pacific Island States have ratified and signed international treaties that create legal obligations requiring them to look after their citizens, and to proactively promote and protect the human rights of their citizens through the human rights-based approach to development, the application of these commitments into practice has been hampered by the perception common among Pacific Island leaders that human rights are a foreign concept, and interfere with their nation building project. Indeed, in the Pacific Region, most if not all of human rights protection and promotion activities are funded by donors. In this context, it is thus hardly surprising that many Pacific Island leaders have chosen to opt out of a human rights-based approach to addressing the HIV epidemic.

Early reports of HIV findings in the Pacific Region focused on black gay men, which had a catastrophic effect on the way HIV became perceived by Pacific Islanders. It brought to the fore issues that continue to be a challenge for human rights advocacy as part of an effective response to HIV. Not only were human rights labelled as foreign, HIV became socially defined as being a disease of the gay and sexually promiscuous. In a social climate that condemns homosexuality, this led to the expression of questions regarding the rights of gay, namely, whether they deserved to be treated as normal and equal? In a profusely Christian Pacific Islands community, some interpretations of the Bible took precedence over others. HIV positive gay men were perceived to have behaved in irresponsible and immoral ways, resulting in their HIV infection. The view that PLHIV had waived or forfeited their human rights and therefore did not deserve equality became connected to the popular conceptualisation of HIV as the “sinner’s disease”. These views are still common in the Pacific Region, and are linked to the ways some Pacific Island Country leaders continue to disregard and downplay the importance of addressing human rights issues as core addressing HIV and AIDS, despite global success stories which point to the contrary, employing moralistic approaches which studies worldwide have proven both ineffective and disastrous to the spread of the virus. It is unfortunate that some leaders from the medical profession have also chosen to promote a response to HIV that resembles how leprosy and tuberculosis were treated by the international community in the past. Further, in suggesting a focus on the promotion of human rights laws as found in international instruments, human rights trainers in the region have also played a part in jeopardizing the endorsement and rolling out of a human rights-based approach tailored to the Pacific context.

In this context, the Pacific Islands AIDS Foundation (PIAF) – a not-for-profit organisation of and for people living with HIV (PLHIV) – has sought to promote, protect, and enforce the rights of PLHIV and people affected by HIV, and protect most-at-risk populations from HIV infection. Pursuing the principle of the greater and more
meaningful involvement of PLHIV, PIAF’s role is that of engaging positive people in the response to HIV, which it has implemented through its AIDS Ambassadors program, supporting positive people to play a central part in the response to HIV in the Pacific Region. These AIDS Ambassadors have played a pivotal, and undeniably challenging role, taking upon themselves high standards of responsibility, denying themselves *prima facie* rights for the sake of public health and national security.

In 2009, PIAF, as part of the Pacific Regional Strategic Implementation Plan (PRSIP), hired a lawyer to assume responsibility for the legal response to HIV in the Pacific Region, as one of the most effective responses to HIV. The strategies of PIAF’s legal program have included the promotion of a human rights-based approach, emphasizing the need for developing a stand-alone legislation that prohibits discrimination and stigma, and promotes the rights to health, confidentiality and privacy of the PLHIV. PIAF has emphasised the need for developing forms of positive discrimination through affirmative action programs which build and strengthen the knowledge, skills, and motivation of PLHIV to take part on equal plain in the HIV response in various institutional, organisational and governmental settings. The focus of PIAF’s legal program, thus, is on addressing human rights violations specific to the HIV epidemic, working towards the gradual fulfilment of the rights and freedoms of PLHIV. PIAF has employed the human rights-based approach in a manner where human rights are positioned both as a key success factor to effectively responding to HIV and AIDS, and as a *behavioural change enforcer* to combat HIV related stigma and discrimination, and protect and fulfil the human rights of those at risk of HIV infection by promoting the need for positive behaviour change among PLHIV. Within the past year, comments made in response to HIV Specific Human Rights Training by key partners and stakeholders in the Pacific region have included: “I did not know that we PLHIV sill have human rights as we thought that after having contracted the virus, we are not good and gone forever” (Fiji); “We have been thinking of offering medals or rewards for PLHIV to come out public as we would like to work with PLHIV but none of them are becoming public by disclosing their status” (Kiribati); “Even though the number of HIV people that have tested positive has doubled, we are more worried about STIs as they number into the hundreds” (Samoa); and “When we had TB and leprosy before, we were able to respond positively” (Tonga).

While HIV rates are today decreasing in many countries of the world, the number of new infections appears to be on the rise in the Pacific Islands. Involving PLHIV in the response has not been a straightforward or easy task. PIAF has been accused of making stars of PLHIV, for example, with some even going so far as suggesting PLHIV receive disproportionately and undeservedly more aid and assistance than HIV negative people. Due to the global financial crisis, funds to development aid and to the HIV response in particular, have dwindled, presenting a further challenge for the implementation of an effective human rights-based approach to HIV and AIDS in the Pacific Islands. These challenges are exacerbated by the vast size of the Pacific, and the aforementioned rejection of human rights as a Western construct interfering with the task of nation building. Clearly, there is still a long way to go in creating an enabling environment for PLHIV. Set against this context, PIAF’s goals for 2011–2012 are ambitious, and include the production of two pieces of legislation every year in the Pacific Region.

This paper will highlight the challenges faced by the Pacific Islands AIDS Foundation’s (PIAF) Legal Programme in trying to promote the recognition of the fundamental human rights of positive people in a culture that has labelled HIV as a “sinner’s disease” and those infected therefore not warranting sympathy or help, and explore different options for bringing about what will likely be one of the most intensive periods of HIV related legal and policy reform in the Pacific.
users in India –

Drug use in general is treated primarily as matters of criminal and penal law in India. As a result, people who use drugs regularly find themselves coming into conflict with the law that pushes them into the margins of society. Drug users languish in prisons and institutions in the name of drug treatment sinking deeper into dependence, disease and debilitation. Drug users continue to be incarcerated in overcrowded prisons, which house large numbers of individuals who have been charged with an offence, but have not yet been convicted.\(^1\) Drug users are over-represented in the prison population and significant number of them keeps moving in and out of prisons.\(^2\) Drug users facing physical and sexual harassment are widely evident practices in prisons.

The legal environment towards drug use remains very harsh on drug users, who face penalties for both consumption and possession. And these are having a direct bearing on the actual scale up of HIV prevention interventions or Harm Reduction programs by the Ministry of Health. Latest update from the National AIDS Control Organization (NACO) indicates HIV prevalence among IDUs has increased and reached up to 9%.

Provisions allowing referral of drug users from prison to drug treatment remain un-utilized and unknown to many including the law enforcement, judiciary and drug users eg., the benign provisions including immunity from prosecution to drug users who volunteer to undergo treatment are rarely invoked. No process of documentation on extreme human rights violations or illegal atrocities to drug users which can be used to file petitions are in place, even with many such cases within the drug treatment sector, health sector and beyond.

Due to criminalization of drug users, private run ‘involuntary type’ drug treatment centers with no standard procedures/methods who charge exorbitant fees becoming a big industry and mushrooming in states like Punjab Haryana and Manipur (for which a case study is given below as Case 1). Drug users often forced to these treatments, physically abused/harassed & even killed eg., the Punjab case in India where a client was beaten up to death in the premises and thrown outside his house \((a\ case\ study\ of\ a\ legal\ intervention\ is\ also\ given\ below\ as\ Case\ 2).\) Government, legislators, politicians, civil societies and stakeholders are rarely willing to take a stand on behalf of drug users as citizens.

**Case 1**

*Private run prison type drug treatment centers in specific North Eastern state of India*

There are at least four privately run drug treatment centers in Churachandpur district of Manipur, a north-eastern state of India. In these centers drug users are chained on their hands and legs and are also charged monthly as treatment fees. These centers applies punishment or giving consequences as the modality of treatment or by way of ‘cleansing’ drug users of their sin of using drugs. Detoxification or medication for detoxification is not provided. ‘Inmates’ as they call to drug users who are in treatment in these centers, are chained both at their hands and legs. Punishment regime is very severe cases of faulting or not following ‘rules’. Those grounded for trying to escape are disciplined by either physical torture, or keeping them chained in bed 24 hours a day, for a minimum of two months, or the combination of both. In some cases there were incidents of deaths from these tortures and parents or guardians of those who died of it were informed that they died in their sleep.

**Case 2**

In August 2008, a death was reported in a centre in Mohali, Chandigarh, which led the District Magistrate to pass orders under Section 144 of the Criminal Procedure Code against all “de-addiction centers” or drug treatment centers under his jurisdiction. According to the order, all centers were directed to provide basic

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facilities of space, sanitation, ventilation, food, water and medicines. The centers were also instructed to have adequate staff – doctors and nurses as well as psychosocial and yoga therapists. When the Court sent notices to the Ministries linked with the Narcotic Drugs and Psychotropic Substances Act, 1985 (NDPS Act), and drug treatment. The following Departments submitted their reply:

**Ministry of Health and Family Welfare:** provides outpatient and inpatient treatment in government hospitals and medical colleges; provides grants to State governments to run drug treatment facilities (122 in number)

**Ministry of Social Justice and Empowerment MOSJE:** funds NGOs for drug prevention, counseling, “de-addiction” and rehabilitation of “addicts”. No rules framed under NDPS yet, as the Act is not within its mandate.

**Ministry of Finance, Department of Revenue:** is responsible for NDPS Act and administration but not drug treatment, which is entrusted to MOSJE.

There is clear indication that the government have faltered in their duty to regulate drug dependence treatment. As a result, unscientific and inhuman practices persist in the name of treatment and resistance to HIV prevention interventions or Harm Reduction programs and its scale up is a significant challenge in India.

55  Nepal  Children Affected by AIDS (CABA)

The United Nation Convention on the Right of Children (CRC), which Nepal has ratified, provides an important framework to guide any response to HIV/AIDS prevention care and support for children. It states that children will be protected from discrimination and the “best interest of the children” will be in primary consideration. It affirms the right of the children to the enjoyment of the highest attainable standard of health. Similarly, the Government of Nepal has clearly listed fundamental human rights in its Interim Constitution, 2007, in its different articles: article 16 mentions the environment and health rights of people; article 17 mentions the right of education and culture; article 18 the right to employment and social security; article 19 the rights upon private property; article 20 the rights of women; article 21 the rights of social justice; and, article 22 the rights of children. Though the Nepali government has clearly mentioned each and every human right of people, their implementation and ensuring, particularly for people living with HIV (PLHA), is almost nil.

Children Affected by the AIDS (CABA) are rejected from school gate, denied from medication at hospital and expelled from their families. The HIV infected children face the double whammy of losing their both parents by the AIDS and themselves being blighted with the disease. PLHA constituencies are advocating by launching campaigns for social security of CABA and single women, and they submitted memorandum to Prime Minister, but government turned its deaf ears over it. The bill has been left useless into the closet.

According to NAPN’S ongoing national mapping, there are 1105 children living with HIV out of 6550 head count, whereas the study is in progress in Nepal. Among them, 71% children have lost either or both parents. Most of them have either dropped out from school or are at very lower grades then their age. Majority of them do not want to go to school due to high stigma of HIV infected children and discrimination to them at school. Children of HIV positive parents are also discriminated and are thought to be HIV positive. Many are expelled from schools, houses and communities on the basis of HIV positive status, even if they are diagnosed to be HIV negative later. Many children are psychologically and emotionally crippled due to the extreme hatred towards them. They endure cruel punishment for a ‘mistake’ they have never done.

In case of the person living with the HIV, medical officer openly marks their HIV status on OPD slips without counseling and their consent while providing services besides anti-retroviral treatment. Not only this, in some cases, medical officers openly refuse to give further care, let alone for emergency cases. In some cases, PLHIV
are denied surgery, solely based on their HIV-status and not the medical condition. This has been happening with pregnant women, children, appendicitis, and accident cases.

Feminization of the HIV epidemic and the fact that women living with HIV are deprived from inheriting family property is challenging; this challenge is being heightened for single women living with HIV and children affected by AIDS (CABA). PLHIV in Nepal are living in miserable condition. Primarily, poverty, unemployment, poor medication and health service systems make the lives of PLHIV even worse. Yet, PLHIV of Nepal is still unaware about their fundamental rights and is being forced to accept very inhuman treatment towards them by a society that views PLHIV as stigma and discrimination. Majority of the people are unaware of the fact that it is illegal and criminal to discriminate people on the basis of HIV-sero status. They are not aware of the fact that perpetrators are worthy to be sent behind the bars or some legal action for their discriminatory actions against PLHIV. PLHIV are not aware of their fundamental rights on the quality and equal service, easy access to treatment, care, support and right to social justice and equality. Nevertheless some try to raise their voice against the discriminations, time consuming, costly and lengthy processes, corruption, high stigma and discrimination towards PLHIV discourage them from filing cases to the concerned authorities or they are discouraged for seeking legal action. Centralized and the complex bureaucracy often discourage PLHIV to register their cases of human right violations.

It’s a regretting to say that Nepal has not yet passed any such protective law on behalf of those CABA. After National association of PLHA in Nepal (NAP+N) advocacy and documentation of Human rights violation of CABA and wide media campaign in Nepal, supreme court has ordered to Ministry of Law and Justice to make protective law for children affected by AIDS and women in Nepal on the 14th May, 2009, pile of dust has accumulated on the bill, but has not been forwarded yet. Some directives are being drafted on behalf of the CABA by the Ministry for Children and Women Development and Social Welfare Board in Nepal; that is also in the form of draft from last year.

Hence, it is urgent to give moral pressure to the Government of Nepal to keep their promise and to respect all the ratified international law and conventions at the ground level. Otherwise, children affected by AIDS will continue to suffer which will mar their manifold developments including psychosocial status.

56 Taiwan  Individual

Neoliberalism?: A Case Study of Taiwan’s HIV Patient(s)

I argue that all Asia governments should found a transnational organization which assist HIV patients on their legal rights, economic concerns, and medical services, which protect them from being discriminated and viciously assaulted both physically and mentally. The transnational organization has different communities, each dealing with a particular issue. All working staff must have professional training, at particular in terms of human rights and ethics as working staff of HIV cases.

Compared with LGBTQ parade on Oct. 23rd, 2011 in Taiwan, where passionate dancing, and music continued to entice participants of pro-LGBTQ activists, cases of HIV patient reign silence. Both involve the issue in terms of rights of LGBTQ, but face different destinations. This paper mainly discusses a real-life case of the HIV patient nicknamed, Shiao-Mi. And his dilemma is impelled by bureaucracy of government in terms of problematic standard operational procedure and ignorance of social-welfare institutions in terms of patients’ privacy in Taiwan.

More and more attention has been put upon the rights of the homosexuals and queers and that is a good thing. Improving one’s self-awareness and collective sensibility towards more accepting queers and the homosexuals
as a part of human beings with normative sense, indeed, pushes democracy ahead and makes an unforgettable leaf of human history. However, one cannot deny that the thorny issue of the queers and homosexuals is not only sexuality, and identity, but also that of HIV and AIDS patients, especially their rights of being an individual. The concept of an individual is not supposed to be expanded upon merely a collective sense towards HIV patients, but also supposed to be constructed upon the rights of an individual to what they need, why they are inflected and how they face their life at the moment when they know their having HIV.

The Event

A quick online news on Nov. 22nd, 2010 reports that a twenty-five-year-old youth named Shiao-Mi whose homosexual identity and HIV symptoms have been revealed during the time when the personal documents were delivered within hierarchy of government in R.O.C. Having learned from Tai-Da Hospital that he is infected with HIV, Shiao-Mi did not cry and seemed to sense it beforehand. He later called up Tai-chung government for relevant information about military services. At the very beginning, Standard Operation Procedure goes smooth but the whole matter changes drastically when Shiao-Mi’s document of being permitted not to join the military services due to his being infected with HIV is delivered to his parents by the district office nearby his dwellings without having Shiao-Mi beforehand informed officially. According to Taiwan’s governmental policy, any personal medical document should be confidential and must be sent to him directly. In other words, the medical document is not supposed to be sent out to Shiao-Mi’s house directly without his personal permit. Both his identity as a queer and as a HIV patients have been forced open to his parents.

Attitude of Shiao-Mi’s Parents

With astonishment, Shiao-Mi’s mother complains about him, saying “why don’t you let us know when you suffer a lot and have such a big trouble.” Shiao-Mi thinks his mother and father must have searched the Internet for information about HIV which is fatal and would devastate men’s immune system. This case, compared with other cases, is more positive since lots of Taiwan’s parents and other family members have not ever imagined that their children might have suffered from HIV. Most of them could not even tolerate the fact that there is one member affected with HIV dwelling with them. Parents in Taiwan tend to be more conservative especially when they face the issue of sexuality, let alone the issue of AIDS and other venereal diseases. Shiao-Mi’s mother, although she is overwhelmed by the fact that her child is a HIV patient, reminds Shiao-Mi to take medicine regularly and not to have others transmitted with HIV from Shiao-Mi.

The Problems

Taiwan, to a large extent, is a democratic country where people enjoy their rights as citizens. However, there is always an exception for queers and HIV patients. The abovementioned incident is not just a particular case and reveals many aspects unusual when we think about the governmental system in Taiwan. And the circumstance HIV patients’ would encounter with. First of all, HIV, when deal with their document with the sign or wording of HIV diagnosis as positive condition, would feel uncomfortable (some even humiliated) by some working staff in rural areas since those working staff have no professional training to HIV and human rights. They could not understand the torture of HIV patients both physically and mentally. Furthermore, due mainly to governmental bureaucracy, HIV patients’ privacy and basic need of being protected is challenged by national apparatus since government signifies mainstream collective sense while HIV patients represents the marginalized under the context of both national authority and heterosexual ideology. The marginalized is always defined by the mainstream society. Therefore, their human rights is basically determined by the mainstream society. Whether they could live happily thereafter will be determined by society. Moreover, HIV patients in Taiwan, once their identity is revealed, will be labeled as abnormal and monstrous. They are no longer accepted by family, community, and a whole society since they are affected with HIV. HIV patients will find it tremendously difficult to obtain a job from organizations and enterprises. Shiao-Mi’s case is apparent when he knows that he is infected with HIV and what he thinks immediately is his obligatory duty to join the military service. He must
apply for not being enlisted into the army for he might be persecuted owing mainly to his sexual inclination and medical reports.

I hope that this report could contribute to arousing people’s attention to not only queers’ identity but also HIV patients’ condition. Too much human rights of queers has been emphasized; however, HIV patients’ rights and basic concern are hardly accentuated.


57 Thailand Individual

"When I can work in safe and fair conditions.
When I am free of discrimination.
When I am free of labels like ‘immoral” or “victim”.
When I am free from unethical researchers.
When I am free to do my job without harassment, violence or breaking the law.
When sex work is recognized as work.
When we have safety, unity, respect and our rights.
When I am free to choose my own way.
THEN I am free to protect myself and others from HIV.”

Closing Ceremony XVth International AIDS Conference
Bangkok, Thailand, 11-16 July 2004
Empower Foundation read by Pornpit Puckmai

Sex workers in Thailand are one of the groups least protected by the law and most penalized and discriminated against by law enforcement. In Thailand, no other sexual act between consenting adults is the subject of criminal law.

After failure of the 1928 law to regulate prostitution, the first Suppression of Prostitution Law was promulgated in 1960 by a military regime enacting a “Social Purification” campaign. A new Suppression and Prevention of Prostitution Act 1996 was designed to protect children and minors from commercial sexual abuse but criminalization of adult prostitution remained. Neither law considered the human rights or well being of sex workers, including our right to be safe from HIV. Both have failed spectacularly to suppress or prevent prostitution. Surely almost a century of legal persecution has shown that prostitution is not a moral problem that can be solved by punishing perceived immorality. Prostitution is not a legal problem that can be solved by criminal law. Prostitution is human rights problem that must be solved by sex workers being able to assert our human rights including having equal opportunities in society and to be treated with equal human dignity. Punitive laws severely limit our ability to assert our human basic rights such as recognition as persons before the law; access to justice; safe fair working conditions; adequate health care; and equal access to social services. Migrant sex workers carry a double burden of criminalization that effectively threatens their right to a life of liberty and security. The legal and policy environment sex workers in Thailand endure is untenable with access to HIV prevention, treatment and care.

The first impact of being classed as a criminal is an attack on our self worth. In all other aspects of our lives we sex workers are law abiding productive members of society. We are the main family bread winner providing support for 5 - 8 other adults in the family. We take our religious, political social and cultural duties seriously. Our customers are respected members of society. We are good parents, neighbors and friends. The fact we are considered criminals before the law engenders a sense of shame. This shame and low self worth is continually
reinforced by media, service providers and law enforcement. The resulting lack of self esteem and confidence leaves many of us feeling ambivalent about our own safety and well being, including feeling ambivalent about protection from HIV.

When sex work is a crime police are obliged to investigate and make arrests. However they are also obliged to prove the crime using evidence. What evidence is there that sexual services have taken place? There is nothing missing, no one hurt and no one is complaining. It is not surprising that police use condoms as the only tangible evidence at hand to provoke a confession. The use of condoms as evidence of the crime of prostitution naturally results in sex workers and owners of entertainment places being reluctant to carry or stock them. This is especially true for those condoms given to sex workers and entertainment venues by HIV projects, including Thai Public Health. The brand name adds weight to the police accusations of prostitution as these condoms are rarely found in other places.

Theoretically, we may have broken one law yet we still have rights under other laws. However, sex workers in Thailand are not seen as persons before the law. Sex workers are made vulnerable to wide ranging extortion by corrupt authorities. Sex workers are routinely threatened with arrest for a variety of crimes in addition to, or instead of prostitution offences e.g. public nuisance, loitering, drug abuse, immigration or traffic violations. This includes sex workers being threatened with arrest when needing to report even serious crimes like forced labor, child sexual abuse or rape. There is no access to justice for sex workers as long as we are deemed first as criminals, not people before the law.

Laws do not protect our rights. Law becomes a tool for corrupt police to get more money. All sex workers in Thailand pay police either directly or via lost income that the employer is obliged to reroute to the police. The more laws applying to us and our work the more money we have to hand over. The National Economic and Social Advisory Council found in a 2003 study that A go-go bar and massage parlor owners in Thailand pay a 3.2 billion baht (US$80 million) a year in police bribes. It has risen since then. The 2008 Anti-trafficking Law has created a new excuse for corrupt authorities to extort money from sex workers and our employers. Instead of just ordinary criminals, migrant sex workers have become translational criminals, or evidence of translational crime. Migrant sex workers tell how the daily bribes doubled and their salary dropped after the law was implemented. If sex work in itself was not a crime, if sex workers were not treated as criminals wherever they come from, even 10% of the informal “tax” the industry currently provides would fund many work place health and safety programs, including workplace HIV education and prevention.

Sex workers are criminals. Criminals are not treated the same as other people in society. We are not considered entitled to the same respect and the same services. Public health services dealing with sex workers are services dealing with criminals. They do not need to be polite or maintain the same standard of professional ethics with us as when they deal with a housewife or a University student or other “good” people. In addition sex workers have been having “dirty sex” we are considered immoral and diseased. This has become the culture of many government health providers. Who would want to visit a place where you know you will be insulted, examined roughly and humiliated even once, let alone return every 2 weeks. We sex workers want to take care of our health and protect society but should not have to sacrifice our dignity to do so. The Prostitution Law and attending public health policies reinforce this culture of stigma and discrimination. The law says to those health providers “Yes, you’re right. These are bad people doing bad things.” Of course they see us as criminals, after all we are the only people in society who are pressured or forced to have health checks by the police. A change of law may send a new massage to them saying “These are human beings, not criminals” It will allow sex workers to help health providers improve their services so sex workers can have real access to sexual health treatment. Sex work is against the law making it a criminal business. It should be no surprise that criminal businesses attract criminal businessmen. Criminals use the cover of Entertainment Places to carry out criminal business like money laundering, drug and arms trafficking etc. Respected business people don’t want to admit they own “dens of vice”. Honest business people don’t want people to think they are involved in criminal acts. While ever prostitution is criminalized, despite the neon flashing lights, sex worker workplaces remain dark places in
society inaccessible to HIV programs. Legally Entertainment places fall under the 1966 Entertainment Place Act (Tabled for amendment 2003) The Act defines the various kinds of "Entertainment Places" and allows such places to operate under a license to be obtained from local police stations. There are no provisions under the Act that promote staff health and safety or labor protection. Under the Act all staff must be fingerprinted and have their history recorded on a police charge sheet. This abuse of the human right to privacy, protection of reputation and equal treatment under the law was finally recognized as such by the Thai National Human Rights Commission in July 2006, though no action has been taken.

With no enforcement of the Labor Law employers have been left to develop their own labor practices and rules which have become standard nationally over the years. Space doesn’t allow a full explanation but suffice to say these rules include requirements that markedly increase our risk of HIV. The “bar rules” inhibit our sexual autonomy by putting us in situations where unprotected sex is likely. The more controlled our work place, the less personal power we have, the higher our risk of HIV. If it is known that we become HIV positive we are dismissed. This means HIV positive workers don’t dare to seek treatment or even information and emotional support until they are very ill, often near death. If entertainment venues were recognized as work places they would be obliged to comply with the same kind of regulations as other businesses and workplaces. Occupational Health and Safety Standards could be developed, implemented and enforced, along with the enforcement of the Thai Labor Law and the Social Security Act.

In 1996 Thailand began to explore policies to manage undocumented migrant workers. Many different systems have been trialed since then. Sixteen years on, to date, no government has ever included entertainment work in the categories available for migrants to find work in. This is despite the size of our industry and the numbers of migrant sex workers already employed. Thai sex workers and employers agree there are enough customers for all. However, instead of allowing migrant sex workers to obey the law and access our rights, the government keeps migrant sex workers as undocumented and doubly criminal.

Although a vital initial step, to just decriminalize sex work by amending the current Suppression and Prevention of Prostitution Act 1996 will not be enough. Sex workers must be recognized and protected as equal human beings and as workers. ABOVE ALL WE MUST ENSURE THAT SEX WORKER LEADERS AND THEIR ORGANIZATIONS HAVE MEANINGFUL PARTICIPATION IN ALL STAGES OF DEVELOPING REFORMS AND CHANGES

Recommendations
1. Decriminalize sex work (not legalize, no registration or mandatory health checks etc)
2. Apply existing Labor Law and Social Security Act to sex work
3. Develop implement and enforce OH&S standards for the entertainment industry
4. Allow migrant sex workers access to at least the same opportunities and rights as other migrant workers

One of my experiences of Police violence

Once, when I was walking on St Marks Road at around seven in the evening, a police van stopped in my path, picked me up and took me to the Cubbon Park police station. One of the policemen asked, ‘Hey khoja, where’re you from son?’ ‘I am from Tamil Nadu.’ (The whole conversation in Kannada.) ‘Why did you come here?’ ‘We’re pottais. No one is willing to give us work. My family does not want me, and so I came here to earn for my stomach.’ ‘Why the hell can’t you do that in Tamil Nadu? Why come here?’ A policeman brought his lathi down on my legs and hands. Another kicked me with a booted foot. ‘Samy, samy! Let me go! I won’t ever come this
side again!’ I cried out.

‘Let you go? Not a chance! Go and sit in that corner. Our senior officer will come and after that we’ll shave off your head and send you to jail!’ I was made to sweep the station and swab its premises—all this while I was waiting for the superintendent to come. There was no response to my plea: ‘Sir, I’ve done all you’ve asked me to. Let me go, my people will be looking out for me!’

I wanted to run away, but there were men with guns standing guard, and what if one of those men shot at me? Also, if I tried to get away, they’d probably beat me and torture me more. I could do nothing but wait. It was well past eleven in the night and there was no sight of the higher official. Around midnight, a policeman with two stars pinned on his shirt came to me. ‘Our saheb won’t come tonight. He’ll be here only tomorrow. He’s asked me to take a statement from you.’

He took me to another room. Adjacent to it was a small cell and there was a man behind bars. He had chains on his feet. The policeman said, ‘Why don’t I put you in the cell along with him? In there, you can be as you want with that fellow!’

I screamed that I did not want to go into the cell. I fell at the policeman’s feet. He kicked me with his boots. He then asked me to take my clothes off—right there, while the prisoner was watching. I pleaded with him and wept, but he forcibly stripped me. When I was standing naked, he stuck his lathi where I’d had my operation and demanded that I stand with my legs apart, like a woman would. He repeatedly struck at that part with his lathi and said, ‘So, can it go in there? Or is it a field one can’t enter? How do you have sex then?’

I felt heart-broken and could not speak. The policeman then shouted at the prisoner. ‘Dai! Have you seen enough? Want to see more?’ The prisoner smiled uneasily and covered his face with his hands. My heart beat very fast, I was petrified that he’d throw me to the prisoner and ask him to do as he wished with me. The policeman then threw his lathi at the prisoner.

It hit the bars of the cell and clattered down. Bending to pick up his lathi, he yelled at the prisoner, ‘Dai! Turn away! Don’t look!’ Picking up a sheet of paper, the policeman scribbled something on it, and asked me, ‘Where did those breasts come from? They grew on their own?’ ‘No, not on their own. I took hormone tablets to grow them.’ ‘Open your mouth wide.’ I obliged him. ‘Bend down. I’ve got to inspect your back.’ I bent and showed him my back. He then asked me to hold my buttocks apart so that he could see my anal passage.

When I did, he thrust his lathi in there and asked, ‘So you get it there?’ I straightened up yelling with the pain of it. He then handed me my clothes and asked me to sit in a corner as before. I spent that entire night there, shivering in the cold. I did not sleep at all.

At around one o’clock, a man handed me a parcel of food and asked me to eat. I spread the paper packet on the floor and began to eat. Since the paper was soggy, some of the food spilled onto the floor. The man forced me to eat that as well and watched me as I did so.

That night I cried silently to myself, thinking of all that I had to go through. There was not a soul there to take pity on me. I felt intensely ashamed and enraged. I even thought that I should perhaps grab one of the guns there and shoot myself. But I did not know how to shoot and besides I was afraid to even go near one of them.

The next morning, at 10 o’clock, the higher official finally arrived. He asked me into his room. ‘Dai? Do you chaps have no other work? Why do you walk the streets? What’re we supposed to do with you guys? We beat you, arrest you, and yet you return to the streets. So many people complain about you, vendors, college students, restaurant owners… If I am to see you fellows again on the road, you’ll be permanently put in jail!’ He then called out to another policeman and asked him to put me in a van.
On the way to court, they told me that I must not speak of how I was beaten or humiliated, instead, I was to accept responsibility for my crime, pay the requisite fine and leave. I agreed to do what they asked of me. Once we reached the court, they said that they’d rather I paid them two hundred rupees. In which case I could go straight home, and they would pay the fine on my behalf. I gave them the money I had hidden inside my petticoat and left, glad to exit that scene forever. I went straight to the hamam (Bath house run by Hijra Community).

