I am a Portuguese, Lawyer, Journalist and International Activist for Human Rights in Encod (www. encod.org), Inpud (www.inpud.net) and in Portugal I direct the Ngo Diferença Real. I am also a drug user and I would like to share with you how we got the Drug Decriminalization and all the fantastic consequences, including the enormous decrease of HIV by drug use.

First we developed a great open relationship with our medical psychiatric doctors and therapists on the drug centers, they started to realize that they had better conversations with DUs with culture, in the university and saw completely different way of understanding the causes of the drug problems, after all this were fantastic persons with great humanity and with a great thinking capacity, different from the old stereotype of the criminal drug user.

I have to insist in the importance of the open mind of several psychiatrics and therapists at this point. We Activists could have changed their mind, but they had the capacity to believe and to understand that punishment was just increasing the problem, so they had to do something in order to provoke real solutions. They admit that by only treating the drug use as a disease and not as a crime things could get better. Then some important psychiatrics that already were, or join politics start to fight for it and this was such a great health, social, criminal problem in Portugal that they fought hard and they could pass their ideas in the parliament and the use of drugs was finally decriminalized in Portugal in 2000.

The entire world announced that this would be a major disaster for Portugal with people from all the places using drugs in the street, but the truth was completely different.

Drug use didn’t increase and all the drug diseases decreased a lot. The graphic of HIV by Drug Use is one of the greatest victories for Human Kind, because we see that this disease is decreasing in an astonishing way and comparing it with HIV by sex that keeps in the same, now we have the scientific proof!

The fantastic result of Portugal was a mix of the action of the civil society, first Activists, then Psychiatrics that had to play a politics paper but in the end it worked.

I also need to say that now the government and the state have a fundamental paper, because the are Public Drug Centers all over the country, they are free and everybody can receive harm reduction, d-tox help and also receive the HIV medicines and assistance for free, as all the other drug diseases in the same place where they receive the drug help as methadone for example. The syringe exchange program and the mobile assistance are also very important for these results.

There is more to say and explain, but this is the essential, I just would like to finish announcing that we are preparing conferences and workshops all over Europe in Psychiatric Universities to incentive more therapists.
understand the Portuguese example and even that some of them join the responsibility of developing also a political career.

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Introduction

Access to affordable medicines is undeniably one of the most important factors in effectively addressing the challenge posed by HIV/AIDS.

Ten years ago countries around the world expressed deep concern with the devastating impact of the global HIV/AIDS epidemic and determined it to be a “global emergency” and committed to take concerted action to deal with the problem. The decade that followed saw unprecedented action at all levels to put millions of people on life-saving antiretroviral drugs (ARVs). These efforts have had significant positive results across countries. This includes more than 25% reduction in the rate of new HIV infections in over 30 countries, significant reduction in mother-to-child transmission of HIV, and unprecedented expansion of access to HIV antiretroviral treatment to over 6 million people, resulting in the reduction of AIDS-related deaths by more than 20% in the past five years.

One major factor that has allowed treatment scale-up to today’s levels was the fact that the price of ARVs dropped dramatically over the past decade, from more than US$10,000 in 2000 to less than $150 today. This price reduction has made lifesaving drugs accessible to millions of people in developing countries.

While efforts to combat the HIV/AIDS epidemic have intensified, there is a continued recognition that efforts need to be significantly heightened to break the back of the epidemic as well as to ensure all PLHIV have access to needed ARVs. According to the UNAIDS, an estimated 15 million people are eligible for ARV treatment in low- and middle-income countries, but only about 6.6 million people have access to HIV treatment.

This was the core message of the recently adopted political declaration of the UN General Assembly (UNGA) on “HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS”. ¹

Through the declaration member states also agreed to “Commit to accelerate efforts to achieve the goal of universal access to antiretroviral treatment......with the target of working towards having 15 million people living with HIV on antiretroviral treatment by 2015”.

The same declaration also noted (in para 36) “...with concern noted that regulations, policies and practices, including those that limit legitimate trade of generic medicines, may seriously limit access to affordable HIV treatment and other pharmaceutical products in low- and middle-income countries”, and recognized that “improvements can be made, inter alia through national legislation, regulatory policy and supply chain management”.

Thus member states participating in the UNGA committed to remove before 2015 obstacles that limit the capacity of low- and middle-income countries to provide affordable and effective HIV prevention and treatment products as well as treatment for opportunistic infections and co-infections. This includes by amending national laws and regulations so as to optimize the full use of existing flexibilities under the Trade-Related Aspects of Intellectual Property Rights (TRIPS) Agreement to promote access to and trade of medicines as well as by addressing policies that prevent access to affordable HIV treatment (see para 71 (a) and (b)).

Against this background this submission aims to in Part II enable a thorough understanding of how amending

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national patent laws to make incorporate the full range of TRIPS flexibilities can enhance availability of affordable generic medicines nationally as well as worldwide, which as noted above is a fundamental key to scale-up of treatment. This part also underscores the need for certain developed countries to revise national laws and policies that are aimed at threatening trade measures against countries that make use of TRIPS flexibilities.

In part III, the submission calls for a revision of the WTO mechanism of 30th August 2003 which pertains to export of pharmaceuticals to countries with insufficient or no manufacturing capacity.

In part IV, the submission identifies a range of TRIPS plus measures and notes that promotion of these measures and thereafter the adoption of such measures at the national level is detrimental to access to affordable medicines and consequently will adversely impact the positive efforts underway to change the trajectory of the HIV epidemic.

Public Health Sensitive Policy Measures: Utilizing the TRIPS flexibilities to facilitate access to affordable generic medicines

The importance of access to affordable generic medicines in scaling up of HIV treatment has been noted above. Accordingly, countries need to ensure that national laws on patents and protection of undisclosed information are sensitive to public health interests and needs and supportive of importation, production and exportation of such medicines.

There is abundant literature on the different flexibilities available in the TRIPS Agreement such as transition periods, compulsory licensing, public non-commercial use of patents, parallel importation, exceptions to patent rights, exemptions to patentability, pre-grant and post-grant oppositions systems and limits on data protection.²

However often there is a failure by governments to appreciate and understand the public health benefits of incorporating these flexibilities in national law in a manner that maximizes the policy space available. Once incorporated, these laws can play an important role in improving access to affordable generic medicines related to treatment of HIV/AIDS.

For example, a case on point is the success of the Indian generic industry. Following the TRIPS Agreement India made full use of the transitional period granted to developing countries with regard to pharmaceuticals. Between 1970 (when India abolished patent protection for pharmaceutical products) and 1 January 2005, the Indian generic industry flourished ranking 4th worldwide in volume of production and 13th in production.³ More importantly during this period India’s ability to produce generic medicines generated competition to originator products. This competition has been a critical factor in the reduction of ARV prices and enhancing availability of these life-saving medicines worldwide.

Unfortunately in 2005, as a result of its TRIPS obligations, India had to put in place patent protection for pharmaceutical products, consequently raising concerns globally as to the impact of such protection on access to affordable ARVs.

Despite the availability of transitional period for least developed countries, few LDCs have embarked on a similar path.

According to paragraph 7 of the Doha Declaration on TRIPS and Public Health (reaffirmed by the TRIPS Council in its Decision of 27 June 2002), in relation to pharmaceutical products, LDCs do not have to implement, and

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apply the TRIPS provisions on patents (Section 5) and on protection of undisclosed information (Section 7) until 1 January 2016. LDCs also do not have to enforce rights under these sections until that date.

However few LDCs have made use of this transitional period despite the obvious benefits of using this flexibility. By not allowing patenting of pharmaceutical products, LDCs will have faster and easier access to affordable generic products. Further the transition period presents LDCs an excellent opportunity to engage in research and development and to progressively build their local generic pharmaceutical industry. This is particularly critical as more and more ARV products are likely to be patented in India following the introduction of pharmaceutical product patent protection in 2005, which would prevent it from manufacturing and exporting generic versions unless certain flexibilities such as compulsory licenses and the mechanism of 30th August 2003 decision are used.

Along a similar note, provisions in India’s patent law that adopts stricter patentability criteria (as its provisions prevent the patenting of “me too” products i.e. the patenting of a drug that is structurally very similar to known patented drugs, with only minor differences) as well as pre-grant opposition has played a significant role in ensuring that a limited number of ARV products are granted patent protection.

For instance in January 2011, the Indian patent office rejected patent applications related to two AIDS medicines – lopinavir/ritonavir and atazanavir - on the basis that they did not merit patents under India’s patents law.4 This decision leaves the door open for the production of more affordable generics that is relied on by patients around the world.

The Indian examples above show how the law can be a “game changer” with regard to improving access to affordable generic ARVs and thus facilitate scale up of treatment. Of course for the law itself to be of any value, it has to be actively used by policy-makers and other stakeholders.

Several developing countries that incorporated certain flexibilities in their patent laws have started using flexibilities with significant positive results for HIV/AIDS treatment. For example:

- Malaysia issued compulsory license to import the cheaper generic version of patented medicines for people with HIV/AIDS. This reduced the average cost of treatment per patient per month by 81% and more than doubled the number of patients who could be treated.5
- The Thai Government issued compulsory licences for three types of medicines including for HIV/AIDS medication and estimates that it could save up to US$24 million each year.6
- Brazil’s compulsory licence on Efaverinz medicine used to treat HIV/AIDS was estimated to save it US$240 million until 2012.7
- Ecuador’s compulsory license for lopinavir/ritonavir, allowed it to access generic versions at half the price of the patented Kaletra.8

Despite this, as noted above, there is still ample scope for countries to incorporate the full range of flexibilities and to actively use these flexibilities to enhance access to ARVs.

A major obstacle in using the flexibilities is the pressure from developed countries. For instance the Trade Act

4 http://msfindia.in/content.php?con_id=85
5 'Malaysia’s experience in increasing access to antiretroviral drugs: exercising the ‘government use’ option’, Chee Yoke Ling, Intellectual Property Rights Series No. 9, Third World Network, 2006. Earlier version available from http://www.twside.org.sg/title2/FTAs/Intellectual_Property/IP_and_Access_to_Medicines/Malaysia%E2%80%99s_Experience_in_Increasing_Access_to_Antiretroviral_Drugs-CheeYokeLing%5BS0ct05%5SD.doc
6 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.
7 http://ictsd.org/i/ip/38960/
8 http://www.citizen.org/pressroom/pressroomredirect.cfm?id=3116
of the US requires the US Trade Representative to publish an annual report that identifies countries that deny adequate and effective protection of IP or that denies fair and equitable market access to US persons that rely on IP protection. To comply with this Act, the USTR issues an annual Special 301 Report that lists countries as being a “Priority Foreign Countries” or as being on the Watch or Priority Watch Lists. These lists are a way of threatening countries to adopt legal or policy changes. Every year the USTR includes multiple countries in the Special 301 Report. This includes countries that make use of TRIPS flexibilities. As a result few developing countries have shown willingness to make full use of the flexibilities that are available.

A change in the US law and approach is likely to go a long way in increasing the use of TRIPS flexibilities.

**Revise the 30th August 2003 decision**

In 2001 there was concern that as developing countries put in place product patent protection in 2005, as required by the TRIPS Agreement (e.g. India), countries with insufficient or no manufacturing capacity may find it difficult to import the required medicines. This is due to the restrictions of Article 31(f) which requires that where a compulsory license is issued, the CL shall be “predominantly for the supply of the domestic market” and thus there is a limit to the amount that can be exported. This restriction is a problem for countries with insufficient or no drug manufacturing capacities, as they may find it difficult to import the required medicines since there is a limit to the amount the potential exporting countries can supply to them.

In 2001, the Doha Declaration recognized this problem and mandated the WTO to find an “expeditious solution”. After a lengthy negotiation, the WTO General Council in August 2003 adopted a decision as a “temporary solution” in the form of an interim waiver to the Article 31(f) restriction, such that countries producing generic versions of patented products under compulsory licenses would be allowed to export the products to eligible importing countries, without having to limit the exported amount. However, the Decision also obliges importing and exporting countries that wish to make use of the waiver to undertake several measures and fulfill several conditions. The decision of 30th August 2003 was translated into a permanent amendment of the TRIPS Agreement on 6th December 2005.

Since the adoption of the 30th August decision, experts and NGOs have pointed out that the measures and conditions are cumbersome and time-consuming and as such unworkable. The mechanism is unrealistic as it is based on a drug-by-drug, country-by-country and case-by-case decision-making process, and thus impractical as an effective health response needs a system that is flexible to be able to respond rapidly to changing circumstances.

This problematic solution has been translated in several national laws. To implement the 30th August decision, in 2004, Canada passed the Bill C-9 which came into force on May 14, 2005 creating Canada's Access to Medicines Regime (CAMR). This law further complicated an already complex mechanism, through its numerous additional requirements. As a result access to ARV drugs was made even more difficult.

In July 2007 Rwanda notified WTO of its intention to use the 30th August 2003 mechanism. Rwanda was importing from Apotex a Canadian generic company under the CAMR. However the first shipment of ApoTriAvir (a combination of Zidovudine, Lamivudine and Nevirapine) arrived one year later i.e. on September 23, 2008. The second shipment arrived on Sept. 17, 2009.

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11 “Neither Expeditious, Nor a Solution: The WTO August 30th Decision is unworkable”, MSF (August 2006). For detailed history and documents on the negotiations of the 30th August Decision 2003 see also http://www.cptech.org/ip/wto/p6/
12 See powerpoint presentation on “ August 30th or CAMR: Success or Failure, by George Tsai, available at “http://accessstomedicineseminar.files.wordpress.com/2010/01/canada_s-access-to-medicine_s-regime2.pdf
The whole process of exporting from Canada to Rwanda was a fragile process, marked with significant delays. Apotex agreed to produce ApoTriAvir in December 2004, with an active prototype ready by April 2005 and yet the first shipment took place 4 years later, in 2008.

Jack Kay, President of Apotex, the generic Canadian company that exported the medicines to Rwanda noted that "If other critical medicines are to go to Africa in a reasonable timeframe, the Federal Government must change the CAMR Legislation. CAMR is unworkable as it now stands. Apotex decided to do this because it was the right thing to do for the people dying from AIDS in Africa”.13

It is apparent that there is a need to urgently revise the 30th August decision. As more important life-saving medicines are patented, there will be a need for a mechanism that rapidly facilitates the import and export of critical generic medicines. However for that to happen, international policies and laws must be supportive of that objective. As shown above, the 30th August decision is a cumbersome legal arrangement that will hamper access to medicines. This is even more so when national laws implementing the decision decide to opt for even more burdensome procedures than necessary, as seen in Canada.

A simple legal mechanism for import and export of generic medicines would go a long way in improving access to affordable generic medicines critical for scaling up treatment.

TRIPS plus policies: Hampering access to affordable medicines

In recent years, the push for the adoption of TRIPS plus measures has further threatened to undermine access to medicines. Developed countries particularly the US and the EU have been pushing through bilateral pressure, trade and investment agreements (e.g. the Trans Pacific Partnership, EU-ASEAN FTA) and WTO accession packages for countries to adopt a variety of TRIPS plus measures. TRIPS plus measures pushed for adoption14 include data exclusivity provisions, patent term extension, patent linkage, limits to TRIPS flexibilities such as compulsory licensing, patentability criteria, extensive provisions on IP enforcement for e.g. border measures that extend to goods in transit although such measures have led to the seizures of quality generic medicines at the EU ports15.

These provisions if adopted and implemented in national laws (which some countries have), will adversely impact access to affordable generics.

For example, in the EU-India FTA negotiations, EU has pushed for India to adopt provisions on data exclusivity, patent term extension and border measures that extends to goods in transit.

This push has heightened concerns about future availability of generic ARVs as India is the source for most of the AIDS medicines. It supplies more than 85% of the first-line antiretroviral drugs used to treat people living with HIV. As such if India introduces data exclusivity, generic companies wishing to register a medicine will be obliged to repeat clinical studies. This creates huge financial barriers that will act as a disincentive to generic companies. Data exclusivity creates a new patent-like barrier to access to medicines and vaccines, even when these products are not patent protected.

On the EU-India FTA negotiations, Loon Gangte, president of the Delhi Network of Positive People (DNP) noted that “The right to life and health of people in developing countries is being sacrificed in this deal,” adding that “Do not put profits before patients. This trade agreement must not undermine India’s ability to provide people living with HIV/AIDS here and outside India with life-saving medicines in the name of open markets.”16

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13 See powerpoint presentation on “August 30th or CAMR: Success or Failure, by George Tsai, available at http://accesstomedicineseminar.files.wordpress.com/2010/01/canada_s-access-to-medicine_s-regime2.pdf
16 See http://www.msf.org.uk/fta_press_20100423.news
While recently the Commerce and Industry Minister of India, Mr Anand Sharma, has given assurances that India will reject any efforts to include "data exclusivity" clauses in bilateral trade agreements, the negotiations have yet to be finalized. In any case the EU has proposed many other TRIPS plus measures for India’s consideration, which would also have an impact on access to medicines.

EU has demanded TRIP plus provisions from other regions as well. For instance in the FTA negotiations between the EU and the Association of Southeast Asian Nations (ASEAN) as a group, EU has demanded a number of TRIPS plus provisions that would make medicines more expensive, including a five year extension of the patent period and data exclusivity.

The US is also known for making extreme TRIPS plus demand on negotiating partners. Recently the US has engaged in the negotiation of an Asia Pacific Regional Trade Agreement known as Trans Pacific Partnership Agreement (TPPA). The US’s TPP negotiating partners are Australia, Brunei, Chile, Malaysia, New Zealand, Peru, Singapore, and Vietnam. If the US were to make demands it insisted on prior to May 2007, the public health consequences for particularly the developing country parties could be devastating. The World Health Organization’s (WHO) model estimates that such demands (when applied to Colombia), would require an extra US$1.5billion to be spent on medicines every year by 2030. If this amount was not spent, Colombians would have to reduce their medicine consumption by 44% by 2030.

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.

Most recently, US has made a proposal to countries negotiating the TPPA arguing for eliminating "pre-grant opposition," an important tool for preventing patent applicants from gaining patent monopolies based on weak or erroneous information, for improving the quality and efficiency of patent office examinations, and for safeguarding access to medicines.

US’s attack on pre-grant opposition, like other U.S. positions on intellectual property in the TPPA, can also be read as an effort to isolate India’s system of more rigorous patent standards. As noted above pre-grant opposition in India has had a positive effect on access to affordable ARVs and is a model that should be widely followed by all countries.

The numerous threats to access to medicines emerging from the various TRIPs plus provision has also been raised by United Nations (UN) bodies including the Special Rapporteurs on the Right to Health, the United Nations Committee on Economic, Social and Cultural Rights and the United Nations Committee on the Rights of the Child.

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17 “No Data Exclusivity Clauses in Trade Pacts, Assures India”, published in SUNS #7186 dated 8 July 2011
It is quite apparent from the above explanation that having the right legal policy in relation to intellectual property in particular patents and protection of undisclosed information is critical. Laws that put in place TRIPS plus provisions can be detrimental to public health. More specifically such provisions will result in high medicines prices and as such hamper the ability of governments and all stakeholders in scaling up treatment. On the other hand, laws that maximize the use of flexibilities set the stage for action to win the battle against HIV/AIDS.

Conclusion

Availability of affordable ARVs is a critical ingredient if the target of treating 15 million people living with HIV is to be achieved by 2015.

The elaboration above shows how adopting the right legal policy in relation to intellectual property can enhance access to ARVs; while on the other hand, a TRIPS plus legislation can raise many obstacles to access to medicines. The discussion above also calls for revision of the WTO decision of 30th August 2003, as a simple mechanism that allows exports to countries with insufficient capacity is fundamental to achieving the political targets set out by the UNGA.

As such the Global Commission on HIV and Law should recommend:

(i) That countries make full use of the flexibilities provided by the TRIPS Agreement. In particular developing and least developed countries should be encouraged to use flexibilities such as transition periods (applicable to LDCs), compulsory licensing, public non-commercial use of patents, exceptions to patent rights, strict patentability criteria to avoid “me-too” patents, international exhaustion of rights, pre-grant and post-grant oppositions systems and limits on data protection.26

(ii) That developed countries stop using the threat of trade sanctions to pressure countries to abandon use of TRIPS flexibilities.

(iii) That the WTO’s TRIPS Council revises the 30th August 2003 decision.

(iv) That developing countries resist adoption of TRIPS plus measures and that developed countries stop pressuring developing countries to adopt such measures.

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<th>Centre for HIV Law and Policy</th>
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<td>The Center for HIV Law and Policy is a national legal and policy resource and strategy center for people with HIV and their advocates. CHLP works to reduce the impact of HIV on vulnerable and marginalized communities and to secure the human rights of people affected by HIV. We support and increase the advocacy power and HIV expertise of attorneys, community members, and service providers, and advance policy initiatives that are grounded in and uphold social justice, science, and the public health. One such initiative, the Positive Justice Project (PJP), is a consortium devoted to ending the abuse of the criminal law against HIV-positive people in the U.S. PJP includes HIV advocates, researchers, health and social service providers, media representatives, policy analysts, law enforcement personnel and people living with HIV. We engage in federal and state policy advocacy, legal resource creation and support, and on educating and mobilizing communities and policy makers in the United States.</td>
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One of the more troubling and charged misuses of the law against people living with HIV has been their criminal prosecution for consensual sex and for conduct, such as spitting or biting, that poses no measurable risk of HIV transmission. HIV criminalization – use of the criminal law to single out people with HIV for punishment that is significantly disproportionate to our treatment of similar or more serious risks of harm – may be one of the more harmful examples of active government support for the disparate treatment of HIV.

Here in the United States, which leads the world in the prosecution and extended imprisonment of people with HIV for consensual and no-risk behavior, 34 states and two territories have HIV-specific criminal laws. Many of those without HIV-specific laws use felony offenses such as aggravated assault, reckless endangerment and attempted murder charges to prosecute people accused of sex without prior disclosure of HIV status – or, in some cases, for hurling saliva at a law enforcement officer. Despite the description of these laws by legislators and prosecutors, in fact, it is not intentional transmission but intentional sex while HIV positive that is the focus of these state laws. The common denominator: the person being charged knows that s/he is HIV-positive. Actual transmission rarely is necessary and frequently doesn’t occur. Exposure without disclosure is enough to become a convicted felon or designated sex offender, barred from unsupervised contact even with young relatives.

The facts of many of these cases read like what should be relics from a less-informed past. Instead, they describe increasingly frequent current events. Over just the last 2.5 years, at least 120 Americans – women, perinatally-infected young men, sex workers, gay men, members of the armed forces – have found themselves behind bars or on sex offender registries or facing indefinite civil commitment as a consequence of being sexually active or colliding with police or corrections officers while HIV positive. It appears that spurned or disappointed partners account for many of the accusations and charges of HIV non-disclosure and exposure. Loss of current and future employment options, lost housing, lost custody of children are only a few of the collateral consequences for those convicted on the felony charges that can follow a bad break-up; There has been no comparable criminal law response to that afforded HIV. Unlike the prevailing reaction to HIV, there seems to be widespread acceptance of the idea that sexually transmitted infections are an implicit risk of sexual intimacy, and thus those individuals who know they are infected with other STIs have not been the focus of the criminal law.

A look at the transmission risk and potential harm of HPV, which affects a far broader percentage of the U.S. population, provides a useful illustration of the uniqueness of the response to HIV. There are many types of HPV. High-risk HPV types cause 99% of cervical cancer cases, and also cause anal and other genital cancers. At least 15 of the high-risk HPV types have statistically similar rates of causing cervical cancer. The probability of HPV transmission during any unprotected sexual act is high. One study from the Netherlands found transmission rates between 43% and 94% per average relationship between discordant heterosexual partners for all the high-risk types of HPV. For two of the primary strains that cause cervical cancer, HPV-16 and HPV-18, there is a transmission probability of 80% and 93% per average relationship between discordant heterosexual partners.

High-risk HPV is transmitted far more easily and more frequently than is HIV, but what are the consequences of infection? The median age of death from cervical cancer is 57, less than 10 years after diagnosis. The five-year survival rate for cervical cancer is 68.6%, although these rates differ by race and fewer than 50% of Black women survive five years after a cervical cancer diagnosis. Thus, although HPV transmission has rarely if ever been the focus of a criminal prosecution, people who have not been vaccinated against HPV have a very high chance of contracting it, and face real risks of significantly shortened life expectancies through HPV-related cancers. Upset partners may rely largely on civil tort law claims when a spoiled relationship includes the collateral damage of an STI, but with HIV, criminal charges are overwhelmingly the chosen course of retribution.

Not only is the risk of HIV addressed largely through the criminal law, but the punishment it garners frequently
is treated far more severely in comparison to other similar or even more serious harms. HIV exposure offenses are treated much more severely than other criminal offenses involving behavior that poses a risk of harm that may be statistically small but threatens a potentially significant harm. For example, almost 40% of fatal traffic crashes are attributable to alcohol impairment, yet a number of state laws impose far less severe penalties than are imposed for risk of HIV transmission. To illustrate: a first-time DUI offense in Illinois is a misdemeanor, with a jail sentence of no more than a year and a fine up to $2,500. But for a first-time offender under the Illinois criminal HIV exposure statute, conviction is a felony, with a sentence of 3 to 7 years and a fine of up to $25,000.

Even more stunning, in a number of states, exposing someone to HIV through consensual sex or other means can produce a far more severe punishment than killing someone with a car. In Oklahoma, the maximum sentence for HIV exposure is 5 times that of vehicular homicide (5 years vs. 1 year) and two times as severe in California (8 years v. 4). In Arkansas, if you kill your partner with a car, you can get up to 5 years in prison; if you are HIV positive and insert your finger or any object into your partner’s genital area, you can get up to 30 years. In Ohio, the typical sentence for vehicular homicide is 6 months imprisonment; yet a man who allegedly failed to disclose his HIV status to his partner was convicted as a sex offender and sentenced to 16 years in prison. There are many more examples of this type of disparity.

A response that reflects the experience, knowledge and the responsibility of all levels of community – PLWHA, activists, health care providers, public health officials, law enforcement professionals – is needed to address HIV criminalization. For starters, it is important to acknowledge and reconsider the inconsistent, arguably inaccurate and potentially damaging way we conceptualize and talk about HIV and transmission risk. If, for example, we characterize vaginal intercourse as “high risk” when it has a per-contact risk of HIV transmission that is 1 in 2000 for female to male and 1 in 1000 for male to female, how does this affect the treatment of HIV risk (both the likelihood of transmission and the harm when it occurs) by prosecutors, courts, jurors and the media?

Ultimately, however, it is critical that government officials – in public health agencies, criminal justice and in policy-making positions – take a leadership role in ending the injustice of HIV criminalization. Peer education is not just for people living with HIV. We need to identify the many professionals in these systems who know that HIV criminalization is wrong for public health and human rights and provide them with the community and political support to speak openly about what they know and to advocate with their peers to do the same.

Public health officials can speak with specificity and authority to the real routes and relative transmission risks of different types of contact, and how those risks compare with other risks in life. They can talk about the realities of life with HIV that puts it in a context with other serious, chronic diseases. They can confirm that there is no evidence that HIV criminal laws have any positive impact on individual risk-taking or on HIV incidence. They can express concerns that HIV testing – something which can, among other benefits, actually reduce risk-behaviors and lead to virus-suppressing treatment for those who test positive – may in fact be reduced by these laws. They can explain how partner notification programs become ethically difficult to implement when the cooperation of people who test positive for HIV could lead to their arrest and prosecution. Elected officials can then take this information to question current law and practices, which admittedly requires the courage of confronting the political downsides of calling for the end of laws and policies that many still support. U.S. Congressperson Barbara Lee has shown exactly this type of leadership; with the REPEAL HIV Discrimination ACT, she has laid out in compelling detail the facts and consequences of HIV criminalization in the U.S., and proposed incentives for state law makers to become better informed and become proactively involved in making needed reforms. This kind of leadership in turn provides the official imprimatur to the public, and those living with or at risk of HIV, that HIV can in fact be normalized and dealt with outside of the criminal law.

One year ago, the United States’ first National HIV/AIDS Strategy (NHAS) was released, and included what many believe were game-changing statements on HIV criminalization. The NHAS pointed out that state HIV-specific
criminal laws reflect long-outdated misperceptions about HIV’s modes and relative risks of transmission, and that all available evidence showed the laws have no positive public health impact. “In many instances,” the NHAS states, “the continued existence and enforcement of these laws run counter to scientific evidence about routes of HIV transmission and may undermine the public health goals of promoting HIV screening and treatment.”

The following March 2011, the National Association of State and Territorial AIDS Directors issued a statement making it clear that they “support level-headed, proven public health approaches that end punitive laws that single out HIV over other STDs and that impose penalties for alleged non-disclosure, exposure and transmission that are severely disproportionate to any actual resulting harm.”

One year into the NHAS, the CDC, the country’s leading public health authority, has shown little in the way of substance or leadership on criminalization. However, in August, 2011, CDC leadership made a critical commitment to address this: to tackle head-on the pervasive public misperceptions surrounding HIV’s routes and actual risks through creation of a separate web site on HIV transmission. CDC officials have confirmed that the website, to be completed by the end of the year, will make clear not only actual statistical transmission risks from different types of sexual contact but will contextualize this risk by explaining how these risks compare with other STIs and even everyday life events that pose risks of harm.

Important steps have been taken, but these are only first steps. What else is needed? What can be done right now for the people living with HIV who are arrested and charged weekly?

- PUBLIC STATEMENTS THAT HIV CRIMINALIZATION IS NOT THE ENDORSED POLICY OF THE UNITED STATES – This needs to come from the White House, the Department of Justice and the Centers for Disease Control and Prevention
- CDC-SUPPORTED FACTSHEETS on how, and how easily or rarely, HIV is and is not transmitted
- DOJ DIRECTIVES AND GUIDANCE to state attorneys general and health commissioners on addressing laws and policies that penalize HIV status and reflect misunderstanding of the infectiousness and consequences of HIV
- FEDERAL AND STATE FUNDING FOR HIV EDUCATION AND TRAINING for members of the bench, bar, law enforcement and the criminal justice system
- OTHER FUNDING INCENTIVES – through DOJ/law enforcement or CDC grants – to states for development of model laws and policies that guide the treatment of HIV in the court system and eliminate HIV-specific laws and punishments.

Thank you for the opportunity to testify on this important issue.

<table>
<thead>
<tr>
<th>Canada</th>
<th>COCQ-SIDA</th>
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</table>
| La Coalition des organismes communautaires québécois de lutte contre le sida (« COCQ-SIDA ») regroupe 39 organismes de lutte contre le VIH/sida à travers la province du Québec. Elle a pour mission de favoriser l’émergence et le soutien d’une action concertée face à la lutte contre le VIH/sida au Québec.

La COCQ-SIDA suit l’évolution de la criminalisation de l’exposition au VIH (« criminalisation ») au Canada depuis plus de dix ans. Elle est actuellement le principal acteur ouvrant à limiter l’expansion de la criminalisation au Québec et mène différentes actions à cette fin (interventions devant les tribunaux, plaidoyer pour la mise en place de directives pour les poursuivants, soutien aux avocats de la défense, information juridique aux personnes vivant avec le VIH [« PVVIH »], conférences, etc.). Au cours des cinq dernières années, la COCQ-SIDA a constaté à quel point les PVVIH et les personnes leur offrant des services (directeurs d’organismes VIH,
intervenants, travailleurs sociaux, professionnels de la santé, etc.) sont inquiets de la criminalisation et de ses impacts. Au Québec, il existe peu de sujet relié au VIH dont on parle autant que celui-ci.

En vertu du droit criminel canadien, une PVVIH peut être déclarée coupable d’un crime si elle ne divulgue pas son statut sérologique à un partenaire sexuel avant un rapport sexuel comportant un risque important de transmission du VIH. Un seul rapport suffit et aucune transmission n’est requise. Le droit criminel canadien est actuellement ambigu quant à ce qui représente un « risque important » de transmission du VIH : alors que certaines PVVIH ont été acquittées suite à des rapports protégés par le condom, des rapports de sexe oral uniquement, ou des rapports lorsque la charge virale était indétectable, d’autres ont été déclarées coupables.

À l’heure actuelle, plus d’une centaine de personnes ont été poursuivies au Canada pour non divulgation alléguée du VIH.

Voici un résumé de quelques points qui nous apparaissent particulièrement préoccupants quant à la criminalisation au Canada, et plus spécifiquement au Québec :

1. Les préjugés, la peur et la méconnaissance du VIH comme moteur des poursuites
Au Canada, aucune PVVIH n’est à l’abri d’une éventuelle poursuite pour non divulgation du VIH. Comme la notion de « risque important » n’est pas clairement définie en droit, il n’existe pas de critère clair quant aux situations pouvant donner lieu à des poursuites. Ceci est particulièrement problématique vu la connaissance très limitée du VIH/sida par les poursuivants, ainsi que toutes les craintes et préjugés qu’ils peuvent entretenir sur la maladie. Il n’est donc pas rare qu’une PVVIH soit accusée suite à un ou des rapports sexuels qui ne représentent pas nécessairement un risque important de transmission du VIH.

Par exemple, en 2008, au Québec, un homme séropositif a été accusé d’agression sexuelle mettant la vie en danger (passible d’emprisonnement à perpétuité) pour avoir eu trois relations orales non protégées, six relations vaginales non protégées, une relation vaginale protégée et une relation anale protégée avec une femme qui n’a pas contracté le VIH, alors qu’il avait une charge virale indétectable. L’homme, qui est actuellement marié à une autre femme qui connaît son statut sérologique, a plaidé coupable après avoir reçu des conseils juridiques de faible qualité. Il purge actuellement une sentence de 2 ans de prison qui lui a été imposée sans qu’aucune discussion n’ait lieu quant au niveau de risque des activités en question. Le juge qui a déterminé la sentence s’est contenté de faire référence au fait que le médecin qui avait établi le diagnostic de séropositivité de l’homme lui avait indiqué, au début des années 1990, qu’il ne pouvait plus avoir de relations sexuelles.1

De plus, il semble actuellement quasi impossible qu’une PVVIH soit jugée de façon juste et non discriminatoire par l’appareil judiciaire canadien. Malgré un niveau élevé d’éducation, les avocats et les juges sont tout aussi propices que tout un chacun à entretenir des préjugés et des craintes irrationnelles face au VIH/sida. En voici deux illustrations :

a. En 2009, le juge Douglas de la Cour de justice de l’Ontario a ordonné à un témoin séropositif au VIH de porter un masque ou de livrer son témoignage à partir d’une autre salle d’audience. Le juge a maintenu que le témoin devait se masquer même après que des expertises, indiquant que le VIH n’est transmissible que par certains contacts avec certains liquides corporels, aient été déposées.2

b. En 2008, un juge de la Cour du Québec acquittait un homme séropositif parce que la Couronne n’avait pas prouvé que la relation d’un soir concernée avait exposé sa partenaire à un risque important de transmission du VIH. Alors que le juge a pris la bonne décision en droit, il a conclu son jugement par des propos inutiles qui

illustraient sa répugnance à acquitter l’accusé : « L’accusé a fait preuve d’un degré d’insouciance et d’égoïsme révoltant. Qu’une personne dupe délibérément sa partenaire sans permettre à cette dernière d’évaluer elle-même le risque est inacceptable et mérite d’être sanctionné. Par contre, en droit criminel, les règles sont strictes et en l’absence de preuve hors de tout doute raisonnable la Cour doit prononcer un acquittement ».  