Indonesia’s laws and regulations which hinder HIV treatment

The so-called war on drugs in Indonesia has been erroneously translated as war on drug users whereas large numbers of drug users, which also recognized as one of key affected populations of HIV/AIDS, have been severely abused by the police and other state apparatus. Narcotics Law number 35 year 2009, clearly states that 4 (four) years of imprisonment is the minimum sentence for drug use. In the name of war on drugs, practice of entrapping is also widely implemented to arrest drug users and drug dealers. Worse, the trapped persons are mostly innocent people, as happened in several cases which have been advocated by LBH Masyarakat.

The criminalization of drug user culminates in at least 2 (two) dreadful conditions. First, the criminalization discourages drug users who are already HIV as well as those who are not yet HIV positive to access HIV prevention and treatment program, such as Needle Syringe Program (NSP). It disseminates fear of being arrested amongst them, as recently took place in Grogol, Petamburan, West Jakarta. Second, it relates to the years of imprisonment for drug users who are arrested. Detained drug users are not only brutally tortured and extorted, but their right to health is often violated as well. For those who are living with HIV, the poor quality of food and sanitation, not to mention the over-capacity of almost all detention centres in Jakarta, will make them easily get sick, i.e. diarrhoea. Also, access to ARV has never been easy. Hence, this appalling condition makes drug user with HIV difficult to access to HIV treatment to prevent the decreasing CD4.

Other key affected population of HIV/AIDS such as transgender and sex worker face similar problems, especially in big cities like Jakarta. Their activities as sex workers are not formally criminalized. However, under the Jakarta regional regulation, those who sell sex or initiate other people to sell sex will be arrested or detained and should pay fine. The “due process” itself is unclear. No proper legal mechanism and fair trial is in place with regard to the arrest and detention. This condition leads the arrest becoming another model of bribery.

Fear of being arrested, sex workers no longer want to stay in the informally-localized place. Most of them choose to find a new place where they can safely sell sex, hiding away from the pursuit of Public Order Agency. Condom distribution as well as other harm reduction approaches and HIV treatment are therefore getting unreachable.

Ongoing Stigma and Discrimination

It is not only the criminalization that has to be faced by PLHIV and key population, stigma and discrimination also become part of their life that they have to deal with. Some laws that criminalize them, in addition to moral prejudice, contributed to stigma and discrimination that are widespread in the society. The lack of adequate information regarding HIV/AIDS makes the situation even desolate.
Rudy (not his real name), is a 5 year old boy living in Medan, North Sumatera, was expelled from his village because of his HIV status. His parents died several months before because of AIDS. Rudy suffered not only from AIDS but also malnutrition. His elder brother had to choose to drop out from school so he could take care of Rudy. No one stood together with them, even their family.

Another story came from Rita (not her real name), one of our paralegals from HIV/AIDS community. She was asked to become one of the actresses in public service advertisement regarding HIV/AIDS. She was supposed to appear in the advertisement with one famous actress. Bearing in mind that the advertisement was about HIV/AIDS, it could be assumed that the famous actress well understood about HIV/AIDS. Wrong! She didn’t know anything about HIV/AIDS. Worse, she dropped Rita off from her car in the street just because she didn’t want to be with Rita in a same car.

There are still much more similar stories with Rita and Rudi. Stigma and discrimination happen in every phase of their life: since birth, education, carrier, until death. Government do very little to erase stigma and discrimination. They even contributed in it by setting up some billboards that embraces strengthening the faith and piety to God as the first thing to do to keep away from HIV/AIDS.

**Practices: What has been and can be done?**

**A Community Legal Empowerment Approach for PLHIV and Key Populations**

LBH Masyarakat, as a legal aid institute which strongly believes that every single person has a unique potential and ability to do something good, has strived to erase stigma and discrimination by strengthening HIV legal services enables people who are socially marginalized to have access to justice for HIV-related problems and to obtain protection and redress.

With support from IDLO and OFID, LBH Masyarakat is conducting a community legal empowerment for PLHIV and key populations in Jakarta. It was started in late 2009 by gathering several key persons from NGOs that concern on HIV issues and members of PLHIV communities and key populations into a focused group discussion (FGD). The meeting was aimed to get more information regarding the legal issues regularly faced by the community.

Equipped with the result from the FGD, we established partnerships with the grass root level communities and followed by intensive community discussions regarding law and human rights. The law and human rights issues delivered in the community discussion were based on the legal issues raised by the FGD participants. However, there were some adjustments regarding the topic that requested by the community. The process of the discussion faced some challenges, such as the consistency of regularity of the discussion, resistances from the community, and the main focus of the community.

In the meantime, we also identified several key potential people to be community paralegals. These community paralegals are equipped not only with intermediated legal education, but also communication and motivation skills. Paralegals will provide first legal aid to the community and assist LBH Masyarakat’s lawyers in advocating community’s legal and human rights issues.

**Documentation for Humane Drugs Policy**

As explained in the background, drug users in Indonesia are still criminalized. Drug users’ right to fair trial and right to health are often violated. Despite these violations are publicly known, efforts to protect their rights and punish the perpetrator fall short due to lack of sufficient evidences or documentation that can represent and confirm the situation.
With support from Open Society Institute (OSI), LBH Masyarakat planned to document the violation suffered by drug users at the pre-trial detention. Under this program, LBH Masyarakat also aims to expand access to justice for drug users dealing with legal process as well as to strengthen their capacity in documentation and advocacy. Drug users will be trained to document human rights violations that are experienced by their fellows. Also, they will be empowered by LBH Masyarakat to conduct case advocacy.

It is believed that more community members empowered, equals expanded access to justice for drug users. Ultimately, the data obtained and empowered drug users altogether will become an effective instrument to address stigma and discrimination experienced by drug users, as a part of their violations’ of rights. Based on the documentation, it is hope to conduct a more-effective drugs policy advocacy. The basic idea of this program is to promote a community-driven drug policy advocacy.

**Shadow Lawyer: Empowering Community in Case Advocacy**

LBH Masyarakat has been conducted legal counseling in more than 10 communities of PLHIV and key populations since the end of 2009. In the process of the counseling, we always looked for some potential community member to be paralegals. Paralegal will play an important role in the case work and policy advocacy together with LBH Masyarakat. There are 3 (three) types of case advocacy undertaken by LBH Masyarakat all of which are provided on pro bono basis; legal advice, shadow lawyer, and legal representation (full legal service).

Shadow lawyer incorporates law students, paralegals from community, and lawyers. It aims to assist and prepare a defendant to be a lawyer for herself. It functions as a guidance provider for her. The paralegal’s role as acting-lawyer in it is really important. Paralegal is the spearhead of the shadow lawyer approach. Paralegal is involved in formulating the advocacy strategy as well as understanding the sense of it. They should also deliver the strategy and things that should be done in each steps of the legal process to the client and family. This may seems easy, but, in fact it’s not. It’s a challenging task to convey a message about advocacy to an ordinary people in a simple language without implies that it’s a simple thing to do.

During a trial, paralegal will be an observer and ensure that the client can implement the strategy provided. If a lawyer has to motivate paralegal, a paralegal then should do the same thing to the client, and make them able to bring up to their best. With these types of advocacy, our paralegals from drug users community has been successfully advocated few drug addicts to rehabilitation through judges’ verdict.

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*LBH Masyarakat provides pro-bono legal aid for underprivileged and marginalized people, undertakes community legal empowerment through providing legal and human rights education, promotes legal reform as well as conducts human rights advocacy at the national and international level.*

<table>
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<tr>
<th>61</th>
<th>China</th>
<th>Yunnan Daytop Rehabilitation and Treatment Centre</th>
</tr>
</thead>
</table>

2005年8月，国际非政府组织亚太艾滋病服务机构委员会（APCASO）在中国云南开始了一个为期5年的项目。该项目主题是：预防与治疗并重 - 扩大艾滋病治疗服务，同时提高艾滋病预防的可及性，简称“预防、治疗和倡导项目 (PTAP：Prevention, treatment and advocacy project)”。2007年7月，经过友好协商，本土非政府组织云南戴托普药物依赖治疗康复中心成为 PTAP 项目的合作机构，全面负责项目在中国的具体实施。

In August 2005, Asia Pacific Council of AIDS Service Organizations launched a five-year Prevention, Treatment and Advocacy Project or PTAP in Yunnan Province of China, which places equal emphasis upon prevention and
In July 2007, upon amicable consultation, a local NGO Daytop Drug Abuse Treatment and Rehabilitation Centre became the partner agency with PTAP to implement the project in China.

In May 2008, Li Wei, a person living with HIV purchased one accidental injury insurance policy with Ping’an Insurance of China against unforeseeable accidents. Later, he found that “periods when the insured live with HIV or AIDS” together with war, military action, riot, armed rebellion and nuclear radioactivity were listed in the Article Six and Nine of the Exclusion Clauses. Li Wei held that these clauses were unfair to the insured living with HIV or AIDS, and it should be deleted. He decided to press charges against the insurance company. He claimed that the company should delete discriminatory insurance clauses, and it should post a public apology and make certain compensation. He hoped to fight for the rights and the equal social status that the 700,000 PLHIV in China deserve.

In July 2007, an HIV and Law Workshop was held in Kunming, capital of Yunnan Province, by Yunnan Daytop Centre, APCASO, International Legal Development Organization and Yunnan Shangyi Law Firm. This was the first HIV and legal training workshop in China that targeted lawyers. Participants of the workshop included more than 20 lawyers from Legal Assistance Centres and legal firms of Kunming and other cities of Yunnan, senior law professors from Law School of Yunnan Province, and Yunnan University of Finance and Economics, as well as master candidates from Law School of Yunnan University and NGO staff. At the end of the training, the participants enhanced their awareness of the basic HIV knowledge and the laws and regulations associated with HIV, understood how different population groups think, and improved their skills to communicate to different population groups and provide legal services to specific groups. Many lawyers said that although they were so ignorant about HIV at the onset, they were inspired by the training to contribute their part to the HIV control and prevention in China.

Before the eve of the 2008 Chinese New Year, Li Wei, a person living with HIV purchased one accidental injury insurance policy with Ping’an Insurance of China against unforeseeable accidents. Later, he found that “periods when the insured live with HIV or AIDS” together with war, military action, riot, armed rebellion and nuclear radioactivity were listed in the Article Six and Nine of the Exclusion Clauses. Li Wei held that these clauses manifestly discriminated against the PLWHAs in China, because the HIV infection is irrelevant to accidental injuries. Therefore, approximately 700,000 PLHIVs in China including him are entitled to equal access to compensation as other regular people.

Based on such ground and after second thought, Li Wei decided to press charges against the insurance company. He claimed that the company should delete discriminatory insurance clauses, and it should post a public apology and make certain compensation. He hoped to fight for the rights and the equal social status that the 700,000 PLHIV in China deserve.

In May 2008, Li Wei commissioned Shang Yi Legal Firm in Yunnan Province to file the lawsuit against the insurance company. On August 28th, 2008, Wuhua District Court of Kunming City conducted closed-door hearing upon the PLHIV vs Insurance Company case. The district court referred the case to the Trial Committee of the court after its second trial and panel discussion. The court postponed the return of verdict out of the reason that the case held huge consequences and it was difficult to reach the verdict. The case aroused great buzz from society as it was the first case where a PLHIV sued the
insurance company in China.

Due to the above case, it was still unable to get the court判决结果, 2009年6月18日，由云南省昆明市中院审判长和亚洲艾滋病服务机构联合实施的中国艾滋病预防、治疗和倡导项目（PTAP）在北京联合举办了一次以艾滋病反歧视法律倡导为主题的研讨会。中国卫生部、国务院防治艾滋病委员会办公室、国内外非政府组织、法律界人士、感染者代表以及媒体代表共计30人参加了这次研讨会。Before the court arrived at a verdict, on June 18th, 2009, an anti HIV discrimination legal advocacy workshop was hosted by PTAP in Beijing. 30 Participants of the workshop came from Ministry of Health, State Council AIDS Working Committee Office, domestic and international NGO, legal professionals, PLHIV and media.

会上，来自中国卫生部的焦振泉处长表示，卫生部正在积极地和保障法联系，希望保障会能够修改保障条款中关于艾滋病感染者和病人的歧视性条款，保障艾滋病感染者和病人的合法权益。对此保障会也做出了反馈，表示愿意修改保障条款中带有对艾滋病感染者和病人歧视的条款。At the workshop, Mr. Jiao Zhenquan, section chief from MoH said that MoH was under proactive communication with China Insurance Regulatory Commission (CIRC) in hope that CIRC would revise those discriminatory against PLHIV in the insurance clauses. The feedback from CIRC was that they were willing to revise.

中国社会科学院的邱仁宗教授表示：“政府在预防、治疗艾滋病工作中，投入了大量的物力到技术层面，而在艾滋病歧视，人权问题等方面却鲜有措施与政策出台。”邱教授建议可以倡导政府出台反艾滋病歧视的相关具体条款，比如说对有歧视行为的单位或个人进行问责、治理，以及采取一定的惩治手段，用行政干预的力量来完善对艾滋病感染者和病人合法权益的保护；同时希望政府把法律上的条款付诸行动，呼吁大家用法律武器（诉讼）来维护自己的合法权益。Professor from China Academy of Social Sciences (CASS) said, “The government has invested substantial HR and financial resources as well as technical support to the HIV prevention and treatment, but in contract, there has been few policies released to address HIV associated discrimination and human rights issue.” Professor suggested advocacy to the government in releasing concrete anti HIV discrimination regulations, such as holding accountable and punishing the discriminating organizations or individuals. Administrative interventions should be adopted to protect the rights and interests of PLWHAs. He also hoped that the government could put such laws and regulations into practice and the PLHIVs could resort to laws (law suits) to protect their rights and interests.

在这次艾滋病反歧视法律研讨会中，各机构人士进行了广泛地交流，也分享了各自在防治艾滋病工作中遇到的问题和经验。会后，参会人士肯定了各机构在艾滋病防治、反歧视领域所付出的努力和贡献，表示将逐步加强为艾滋病感染者和病人维权的力度。The participants from various organizations conducted extensive discussion at the workshop and shared the issues and the lesson learnt in their respective HIV prevention and control work. At the end, the participants recognized the efforts and contributions made by the organizations in HIV prevention and control, and the fight against discrimination. They also expressed the commitment to work harder to protect the rights of the PLWHAs.

2009年6月25日，云南省昆明市五华区人民法院向李伟的代理人（云南上义律师事务所）送达了民事判决书，判决结果为驳回李伟诉讼请求。云南上义律师事务所联合云南省中院审判长和亚洲艾滋病服务机构联合实施的中国艾滋病预防、治疗和倡导项目（PTAP）在北京联合举办了一次以艾滋病反歧视法律倡导为主题的研讨会。中国卫生部、国务院防治艾滋病委员会办公室、国内外非政府组织、法律界人士、感染者代表以及媒体代表共计30人参加了这次研讨会。Before the court arrived at a verdict, on June 18th, 2009, an anti HIV discrimination legal advocacy workshop was hosted by PTAP in Beijing. 30 Participants of the workshop came from Ministry of Health, State Council AIDS Working Committee Office, domestic and international NGO, legal professionals, PLHIV and media.

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Malaysia participating in the Trans-Pacific Partnership trade agreement (TPPTA) negotiations.

Introduction

The Positive Malaysian Treatment Access & Advocacy Group (MTAAG+) is a group of people living with HIV/AIDS (PLHIV) doing HIV/AIDS treatment literacy and advocacy and networking. Ministry of Health accumulative number of reported 87,710 PLHIV in Malaysia. As we represent many Malaysians living with HIV/AIDS, we are very concerned that the life-saving medicines we need may become unaffordable if Malaysia joins the TPPTA. The price of patented medicines in Malaysia are already high enough to be of concern. For example a 2005 study using WHO methodology found that for a family of three receiving the lowest level of Malaysian civil servant salary, it would take two-months’ salary to pay for one month of patented medicines. Similarly, an article by Azmi and Alavi found that patented medicines can be 1,044% more expensive than their generic equivalents in Malaysia. The Malaysian government is already struggling to provide all the HIV/AIDS medicines required for free.

Since the negotiating texts have not been disclosed, we have been unable to determine the obligations in the TPPTA that could affect our right to health, including our access to affordable medicines. However, based on past US free trade agreements (FTAs) we are worried that the TPPTA will contain stronger intellectual property and other provisions that will negatively impact our health.

Prior to May 2007, the intellectual property chapters of USFTAs alone contained many obligations which, if imposed on Malaysia, would harm our health. A table listing some of these provisions, their impact on medicine prices and the UN Special Rapporteur on the Right to Health’s recommendation on them is below.

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4. While the USFTAs after May 2007 have had fewer TRIPS+ provisions, they still contain many obligations that we believe would undermine our right to health.
<table>
<thead>
<tr>
<th>USFTA provision</th>
<th>Impact on medicine price</th>
<th>UN Special Rapporteur’s recommendation to developing countries⁵</th>
</tr>
</thead>
<tbody>
<tr>
<td>Join the Patent Cooperation Treaty (PCT)</td>
<td>More medicines will be patented (based on the experience of other countries which joined the PCT⁶). Patented medicines have cost US$15000 per patient per year instead of US$80 per patient per year for generics.⁷</td>
<td>Establish high patentability standards (which would not be possible under current proposals at the PCT)</td>
</tr>
<tr>
<td>Requiring patents on new uses of existing medicines</td>
<td>Would cause an 8% increase in medicine prices in Colombia by 2020⁸</td>
<td>Exclude patents on new uses</td>
</tr>
<tr>
<td>Prohibiting pre-grant patent oppositions</td>
<td>Likely to mean that more medicines are patented for longer and patented medicines have cost US$15000 per patient per year instead of US$80 per patient per year for generics.⁹</td>
<td>Allow pre (and post) grant opposition</td>
</tr>
<tr>
<td>Requiring longer patent terms</td>
<td>Korean National Health Insurance Corporation estimates it will cost US$757 million if it has to agree to a four year extension in its USFTA negotiations.¹⁰</td>
<td>The extension of patent life in developing countries can significantly impact the ability of patients to access medicines, and may pose a burden for national health budgets</td>
</tr>
<tr>
<td>Limiting the grounds on which compulsory licences could be issued</td>
<td>World Bank estimated that if Thailand uses compulsory licensing to reduce the cost of second-line antiretroviral therapy to treat people living with HIV/AIDS by 90%, the government would reduce its future budgetary obligations by US$3.2 billion discounted to 2025.¹¹</td>
<td>Allow all possible grounds for compulsory licences</td>
</tr>
<tr>
<td>Prohibiting parallel importation</td>
<td>Depends on the price at which it is available elsewhere</td>
<td>Allow parallel importation</td>
</tr>
</tbody>
</table>

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⁵ A/HRC/11/12
⁶ http://www.wipo.int/ipstats/en/
⁸ Intellectual Property In The FTA: Impacts On Pharmaceutical Spending And Access To Medicines In Colombia, Miguel Ernesto Cortes Gamba, Mision Salud, Fundacion Ifarma, Bogota 2006
¹⁰ http://english.hani.co.kr/arti/englishedition/e_business/165065.html
### Requiring data exclusivity (DE)

- A medicine which received data exclusivity in Guatemala was 845600% more expensive than the generic version.\(^\text{12}\)
- 8 years of data exclusivity alone in Canada would have added $600 million to prescription medicine costs alone in the last five years.\(^\text{13}\)
- DE would require Colombia to spend an additional US$675million per year by 2020 and US$989million per year by 2030.\(^\text{14}\) If this is not spent, Colombians will have to reduce their medicine consumption by 30% by 2020.\(^\text{15}\)
- DE raises ethical concerns of replicating trials on human populations and it deters and considerably delays the entry of generic medicines and can lead to the maintenance of high prices of medicines.

### Linkage of medicine registration to patent status

- Linkage would require increased spending by Colombia of US$53million per year by 2030.\(^\text{16}\)
- Developed countries should not encourage developing countries to enter into TRIPS-plus FTAs. (And the WHO recommends avoiding linkage).\(^\text{17}\)

## Additional studies on the impact of TRIPS+ provisions on medicine prices

The World Health Organization (WHO) has an economic model of the impact of provisions which provide stronger intellectual property protection than the World Trade Organization’s Agreement on Trade-Related aspects of Intellectual Property Rights (TRIPS) requires (known as ‘TRIPS+’) on medicine consumption. The model predicts that the full impact of medicine price rises will not be felt until about 15 years after the USFTA begins because the stronger IP protection only applies to each new medicine after the FTA starts so it will not affect all medicines in a country and the overall medicine price until about 15 years has passed.

When the WHO model was applied to Colombia, it found that the effect of most of these TRIPS-plus provisions (prior to May 2007) is that Colombia would require an extra US$1.5billion to be spent on medicines every year by 2030.\(^\text{18}\) If this were not spent, Colombians will have to reduce their medicine consumption by 44% by 2030.\(^\text{19}\)

A study of the impact thus far of the TRIPS-plus provisions of the Jordan-USFTA found that: one hospital alone has increased its medicine spending six-fold, medicine prices in Jordan have already increased 20% since 2001 when the FTA began, over 25% of the Ministry of Health’s budget is now spent on buying medicines, data exclusivity has delayed the introduction of cheaper generic versions of 79% of medicines launched by 21 multinational companies between 2002 and mid-2006 and ultimately the higher medicine prices are threatening the financial sustainability of government public health programs.\(^\text{20}\) However, other countries could expect

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\(^\text{13}\) http://www.canadiangenerics.ca/en/news/nov_14_06.shtml


\(^\text{15}\) Intellectual Property In The FTA: Impacts On Pharmaceutical Spending And Access To Medicines In Colombia, Miguel Ernesto Cortes Gamba, Mision Salud, Fundacion IFARMA, Bogota 2006.

\(^\text{16}\) Intellectual Property In The FTA: Impacts On Pharmaceutical Spending And Access To Medicines In Colombia, Miguel Ernesto Cortes Gamba, Mision Salud, Fundacion IFARMA, Bogota 2006.

\(^\text{17}\) www.wpro.who.int/NR/.../BriefingNote2DataexclusivityMarch2006.doc


worse outcomes because recent USFTAs can have twice as many provisions that are likely to delay the introduction of cheaper generic versions of medicines as the Jordanian one and the Jordan-USFTA has not yet been in force for the approximately 15 years the WHO’s model predicts it will take for the full effects to be felt of these provisions on medicine prices.

We were very encouraged when the Malaysian Government issued a compulsory license in 2003 to import some generic antiretrovirals (ARVs) to treat HIV/AIDS from India for use by the Ministry of Health (MOH). The average monthly treatment cost by government hospitals and clinics fell by 81% from US$315 to US$58 and more than doubled the number of patients who could be treated.\(^\text{21}\) The MOH has achieved 9,962 people to be on ARV therapy. But this is still below the targeted 26,700 patients that needed urgent treatment with new WHO treatment guideline with CD4 350 and below.

The Thai Government (amongst others) recently issued compulsory licences for three types of medicines and estimates that it could save it up to US$24million each year.\(^\text{22}\) However a number of provisions in a TPPTA could prevent the use of compulsory licences, including data exclusivity and linkage.

### Human rights obligations

According to the UN Special Rapporteur,\(^\text{23}\) access to medicines forms an indispensable part of the right to health and States have an obligation under the right to health to ensure that medicines are available and financially affordable. Developed States also have a responsibility to take steps towards the full realization of the right to health through international assistance and cooperation. Moreover, all States parties to the International Covenant on Economic, Social and Cultural Rights have a legal obligation not to interfere with the rights conferred under the Universal Declaration of Human Rights and the Covenant, including the right to health. The UN Special Rapporteurs on the Right to Health have repeatedly expressed concerns about these provisions. For example, Anand Grover said that ‘TRIPS and FTAs have had an adverse impact on prices and availability of medicines, making it difficult for countries to comply with their obligations to respect, protect, and fulfil the right to health’.\(^\text{24}\)

His predecessor, Paul Hunt, said he was ‘deeply concerned that the US-Peru trade agreement will water-down internationally agreed health safeguards, leading to higher prices for essential drugs that millions of Peruvians will find unaffordable’. He stated that ‘The US-Peru trade agreement must not restrict Peru’s ability to use the public health safeguards enshrined in TRIPS and the Doha Declaration . . . Both the US and Peru must honour these binding obligations during their negotiations. If the final agreement has the effect of restricting access to essential drugs it will be inconsistent with Peru’s national and international human rights obligations’. Mr Hunt concluded that ‘in accordance with its human rights responsibility of international cooperation, the US must not apply any pressure on Peru to enter into commitments that are either ‘TRIPS-plus’ or inconsistent with Peru’s constitutional and international human rights obligations’.\(^\text{25}\)

Many others have expressed their concerns about the way the intellectual property provisions found in USFTAs make medicines more expensive, including the World Health Assembly,\(^\text{26}\) the WHO’s Commission on Intellectual Property Rights, Innovation and Public Health,\(^\text{27}\) Ministers of Health from ten Latin American countries,\(^\text{28}\) the

oviralDrugs-CheeYokeLing%5BOct05%5D.doc
\(^{22}\) http://www.bangkokpost.net/breaking_news/breakingnews.php?id=116803
\(^{23}\) A/HRC/11/12
\(^{24}\) A/HRC/11/12
\(^{25}\) http://www.unhchr.ch/huricane/huricane.nsf/0/35C240E546171AC1C1256EC800308A377opendocument
\(^{26}\) WHA56.27, May 2003, http://www.who.int/gb/ebwha/pdf_files/WHA56/Aa56r27.pdf
Ministers of Health of the African Union, the African Union’s Ministers of Trade, the UK Government’s Commission on Intellectual Property Rights and Nobel Peace Prize winning Doctors Without Borders. As a Party to the Convention the Rights of the Child (CRC), Malaysia is bound by Article 24 of the Convention which sets out the right of the child to the highest attainable standard of health and includes an obligation on the Malaysian Government to ensure the provision of health care to all children. Furthermore, according to the Committee on the Rights of the Child, States Parties have an obligation to provide antiretroviral medicines to HIV+ mothers and children. Malaysia currently provides free antiretroviral therapy to HIV+ pregnant women and HIV+ children. However the sustainability of this assistance is already proving difficult and the permanently lower government revenue as tariffs are reduced under the TPPTA and TRIPS+ provisions are likely to further threaten Malaysia’s ability to fulfill this human rights obligation.

The Committee on the Rights of the Child has already asked pointed questions as to how Malaysia will ensure that FTAs do not affect the provision of generic medicines, especially for HIV/AIDS. The Committee has expressed concern over the way in which TRIPS+ provisions in other USFTAs may harm access to affordable medicines and has repeatedly urged countries negotiating such agreements to ensure they do not negatively affect the right of children to access affordable medicines.

The United States has reaffirmed its support for the full use of TRIPS flexibilities in the 2010 United Nations General Assembly resolution on the Millennium Development Goals. (In 2006 the General Assembly’s resolution on HIV/AIDS also reaffirmed the right to use all the safeguards in TRIPS and assist developing countries to use these flexibilities.)

We were encouraged to read that ‘President-elect Barack Obama and Vice President-elect Joe Biden believe that people in developing countries living with HIV/AIDS should have access to safe, affordable generic drugs to treat HIV/AIDS. They will break the stranglehold that a few big drug and insurance companies have on these life-saving drugs. They support the rights of sovereign nations to access quality-assured, low-cost generic medication to meet their pressing public health needs under the WTO’s Declaration on Trade Related Aspects of Intellectual Property Rights (TRIPS).’ We look forward to seeing this implemented by President Obama ensuring that any TPPTA only has TRIPS-level of intellectual property protection.

No generic medicines means no access to affordable life-saving AIDS drugs. This will translate to more deaths for PLHIV. In Malaysia, figures in June 2006 show that there are 73,427 reported cases of HIV infection, and 10,959 AIDS cases in Malaysia. Between 1986 and June 2006, we have already lost 8,334 lives.

For PLHIV, the treatment that we need is a lifelong treatment. For us, it is a matter of life and death. So we strongly appeal to you, to safeguard our human right to affordable medicines and treatment. Please do not include in the TPPTA an intellectual property chapter or any TRIPS+ or other provisions that will harm the health
of Malaysians.

Without ARVs, more PLHIV will die.

Solidarity and Action Against The HIV Infection in India (SAATHII, Positive Women’s Network (PWN+) and State chapters of PWN+ from Orissa, Manipur, Tamil Nadu and Maharashtra

Background

Women infected with or affected by HIV/AIDS (WIAHIV) face human rights violations and denial of property. Previous studies have shown that women who own property are more socially and economically empowered and less vulnerable to domestic violence. The Indian non-profit agencies Solidarity and Action Against The HIV Infection in India (SAATHII) and Positive Women’s Network (PWN+) have launched a European Union-funded intervention to empower WIAHIV through legal literacy on property ownership and gender-based violence; and to mobilize legal support through local legal aid bodies and civil society coalitions.

A baseline study assessed key human rights violations and legal issues that WIAHIV currently face, such as denial of property, domestic violence, and harassment/discrimination in communities and in other institutional settings. It also explored their awareness and utilization of legal and other formal and informal mechanisms for seeking recourse.

Methods

The mixed method study was carried out in 18 focal districts of four states of India - Tamil Nadu, Maharashtra, Orissa and Manipur. In each district, quantitative data were collected from a stratified random sample of 80-100 WIAHIV (> 18 years) via a semi-structured questionnaire and analyzed by frequency tables, tests of independence, and multinomial logistic regression. Qualitative data were collected through eight focus group discussions and twelve key informant interviews, and were subjected to qualitative content analysis.