Aucune preuve n’avait été déposée quant à une quelconque intention de la part de l’accusé.

Il n’est pas rare de constater que les poursuivants basent leurs décisions sur des pulsions émotives plutôt que sur des motifs rationnels. Dans le cadre d’une intervention que nous avons effectuée en Cour d’appel du Québec, nous avons été témoin d’une procureur qui, lors de sa plaidoirie, a cessé de plaider le droit et tenter de convaincre les juges qu’une PVVIH devrait avoir une obligation de divulgation même lorsqu’il n’y a pas de risque important de transmission du VIH.

Vu le manque de clarté du droit et l’agressivité des poursuivants dans ce type d’affaires, les personnes séropositives du Canada vivent avec une épée de Damoclès au-dessus de la tête. La COCQ-SIDA a reçu différents témoignages de la façon dont les personnes vivant avec le VIH gèrent cette situation. Plusieurs nous ont indiqué avoir renoncé à toute vie sexuelle active, d’autres s’assurer d’être en mesure de pouvoir prouver la divulgation faite à leur partenaire, et d’autres ne pas vouloir laisser cette situation influencer leur vie sexuelle. Nous n’avons en revanche pas encore rencontré de personnes vivant avec le VIH que ces poursuites laissaient indifférentes.

2. Taux de culpabilité élevé

En droit criminel canadien, un accusé doit être acquitté dès lors qu’un doute raisonnable subsiste dans la tête du juge à l’effet qu’un des éléments de l’infraction n’a peut-être pas été commis. Il s’agit d’un standard de preuve élevé qui a pour but d’éviter que des innocents soient déclarés coupables, même si cela signifie parfois acquitter des personnes qui ont commis un crime.

Le taux de culpabilité des poursuites pour non divulgation du VIH à travers le Canada est de 63%. Au Québec, le pourcentage est encore plus élevé. Des 10 cas de poursuites au Québec dont l’issue est connue de la COCQ-SIDA, trois se sont soldées par un plaidoyer de culpabilité, six par une déclaration de culpabilité à l’issue d’un procès et une par un acquittement. Ceci représente un taux de culpabilité de 90%.

3. La gravité des accusations et des sentences utilisées

En 1998, la Cour suprême du Canada a confirmé que l’infraction de voies de fait du Code criminel canadien pouvait être utilisées dans les cas de non divulgation allégué du VIH. Forts de cette confirmation, les procureurs de la Couronne canadienne ont depuis eu recours à une gamme d’infractions de plus en plus graves, dont les principales sont les suivantes :

<table>
<thead>
<tr>
<th>Infraction du Code criminel canadien</th>
<th>Peine maximale (prison)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voies de fait grave (mettant la vie en danger)</td>
<td>14 ans</td>
</tr>
<tr>
<td>Agression sexuelle</td>
<td>10 ans</td>
</tr>
<tr>
<td>Agression sexuelle grave (mettant la vie en danger)</td>
<td>Perpétuité</td>
</tr>
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</table>

Ce sont parmi les infractions les plus graves du Code criminel canadien. De plus, en 2009, un homme a été accusé et déclaré coupable de meurtre au premier degré pour non divulgation du VIH en Ontario.

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L’utilisation d’infractions aussi graves renforce la perception du public à l’effet qu’une personne qui ne divulgue pas sa séropositivité dans le cadre de toute activité sexuelle commet un crime des plus répréhensibles. Au moment de la détermination de la peine d’un homme déclaré coupable d’agression sexuelle grave pour avoir exposé et transmis le VIH à sa conjointe, un juge de la Cour du Québec rappelait « la gravité objective [de ce] crime passible d’emprisonnement à perpétuité » pour justifier une peine de près de sept ans de prison.7

L’usage d’infractions d’ordre sexuel est en soi particulièrement problématique. Dans l’imaginaire collectif canadien, les personnes vivant avec le VIH se retrouvent associées aux agresseurs sexuels, avec tout le rejet et la stigmatisation que cela peut entraîner. Lors de ses activités terrains, la COCQ-SIDA a constaté que la population fait mal la distinction entre les cas de non divulgation du VIH et les réels cas d’agressions sexuelles (i.e. où la victime n’a réellement pas voulu avoir de relation sexuelle). Il n’est d’ailleurs pas rare de voir des titres d’articles de journaux qui alimentent cette confusion, tel que « The HIV risk in sexual assault can’t be eliminated ».8 Bref, non seulement les personnes vivant avec le VIH sont pointées du doigt comme des criminels, elles se retrouvent par le fait même associées à l’un des crimes considérés les plus répréhensibles par la société.

Enfin, une PVVIH déclarée coupable d’agression sexuelle court aussi le risque d’être fichée sur le Registre national des délinquants sexuels, tel un prédateur sexuel.

Conclusion

L’année 2012 risque d’être une année charnière puisque la Cour suprême du Canada sera appelée à se prononcer, pour la première fois depuis 2003, sur une affaire de non divulgation du VIH. Plusieurs organismes VIH se mobilisent actuellement pour présenter leurs arguments et préoccupations devant la plus haute cour du pays. L’enjeu sera de taille puisque certains poursuivants s’apprêtent à plaider qu’une PVVIH devraient avoir l’obligation de divulguer sa séropositivité avant toute activité sexuelle et ce, peu importe le niveau de risque.9

5 Germany Individual

Community based research, mapping and advocacy:
HIV related entry and residence restrictions as a marker of the global discrimination of people living with HIV

10 out of 21 countries selected for the High Income Country Dialogue Meeting have a history of discriminatory legal proscriptions on HIV-specific restrictions on entry and residence. We add Andorra and Cyprus to the list; both countries are in Europe or EU Member States, both are rich part of the countries with the most discriminatory laws and practices in this area. Five out of 23 countries considered to participate in the meeting have restrictions on entry and residence of PLWHIV.

Out of the 12 countries with a history of restrictions (this includes Andorra and Cyprus), 6 countries have revised their laws within the past decade, as a consequence of advocacy efforts by the HIV community and other stakeholders. We present this data to demonstrate that community based research by mapping the legal situation in different countries and advocacy is effective and results in changing laws and legal practices. HIV-specific restrictions on entry and stay have been introduced by States in the mid 1980s, when epidemic drivers and HIV transmission were poorly understood, and societies reacted with panic and prejudices. Many countries assumed that the spread of HIV can be stopped at borders with the implementation of screening and testing policies. However, since the early 1990s, we know that these restrictions are irrational: there is no public health justification for such practices, which are in fact detrimental to public health and evidence based prevention.

9 R. c. Mabior, mémoire de la Couronne du Manitoba pour permission d’en appeler devant la Cour suprême du Canada.
It is difficult to understand why some States continue to ignore sound public health evidence and basic human rights principles. It may be ignorance, combined with prejudices and negative perceptions of people living with HIV and arguments that they may pose a burden for health budgets, be source of transmission, or not contribute to society may be among the reasons.

In 1996 we started our work on HIV-specific entry and residence restrictions by contacting diplomatic and consular representations around the world, mapping the situation, publishing booklets and finally creating the global web database hivrestrictions.org. In the beginning, our work was mostly driven by the entry ban imposed by the United States. However, the better our data became, the more we were astonished by the scope of the problem. At a certain time, more than 100 countries imposed HIV specific restrictions on entry and residence. Over time, such restrictions became less and less acceptable. The international HIV community, international stakeholders, such as the World Health Organisation, UNAIDS, the International AIDS Society and the Global Fund started a dialogue with countries imposing HIV specific restrictions. The decision not to hold AIDS conferences in countries with restrictions, reconfirmed by the International AIDS Society in 2007, has proven to be a very strong advocacy tool; not only the United States was pushed to reconsider its policy. Canadian activists achieved changes in Canada’s in the country’s entry policies prior to the International AIDS Conference in Toronto 2006: Canada stopped requiring HIV disclosure in short term visa applications.

UNAIDS demonstrated leadership by creating the International Task Team on HIV-related Travel Restrictions in 2008 and issued policy recommendations to abolish restrictions. This effort has been successful: The number of countries with restrictions has dropped to circa 60 countries. Scandinavian countries also contributed to advocacy efforts: In 2007 the Foreign Ministers of Norway, Sweden and Denmark jointly wrote to their American colleague Condoleezza Rice, requesting reconsideration of the United States entry bar. For the first time, discussions about HIV-specific entry and residence restrictions have been taken to the State level.

Based on our experiences, we are considering broadening the scope of the database to other human rights violations and vulnerable groups, such as people using drugs, sex workers, criminalisation of HIV transmission and people on opioid substitution treatment are on our workplan.

Good examples on leadership by removing unsubstantiated restriction have been demonstrated by a number of countries. However, it is still a long way until restrictions are abolished in all countries: Rich countries with their developed democratic societies have a specific responsibility and should set the example for the others.

**Andorra**
- No work or residency permits granted to people with HIV, hepatitis, cancer or diabetes. Restrictions apply to all foreigners, including EU citizens.

**Canada**
- Foreigners intending to stay in Canada for more than 6 months have to undergo a medical examination. Since January 2002, the testing for HIV is one of the mandatory examinations. Due to the new regulations, the majority of foreigners testing positive for HIV won't be granted a residence permit for Canada.

**Cyprus**
- Foreign nationals applying for a residence permit in order to work or to study must undergo a medical examination by the Health Ministry to confirm that there is no infection with HIV, hepatitis B/C or syphilis. Discriminatory practices by the police forces have been reported.
Germany (Bavaria)
- Foreigners intending to stay for more than 180 days in Bavaria may be requested to undergo an HIV test. This measure is applicable in Bavaria only. The execution of such a test lies within the remit of the responsible officer and can only be done in case of concrete suspicion. The test also includes tuberculosis and syphilis.

Israel
- There are specific regulations for working migrants: the “foreign workers law” requires a health check, including an HIV test. Documented migrants from endemic zones (like sub-Saharan Africa) are checked for HIV on arrival.

The Law of Return (1948) gives the right to deny entry in the presence of transmissible diseases presenting a danger to public health.

Appendix:

18 Countries without restrictions in 2011: Austria, Belgium, Denmark, Finland, France, Greece, Iceland, Ireland, Italy, Netherlands, Norway, Portugal, Spain, Sweden, Switzerland, Turkey, United Kingdom and United States.

12 Countries with a known history of restrictions: Austria, Belgium, Canada, France, Germany, Greece, Israel, Italy, Spain, Turkey, United Kingdom and United States.

5 Countries that still impose restrictions in 2011: Andorra, Canada, Cyprus, Germany (Bavaria), Israel

ANDORRA - No restrictions for tourists (1) Special regulations exist for individuals applying for residence or work permits. Applications will be denied if the applicant does have a disease a) representing a possible threat to public health and b) preventing the pursuit of employment (1). 5 known cases of denied applications since 2005; there have been accusations that tests are carried out without informed consent (1). Restrictions apply to all foreigners, including EU citizens (Andorra is not a member of the European Union).

CANADA - No restrictions for short-term tourist stays, no HIV certificates have to be presented at entry (2, 1). Individuals applying for a visa to enter Canada as short-term visitors are NOT required to disclose known HIV infection on the visa application form. Canada does NOT routinely impose mandatory HIV testing on short-term visitors, nor does it categorically bar visitors based on their HIV-positive status (5). Starting from 2002 a HIV test is an obligatory part of medical routine checks. The majority of HIV-positive foreigners will no longer have access to a residence permit. HIV-positive status does NOT prevent a person from visiting Canada, except for the rare and exceptional circumstance where the person's health condition is such that they are assessed as likely to require health and social services during their stay in Canada, that will create an excessive demand on Canada’s public system (e.g., hospitalization). This is the same standard applicable to all persons (5). HIV-positive refugees, as well as HIV-positive relatives of persons with a residence permit, are allowed to enter Canada (5). Additional information: http://www.aidslaw.ca/

CYPRUS - No restrictions for short-term tourist stays. No HIV testing on entry (1, 2) Foreign nationals applying for a residence permit for work or study must undergo a Health Ministry medical examination to confirm there is no infection with HIV, hepatitis B/C or syphilis (1). Legislation mandates that aliens known to have certain communicable diseases and HIV be denied entry into the country (4). HIV tests particularly important for construction workers, barmaids, housemaids, people working in the tourism industry; exceptions for employees from international enterprises and the UN. If the result of the examination is positive, no residence permit is granted. This does not apply to citizens of the EU (2, 1).

GERMANY (BAVARIA) - No specific entry regulations for PLHIV. No problems for short-term entry (1) Foreigners
intending to stay for more than 180 days in Bavaria may be requested to undergo an HIV test. This measure is applicable in Bavaria only. The execution of such a test lies within the remit of the responsible officer and can only be done in case of concrete suspicion. The test also includes tuberculosis and syphilis. (Declaration by the Ministry of Interior Affairs of the State of Bavaria). Citizens of the European Union and Switzerland are exempt from this regulation (3)

ISRAEL- No restrictions for PLHIV. Documented migrants coming from endemic regions must undergo testing. HIV testing required for migrant workers. Foreigners are advised to purchase health insurance if they stay in the country. Migrant workers are obliged to do so (1). The Ministry of Health reserves the right to deny entry to visitors who declare their positive HIV status (4).

1 = Information from the embassy of the target country in Germany
2 = Information from the German embassy in the target country
3 = Aids Info Docu Switzerland. Source: Federal Department for Foreign Affairs, Bern/CH, DP VI/Section of Consular Protection, 15.03.2000
4 = Homepage of the US State Department; Travel Publications, February 2010: http://travel.state.gov/search.php?query=HIV&metaname=swishdefault&sort=swishtitle&start=0
5 = Information from an NGO working in the respective country

Sources:
Database: www.hivrestrictions.org

6 USA Individual

The Impact of PEPFAR on Sex Workers

This statement describes the implications and effects of the Anti-prostitution Pledge (herein referred to as “the pledge”) in the US President’s Emergency Plan for AIDS Relief.¹ We present our observations here about funding restrictions in US foreign aid – particularly clauses restricting work that can be done with sex workers in HIV prevention and anti-trafficking efforts – to illustrate how these restrictions on foreign aid promote violations of the rights and compromises the health of sex workers around the world. The authors, Dan Allman, Ph.D. and Melissa Ditmore, Ph.D. work, in various capacities, with sex workers and HIV and AIDS projects around the world. We are researchers who have documented the varied effects of this funding restriction. We have presented this information at international conferences and in peer-reviewed publications where it has been well received.² The work we describe here has applied a case study methodology. In contrast to a case study methodology, a case study methodology protects the anonymity of informants by using a composite narrative rather than telling details that could expose identities of individuals and projects.

PEPFAR is foreign assistance from the US government for HIV and AIDS programming. Currently PEPFAR operates in over 150 countries. PEPFAR has facilitated the provision of ARV treatment to thousands of

individuals and expanded services for many, including sex workers, in some places. However, this funding is conditional: recipients of PEPFAR funds are required to sign contracts that include a clause specifying that the recipient is ‘opposed to prostitution and sex trafficking because of the psychological and physical risks they pose for women, men and children.’ This condition for funding is colloquially known as the “anti-prostitution pledge” or the “anti-prostitution loyalty oath”. This contract language is an adaptation: earlier versions included in the laws creating PEPFAR and its 2008 reauthorization were different, but the effects were not. Despite the fact that sex workers face disproportionate risk for HIV, and despite the current US administration’s efforts to base policy upon evidence, we argue in our work that the pledge is not grounded in evidence or is grounded on tenuous (or partisan) interpretations of that evidence. What we have found across our research is that by inadvertently promoting stigma against sex workers in health programs the pledge in all its forms increases sex workers’ vulnerability to HIV infection. It does this through undermining the ability of sex workers to access to HIV treatment, care and support. Examples of this include sex workers being denied access to services and goods including healthcare; and sex workers having to confront greater stigma and discrimination in health care and other settings, all of which culminate in violations of human rights. In spite of its intent, the pledge appears to encourage violations of sex workers’ rights around the world, especially in health and social care settings and in programs designed to assist sex workers interested in transitioning to other forms employment. Stigmatization and discrimination are social drivers of the HIV pandemic and to promote such, even inadvertently, is counter to UN recommendations in HIV and AIDS programming.

These real life examples illustrate the adverse effects of the pledge:

- Some projects for sex workers have closed.
- Sex workers have been excluded from services and denied information about HIV and its transmission in Asia.
- Organizations in Africa that propose to ‘rehabilitate’ sex workers further stigmatize sex workers who supplement their incomes after rehabilitation with sex work. This stigmatization encourages people to hide their involvement in sex work, typically by not carrying safe sex commodities such as condoms. This severely inhibits their ability to practice safe sex in their sexual transactions.
- Sex worker organizations have been dropped from NGO networks in which they had previously participated in response to the pledge.
- Faith-based organizations with PEPFAR funding have sponsored condom burnings in Uganda, decreasing access to safe sex commodities while promoting stigma against sex workers and others.
- Sex workers have reported higher levels of stigmatization in research settings after the implementation of ...
In addition to the human rights violations documented here, anecdotal reports of similar practices in other areas have also been made. These examples have demonstrated how the pledge directly undermines the publicly funded safer sex promotion and HIV prevention efforts supported by PEPFAR. One form this undermining takes is the suppression of information about what works for HIV prevention and AIDS programming with sex workers. Because organizations are insecure in their funding, reports about effective sex work projects and research with sex workers have been censored by organizations that fear investigation by US congressional representatives and/or losing their funding. In one example, after publication of a USAID-funded study about violence against sex workers in Cambodia, the US-based funding recipient, POLICY Project, was investigated by congressional staff at the behest of the elected Representative who proposed the inclusion of the pledge in PEPFAR. This was perceived to be vindictive; no violations were found but the long investigation prevented the organization from being able to fulfill its obligations.

In light of the disproportionate effects of HIV among sex workers and the urgent need to scale up programming, the PEPFAR anti-prostitution pledge risks the health and threatens the lives of thousands. The fear of being branded as ‘pro-prostitution’ has inhibited dialog and information sharing about HIV and AIDS programming for sex workers to such an extent that many organizations no longer promote or publicize their successes. This has contributed to a lacuna in the literature about HIV programming with sex workers.

Stigmatization and marginalization increase risk of contracting or transmitting HIV. For this reason, the United Nations Secretary General Ban Ki Moon has spoken out against stigmatization of key populations in the fight against HIV and AIDS, saying “Overt and covert stigmatization and discrimination against these groups is a significant factor impeding data collection and targeted funding and programming.” Sex workers are one of the key populations referred to in this statement; indeed, sex workers experience stigma and discrimination in many settings. The elimination of the anti-prostitution pledge from US funding contracts would be a forward step against stigmatization of sex workers in US-funded healthcare settings. Short of eliminating the pledge, clarification about what is permitted is necessary. Inconsistent interpretation has exacerbated the problems created by the pledge. Communicating changes and explicit rules clearly and succinctly might eliminate or at the very least reduce the multiple interpretations and the HIV related and other harms experienced by sex workers and those providing care and support to them.

### Legal Implications of Changing Pharmacological Treatment Based on Fixed-dose Combinations of Antiretrovirals to the Components of these Combinations

Due to the current economic crisis occurring in Spain, some autonomous communities and hospitals have decided to change treatments based on fixed-dose combinations of antiretrovirals (FDCA) to the generic or non-generic components of these combinations. This change in treatment has a series of implications on a legal level since it would amount to a breach of the guarantees recognised in Law 16/2003 on the Cohesion and Quality of the National Health System, thus affecting the principle of equal treatment recognised in the Constitution.

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18 Confidential correspondence with former POLICY Project staff.
Likewise, it would violate the right recognised in Law 29/2006 on Guarantees and Rational Use of Pharmaceuticals and Health Products for all citizens to have equal access to pharmaceuticals throughout the National Health System (NHS).

Law 16/2003, which is based on the recognition of the assumption of powers by the autonomous communities in the field of health care, is designed to guarantee equity, quality and social participation in the NHS. Equity, in terms of developing the constitutional principle of equality, guarantees equal access to services throughout the entire country, allowing the free circulation of all citizens. Law 16/2003 also sets out legal provisions for health services, which are established by the catalogue of NHS services, the aim of which is to guarantee basic and common conditions for an appropriate level of continuing comprehensive care. The catalogue covers pharmaceutical services, including pharmaceuticals, health products and sets of procedures designed in such a way that patients receive them in accordance with their clinical needs, in the precise dose, according to their individual requirements, for the appropriate amount of time and at the lowest possible cost to them and the community.

Access to pharmaceuticals for non-hospitalised patients is regulated by Law 29/2006. This law establishes that pharmaceutical service is a universal benefit that patients must receive and use in accordance with their clinical needs, in the precise dose, according to their individual requirements, for the appropriate amount of time and at the lowest possible cost. Article 88 recognises the right of all citizens to equal access to pharmaceuticals throughout the NHS without prejudice to the measures designed to rationalise the prescription and use of pharmaceuticals that the autonomous communities may adopt in accordance with their powers.

Bearing in mind the rights and guarantees included in the aforementioned rules of law, the decision in some autonomous communities and hospitals to substitute pharmacological treatment based on FDCA with the components of the combinations amounts to a breach of the principle of equality, since neither accessibility nor mobility is guaranteed for all citizens. The pharmaceutical service that two people in the same clinical situation may receive would vary depending on the autonomous community in which they reside and it could also happen that these two people with HIV, even if they reside in the same autonomous community, could receive different treatments depending on the hospital in which they are treated. “Local level approval of the option to break down these FDCA in specific centres or autonomous communities could result in access to different levels of excellence in antiretroviral treatment administered according to economist criteria depending on the geographic area of residence in a country or even on the hospital where the treatment is carried out, despite a common National Health System” (Llibre, 2010). A change in treatment, as suggested, amounts to a modification in the conditions of dispensing pharmaceutical products to citizens according to the place in Spain where they reside or to which they move and, as a consequence, would produce a breach of the principle of equality and discriminatory treatment.

Law 29/2006 establishes a set of principles for the rational use of pharmaceuticals that conditions the type of treatment advocated, whether generic medicine or medicines that are governed by exclusive patent rights. One of these principles of rational use is prescription by active ingredient, which is designed to guarantee these rights at the lowest possible cost to the community, since the public financing of pharmaceuticals is submitted to a system of reference prices, i.e., the amount of financing for the pharmaceutical services included in each of the sets of medication, whenever they are prescribed and dispensed using an official NHS medical prescription form. Thus, when the prescribed active ingredient can be dispensed using generic medicines, this shall prevail.

However, generic medicines do not always exist on the market since, as a general rule, authorised generic medicines cannot be marketed until ten years after the date of the initial authorisation of the reference-accepted medicine. Irrespective of the discussion regarding the breach of patient rights or exclusivity, it is relevant to know what is to be done when a pharmacological treatment based on FDCA has been prescribed and there is no generic alternative that does not consist of breaking down the pharmacological treatment based on FDCA.
Bearing in mind the provisions in Law 29/2006, the rule states that any change in pharmacological treatment based on brand label FDCA must be made with another pharmacological treatment based on a generic FDCA and not on the components. The law permits the substitution of prescribed pharmaceuticals (pharmacological treatment based on FDCA) provided two cumulative requirements are met: lower price and identical qualitative and quantitative composition of active ingredients, pharmaceutical form, route of administration, dose and presentation of the prescribed pharmaceutical. If one of these requirements is not met, the substitution cannot take place.

Furthermore, a measure of this type can only be adopted by public administrations after discussion with all the concerned parties, associations of people living with HIV and scientific associations dedicated to the care of and research into HIV.

Among its underlying principles, Law 16/2003 recognises the need to establish mechanisms for the participation of citizens, both with respect to the autonomy of individual decisions and in the consideration of their expectations as a group of health system users, and to allow the exchange of knowledge and experiences. The legislation provides for a series of mechanisms for citizen and professional participation so that the adoption of measures in the field of health only occurs after a critical debate on them, in which the concerned parties can put forth their arguments in favour of or against them. These mechanisms, without a doubt, are favourable to governance and empower people with HIV. The way in which the decision to change pharmacological treatment was made in terms of people with HIV does not seem to have respected this process since the affected parties learned about this change either because their doctor told them about it or because the hospital pharmacy communicated it to them. With respect to scientific associations, they do not seem to have indicated their support for this type of change in treatment, given that the latest version of the National consensus document by GESIDA/National AIDS Plan on antiretroviral treatment in adults infected by the human immunodeficiency virus issued in January 2011, included as one of its general principles that when choosing between different possible antiretroviral treatments (ART) that are similar in terms of their antiretroviral power, the following will be taken into consideration, in addition to the cost: side effects, compliance, prior treatment, cross-resistance, pharmacological interactions, availability and patient or doctor preference.

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**Impacts of criminal prosecutions for HIV exposure and transmission on people living with HIV: Interim report from a Canadian study**

**Rationale**

In Canada, there has been a rising number of criminal prosecutions of people living with HIV (PHA) for HIV exposure and transmission since the landmark Cuerrier decision of the Supreme Court of Canada. This study came about to see how PHAs perceive the law and the legal obligation to disclose, and to see how PHAs are affected by the changing public climate of increasing prominence of criminal discourses applied to HIV. This study follows preliminary research reported in: Barry D Adam, Richard Elliott, Winston Husbands, James Murray and John Maxwell. 2008. “Effects of the criminalization of HIV transmission in Cuerrier on men reporting unprotected sex with men” Canadian Journal of Law and Society 23 (1–2):137–153.

The study came about from a series of meetings of people from academic, community, government, and PHA organizations. Ontario-based AIDS service organizations (ASO) were engaged in the development, conceptualization, implementation, and analysis of the study.

**Methodology**
A set of questions on AIDS and the law were included in the two most broad-based surveys of PHAs in Ontario, the Ontario HIV Treatment Network Cohort Study (OCS) (http://www.ohtncohorts.org) (N=492) and the Positive Spaces, Healthy Places (PSHP) (http://www.pshp.ca/) (N=438) study. In addition, in-depth interviews were done with 122 PHAs, who were broadly representative of the demographics of HIV in Ontario.

Information sources and awareness of the law among people living with HIV

When asked, “Have you heard that Canadian law requires you to tell your sexual partners that you are HIV-positive, at least in some circumstances?”, 87.4% of OCS and 95.5% of PSHP respondents, checked “yes.” When asked how they heard about this, they responded as follows:

<table>
<thead>
<tr>
<th>Information source</th>
<th>PSHP (%)</th>
<th>OCS (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>From the media</td>
<td>244 (56%)</td>
<td>315 (64.0%)</td>
</tr>
<tr>
<td>From an ASO</td>
<td>236 (54%)</td>
<td>65 (13.2%)</td>
</tr>
<tr>
<td>From another HIV-positive person</td>
<td>137 (31%)</td>
<td>31 (6.3%)</td>
</tr>
<tr>
<td>From an HIV clinic</td>
<td>94 (21%)</td>
<td>68 (13.8%)</td>
</tr>
<tr>
<td>From friends or Family</td>
<td>78 (18%)</td>
<td>40 (8.1%)</td>
</tr>
<tr>
<td>From a physician who was treating me</td>
<td>75 (17%)</td>
<td>95 (19.3%)</td>
</tr>
<tr>
<td>From a nurse or health care provider</td>
<td>54 (12%)</td>
<td>55 (11.2%)</td>
</tr>
<tr>
<td>From a social service agency</td>
<td>51 (12%)</td>
<td>36 (8.5%)</td>
</tr>
</tbody>
</table>

Impacts of criminal prosecutions for HIV exposure and transmission on people living with HIV

The 122 PHAs interviewed from 4 sites of the OCS were asked, “How do you feel the current public climate around HIV and the law is affecting HIV-positive people?”. A wide range of themes emerged:

(1) Significant numbers of study participants felt unaffected because they (a) always disclosed their sero-status in sexual encounters, (b) openly negotiated sero-status often preferring sero-concordant partners, (c) felt that disclosure of sero-status was the morally right thing to do regardless of the law, or (d) were not having sex anyway.

(2) Other PHAs took a more situational or conditional strategy, believing that disclosure was unnecessary if safe sex were practised, assessed how safe they felt before disclosing, or disclosed only if a relationship had potential to be more than casual.

(3) The largest number of respondents believed that criminalization had unfairly shifted the burden of proof so that PHAs were held to be guilty until proven innocent and that (a) PHAs were now caught in a difficult he-said/she-said situation of having to justify their actions, (b) disgruntled partners now had a legal weapon to wield against them regardless of the facts, and (c) the onus now fell on women whose male partners could ignore their wishes.

In terms of general impact, many respondents reported: (a) a heightened sense of fear and vulnerability, but others felt that (b) the climate of acceptance was still better than in the early days of the epidemic, or that (c) the prosecution of the high profile cases was justified and the high profile cases were giving all PHAs a bad name.

What do HIV-positive people think about the criminalization of HIV transmission?

Survey results show that the PSHP sample believes that criminal law should not be applied where: (a) there is no disclosure but protected sex occurs (54% agree, 28% disagree, 17% DK) or (b) there is no disclosure and oral sex occurs (45% agree, 35% disagree, 18% DK). PSHP respondents do believe that “someone with HIV should be
charged with a crime and perhaps sent to prison” for: (a) no disclosure “and it’s clear that the person wanted to pass HIV to their partner” (90% agree, 3% disagree, 6% DK), (b) no disclosure with undetectable viral load (79% agree, 13% disagree, 8% DK), and (c) no disclosure before unprotected sex (63% agree, 15% disagree, 19% DK). On the key question, “Do you think someone with HIV should be charged with a crime, and perhaps sent to prison, for having unprotected vaginal or anal sex without telling sexual partners he or she has HIV before having sex?”, there are no significant differences of opinion according to gender, sexual orientation, or ethnicity (except for Aboriginal status which was associated with somewhat more punitive views).

More educated respondents show less punitive views: (a) 74% with less than high school support criminalization for nondisclosure and unprotected sex, declining to 39% among those with a 4-year degree or more (p<.0001) and (b) 84% with less than a high school education support criminalization for nondisclosure with undetectable viral load, falling to 70% for those with a 4-year degree or more (p=.029). The greatest variation in opinion occurs around the question of nondisclosure with oral sex with support for criminalization ranging from (a) 51% among heterosexual men, 50% among heterosexual women, 31% among bisexual men, and 21% among gay men (p<.0001), (b) 50% among Aboriginal people, 44% among African and Caribbean people, and 30% among white people (p=.019), and (c) 50% with less than high school education to 20% with a 4 year degree or more (p=.014).

**Sexual interactions and expectations of people living with HIV in the Canadian context of criminalization**

Finally, the questionnaire also inquired into self-reported disclosure practices. In response to the question, “Concerning HIV-negative partners and partners whose HIV status I did not know, with whom I had anal or vaginal sex in the last six months (please check all that apply),” survey participants indicated the following:

<table>
<thead>
<tr>
<th>Reason for Not Disclosing</th>
<th>PSHP</th>
<th>OCS</th>
</tr>
</thead>
<tbody>
<tr>
<td>I told of all my partners that I am HIV-positive</td>
<td>196 (45%)</td>
<td>136 (27.6%)</td>
</tr>
<tr>
<td>I did not tell any of my partners that I am HIV-positive</td>
<td>24 (5%)</td>
<td>20 (4.1%)</td>
</tr>
<tr>
<td>I told some of my partners that I am HIV-positive and did not tell others</td>
<td>38 (9%)</td>
<td>28 (5.7%)</td>
</tr>
<tr>
<td>I dropped hints that I could be HIV-positive</td>
<td>20 (5%)</td>
<td>20 (4.1%)</td>
</tr>
<tr>
<td>I didn’t feel it was necessary to tell my partner(s) because we had protected sex</td>
<td>41 (9%)</td>
<td>24 (4.9%)</td>
</tr>
<tr>
<td>I didn’t feel it was necessary to tell my partner(s) because they should presume everyone is positive</td>
<td>20 (5%)</td>
<td>11 (2.2%)</td>
</tr>
<tr>
<td>I didn’t feel it was necessary to tell my partner(s) because they were willing to have unprotected sex</td>
<td>14 (3%)</td>
<td>6 (1.2%)</td>
</tr>
<tr>
<td>I didn’t feel it was necessary to tell my partner(s) because it is their responsibility to use a condom if they want to</td>
<td>17 (4%)</td>
<td>5 (1.0%)</td>
</tr>
<tr>
<td>I was afraid to tell my partner(s) I was HIV-positive</td>
<td>26 (6%)</td>
<td>19 (3.9%)</td>
</tr>
<tr>
<td>I did not have an HIV-negative partner or partner(s) whose HIV status I did not know</td>
<td>141 (32%)</td>
<td>117 (23.8%)</td>
</tr>
</tbody>
</table>

The remaining respondents reported either no sexual partners or only HIV-positive partners.

9 United Kingdom National Children’s Bureau

The Children and Young People HIV Network
The Children and Young People HIV Network\(^1\) is hosted by the National Children’s Bureau\(^2\), a national organisation which works to improve the well-being of all children and young people across every aspect of their lives. The Network brings together a diverse group of over 500 individuals and organisations concerned with children and young people infected with and affected by HIV and AIDS. It covers England and Wales, and includes those in Scotland and Northern Ireland where possible. The aims of the Network are to provide an effective voice for this cohort, to challenge HIV-related stigma and discrimination and to build child-centred policy and practice recommendations. The network meets its aims through national and local policy and practice development, the development and dissemination of good practice and resources, cross-sector communication, lobbying, advocacy and media work.

**The UK cohort of children and young people living with HIV**

In mid-2010, the UK was home to an estimated 11.6 million people under the age of 16\(^3\). Statistical data on children infected with HIV in the UK and Ireland is collected by the Collaborative HIV Paediatric Study (CHIPS).\(^4\) Its latest data\(^5\) is from 2010. A total of 1,699 children were reported to CHIPS by the end of March 2011, comprising virtually all of those receiving HIV-related care from 2006 onwards: 1,190 are alive and accessing paediatric HIV care, and 305 have transferred to adult care. The following statistics help to illustrate the nature of the UK and Ireland cohort:

- The median age of a child living with HIV is rising, and stood at 12.4 years in 2010. Last year, 70% of the cohort were over the age of 10.
- 97% of children reported to CHIPS are known to have been vertically infected.
- 79% of the children are of black African ethnicity.
- 48% of the children were born in the UK and Ireland.
- 53% of the children are seen at clinics (though not necessarily living) in London. 36% of the remaining children access care elsewhere in England; 4% in Scotland; 1% in Wales; 5% in the Republic of Ireland; and <1% in Northern Ireland.

Data on young adults collected by the Survey of Prevalent HIV Infections Diagnosed (SOPHID)\(^6\) shows that in 2009, there were 2,262 individuals aged 16-24 accessing HIV care\(^7\) in England, Wales and Northern Ireland. 401 of these cases are recorded as attributable to vertical transmission. Heterosexual sex and sex between men are the two most common categories of exposure to HIV, and the ethnic group with greatest representation in this age group is white (45% of cases).

**Legal issues affecting children and young people who are living with or affected by HIV in the UK**

Some key areas of the legal landscape identified as specifically important for children and young people living with or affected by HIV in the UK are as follows.