Results

Nearly forty percent of WIAHIV reported experiences of stigma and discrimination. Most common experiences included public humiliation, isolation, abandonment, and discrimination while seeking healthcare services. Of the respondents whose families owned property, 61 (27.7%) women reported denial of property by their in-laws. After the death of their husband, women reported that they were either forced out of their marital home, or were treated so poorly by their in-laws that they had no choice but to leave. Only 24 (6.38%) women in the sample had property in their name. There was no statistically significant association between property ownership and domestic violence in our sample. Fifty percent of WIAHIV in the sample (188 of N=376) experienced domestic violence. Qualitative findings suggest that the main reasons for domestic violence included: arguments over property, alcohol consumption, refusal of sex/safer-sex-practices, and influence of other individuals. Many HIV-positive respondents indicated that they do not disclose their HIV status to their families or communities for fear of how they would be treated. As marriage and property inheritance laws in India vary based on religion, responses on these issues depended on the religion of the respondents. Among Hindus, nearly 81% of women were aware that both men and women have equal rights to property, and 75% of them were aware of how property is divided following death of a male family member. Twenty-two percent (85) of the total respondents were aware of the existence of free legal aid cells. Out of the 61 women who faced property denial-related conflicts, only 12 (20%) approached the police and courts for solving the dispute, while 27 (40%) sought non-formal dispute settlement through panchayat heads or community leaders. Respondents
who had sought formal legal recourse preferred these because they perceived these to be trustworthy and their judgement unbiased. Those who had utilized non-formal dispute settlement mechanisms such as panchayats reported that these did not incur the costs and time-delays associated with formal legal services.

Conclusion

The results of this study highlight the importance of educating and empowering WIAHIV on securing their rights related to property inheritance and domestic violence, and the mechanisms for legal remedy. Despite the lack of significant statistical association between domestic violence and property ownership, the high prevalence of domestic violence and low prevalence of property ownership in our sample suggests that both are critical issues to be addressed. These results, taken together with previous work by PWN+ and SAATHII, suggest that the legal system needs to accelerate its response to cases. Finally, awareness of and access to free legal aid services needs to be enhanced.

This submission is by Fridae – Asia’s leading lesbian, gay, bisexual and transgender online portal – on behalf of individuals, community-based organisations and other stakeholders that constitute the Developed Asia region.

Developed Asia, a distinct sub-region as defined by the Asia Pacific Coalition on Male Sexual Health (APCOM) includes Hong Kong, Japan, Macau, Singapore, South Korea and Taiwan. These six countries that share similar HIV epidemics with highly-evolved gay, bisexual and transgender communities, as well as similar challenges in advocating for sufficient government investment in HIV/STI prevention and sexual health. All six countries sit outside international mechanisms for HIV assistance and development.

On December 2-3 of this year, Fridae and Action for AIDS – Singapore’s peak nongovernment organisation for HIV – held the first ever Developed Asia Regional Consultation on HIV in men-who-have-sex-with-men (MSM) and transgender people (TG) in Singapore.

Over the course of two-days, this landmark event brought together health sector officials, researchers/academics, United Nations officials and community representatives representing 40 organisations from the six countries, as well as China, Malaysia and Thailand in recognition of the fact that many MSM and TG from these three additional countries also share economic, geographic and epidemiologic linkages with “developed Asia”.

The primary outcome of this Developed Asia Consultation was the creation of a working group to steer the formalisation of a community-led network for developed Asia on HIV with core values acknowledging the diversity of sexual orientation and gender identity, as well as encouraging greater participation of young people and people living with HIV. It is hoped that this network will provide the mechanism for increased collaboration and improve efforts towards a coordinated regional HIV response.

The evidence on which this submission is based

This submission is based on the following:

--- A “breakout session” on ‘Restrictive legal and policy environments’ during the Developed Asia Regional Consultation where delegates from the 9 countries and regions discussed the prevailing environment in each of their settings in terms of HIV and sexual health. Delegates considered solutions on how regional and national action could result in positive change at a national-level.
Note: Fridae acknowledges that more evidence is required to support the anecdotal information supplied in this submission. Improving data and strategic knowledge was a key priority raised for the network formed Developed Asia Working Group. Meanwhile, should the Commission for HIV and the law require additional information, there is a sufficient framework for further investigation to be implemented.

What are the challenges faced?

--- Few legal protections exist for sexual minorities and/or PLHIV in many countries (especially in Japan, Malaysia, Singapore; further clarity is required in Hong Kong on recent legal reforms). This has significant impacts on access to sexual health services and the continuum of HIV care, treatment and support.
--- Some countries criminalize homosexual acts (in particular Malaysia, Singapore and South Korea – within the jurisdiction of the Korean military code), thus reinforcing and institutionalising stigma and discrimination that drives these communities further underground and out of reach of public health workers.
--- Lack of public debate and/or censorship on issues that relate to sexual minorities (in Malaysia and Singapore). This has an impact on the ability to implement HIV prevention programs and also hinders attempts to address stigma and discrimination of most-at-risk populations.
--- Some countries place limits on civil society activity and restrict the types of groups that can register as civil society/non-government associations/organizations (China, Malaysia and Singapore). This inhibits the creation of community-led responses, a strategy which are known to be more effective in other settings.
--- Lack of reporting of legal or human rights violations in all countries results in poor quality evidence, and lack of visibility.
--- Poor cross-governmental implementation in countries where protective laws do exist for sexual minorities and PLHIV (Taiwan); there is a disconnection between law enforcement policy/practice and law-makers/bureaucrats.
--- Discriminatory religious laws are in place in some countries/provinces (Sharia law implement in some Malaysian states)
--- Strategies must effectively address the concerns and attitudes of the general population in order to achieve advocacy goals and improved enabling environment.
--- Few resources or funds exist that can assist in advocating for an enabling environments in the countries of Developed Asia as they do not qualify for international development funds.

In addition, other related issues that were raised:

--- Issues around the sexual health of young people
There are significant barriers to engage national ministries of education regarding the provision of sufficient and effective sexual health and HIV prevention information to young people that is inclusive or non-judgemental towards sexual minorities.
--- Drug use and harm reduction
Evidence from the 2010 Asia Internet MSM Sex Survey (2010AIMSS.com) conducted by Fridae shows evidence of non-injecting, “recreational” drug-use (especially non-injecting, “recreational” drugs) amongst MSM and TG is on the increase across Developed Asia. This tread has an impact on HIV and STI transmission. Criminalisation of drug-use has impeded HIV program-makers from adopting targeted HIV prevention strategies that are aimed are reducing harm and HIV risk. While credible evidence was presented at the 2010 International AIDS Conference that a “war on drugs” strategy is ineffective, few avenues for effective dialogue and implementation on this matter exist within Developed Asia.
--- People Living with HIV
Short-term travel restrictions for people known to be living with HIV exist (Singapore); barriers exist on migration for people living with HIV in most Developed Asia countries.

What examples exist of good practice?
Regional consultations on legal issues (which include all stakeholders: public health, legal, law enforcement) have taken place in other Asian sub-regions. This can be applied to Developed Asia.

There are examples of community groups working with elected government reps/independent human rights commissions to advocate for change (Malaysia, Thailand).

Alliances have been formed with other lobby groups (eg. women’s groups, labor unions) to help address stigma, discrimination and improve the enabling environment (Hong Kong, Singapore, Taiwan).

What opportunities do we see?

Organisations that serve sexual minorities and those most-at-risk of HIV in Developed Asia need to:

- Become more effective at engaging the Asia-Pacific Parliamentary Forum/ASEAN HIV Secretariat/ASEAN Human Rights Secretariat/UN Human Rights Council
- Improve the quality of advocacy skills within community organisation through workshops
- Foster the talent of emerging leaders and young people wanting to be active within their community.
- Map support services that available for sexual minorities in need of legal assistance.
- Gather more data, build evidence to advocate for change
- Find more allies within local, national and regional networks, within government and the general bureaucracy, other lobby groups outside of HIV/sexual minorities
- Invite other stakeholders to strategic regional consultations; a proposed meeting focussing on HIV and human rights could bring together public health, legal and law enforcement officials together for the first time.
- Encourage Aid Agencies from Developed Asia countries to align HIV development assistance projects so that outcomes have positive impacts on most-at-risk populations on both donor and recipient countries.
- Seek out and distribute capacity-building toolkits for advocates to apply in their local settings.

What are our recommendations to the Commission?

In making a recommendation to the commission, we echo the points raised in a parallel submission from the Asia Pacific Coalition on Male Sexual Health (APCOM) based on the Multi-City HIV Initiative covering six mega-cities of Asia (Bangkok, Chengdu, Ho Chi Minh, Jakarta, Manila and Yangon). In particular we feel the Commission could help the communities most-affected by HIV in Developed Asia by providing:

- Assistance and skills training on advocacy issues
- Encouragement of collaboration between community, health official and crossgovernmental policymakers/implementers
- Access to toolkits for sensitivity training across various levels of civil society
- Monitoring and evaluation of advocacy initiatives.

Effective communication is critical to the success of any advocacy or behavior change campaign, and we ask that resources be made available for translation of material into the key languages of Developed Asia: Chinese (simplified and traditional) English, Japanese and Korean.

Barriers to an Enabling Legal Environment for the National Response to HIV and AIDS

1. Major Barrier: Weak national capacity to access justice and lack of justice sector capacity to respond appropriately to HIV and related legal issues: The inability to access to justice is the primary legal barrier to the human rights-based response HIV at country level.

Even well-designed laws and regulations can have little impact if confidential, timely and affordable redress is
not accessible to people living with HIV (PLHIV) and key affected populations (KAPs). For example, in Papua New Guinea, HIV-related discrimination is widespread. Few cases have been brought under the HIV/AIDS Management and Prevention (HAMP) Act, because both PLHIV and legal service providers are often unfamiliar with the law prohibiting such discrimination in PNG.

To improve access to justice, these populations urgently need quality and affordable legal services.

HIV-related legal services are legal services for people living with HIV, people affected by HIV and key populations that directly relate to legal issues that affect their vulnerability to HIV and/or increase the impact of HIV in their lives. They may be delivered in a variety of settings, for example in conjunction with HIV prevention, treatment, care and support services, in conjunction with other legal services addressing other needs (not necessarily HIV-related) or on a stand-alone basis. (Toolkit: Scaling Up HIV-related Legal Services. IDLO, UNAIDS, UNDP, 2009)

Such services empower communities to utilize the tools and protections provided by legal frameworks, and help bridge the gap between national laws and their effective implementation. In the hostile legal environments in many countries in Asia and the Pacific region (e.g. where the criminal laws are applied inappropriately), quality legal services can obtain better outcomes for clients and communities, and generate data for appropriate law and policy reform.

Response: In Asia Pacific region, IDLO supports governments and civil society organizations in four countries to design and deliver HIV-related legal services. These initiatives focus on improving access to justice through locally appropriate models, which include community outreach, legal hotlines, paralegal capacity building, and professional support and referral networks.

Recommendations:

a) Strengthen and expand access to justice for PLHIV and KAPs and support quality, affordable legal services by building the capacity of both government and non-governmental facilities.

b) In consultation with national and local authorities, map existing HIV-related legal services, gaps and needs to identify priority areas for support, consistent with local epidemics.

c) Include costed proposals to strengthen and expand HIV-related legal services in national AIDS strategies and plans.

d) Include specific budget lines to strengthen and expand HIV-related legal services in national AIDS program budgets and/or national legal aid program budgets (as locally appropriate).

e) Build the capacity of national gatekeepers (e.g. Ministry of Health and Ministry of Justice staff, national AIDS program staff, Global Fund Country Coordinating Mechanism (CCM) chairpersons, UN and other agency staff) to program HIV-related legal services.

f) Include HIV-related legal issues in mainstream legal aid programs (e.g. Tamil Nadu (India) State AIDS Control Society (TANSACS) and Tamil Nadu State Legal Services Authority (TNSLSA); and Papua New Guinea Office of the Public Solicitor (from 2011)).

Other barriers to an Enabling Legal Environment for the National Response to HIV and AIDS

2. People living with HIV and key affected populations lack of awareness of their rights under the law. In IDLO and other needs assessment studies across the region a common theme has emerged - PLHIV and KAPs have limited awareness of their rights, little knowledge of the law and little understanding of how the laws work.
Response: IDLO has supported local partners to engage with positive communities and key affected populations, building awareness of rights and legal literacy.

Recommendation: Strengthen legal literacy of people living with HIV and affected communities. This should include specific information on local laws and policies, and where to access legal services, in addition to general human rights education.

3. Lack of sensitivity, and awareness of the law relating to HIV, on the part of lawyers. Lawyers with little sensitivity to the lives and experiences of clients from positive communities or key affected populations are a substantial barrier to legal services. PLHIV and KAPs in Asia Pacific region have reported negative experiences with lawyers. Individuals were treated in a judgmental manner, without sensitivity or respect, which deters people from seeking legal advice and representation.

Response: IDLO has supported local partners to implement seminars for lawyers on HIV and the law, building sensitivity and practical skills on managing clients from positive and KAP communities.

Recommendation: Capacity building for legal service providers (lawyers and paralegals) must include sensitization to the issues faced by PLHIV and KAPs and the impact of the law upon these groups, as well as the law applicable in a given context.

4. Limited legal resources: Community and government legal aid services in Asia Pacific are often stretched beyond capacity under their regular workload. This creates long waiting periods for all clients, including PLHIV and KAPs.

Response: IDLO has provided technical and financial support to legal service providers to enable them to engage additional lawyers and take on HIV-related matters.

Recommendation: Provide financial and technical support to suitable community legal aid centres and government legal aid bodies or community organizations with the capacity to develop in-house legal services.

5. Abuse of powers by police: Police misuse of powers has a critical impact on the response to HIV.

Key issues reported by IDLO partner organizations include: unlawful arrest, physical and sexual assault, verbal abuse, bribery, refusal to grant lawful rights and entitlements in detention, and refusal to support access to anti-retroviral medication in detention.

Recommendation: Build police capacity to respect the rights of PLHIV and KAPs through training and the implementation of codes of practice and guidelines on issues such as harm reduction through condom distribution to sex workers and men who have sex with men, and needle and syringe exchange programs. Support programs to strengthen enforcement of the law and codes of practice within the police force. Educate communities on their rights on arrest and in detention, and provide practical tips on how to deal with the police and other justice sector authorities.

6. Police arrest quotas: In some Asia-Pacific countries, police are required to meet formal or informal weekly arrest quotas, which results in the unlawful arrest of key affected populations and interference with harm reduction programs (such as methadone maintenance programs).

Recommendation: The negative impact of such practices should be documented and government bodies alerted.

7. Lack of confidentiality in legal proceedings: In many Asia-Pacific countries, court practices do not provide for mechanisms to protect the identity of litigants in cases where public exposure could result in harm and deter
legitimate legal action by people living with HIV and members of key populations. This represents a considerable disincentive to legal action to redress rights violations.

Recommendation: Document and share good practices and change court procedure to permit closed hearings and orders to protect confidentiality in such circumstances.

Examples of legal issues identified in specific countries in Asia Pacific region

China: IDLO local partner: Yunnan University Legal Aid Centre (LAC) in Kunming, Yunnan Province.

- IDU clients report obstacles posed by state bureaucracy and services. State-issued identification is required in order to apply for Methadone Maintenance Treatment (MMT). When identification documents are lost, individuals must go through a re-application process which generally incorporates drug testing – this in turn may have repercussions for bail terms and compulsory detoxification sentences. The LAC helps clients obtain identification documents and hence avoid arrest and detention.

Indonesia: IDLO local partner: Lembaga Bantuan Hukum Masayarakat (LBHM - the Community Legal Aid Institute) in Jakarta.

- IDUs report being framed by the police (drugs placed on the individuals’ motorbike or person) and unlawful arrest.
- PLHIV report discrimination in health care, education and employment settings. The national Human Rights Act defines discrimination broadly, arguably broadly enough to cover PLHIV, but this has not been tested.
- Transgenders report not being able to rely on the police to enforce their rights if they are physically or sexually assaulted. Transgenders report being openly ridiculed, shamed or assaulted by the police.
- LBHM uses a community legal empowerment model to support PLHIV and KAPs to understand the law and obtain justice through their own actions.


- Legal aid programs are mostly centered in the capital and the needy key populations are out of service access.
- Key populations and communities are not aware of their rights.
- People living with HIV report eviction by their own relatives and guardians, violating property and inheritance rights.
- Violation of the right to education for children living with HIV, including expulsion from school.
- Denial of health care services, the right at work, access to insurance due to HIV status.
- Capacity building on appropriate intellectual property law reform to ensure continuing access to medicines requested by government and civil society stakeholders.


- Women are particularly vulnerable to domestic violence and sexual assault, placing them at increased risk of HIV. A combination of cultural norms, limited resources and weak rule of law mean that matters involving violence against women are often resolved outside the formal legal system, usually to the disadvantage of women.
- PLHIV report HIV screening in the employment process, although the HAMP Act (noted above) prohibits testing without consent and HIV screening in the employment process.
- PLHIV report widespread breaches of confidentiality in health care and employment settings. HIV
test results are commonly delivered in public situations or to a related or unrelated person (again, contrary to the HAMP Act).

- The HAMP Act specifically criminalizes transmission of HIV, which opens up the possibility of misuse of the Act. Cases have been initiated under this provision, but none have proceeded to judgment, to date.
- Sex work, and sex between adult males in private, are criminalized under PNG law. This makes HIV prevention education more difficult because these populations are less accessible.

Annex:

Ten Reasons Why Legal Services Must be Central to a Rights-based Response to HIV http://www.idlo.int/Publications/10reasonsWhyHIV.pdf

Further information about HIV-related Legal Services in Asia Pacific


3. Mapping Initiatives to Strengthen the Legal Response to HIV in China (Peking University, China Academy of Social Science, UNAIDS, IDLO, 2010) (also available in Chinese) http://www.idlo.int/english/WhatWeDo/Programs/Health/Pages/Details.aspx?ItemsID=231


Because informing people of their rights, while failing to provide ways to realize them, can be counterproductive and increase the burden on affected communities.

Many programs include human rights education for people living with HIV and key populations. We also need to offer concrete, practical and affordable ways to address the human rights abuses faced by people living with and vulnerable to HIV.

Because law reform is a long-term goal, while legal services can improve peoples’ lives right now.

Even in a hostile legal environment, lawyers can get better results for clients than if they are left to deal with employers, landlords, health authorities, and the justice sector on their own. Lawyers can intervene with police and other public authorities to achieve changes in the ways laws are implemented, such as guidelines on the discretion to prosecute.

Because taking legal action empowers individuals by affirming their right to recognition everywhere as a person before the law.

Whatever the outcome, legal support empowers individuals and groups to understand the legal context in which
they live. Legal empowerment approaches also affirm dignity and self-esteem, which have other positive health and social benefits.

Because lawyers and paralegals can use a range of legal and non-legal tools to solve problems, including working with traditional legal systems and community leaders.

Formal justice systems can be slow, expensive and unpredictable. Lawyers and paralegals can use alternative dispute resolution mechanisms and support recourse to traditional legal structures such as community leaders.

Because legal action requires all parties to state their case in an open, structured forum.

Many issues such as discrimination in employment and health care are complex. Employers (e.g. restaurants, airlines) complain about customer preference and safety. Medical personnel complain they lack basic resources such as latex glove and sterilization equipment to prevent workplace infection. Legal action permits an open examination of these claims, and can allow for public policy and public health evidence as well.

Because legal services can also provide data on complaints and outcomes which can improve law and policy reforms.

Law and policy reform must be based on local realities as well as international law and best practice. Legal services can collect data on complaints and outcomes and provide these to policy makers, thus assisting the reform process.

Because engaging the legal profession and the courts in resolving HIV-related issues and disputes strengthens the rule of law and good governance more generally.

In contexts where the rule of law is weak, public protest may be the only way to bring crucial issues to the attention of governments. Strengthening the ability of the legal profession and the courts to deliver sound decisions on HIV related issues also contributes to social harmony.

Because legal services can be delivered in multiple ways, including by engaging law students, peer counselors, and by using paralegals and other community educators for referral.

The Toolkit: Scaling up HIV-related Legal Services (IDLO, UNAIDS, UNDP, 2009) identifies eight ways in which HIV-related legal services are delivered in different countries and contexts. Working with law students, in particular, builds the capacity of future lawyers and community leaders to address HIV from a rights-based approach.

Because the integration of HIV-related legal issues into existing access to justice and legal aid programs mainstreams the response to HIV for long term sustainability.

Although HIV-specific legal clinics may be appropriate in some contexts, scale up can often be achieved through integration of HIV concerns into mainstream legal aid programs.

Because legal challenges combined with social mobilization can achieve policy reform and educate communities in ways which can have a huge impact nationally, and even globally.

The revolution in drug pricing for developing countries over the last decade was largely driven by strategic litigation in South Africa. Not only have prices for anti-retroviral therapies dropped, but pricing for medications for other diseases of public health significance in developing countries is now under examination. This is a huge contribution to global health and development.
Problems in implementing harm reduction program in Nepal and initiatives taken to overcome

I am a 32 year ex drug user background person living in Nepal. I have been involved in an organization, Naya Goreto which is continuously advocating to create an enabling environment for People who use drugs/PLWHA and harm reduction policy with different stakeholders for securing the rights of marginalized and deprived groups. It has been 11 years since I have left using drugs. Like other people in Nepal, I have also experienced bitter realities in my life during the period of extensive drug use. As in other countries it is illegal to use drug in Nepal as well. There are laws and policies made for securing the rights of the drug users in Nepal as well. But, the prevailing laws and policies in Nepal are not adequate and do not address the real problems of the drug users. Till now drug users are misbehaved by the government and treated as a criminal by the police administration as well as every communities of the country. when The police personnel finds or see any drug user without reason they gives them mentally and physical harass. This activity has also resulted in deaths of some of the drug users in Nepal. Likewise, during my drug using period I have also been mistreated as a criminal many times. Luckily I have been able to release from being criminalized. But if there were proper law and policies regarding drug use then the behavior of the police administration and community would have been different and friendly towards the drug users. And they will be treated as a patient instead of criminal.

This activity is also leading a drug user to use drugs in a small groups escaping from the police personnel since they are treated like criminals if found using. So this is resulting in sharing of needles among the peers using drugs and has resulted in the incidence of infecting HIV to the circle. Drug users not only infect their sharing partners but unfortunately it is their family members and spouses and sex partners who are transmitted blood borne diseases and HIV unknowingly. These are all because of the consequences of inadequate and improper laws and policies on drug use. If there were proper policies on drug use, the drug users would not be treated as a criminal. The harm reduction principles and policies needs to be accepted from the state level in order to prevent them from blood borne diseases and HIV.

In Nepal it is known that the HIV is treated like a mental health problem. Even the constitution of the country has addressed it as a mental health issue. But in reality it is not a mental health problem. The feelings, pains and the sorrows of the drug users are not taken care by the state and in turn it is creating several problems to them. Since, drug use have been stated as a disease by the World Health Organization (WHO) in 1935, there is a need to treat drug issues from public health approach. The public health approach treats other diseases properly and provides services free of cost. But the drug use problems have not been able to incorporate in the public health approach in Nepal mainly because of the weak laws and policies on it. If the drug use problem are addressed by the constitution then this problem is solved as public health issue securing the right of the drug users.

In the process of continuously provoking the need of proper harm reduction policies and incorporating drug use issue in the public health approach Naya Goreto has conducted several advocacy programs with different stakeholders from it’s establishment. Naya Goreto has worked for securing the rights of the marginalized and deprived groups of the country through drug use. Likewise, the constituent assembly election in Nepal in 2007 provided an opportunity to amend the constitution of the country. It provided opportunities for incorporating the drug issues in the public health approach and formulate proper harm reduction laws and principles in the country.

As the continuation of the effort, Naya Goreto in the financial support of UNESCO/ Deustcher Ordien International (DOI) and in technical partnership with The Mainline Foundation initiated a project “Advocacy for balanced policy and strategy development in Nepal to incorporate harm reduction principles and policies” with the Constituent Assembly members in January 2010.
The projected target of the project was to train 60 constituent assembly members on harm reduction issues so that they could play a role as peer educator to other members. As a result of this vigorous peer education NG was able to achieve more than 170 parliamentarians during the programs. Furthermore, NG has accomplished both programs successfully even in unstable political situation of country.

Major objectives of the project:
- To address the Harm Reduction program as a public health approach in the upcoming constitution,
- To address the drug use problem as a health issue rather than crime or any mental problems,
- To motivate the CA members for making and amending laws and policies in creating an enabling environment for the people who use drugs,
- To support legislative committees for formulating national policies and strategies based on harm reduction principles,
- To create a drug user friendly environment by creating employment opportunities through the amended constitution and its policies

The project was accomplished with the following key activities:

A preliminary consultation meetings with the key CA members was performed for planning and designing the future programs.

Naya Goreto through 3 trainings trained 70 Constituent Assembly members on the prospects of harm reduction program and drug use issues with the expectations that proper harm reduction principles and policies are developed and formulated through the constitution.

Naya Goreto conducted two Advocacy workshop meetings with more than 170 Constituent Assembly members and other delegates from different institutions on “Influencing policy and strategy to incorporate harm reduction principles.” International persons having long experience on harm reduction issues and international laws on harm reduction and drug use. Ms. Tripti Tandon, from Lawyers collective India, Mr. Tarik Zafar representing Nai Zindagi as well as Mr. Patrick O’ Gorman played a key role in delivering message on the need of harm reduction policies. They also shared the negative consequences they had in absence of the harm reduction principles and motivated them to formulate laws and policies regarding harm reduction.

Each of the CA member represented in the workshops signed in a flex with a title “People who use drug should not be criminalized rather they should have universal access to treatment” and “Incorporate drug use in public health to secure human rights”. This campaigning was done for making them commit in putting up efforts for securing the rights of the drug users and PLWHA through constitution.

Naya Goreto in the collaboration with The Mainline Foundation and Youth Vision developed a documentary named “Tea is hot, Life is short, Forget me not” focusing on the issues of drug rehabilitation and detoxification. The documentary was mainly prepared for disseminating information to the parliamentarians that the drug users could also be an active force of the economy when they are shown positive ways and inspirations. As a result of it, the documentary was released during the first program as an inauguration ceremony from the chief guest. Thus this documentary was developed impart knowledge on harm reduction program as well as exemplify the drug users as a part of the development of society.

The major outcomes of the program were:
- CA members got opportunity to know about the harm reduction issues
- CA members were aware on the situation of the drug use in the country and the effects of the drug use in the development of the country
- The program made clear on the attempts that needs to be taken in order to prevent the young
people from using drugs in their lives
- The program helped the CA members to realize the need of proper harm reduction principles and policies in the country
- CA members were dedicated to lobby the issues of harm reduction with their colleagues

Conclusion:

Nepal though being one of the leading countries in south Asia in implementing harm reduction program desired output has not been achieved. Drug use in Nepal is still considered as a crime even though it has been declared as a disease by WHO in 1935. There are no specific laws and policies in Nepal where the drug use issues are addressed and fundamental human rights are secured. Since Nepal is re-drafting it’s constitution, it has provided an unique opportunity for the civil societies and human rights based organizations to raise a voice for including these issues in the constitution. Through the implementation of this project it was anticipated that a favorable policy and law regarding Harm Reduction and Human rights is developed and implemented and mentioned in the constitution.

68 Australia

National Association of People Living with HIV/AIDS (NAPWA)

About NAPWA

The National Association of People Living with HIV/AIDS (NAPWA) is the peak national organisation providing advocacy, policy, education and outreach for people living with HIV in Australia. NAPWA membership includes PLHIV organisations in each state and territory and the following affiliate members: Positive Heterosexuals (NSW); Positive Women (Victoria); Straight Arrows (Victoria); and the Positive Aboriginal and Torres Strait Islander Network (PATSN). NAPWA works across a range of health care and HIV-positive education initiatives to promote the highest quality standards of care and to encourage appropriate clinical and social research into the prevention and treatment of HIV.

Background

This submission confines itself to the issue of the criminalisation of HIV exposure and transmission and the management of persons with HIV who place others at risk of infection.

In the early years of the epidemic, the Australian response to HIV was characterised by a progressive law reform agenda that aimed to support a public health response to the virus. This response prioritised education and the engagement of affected communities over punitive legal sanctions. The legislative framework included anti-discrimination legislation that protects people living with HIV and the decriminalisation of homosexuality in the jurisdictions where such laws existed.

Public Health Laws

Various public health laws have been enacted across Australian states and territories. A set of National Guidelines for the Management of People with HIV Who Place Others at Risk were endorsed by the Australian Health Ministers’ Conference in 2008.1 These guidelines are intended to promote national consistency and to provide a comprehensive alternative to the use of criminal sanctions for the control of PLHIV who place others at risk.

The guidelines are based on the principles that:

- The human rights of PLHIV should be respected.
- There is an equal responsibility for HIV prevention among all people regardless of HIV status.
- When dealing with PLHIV who risk infecting others, a graduated scale of interventions should be used that begins with education and counselling and only employs more interventionist strategies if these have been demonstrated to be ineffective.
- At the end of this scale of interventions there is a capacity, through the public health act, to detain involuntarily and refer cases to police where there is behaviour that recklessly or negligently endangers or causes serious harm.

The guidelines are intended to shape public health law, which is a state responsibility. They recommend a five-tiered approach to management.

1. Counselling, education and support – usually by the client’s primary health care provider, with the assistance of specialist HIV case workers, as appropriate.

2. Counselling, education and support under advice from the HIV Advisory Panel or the Chief Health Officer or equivalent - management in the community under recommendations from the Chief Health Officer or equivalent and/or the HIV Advisory Panel but without a Behavioural Order. The HIV Advisory Panel is a panel of public health, clinical and community-based HIV experts.

3. Management under a behavioural order

4. Detention and/or Isolation

5. Referral to police - under the Crimes Act or other relevant act.

These guidelines recognise that in most cases there are various reasons to eschew criminal sanction and use alternative forms of management.

**Problems with the criminalisation of HIV exposure or transmission**

*Criminalisation of HIV exposure or transmission undermines prevention efforts.* It creates fear and distrust among PLHIV and those at risk of HIV. It discourages PLHIV from disclosing their status to sexual partners and those at risk from seeking testing. It may discourage PLHIV from engaging with clinical care if they fear their status will not remain confidential or their behaviour will be scrutinised unreasonably.

*Criminalisation of HIV exposure or transmission promotes the stigmatisation of PLHIV.* It reinforces the stereotype that people with HIV are immoral and dangerous and that people without HIV are their potential victims.

*Laws that criminalise HIV exposure or transmission often impact selectively and unfairly on the most socially marginal.* This includes immigrants, refugees, foreigners, sex workers, MSM and transgender people. A disproportionate number of prosecutions in Australia have targeted male immigrants from sub-Saharan Africa.

*Criminal law is not adept at taking into account the subtle gradations of HIV risk or the changing implications of an HIV diagnosis.* In some jurisdictions, use of a condom is not a defence against a charge of exposure. In the current era of effective antiretroviral treatment, a person with HIV whose virus is effectively controlled with treatments is much less infectious than someone not receiving treatment, and arguably someone who does not know they are infected. Even the risk among MSM varies considerably, depending on viral load and the particular sex act involved.

When prosecutions do occur they often rely on laws relating to grievous bodily harm, assault or even attempted manslaughter. The use of such laws does not take into account the significant advances in the treatment of HIV over the past 15 years. HIV is no longer regarded as a fatal infection but one that is chronic and treatable.
People living with HIV in the developed world can now expect similar life spans as the general population.6

Criminal prosecutions for HIV exposure or transmission in Australia

Despite comprehensive public health measures for the management of PLHIV who place others at risk, criminal law is still used in circumstances where it is unwarranted or of little benefit. Criminal law is a matter for the states and territories in Australia and laws vary considerably across the country. The only jurisdiction with an HIV specific law is Victoria. This contravenes the recommendations of the International Guidelines on HIV/AIDS and Human Rights.7 Three jurisdictions, Victoria, South Australia and the Northern Territory, can criminalise exposure to HIV even when no transmission has occurred. All other jurisdictions criminalise transmission of a ‘serious disease’ (or similar).8

Since the first charge of HIV transmission/exposure in 1992, there have been at least 22 criminal prosecutions in Australia. There has been a trend toward increasing numbers of prosecutions in recent years and a disproportionate number of these have occurred in Victoria (the jurisdiction with HIV specific laws).9 All prosecutions have been of men and the victims have been a mix of men and 3 women. A disproportionate number of men from sub-Saharan Africa have been targets of prosecution. This trend is of considerable concern and seems to be occurring independently of the workings of the public health mechanisms detailed above. This raises the question of what is needed to strengthen the public health approach further and decrease reliance on criminal law.

A number of strategies are worth exploring. These include:

- Education of police and prosecutors of the existence and workings of the public health mechanisms for managing PLHIV who place others at risk of infection.
- Law reform that includes the removal of all HIV-specific laws that criminalise transmission, exposure or failure to disclose status.
- Inclusion of the use of condoms or other risk reduction strategies as a possible defence in a criminal case.
- Education of prosecutors about the relatively low risk of various activities that do not warrant prosecution.
- Education of the legal sector more broadly about the negative public health impact of criminal prosecutions of HIV transmission and/or exposure.

Conclusion

Australia has taken an effective and progressive path in devising a public health mechanism for the management of PLHIV who place others at risk of transmission. There is nonetheless room for improvement in the use of those laws in preference to the criminal law. There is further work to be done to repeal HIV specific transmission/exposure laws and to educate the legal sector about the public health alternatives. It is also worth acknowledging the stigmatising effects of HIV criminal prosecutions on all people living with HIV. These cases create fear and thus impact on the well being of PLHIV and prevention efforts as people with HIV are less likely to disclose their status to sexual partners and less likely to actively and openly engage with clinical care.10


9 Cameron and Rule. op. cit. pp.21-22


69 India Individual

**Law enforcement agencies as Agents of Change in India**

Through this submission, I would like to share experiences from Asansol and Kolkata in West Bengal. The experiences are related to two interventions among sex workers and injecting drug users who are not only criminalised, but also socially marginalised groups.

**DISHA Jana Kalyan Kendra (DISHA)**

Asansol in Burdwan district of West Bengal is a mining and industrial hub. I was designated as Additional Superintendent of Police in Asansol between 1994 and 1996. Continuous police raids in the area to apprehend criminals from the red light area attracted my attention to some of the ground realities. Asansol underworld was controlled by pimps called *bherus* and was dominated by local mafia. Thus, a high incidence of violence prevailed with exploitation of sex workers by *bheruia*ns, quacks, and other individuals in the name of politics, administration and crime.

The idea for the project came about when a local doctor came to the police with a request for an arms license. Apart from exploitation, we had realized that most sex workers did not have access to any medical facility. Thus, we initiated the DISHA Jana Kalyan Kendra (DISHA) in this red light area. A group of people including epidemiologists, doctors, social workers and members of the community joined hands with the police to get the project started.

The nexus between crime and sex work was a starting point in planning the intervention. Nevertheless, DISHA evolved into an organisation working for the holistic development and welfare of sex workers. Over the last 15 years, DISHA did face some challenges. However, with the support of the community, it is still able to continue its work. Some of the salient features of DISHA’s work are:

- It was not meant to be a reformist programme but an enabling and empowering one so that sex workers could live with dignity.

- The first interventions in the area included setting up of a bank and a health clinic, which contributed immensely as confidence gaining measures.
- The police took care not to enter the red light area after dark. This sensitivity to their needs and realities helped the sex workers to come forward and reach out to the initiatives offered to them.

- The police presence was gradually seen as a blessing by the sex workers; it gave them protection from exploitation by pimps, agents and difficult clients.

- The project was conceived as a holistic welfare project focusing on the quality of life of the sex workers instead of concentrating on HIV alone. It also fulfilled the education and vocational training needs of children of sex workers.

- The Additional Superintendent of Police in Asansol is the ex-officio President and the Deputy Superintendent and Officer in Charge of the local Police Station are ex-officio key functionaries of the organisation. There is a feeling of continuity to it and all police officers in the Asansol area are directly or indirectly connected to it.

- The community members are actively working as staff in the projects; this gives a powerful and realistic dimension to the interventions.

For more details about DISHA, please visit [www.dishajanakalyankendra.org](http://www.dishajanakalyankendra.org)

**Society for Community Intervention and Research (SCIR)**

On similar lines, the Society for Community Intervention and Research (SCIR) was started in Kolkata. Here too police officers, researchers, doctors, and community members came forward to join hands. There was high incidence of drug usage among the poorer sections of the community and these drug users were involved in crime – mostly petty crime – to sustain their addiction. The Police had tried conventional ways to address the problem, with limited success.

SCIR was established in 1996 to serve different target groups - substance users especially injecting drug users, prisoners, and people living with HIV. Currently, it implements the largest intervention for injecting drug users in West Bengal and reaches more than 2500 substance users and their families. It specializes in harm reduction with a focus on needle exchange, oral substitution therapy (OST) as well as care and support, with a focus on income generation and self employment.

For more details about SCIR, please visit [www.scir.in](http://www.scir.in)

**Lessons Learned**

In both projects, as a result of the interventions, the target beneficiaries have a deeper understanding of the multifaceted issues they face, what they need to do to overcome them and the value of working together with law enforcement agencies. In short this has reduced vulnerability and strengthened health seeking behavior. More specifically, the interventions have increased the level of awareness on Sexually Transmitted Infections, HIV, Hepatitis B, Hepatitis C and its prevention. In addition, awareness about safer injecting practices, prevention of abscesses, importance of family, and community support, and health seeking behaviour have improved.

Apart from the health benefits, evidence also indicates several other benefits like improvement of banking habits, and reduction in violence against women. At a time when the Health Department was unable to make any inroads in the red light area to campaign against HIV in the late 1990s the DISHA model came very handy and they started supporting the project.

Both projects are at a point in their history where lessons have been learned. More specifically, the work
suggests that:

1. Law enforcement agencies can make an effective contribution to HIV prevention, care and treatment: Both projects were initiated with the vision of the police, who brought their administrative strength and mobilisation to the creation, expansion and visibility to the projects.

- **Police—bringing legitimacy and credibility**: In both projects, the police through their position as law enforcers have been able to harness other networks and institutions to the project.

- **Police—from punishers to protectors**: Drug users and sex workers would normally avoid and fear the police. While this was the case originally, now they see police as protecting their rights.

- **Police—seeing sex workers and drug users with new eyes**: The police who have been involved in the projects have stepped outside their ‘law and order’ role and responded to the challenge in a proactive way. They now see their work as more than ‘maintaining law and order’ and contributing positively to society.

- **Police—as change agents**: Both projects demonstrate police as agents of change. While they are keepers of law and order, they are witness to change and more than that have been the harbingers of change. This gives them an enormous sense of personal and professional achievement.

2. Investing in rehabilitated individual’s works: Both projects have focused on investing in people they have helped rehabilitate – be ensuring training, counselling, job security, and providing an environment of trust and compassion. Some of the earlier beneficiaries are now counsellors, peer educators, and administrators of the projects.

3. People respond well to affection, patience and concern: In both projects there has been a view that compassion, love and humanity is of greater value than punishment and incarceration. This has helped the targeted population see themselves as people who matter, and led to building their self esteem and sense of confidence.

4. Networking enhances results and sustainability: From the beginning of the projects, many stakeholders have been involved – police, local community including schools, health services, business people, medical professionals, politicians, and sports personalities. Moreover, national, state and local mechanisms like the National AIDS Control Organization (NACO), State AIDS Prevention and Control Society, as well as national and state networks working on rights of sex workers, self help groups, and banks. Both these projects are implementing the targeted interventions programme under the West Bengal SACPS and NACO.

5. Responding to Needs, in a holistic way: The project creators and managers have been able to respond to the needs of the community – provision of schools, toilets, safe water, electricity, healthcare, livelihoods training and opportunities – seeing these as essential to not just the means but the ends of the project.

These projects focus on HIV prevention and have created a safe environment for delivery of basic HIV prevention services for IDUs and sex workers. What started 15 years back in West Bengal and is growing everyday strengthens the thesis that an alliance between vulnerable communities and police is possible and can be an effective partnership in protecting human rights and creating an enabling environment.

**Next steps:**
Fiscal sustainability is essential for which the management and staff need more professional training in project planning, implementation, documentation and monitoring and evaluation. For both the sex workers and injecting drug users, rehabilitation and income generation is essential. This requires alliances with job training programmes and industries where they could find employment.
From the interventions described here, it is evident that there is added value in having innovative partnerships – between civil society organisations, law enforcement agencies, and advocacy groups. At the behest of UNAIDS and NACO, the Ministry of Home Affairs has sent a Government order to all State Director Generals of Police to designate Officers-in-Charge for NGO Coordination, at State and District level. These officers can support NGOs and create an enabling environment for delivery of HIV prevention services.

The issue of transgenderism\(^1\) poses particular challenges both conceptually and for practice. While the HIV and AIDS epidemic has brought focus to the sexual minority community in a general sense – it is largely focused on what is termed as the MSM population. Even when transgenders as a group have also found a place in the debate, it is still largely limited to their sexual interactions and issues related to the prevention of the spread of HIV. Now the limitation of the discourse is beginning to be recognized and the idea of exploring transgenderism as an identity, as a way of being etc is gaining currency, especially in the context of vulnerabilities relating to HIV transmission.

The Hijra community in India has traditionally been involved in visiting homes on auspicious occasions like weddings and child birth; however a large percentage of the Hijra community in Mumbai and elsewhere in the country have been part of the sex trade. The existing scenario is that the mainstream society in India does not accept Hijras, who are often, objects of ridicule, mockery and exploitation. The social and cultural practice of exploitation with discrimination coupled with poverty, illiteracy and limited opportunities of employment have forced the community onto a path of high-risk behaviour. The combination of high-risk behaviour with limited prevention alternatives has resulted in increased vulnerability of Hijras to HIV and STI.

The Population of Transgender is quite significant in India. When Hijra is a common phrase and faces of traditional transgender communities, emerging new identities and definitions of gender variant males and gender queer people are also popularized in urban social and political discourse. Every day, people who live at variance to expected gender norms face violence, abuse, rape, torture and hate crime all over the world, in their home as well as in the public arena. Though most cases of violence were never get documented properly. The basic human rights of Trans people are being ignored or denied in all nations – be it out of ignorance, prejudice, fear or hate and Trans people face daily discrimination, which results in social exclusion, poverty, poor health care and little prospects of appropriate employment. Far from protecting Trans citizens, States and International bodies reinforce social transphobia through short sighted negligence or reactionary politics.

Because of the failure of national law and social justice, in far too many States Trans people are being forced to live a gender which they experience as fundamentally wrong for them. Contributing factors include that current International health classifications still consider all Trans people as mentally “disordered”. This outdated vision is insulting and incorrect and is used to justify daily discrimination and stigmatization in all aspects of Trans people’s lives. Recently though in some countries in the region and one of the prominent south Indian State – Tamilnadu, with very different social and cultural contexts significant legal advances have been made. Following in the wake of bold judicial decisions, State action has led to increased acceptance of Trans people within society. This demonstrates that understanding and progress is possible. Later few more states in India took bold and innovative strategies to protect and socially included the transgender population with coming up various scheme such as elderly pension scheme, free legal aid etc but due to the proper understanding and clear objectives its restricted it only Hijra population and also in particular those who know these benefits. Most of the government staff is unaware of these policies and the community face ridiculed.

In National AIDS control Project phase three (NACP III), Hijra and transgender constitutes a core group vulnerable to HIV/AIDS. Along with male sex worker Hijra and transgender are also at substantial risk for
acquiring HIV. Transgender and Hijras in India have high HIV prevalence (>20%) and are prioritized by the National AIDS Control Organization (NACO), India, for HIV preventive interventions. In 2002-03 a study was conducted in Mumbai, India indicate HIV prevalence among transgender (Hijra) sex worker were 56% (n = 163). In 2005, the prevalence rate among the same population was come down to 40%. In 2003, in Chennai city a similar study was conducted among 1200 Transgender population revealed 45% prevalence rate. It was some how clear that the social hierarchy and community norms among Hijra communities influence HIV prevention behaviours among Hijras. All though Hijra community norms and social hierarchy have both positive and negative influences on HIV risk behaviours among Hijras. In entire East and Northern India Sexual silence in certain Gharanas make the situation worst. Hijras from certain Gharanas are not supposed to have sex as they are dedicated to the Goddess. Gurus from that Gharana may not approve of distributing condoms to them. Thus, the respect accorded to Gurus; not in a position to challenge Guru’s beliefs or activities (since one could be punished for it – ‘Dund’); and the religious beliefs – all pose challenges to talk about safer sex and HIV/STI among certain sections of the communities. It’s desirable, interventions should promote positive community norms, such as consistent condom use and uptake of HIV testing; break the silence about sex/condoms in some Gharanas; and provide education to reduce stigma/discrimination against HIV-positive Hijras and Trans people. In light of this situation, it becomes necessary to critically evaluate the existing situation of the transgender population in India and produce a strategy that can counter the stigma at the social and political levels and reduce the vulnerability to HIV/AIDS.

India UNGASS 2010 report estimates that there are 3.1 million MSM for India Currently there are no national estimates of the either the enumeration or prevalence of HIV among transgender populations due to lack of data collection on transgender populations at the national level. Anecdotal guestimates peg the transgender populace between .5 – 1 million in India. Recent national and regional consultations in India have highlighted the need to address TG – Hijra populations, some of the community recommendations with regard to NACO and NACP 3 are as follows

To halt and reverse the epidemic, which is the overarching objective of NACP-III, among transgenders and Hijras, there must be comprehensive programme strategies and action instead of fragmented projects with insular outlooks and limited impact. The National AIDS Control Programme (NACO) at the national level and the State AIDS Control Societies (SACS) at the decentralized level must lead a process to move from project to programme operations. In this paradigm, where partnerships are instrumental, aligning of responsibilities and actions of government, community and donors’ efforts is important.

It must be noted here, that people with ‘different’ sexual, gender and cultural identities and lifestyles are often, due to lack of understanding and/or convenience, clubbed together under the term “MSM.” It must be clarified that ‘men having sex with men’ signifies sexual behaviour and not identity. In addition, the culturally distinguishable Hijras have made a strong appeal during the regional consultations to be treated and respected as a unique community. Thus, separate targeted interventions for Hijras are recommended instead of being clubbed with interventions for and with MSM.

Guiding Principles

NACP III “Guiding principles include the Three Ones, equity, legal, ethical and human rights, PLHA and civil

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1 Trans HIV Prevalence (Mumbai, India) (2002-2003, n = 163 TW): 56%

2 Mumbai India(2005? n = 205 TWSW & non-SW): 40%

In order to most effectively scale up Hijras and TG interventions, the community representatives felt that certain values and principles should be followed by all persons and organizations involved in planning, managing, and implementing those interventions. Some of the guiding principles are as follows:

- In any environment, when resource investments are made, all local community groups should be consulted and consensus built. This will ensure that external investment does not divide the community and challenge the very basis of them coming together;
- Community ownership: reviews, assessments, monitoring and evaluation of programs implemented by community groups and community organizations in conjunction with NGOs or by themselves should include people from such communities as part of the team.
- Programmes should be built on evidence, and where clear evidence does not exist efforts should be supported to gather such evidence.

The general and overarching recommendations given below provide more specific details for action in the third phase of the National AIDS Control Programme (NACP-III) for improving universal access to HIV prevention, care, support and treatment for Transgenders and Hijras through enhanced community mobilization and engagement with a central role for CBOs in the Programme.

These recommendations are meant not just for NACO and its decentralised structures, but for all other key stakeholders such as NGOs, CBOs, Donors, INGOs, Researchers and Technical Institutions. Our submission to restricted towards NATIONAL AIDS CONTROL ORGANISATION is primerly in federal situation this is the only agency make us visible but in there gender policy the inclusion of Transgender is not in place. The Agency does not recognize the various transgender faces and structural vulnerability and trans supportive law and legislation. But this is the only agency for us to penetrate our cause and our issue to the federal government.

NACO is instrumental for changing the same sex decriminalization process but that law is not implicitly changing the violence and discrimination against Trans population in the country. NACO should speed up efforts to stamp out transphobia and ensure that transgender persons are no longer discriminated against in any field. For this, they should share examples of best practice and engage in educational campaigns promoting respect and mutual understanding. The information deficit on the specific problems of transgender people and the bullying and ridiculing they are subject to also need to be addressed.

### Drug Treatment and the Law – ANPUD position on CCDU

The Asian Network of People who Use Drugs (ANPUD) views drug dependence as a chronic relapsing health condition that needs long term treatment. We believe that treatment for drug dependence should be offered on a voluntary basis, comprehensive, informed by evidence and respectful of human rights. The responsibility for treatment and rehabilitation of drug dependence should lie with Health Ministries. Law enforcement agencies, which are administered by criminal law, should focus on supply reduction activities.

ANPUD is cognizant and aware of the growing number of compulsory drug detention centres in East and South East Asia where people who use drugs are forcibly detained for long periods of time. In the guise of Drug Treatment, these centres violate basic human rights and personal freedom, and people who use drugs are subjected to torture, poor living conditions, forced HIV testing and forced labour.
ANPUD denounces the forced detention of people who use drugs in such detention centres. We encourage and support any effort to completely abolish these drug detention centres. Until then, we strongly recommend that existing centres implement the full range of services that make up the comprehensive harm reduction package of services.

ANPUD urges all donors and the UN community to ensure check and ensure if their resources are not being used for the establishment, maintenance and operations of such centres. We recommend that those who are currently resourcing these centres immediately stop funding them and instead redirect the resources to evidence based community led responses.

ANPUD also urges international agencies responsible for health and drug dependence to immediately evaluate all detention centres in Asia and issue clear guidelines on the minimum standards of drug dependence treatment based on human rights and evidence.

By forcibly incarcerating people who use drugs in these centres the governments are contributing to the prevailing social stigma and discrimination experienced by people who use illicit drugs.

The vast majority of the world’s population use alcohol and tobacco which are legal drugs and are easily available everywhere while a small proportion use currently illegal drugs. We really need to reclassify different drugs on the basis of the harms they cause.

For example, WHO reported that the extent of psychoactive substance use worldwide was estimated at 2 billion alcohol users, 1.3 billion tobacco smokers and 185 million drug users in 2002 (UNDCP 2002). WHO reported the impact of drugs on the global burden of disease, and tobacco, alcohol and illicit drugs contributed together 12.4% of all deaths worldwide in the year 2000. Mortality (deaths) related to tobacco was 8.8%, alcohol 3.2% for alcohol, and 0.4% for all illicit drugs. It is clear that the vast majority of drug related deaths are related to alcohol and tobacco and yet these are ‘legal’ drugs. How have we come to this situation?

Drug dependence is defined as a chronic relapsing and remitting medical condition. People may need many episodes of treatment in order to overcome their dependence. But we have to acknowledge that some people will never be able to lead a drug free life and keep going through a circle of using drugs, abstinence and relapse. These people need to be managed, just as other chronic diseases such as diabetes or heart disease. Those who have diabetes need to take their medication every day. We don’t tell diabetics that you will get medications for one or six months and then you must stop. So why is it that we tend to impose limits and give low doses of medications such as methadone or buprenorphine when we treat people who use illegal drugs?

If you are forced to undergo treatment and you are not yet ready, the chances of relapse are high. People have to be ready for treatment and must want treatment. Putting people in prison or drug detention centres demoralizes the person, and they start to think there is something wrong with them. Telling people that they are bad, useless, or horrible or because they use drugs does not allow them to maintain their dignity and self respect. After spending so much time in drug treatment centres and prison drug users feel left behind. Friends and colleagues have all moved on in their lives, while drug users remain stuck in the cycle of drug dependence. What can drug users do when they get out of prison or treatment institutions?

Because of the stigma associated with illegal drugs, drug users have to hide the fact that they are using. They begin to lead double lives in which you have to lie to your family and others – no, I don’t use drugs! Because it is an illegal drug, you cannot go to the wine shop or cigarette shop and buy your drug just as alcohol and tobacco users do. Life revolves around a vicious cycle: get money for drugs, find the dealer, buy the drug and use it. This cycle is repeated every day, and often a few times a day. So drug users are very busy and do not have the time and space for other things. Once dependent, the person is only concerned about obtaining their drug and neglect to fulfill social or family obligations.
When people want to stop using drugs and enter treatment but relapse, they are condemned by society and family. It is not a simple matter of exerting will power or that you are a weak person. Over time, drugs such as heroin alter the brain and the body stops manufacturing the natural painkillers (endorphins) in our body which results in the body demanding the drug. We must not make people feel guilty or ashamed because of this medical condition. It is better to suggest that the person try some other forms of treatment such as MMT or buprenorphine maintenance.

In places where you can get methadone and the clinicians are understanding and supportive, something remarkable begins to happen. Once drug users get onto OST, they begin to stabilize their lives and make other life changes. They no longer are obsessed or have to worry about finding money to buy drugs or fear that the police will arrest them anymore as they are taking a legal drug. They now live in a safe environment and have more time for other aspects of their lives that was neglected for so long. They reengage with family and society and can tell people that they are undergoing treatment and no longer taking drugs. This makes a huge difference in the mental make up and impacts positively on drug users. Self esteem rises and they begin to perceive themselves as normal citizens. Methadone or buprenorphine are life saving medicines and should be made available wherever there is a need.

We should not make people feel ashamed to be on methadone. It is just another medicine and it is so much better than taking illegal heroin. Once one MMT you are on the same level like other members of society. OST helps people in a humane way and gives people who use drugs the opportunity to move on in their lives.

100 years ago many of the drugs that are illegal now were legal. The classification of drugs has had a severe impact on the people that are using illegal drugs. Many countries have tried to ban drugs. For example the US imposed prohibition of alcohol, but found that criminal syndicates took over, and began to supply locally brewed alcohol that caused much harm.

Prohibition didn’t stop the use of alcohol and soon this decision was reversed and alcohol was legalized again. Similarly, we need to reexamine our policies in our own contexts. In Asia, opium and cannabis have been the traditional drugs used for 100’s of years, and these were never considered a problem. Society imposed social control and we didn’t read or hear of a ‘drug menace’ or problem until opium and cannabis became illegal. But the unintended result was that more potent and harmful drugs such as heroin and ATS replaced opium and cannabis in the Asian region.

We have to change the way we are dealing with drugs because it affects us all- our brothers and sisters, parents, friends, children – everyone is affected.
We believe there is a new HIV crisis on the horizon, one that requires our collective resolve and even harder work to address. When Naz first started its work, an HIV-positive test result was often called a death sentence. Then there was treatment and while the quest for a cure continues, people living with HIV can lead long, healthy and productive lives with the help of anti-retroviral therapy.

The story of how we in India and indeed many in Asia, Africa and Latin America got treatment is well known. But given the current crisis, this story perhaps bears some repetition. In 2001, it was Indian generic companies that announced to the world that they could offer HIV treatment for as low as $350 per patient per year. This was a shocking announcement given that the best discount from Multinational Pharmaceutical Companies at the time was $10,000 per patient per year.

The announcement of Indian companies transformed the approach to the HIV epidemic. Suddenly the prospect of saving millions of lives became a reality. Governments around the world agreed to start providing life long treatment. And many developed countries agreed to start funding this effort. The Global Fund was set up. And then the French government’s own initiative, now expanded to include many other countries, UNITAID joined the fight to provide funding and treatment.

As UNITAID announced a few months ago, a new study has shown that over 80% of ARVs available in the developing world are procured from Indian generic companies. In 2008, Indian-produced generics accounted for 91% of paediatric ARV volume. This has been possible because in 2005, India in complying with its World Trade Organisation obligations under the TRIPS Agreement has balanced public interest with private rights. India’s patent law which is fully TRIPS compliant incorporates several health safeguards. With the help of these health safeguards, people living with HIV in India have been able to ensure that generic production of several HIV drugs including, nevirapine hemihydrate, a syrup form of an HIV medicine and useful in the treatment of children, continues.

But as the same UNITAID press release noted, this supply of generic ARVs is today in danger. And from an unexpected source - the European Commission. As you know the EU and India are currently negotiating a free trade agreement (FTA). It has been extremely disheartening for us to learn (directly through the negotiating texts of the FTA) that the EC is demanding from India intellectual property protection far in excess of India’s international commitments at the WTO. As the UNITAID press release notes, “The findings of this study raise grave concerns for us because UNITAID relies heavily on Indian generic manufacturers to supply quality-assured, patient-friendly, low cost AIDS medicines in over 50 countries,” said Jorge Bermudez, UNITAID Executive Secretary. “What we need today is a more flexible approach to scale up treatment and not the opposite.” [UNITAID, India’s central role in AIDS medicines supply could be threatened by trade agreements, new study says, 14 September 2010]

What has been even more disappointing is that the EC continues to be ambiguous about its demands from India. The EC continues to claim that the agreement will not impact access to medicines. The evidence is entirely to the contrary. Just one demand of the EC, for data exclusivity, has had disastrous effects in other countries where it has been introduced.
A study of medicine prices in Guatemala has shown price differences in the same therapeutic class ranging up to 845,000% because of data exclusivity. [Shaffer and Brenner, A Trade Agreement’s Impact on Access to Drugs, Health Affairs (web exclusive), 2009] A study on the impact of data exclusivity in Jordan found that of 103 medicines registered and launched since 2001 that currently have no patent protection in Jordan, at least 79 per cent have no competition from a generic equivalent as a consequence of data exclusivity. [All costs, no benefits: how TRIPS-plus intellectual property rules in the US-Jordan FTA affect access to medicines, Oxfam Briefing Paper, March 2007.]

The World Health Organisation has advised developing countries not to adopt data exclusivity. In fact, the WHO noted in a recent press report on the EU-India FTA that, “If data exclusivity clauses are indeed included that go beyond the patent period, then we have real public health and ethical concerns about this…First, it would delay the market entry of generics; and secondly if generic manufacturers are forced to repeat clinical trials, it is ethically unjust to conduct such trials on patients when the data are already available.” [EU deal threatens HIV drug supplies, Al Jazeera, 24 November 2010]

Even President Bill Clinton in his article on World AIDS Day has noted that among the barriers to access to treatment are “trade agreements that prevent generic manufacturers from supplying effective ARVs for the developing world…” [Bill Clinton, We need to save more lives – with less, The Independent, 1 December 2010]

We need strong leadership from the global community that is concerned about HIV against these demands of the European Commission. With the EC pursuing such agreements not only with India but several other developing countries, it is no wonder that Medecins Sans Frontieres, whose patients also rely on Indian generic medicines, has launched its campaign – Europe, Hands Off Our Medicine! Specifically, the European Commission must drop its demands for TRIPS-plus provisions in the FTA including:

1. DATA EXCLUSIVITY, as it will not permit the placing of affordable versions of pediatric doses and combinations of “off-patent” medicines on the market.

2. PATENT TERM EXTENSION, as it will extend patent life beyond 20 years.

3. INVESTMENT RULES, as it will enable foreign companies to take the Indian government to private arbitration over domestic health policies like measures to reduce prices of medicines.

4. BORDER MEASURES, as it will deny medicines to patients in other developing countries with custom officials seizing generic medicines in transit.

5. INJUNCTIONS, as it undermines the independence of the Indian judiciary to protect right to health of patients over corporate profits.

6. OTHER IP ENFORCEMENT MEASURES, as it puts third parties like treatment providers at risk of police actions and court cases.
I have been working on gender and children’s issues for the last ten years in the context of HIV/AIDS and STI (sexually transmitted infections). For the last four years, I am with the Naz Foundation (India) Trust, a Delhi based NGO working towards preventing the spread of HIV, MSM issues, advocacy, care and support. As a counsellor under the Home based care programme, I have been involved in providing care and support to families infected and affected by HIV. This involved psycho-social counselling, linking them with existing services – medical, educational, nutritional, livelihood opportunities and networking.

By the end of 2009, the estimated number of people living with HIV and AIDS was around 33.3 million and half of this infected population are women (UNAIDS report on global AIDS epidemic, 2010). In the initial phase of the epidemic, it was believed that HIV infection was more likely to affect sex workers, bridge population or men, but in the recent years the shift has been towards women in monogamous relationship.

A study by UNAIDS, UNIFEM and UNFPA, “Woman and HIV: Confronting the Crisis”, revealed that 98 percent of women living with HIV exist in developing countries. The reason behind this is woman’s social role and their biological vulnerability. Another reason that worsens the situation of woman is their negotiation skill for using condom or demand safer sex or consensual sex.

I would like to narrate the story of Harpreet (name changed). At the age 30 years, she had already witnessed a life which was no less than a nightmare for her. She had no formal education. Like any other woman from her socio-economic strata, she had dreamt of a good home, husband and to be able to lead a peaceful life. But destiny had other plans.

Harpreet got married at the age of 17 years and soon became mother of four children. Her husband was alcoholic and died after nine years of marriage. As her in-laws refused to take care of her and her children, she shifted to her parents’ home. Their financial condition was not very sound so they wanted her to get married again. Soon their search came to an end as her younger sister came up with the marriage proposal of her brother-in-law. They got married on the condition that he would take care of the two younger children. Harpreet was very happy and thought that her second husband was god to her since he had accepted her with her children.