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\(^1\) For further information: Children and Young People HIV Network website. http://www.ncb.org.uk/hiv
\(^2\) For further information: NCB website. http://www.ncb.org.uk
\(^4\) For further information: Collaborative HIV Paediatric Study (CHIPS) website. http://www.chipscohort.ac.uk/default.asp
- Consent to testing and treatment (in terms of compliance with measures taken to prevent vertical transmission; consent to test children of HIV-positive parents; consent to treat HIV-positive children; and competent young people refusing treatment)
- Child protection
- Immigration and access to healthcare for non-UK citizens
- Discrimination – Equality Act 2010 (UK)
- Confidentiality
- Licensing of drugs for treating paediatric HIV
- Criminalisation of HIV transmission – Offences Against the Person Act 1861 (England and Wales).

The Children and Young People HIV Network is able to provide further information, or seek input from other agencies and from young people themselves, on any of the above. However, this submission will focus on criminalisation of HIV transmission as the Network has most recently been involved in work on this subject.

**Young people and criminalisation of HIV transmission in England and Wales**

The law used in England and Wales to prosecute people for HIV transmission is the Offences Against the Person Act 1861 (OAPA 1861). People have been prosecuted under the sections of the OAPA 1861 on ‘grievous bodily harm’. There are two possible offences – ‘reckless transmission’ (under section 20) and ‘intentional transmission’ (under section 18). There has never yet been a successful prosecution for intentional transmission. As of August 2010, there had been 20 prosecutions for reckless transmission since the first case in 2003, 14 of which were successful.

The following conditions are necessary at the time of the alleged offence for an individual to be found guilty of reckless HIV transmission: knowing one’s own HIV-positive status; understanding how HIV is transmitted; having sex with someone who is unaware of one’s HIV status; having sex without a condom; and HIV transmission occurring.

Two UK charities, the National AIDS Trust (NAT) and the Terrence Higgins Trust (THT), have worked with the Crown Prosecution Service (CPS), which is responsible for prosecuting criminal cases investigated by the police in England and Wales, and the Association of Chief Police Officers (ACPO, working in England, Wales and

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16 For further information: Offences Against the Person Act 1861. Available at http://www.legislation.gov.uk/ukpga/Vict/24/13
Northern Ireland), to develop guidance on police investigation in relation to HIV transmission. The Children and Young People HIV Network inputted into this work. The CPS were asked to produce guidance specifically relating to young people with HIV. However, no such guidance has yet been developed. ACPO produced a document alerting police officers of the requirement to have special consideration of their process where the accused is under 18, and recommending the involvement of an appropriate adult and the individual’s HIV clinician.

Some young people living with HIV in the UK appear to engage in risk behaviours for sexual transmission of HIV. Body & Soul, a charity supporting children, young people and families affected by HIV, recently conducted a survey of 51 adolescent users of their support service. These were individuals aged 13-20; the median age was 17. 64% of respondents were HIV-positive; the remaining 36% were affected by HIV. 54% of the youth were female. Body & Soul found that the median age of sexual debut amongst respondents was 14. 62.5% of respondents reported always using condoms, 29% sometimes using condoms, and 8.3% never using condoms. Whilst the survey did not ask about disclosure to sexual partners, its findings suggest that there may be the potential for some HIV-positive young people to find themselves open to accusations of reckless transmission.

Little evidence has been published of young HIV-positive people’s sexual behaviour or their feelings about and experiences of criminal law in relation to HIV transmission. However, the following case study from the Children and Young People HIV Network publication Looking After HIV illustrates one young person’s anxiety about criminal prosecution, and the need for clarity in this area. ‘Lee’ is a ‘looked after’ adolescent, i.e. under the care of the local authority.

Lee had unsafe sex with his girlfriend to whom he had not disclosed his HIV status. He was concerned about the event and shared it with staff at his children’s home; they in turn reported it to the social services’ duty social work team. The duty team did not know how to respond and referred it to their manager. A child protection response was undertaken regarding the girl. There was a panic response, immediate action was considered necessary, strategy meetings were held between different managers within the children’s service and a significant number of social services staff then learnt about Lee’s HIV status. The girl’s parents learnt what had happened and began proceedings to prosecute for reckless transmission of HIV under Section 20 of the Offences Against the Person’s Act 1861, although there was no evidence that transmission of HIV had taken place. Lee was referred to a specialist legal advisor. After this meeting he panicked and went straight to the police station and handed himself in. The police did not know what to charge him with and so charged him with sexual assault, although the girl was the same age as him and at this stage was still untested. The girl concerned was later tested by an adult sexual health service. She tested negative for HIV. Her parents and the police dropped all charges.

In the absence of guidance in this area that specifically relates to children and young people, key concerns from professionals raised in discussions between the Children and Young People HIV Network, NAT, THT and others,
include:
- The various age limits involved (the age of criminal responsibility being 10; the legal age of consent being 16; the youth justice system being applicable to individuals under 18; the use of ‘Gillick competence’ to assess young people’s understanding in medical contexts but not in criminal law)
- How the concept of ‘recklessness’ relates to the context of adolescent brain development
- The potentially short period of time between a young person becoming aware of his or her own HIV status (possibly having been advised not to disclose their status to anybody), and becoming sexually active, and the extent of the shift in thinking and understanding required to handle this
- The difficulty of establishing or proving a young person’s level of understanding of HIV, HIV prevention and transmission, and criminalisation, particularly given the need for further evidence on how HIV and HIV treatment may impact on cognitive development
- The trauma of an accusation, investigation and potential prosecution for a young person, and the potential anxiety of any HIV-positive adolescent about this possibility at a time of developing sexual awareness
- The possible legal position of professionals and parents if a young person who has not yet been disclosed to has unprotected sex, or if it is deemed that professionals have neglected to inform a young person of the law

Limited right and access to health care for undocumented migrants with HIV in Germany

This contribution covers the situation of undocumented migrants living with HIV in Germany – similar situations occur in other European countries.

In 2010 approx. 11% of all PLHIV in Germany were migrants\(^1\) – and the trend is rising. A special situation is faced by HIV-positive migrants in Germany with no residence permit. In case they are in need of treatment they have two choices: either they start an application process for a residence permit as this is obligatory to receive treatment (and bears the risk of deportation at the same time). Or they decide to stay illegally, stay without treatment and risk their lives. Both decisions might have unforeseeable consequences and put a high burden on PLHIV and NGOs. The preconditions that put PLHIV without a residence permit in such a situation are rooted in German law regulation and implementation.

The consequence of these laws and the according practices is that the right to the best possible attainable standard of care is constantly violated, with devastating impact for the populations concerned. The right to healthcare for all people regardless their residence permit status or income is defined in the European Social Charter of the Council of Europe\(^2\), adopted in 1961. Part 1, Right/ Principle 11 of the Charter states: “Everyone has the right to benefit from any measures enabling him to enjoy the highest possible standard of health attainable”; Also in Part 1, Right/ Principle 13 it says: “Anyone without adequate resources has the right to social and medical assistance”.

The International Covenant on Economic, Social and Cultural Rights, adopted in 1966\(^3\) acknowledges in article 12: “The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”.

Following indices such as the GDP ranking, Germany is one of the richest countries in the world with a strong economy and high public health standards\(^4\). Still the rights described above are only guaranteed for registered citizens, dependent on residence permit status.

Asylum seekers – as long as their application is not yet decided upon - have only limited access to health care services. For HIV positive asylum seekers access to ARVs will only be facilitated and costs will be covered when opportunistic infections or other life threatening conditions occur - a clear malpractice in the light of defined HIV-treatment standards that are valid and relevant for every individual.

The situation for undocumented migrants is even worse: for people concerned, only emergency treatment is available.

Cynically, relatively “good chances” to avoid deportation of undocumented persons exist, if they are already in a late stage of an HIV infection: the more seriously ill they are, the better are the chances. Counselors of NGOs face the strange situation to tell clients who are undocumented, that they have only chances to stay in the country if they are seriously sick. One example to demonstrate what that means: (anonymous, people are known to the authors)

\(^{3}\) http://www2.ohchr.org/english/law/cescr.htm Last access: August 4, 2011
“During a visit of her relative, Yvonne develops pneumonia. She gets taken to the hospital; her condition worsens within a short time. She falls into coma and gets taken to the emergency unit. There she gets diagnosed with HIV. It becomes obvious that Yvonne doesn’t have a health insurance and a residence permit. The nurses in the hospital get in touch with the local AIDS organization.

In order to guarantee the continuity of the treatment all people involved decide to announce Yvonne at the Aliens Department. This must be done in substitution and without her authorization, since she is still unconscious. Luckily her passport is available and her relative agrees to the decision that the social worker of the local NGO gets in touch with the Aliens Department. Yvonne’s doctors confirm in a paper that she is not in a condition to travel. With theses papers the NGO succeeds to get her a certificate that states that her presence in the country is known and tolerated. It might be possible to receive an official toleration (“Duldung”) as soon as an authorization by Yvonne can be delivered. For the time being these papers guarantee the coverage of the costs by the local social security office.

After two weeks Yvonne’s condition improves that far that communication becomes possible. The amount of problems she is facing is almost unbearable: the HIV-Infection, the high costs of treatment and the lack of knowledge how to cover everything, the questions how and where to continue in the future. Long visits by the relative and the social worker in the hospital follow. With the authorization by Yvonne the official toleration and the benefits foreseen in the law for asylum seekers can be applied for. They succeed to get full coverage of the costs by the social welfare office. When the release from hospital gets closer accommodation in a home for asylum seekers must be organized.

When dealing with these issues they also always talk about the future: how to proceed? Is returning to the home country a realistic option? Will medication be affordable? Will it be available at all? Service and support organizations in the home countries are contacted and questioned on the local situation. Yvonne needs to come to a decision: Actually she had wanted to go back home – but it’s getting more and more uncertain, if she’ll be able to continue there with the medication needed because of the progressed HIV infection. Information provided by the service and support organization is clear. One of the drugs she necessarily needs will hardly be available there and only high priced. So, will she stay in Germany? For Yvonne this is a tough decision to take. But she will stay. She succeeds in getting the HIV infection issued as an obstacle for deportation and in finally receiving a regulated residence permit – after more than three years. In the meantime Yvonne takes part in a German language course and in an education as health care assistant that is especially offered to migrants”.

As explained above, the risk of deportation is a constant threat people in this situation face. Another case study is cited for demonstration:

“Mr. Z. from Morocco has both no residence permit and an entry ban to the Schengen area because of former convictions in Italy. He is already sick but not in a health threatening condition. He decides to come out and show up. For a couple of months now he has been living with a very uncertain residence permit status and he is threatened by deportation – but his treatment is guaranteed for now. But the situation stays paradox: Should his health status improve because of the treatment, the risk to get deported rises”.

Examples like this are quite common; they demonstrate the severity of the situation and the human rights related problems that go along with it.

Law regulation and implementation should guarantee that people with severe chronic diseases receive adequate treatment and do not get deported to countries where this cannot be guaranteed!

We want to stress the so-called “Migration and AIDS community recommendations”: These recommendations were developed by members of the European HIV community and are based on the European conference “The Right to HIV/AIDS Prevention, Treatment, Care and Support for Migrants and Ethnic Minorities in Europe: The
Community Perspective” that took place in Lisbon, 7-8 June 2007.  

“1. All relevant actors should recognize the right to health as a fundamental human right and should ensure universal access care. Special effort should be made to ensure access by vulnerable and marginalized groups such as members of ethnic minorities, undocumented migrants, migrant sex workers, incarcerated migrants, migrant people living with HIV and migrant injecting drug users.

4. We request an end to harmful practices, such as deportation connected with HIV status. It is unacceptable to deport people to places where treatment and care are not guaranteed. Furthermore we request an end to repression, criminalization and “illegalization” of marginalized and stigmatized groups as these practices pose serious obstacles to accessing HIV/AIDS prevention, treatment and care.”

To ensure the compliance of human-rights and a highest possible standard of health attainable for all people, independent of their residence permit status, these recommendations and their implications should be guiding not only for German law regulation and implementation but for all countries and multi-country institutions of the international community.

Sources:


11 France SIDA Information Service

For the past 20 years SIS has been indentified as a structure of reference in France.

SIDA INFO SERVICE is a nonprofit organization offering several national lines concerning access of information, support, guidance and prevention regarding populations of persons with HIV/Aids, STIs and sexual and reproductive health.

One of these lines, called SIDA INFO DROIT (Law and HIV Info), is specifically devoted to promote the rights of persons afflicted and especially highly vulnerable groups. The team is composed by professional lawyers, who usually work in law firms, and accept to make available their knowledge and skills for one or two days a week.

Both of the managers are also members of governmental commissions as legal experts law concerning persons living with HIV/Aids.

They are recently negotiate, on demand of Madame Christine Lagarde (former French Finance Minister) with insurance companies and banks a legal convention improving the capacity of the persons living with HIV/Aids to get a home loan with a regular insurance.

An Observatory is compiling statistics during 1989, and SIS has been one of the most important organizations promoting the rights of persons living with HIV/Aids.
Unequal services, unequal rights.  
People with HIV in Germany’s prisons

According to the GDP ranking, the Federal Republic of Germany is one of the richest countries in the world. The public health standards are high, but not for everyone in the country, especially not for prisoners.

Germany is a federal state, uniting 16 different states, with its own parliaments, administrations, et cetera. The responsibility for prisons is ruled at state level, with the result that every state in the country has its own regulations. This leads to different situations in prison, regarding access to health care, harm reduction and prevention. The stewardship for health in prison is under the authority of the Ministries of Justice (MOJ) and not the Ministries of Health, a fact resulting into double standards and malpractices in prison. One of the consequences is that the system of prison health is singled out and not part of the public health system.

This contribution covers violations of rights for prisoners in the German, notably in the states of North Rhine-Westphalia and Bavaria. The information is based on own research and experiences, gathered as a community oriented person, working for a NGO on behalf of prisoners. Similar violations of rights happen in other German and European states/countries.

In 1990, the United Nations developed Basic Principles for the Treatment of Prisoners. Principle 9 indicates: “Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation”\(^1\).

It appears that basic principles have very little impact on prisoners with HIV or other chronic conditions in our country.

Some examples:

**Forced outing of HIV-status in North Rhine Westphalia’s prisons**

If a prisoner with HIV in North Rhine Westphalia wants to share a room with other prisoners or if he wants to participate in social activities, he needs to declare his HIV-status in written form. If he isn’t willing to declare this, he cannot participate in certain social activities and will be forced to stay isolated in his cell. The same happens if the prisoner without HIV decides not to take the “risk” to stay in a room together with somebody with HIV. This practice clearly violates the right to privacy and confidentiality. It is highly discriminative, a hardship especially for prisoners who are newly infected, who might need time to cope with the test result and fear the discrimination by other prisoners. HIV is not only in prison associated with men having sex with men (MSM), sex work or drug use. Members of these groups are at the bottom of the prison hierarchy among prisoners; those at the bottom of the prison hierarchy bear higher risks.

On June 22, 2011 a public hearing in the state Parliament addressed this issue. Invited prison health experts discussed this practice. It exists since 1987 and is unique in the 26 countries of the European Union. The highly discriminative nature becomes obvious when HIV is compared with Hepatitis C that is much more prevalent in prison\(^2\) and ten times more infectious than HIV\(^3\). NGOs argued that the practice provides a false sense of

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\(^1\) Health in prisons. A WHO guide to the essentials in prison health, Edited by: Lars Møller, Heino Stöver, Ralf Jürgens, Alex Gatherer and Haik Nikogosian, page 7, WHO, 2007

\(^2\) 14,3 to 17,6 percent of prisoners in Germany are infected with Hepatitis C, which is 26 to 32 fold higher compared to the outside population (source: Keppler, K., Stöver, H., Schulte, B. & Reimer, J. (2010): Prison Health is Public Health! Angleichungs- und Umsetzungsprobleme in der gesundheitlichen Versorgung Gefangener im deutschen Justizvollzug. Bundesgesundheitsblatt, 53, 233-244)

\(^3\)
security (not every prisoner is tested, window period etc.) and undermines prevention strategies. Only experts representing the voices of the prison system denied the discriminative nature of the regulation and defended the practice with the option to enlarge it to Hepatitis and other diseases. We expect a decision by the local government in autumn.

**Limited access to condoms in Bavarian and North Rhine Westphalia’s prisons**

The HIV prevalence in Germany’s prisons is with 0.8 to 1.2 percent 16 to 24 times higher than in the outside population⁴. Studies demonstrate high rates of sex between men in prison⁵, a topic usually tabooed among prisoners and staff. Safer sex in prison is in many cases not possible since condoms and lubricants are not anonymously available. Prisoners usually need to request condoms by health care or social service personnel, meaning, they have to admit that they are having sex with other men: a high threshold for many prisoners, especially for prisoners with lack of a gay identity.

Back in 2006, we initiated community based research in all Bavarian prisons by sending questionnaires to the physicians working in prison: between 2003 and 2005 only 43 condoms were handed out for 7900 prisoners each year. These astonishing results were later confirmed by the Bavarian Ministry of Justice. It was promised that the situation would change but the need for anonymous distribution of condoms was denied. Today, NGOs working in Bavarian prisons record that the situation hasn’t changed much. MSM who are not able to take the threshold and talk openly about their sexual behaviours are deprived of their right to protect themselves, in light of the above mentioned basic principles a clear malpractice.

The situation in North Rhine Westphalia is comparable: the public hearing on June 22, 2011 brought to light that a ministerial degree of 1997, released to promote unanimous availability of condoms for prisoners, was never turned into practice. Reasons mentioned are that prisoners might misuse the condoms, use it for smuggling drugs. et cetera.