Within few months of the marriage, her dreams shattered. She was devastated when she came to know that her husband was bisexual and had physical relationship with other women and a man in the neighbourhood. She was not in a position to get out of the situation. She was pregnant and gave birth to a baby boy in the month of December. In the severe cold, she was asked to sleep on the terrace as a punishment which resulted in the
child’s death due to severe cold.

During her pregnancy, Harpreet also came to know that she was HIV positive. She did not even react to her HIV positive status as she had already undergone so much pain in her life. After a while, with pressure from the hospital, her husband underwent HIV testing and was found to be HIV positive. The blame game started. Her in-laws threw her out of the house. Harpreet had always wanted to go back as her parents were unhappy about keeping her at her in-laws’ place. She kept switching between her parents and in-laws’ place. Meanwhile she again got pregnant. This girl child survived for only 13 days.

As part of the Naz home based care programme, we worked with her for over a year. We provided her ration support. Her ARV adherence was poor, so we provided her psycho social support. Many a times she would gather courage to live life but was under constant burden being a HIV positive woman with four children and two unsuccessful marriages.

At a later stage, even her parents withdrew their support. Her in-laws continued to blame her for giving the infection to their son. Harpreet is sure that she has got HIV from her second husband but she cannot prove it.

At present, Harpreet is working in a small factory and taking care of her four children. She is living on her own.

I have in the last four years come across many such Harpreets in families infected and affected by HIV. In most of the cases women in monogamous relationship get the infection from their husbands – the bread winners of the family. She is usually an illiterate, unskilled housewife left to care for her children and ensure the wellbeing of the family. They are denied property rights and most of the times their basic rights of food, shelter and access to medical support are violated due to the prevailing stigma in our society. On top of all these women are always left behind to bear the blame of giving infection to their husband.

I strongly support the concern of The Global Commission on HIV and the Law to make recommendation for effective HIV responses that protect and promote the human rights of people living with HIV/AIDS, especially children and women, who continue to remain vulnerable and voiceless.

Recovering Nepal [RN] is a national network of people who use drugs & drug service organizations in Nepal having 150 member organizations across Nepal. RN is dedicated to improve health, human rights and well-being of people who use drugs [PWUD] in the country.

Drug users’ vulnerability in Nepal is related to frequent incarceration, violence, stigmatization, and poor association with social and healthcare resources. The “war on drugs” influences national drug policies and government doesn’t always employ scientific evidence and best practices. Therefore, drug policies some time contribute to the spread of HIV and to the failure of HIV treatment.

The HIV epidemic linked to injecting drug usage is still high and jump starting the epidemic in the drug using community. Inadequate service, harmful laws, prevailing stigma & discrimination is fueling the epidemic. In Nepal, Harm reduction & HIV intervention began quite early. However, access to service including legal aid for PWUD has always remained a challenge.

Inconsistencies in addressing drug use and HIV and AIDS in the government and in UN system are is visible. Such inconsistencies are common even in donors as well—the United States Agency for International Development [USAID], for example, abruptly denied support for clean needle syringe programmes & other prevention services for PWUD in the past.
A divided approach to drug use and HIV is common in Nepal, and that the split appears to be accelerating, rather than containing, the spread of HIV.

Such inconsistencies in national policies and programs have raised tensions between prioritization of criminal enforcement or public health approaches. Policies on drugs and HIV are often developed separately, with neither coordination nor coherence. Strikingly, failure to adequately addressing IDU issues extends even to government national planning bodies.

Nepal’s drug law, still the most stringent. Nepal still criminalizes purchase or possession even for small amounts of illicit substances (e.g., amounts for personal use), and apply severe penalties to possession of both hard and soft drugs. It is illegal to carry drug without a prescription, and possession of even a needle may result in imprisonment.

Nepal, for example, passed New Drug Control Policy [2006] and Drug control Strategy [2010] providing protection against discrimination for people who use drugs. These changes, however, often exist only on paper, and apparently conflicts with Narcotic Drug Control Act [1976 hereinafter Drug Law] later amended in 1993, with local law enforcement continuing to threaten, stigmatize, and punish drug users and their families. & partners

In practice treatment option has been progressively replaced by incarceration, or incarceration followed by a requirement for forced treatment. Nepal Police detains those found in possession of drugs, and to commit them to compulsory rehabilitation centers where they can remain for up to 3 or more months.

Anti-drugs campaigns are often matched with campaigns against drug use and users conducted in the court of public opinion include stigmatizing media coverage, public beatings of drug users, and public shame. Anti-drug user campaigns have frequently emphasized the idea that ‘drug users are spreading HIV’ to the rest of population. Sometimes, Anti-drug campaign starts as door-to-door visits by police—have resulted in sharp increases in imprisonment, registration of drug users, and forced detoxification.

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The law does not distinct between cannabis and other drugs, between private and public use, and between personal use and commercial production. Sharp expansion in arrests and increased powers of surveillance, rather than relaxation of regulation, appear to be the norm.

A practice allowing syringes to be purchased over the counter is not common when drug users fear arrest at the pharmacy. Still police officers linger nearby waiting to beat up, arrest, or extort drug users seeking help. Often, workers in programs serving drug users are themselves arrested, or humiliated by police. [E.g. In Pokhara, police took prevention tools away from outreach workers, crushed their sterile syringes, and forced them to tear up identification cards they issued to PWUD].

Widespread arrests of PWUD who are then imprisoned or compelled to enter mandatory treatment, are common in Nepal. These round ups frequently include not only all in possession of drugs, but all suspected to be drug users on the basis of appearance, needle marks (tracks), social association or geographical location.

Nepal Police are given power to decide who goes into treatment and for how long rather than by health professionals. Suspicion of drug use is sufficient to result in police detention and forced treatment. PWUD must register—with their parents—to enter treatment, and must subsequently identify themselves as drug users. Once on the list, it is unclear how one’s name is removed.

Concentration of drug users in prisons and mandatory treatment facilities is more powerful factor in HIV transmission. Vastly overcrowded, limiting access to HIV prevention tools fueling infection among these populations. Little or no HIV care and exposing inmates to a range of other infectious diseases including tuberculosis.
Segregation of those who are HIV positive, a common strategy, is often the single answer to HIV prevention in prisons.

More than 20 years into the HIV response, government does not provide national funds for harm reduction and HIV services, where programs operate, with donor limited financial support. Coverage is intermittent and vastly incommensurate with the need and legal aid is largely missing.

Accessibility is the key to Nepal’s HIV response, where entrance into services frequently requires protracted paperwork, waiting lists, and referrals. Treatment for detainees and prisoners, for whom prevention services [clean needle/syringes OST] is not available.

Relapse after forced treatment exceeds high. Staff varies widely in knowledge and training, and few standards exist for any aspect of care provided.

Forced labor and punitive “trainings” is common in some treatment centers. Treatment is often an exercise in physical endurance, psychological humiliation, or exploitation. In one, “treatment & rehabilitation center” run by sister NGO of one of the major political parties includes long hours of exercise, chanting of political slogans includes hours of military drills in the hot sun, political instruction, strict searches of personal belongings and a demand for discipline is so severe. While treatment models have changed little for more than a decade, the government has not yet announced a new national rehabilitation program

While the official state mechanism to monitor human right violations of PWUD and PLHIV is not very specific, Recovering Nepal along with media, activists collect and share cases related to human rights violation.

Due to political instability and frequent changes in government, staging consistent and focused advocacy initiatives have been a major road block for policy advocacy and legal reform.

**Remedial action**

There is a need to align national laws with international requirements and public health evidence to increase access to services: Reforming law on the street: improving police practices towards PWUD. There is a need for structural interventions to de-emphasise the criminalisation of PWUD and foster their rights literacy and access to legal aid.

Reducing drug related harm means not only sound public health policies but needs a reform of drug policies as well. Weak public healthcare systems must be strengthened in order to improve their capacity to respond to drug related health problems, and these efforts must be articulated with drug users’ organizations

Flexibility of control under current drug law and fulfilling the requirement of balancing between access and control so that existing law can be modified to satisfy the twin requirements of access and control.

Unduly strict interpretation of UN drug control treaties directly undermines HIV prevention efforts by discouraging the country from implementing effective, realistic, and compassionate public health policies. International bodies like the UN Commission on Narcotic Drugs and national governments must give greater consideration to the human rights, including access to treatment, of injection drug users. By incorporating a human rights & public health perspective could do much to improve access to treatment and better protect the health of PWUD.

National level reform is essential to include drug use issues in national HIV plans, and of HIV issues in national drug plans. Repeal of mandatory imprisonment for possession of small amounts of illicit drugs and decriminalization of drug use, permitting purchase of syringes without prescription, and public education about the right to do so. Repeal of legislation or practices through which drug users are criminalized on the basis of
addiction alone or past behavior. Protection of confidentiality of IDUs and people with HIV in health care and
drug treatment settings. Provision of HIV treatment and support to those with HIV in penal or treatment
facilities is essential. End to practices depriving drug users of getting service while in police custody.
Implementation of harm reduction and HIV prevention efforts in closed settings and for those recently released
is urgent.

| 75 | Sri Lanka | Individual |

Equality of Access for Children Living with HIV

One of the gaps in Sri Lanka is the lack of a law and policy that recognizes the rights of PLHIV and provides
detailed guidance for service providers. A particular gap relates to the situation of children who have tested
positive for HIV and have difficulty in accessing the treatment, care, support and education they require.

This is illustrated by the cases of Ashana and Arvindh (names changed). Ashana (ten) and Arvindh (eight), both
orphaned, tested positive for HIV at an early age. Custody of the children was given to the Department of
Probation and Child Care Services and they were provided shelter in a children’s home.

The children’s home however, lacked the support and facilities that Ashana and Arvindh required. This had an
impact on the children and their mental and physical development was considerably slower compared to
children of their age.

The Department of Probation and Child Care Services sought the assistance of a non-governmental organization
providing child support services. Through the intervention of the organization and the special support that the
care givers of the organization provided, it became possible for the two children to acquire some of the skills
that their peers had already acquired.

The non-governmental organization assisted the children in accessing education and ensured that the HIV status
of the two children would remain confidential, except in those cases where it became relevant to disclose their
status. This occurred mainly because of the intervention of the non-governmental organization.

There is a need however, to ensure that all children living with HIV have access to the treatment, support, care
and education that they require.

A policy that will provide clear guidelines to service providers, including to educational institutions, and ensure
equality of access to all children living with HIV, is a priority in Sri Lanka.

| 76 | Indonesia | Performa |

Here in this e-mail I attach the report, contact details, and submission template.
The format of our report is an online video that could be downloaded through Vimeo:

Title: Access Limitation to HIV Treatment: The Impact of Drug Use Criminalization in Indonesia
Link: www.vimeo.com/18085720
Password: performa

Please let me know should the commission needs more information from us.

Key Issues : (3) Laws and practices that facilitate or impede HIV-related treatment access

Format : Video Online

Link : [http://www.vimeo.com/18085720](http://www.vimeo.com/18085720)  Password : performa


Mayoritas Warga Binaan yang dilimpahkan adalah Warga Binaan terkait kasus NAPZA yang keberadaannya di DKI Jakarta sudah tidak tertampung pada Lapas / Rutan yang ada. Warga Binaan terkait kasus NAPZA yang dilimpahkan ke Jawa Tengah, mayoritas yang terinfeksi HIV dan sudah mengalami infeksi oportunistik. Tidak dilakukan penyaringan untuk memilih Warga Binaan yang cukup sehat saat melakukan pelimpahan ke Jawa Tengah.


Setelah Masyarakat Peduli AIDS di Jawa Tengah mengadakan rangkaian aksi untuk menentang keberlanjutan kebijakan transfer Warga Binaan serta menuntut perbaikan fasilitas kesehatan bagi Warga Binaan, Jawa Tengah mulai memperbaiki sistem layanan kesehatan di Lapas.


Pasien dengan HIV dan infeksi oportunistik tidak diberikan perawatan khusus, bahkan paramedik dan dokter cenderung enggan untuk menengok keadaan pasien rujukan Lapas / Rutan tersebut. Sipir dari Lapas / Rutan yang ditugaskan untuk menjaga pasien seringkali meninggalkan si pasien sendiri disaat si pasien sangat membutuhkan bantuan orang lain.

Diperlukan sistem pengawasan bagi penyedia layanan kesehatan bagi Warga Binaan Lapas / Rutan. Karena Warga Binaan seringkali lolos dari perhatian masyarakat umum karena miskinnya publikasi dan ketertutupan lingkungan Lapas / Rutan dari ekspos media masa.
The Delhi Network of Positive People (DNP+) was founded in 1999 as a support group of PLHIV. We actively lobby for treatment access and provide counselling and other support services to the PLHIV community.

We are writing to express our concerns regarding the ongoing negotiations on an India-EU FTA. As patients relying on life-long treatment we are intimately familiar with the impact of intellectual property rights in access to treatment.

There are today 2.3 million people living with HIV in India. While the Indian government’s treatment programme is steadily improving, there are significant gaps in treatment access for PLHIV in India. For instance, accessing treatment for opportunistic infections has been very difficult and our friends and colleagues have to purchase these from the private sector. Of great concern to us is treatment for co-infections like Tuberculosis and hepatitis-C. For hepatitis-C which is a growing concern for PLHIV who are or were injecting drug users there is no government treatment – the key medicine for the treatment has been patented in India and costs Rs. 5,00,000 to 7,00,000. This is far out of the reach of most of those in need of treatment. For us, therefore the issue of accessibility and affordability of medicines is extremely important.

As you know India’s position in the access to medicines debate is a unique one also as a key supplier of safe, effective and affordable medicines to millions of patients across the developing world. In 2005 when India had to comply with its obligations under the TRIPS Agreement, we worked with several health and public interest groups to sensitise our law makers on the need for public health safeguards in the implementation of an intellectual property regime. As a result, Indian law has some key health safeguards:

- **Prevention of evergreening**: Section 3(d) of India’s Patents Act does not permit patents on new forms or new uses of existing medicines unless a significant increase in efficacy is demonstrated. This provision is particularly aimed at the practice of evergreening by pharmaceutical companies which attempt to extend patent monopolies by making minor changes to existing medicines.

- **Oppositions by public interest and health groups**: Under the law, public interest groups can file oppositions to patent applications or granted patents and bring material to the notice of the patent examiner to show that a patent should not be granted on a particular medicine.

- **Compulsory licensing**: Indian law allows for the grant of a compulsory licence in several situations including where a medicine is not reasonably priced or available.

Since India amended its patent law and included public health safeguards, we have along with several other positive networks, cancer groups and health groups around India been involved in opposing patent applications on medicines for HIV and opportunistic infections. PLHIV networks have filed oppositions to patent applications or granted patents on *Zidovudine/lamivudine, Nevaripine Hemihydrate (syrup), Tenofovir Fumarate or tdf, Atazanavir, Amprenavir, Valganciclovir, Abacavir, Lopinavir, Lopinavir/Ritonavir, Tenofovir or tdf, Ritonavir, Efavirenz*, and *Pegylated Interferon*.

Some crucial victories have included the withdrawal of the patent application on *zidovudine/lamivudine and the rejection of the patent applications for nevirapine syrup, tenofovir disoproxil fumarate, valganciclovir and most recently of the lopinavir/ritonavir heat stable tablet.*

**Concerns on the EU-India FTA negotiations**
Secrecy – no public consultation or public scrutiny of draft negotiating texts: Since 2007, the Indian government and the European Commission have been negotiating an FTA with no public scrutiny or public consultation. Leaked texts over the years have confirmed the worst suspicions of public interest groups about the EC making TRIPS-plus demands of the Indian government on behalf of its pharmaceutical industry. Neither side has conducted an impact assessment of these demands. Certainly no one is speaking in terms of the right to health and the right to medicines. Human rights it seems are mere commodities to be traded for larger market share.

Misleading statements and Misinformation

One of the continuing features of the engagement between civil society and the governments of India and EU has been the extent of misleading statements and misinformation. In particular, an oft-repeated claim of the EC has been that it respects the Doha Declaration and has put this in the FTA. It is true – there is a provision in the negotiating text about the Doha Declaration which embodies the respect for all countries to adopt and implement the “flexibilities” of TRIPS. Followed immediately by provisions like data exclusivity and IP enforcement that roll back the safeguards in Indian law, this provision on the Doha Declaration is meaningless. All discussion of India’s ability to continue manufacturing generics is being reduced to compulsory licencing and exceptional circumstances.

Data Exclusivity (DE): Attacking Section 3(d)

The EC remains adamant on its demand that India implement DE. This is a direct attempt to undermine the effects of Section 3(d) which public interest groups are using to keep some of the most important medicines off-patent. Take the case of Valganciclovir, an important medicine for the treatment of cytomegalovirus or CMV - an OI that is largely ignored as the price of the drug is too high or the older version of the drug is too traumatic to use (an injection directly in the eye). After a long legal battle, in a post-grant opposition decision in which DNP+ was one of the parties, the Indian Patent Office agreed that as a new form of a known substance (pro-drug of ganciclovir) and as a form that was obvious, the patent on valganciclovir had been wrongly granted. However had DE, existed in India this victory would have meant nothing as the market monopoly of Roche would continue through DE as demanded by the EU. As noted by the CIPIH report: “If the patent period has expired, or there is no patent on the product, this sui generis data exclusivity may act independently of patent status to delay the entry of any generic companies wishing to enter the market. This is because the regulators cannot use the data in the period of protection to approve a product, even if the product is demonstrated to be bio-equivalent, where required. The only alternative for a generic company would be to repeat clinical trials, which would be costly and wasteful, and would raise ethical issues since it would involve replicating tests in humans to demonstrate what is already known to be effective. These sui generis regimes, which provide for data exclusivity need to be clearly differentiated from the TRIPS agreement’s requirement for data protection.” An Oxfam study of the impact of the US-Jordan FTA, found that of 103 non-patented medicines registered since 2001, at least 79 per cent have no competition from a generic equivalent as a consequence of DE. [All costs, no benefits: how TRIPS-plus intellectual property rules in the US-Jordan FTA affect access to medicines, Oxfam Briefing Paper, March 2007.]

In fact DE would completely undermine the Indian system of drug registration which for now is not originator centric meaning that India is not at the mercy of the business or other considerations of big pharma in choosing whether or not to register their medicines in India.

IP Enforcement

The second major demand of the EC is on IP enforcement. The range of measures being asked for range from providing patent holders opportunities to continuously apply for injunctions at all stages of patent enforcement
thereby decreasing the space for the Indian judiciary to weigh public health concerns over profits to “third party liability” or involving the whole chain of manufacture, supply and distribution of generic companies. The extreme enforcement measures being demanded by the EC are designed to have a chilling effect on the generic industry. The space in this submission is insufficient to explain this fully but we believe this is an extremely critical aspect of the growing backlash against generic medicines and request the Commission to allow us to submit a more detailed analysis of these demands.

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We have witnessed the ambivalence of the Indian Government in the past two years to any commitment on providing second line treatment due to cost considerations. Finally the Supreme Court has had to step in and order the universalisation of second line treatment. Any roll back of the health safeguards in India’s law will have a disastrous effect on the future of access to medicines. Yet, despite all the evidence to the contrary the EC and the Indian government persist in negotiating TRIPS-plus measures in the EU-India FTA. We ask the Commission to examine closely the impact of these negotiations on the future of access to treatment.

78  Singapore  
Individual

Persons Living With HIV (PLWHIV) face discrimination in Singapore, especially given the lack of general anti-discrimination laws. Non-citizens found to be HIV-positive become “prohibited immigrants” under Section 8 of the Immigration Act. However, the Government has since year 2000, ceased to deport HIV-infected non-Singaporean spouses of Singaporeans. Mandatory testing is carried out on certain persons (including all work permit holders, prisoners, new healthcare workers and military servicemen). It is a concern that non-Singaporeans found to be HIV-positive will be deported with little regard to counseling and access to treatment. The Infectious Diseases Act criminalises unsafe sex amongst individuals, regardless of whether they knew they had HIV at that point in time; to date, there has been at least one prosecution under this law. While the Government does provide subsidized healthcare to PLWHIV, the subsidies do not cover most anti-retroviral medication (ARV), which are deemed to be non-standard drugs. There is very limited financial aid available for PLWHIV who cannot afford the medication. The right to information is not being met by the Government’s official position on education, which advocates “Abstinence and Being Faithful” and does not officially permit education on condom use. Finally, the continued existence of Section 377A of the Penal Code makes effective outreach to men who have sex with men very difficult, as it could be seen as promoting or advocating the commission of an illegal act.

1 The first cases of HIV/AIDS in Singapore were recognized in 1985. Since then, there has been a steady rise in the number of new infections and the number of people living with AIDS. The ministry of health reported that there were 463 newly diagnosed cases of HIV/AIDS in 2009, 3,126 people living with HIV/AIDS and 1037 deaths from AIDS since the start of the epidemic. (http://www.moh.gov.sg/mohcorp/diseases.aspx?id=420 accessed 9 Sep 2010.

2 Immigration Act (Cap. 133). See Appendix Section Q. They are then prohibited from entering or remaining in Singapore, even if their livelihoods and/or partners are in the country.


5 Parliament Question - Case of Mr Chan Mun Chiong (Charge under section 377A of Penal Code). See Appendix Section R.


7 Section 377A of the Penal Code criminalises private consensual sex between adult men. However, the same acts by an opposite-sex heterosexual couple are legal. Section 377A is therefore discriminatory and violates Articles 7 and 12 of the UDHR, as well as Article 12(1) of the Singapore Constitution. Despite the Government’s public promise not to “proactively” enforce Section 377A, as at the time of writing of this submission, there is at least one
active prosecution under Section 377A before the courts.


79 Sri Lanka Individual

Dignity in Life and Dignity in Death

The right to be treated with dignity both in life and in death is a basic human right. Nigel de Silva had to strive hard to have his dignity respected in life, and his family and friends had to battle hard to ensure his dignity was respected after death.

Nigel de Silva was one of Sri Lanka’s most prominent HIV activists. He worked with Equal Ground, a gay and lesbian rights group and was a frequent public speaker talking about HIV and educating people on methods of prevention and the challenges of living with HIV.

Nigel tested positive for HIV after he was gang raped on a cruise ship on which he worked. He returned to Sri Lanka and starting working, but was dismissed from his job after his employer discovered that he was HIV positive.

Nigel had to contend with discrimination on two fronts: he was gay and he was HIV positive. Because of his HIV status he lost his job. In addition he lived in a society in which the legal system criminalizes homosexuality and had to contend with the stigma and marginalization that are part of the everyday lives of many gays, lesbians and transgendered persons.

On the 5th of December 2010, Nigel sought admission to a private hospital in Colombo. He died a few hours later. The cause of death according to the hospital was coronary failure.

After his death Nigel’s body was placed in plastic and sealed in a coffin. The undertaker refused to embalm the body. While Nigel had asked to be cremated, this wish was not granted to him because of his HIV status. Where Nigel wished his body to be displayed in an open coffin, this wish again was not granted because of his HIV status. While he had to contend with the stigma of HIV in his life, this stigma pursued him even after death.

The events surrounding Nigel’s death illustrate the need for medical institutions and undertakers to have a policy in place to deal with the deaths of those who had been living with HIV. In Sri Lanka there is no law or policy that recognizes the rights of PLHIV and identifies the duties of medical institutions, doctors, undertakers, the police and other stakeholders. Fundamental to such a policy must be the right to be treated with dignity both in life and in death and to be accorded all other rites that any other person is entitled to in death. A person’s HIV status should not prevent friends and family from giving a person who had lived with HIV a funeral with dignity and in accordance with his or her wishes.

80 Sri Lanka Individual

Equal and Effective Access to Health Care

The criminalization of homosexuality in Sri Lanka and the consequent threat of prosecution have prevented vulnerable groups such as gays, drug users and the transgendered from accessing preventive and curative HIV
related health services.

An effective HIV prevention programme must ensure that the most vulnerable groups including sex workers, men who have sex with men, and drug users, have access to regular and effective health services. Currently members of vulnerable groups are either reluctant or unable to access health care services for several reasons:

1. A lack of knowledge about how and where to access services.
2. A fear that privacy may be invaded and confidentiality breached.
3. A lack of counseling and information support services.

HIV related health clinics must create an enabling environment that encourages vulnerable groups to use their facilities; guarantee confidentiality; and provide effective counseling and support services where required.

While strengthening the existing health care system is a priority, the country also needs a law that will articulate a series of rights that PLHIV are specifically entitled to and lay down the responsibilities of the several stakeholders, including the health care system, the educational system, the law enforcement agencies and the judiciary. The country also needs an HIV policy that will ensure equal access to health services; equal access to the necessary care and support; guarantee privacy and confidentiality; and ensure dignified funeral rites in accordance with the person’s wishes, in the case of death.

In some countries PLHIV have access to special social benefits because of the reduced opportunities they have for employment. Their children may also be entitled to social benefits to ensure that they continue with their education and have access to opportunities that other children have.

| 81 | India | Médecins Sans Frontières (MSF) |

Re: Trade Agreements and Access to Medicines

Médecins Sans Frontières (MSF) is an international, independent, medical humanitarian organisation that delivers emergency aid to people affected by armed conflict, epidemics, healthcare exclusion and natural disasters. MSF combines the provision of emergency medical care with a commitment to speak out about the suffering people endure and the obstacles encountered in providing assistance. MSF offers assistance to people based only on need and irrespective of race, religion, gender or political affiliation. The Campaign for Access to Essential Medicines is an international project of MSF, set up with the objective of making new "life-saving and essential" medicines, vaccines and diagnostic tools affordable and accessible; and to stimulate needs-driven research for the greatest medical needs.

More than 80% of the medicines MSF uses to treat its more than 160,000 patients on AIDS treatment come from generic producers in India. A study published in September 2010 in the *Journal of the International AIDS Society* reviewed 17,000 donor-funded purchases of AIDS medicines made by 115 low- and middle-income countries between 2003 and 2008, and found that more than 80% of these came from India. The proportion of AIDS medicines produced by Indian manufacturers is even higher – up to 90% - with certain important medical needs such as paediatric medicines to treat HIV in children. Accessing affordable medicines from India is a lifeline for all developing countries – but this situation is now under attack, and the European Commission is playing a leading role in these attacks.

The trade agreements and policies being pursued by the European Commission will likely impede access to medicines and are accordingly being brought to the notice of the Global Commission on HIV and Law.
The European Commission’s multiple attacks on access to medicines

The attacks of the EC on access to medicines are taking multiple forms – customs regulations that block trade in generic drugs, bilateral free trade agreements, and the international anti-counterfeiting trade agreement or ACTA.

Customs regulations and the detention of generic medicines

European governments have hindered the flow of legitimate generic medicines by detaining shipments of drugs destined for patients in developing countries as these medicines were transiting through the EU. The EU took these steps on the basis of EC customs regulations that concern violations of patents or trademarks. Cynically, the EC has tried to justify these detentions on the grounds of public safety, stating that these rules are needed to combat fake medicines. While fake medicines are indeed a public health threat, these rules have in fact been used to hamper the transit, storage and export of legitimate generic medicines for people living in developing countries. These detentions can lead to significant delays in the delivery of medicines, or even stock outs, for patients who in many cases rely on these drugs to stay alive.

Free trade agreements

Through bilateral trade agreements, the EC is seeking to get countries to agree to higher standards of intellectual property (IP) protection and enforcement than even the TRIPS agreement requires. EC trade negotiators remain staunchly in favour of expanding the IP system and the rights and benefits of IP holders at the expense of access to medicines for millions of people in developing countries. In addition, these trade policies undermine the EU and member states’ own efforts to increase access to medicines to people living in developing countries, as they purchase key medicines for people living with HIV/AIDS from India via bilateral or multilateral financing mechanisms.

The EC is currently negotiating such free trade agreements (FTAs) with several developing countries, including India, Brazil, Thailand and the Philippines. Of these, the most concerning is the one being negotiated with India, given the developing world’s dependence on the country’s generic manufacturing capacity. Negotiations for a bilateral trade agreement between the European Commission and India are now entering their final round and are set to conclude in late 2010. The FTA is expected to be completed by March 2011.

The secret treaty – ACTA

Rich countries, including those in the EU, have been using a secret treaty to aggressively champion heightened intellectual property enforcement measures that will have a detrimental impact on access to medicines. The anti-counterfeiting trade agreement (ACTA) negotiations are nearing finalisation after more than two years. Early non-official indications are that the EC has not succeeded in imposing many of its problematic clauses it was pursuing, but the vast majority of these provisions are the same ones the EC is seeking to get India to agree to in the FTA. In other words, the EC is now effectively trying to push terms on a developing country that may have been deemed too intrusive or onerous for rich countries negotiating ACTA.

Most developing countries are not part of this negotiation, but the EC and others have made it clear that they intend to put pressure on these countries to sign up to this non-negotiated agreement once it is completed. The danger of ACTA becoming the new global standards is therefore very real. The potential consequences for access to medicines are considerable – the positions taken by the EC could ultimately limit considerably the manufacture, distribution and availability of affordable generic medicines across the developing world.

While there have been attempts to justify ACTA as a way to deal with the hazard of fake medicines, ACTA has nothing to do with improving the quality of medicines used in developing countries at all. Its purpose is to protect private commercial interests, such as those of pharmaceutical companies. In fact, because ACTA
jeopardizes access to low-cost, quality generic medicines, it may lead to a shortage of affordable medicines, which itself usually leads to increased illegal trade in spurious and fake medicines.

This treaty aims to create a global enforcement regime for intellectual property rights. This is in direct challenge to the fact that patent and trademark rights are not global and differ from country to country. Developing countries have the right to design their intellectual property laws in a way that takes their public health needs into account – India’s patent law, for example, restricts abusive patenting in an effort to balance the need to protect intellectual property with the need to protect public health. But ACTA would heighten intellectual property standards across the board.

The European Commission has been aggressively pushing the agenda at these negotiations, targeting intellectual property in the area of pharmaceuticals. It takes the worst of the EC rules, such as the customs regulations and those it seeks to impose in India via the FTA, and attempts to transform this into a global agreement.

ACTA does not include protections for patients, or safeguards to prevent abuse. ACTA would limit competition, thus increasing the cost of medicines, because of its deterrents for generic manufacturing and export. But very little in ACTA recognizes the need to protect the public.

We request the Commission to examine closely the EC’s trade policies as well as specific demands for changes in the laws of developing countries like India and their likely impact on access to medicines. This includes:

1. The demand for data exclusivity
2. The demand for Patent Term Extension
3. The demand for Intellectual property enforcement measures including:
   a. The demand for border measures (including on allegations of trademark infringement)
   b. Patent and civil trademark disputes
   c. Injunctions
   d. Excessive punishment for intellectual property infringement (including injunctions, damages, and criminal sanctions.)
4. The demand for Investment provisions that include intellectual property and allow foreign investors to take a government to private arbitration over actions like compulsory licensing, or setting price controls or regulations.

The leaked text of the IP chapter being negotiated between EU and India is available here [http://www.bilaterals.org/IMG/doc_23_April_2010_Preliminary_Consultation_Draft_on_IPR_Chapter_of_EU_India_FTA.doc](http://www.bilaterals.org/IMG/doc_23_April_2010_Preliminary_Consultation_Draft_on_IPR_Chapter_of_EU_India_FTA.doc)


Our own detailed analysis of the impact of these provisions is available here for your reference: [http://www.msfaccess.org/fileadmin/user_upload/medinnov_accesspatents/HANDS%20OFF%20briefing_7102010.pdf](http://www.msfaccess.org/fileadmin/user_upload/medinnov_accesspatents/HANDS%20OFF%20briefing_7102010.pdf)

Against the background of continued problems of millions lacking access to medicines because of high drug
prices, falling donor commitments to health, and the real danger of not meeting the Millennium Development Goals, the EC’s focus on intellectual property enforcement is hypocritical and immoral. It will deepen global health inequity, and exacerbate the problems that millions of people, in MSF projects and beyond, face in accessing to life-saving medicines. We are happy to appear before the Commission and depose as to the Access Campaign -India’s experience with laws and policies that impede access to treatment and in particular on the impact of intellectual property rights in this regard. Please do not hesitate to contact us for more information or evidence in this regard.

China Access to Medicines Research Group

Sustainable Access to All ARVs in China and Intellectual Property Laws

**China Access to Medicines Research Group** established in 2007, is a voluntary based research network consists of public interests lawyers and public health experts. It has cooperated with INGOs such as Medecins sans Frontieres and Third World Network on access to medicines and intellectual property researches and advocacy in China. It presented in a number of international forums, including UN MDG informal hearing for NGOs, and the Vienna World AIDS Conference 2010. It also translated and published a number of research works on access to medicines.

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Background and major challenges for accessing to all ARVs in China

Since 1985, when the first AIDS patient was reported in China, the rate of epidemic occurrence has become increasingly grave. Currently, governmental data shows that there are around 700,000 people living with HIV/AIDS in China. Among them, 85,000 people are patients with AIDS. In the year 2003, the Chinese government initiated the “four free and one care policy.” Through this program, the rural or urban HIV/AIDS patients, who have not joined the basic medical insurance programs, can receive access to free ARV drugs and treatment in designated hospitals. The policy also includes provision of free consulting, primary screening, and prevention of mother-to-child transmission.

The main obstacles for the prevention and treatment of HIV/AIDS in China are still quite significant. Among the others, the availability and accessibility of ARVs in China remain a big challenge in scaling up treatment and responding to the increasing drug resistance and need for advanced treatment regimen. First, the choice of medicines is still narrow, especially for newer ARVs that have been used in developed world in responding to drug resistance and severe side effect. Second, though China is one of the biggest suppliers of Active Pharmaceutical Ingredient (API) for ARV production in the world, Chinese AIDS patients could not have access to generic version of some key ARVs in a sustainable way due to patent and regulatory monopolies. Thirdly, new challenges are getting severe as nearly all newer ARV for second and third line treatment have been patented in China, and not available in an affordable manner. In addition, the access barriers on individual drugs also result the lack of fixed-does combination (FDC) which has been recommended by WHO as a useful tool to improve adherence of treatment.

**China’s patent law reform and indication to access to medicines**

Chinese patent law was first issued in 1985 and was revised three times in 1992, 2000 and 2008 respectively. Chinese patent law completed its third revision in December 2008 following the developments of TRIPS under

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WTO rules. The third revision of the Chinese patent law integrated more TRIPS flexibilities and some new mechanisms in favor of access to medicines.

A. Compulsory license

The third revision of Chinese patent law strengthened its provisions on compulsory license. First, a compulsory license can be issued on the grounds of preventing anti-competition practices. Secondly, compulsory licenses can be issued for “government use” during the time of a national emergency or for public interests purposes. Thirdly, a compulsory license can be issued for public health purposes and the products made under such license can be exported to eligible countries in accord with international rules.

B. Parallel importation

The third revision added the rule of parallel importation under Art 69(1). Parallel importation refers to the import of goods outside of the distributive channel of the patent owner. Accordingly, after the first selling of a patented product by the patent owner or its authorized agencies, the patent right is deemed exhausted. This product can be imported by a party from a third country where the same product is under patent and sold at a higher price. This is not considered as infringing the patent right.

C. Bolar exception

Bolar exception is added under Art. 69(5) as a non-infringing practice. A corresponding provision can be found under Art 19 of the Measures for Drug Registration Regulation, issued by the State Drug and Food Administration. This article allows that a generic drug application can be filed 2 years before the patent term ended.

Issues remaining under Chinese patent system regarding access to medicines

A. Patentability criteria

Patentability criteria are the fundamental flexibilities for domestic patent law. A broad definition on patentability might allow trivial changes on an existing chemical compound being granted a patent. International researchers have made suggestions that broad definition of patentability is not desirable for developing countries.

The current Chinese patentability criterion in examination practices allows a broad recognition for pharmaceutical patent applications. For instance, the Brazilian Patent Office rejected a patent application by the US based drug company Gilead on an essential HIV/AIDS medicine tenofovir disoproxil fumarate (TDF) in 2008. The rejection was made on the ground that it was lacking in inventiveness, because TDF is a salt form of a known chemical compound. However, Chinese patentability allows salt form to be patentable which might open the door for minor changes on known chemical compounds to be patented.

B. Data exclusivity

Art 39.3 of TRIPS agreement requires member states protect undisclosed experimental data from unreasonable disclosure. However, data protection does not imply a “data exclusivity” protection that can block the application for generic drug registration from referring to the originator’s data.

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2 See. Art 48 (2) of Chinese Patent Law, revised on 2008
Current Chinese law sets a 6 years data exclusivity protection term under Art 35 of the Implementation Rule of Drug Administration Law. It has potential impact on introducing generic versions when the originator company does not have a patent in China or when a compulsory license is to be used. Although Art 35.3(1), the implementation rule for drug administration law, stated that “data exclusivity” could be exempted under the circumstances of “public interests”, no link has been made between this provision and the patent law.

**Policy opportunities for China towards sustainable access to all ARVs**

**A. Health reform and essential medicines mechanism building**

China is undertaking the health reform with establishing the national essential medicines mechanism at the center. One key objectives of the reform is to provide universal access to essential medicines by 2020. The current essential medicines list has included medicines treating heart diseases, cancers and HIV/AIDS.

If key drugs treating those diseases would for long time under patent in China, the implementation of essential medicines regime would be affected. So, it is time for China to find a holistic approach in dealing with drug patent issues, and find a sustainable gateway in preparing universal access to essential medicines by all.

**B. Strategy of establishing innovative society**

Chinese government has announced its determination of upgrading the industrial structure and going towards an innovative society. It would give policy spaces for China to scrutinize the exact function of patent regarding innovation capacities. It is also a time for advocating a relooking at the patentability criteria for chemical pharmaceuticals, and to prevent trivial changes of known chemicals to be patented, thus to prevent abuse of patent by multinational pharmaceutical companies.

**Concluding remarks**

China has made significant progresses in scaling up HIV/AIDS treatment domestically by providing some ARVs for free. Access to full range of ARVs, including the newer generation of drugs, remain a challenge due to patent protection and high prices of those drugs. Reform of China’s patent law, and the ongoing health reform and country strategic planning process may provide new policy opportunities for China, to formulate a holistic strategy for domestic development pathway in pharmaceutical sectors, in order to moving towards a sustainable access to all ARVs, and finally providing universal access to essential medicines under health security regime for all its citizens.

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**Rights of Participation**

Palitha Wijebandara’s life changed after he took the routine medical test in the company he was employed in. He was employed in Saudi Arabia at that time and when the results of his test arrived he was confined to his lodgings and not told why. Two more blood tests later he was told that he was HIV positive and immediately put on a plane to Sri Lanka.

The discovery that he was HIV positive turned Palitha’s life upside down. He had to struggle to learn about HIV; struggle to manage the stigma; and struggle to live a positive life. Since returning he has stayed away from applying for mainstream employment because of the fear that he would have to face a blood test once again and be rejected on the basis of his HIV status.
Several years later though his life has changed once more and Palitha has surmounted some of the challenges he initially faced. He has now become a passionate activist speaking regularly to local and international audiences on how to live positively and robustly with HIV. He worked for several years with an organization that supported PLHIV and more recently started work with a LGBT rights group.

According to Palitha a lack of knowledge among the general public and even among health care providers is an obstacle to ensuring that the rights of PLHIV are respected and promoted. This lack of knowledge results in the discrimination and stigmatization of those living with HIV.

Breaches of confidentiality are a common occurrence. Palitha recounted at least two instances where information on a person’s HIV status was shared with members of the family or the community, resulting in the instant isolation of the person.

A weakness of many of the current awareness programmes is that they do not involve PLHIV. According to Palitha, ‘you cannot stop the spread of HIV unless you seek the active participation of those living with HIV’. ‘By not involving those living with HIV you are reinforcing the view that these people cannot make a positive contribution to society’.

Palitha notes that those living with HIV struggle to earn a livelihood having fewer opportunities for work than those without HIV. The fear of having to face a company administered blood test acts as a barrier to their full participation in the labour force. Companies are reluctant to retain an employee who tests positive for HIV.

While prevention programmes are crucial to minimize the spread of the virus, recognizing the full gamut of rights that PLHIV are entitled to is equally important. Those with HIV must be granted equal rights and ‘society must recognize they too have a positive contribution to make’, says Palitha.

One aspect of Palitha’s experiences highlights the vulnerability of migrant workers. A migrant worker’s tenuous status in his or her state of employment makes them vulnerable to both exploitation and easy expulsion. The Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families recognizes the rights of migrant workers, including the right against arbitrary expulsion; the right to receive information; and the right against arbitrary deprivation of liberty. The social reality however, is different. While migrant workers themselves are vulnerable, being HIV positive; a woman; or from a sexual minority; enhances their vulnerability.

Another aspect of Palitha’s experiences however, shows that those with HIV need not necessarily have to live in life’s shadow. PLHIV are entitled to a robust life; to share in the fruits of human endeavour; and to participate in all aspects of social life, on equal terms with the rest of society.

Purple Sky Network (PSN) is a network of national technical working groups for men who have sex with men (MSM), transgender people (TG) and HIV, in the Greater Mekong Subregion (GMS) of Southeast Asia. We work through the local networks of technical working groups in Cambodia, Guangxi, Lao PDR, Myanmar, Thailand, Vietnam and Yunnan to strengthen the response to HIV for MSM and TG communities.

PSN has contributed to raising the profile of MSM and HIV at country level through the establishment and strengthening of country Technical Working Groups (TWG). PSN recognizes that for effective subregional advocacy work it needs to have strong in-country MSM and TG program coordination. The primary purpose of the TWGs is to serve as a forum for in-depth discussion and coordination to ensure best possible technical
inputs and support from government, civil society, international and national partners to reduce the impact of HIV and AIDS among MSM and TG. The TWGs advocate for appropriate services and interventions for MSM and TG. Since 2006 TWGs have worked towards including MSM in National HIV Strategic Plans and are developing national HIV strategies specifically for MSM. Strengthening of the TWGs has involved skill development in the areas of advocacy and behavior change communication, the provision of small grants for collaborative advocacy work and networking opportunities with other TWGs at the PSN Network Meeting.

In 2010 the Network has found the following violation of rights of men who have sex with men and transgender people:

**Thailand**

- The police use condoms as evidence to arrest people, close down entertainment venues and thus hamper prevention efforts. MSM and TG are compelled not to carry condoms and entertainment venue owners do not supply them for fear of being prosecuted under anti-prostitution law.
- Transgender women are not officially recognized as women referred to as Mister on their identity cards, which causes complications when travelling, dealing professionally and hampers access to other services
- Transgender people who undertake the process of national military conscription are dismissed from the military under the ruling - ‘this person’s body is not in line with their birth sex’.

**Cambodia**

In Phnom Penh, Cambodia, transgender and female sex workers have been continually harassed by police citing anti-trafficking laws and forcing sex workers into streets and parks where physical dangers increase and access to private spaces and safe sex commodities are limited or non-existent.

**Myanmar**

In Yangon, thirteen young men have been sentenced to two years in jail for alleged prostitution with men and contacting other men via the Internet. They were initially in police custody for a week and were beaten at that time. The thirteen were rounded up by police who were said to be trying to solve the murder of a gay Myanmar man over five years ago.

**Vietnam**

In Vietnam, the rape of a transgender woman in the north-central province of Quang Binh has sparked a serious debate among legal professionals after judicial authorities decline to prosecute the perpetrators because Vietnamese law only applies to the rape of women by men.

Recently, PSN was involved in the Men who have Sex with Men and Transgender Populations Multi-City HIV Initiative with the Action Planning Meeting held in Hong Kong on 7-9 December 2010. GMS cities included in this Initiative were Bangkok, Ho Chi Minh City and Yangon. The three city-level scanning reports inform the following:

**Bangkok**

Prostitution remains illegal in Thailand (though sex between men is not) and the associated stigma with being MSM, TG and/or a sex worker means little power to advocate for themselves. The illegality of sex work means that the police often use the presence of condoms as evidence of prostitution, and their raids on bars, clubs and other venues hamper HIV prevention efforts.

**Ho Chi Minh City**
Prostitution is illegal in Vietnam, though, sex between men is legal, but discrimination toward MSM and TG people is rooted, especially as the state run media described homosexuality as a ‘social evil’ and have proposed laws to allow for the arrest of gay men. There is little understanding of transgenders in Vietnam as they are included under MSM programming, though it is reported that when TG people go to public health services, they are discriminated against and mistreated.

Yangon

Yangon was the only city where there was no government involvement in the scanning process which illustrates the difficulty in engaging with the government. Both homosexuality and prostitution are illegal in Myanmar. Movements of MSM and TG are restricted and their rights are regularly violated through arrests and intimidation by police and other authorities. Restriction on the registration of community based organization is a barrier to developing and expanding civil society.

Recommendations

PSN makes the following recommendations to the Global Commission on HIV and the Law:

- Provide a framework and recommendation for government ministries to work together for a coordinated effort that does not hamper HIV prevention among MSM and TG and to reduce stigma and discrimination within the ministries.
- Encourage human rights groups to also look at issues of stigma and discrimination and violations in the context of sex between men and male to female transgender people. Also to help community groups to better understand human rights framework.
- Recommend for funding to be made available for rights-based approach programming including component of documentation of rights violation at community level for community advocacy.

India

Since 2000, the history of TRIPS has been intertwined with that of the HIV epidemic. In 2000, when the UN Secretary General issued his Millennium Report pleading for a global development plan, he noted that AIDS deaths at the time were estimated at 16 million. And that Africa was being ravaged by the virus. The report also noted that the emergence of effective treatment combined with improved basic healthcare and social policies had, “brought dramatic increases in life expectancy and sharp declines in infant mortality.”

Despite this, all the UN Secretary General could do at the time was make a weak plea for the 36 million people living with HIV at the time to get greater access to HIV treatment and for the pharmaceutical industry to collaborate in this effort – collaboration that had resulted in some drug donations and a discounted price of $10,000 per patient per year. While the document’s goal on HIV itself was ambitious (to halt and reverse the epidemic by 2015), the UN General Assembly could not find a way to secure access to HIV treatment and the UN Secretary General’s weak plea became a muted commitment in the MDG Resolution.

But within six months of the MDG resolution, the HIV treatment scenario changed dramatically as an Indian generic company offered first line AIDS treatment to MSF for $350 per patient per month and for $600 to developing country governments. Eventually Indian companies were able to offer not only cheaper prices but simpler treatment regimens in the form of combinations.

Less than a year after the MDG resolution, a far more ambitious UN General Assembly adopted the ‘Declaration of Commitment on HIV/AIDS.’ Buoyed by the offer from the Indian companies, the Declaration referred to the
achievement of the MDGs but unlike the MDG resolution had clearer direction to offer on access to medicines with a specific recognition that it was a fundamental part of the right to health. By 2006, governments agreed to come as close as possible to “universal access to care, treatment and support by 2010” and target 6.B was included in the MDGs in 2006.

The offer by the Indian companies meant that governments around the world could no longer claim cost or complicated treatment as an excuse and global political will met the Indian offer with the funds to help countries in the South set up extensive government run HIV treatment programmes. Even Northern aid programmes like the PEPFAR could not sustain reliance on patented medicines and soon switched to generic suppliers.

It was no wonder then that the 2005 TRIPS deadline for India caused tremendous concern. Rallies across the globe begged India not to shut off the supply of generic ARVs. The Indian Parliament resolved to use the only option it had –make the maximum use of “flexibilities” in TRIPS.

For decades countries in the South have been told that TRIPS has sufficient “flexibility” in it to allow countries to safeguard their health concerns. But TRIPS does not function in a vacuum. When South Africa tried in 1999 to use these flexibilities, it was sued by 39 pharmaceutical companies. Global outrage finally forced the companies to drop their law suit. It also prompted in 2001, the adoption of the Doha Declaration which re-affirmed “that the (TRIPS) Agreement can and should be interpreted and implemented in a manner supportive of WTO Members’ right to protect public health and, in particular, to promote access to medicines for all”.

Among the flexibilities in the Indian law is Section 3(d) which guards against the common practice of ‘evergreening’ by the pharmaceutical industry. Of course Swiss MNC Novartis AG challenged Section 3(d) in Indian courts. Though it lost that case it has filed yet another in the Indian Supreme Court trying to weaken this provision. To be fair it seems that getting sued by a multinational pharmaceutical company is par for the course when a country tries to use TRIPS “flexibilities.” Such as the South African example above. Or the experience of the Philippines which attempted to use the “Bolar exception” and got sued by Pfizer. Or German MNC Bayer suing the Indian government to try and implement ‘patent linkages’. Or US Company Abbott going another route and withdrawing its medicines from the Thai market in response to CLs issued by Thailand.

The use of Section 3(d) by public interest groups has resulted in some crucial victories – the most recent being the rejection of several patent applications on Tenofovir. Several authors in their hurry to make quantitative calculations of the impact of this provision have failed to note the list of important medicines that generic production continues on thanks to this provision. Still each of these victories is being appealed and the Indian government and health groups are being dragged through the legal system every time. And medicines are now being patented.

Legal muscle is one aspect of MNC power. Lobbying is another. India has been witness to numerous lobbying exercises on increasing intellectual property in India. This includes joint workshops by the US Patents and Trademark Office and Pfizer to inform Indian NGOs and media of the importance of IP and lobbying against key TRIPS flexibilities like not having data exclusivity or the detrimental impact of Section 3(d). And more recently, a letter from the US Secretary of Commerce to the Indian government making the case for Gilead Sciences whose patent applications on tenofivir have been rejected. Our own government is not immune to the lobbying where CEOs of big pharma were not only given an audience by the Indian Prime Minister’s Office in mid-2010, their demands for more IP protection were circulated amongst all relevant Indian ministries.

The new TRIPS compliant law in India is also having an impact on business models and considerations of Indian generic companies. Several top Indian companies have been bought over by MNC pharma or have tie-ups with them. These buy-outs and tie-ups mean that these companies are now extremely unlikely to challenge patents, launch new medicines and take on MNC pharma in legal battles. The Indian government is today considering the use of compulsory licencing for those medicines that are patented and highly priced. MNC pharma have more
than displayed their displeasure at the issue of compulsory licences and generic producers aligned with these companies are hardly likely to pick up these CLs.

Add to this the recent aggressive push by the EC for FTAs with aggressive TRIPS-plus provisions. That developed countries no longer have any responsibility in not pushing such agreements is reflected even in the 2010 MDG Outcome Document (“...it is for each Government to evaluate the trade-off between the benefits of accepting international rules and commitments and the constraints posed by the loss of policy space.” Para 37). IP enforcement is being pushed through ACTA and so-called anti-counterfeiting laws and policies appearing in several countries and international agencies. An interesting aspect of the response to the growing criticism of these actions is a sort of “divide and rule” approach being adopted by developed countries. Where promises of ensuring medicines are being made for Africa and least developed countries while developing countries where the crisis in AIDS treatment is really rearing its head are left to fend for themselves.

What the world witnessed in the late 90s and the early 2000s with the HIV treatment crisis was really a glimpse of the future. Where new medicines were monopolised, countries in the South could not manufacture them and patients were held hostage to the profit motives of pharmaceutical companies.

A year after the MDG Resolution, the world changed. Or so many of us thought. Looking back at a decade of highs and lows in access to HIV treatment it seems more and more that the arrival of generic ARV medicines was an aberration in the slow but inexorable push of the global economic framework towards monopolies in medicines.

The question for many governments and public interest groups now is that if a country like India – arguably in the best position to use these flexibilities with its booming generic industry, strong civil society and international stature cannot counter the adverse impacts of TRIPS, what hope is there for other countries. In the end, the Indian experiment may only show that no amount of patchwork, bandaids and use of “flexibilities” can counter the systemic bias in the international economic system, stacked as it was from the beginning against the South. The bilateral pressure created on countries using these flexibilities from the North and the legal and other challenges by MNC pharma play no small role in entrenching this system. In the end, it seems we are back to where we started. As first line ARVs continue to be supplied and fewer people on second line, there may be some sense of complacency among international actors. But all the ingredients for the next treatment crisis are already in place and a realistic and hard assessment of TRIPS and the reality of the so-called “flexibilities” is the need of the hour.

86  India

Women’s Initiatives (WINS)

Issues of law and HIV pertaining to children.

WINS works in Tirupati, Andhra Pradesh, with marginalized women and children in HIV families in rural areas. The number of HIV infected children, AIDS orphans and their problems are increasing gradually, as the epidemic has sneaked in two decades back.

Most AIDS orphans and HIV children have tough time growing up in their relative’s homes. In most families, they use the girl child as a “domestic help” and expect that the child would take up the adult role and shoulder the responsibility of running the household, taking care of the sibling, and care for the elderly, and taking care of terminally ill Parent. The shame, guilt, humiliation, torture and cruelty the children face within home is heart rending. They have no friends to vent out their feelings either in school or in the neighborhood. They look forward to the visits of social workers. There is hardly any chance or space or forum for such children to talk about their pressures. Support group meetings are the ideal place for these children and single women to pour out their pains and pleasures.
Juvenile Justice Act talks about children in difficult circumstances, including Children affected and infected by HIV. It has also stipulates the setting up of Child Welfare Committees in the district to look into the issues of OVC. But the fact is they are non existent. When force was brought on to address children’s issues the officials were completely insensitive and their response was flippan and dismissive. They believe that government schemes work wonderfully well and the children or NGOs have no grounds to complain.

Recently there has been an effort in AP, to start Integrated Child Protection Service to merge all the programs of Women and Children welfare department into one and they need NGO representation. But unfortunately, selection of NGO members is secretive. As can be expected only pliant organizations toeing the government line find place on the committees. Activist organizations and individuals who ask uncomfortable questions can expect a very cold shoulder.

Right to Education Act stipulates that all children between the age of 6-14 be in school. But it is impossible for a child in an HIV family to get admission or continue schooling, without financial support for education costs. When mother/father is ill, or dead, and when their households have no regular income and are seeped in debts, they cannot attend school, much less get good grades. Most of the children whether HIV infected/affected are in schools because they hide their. There is a real fear of repercussions from friends, teachers and parents of the other children.

Child labour (Regulation) Act is silent on how the child headed or a grandparent headed household are expected to get their meals. The state schemes are not viable, for example to get a pension amount of Rs.200/- for a month, a woman has to open a bank account by paying Rs.700/- and travel at least twice to get the passbook, produce residence and income certificates, proof that she is poor and widowed. In such a case, it is, but natural for her to send her minor children to work and sustain the family.

Child marriage is common in villages and it is more so when the girls are orphans. As the children lack the feeling of belonging they are easily lured. There are predators that trap her because she is vulnerable. HIV positive men prefer to marry uninfected women, as she will guarantee him nursing care as well as give him an heir and propagate his name. NGOs and Activists and few sensitive Govt.Officers have rendered meaningful support during trying times.

87 Sri Lanka Individual

Police and Sex Work in Sri Lanka

Nayana got into sex work in 1987 when she was ‘sold’ by her husband to another man. Her two young daughters were given in adoption around the same time.

Nayana has attempted to give up sex work on a few occasions. In 1992 she got a job as a cleaner. On one occasion while returning home after her cleaning job she was taken into police custody even though she was not soliciting. Yet because she had previously been identified as a sex worker police still took her into custody even though she was not soliciting. ‘The police tell us that they need to file a certain number of cases every month. So if they recognize someone they have taken in previously, they will take them in again, even if we are not engaged in sex work’, says Nayana. On another occasion she was arrested from a residence she was sharing with her male partner.

Soliciting for sex on the street is illegal in Sri Lanka and police use a 1840s law to repeatedly harass sex workers. Some sex workers are forced to provide sexual favours or money in order to buy their freedom. Since soliciting on the street is illegal sex workers have no option but to endure the harassment and humiliation that the police
engage in.

In 2007 Nayana’s two daughters who were living abroad had traced her and provided her the means to stay out of sex work. Yet in November 2010 she was picked up yet again by the police and publicly humiliated.

Possession of condoms is used as prima facie evidence of sex work. ‘Only a sex worker needs condoms’ is a frequent taunt of the police says Nayana. Possession of condoms is used as an excuse to humiliate sex workers and then take them into custody.

The Community Strength Development Foundation (CSDF) which provides a variety of support services to sex workers in Sri Lanka also complains that the police practice of arresting and harassing sex workers in Sri Lanka has prevented them from implementing an effective HIV prevention programme.

The CSDF operates a HIV prevention programme that distributes condoms among sex workers, provides counseling services and helps sex workers access health care.

CSDF’s HIV programme has been hampered by a number of police practices including the practice of arresting sex workers at all times of the day. Sex workers are reluctant to carry condoms with them for the fear of being ‘picked up’ by the police, says CSDF.

According to CSDF sex workers that spend time in prison or police custody return to sex work and try to ‘make up’ the lost time by engaging additional clients. They also tend to engage in ‘high risk’ sexual activity to make up for the lost time.

The police also frequently raid ‘condom drop off points’. The CSDF uses these ‘condom drop off points’ to enable sex workers to access condoms with ease. However, frequent police raids at these points have made this task much harder.

Police practices in Sri Lanka need to be changed to ensure that they are sensitive to and support groups (including sex workers) that are most vulnerable to HIV. Police humiliation and harassment of sex workers must cease and the police should instead partner health officials to promote safe sex practices among sex workers.

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**Cambodia Community Empowerment Program**

Exclusion of and human rights violations against the Lesbian, Gay, Bi-sexual, Transgender (LBGT) community, entertainment workers (EW), People who live with HIV/AIDS (PLHIV), Orphan Vulnerable Children (OVC), Drug Users and Immigrant in Cambodia. In Cambodia diverse sexual orientation and gender identity remains culturally unrecognised. As the country recovers from years of civil war and citizens begin to claim their rights, the LGBT (esp. transgender) community has remained largely underground. Although homosexual acts are legal in Cambodia, openly Lesbian, Gay, Bisexual and Transgender people remain politically and socially marginalized. LGBT Cambodians suffer from discrimination & abuse; including violence, workplace discrimination, social & familial exclusion. Currently, whilst some NGOs are working on LGBT health issues and social space is opening up in which LGBT Cambodians can express themselves, there is no group focusing on promoting and protecting LGBT Rights and mainstreaming those rights.

Similarly, EW, PLHIV, Drug Users and OVC are over looked. They suffer from discrimination, abuse and HIV transmission; including violence, social & familial exclusion just because of their job title, types of diseases and economic status. Most of NGOs are working on health issues especially, HIV preventions but not empowering the entertainment workers, Drug users, OVC, Immigrant and a little bit on PLHIV to use their rights.
There are no laws to protect LGBT (esp. Transgender) and Female Sex-workers in the kingdom. There are a lot of violence and discrimination against these groups of people and everywhere. Corruption is the best player now to keep LGBT, EW, PLHV, Drug Users, OVC, and Immigrant at risk of HIV transmission. Those Transgender and Sex workers have arrested and sent to prison if they don’t pay money between 10 to 100 $. The brothels were closed down, but there are a lot of those sex workers become indirect sex workers (sometimes called entertainment workers). The 100% condom use policy is not workable as many cases that police arrested people who have condoms in their hands or sit in the public parks late at nights. And said those people are against Human Trafficking Law as well as The Kingdom’s Culture.... The culture keep those younger generations to not talking about sex or sex education are not included in school system. And those young generations are soon having sex and unsafe sex. Those adult people are watching porn movies through internet, Bluetooth,...The more younger generations will be facing more HIV transmission compare to their older generation.

**The Solution** The Community Empowerment Program - is designed to address this situation, by facilitating a network of LGBT, EW, PLHV, Drug Users, OVC, Immigrant and empowering – rather than attempting to lead from the ‘top down’ - these groups to take grass roots actions to improve respect for these groups rights throughout Cambodia and to raise awareness and understanding of their issues and rights. The premise on which the project is based on is civic-driven change – that bringing about respect for their rights is best brought about by individuals, communities, CBOs and SBOs, but that these groups need to be empowered to work effectively through skills and knowledge sharing, and practical assistance. The Network will not be strongly branded, speak on behalf of its participants nor enforce unnatural joint advocacy. The Network will encourage natural alliances between its participants; these alliances will not necessarily. The Network will see International and national NGOs playing an assistance/empowerment role where requested, rather than leading others. The Network will result in community-driven action to promote and protect their Rights.

Simultaneously – linking into the Research, Policy and Advocacy Program – we will initiate dialogue and undertake detailed research and analysis of the situation of the LGBT, EW, PLHV, Drug Users, OVC, Immigrant Network in the Region with regards to rights; advocating nationally, regionally and internationally for policy, legislative and other changes to bring about improvement for respect for their rights in the Region.