**Discrimination at workplaces in prison**

Work related discrimination in Germany is currently high on the advocacy agenda. A community based campaign says: “I have to live with HIV but not with colleagues that discriminate”.⁶ Unluckily, Prisoners don’t have the freedom to choose. Outside prison, anti-discrimination laws are enforced, making it legally impossible to dismiss people on the ground of their HIV status; the only limitations apply currently to physicians who operate. This situation is not reflected in the judicial system: prisoners with HIV live in a system that still implements practices to promote work place based discrimination. Prisoners with HIV are very often not allowed to work in the kitchen or in the bakery, a clear discrimination based on HIV-status and wrong perception on infectiousness, beside any public health justification. This leads not only to the deprivation of a possible income for prisoners: it applies as well to trainings for certain professions. Prisoners with HIV are deprived of the right to education and equal treatment.

**HIV-positive prisoners sometimes excluded from recreation activities**

Another example from Bavaria: the irrational fears of transmissions lead to other forms of limitations for prisoners: back in 2006, a young prisoner with HIV and Hepatitis C co-infection was not allowed to enter the fitness room to do his exercises. He might transmit his disease to other prisoners. Any reasoning with the

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⁶ http://www.aidshilfe.de/de/shop/wat-2010-postkarte-motiv-arbeitswelt.
physician responsible for this decision on how transmissions are possible did not convince. Together with colleagues we had to file a petition to the state government arguing that this practice is clearly discriminative and beyond scientific evidence. There are no equivalent regulations in the outside world, neither in sport clubs, nor in fitness parlors. We succeeded with the petition, with the result that the prisoner was moved to a prison in the next city. There, the prisoner wasn’t allowed to play soccer... Only a letter to the Minister of Justice, where we threatened to involve the public helped to end this nightmare.

**Conclusion**

This contribution highlighted issues less broadly discussed than other limitations of rights of prisoners. It did not mention the obvious: the deprivation of rights related to the access to clean needles and syringes, to opioid substitution treatment, to diamorphine treatment, to adequate antiretroviral treatment for HIV or treatment for Hepatitis C, access to information or voluntary counseling and testing, et cetera. Compared to the outside world, the reality in prison demonstrates broad discrepancies, with dramatic impact for the public health system. In most cases, prisoners return back to the societies where they belong to. In terms of prevention and public health: whatever has not been achieved in prison will come back to the society at large.

The points mentioned here deliver strong arguments to restructure the prison health systems. The stewardship of prison health should move from the MOJ to the MOH. The principle of equivalence, derived from the United Nations developed Basic Principles, will never be achieved unless we come to structural changes.

The fight for human right for prisoners is fundamental for the kind of reforms needed. Segregated prison health systems lead inherently to unequal services and the deprivation of prisoners rights.

**Appendix/Sources:**


Does it matter which Ministry is responsible for health in prison? Why the stewardship for prison health should move from Ministries of Justice or Interior to Ministry of Health, EATG discussion paper. Peter Wiessner and Raminta Stuikyte, November, 2010 (http://www.eatg.org/eatg/Publications/Discussion-Papers/Discussion-Paper-on-the-Stewardship-of-Prison-Health)


13 Canada Canadian HIV/AIDS Legal Network, Children Can’t Wait! Dying for Drugs in Developing Countries

**Introduction**

The Canadian HIV/AIDS Legal Network ([www.aidslaw.ca](http://www.aidslaw.ca)) promotes the human rights of people living with and vulnerable to HIV/AIDS, in Canada and internationally, through research and analysis, advocacy and litigation, public education and community mobilization.

**Laws and practices that criminalise people living with HIV and vulnerable to HIV**

A. People who use drugs

Insite, Vancouver’s [supervised injection facility](http://www.aidslaw.ca), has decreased rates of syringe-sharing and deaths from
overdose, reduced the risk of HIV and hepatitis C (HCV) transmission and increased the chances of directing drug users to addiction treatment services.\(^1\) In 2008, a trial court judgment protected Insite from closure, thus enabling the facility to operate without fear of users or staff being criminally prosecuted.\(^2\) This decision was affirmed by that province’s appellate court in 2010.\(^3\) However, the federal government appealed the decision to the Supreme Court of Canada (decision pending) and maintains a moratorium on considering new applications to open any other such facilities.

In 2011, the federal government announced its intention to introduce legislation that would impose mandatory minimum sentences for certain drug offences, despite a Department of Justice review that concluded that mandatory minimum sentences for drug offences have little impact on crime and two decades of disastrous experience in the United States with similar legislation.\(^4\) Such legislation would incarcerate more people who are already vulnerable to HIV and HCV infection, where drug use will continue, but often with even higher risks for transmission of such blood-borne infections because prisoners lack access to sterile injection equipment.

B. People in prison

In Canada, estimates of HIV and HCV prevalence in prisons are at least ten and thirty times, respectively, the reported prevalence in the population as a whole.\(^5\) A 2007 national survey revealed that 15 percent of people incarcerated in federal prisons reported having injected an illegal drug since arriving at their current institution and almost half of those injected with a needle already used by someone else.\(^6\) To date, prison-based needle and syringe programs (PNSPs) have been introduced in over 60 prisons in 11 countries,\(^7\) and evaluations of PNSPs have consistently demonstrated that they reduce the use of non-sterile injecting equipment and resulting blood-borne infections, do not lead to increased drug use or injecting, reduce drug overdoses, facilitate referral of users to drug treatment programmes and have not resulted in needles or syringes being used as weapons.\(^8\) Moreover, such programs have been supported by numerous organizations in Canada, including the Canadian and Ontario Medical Associations, the Correctional Investigator of Canada (federal prisons ombudsman) and the Canadian Human Rights Commission. Yet, federal, provincial and territorial governments have to date failed, or explicitly refused, to authorize PNSPs in their institutions, preferring to focus almost exclusively on drug interdiction.

C. Sex workers

While prostitution is legal in Canada, certain provisions of the Criminal Code make illegal virtually every activity related to prostitution and render sex workers vulnerable to violence and HIV. Sections 210 to 213 of the Criminal Code criminalize keeping or transporting a person to a “bawdy house”, “living on the avails” of prostitution by someone else, and “communicating in public for the purposes of prostitution.” The preponderance of credible evidence demonstrates that these provisions contribute to sex workers’ risk of

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6. Ibid. For first-hand accounts of sharing injection equipment inside prisons, from people currently or formerly incarcerated, see S. Chu & K. Peddle, Under the Skin: A People’s Case for Prison Needle and Syringe Programs (Canadian HIV/AIDS Legal Network, 2010), on-line via www.aidslaw.ca/undertheskin.


experiencing violence and other threats to their health and safety by preventing them from adequately screening clients and from working indoors in a protected environment and in association with others (including bodyguards), forcing them to work in more secluded areas to avoid police detection and prosecution, and impeding their access to health services. These risks are borne disproportionately by street-based sex workers, who are disproportionately transgender persons, Aboriginal persons or people with drug dependence. In 2010, an Ontario trial court struck down these Criminal Code provisions as violating constitutional rights to freedom of expression and to security of the person — the latter because those provisions force sex workers into more dangerous situations and contribute to a greater risk of violence and other threats to their health and safety, thereby impermissibly violating constitutional rights to liberty and to security of the person. The federal government chose to appeal the decision, which is currently before the Ontario Court of Appeal.

D. Criminalization of HIV non-disclosure

Although there is no evidence that criminalizing HIV non-disclosure can play any significant role in HIV prevention, the number of prosecutions against people living with HIV (PLHIV) continues to increase in Canada. With a total of 130 people charged (at time of writing) for not disclosing their HIV-positive status to sexual partners, Canada is considered a world leader in prosecutions against PLHIV. There are no specific HIV-related crimes in the Criminal Code. Rather, existing Criminal Code offences have been applied to HIV non-disclosure. Increasingly, defendants are facing charges of aggravated sexual assault, which carries a maximum penalty of life imprisonment and for which conditional sentencing (i.e., serving a sentence of imprisonment in the community under certain restrictions, e.g., house arrest) is not an option. Persons convicted are also recorded on a sex offender registry. In 2009, a person living with HIV was convicted for the first time in Canada (and possibly the world) of first-degree murder for not disclosing his HIV status before having unprotected sex. (A few more people have since been charged with attempted murder.) In August 2011, he became the first person in Canada declared a “dangerous offender” for conduct related to HIV non-disclosure. Under the current law, PLHIV have a duty to disclose their HIV-positive status before engaging in conduct that poses a “significant risk” of transmitting the virus. However, what constitutes a “significant risk” has as yet to be clarified by the Court. The law’s uncertainty has led to inconsistent decisions across the country and facilitated an extensive use of the criminal law. Some people have been charged and/or convicted for having protected or oral sex alone while others have been acquitted. In two recent decisions, the Courts of Appeal of Manitoba and Quebec ruled that when a condom is used or when a person has an undetectable viral load there is no significant risk of transmission and thus, no duty to disclose should be required. The Supreme Court of Canada is scheduled to hear the prosecution’s appeal in at least one (and perhaps both) of these cases in 2012.

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

A. Canada’s Access to Medicines Regime

9 G. Betteridge, Sex, work, rights: reforming Canadian criminal laws on prostitution (Canadian HIV/AIDS Legal Network, 2005); Pivot Legal Society, Voices for dignity: a call to end the harms caused by Canada’s sex trade laws (2004).
10 Bedford v. Canada, 2010 ONSC 4264 (Ontario Superior Court of Justice).
11 This information is based on the tracking of cases conducted by the Canadian HIV/AIDS Legal Network.
13 Criminal Code, section 268.
14 Criminal Code, sections 742.1 and 752.
15 In some provinces, registration on the provincial sex offender registry can be mandatory when a person is convicted of a sexual offence.
17 This information is based on the tracking of cases conducted by the Canadian HIV/AIDS Legal Network. See also N. McKinnon, “Two new complainants come forward in Ottawa HIV case,” Xtra!, September 23, 2010 (on-line edition).
Created by legislation passed unanimously in Canada’s Parliament in May 2004, Canada’s Access to Medicines Regime (CAMR) was intended to allow compulsory licensing of pharmaceutical products patented in Canada for the limited purpose of authorizing Canadian generic drug manufacturers to legally produce and export lower-cost versions of patented, brand-name medicines to developing countries. The Government claimed at the time that CAMR would “go a long way toward improving global health.”22 Yet more than seven years later, CAMR has been used only once by a single generic manufacturer (Apotex Inc.) for a single authorization to produce one order of a fixed-dose combination antiretroviral AIDS drug for export to a single country (Rwanda).23 The current CAMR has been widely criticized as imposing a number of unnecessary requirements on both importing countries and Canadian generic manufacturers that have hindered the ability to provide an efficient solution to public health crises in the developing world.24 The sole generic manufacturer that used CAMR has stated its unwillingness to do so again in its current form, while developing countries have repeatedly pointed out how Canada’s law does not accommodate their practical realities of drug procurement.25 Recommendations for reform have come not only from diverse civil society organizations and international legal experts, but also from within Parliament itself, including a Senate committee.26 Many of CAMR’s current limitations are not required by the World Trade Organization’s (WTO) Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) and the subsequent WTO General Council Decision of August 30, 2003 upon which CAMR is based.

In 2009, two bills were introduced in the Canadian Senate and House of Commons, respectively, each proposing identical reforms to streamline CAMR and make it easier to use.27 Central to the proposed amendments was the introduction of a “one-licence solution” permitting a generic manufacturer to supply multiple eligible countries, in the quantities they identify as necessary over time, under a single licence. One bill passed with a strong majority in the House of Commons in March 2011, but opposition by the federal government delayed its passage in the Senate until it died on the Order Paper two weeks later. In order to meet its stated intention of assisting developing nations with access to affordable life saving medicines, Canada needs to simplify CAMR. Failure to take such action, in line with Canada’s legislatively stated commitment to improving access to medicines, is to disregard its obligation of international assistance and cooperation in realizing the right to the highest attainable standard of health under the International Covenant on Economic, Social and Cultural Rights (Articles 2 and 12).

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24 E.g., Médecins Sans Frontières, Neither Expeditious, Nor a Solution: The WTO August 30th Decision is Unworkable – An Illustration Through Canada’s Jean Chrétien Pledge to Africa, August 2006.
26 Senate Standing Committee on Foreign Affairs and International Trade, “Overcoming 40 Years of Failure: A New Road Map for Sub-Saharan Africa”, February 2007, p. 117, on-line: http://www.parl.gc.ca/39/1/parlbus/commbus/senate/com-e/fore-e/rep-e/repafrifeb07-e.pdf. It is important to note that, consistent with the outcome of WTO negotiations on which it is based, CAMR has never been, and should not be, limited to simply responding to the need for AIDS drugs in African countries, but is more broadly applicable to address public health problems in a wide range of eligible countries.
About Us

The American Society for Muslim Advancement (ASMA) is a New York based nonprofit organization founded in 1997 to elevate the discourse on Islam and foster environments in which Muslims thrive. We are dedicated to strengthening an authentic expression of Islam based on cultural and religious harmony through interfaith collaboration, youth and women’s empowerment, and arts and cultural exchange.

We pursue our mission through five strategies: we educate, incubate, advocate, organize, and mobilize. Specifically, we provide accessible and reliable information about Islamic theology, law, and societies, as well as media and leadership training. With this information, we pilot new approaches to solving enduring challenges facing the global Muslim community. We promote collaboration in pursuit of an ethical and equitable Islam. Additionally, we convene leaders and support their efforts in addressing pressing contemporary social issues.

ASMA’s approach is wholly inclusive, and we collaborate with leaders and activists from every faith in creating holistic programs, products, and services. Our program participants, partners, and employees represent a wide spectrum of religions, ethnicities, professions, ages, and genders.

Our Work

Our work focuses on educating and empowering Muslim women through human rights-inspired and gender-sensitized religion-based perspectives on contemporary social issues. To effectuate these goals, ASMA has spearheaded two pioneering programs: the Muslim Women’s Shura Council and the Women’s Islamic Initiative in Spirituality and Equality (WISE).

ASMA’s Muslim Women’s Shura Council is a global consultative council of over 25 leading female civil society activists and religio-legal scholars. Our vision is to generate a space in which Muslim women actively dialogue, debate, and collaborate on pressing issues of social justice, in order to articulate an ethical and egalitarian Islam. From this space, policy statements are written, unanimously approved by the council-members, and disseminated to our global network.

The Women’s Islamic Initiative in Spirituality and Equality (WISE) is a global program, social network, and grassroots movement led by Muslim women. WISE uses principles from the Qur’an and Shari’a, including the statements produced by the Muslim Women’s Shura Council, to advance the realization of women’s human rights with religious authenticity and recognize the interrelated social, economic, and political factors that contribute to gender-based inequality.

All the work produced by the Muslim Women’s Shura Council and WISE is thoroughly consolidated and presented through our WISE e-portal (see: www.wisemuslimwomen.org). This e-portal is the first of its kind resource for Muslim women, generated by Muslim women. The interactive website features the Shura Council statements available in multiple languages and detailed “Current Issue” pages, highlighting over twenty topics that dramatically affect Muslim women globally. Through this educational resource, the e-portal seeks to be the preeminent reference guide for Muslim Women.

Our Work in Relation to HIV/AIDS

We at the American Society for Muslim Advancement seek to educate American Muslims, as well as the global Muslim population, on the most pressing social justice issues affecting contemporary societies. To do this, through our Muslim Women’s Shura Council, the WISE Compact was agreed upon. The WISE Compact
encapsulates the core principles of Islamic law, as derived from the Maqasid al-Shari’a, specifically the right to wealth, mind, religion, family, dignity, and life. Through our engagement with the sources of Islamic law and publications on contemporary theological issues, we create socio-legal environments that have a profound effect on the lives of Muslims throughout the world.

Central to our work is the understanding that too often, many individuals presuppose what is condoned and prohibited by religious law. In this, many devout religious individuals believe that what is rooted in a local tradition or custom is actually required and sanctioned in the name of divine will. Our works attempts to challenge unjust and harmful cultural practices, often wrongly justified in the name of Islam. Particular to the HIV/AIDS context, there appears to be a trend emerging from contemporary literature on Islam that focuses on viewing the suffering of infected with the disease as the justified after-effects of sinful activity (e.g., men who seek to be strict with, injecting drug users, female sex-workers, etc.). This attributing of blame to the infected individual is counter to the compassion seen throughout Islamic law. In this vein, there is an additional trend, seeking to produce solutions from within the Islamic legal framework, engaging with religious leaders, and aiming to prevent and treat HIV-infections.

It is in this second trend that our statements can be mobilized to aid in the fight against HIV/AIDS. At ASMA, particularly through the Shura Council, we argue for the full realization of a women’s right to health, most recently through two campaigns geared towards the elimination of violence against Muslim women. Council statements on “Female Genital Cutting” and “Jihad against Violence” condemn violence against women in all its forms. While rarely spoken about, female genital cutting has a presence in the United States, affecting some recent immigrant communities from Asia and Africa. Our statement on female genital cutting declares that not only does this cultural practice increase a woman’s risk of contracting sexually transmitted diseases, including HIV/AIDS, but additionally maintains that it violates the central tenants of Islamic law. As such, through its Shura Council statements, ASMA advocates that this un-Islamic tradition should be abolished.

Additionally, ASMA’s larger Jihad Against Violence campaign is rooted in the “Jihad Against Violence” statement, condemning both international terrorism and domestic violence. In this statement, we thoroughly denounce the assertion-based on a frequently misunderstood Qur’anic verse that men have a right to strike their wives. It has been suggested by numerous studies that domestic violence creates environments where women and children are more susceptible to HIV/AIDS infection. The belief that Islam condones domestic violence is thoroughly incorrect and further infringes upon the rights of women to have access to education, treatment and prevention services. This type of violence marginalizes women and can lead to spousal abandonment, rendering women increasingly vulnerable to HIV/AIDS. At ASMA, we dialogue with the American Muslim community and inform them that women have the right to be treated with dignity and respect, empowering them to ensure their individual health and the health of those individuals most in need.