**Activities**

1. **Build network of those working in HIV areas:** We should build on the infrastructure it is developing to facilitate a more vibrant civil society, to develop information resources to facilitate the Network. The activities in this regard will include the following:

   a. The development and maintenance of an online LGBT, EW, PLHV, Drug Users, OVC, Immigrant rights portal with relevant resources available in National and International languages.

   b. Development of a hotline, helpdesk and referral system to provide a mechanism through which Network Participants can – amongst other things – report ongoing LGBT, EW, PLHV, Drug Users, OVC, Immigrant violations and seek guidance with regard to organizations that can provide assistance and services on any given LGBT, EW, PLHV, Drug Users, OVC, Immigrant issues.

   c. Creation of the network introductory resources - in hard and soft copy – available through the Human Rights Portal and the LGBT, EW, PLHV, Drug Users, OVC, Immigrant Portal, and by delivery throughout the region. These introductory resources will include a guidance manual to the Network and its resources.

   d. Creation of a living Directory that will provide information on the Network Participants. This directory will be regularly updated as more communities, CBOs, SBOs, HRDs, private sector organisations and others become involved in the Network and will set out the name, contact information and areas of specialism of each Network Participant.
2. Developing an LGBT, EW, PLHV, Drug Users, OVC, Immigrant Rights training curriculum, training those in the HIV sector to be aware of LGBT, EW, PLHV, Drug Users, OVC, Immigrant issues (i.e. mainstreaming LGBT, EW, PLHV, Drug Users, OVC, Immigrant rights into the provision of health);

a. We should identify Target Beneficiaries – individuals, communities, CBOs, SBOs, HRDs, private sector organisations and others throughout Cambodia - to participate in the Network. We will achieve this through the following actions:

- Use our own extensive contacts and those of existing partner NGOs and Target Beneficiaries;
- Utilize publicly available information in hard copy and online; and
- Send Project staff on field trips to identify Target Beneficiaries.

3. Conducting training around the country to the network participants;

a. Network participants are provided with the introductory resources including the guidance manual to the Human Rights Portal and LGBT Portal, EW, PLHV, Drug Users, OVC, Immigrant Portal and introductory manual as well as the LGBT Rights Network Directory. Distribution of these materials will be made in soft and (where necessary) hard copy.

b. Network Participants are trained on using the LGBT Rights Network infrastructure, including – for those with access to the internet – the Human Rights Portal, and other Portals.

c. With their permission, Network Participants are ‘mapped’ on the Google map on the Human Rights Portal - linked to the other Portals - so that other participants are aware of their participation in the Network.

d. Knowledge transfer, to include:

- Legal expertise: We should be in a position to offer information in areas of human rights expertise to the Network Participants. Specifically, the legal expertise will provide training on LGBT, EW, PLHV, Drug Users, OVC, and Immigrant Rights, that is non-discrimination and equality their rights to enjoy universal human rights.
- Human Rights Library: The Human Rights Libraries should be more active in the process of developing library and resource centre any place where are easy to access. These libraries will contain human rights - including LGBT, EW, PLHV, Drug Users, OVC, and Immigrant Rights – resources that will be made available to the public. Network Participants will be encouraged to use the Human Rights Library.

e. Skills transfer, to include:

- Monitoring and Documentation: The monitoring and documentation of human rights violations. We can offer training to Network Participants on monitoring and documenting LGBT Rights violations.
- National, Regional and International Mechanisms: The legal expertise and Network Participants can facilitate engagement with complex and demanding national, regional and international Human Rights mechanisms.

f. Practical Assistance, to include:

- Raising Awareness: The legal expertise and others can assist Network Participants to advocate and raise awareness about their work and specific concerns.

Protection: The legal expertise can provide assistance to individuals and/or organisations facing intimidation or threat as a result of their activities in the furtherance of LGBT, EW, PLHV, Drug Users, OVC, and Immigrant Rights. Intimidation and threats can take a number of forms, including threats to the personal safety of and
criminal charges against individuals. The legal expertise can link Network Participants with international organisations that provide financial and other forms of assistance to human rights defenders who are the subject of threats and intimidation. The assistance can come in a number of ways including the provision of financial aid in order to secure legal services, to pay for medical assistance or to provide for the family of a human rights defender who has had to go into hiding. In this regard, the legal expertise will make information available to Network Participants concerning lawyers and other services that may be relevant to individuals under threat and can act as a link between the Network Participants in question and the lawyers and relevant service providers.

### Compulsory Licences

AIDS treatment is an important illustration of the benefits of encouraging generic competition. It was only with the arrival of generic anti-retrovirals produced by Indian companies on the market in 2001 that prices started to reduce significantly - from $10439 to $350 for first-line AIDS treatment.

Today, Tenofovir a crucial first and second line HIV drug is now available at $85 per patient per year with increased generic production - a drug that cost thousands of dollars and was not even available in India and other developing countries in 2004.

This price reduction due to generic competition from India continues to help save millions of lives of people living with HIV/AIDS.

But, the World Trade Organisation’s (WTO) Agreement on Trade Related Aspects of Intellectual Property Rights (the TRIPS Agreement) made it mandatory for India to have a product patent regime for medicines by 2005, a commitment fulfilled by Parliament on 23 March 2005 when it amended the Patents Act, 1970.

There is a growing concern about those new pharmaceutical compounds invented after 1995 that have been patented in India. Under the amended law, a company holding a patent on a new drug in India can effectively prevent the generic pharmaceutical industry from producing or selling the drug in the developing world during the patent’s term - which, according to WTO rules, is a minimum of 20 years. This in turn allows companies to charge high prices, because there are no competitors in the market.

Patent monopolies in India in the coming years will likely result in high prices for new essential drugs putting them out of reach for the majority of Indians and those living in developing countries. Patients needing to switch to newer treatment would bear the brunt of this, particularly as resistance to current HIV/AIDS and tuberculosis medicines is growing across the world.

Five years after the after the amendment of the India Patent Act, the effects of the product patent regime are now being seen.

Newer patented drugs are prohibitively expensive for the government to purchase and will remain out of reach for patients. Southern Railways procurement prices in India for two patented pharmaceutical products reflect this reality. The patented breast cancer drug *trastuzumab*\(^1\) costs Rs. 90,432 per injection and the patented hepatitis C drug *pegylated interferon alpha 2b*\(^2\) costs Rs. 11,492 per vial\(^3\).

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\(^1\) Patent No: IN205534
\(^2\) Patent No: IN207233
HIV is a lifelong disease and as resistance develops patients need to move onto newer treatments. Anecdotal data suggests that some PLHIVs on treatment are experiencing resistance to not only first but also second line ARV medicines. For those who fail second line, salvage therapy is likely to be with *darunavir* (boosted with *ritonavir*), *etravirine* and *raltegravir*. While *darunavir* and *ritonavir* are generically produced there is no generic production of *etravirine* and *raltegravir*.

India is now witnessing the effects of patenting on the availability and price of new medicines for HIV. Patents on *raltegravir* and *etravirine* (new ARV compounds) in India discourage generic manufacturers from developing the API (raw material), investing in process technology that will make production more cost effective, obtaining preliminary manufacturing licenses for sample batches, developing easier to use fixed dose combinations, investing in bioavailability and stability studies for pre-qualifying the drug with the World Health Organisation. Currently the maximum retail price (MRP) in India itself for *raltegravir* drug is about $7 a day which works out to approximately 2555$ per patient per year (ppy). For *etravirine* the approximate price for Africa is $3,204 ppy.

It is therefore appropriate that the Indian government now consider compulsory licensing to open up generic production of new medicines including ARVs.

Compulsory licensing is the authorisation given by the government, judiciary or the competition commission to a third party to produce, market and supply a generic version of a patented drug, without the consent of the patent holder. Under Article 31 of the TRIPS Agreement, CLs are a legally recognised means to overcome barriers in accessing affordable medicines. Generic competition has not only led to significant price reductions but also brings with it benefits of multiple quality suppliers and registrations of the medicines with drug authorities in developing countries.

Encouraging data, on AIDS treatment, shows that we can make progress against the epidemic – by decentralizing treatment; and by putting people on better treatment, earlier. But just as these new WHO treatment guidelines are being integrated into developing country treatment protocols, a stagnation in donor funding, coupled with patents in India threaten to block future supplies to AIDS programmes.

I would like to present my views as a public health lawyer on the growing concerns on ARV patents in India and the measures that can be taken to mitigate it before a full blown crisis hits AIDS treatment programmes in developing countries.

**Intellectual property rights and access to medicines**

I am a person living with both HIV and Hepatitis C (HCV) for many years. I have been on ARV for more than 5 years and I had an unsuccessful treatment for HCV in the past and currently I have been on treatment again for HCV for the second time. My treatment for HCV is mainly supported by few individuals and organisation that I worked for as I can not afford it. HCV is usually treated by Pegalted interferon in combination with ribavirin for 12 months. Peg Interferon injection is given once a week with daily ribavirin tablet. I pay more than 15,000 Indian rupees (about 336 USD) for one week supply of the two medicines.

Currently Peg interferon is patented in India and many other countries so the patent holders are selling the medicines beyond affordable price thereby leaving many people like me out of reach of the medicines. I have seen many people dying because of HCV. They simply could not afford the medicines.

The availability of HIV drugs in the developing world became a reality when generic companies started
producing them like the ones in India. Similarly we need to promote laws and policies that will facilitate the availability and affordability of all life saving medicines including for HCV.

I hope the commission will consider my submission as of worthy and discuss about how protection of intellectual property rights can prevent millions of people from accessing life saving medicines and what actions government of developing countries should take up.

91 Malaysia

LAC/PT/MAC Legal Clinic of the Malaysian Bar Council

Introduction: The Bar Council of Malaysia

http://malaysianbar.org.my

- Article 8 of the Malaysian Constitution “All persons are equal before the law and are entitled to the equal protection of the law”
- Section 42(h) Legal Profession Act 1979 “The purpose of the Malaysian Bar shall be to make provision for or assist in the promotion of a scheme whereby persons may be represented by advocates and solicitors”

The Malaysian Bar is a creature of statute established under the Advocates and Solicitors' Ordinance 1947 which ordinance was subsequently repealed by the Legal Profession Act 1976. It is an independent Bar whose aim is to uphold the rule of law and the cause of justice and protect the interest of the legal profession as well as that of the public. The legal profession in Malaysia is a fused one with a membership of approximately 12,000 members and its membership is increasing by 10% to 15% annually.

The Bar Council Created the Legal Aid Centre in all states in Malaysia except for Sabah & Sarawak and annually all lawyers contribute RM100 each for the Legal Aid Fund which is run by the National Legal Aid Committee. The NLAC oversees all the state Legal Aid Centres (LAC).

Motto

Ignorance of the law may be bliss but it is not a defense. The law and legal system is seen to be present and practical in every aspect of our daily lives and routines.

Therefore the Legal Aid Centre’s (LAC) objective is to enlighten the public various fundamental and legal rights and liberties that they are entitled to.

Legal Aid is a step towards affording equal opportunity to the poor and the under privileged to secure justice which is their basic unfettered right. The primary objective in legal aid is to provide all citizens equal opportunity for the enforcements of their fundamental right to equality before the law.

History of Legal Aid

In 1976 the Legal Profession Act was passed and the Malaysian Bar was established as a body corporate. Inter alia, under object and powers of the Bar, Section 42 (1) states that the purpose of the Malaysian Bar shall be:

a. to uphold the cause of justice without regards to its own interest or that of its members influenced by fear or favor;
b. to protect and assist the public in all matters touching ancillary or incidental to the law;
c. to make provision for or assist in the promotion of a scheme whereby impecunious persons may
be represented by advocates and solicitors.

Kuala Lumpur Legal Aid Centre (Capital City of Malaysia)

The Kuala Lumpur Legal Aid Centre is the most active and well known Legal Aid Centre in Malaysia. It was set up and began operating various projects/program such as Dock Brief Program, Prison Programs, UNCHR, Women Clinic, Walk In Clinics and the 1st ever Centre which renders pro bono legal services for the marginalized communities namely the female Sex Workers (SW), Men Having Sex with Men (MSM), Transgender (TS), People Living with HIV (PLHIV), Drug Users (DU) and small number of lesbian group (hereinafter referred to as the “marginalized communities”).

LAC/PT/MAC Legal Clinic (Legal Clinic for the Marginalized Communities)

The LAC/PT/MAC Legal Clinic has been operating and providing legal assistance for the past 12 years to the marginalized communities. It’s an innovative collaboration between the legal fraternity, PT Foundation and Malaysian AIDS Council (two leading national HIV/AIDS non-governmental organizations in Malaysia) to address HIV related issues affecting the marginalized communities from a legal standpoint. The LAC/PT/MAC Legal Clinic stands for Legal Aid Centre in partnership with PT and MAC Legal Clinic and is composed of lawyers of the Malaysian Bar Council and pupil in chambers (qualified lawyers before being called to the Bar and robbed as Advocate & Solicitor) offering their services to help vulnerable and at-risk population groups affected by HIV and AIDS in the country.

Through the legal clinic, the LAC/PT/MAC Legal Clinic committee and their pupil in chambers are helping to address stigma and discrimination, provide legal counseling, legal intervention (escorting/telephone calls for the communities) and raise awareness on human rights and other legal issues related to HIV and AIDS. The committee has and continues to empower the marginalized communities to advocate and protect their basic human rights.

Our key program areas and examples of activities are:

1. Addressing stigma and discrimination
   b. Training of trainers – for new and young lawyers to understand the law vis-à-vis HIV so they understand they have a role to play in the national response

2. Outreach work
   a. OutDo outreach clinic – for women to understand the law and HIV.
   b. “Carnival Jom Ke Chow Kit” – sex workers program
   c. SAFE clinic in Brickfields – confidential VCT and screening services for HIV and STI open to all
   d. Legal assistance in cases of arrest of sex workers, MSM, PLHIV, Drug Users or transgender.

3. Awareness raising
   a. Law Awareness Campaign – a yearly campaign by the National Legal Aid Committee of Malaysian Bar Council for PLHIV, sex workers, transgender, other marginalized groups and the public.
b. Workshops on laws, human rights and HIV for the marginalized communities.

c. Frequent email dissemination of news related to human rights and HIV.

d. Video interviews with university students on topic of transgender and their plight under Malaysian law.

e. Production and dissemination of posters and brochures on HIV and law.

f. Paralegal and Human Rights Awareness Workshop attended by Transgender from other States including Sabah and Sarawak. The invited speakers were from the Attorney General Chambers (AG), Police Departments, Religious Authorities, SUHAKAM (Human Rights Organization), Lawyers and Interested groups acting for PLHIV

g. We had participated in the International AIDS Memorial day whereby we managed to place our leaflets into 200 goodie bags for people dissemination and we conducted legal clinic booth to provide free legal advise for PLHIV

h. We were interviewed by a documentary journalist Poh Si. This documentary was to be submitted for the annual competition held by KOMAS (Freedom Film Fest) on issues related to the laws which affect TS under the syariah and the civil laws. Her documentary called “Pecah Lobang” was based on Muslim Transsexuals in Malaysia and the issues they faced including the legal hurdles which defy their basic rights. The said documentary is currently being sold by KOMAS and the site is http://pecahlobang.com.

i. We also conducted legal intervention with DBKL on a welfare home (“Crisis Home”) which housed people living with HIV/AIDS. The said home was facing demolition due to the complaints of the surrounding residents who did not want HIV positive people living close to them. We provided legal advise and issued letters to DBKL to reconsider their decision and the matter been kept in abeyance. The home’s express gratitude to LAC was mentioned in the Home’s newsletter.

In 2009 and 2010, the LAC/PT/MAC committee's collaboration has made good impact on improving awareness and knowledge of the law and HIV for the key marginalized communities, and their ability to advocate or use the law to their benefit. It has reached out to all the key communities and the public as well as partnered with related NGOs on issues ranging from women, employment to police harassment.

Equally important is facilitating dialogue with religious authorities to understand both the law and the communities affected by HIV so that they are not victimized.

The LAC/PT/MAC Legal Clinic committee is also in the process of drafting the 1st Malaysian HIV Bill which we hope will someday be adopted as a statutory act of Parliament and will define the rights and protection afforded to HIV patients in this country. The Bill will substantially deal with issues of discrimination, harassment and vilification which are commonly faced by HIV patients due to their disability and/or sexual orientation. Currently, we are seriously lacking in Malaysia are a law that protects these marginalized communities against discrimination, harassment and vilification that they face in areas of employment, education, services and benefits that they should by right have excess to.

Through its many activities, this LAC/PT/MAC collaboration has made significant contributions to the national HIV response in the area of HIV and the law. But much more needs to be done as evidenced by the continued harassment, beatings, verbal abuse, ill treatment of those arrested or detained by the relevant enforcement authorities.
One of our objectives is to continuously educate these marginalized communities on their rights which is afforded to every citizen of the country under our Federal Constitution and to give them the basic legal knowledge and procedures (arrest, detention, court process etc) so that they may utilize it and so that may ensure that is no abuse of power by the relevant enforcement authorities, which is prevalent and a common complaint among the marginalized communities.

The LAC/PT/MAC Legal Clinic also recognizes three key challenges:

1. Lack of volunteer lawyers interested in helping HIV affected communities or handling challenging cases for free;
2. Legal clinics should be set up in more states in the country to improve accessibility to legal counsel and services as currently we only have the resources to offer such services in Kuala Lumpur;
3. A special fund should be set up where monetary support can be sourced to help defend individuals from the marginalized communities especially for ‘test’ cases or for duty solicitors (paid lawyers to act for arrested people/on call lawyers)

The number of criminal and civil cases handled by the LAC/PT/MAC Legal Clinic has grown from 20 in 2009 to 41 in 2010. The type of cases that were dealt with includes cross dressings offences (under the Islamic syariah law), employment, unlawful arrest (civil and syariah), identity card, expulsion from school, breach of contract, discrimination by employers and financial aid matters.

This shows two things: one, more cases of the marginalized communities are being prosecuted, and two, an improved awareness for those affected (by arrest or harassment) to access the law (i.e. to turn to our legal aid clinic) to protect their rights.

CHRISTIAN POPULATIONS AS LAW MAKERS, LAW ENFORCERS AND LAW REINFORCERS

The reduction of law-related harm for Christians

The reduction of law-related harm is an on-going problem for Christians, which can be traced back to the time of Christ and earlier. Christians commonly perceive ourselves as people who champion and live by grace. However, contrary to this, our collective, public presence, in the presence of HIV, is commonly identified with dangerous and life-threatening law enforcement.

Christian understandings of sexuality are commonly outlined in relation to laws defining heterosexual marriage. Christian aspirations of ideal human existence are often framed around moral judgements of ‘goodness’, ‘purity’, ‘holiness’, ‘righteousness’, etc, which are commonly reflected in legislation and rulemaking.

The progress of HIV in Asia and the Pacific has both permitted and demanded that populations of drug users, sex workers, men who have sex with men, migrants, young people, and women, describe their own experiences of sexuality and humanity. A kind of estrangement has developed between people who talked about HIV in their own terms, and those who have persisted with reference to legal frameworks. I sense that this estrangement may become unnecessary, exaggerated conflict with the clarification of vulnerability to HIV within the framework of human rights.
The reduction of drug-related harm

Between 1993 and 2007, I worked with drug users and people living with HIV in India. I worked with an NGO, called Sharan, in the design and scaling up of a continuum of care for drug users. The ability of drug users to participate in sustained health seeking was significantly aided by securing predictable and legal access to oral substitution therapy, as well as a supportive law enforcement and policy environments.

Based on my experience with Sharan, I outlined a response to the dilemmas raised by ‘harm reduction’ amongst drug users, which confronted Christians, who were interested in HIV prevention. A short paper, called ‘The reduction of law-related harm – A Biblical Affirmation of HIV prevention’, was published in theological journals in both India1 and Australia2. In it, I argued that Christians make 3 specific affirmations:

1. Affirm a commitment to life over a commitment to law, because sometimes, attempts to be faithful to law have harmful consequences.

2. Increase the opportunity for people to change, affirming and enabling small changes (though many argue that this is ‘making sin safer’).

3. Evaluate, revise and update the law because it often isn’t detailed enough and can’t predict many things, which have not yet happened.

These affirmations have proven to be acceptable reference points within the growing Christian acceptance of the reduction of drug-related harm in India. However, they do not address the complexities arising in contexts of competing (legal) foundations.

A competitive legal context

From 2005-2007 I worked in North East India as a ‘harm reduction adviser’ in AVAHAN, a large scale, HIV prevention initiative, sponsored by the Gates Foundation. Unlike many places in India and around the world at that time, the states of Nagaland and Manipur had access to life-saving policies on paper, as well as substantial human and financial resources for HIV prevention. Despite these policies and resources, drug users still faced a range of life-threatening situations due to the complex array of different legal frameworks around them. The legal frameworks interacting simultaneously, often unpredictably, and sometimes violently, in this region include local law enforcement, national border control, ‘national security’ restrictions, international drug control, Christian moral law, the customary laws of various tribes, and competing insurgent movements.

Seeing the action of Christian moral law in this dangerous blend of legal frameworks, motivated me to sustain my involvement in the subject of HIV prevention, even when the vital personal interactions with drug users and people living with HIV were not constantly present.

A ‘profound’ challenge for Christians

Since returning to Australia in 2007, I have been facilitator of the Micah Network’s HIV Forum. In 2008, the Micah Network supported the World Evangelical Alliance (WEA) to design a ‘Call to Action’. A one page document, entitled ‘HIV – Call to Action’ was endorsed by the WEA’s General Assembly. The following is an uninterrupted quotation from that document (the bold italics are mine).

“...we will seek to live out incarnational faith working in partnership with the most marginalised and vulnerable to HIV infection.

As a community of Evangelical Christians we believe that all people regardless of belief, identity, gender, ethnicity or health are created in the image of God (Genesis 1:27). Hence it is an essential element of our identity that we bear witness to the love of God for all people in word and deed, in private and in public. We
therefore resolve to strengthen our theological reflection and practical action in our advocacy, respect for life and justice with dignity for all people. We realize that this resolution will profoundly challenge us as we deeply long to be a holy people who please God (1 Peter 1:15-16; Matthew 5:8). We reaffirm that we all live in and by the grace of God (Ephesians 2:8-9; Romans 5:1-2) and agape love (1 Corinthians 13:1-8).

We commit to working in HIV prevention in partnership with others to halt and reverse the spread of HIV. In so doing we understand that there are many social drivers that contribute to HIV transmission and that no one group or organisation can do everything. We will therefore work alongside other sectors of society so that all people will know how to protect themselves from infection and have access to the services needed to do so.”

At the heart of the above quote is a recognition that this statement is profoundly challenging to Christian groups. Below are three of these ‘profound’ challenges.

Human rights – a competing foundation?

Human rights is perceived by many Christians to be an inferior foundation in competition with a guiding foundation drawn from Christian sacred texts. The commitments and visions from the above WEA statement, which I have highlighted in bold italics are the same commitments and visions of dignity for all humans and a world without HIV, which are articulated in the ‘Call for submissions’ by the Global Commission on HIV and the Law. While the Global Commission and the WEA articulate the same visions and commitments, one appeals to human rights, and the other appeals to the Bible as their points of reference.

The language of human rights

Following the International AIDS Conference in 2010, with its strong emphasis on human rights, I posed the following question to the Micah Network’s thematic online HIV Forum... "Are we willing and able to participate in HIV and AIDS-related responses which are understood and described in terms of human rights?" The question attracted an animated discussion, which highlighted that many people who practised values of justice, dignity and equal value for all in their work, were not comfortable with the use of human rights language. Many people struggle to entertain notions of human rights which do not simultaneously articulate human responsibilities, or which appear to elevate the rights of individuals over the rights of communities. Christians are confronted by the problem that renewed resolve to enter into multi-sectoral partnerships may be undermined by unwillingness or inability to speak the same language as other population sectors.

The question of ‘all people’

Justice is the common foundational value, underpinning Christian approaches to the application of human rights to HIV prevention. However, existing understandings of justice have not yet been applied within Christian scholarship to support the human rights of all people. Some populations of women and ‘people who are living with HIV’ have articulated a social critique, which has established their specific contexts of injustice before custodians of Christian moral law. However, these approaches may not remain acceptable when applied by homosexuals, drug users and young people — i.e. populations who are perceived to be in need of correction according to the laws of today. For example, neither drug users, nor homosexuals, nor sex workers were acknowledged among those attributed with informing the theologians’ understanding of HIV epidemics in the Ecumenical Advocacy Alliance’s Global Theological Conversation on HIV prevention6, even though all three populations did influence the theologians guiding the discussion.

Conclusion

Many will correctly argue that the problems outlined above are problems of our own making. That is consistent with the identity of law-makers, law-enforcers and law reinforcers, which Christians intentionally and unintentionally bear. I have not attempted to assess the severity or priority of these problems in the Asia-Pacific region. However, overcoming the estrangement of populations with ‘Christian’ identity from criminalized and
marginalised populations, with their unique wisdom for working towards safe and respectful societies, cannot be resolved apart from one another. I hope that this important regional dialogue will some how support Christians to recognise and respond humanely to the grace extended by people who have been marginalised by law-making, law-enforcement and law reinforcement.


4 The Micah Network is a Global network of Christians who want commitments to justice and compassion to be essential expressions of their faith.

5 Full text is available at http://www.worlddevangelicals.org/news/article.htm?id=2242


Introduction

In every country in the region law has an important impact on how sex workers work and live and therefore on public health. Law, and how it is enforced, plays a key role in determining sex workers vulnerability and resistance to human rights abuses, social exclusion, poverty and illness.

Justice eludes sex workers throughout the region. Women, men and transgenders who sell sex are in prisons and detention centres in many countries. Millions of sex workers sell sexual services in substandard physical workplaces with abusive conditions and no tools for obtaining better conditions. There is a lack of proper resource allocation for local programming and for regional, national and local advocacy.

Sex workers in Asia and the Pacific have a long history of advocating for changes to the laws, rules and policies that affect female, male and transgender sex workers. Some of the reforms that sex workers demand are universal, such as removal of criminal laws against the sex industry and the proper use of law to protect sex workers from violence and crime. Some demands are country specific according to local legal systems and cultural contexts.

Our recommendations and demands aim not only to improve the lives of sex workers but to achieve public health, social and economic goals and advance gender and sexuality rights as well. Moreover we assert that our agenda for legal rights has the potential to create an environment in which child sexual abuse, human trafficking and other exploitation and crime associated with criminalised commercial sex can be addressed.

Human rights apply to all people, including female, male, and transgender people who sell sex and people living with HIV. Governments have a responsibility to promote, protect and fulfil these rights by putting in place relevant laws, policies and programmes.

In reality, sex workers are one of the social groups least protected by law, most harassed by law enforcement
agencies and most seriously discriminated against within their communities.

In almost all countries some activities associated with commercial sex buying, selling and brokering commercial sex or some are illegal. In a few all aspects are illegal – or facilitating commercial sex. As a result

A complex landscape

A vast range of laws, regulations, bylaws, ordinances, and other legal instruments permit police and other authorities to harass, arrest and detain vulnerable groups, often arbitrarily, in a manner that impedes their access to HIV services and violates their basic rights. These include criminal laws, immigration laws, municipal by-laws, zoning laws, family laws, employment laws, and public health laws.

The Commission must understand and address this complexity and its importance in the lives of sex workers. Its recommendations must reflect the broad experience not just the formal process of the criminal law. In fact very few sex workers in Asia are charged with prostitution and jailed or fined for it.

The Commission should recognize that we need multiple avenues of redress opened up. This includes changes in regulations that enable sex workers to obtain full citizenship benefits, legal-aid services and know-your-rights campaigns as well as political commitment to recognizing the urgent need for law reform and actions to defend human rights, for example by prosecuting police that rape and beat sex workers.

Key Issues:

APNSW hopes to present to the Commission on these select Key issues:

- The impact of criminal laws on the health and human rights of sex workers and others who work in the sex industry or are affected by it.

- The need for legal recognition of sex work as an occupation and the recognition of sex workers as full legal persons.

- The impact of anti-trafficking laws and programmes on sex workers and sex industry HIV programmes

- State directed and state sanctioned violence against sex workers

- The practice of using condoms as evidence and/or destroying condoms and safer sex materials.

- Mandatory and coercive medical procedures including HIV testing

- laws that criminalise HIV+ sex workers and policies and programmes that discriminate against them

Recommendations

- Removal of all laws that directly or indirectly violate the human rights of sex workers.

- Recognition of sex work as an occupation.

- Urgent review of the research, interventions, policy and full scope of national and international law that governs understandings of, and responses to, sex trafficking and slavery like practices within sex industries.

- A review of the impact of the various international treaties that affect sex workers such as the Palermo Protocol and CEDAW which have varying definitions of what constitutes prostitution, trafficking and exploitation of sex workers.
- An end to the law enforcement practice of using condoms as evidence and/or destroying condoms and safer sex materials.

- Legislation that protects sex workers’ privacy and makes discrimination on the grounds of sex work status unlawful.

- Measures to prevent institutional and criminal violence.

- An end to mandatory and forced medical procedures, including HIV testing.

- The legal right to migrate and travel like other citizens and workers, and access to services during migration.

- Repeal of laws that criminalise people living with HIV who sell sex.

- Human rights monitoring of detention procedures.

- Proper enforcement of existing laws that could protect sex workers from violence and rights violations.

- An end to the discrimination experienced by children of sex workers and other family members.

- Improved training for police.

- Decriminalisation of drug use, homosexuality, and HIV transmission.

- Proper information and better research about sex trafficking including better research and estimates of numbers.

- Improved resources and mechanisms for monitoring the health and human rights of sex workers and the impact of policy and programmes at country, regional and global level.

- Expanding the agenda of women and HIV to include female sex workers.

- Meaningful involvement of sex workers in sexual health projects and policy development.

- HIV programmes need to be grounded in evidence- not based on discrimination. To this ends we call for repeal of the PEPFAR antipronstitution pledge.

- Access to voluntary, confidential, affordable health care for all sex workers. This includes sexual and reproductive health, TB, malaria and health services that meet the needs of male and transgender sex workers.

- Access to education, development, and humanitarian programmes and economic opportunities- especially access to social security, workers benefits and other retirement options for older sex workers.

- Humane medical care, nutrition, and sanitation in prisons.

- Treatment, including PMTCT, for pregnant HIV positive sex workers and care plans for mother and child.

- Better coordination and harmonised efforts within and between different government sectors and community agencies.

- Improved training of health care professionals and rules that obligate NGOs and medical staff to treat sex workers with respect.
- Better access to financial services such as banking, credit and microcredit (including workers savings programmes and cooperatives)

- Evaluation and accountability of economic empowerment and credit programmes set up for sex workers.

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"Existing law that panelize accessing Health Care service by the People who Inject Drug community in India".

**Background:** In early 1990s when HIV epidemic started among people who inject drugs, and the implications were imminent as HIV prevalence among the PWID was 90%, one of the highest in the world in the state of Manipur. Drug user families, friends and society were also affected at large, and the damages came into focus because of the catastrophes of a colossal economic, social and human cost brought into Manipur by the epidemic of drug use and HIV. Nevertheless, after two decade, now most of the state in India injecting drug use problem has been increasing.

**Key arguments:**

- Due to Narcotic Drugs and Psychotropic Substance (NDPS) Act in the country, drug users are treated as criminals. Law enforcers instigate whatever they want to penalise drug users, and existing law has been impacting the lives of drug users especially in accessing harm reduction or health care services openly in the society.
- Drug users are often harassed by various sections of the society - pressure groups like women’s groups, local clubs, anti-drug organisations, underworld persons, and even security personnel.
- Police and security personnel often harass and beat up anyone when caught with syringe in public places. Thus drug users continue to be exposed to risk associated behaviours. Even when a drug user is out of drugs (clean), they are often harassed and subjected to extortion for being former drug user.
- Marginalisation of drug users by law, fuels spread of HIV and other blood borne viruses not only among drug users, but also among women and children in the family and general community at large.
- There is lack of family support and drug users are often isolated from the local community, making it very difficult to address the issues. Stigma and discrimination towards drug users is still an issue in the society.
- More than a decade of NACO Programme in the country, PWIDs people still have very limited access to HIV services, since drug users are treated as criminals. This situation compromises existing harm reduction programmes specially to reduce the incidence of blood borne viruses.
- Existing Ministry of Social Justice and Empowerment (MSJE) drug funding treatment centres, are not able to cover all drug users who are below the poverty line or repeatedly relapse.
- FWIDs have often been physically harassed, and sexually abused by law enforcers and society at large.
- The NDPS Act has been giving a negative impact among young people who use drugs. Due to lack of experience, young drug users often end up in jail during their initial drug use, exposing them to extreme criminal ways of life. Due to this exposure, their innocence is lost by the time they came out of jail.

**Recommendation:**

- Plan and strengthen ongoing sensitisation and advocacy programmes among the stakeholders.
- To provide information and education among the PWID community on their right issues.
- To create enabling environment to increase ownership & participation for effective response in the existing HIV/AIDS program.
Like many of ME here today, transgendered individuals - transexuals, transvestites, GENDER VARIANT MALES, drag queens, who are physically intersexed or who embrace any behaviour or identity that crosses over or moves between the dominant culture's notion of male and female - we have been abused by the medical and psychiatric professions. Babies born with ambiguous genitals have had their bodies surgically altered without their consent, and often without even the consent of their parents. Children who exhibit gender or sexual behaviours that challenge the rigidity of conventional sexual or gender behaviours have been subjected to coercive behaviour modification techniques in psychiatric clinics in order to prevent them from becoming gay or transexual adults.

Transexual women who choose to transform their bodies so that others may see them the way they see themselves have been raped by the therapists who enabled their genital reconstruction surgery. We have been compelled to exchange sexual services for hormones. If we are female to male gay men we have been told by the so called experts on transexuality that we simply don't exist. We have been arrested, institutionalised, drugged, shocked, beaten and emotionally assaulted just because we insist on expressing ourselves the way we choose, leading the life we want to lead, being the people we want to be. These are things transgendered people share with many of the non transgender survivors of psychiatric abuse. We too get fucked over by power because we are different. We stand by you in solidarity to protest. We raise our voices with you to demand that this mistreatment stop. We work alongside you to bring these crimes to an end. But transgendered people are also involved in another kind of struggle with the psychiatric and medical establishment. We are engaged in struggle to gain control of our very identities. People with male bodies who seek to live as women or with female bodies as men, as well as people who radically reject their culture's ordering of gendered reality, are known to exist in many human cultures around the world and in all eras of recorded history. And yet the medical establishment claims the power to create us. It writes the books that seek to define us. It controls the procedures that enable us to live lives of our own design. Whereas I say I am achieving my desired gender, the doctors say they have assigned it. They do not make us who we are. While it is true that hormone use requires competent monitoring and that genital reconstruction surgery requires a skilled hand, neither hormones nor surgery require administration by non transexuals. We should not have to gain permission of people who have little comprehension of our lives in order to do what we want to do with our flesh. Transexuals are the most vulnerable group in the transgendered population because we renounce, for the rest of our lives, the privilege of having a natural body. It is significant that there is no diagnostic test for transexuality other than self reporting. The only way the shrinks know we're transexual is when we walk into their offices and say "I'm not happy with the body I was born into and I want to change my sex." If we insist on this desire for a few months they sign a piece of paper declaring us to be suffering from Gender Dysphoria Syndrome and referring us to an endocrinologist. If we perform to their satisfaction in our desired gender for at least a year, they'll sign another piece of paper granting us surgery. This assume that we can afford to support ourselves while we are transition. This assumes we can afford expensive medical insurance we probably don't even have. This assumes we don't get killed by some scared, hate filled bigot because we don't always pass as born members of our chosen gender. We do not willingly abide these conditions.

Our situation is simple. Other people - psychiatrists, therapists, doctors, exercise non consensual power over our bodies and our lives. As transsexuals we do not control the means of our own production. This has always been
the grounds for resistance, rebellion and insurrection.

We are a gender minority suffering from medical and psychiatric colonisation. You are our oppressors not our helpers. We are not a disease. We are not an emotional disorder. We are not crazy. We should not be in your Diagnostic and Statistical manual. We demand, as well, the quality healthcare for our particular medical needs that every human being deserves as an inalienable right.

As queer people, we transexuals and other gender minorities draw inspiration from the lesbian and gay movement that emerged after the Stonewall riots. We cannot forget however, as others do, that Stonewall began as an act of Transgender solidarity when street queers came to the aid of a female to male cross dresser - a passing woman who was resisting arrest. We protest the transphobia we encounter in the queer community that has co-opted our uprising and made it the symbol of less radical cause. But we take heart from the fact that homosexuality was considered a mental illness by the APA until 1973, until determined and militant political activism succeeded in overturning the stigmatisation and pathologization of many queer lives. As radical anthropologist Gayle Rubin has noted gay liberation merely paves the way for a broader movement. "Sexuality's keep marching out of the pages of the Diagnostic and Statistical manual and onto the pages of social history. At the moment, several other groups are trying to emulate the successes of homosexuals. Bi sexuals, sadomasochists, individuals who prefer cross generational encounters, transexuals and transvestites are all in various state of community formation and gender acquisition." And I would add, we are in various stages of revolt. As transgender activists, we believe, in the words of our stone butch comrade Leslie Feinburg, that transgender liberation is a movement whose time has come.

HIV & AIDS movement and activism provide us the stage to voice out our issues. Until and unless HIV activism become people's own and developmental discourse the impact will never be positive. If our life changes with dignity, with social security and positive recognization we will change!

May our rage inform our actions, and may our actions transform the world as they have transformed us.

Larkana has remained the popular city of Sindh Province due to political background of Shaheed Zulfikar Ali Bhutto and Murhtarma Benazir Bhutto former prime ministers of Pakistan. Larkana is also famous for culture and tourism because of Indus civilization which is more than 5000 years old that elements are currently present where world of people come and see. The history shows this civilization was very modern, technical, and colonial because till date every aspect can observe in shape of Moen Jo Daro (the City Of Dead) great example of the Indus civilization.

Larkana is in Northern areas of Sindh province and has central position due to geographical boundary/area. Larkana is very close to Baluchistan Province and has a motorway that connects it to the Punjab province as well. Larkana has completed its 100 year and has adequate resources in health, education, agriculture and satisfactory job employment.

Pakistan is Islamic country and according to the constitution and religion use and sale of illegal drugs, vine, sale of sex and purchase are criminal acts, therefore people remain in fear to declare themselves as sex worker, homosexual, a transgender person and drug user. Perhaps the Larkana is the city where drug users, sex workers, transgender person, and even migrants are practicing their activities according to the nature and behaviors.

This was the first time where Larkana noticed apart from other originates that was HIV/AIDS. The earlier cases which identified were the result of outbreak among injecting drug users (IDUs) in 2003. This outbreak presented new figure before the world regarding to HIV/AIDS and considered Pakistan as low prevalence but high risk
country.

In the outbreak 57 drug users (DUs) got test for HIV and 17 declared positive. These positive people prison at Central Jail Larkana where first case of HIV identified from, as in the background of HIV there was one prisoner had critical situation regarding to health finally he was tested for HIV and declared positive actually he was drug user and this was the main reason of having outbreak among drugs users in the Larkana.

Now figures have been out in the news papers, media also highlighted that Larkana is at critical stage because use of drugs is key reason of increasing HIV and drug users do these practices openly likewise get involve in sexual practices with their spouses, male sex workers and female sex workers. So drug users, male sex worker and female sex workers should stop their activities. The community also did re-act that sale of illegal drugs and sex should bane in the city, at this stage district administration closed brothel and raid on suspected spots where male, female sex workers do sexual practices as well as arrested many drug users, male sex workers, female sex workers, and transgender person.

This was the start where law enforcement agencies did harass, abuse and arrests the sex workers, drug user transgender person now it has become trend when ever transfer posting take places the first action is raid on sex workers male, female, and drug users.

The service providers or organization always have to dialogue with law enforcement agencies to respect their rights rather than harass and abuse but they have strong statements to arrest them. When dialogue held with marginalized communities or target groups they reported we are the victim of physical torture by law enforcement agencies also. In this situation the target population feels discriminatory role by the law enforcement agencies which has negative impact on behaviors of target population that mainly leads to risky behavior as revenge and that become the result of increasing rate of HIV.

As in organizational experiences many of the sex workers, transgender, and drug users became victim of law enforcement agencies by harassment, sexual abuse and drug use. A transgender person named as “KASHISH” is serving as outreach worker in Male Sexual health program by community support foundation he has been harassed, abused and arrested many times because on charge of selling sex but the law enforcement agencies couldn’t understand that he was promoting the skills and knowledge about HIV towards other sex workers, and transgender.

Now this was also challenge for the organization to grant his bail because this was third time he has been arrested. Kashish has embracement towards law enforcement agencies on being arrested time by time. In these circumstances a new challenge organization has to face that is denial among target group. At first hand they refuse to declare themselves as transgender, sex workers and also avoid getting services regarding to prevention and treatment.

As we know sale of illegal drugs is crime before the state but mainly drug users are so called responsible for this because they purchase such illegal drugs and use. This is responsibility of state to control illegal drugs not to arrest drug user for control. Many times drug users are being arrested and prison at jail but it don’t end here as they release start same practices with much desire than earlier to promote use of drugs as in revenge because control get more difficult.

In this situation any intervention couldn’t provide satisfactory results in order to reverse the rate of HIV/AIDS because whatever intervention takes place is for shorter period of the time and even in this shorter period if these matters get involve the project would not be successful. In the result we will have increasing number of drug users, transgender and sex workers who are from general population therefore not only target population but also general population is at risk of HIV.

This is reality that understanding the rights is big matter to deal and there is dire need to understand, practice
and enjoy these rights. This also should be notice that state must understand rights of individuals and develop policies accordingly. This is also responsibility of the state to implement these policies because till implementation doesn’t take place planning cannot give positive results.

This is the responsibility of every individual; institute; organization and department to understand rights and act accordingly otherwise each will face high stigma and discrimination because not only target but general population gets victim of wrong doings also. Being an organization Community Support Foundation has lot of hazards to intervene any project regarding to HIV/AIDS because we want to change behaviors and that can be possible when the target population have knowledge, positive attitude, give values than otherwise it would be very difficult in sense of abusing, harassment and punishing because this all has negative impact always which let not them to change behaviors and this is the main reason to lead HIV rather than reducing the rate.

Moreover, there is need to work in coalition where public private mix strategies through intervention can take place. This will also help in building capacity of law enforcement agencies and other department to work on issue of HIV/AIDS.

Perhaps, human rights must discussed at all corners especially in the context of HIV/AIDS so that each can understand the importance that why we emphasize on reversal of HIV/AIDS. It is growing evidence that children, youth and adult population is very near to the risk of HIV some do this unknowingly and some has denial which is why HIV is an epidemic.

The state must understand this also to be supportive to those organizations which are working on such critical issue because change is continuous phase not a process of single time through which we can say the goal has been achieved. It has been observed, analyzed and assessed that HIV rate is increasing than earlier it is due to lack of interest to work on issue or policies, programs, interventions are for smaller period of time till any program touch the success the exit strategy adopted.

Therefore the state must implement such policies and direct to the state agents in support of the organizations because organizations have lot of hazards in running HIV programs mainly stigma & discrimination towards target population by law enforcement agencies. Thus, it would be start to new methodology for HIV reversal.

This will be also called a dramatically change where government, NGOs and target population serve each other and rights properly understand by all. And time will come where no sex worker, transgender person, and drug user get denial from their practices may this become the new morning for each and every one because if we say the target population is on risk so I would say who those ofcourse people from general population are.

Now the organizations will have easiest task to intervene the project, facilitate the target population according to the human rights in the context of HIV/AIDS.

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**Impact of intellectual property protection on medicine prices**

Intellectual property protection increases medicine prices. For example, the patented version of medicines to treat AIDS cost US$15,000 per patient per year, but now there is generic competition, the generic version costs less than US$80 per patient per year.¹

While the World Trade Organization’s (WTO) Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) sets the minimum standards of intellectual property (IP) protection for its member countries, 11 countries in the Asia-Pacific region are still not WTO members and so are not bound by TRIPS. Nevertheless, they may be pressured by developed countries to implement IP protection anyway and a number of them are negotiating an FTA with a developed country which is likely to require them to agree to stronger IP protection than even TRIPS requires (known as ‘TRIPS+’), see below.

Six countries in the Asia-Pacific region are in the process of joining the WTO and so are very likely to face demands to agree to TRIPS+ obligations during this process.\(^2\)

TRIPS contains flexibilities that if used can reduce the impact on medicine prices. However, these flexibilities can be undermined by TRIPS+ provisions.

Most countries in the Asia-Pacific region are in the process of negotiating one or more free trade agreements (FTAs) with a developed country. Based on past FTAs negotiated by these developed countries, these FTAs are likely to contain a number of TRIPS+ provisions that can make medicines more expensive. These provisions can occur in the IP or investment chapters.

The IP chapter may contain requirements to join additional treaties, data exclusivity, patent term extensions, additional enforcement of IP etc, the effects of which are well known.\(^3\) For example, the European Union (EU) has a TRIPS+ IP enforcement law which it is exporting to the developing countries that it is negotiating FTAs with. This law has resulted in the seizure of multiple shipments of generic medicines which did not infringe IP laws in the exporting country (India) or the importing country (including in Latin America and Africa – where it was bought on behalf of UNITAID – a medicine purchasing facility established by a group of governments including two EU members\(^4\)) but were merely in transit in the EU.\(^5\) These seizures have resulted in the destruction or non-receipt by developing countries of life-saving affordable legitimate generic medicines.\(^6\) Many developing countries have expressed their concern at the WTO over these seizures.\(^7\)

It is therefore not surprising that in the current Trans-Pacific Partnership (TPP) free trade agreement negotiations involving Australia, Brunei, Chile, Malaysia, New Zealand, Peru, Singapore, the USA and Vietnam, a leaked position paper shows that the New Zealand Government (a net IP importer) has expressed caution about agreeing to TRIPS-plus provisions, given the different levels of economic development amongst the TPP countries.\(^8\)

**Impact of investment provisions on medicine prices**

However, the investment chapter of an FTA (or the equivalent provisions in a bilateral investment treaty (BIT)) can also limit the use of TRIPS flexibilities. This is because these provisions generally define ‘investment’ broadly, to include patents, clinical-trial data, market share, profits etc. There is also often an ‘expropriation’ provision, so that if the governments which have agreed to these provisions do anything that reduces the value of the investment, they must provide compensation and interest. This may mean that a compulsory licence reduces the value of the patent (which is considered to be an investment), so the investment provisions would require the government issuing the compulsory licence to pay compensation and interest. This is likely to discourage governments from using compulsory licences to obtain cheaper generic versions of medicines because by the time they pay the compensation and interest, it is unlikely to be any cheaper. It may also mean that there is

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\(^2\) Based on past WTO accessions.

\(^3\) See for example ‘Intellectual property in free trade agreements’, Sanya Reid Smith, Third World Network, 2008.


\(^5\) See for example WTO document: WT/DS408/1.

\(^6\) See for example WTO document: WT/DS408/1.


\(^8\) http://www.citizen.org/documents/NZleakedIPpaper-1.pdf
infinite data exclusivity, because the clinical trial data can also be considered as an investment. Therefore if a government ever registers the generic version, it could be considered to be expropriation and so compensation and interest would have to be paid.

**Impact of other chapters on the right to health**

Furthermore, other chapters of an FTA with a developed country can affect the right to health. For example:

- The developed country may require 80-100% of tariffs on its products to be removed. However, developing countries are more dependent on tariff revenue than developed countries (as it is easier to collect than income and other taxes). For example, Bangladesh receives 31% of its government revenue from tariffs, whereas the USA only relies on tariffs for 1% of its government revenue. When developing countries cut tariffs (for example due to an FTA), International Monetary Fund economists note that middle income countries are only likely to recover 45-60% of lost tariff revenue from other taxation sources and low-income countries are at best likely to recover 30% or less of lost tariff revenue from other taxation sources.\(^9\) They note that a value-added tax is not proven to make up for the lost revenue from lowering tariffs. If the health budget is not protected, this permanent revenue loss will mean a drop in health care services that can be provided, including to people living with HIV/AIDS (PLHIV).

- Services and investment liberalisation can have a negative impact on the right to health in a number of ways (both directly and indirectly (for example via the impact on affordable access to water)).\(^11\)

- These risks have been recognised by countries such as Ecuador in its 2008 Constitution and National Development Plan (National Plan for Good Living)\(^12\) which include:

  - A prohibition on the negotiation of agreements resembling free trade agreements\(^13\)

  - A requirement that guaranteeing the availability and access to medicines and public health interests shall prevail over economic and commercial interests\(^14\)

  - A requirement that the application of international trade instruments shall not undermine directly or indirectly the right to health\(^15\)

  - A prohibition on the privatisation of water\(^16\)

**Conclusion**

When any developing country or LDC agrees to TRIPS+ obligations, its impact on the right to health in that country is worrying. However, it is particularly troubling when a country which is a source of generic medicines for many other countries considers implementing TRIPS+ provisions.

India is currently negotiating FTAs with a number of developed countries and it is the largest supplier of generic

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\(^9\) More analysis of the way in which FTAs between developed and developing countries and WTO disciplines can affect the Millennium Development Goals can be seen at http://www.twnside.org.sg/announcement/MDGs&tradeagreementsSeptember2010.pdf.


\(^12\) These must be complied with according to Article 280 of the Constitution and Article 424 of the Constitution (public standards and acts which do not conform to the Constitution are not legally binding).

\(^13\) National Plan for Good Living

\(^14\) http://www.mmrree.gob.ec/pol_exterior/constit_eng.pdf

\(^15\) http://www.mmrree.gob.ec/pol_exterior/constit_eng.pdf

\(^16\) http://www.mmrree.gob.ec/pol_exterior/constit_eng.pdf
medicines to the developing world. The United Nations Special Rapporteur on the right to health has warned that the proposed EU-India FTA threatens the production of generic medicines.\(^\text{17}\) He noted that ‘millions of people in India and around the world may not be able to access to necessary, life-saving and life-prolonging medicines. People living with HIV would be disproportionately affected, because the majority of antiretroviral treatments used to treat HIV around the world are provided through generic medicines produced in India.’ He also reminded governments that ‘The United Nations Committee on Economic, Cultural, and Social Rights has also noted that State parties must respect the enjoyment of the right to health in other countries, and take steps to ensure that international agreements do not infringe or adversely impact upon the right to health.’ The Special Rapporteur concluded that IP provisions in the draft EU-India FTA should be urgently reconsidered.

Therefore we believe the Commission should recommend that:

1. Developing countries make full use of the TRIPS flexibilities
2. Least developed countries (LDCs) make full use of the transition period before they have to comply with the substantive provisions of TRIPS
3. Developing and least developed countries not agree to TRIPS+ provisions in any forum or chapter
4. Developed countries not ask for or insist on developing or least developed countries’ agreement to TRIPS+ provisions in any forum or chapter
5. Developed countries not ask developing or least developed countries to abstain from using their TRIPS flexibilities and transition periods
6. Developed countries not ask for developing or least developed countries to agree to provisions in trade or investment negotiations that would harm the right to health

Introduction

Antiretrovirals and other medicines are vital to ensuring the survival of people living with HIV/AIDS (PLHIV). However, intellectual property (IP) protection can make these medicines unaffordable. The effects of this can already be seen in the 10 million PLHIV who need treatment today and do not have access to it.¹

Stretched budget

Medicines take up a large portion of government and out-of-pocket spending. For example, for ministries of health in most developing countries, medicine expenditure is second only to staff salaries and benefits, accounting for perhaps 50-90% of non-personnel costs.² In Pakistan and the Ivory Coast, more than 90% of household health expenditure was related to medicines.³

According to 2004 data, the Malaysian Government spends RM800 million (1 US = 3.82 RM) annually on medicines to subsidize almost 97% of the healthcare cost.⁴ However, even in 2004, the Malaysian Government was unable to sustain the budgetary burden of subsidising these medicines.⁵ With a budget deficit of 7% of gross domestic product last year,⁶ Malaysia’s health budget is increasingly stretched.

TRIPS

For its 153 member countries,⁷ the World Trade Organization’s (WTO) Agreement on Trade-Related aspects of Intellectual Property Rights (TRIPS) sets the minimum level of IP protection. This requires patents on medicines for 20 years.⁸ (Least developed WTO members have until at least 1 January 2016 until they have to allow patents on medicines).

As patents are monopolies, the patent owner can charge high prices for its medicine as can be seen in the examples below.

TRIPS has a number of exceptions and flexibilities which countries can use to reduce the impact of IP protection on medicine prices. These include:⁹ high standards of patentability (so combinations of known antiretrovirals etc do not receive patents), maximising the ability to oppose patents before and after they are granted (to ensure that only high quality patents are awarded), allowing registration of the generic version during the patent term (‘Bolar working’), allowing parallel importation (the importation of the patented medicine from another country where it is cheaper) and compulsory licences.

Compulsory licences will be used as an example of the way in which use of these TRIPS flexibilities can make medicines (which are ‘an indispensable part of the right to health’¹⁰) more affordable. Countries which provide evidence of the increased access to treatment which is possible from use of TRIPS flexibilities include:

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⁴ http://www.haiweb.org/medicines/requests/surveys/200410MY/MalaysiaReportFINALvers2.doc
⁵ http://www.haiweb.org/medicines/requests/surveys/200410MY/MalaysiaReportFINALvers2.doc
⁷ http://www.wto.org/english/thewto_e/whatis_e/tif_e/org6_e.htm
¹⁰ A/61/338
Malaysia issued a type of compulsory licence to import the cheaper generic version of patented medicines for people with HIV/AIDS. It reduced the average cost of treatment per patient per month by 81% and more than doubled the number of patients who could be treated.\(^{11}\)

The Thai Government recently issued compulsory licences for three types of medicines and estimates that it could save it up to US$24 million each year.\(^{12}\) The World Bank has estimated that if Thailand uses compulsory licensing to reduce the cost of second-line antiretroviral therapy to treat people living with HIV/AIDS by 90%, the government would reduce its future budgetary obligations by US$3.2 billion discounted to 2025.\(^{13}\)

Brazil’s compulsory licence on one medicine used to treat HIV/AIDS was estimated to save it US$240 million until 2012.\(^{14}\)

Ecuador’s compulsory license for lopinavir/ritonavir, allowed it to access generic versions at half the price of the patented Kaletra.\(^{15}\)

**TRIPS+**

However, the use of these TRIPS flexibilities can be barred by requirements to comply with stronger IP protection (known as ‘TRIPS+’). For example, one of the many ways TRIPS+ provisions can make medicines more expensive is by effectively preventing compulsory licensing (and all the access to treatment that can provide, see examples above) by ‘data exclusivity’.\(^{16}\)

Developing and least-developed countries have TRIPS+ laws for a number of reasons including:

1. inherited colonial laws that have not been amended yet
2. bilateral pressure from developed countries\(^{17}\) (including via the USA’s Special 301 system)
3. free trade agreements (FTAs) with developed countries
4. joining the WTO after 1995 (‘WTO accession’) 
5. investment provisions (including in bilateral investment treaties)
6. TRIPS+ enforcement negotiations in a number of fora\(^{18}\)

Malaysia is currently negotiating an FTA with the USA (via the Trans-Pacific Partnership)\(^{19}\) and the European Union\(^{20}\). 


\(^{12}\) http://www.bangkokpost.net/breaking_news/breakingnews.php?id=116803. The Thai Ministry of Health has extensive additional documentation on its compulsory licensing system and the amount of money it has saved. Contact details of the relevant Thai officials can be provided if required.


\(^{14}\) http://ictsd.org/i/ip/38960/

\(^{15}\) http://www.citizen.org/pressroom/pressroomredirect.cfm?id=3116


\(^{17}\) See for example US government pressure of the Philippines government on this issue, http://www.cptech.org/ip/health/c/phil/philtimeline.html

\(^{18}\) See for example http://digitalcommons.wcl.american.edu/cgi/viewcontent.cgi?article=1016&context=research


\(^{20}\) http://www.bilaterals.org/spip.php?article18398
If the USA goes backwards and returns to the extreme TRIPS+ demands it used to insist on prior to May 2007, the World Health Organization’s (WHO) model estimates that (when applied to Colombia), it would require an extra US$1.5 billion to be spent on medicines every year by 2030. \(^{21}\) If this were not spent, Colombians would have to reduce their medicine consumption by 44% by 2030. \(^{22}\)

When the European Union was negotiating an FTA with the Association of Southeast Asian Nations (ASEAN) as a group, it demanded a number of TRIPS+ provisions that would make medicines more expensive, including a five year extension of the patent period and data exclusivity. \(^{23}\) In addition to preventing compulsory licences from being effective, data exclusivity is an additional monopoly, separate to patents. When Guatemala introduced data exclusivity due to its USFTA, instead of paying $0.01 for the generic version of the medicine, the data exclusivity monopoly allowed the IP owner to charge $84.56 for the same medicine. \(^{24}\) Malaysia can expect to face the same demands as ASEAN did, now that the FTA negotiations are occurring with individual ASEAN countries instead.

Therefore it is not surprising that concern has been expressed about the way TRIPS+ provisions make medicines more expensive by United Nations (UN) bodies including the Special Rapporteurs on the Right to Health, the United Nations Committee on Economic, Social and Cultural Rights \(^{25}\) and the United Nations Committee on the Rights of the Child \(^{26}\).

In FTA negotiations, PLHIV may be told that the cost of higher medicine prices will be offset by increased exports. However, health is a human right and cannot be compromised for (what are often insignificant and diminishing (as other countries also obtain this market access through FTA and WTO negotiations)) increases in exports. Furthermore, stronger IP protection causes medicine prices rise for about 15 years according to the WHO model \(^{27}\) and then stay constant, while the benefits of any increased exports erodes.

The relative size of the costs and benefits can be seen in Australian research which estimated that if TRIPS+ provisions in the Australia-US FTA increased monopolies for two years (for example due to patent term extensions or data exclusivity which are often demanded for 5 years) for just the top five medicines being reimbursed, this could increase the cost by $1.5 billion over 2006-2009. This is much more than the $53 million a year in economic gains from the entire FTA that the model commissioned by the Senate Committee investigating the same FTA predicted. \(^{28}\)

**Conclusion**

Therefore based on the evidence and concerns expressed about the impact of IP on the affordability of medicines...
treatment, we urge the Commission to recommend that:

1. Developing countries make full use of the TRIPS flexibilities and least developed countries make full use of the transition period before they have to comply with the substantive provisions of TRIPS (as the UN Special Rapporteur on the Right to Health recommends)  

2. Developing and least developed countries not agree to TRIPS+ provisions in any forum  

3. Developed countries not ask for or insist on developing or least developed countries’ agreement to TRIPS+ provisions, or ask them to abstain from using their TRIPS flexibilities and transition periods

| 99 | India | Individual |

A DEATH HAD TO HAPPEN FOR CHANGE - - FOR IMPARTIALITY TO LIVE  

(Translated from Tamil)

Chandra & Marimuthu were a couple who lived in Vavikadai, Erode District of Tamilnadu. Their marriage was an arranged. Marimuthu was working as a driver and due to the nature of his work did not reach home sometimes. They had two children, one girl and one boy. Easwaran, the boy was born was the time they came to know their HIV status.

Marimuthu fell sick often and with medical care would be alright only to fall sick again soon. As this was recurring over a period of time, his doctors advised him to undergo a HIV test which came positive. Chandra and Marimuthu were extremely upset when they came to know about it.

They were very depressed as they could not share their suffering with anybody. A field worker (FW) of CHAHA programme came to know about them and visited them. It was only then that their acute situation came to light.

The villager came to know about their HIV status and promptly stopped allowing them to take water from public water pump. They were out casted; nobody talked to them or cared. As told to the FW they are not even allowed to buy their day to day requirements from the shop nearby and had to go all the way to next village. Hearing this, CHAHA started working on making the village people aware and put a stop to this discrimination.

To worsen the situation, Chandra’s husband suddenly died and villagers didn’t even come to their house. They did not allow them to take his body to the cremation ground either. When our CHAHA project coordinator and FW came to know about this, they met the Panchayat leader and explained about our work and also about how to treat the people who are affected by HIV and AIDS. The panchayat leader understood and supported them and further agreed to take care of the funeral expenses.

The Panchayat leader requested the CHAHA programme to create awareness in the village about HIV and AIDS. Accepting this, our Project Coordinator and FW met the villagers on a get together of Gram Sabha and explained about what the issues of HIV, starting from the very basics of transmission and prevention, clearing the myths and misconceptions surrounding it. One important aspect covered was caring of those affected, the need of support, love and affection.

Because of this meeting, there was a big change that happened in the villager folk attitude and they asked
several questions and seeked clarifications.

When everything seemed to be coming back to some kind of normalcy in Chandra’s life a road accident killed her son. This completely broke Chandra, but the death of her son was the turning point for the villagers. They came forward to support her. These were the very people who discriminated her some time ago.

Now Chandra and her daughter are fully supported by their village people.

Because of them, till now the project has identified 7 more PLHA in the same village and are supporting them. The villagers strongly believe that they are now fully aware about HIV related Stigma and Discrimination, and the project has been a strong medium for this change.