Orphans are similarly vulnerable to the epidemic. Our statement on “Adoption and the Care of Orphan Children” makes the case for adoption within an Islamic framework. We aim to secure the rights of children, as absolutely guaranteed by Islam, and prevent the abuse and disease that abandoned children often suffer from. A second key principle rooted in the Shari’a is the protection and promotion of the family. A harmonious family has always been the cornerstone of just and thriving societies. Furthermore, intact and happy families bolster the well-being of individual family members, mitigating the threat of HIV/AIDS.

At ASMA, we are currently developing a “Current Issue” page on HIV/AIDS. Understanding that while epidemiological data among many American Muslim communities is scant, Muslims around the world, including

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in high-income countries, must be equipped to both prevent infection and treat those infected with the disease. Lack of statistical evidence should not be used as an excuse to refrain from educating and empowering women in relation to HIV/AIDS. We actively endeavor to reframe the discourse on religious law in the United States and the world at-large. It is through our Shura Council statements and WISE global network that the American Society for Muslim Advancement wishes to dialogue with the larger NGO-community and be of service in the fight against HIV/AIDS.

**15 Norway**

**HIV Manifesto Norway**

**Solution-Oriented Activism by Impatient HIV+ Norwegians, seeking better living conditions for all PLHIV-Nationally and Globally**

**Background for the group and our involvement against criminalisation of PLHIV**

The HIV Manifesto Group was established four years ago by two Norwegian HIV positive persons. We had been discussing, in frustration, and for years, why things did not seem to move forwards. Huge medical progress had been made in recent years, and a HIV-diagnosis was no longer the death-sentence it used to be. We were told to plan for a long life, with more or less a normal expected lifespan. But a life tainted by stigma? Decades of living with our times most heavily burdened social “stamp”? At one point we decided to either stop complaining, or take action ourselves. We chose the latter, and these years since have been very interesting, meaningful and rewarding. Several other PLHIV have joined our work, people of varied backgrounds, sex, and age. We all share a strong and genuine wish to contribute to a better quality of life for people diagnosed with HIV in Norway, and globally.

One of our members is Kim Fangen, a well known HIV-activist, working both in Norway and globally. According to Karl Lemmen in Deutsche AIDS-Hilfe, who we recently met at a meeting in DAH in Berlin, Kim has a substantial personal credit for putting travel-restrictions on the political agenda globally and in the UN. We are very proud that he has chosen to work with us, after having witnessed our work for two years.

Our first big focus issue has been the criminalization of HIV. We believe this harmful practice strengthens the prejudices many people affected by this medical diagnosis experience, nationally and globally.

In recent months we have also worked on establishing a Norwegian HIV-patients advisory-board. Kim is in charge of this project, and we have managed to gather several HIV-positive representatives, from different backgrounds, ages, and nationalities. Also we have initiated a cooperation with Oslo University Hospital. Our aim is to develop new tools to create better and safer treatment options, with a user-friendly universal standard of treatment, improved IKT-systems, and to help us identify important topics to work with in future.

Today we experience much support from PLHIV both in Norway, and from contacts in other countries.

We are currently in the process of creating a new web-page. In the meantime, more information about our work can be found on our existing pages. Here we also provide an extensive argumentation for our efforts to end the criminalisation of HIV:

English: [http://solutio.no/HivManifestoEng.html](http://solutio.no/HivManifestoEng.html)
Norwegian: [http://solutio.no/Hivmanifest.html](http://solutio.no/Hivmanifest.html)

**The Norwegian penal code section § 155**
“Any person who, having sufficient cause to believe that he is a bearer of a generally contagious disease, wilfully or negligently infects or exposes another person to the risk of infection shall be liable to imprisonment for a term not exceeding six years if the offense is committed wilfully and to imprisonment for a term not exceeding three years if the offense is committed negligently. Any person who aids and abets such an offense shall be liable to the same penalty. If the aggrieved person is one of the offender’s next-of-kin, a public prosecution shall be instituted only at the request of the aggrieved person unless it is required in the public interest.”

OUR MANIFESTO: HIV-CRIMINALISATION IS COUNTER-EFFECTIVE AND HARMS THE SOCIETY

Every organization, group, and person affirming their support to this manifesto, concurs with our view that the Norwegian Penal Code §155 must be abolished.

This legal paragraph was introduced in 1902 in order to protect society from the public threat of infectious diseases. However, it has only been applied in cases involving HIV, and is often referred to as the «HIV-paragraph».

It has never been documented that §155 prevents HIV transmission. On the contrary, there are reasons to believe that it imposes several negative consequences for both individuals and society. The paragraph induces a false security for HIV-negative people, a psychological burden for people living with HIV, and a hurdle that undermines effective public health initiatives. Society must realise that criminalisation represents an erroneous strategy in the fight against HIV.

We ask the Norwegian authorities to comply with the requests of the joint United Nations programme on HIV/AIDS, UNAIDS, to avoid criminalisation of people living with HIV, in accordance with fundamental human rights.

We further recommend the Norwegian authorities to fulfil their humanitarian and ethical responsibilities, and abolish § 155 now!

ENDORSEMENTS

This manifesto has been endorsed by leading HIV-, and other organisations, doctors, healthcare centres, politicians, artists, and various private supporters. Both from Norway and other countries.

Among our supporters are:
- Craig McClure – (Former) Executive Director, International AIDS Society
- RFSL – Sweden’s leading organisation for gay and lesbian people
- Deutsche AIDS-Hilfe
- Sexuality Policy Watch
- Anette Trettebergstuen – member of the Norwegian Parliament
- BrynsengLegene – One of Norway’s largest HIV-test clinics
- HomoPositiv – A leading group for HIV-positive gay men

Also The Norwegian organisation for Infectious Medicine, and The Norwegian Church-council, wrote to the Justice-comity, stating they believe criminalisation in counter-effective and discriminatory.

EXCERPTS FROM THE BACKGROUND-INFORMATION THAT CAME WITH THE MANIFESTO, VARIOUS PUBLICATIONS AND OUR WEB-PAGES:

Criminalization of sexuality - a dangerous path
Prosecution of consensual sexual activity between adults takes place in Norway today. The Norwegian Penal Code § 155 is used to prosecute HIV positive people who exposes another person to any kind of risk of infection. This paragraph also lays the ground for prosecuting other forms of consensual sexual activity between adults. This practice is strongly criticized by many leading figures in the fields of medicine, law and human rights.

Our goal

Many HIV positive people state that the social burden of their diagnosis is heavier than the medical. In addition, criminalisation and prejudice are hindrances for openness and anti-stigma-efforts. Stigma and secrecy in turn hampers prevention efforts. Our goal is that HIV is considered purely a medical diagnosis, which comes without social prejudice. Both in Norway and globally.

Actions

Two years ago we produced 500 copies of our printed, numbered, 4-page manifesto, which was distributed to all members of the Norwegian Parliament, media, and national and international organisations. We had two goals with our manifesto: 1. To increase the public focus on HIV and criminalisation. 2. To get endorsements. The response was overwhelming, and the manifesto was endorsed by a number of important Norwegian and international organisations and persons. We soon set up our own web-site: http://solutio.no/Hivmanifest.html which has many hits.

Achievements

In addition to the work with the manifesto and our web-page, we have “spread our message” in media, nationally and internationally, which has resulted in many articles in various newspapers. The hardest-hitting media-piece we were involved in, was a full page text written on our request (and we supplied him with background information) by South African Supreme Court judge and HIV activist Edwin Cameron, "Norway's exports of stigma". It was in print in one of the leading Norwegian newspapers, Dagbladet, spring 2009, and attracted much attention. Later we translated it, and distributed it globally: http://www.poz.com/articles/cameron_norway_hiv_criminalization_401_16670.shtml In this chronicle Justice Cameron strongly criticizes the Norwegian government for this legislation, and practice, and tells about the devastating consequences this has on his home continent Africa.

Later we were invited to contribute with a report to UNGASS COUNTRY PROGRESS REPORT NORWAY 2008-2009 by the Norwegian Directorate of Health, which resulted in a 4-page-update, pages 28-31: http://data.unaids.org/pub/Report/2010/norway_2010_country_progress_report_en.pdf

Conclusions

Today, four years after we started our work, we are proud to conclude that our voluntarily efforts have borne rich fruits. Criminalisation of HIV has definitely been put on the agenda in Norway, and globally, and recently the Norwegian Parliament called for a national group to be formed, to evaluate whether this law should be kept or abolished. This group is now established, and they are working actively to evaluate the criminalisation-practice. In 2010 LNU, The Norwegian Children and Youth Council, an umbrella-organisation for 73 children and youth organisations in Norway launched their North South campaign, with the goal to have HIV-criminalisation and travel restrictions abolished, after having interviewed a member of our group. We recognised several quotes and opinions from our manifesto and web-pages, and feel great honour and gratitude that the youth are now on our case! http://www.lnu.no/interesse/kampanjer/avsluttet/hiv-er-ingen-forbrytelse/
Lately, also the Norwegian Red Cross Youth organisation has fronted our case, asking for an end to this discriminating politics in Norway, stating it is a major part of the global problem of stigmatisation of PLHIV.

| 16 | Denmark | AIDS-Fondet (Danish Aids foundation) |

Denmark in February this year suspended a law criminalizing wilful infection or exposure to the risk of infection of HIV while it considers revising its law. I would like to share with the commission the advocacy work carried out by the Danish NGO AIDS-Fondet prior to what we hope is the first step of decriminalising HIV in Denmark. It is my hope that our positive experience can be an inspiration for others in this rather complicated and sensitive field.

**Background**

The Danish law criminalising HIV/AIDS was a reaction to an unusual case back in 1994 of one PLWH who had unsafe sex with 23 women and infected a number of the women. He was not convicted of any crime as the parliament just a few years back had made a decision to decriminalise the transmission of STDs in general. This decision was made on the basis that criminalising STDs made people hide, not coming forward for treatment and thereby increasing the risk of transmitting the diseases. This was also the reason why the Danish High Court did not find the person living with HIV guilty of any crime. The Danish public reacted very strongly to this and felt very much that they needed protection from people living with HIV having unsafe sex. A law criminalising and singling out HIV was quickly thereafter passed in the Danish parliament.

Today many Danes including politicians still remember this one case and public opinion is the law on HIV is fair and necessary to protect the general population from HIV. During the years when initiating discussions on the law reactions have been very strong and for a long time we had no hope of succeeding in decriminalising HIV. You could say that 17 years down the road the 5000 people living with HIV in Denmark is still living in the shadow of this one persons actions.

**Strategy to change the law**

It was the remarkable progress in treatment options for people living with HIV allowing for the possibility of a normal life expectancy, and the fact that treatment greatly reduces the possibility of exposing others to HIV that made AIDS-Fondet gain new hope for a change of the law on HIV. We developed a strategy to make this change happen.

According to the strategy our *first step* was to convince the government that the above mentioned progress in treatment was in fact making the Danish law obsolete. We successfully pursued this part and the decision to suspend the law of February this year is due to the government’s recognition that the law is most likely outdated.

*Next step* was to convince the government that when revising the law due to obsolescence to take into consideration that punitive laws on HIV and AIDS undercut basic HIV prevention and sexual health messages and are ineffective in reducing the spread of HIV. Since HIV mainly spreads from persons not aware of their HIV status, such laws only fuel ignorance, fear, stigma and discrimination against people aware they are living with the virus. Such laws are in fact counterproductive since they lessen the likelihood that individuals will learn their HIV status and access treatment. An inter-ministerial working group is to come up with a suggestion to a revision of the law any day soon and we will then know if we also succeed with this part.

**AIDS-Fondet’s advocacy campaign to change the law**
Our advocacy campaign included a range of activities i.e:

- organising a national conference with a panel debate on decriminalising HIV with attendance of parliamentarians
- building networks of ‘friendly’ medical HIV specialists and parliamentarians
- writing and placing chronicles in national newspapers in cooperation with parliamentarians and MD’s
- meetings with and letters to ministers, parliamentarians and the National Board of Health
- participation in discussions in media;
- connecting to international networks working on the same issues for instance the Norwegian HIV Law Commission, Hiv-Norge, UNAIDS, the south African high court judge Edwin Cameron and the HIV Criminalisation blog by Edwin Bernard.
- via international networks collecting signatures from 122 organisations from all over the world endorsing a letter to the Minister of Justice and the minister of Health congratulating the ministers on their decision to suspend the Danish Penal Code and asking them to ensure that during the revision process it is taken into due consideration whether the particular section singling out HIV should exist in the Penal Code at all.

**Working with and for PLWH**

In our work we have worked closely with the Danish patient organisation Hiv-Denmark and are a member of their legal committee. We have taken great advantage of the work of the committee following all Danish cases on the Penal Code. From Hiv-Denmark and from our daily contact with PLWH we experience concrete evidence of people not accessing prevention options due to fear of prosecution and are strongly convinced that decriminalising HIV would improve HIV prevention work. We i.e. had cases where PLWH had unsafe sex while being drunk but did not dare to encourage PEP treatment to their partner; in other cases PLWH are reluctant to participate in contact tracing.

We are in contact with several PLWH who are not willing to be open about living with HIV due to fear of accusations of unsafe sex. We regret this situation as we are convinced PLWH who are willing to come forward can make a remarkable difference in HIV prevention.

From research we know that most late testers did not test in time due to stigma and discrimination. Many PLWH share with us the feeling that our government, the very highest level of society, by upholding the law criminalising HIV is contributing to this stigmatising. They believe that it would make a remarkable difference on the general public’s attitude towards PLWH would the government lead the way by decriminalising the disease.

In AIDS-Fondet we continue our advocacy work to make a positive change in criminalisation of HIV.

### 17 Sweden

**Swedish Association for sexuality Education, LGBT and HIV**

**HIV and Rights Instead of HIV Criminalization: The Case of Sweden**

**Introduction**

RFSU (the Swedish Association for Sexuality Education), RFSL (the Swedish Federation for Lesbian, Gay, Bisexual and Transgender Rights) and HIV-Sweden (the Swedish organization for People living with HIV and their rights) have been working in a joint advocacy project on the criminalization of HIV transmission and exposure in Sweden since 2010. The project comes to an end after three years, in December 2012. The project gathers three key constituencies – the SRHR community (RFSU), the LGBT community (RFSL) and the PLWH community (HIV-
Sweden) – in an effort to bring about a change in the Swedish legislative framework affecting PLWH. The Swedish 2004 Communicable Diseases Act requires an HIV-positive person to inform a prospective sexual partner of his/her status. A failure to follow this and other instructions by doctors could ultimately result in forced isolation. HIV-positive persons can be prosecuted and convicted under Swedish criminal law for intentional or careless transmission of HIV as well as for intentionally or carelessly endangering their partners. More than 40 persons have been tried in Swedish courts for transmitting or exposing other persons to HIV through sex for the past two decades. The vast majority of prosecutions have concerned completely consensual sexual acts.

Concerns

About 5300 persons are living with HIV in Sweden, a relatively low number for a country with approximately 9 million inhabitants. However, there is no evidence that the application of general criminal law to PLWH have contributed to HIV prevention efforts in Sweden.

Rather, we believe that the frequent investigations, prosecutions and trials about HIV transmission and exposure – often heavily publicized – have led to increased discrimination and stigmatisation of PLWH. Studies also show that there is arbitrariness in the application of criminal justice in these cases: courts have problems in understanding the HIV infection and in interpreting Supreme Court precedents. The result is arbitrariness in determining intent, risk of transmission and as a result labelling of crimes and in determining penalties.

We believe that Sweden’s failure to adhere to the 2008 UNAIDS Policy Brief, which calls for criminalisation to be limited to cases of intentional transmission, together with the mandatory requirement to disclose HIV infection to sexual partners according to the Communicable Diseases Act creates a stigmatising legislative framework, affecting both individuals who are reported to the police, possibly resulting in prosecution and trial, as well as the whole community of people living with HIV.

Uniquely, one of the Swedish criminal trials concerned a woman who was convicted of vertical exposure (i.e. no transmission of HIV occurred). Lillemor, depicted in the 2010 documentary “How Could She Go On Living As If It Weren’t There”, was sentenced to 2.5 years in prison for attempted gross assault of her children. Her crime: giving birth to her children without informing hospital staff about her HIV infection. In a precedent from 2004, the Supreme Court attempted to provide guidance on how to determine intent and negligence in cases concerning HIV transmission or exposure. However, the way in which district courts and courts of appeal have decided similar cases after this precedent has not been foreseeable.

The case tried in the Supreme Court concerned a man who at first was sentenced for attempted aggravated assault. The man had not told (most of) his sex partners that he was living with HIV before they had unprotected sex. This he explained, he had not seen as a risk of transmitting HIV because of his low viral load. The verdict from the Supreme Court stated that the risk of transmission of infection at each intercourse had been very low but that the man was guilty of unlawful risk taking and therefore should be sentenced for the crime of incitement to danger instead and his prison sentence was reduced from three years to one year.

Problems

We believe that the current Swedish legislative framework is a reflection of a view that HIV prevention ultimately isn’t a responsibility for all parties in a sexual encounter but only the person who knows that s/he carries an HIV infection. In Sweden, knowing one’s HIV status is not necessarily a benefit to the individual concerned, since the knowledge brings with it obligations that the affected persons might not necessarily have the tools to cope with. Is it reasonable and feasible that an HIV-positive person always will be always be able to disclose his or her status to a new, or for that matter, regular sexual partner? Is it reasonable that some individuals in the MSM community interpret silence on HIV status as a go-ahead sign indicating that
unprotected sex is OK? Is it possible for the government of Sweden to create an environment that allows for people to disclose their HIV status to sexual partners when participating consensual sex in some cases is viewed as a crime? This view on the individual’s responsibility has long been part of the Swedish HIV response.

Sweden failed to respect the rights of people living with HIV in other ways in the 90s and early 00s. Its laws and policies allowing for forcible isolation of people living with HIV was heavily criticised by many actors in the international community and amounted to arbitrary detention. See for instance the case of Enhorn v. Sweden, in which the European Court of Human Rights found that Sweden was in violation of the prohibition of arbitrary detention according to Article 5 of the European Convention on Human Rights and Fundamental Freedoms.

For the individual, the legislative framework tends to be about the obligations under the legislative framework not the rights that it is supposed to provide in terms of e.g. access to care, treatment and support. How is the individual diagnosed with HIV supposed to deal with the responsibility placed on them? How are the possibilities for the individual to get information about for instance the uncertainties that sexual encounters are all about, what information to disclose and when, and what happens in situations of for instance condom failure? Some individuals choose not to have sex at all, to the detriment of individual’s own well-being and, ultimately, society as a whole.

**HIV and Rights Instead of HIV Criminalization: The Case of Sweden**

The aim of our joint project, funded by the International Planned Parenthood Federation (IPPF) Innovation Fund, is to bring about a change in the Swedish policy of criminalization and bring it in line with the UNAIDS policy brief. We hope to contribute to this by primarily doing three things:

- Educate and inform politicians in government and parliament as well as other decision-makers to ensure that the need for a review of legislation as well as criminal justice practice
- To increase awareness amongst politicians and decision-makers on the negative impact of criminalization on HIV-prevention and the human rights of PLWH.
- To win support within political parties for a review of the Swedish criminal and public health legislation and regulations and practices.

Since we also know that there is arbitrariness in the application of criminal justice in court cases regarding transmission of, or exposing other persons to, HIV through sex we are also targeting professionals within the judicial system. We hope to increase the awareness of the problem of unfair application of criminal law that affects PLWH in Sweden in a negative way as well as increase the awareness about the Supreme Court precedent from 2004.

The project includes different advocacy and media strategies. We will host seminars targeting for example parliamentarians, governmental representatives and other relevant decision makers and representatives from the legal system. We will host a conference in late November 2011, write articles and educate members within our organizations to enable them to discuss the issue of HIV and criminalization on different strategic arenas. A lot of work is being done by networking and we have also worked a great deal on finding champions from the different target groups willing to speak out on the issue of HIV and criminalization. The project runs through 3 years, from 2010-2012.

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<table>
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<th>18</th>
<th>Canada</th>
<th>African and Caribbean Council on HIV/AIDS in Ontario (ACCHO)</th>
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</table>

**Introduction**
While there have been efforts to examine the general implications of the criminalization of HIV non-disclosure, little attention has been given to its potential impact on key vulnerable populations, including new immigrants, sex workers, prisoners, people who use drugs, and members of racialized communities. Out of all the cases of HIV non-disclosure, a significant number of those charged have been members of Black, African or Caribbean communities. In the province of Ontario, nearly 50% of the heterosexual men charged between 2004 and 2009 have been Black. Hence, the focus of this submission by the African and Caribbean Council on HIV/AIDS in Ontario (ACCHO) will be on the impact of the criminalization of HIV non-disclosure on African, Caribbean and Black (ACB) communities in Ontario, Canada.1

In Canada, a person living with HIV/AIDS can be prosecuted for not disclosing his or her HIV-positive status before engaging in an activity that presents a significant risk of HIV transmission. Most cases of HIV non-disclosure are linked to sexual exposure or transmission. The criminal law is applied to both exposure and HIV transmission.

Between 1989 and December 31, 2009, there have been more than 100 criminal prosecutions for HIV exposure and transmission in Canada, with the bulk of cases occurring after 2003. With the increasing number of cases reported in the last 10 years, the criminalization of HIV non-disclosure has been the subject of many debates. In the province of Ontario alone, since the late 1990s, 37 individuals have been prosecuted, out of which 24 were convicted.

**Context**

ACB people are overrepresented among HIV infections in Canada. Most countries in the Caribbean and sub-Saharan Africa have been classified as HIV-endemic,2 and people from countries where HIV is endemic account for almost one quarter of all new HIV cases in Ontario.3 ACB people and their communities in Ontario have also suffered a legacy of discrimination. All these factors (among others) provide the context for the racialized nature of the criminalization of HIV non-disclosure.

HIV vulnerability among ACB people and communities can be understood in terms of the social determinants of health. Limited access to safe and affordable housing; migration status; unemployment and underemployment; gendered norms that prescribe male domination over women; a reluctance to talk about sex, sexuality and health; pervasive homophobia; and barriers to accessing HIV supports and services, other social services and educational opportunities — all shape the experiences of those living with or affected by HIV. The intersectionality of gender, race, poverty, stigma, denial, fear and discrimination influence the exclusion and marginalization that, unfortunately, is experienced by so many ACB people in Ontario and the rest of Canada.

In order to understand how the criminalization of HIV non-disclosure is a racialized issue, and to develop appropriate interventions and responses, we must recognize the historic legacy of racism and injustice within which the contemporary criminalization of HIV exposure sits. Deep-seated racism has long been a feature of Black peoples’ interactions with police, courts and prisons.4 Dating back to the era of slavery, racist beliefs and practices have permeated criminal justice institutions.

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1 The African and Caribbean Council on HIV/AIDS in Ontario (ACCHO) provides leadership in the response to HIV and AIDS in ACB communities in Ontario, Canada. It is a coalition of organizations and individuals committed to HIV prevention, education, advocacy, research, treatment, care and support for ACB communities. ACCHO and its members strive to reduce the incidence of HIV among ACB people in Ontario, and to improve the quality of life for those infected and affected by HIV/AIDS. This submission is based on the ACCHO’s report, Criminals and Victims? The Impact of the Criminalization of HIV Non-Disclosure on African, Caribbean and Black Communities in Ontario, which was launched in December 2011.

2 The majority of HIV-infected persons from HIV-endemic countries in Ontario are Black.


Today, the relationship between police and racialized people is troubling, especially in urban areas. Racialized communities often complain of over-policing and also of slower response times to complaints. Moreover, the practice of racial profiling is now well documented. Racialized people tend to be underrepresented among lawyers, judges and juries, leading many accused to feel justice will not be done because the system does not understand or represent them. Lawyers and judges are also criticized for relying on stereotypical views of racial minorities, and for failing to recognize (or being unprepared to deal with) issues of race and racism.

As a result, although the Canadian justice system strives to provide an impartial adjudicative process that dispenses —justice regardless of race, it does not deliver on its promise of equality and at times contributes to the marginalization of people of colour within Canada. Moreover, the law has a difficult time taking into consideration the obstacles and various forms of oppression that racialized persons face within our society. Fitting a nuanced and contextualized understanding of HIV disclosure, sex, and intimate interpersonal encounters is very difficult.

Disclosure

The criminalization of HIV non-disclosure has been denounced by many as it undermines the response to HIV/AIDS. Given the broader implications of disclosure, requiring an ACB person living with HIV/AIDS to disclose their status within the context of sexual encounters grossly overlooks the fact that disclosure requires support, time and trust.

Many factors, such as stigma and discrimination, racism, homophobia, sexism, power imbalances, and other determinants of health impact an individual’s ability to disclose their HIV status. Individuals find themselves in different social positions — mediated by their sex, age, education, language, immigration status, economic security and sexuality, among other factors — which impact on their ability and willingness to seek and reveal personal information and/or reduce risk.

In addition to the criminal law, ACB people living with HIV/AIDS struggle with whether to disclose to their children, families, employers, colleagues and health-care providers, among others. To avoid criminalization, rejection, or experiencing stigma and discrimination, people who are living with HIV/AIDS often avoid intimate relationships and isolate themselves, which can negatively impact their general health and well-being.

19 Canada

ABDGN – African Black Diaspora Global Network

CONNECTING THE DOTS: DEPORTATION AMONGST AFRICAN/BLACK POPULATIONS LIVING WITH HIV IN HIGH INCOME COUNTRIES

African and Black Diaspora Global Network (ABDGN)

This submission is coordinated by ABDGN, a unified “network of networks” based in Toronto, Canada whose...
mission is to strengthen the global response to existing and emerging HIV and AIDS epidemics amongst African/Caribbean/Black populations in the Diaspora (ABD), including migrant/immigrant/refugee (MIR) populations. The network is guided by a Governing Council with representatives from the following organizations:

- Women’s Health in Women’s Hands Community Health Centre (WHIWH)-Canada
- African and Caribbean Council on HIV /AIDS in Ontario (ACCHO)-Canada
- Interagency Coalition on AIDS and Development (ICAD)-Canada
- African Services Committee (ASC)- United States
- Black AIDS Institute (BAI)-United States
- Caribbean Vulnerable Communities Coalition (CVC)-Jamaica
- AIDES-France
- African Health Policy Network (AHPN)- United Kingdom
- European AIDS Treatment Group (EATG)-European Union
- Positive Women Victoria-Australia

“Despite stereotypes and common assumptions it is neither migrants nor migration per se that increase the risks of HIV transmission: it is the trying conditions and hardships that many face throughout the migration experience that makes them more vulnerable to infection.”(United Nations Population Division-State of the World Population 2006)

When looking at rates of new HIV infections across many high income countries, ABD populations are often disproportionately affected, creating a disturbing global pattern of common disadvantage and inequity (see Appendix 1). We believe it is important for us to begin “connecting the dots” to ensure that the experiences of ABD populations in high income countries living with HIV are not seen in isolation, but rather as an interconnected and widely prevalent phenomenon that warrants greater and immediate global attention.

“The deportation of people living with HIV based on HIV status itself has no public health justification, and policies that support it are discriminatory and threaten lives. At the global level it endangers the goal for universal access.”(Peter Weissner, Deutsch AIDS-Hilfe, 2010)

Some of the most egregious failures of national and international laws to protect the human rights of ABD populations in high income countries, particularly for migrant/refugee/asylum seeker populations, are within the context of deportations. In many high income countries, inadequate laws, procedures, policies and treatment guidelines for deportees living with HIV have led to treatment delays, interruptions, and stoppages. This diminished access to treatment can have direct impacts on multiple intersecting factors including health status, mental health, HIV drug resistance, diminished personal agency, and access to basic human rights.

Case Study

Mary, 55, fled Uganda after she was persecuted for her opposition to the government. She suffered torture by soldiers including rape and later discovered that she had been infected with HIV. She claimed asylum in the UK and in November 2007, was detained at Yarl’s Wood Immigration Removal Centre.

“I was scared that I was going to die in Yarl’s Wood when they refused to give my medication. It was as if they were turning off my life support machine. The way they treated me was inhuman. I felt as if I was a criminal. I was traumatized for a long time after my release” (Medical Justice, Detained and Denied, 2011)

Further, in the case of ABD deportees, some are returned to developing countries with reduced treatment access, inferior drug regimens, or inadequate social supports and mechanisms. This practice in many cases is a violation of numerous international laws. When you consider those who left conflict situations, or fled from persecution for their political beliefs or sexual orientation, the added stigma and discrimination faced by living
with HIV further creates additional vulnerabilities, and sometimes loss of life.

“How many rights does a migrant have? While people move, their rights do not travel with them.” (Dr. David Ingleby, European Research Centre on Migration and Ethnic Relations, 2011)

The time is now to advocate for member states in high income countries, and countries all around the globe to apply the international law principle of non-refoulement (absolute prohibition on the forced departure of a person to another state where there are substantial grounds for believing that the person would be in danger of being subjected to torture or other cruel, inhuman or degrading treatment or punishment).

Deportation Ruling-Finland

Karara v Finland, Decision of May 29, 1998-deportation of an HIV positive Ugandan national to Uganda was permitted on the basis that his illness had not yet reached an advanced stage and treatment was available in Uganda (Human Rights Watch, Return to Risk, 2009)

We advocate for the principle non-refoulement to be applied within an enabling legal environment that upholds various other international human rights and humanitarian treaties, conventions and guidelines:

- International Covenant on Social, Economic and Cultural Rights-Article 12;
- Convention on the Elimination of All Forms of Discrimination Against Women;
- Convention on the Elimination of All Forms of Racial Discrimination;
- Convention Against Torture, and Other Cruel, Inhuman or Degrading Treatment or Punishment-Article 3;
- International Covenant on Civil and Political Rights-Article 17, 19

Case Study

PM was born in Sub-Saharan Africa. She came to the UK after being harassed by her late husband’s family and one year after arrival she was diagnosed with HIV. She claimed asylum, but this was refused. In 2009, after being in the UK for almost a decade, PM was arrested and detained in Yarl’s Wood Immigration Removal Centre (IRC). Three months after being detained she tried to kill herself by taking an overdose of her HIV medication and drinking fabric conditioner. As a result she was transferred to a local psychiatric ward. Whilst held in this ward she did not receive all of her HIV medication for six days. About three weeks after her suicide attempt, she was informed that she was to be deported. (Medical Justice, Detained and Denied, 2011)

We acknowledge the remarkable scientific, evidenced-based research and biomedical breakthroughs in 2011 regarding antiretroviral treatment as prevention, new prevention technologies, as well as innovative paradigm shifts like Treatment 2.0 by UNAIDS and the Strategic Investment Framework developed by Bernard Schwartlander and colleagues published in the Lancet in 2011. We also applaud member states for their commitments to migrant and mobile populations in the 2011 UN General Assembly Political Declaration on HIV and AIDS. However, the numerous threats to universal access, including deportation of ABD individuals living with HIV, must be averted through the application and adoption of legal frameworks by all nations that ensure health and human rights.

We advocate for national governments in host and destination countries to develop shared continuity of care policies and mechanisms for deportees living with HIV, in partnership with health and surveillance authorities, civil society, and human rights stakeholders. We advocate for improved and harmonized data collection, monitoring and surveillance protocols for ABD migrant and mobile populations at the country level to track shared epidemics across the Diaspora. We advocate for the review of existing deportation polices and standards
of care at the country level and the expulsion of practices that violate national or international human rights laws. We advocate protecting the greater involvement and agency of ABD migrant/refugee/asylum populations throughout the deportation process, and inviting governments and communities in high income countries to take action and end these devastating abuses to health and human rights.

### APPENDIX 1

<table>
<thead>
<tr>
<th>Country/Region</th>
<th>Year(s)</th>
<th>Proportion of HIV among ABD Populations</th>
<th>Source</th>
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<tbody>
<tr>
<td>Australia</td>
<td>2005-2009</td>
<td>Of 1185 newly diagnosed cases of HIV attributable to heterosexual contact, 58% were in people from high prevalence countries</td>
<td>NCHECR, 2010</td>
</tr>
<tr>
<td>Austria</td>
<td>2006</td>
<td>Migrants represented 37% of new HIV infections in 2006 with the majority coming from SSA</td>
<td>ECDC, 2010</td>
</tr>
<tr>
<td>Belgium</td>
<td>Up to 2006</td>
<td>People categorized as foreign-born account for more than 50% of all reported HIV cases</td>
<td>EuroHIV, 2006</td>
</tr>
<tr>
<td>Canada</td>
<td>2008</td>
<td>Of the estimated 65,000 people living with HIV in Canada in 2008, 9,250 were people from the HIV-endemic category, the majority of whom were born in Sub-Saharan Africa or the Caribbean, representing an estimated 14% of all people living with HIV in Canada. People from HIV-endemic countries made up 2.2% of the Canadian population in 2006, but constituted 16% of all estimated new HIV infections in Canada in 2008; with an estimated infection rate that was 8.5 times higher compared to other Canadians that year.</td>
<td>PHAC, 2010</td>
</tr>
<tr>
<td>Denmark</td>
<td>2006</td>
<td>Migrants represented 40% of new HIV infections in 2006 with the majority coming from SSA</td>
<td>ECDC, 2010</td>
</tr>
<tr>
<td>EU27 plus Norway and Iceland</td>
<td>2006</td>
<td>Of those with known geographical origin, 77% (1050) AIDS cases were from SSA. Of the 57 cases of AIDS due to MTCT with known geographical origin, 13 (23%) were from SSA</td>
<td>ECDC 2009c, 18</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Out those with known geographical origin, 60% (5046/8354) of HIV infections</td>
<td>ECDC 2009c, 18</td>
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</table>
TACKLING DISCRIMINATION AND STIGMA USING HOLISTIC, CULTURALLY SENSITIVE LEGAL ADVOCACY FOR POOR WOMEN OF COLOR

Introduction

Fifteen years ago advocates in the United States successfully argued that HIV should be treated as a medical disability and that Medicaid should cover the costs of treatment, which meant that HIV positive individuals with low incomes had access to medical care and life saving drugs. The next phase of the fight against HIV will be addressing the individual and social factors that lead to high rates of HIV infection, poorer health outcomes, and death among certain marginalized populations. One such mechanism for addressing these factors is the provision of legal aid to people living with HIV/AIDS. At the High Income Countries Dialogue AIDS Action Committee of Massachusetts, Inc. (“AIDS Action”) seeks to share our experience and knowledge of how we have implemented a successful model for providing legal services to people living with HIV/AIDS as a powerful instrument to challenge stigma, promote public health and protect human rights. Founded in 1983, AIDS Action is New England’s first and largest AIDS service organization. AIDS Action’s mission is to stop the epidemic and related health inequities by eliminating new infections, maximizing healthier outcomes of those infected and at risk, and attacking the root causes of HIV/AIDS.

Experience

AIDS Action’s attorneys have a long history of working with HIV-positive clients and their providers. Over the
years the focus of AIDS Action’s legal advocacy has changed in response to the needs of the epidemic. In the last five to six years the greater needs of our clients have changed from end of life planning to maintaining housing, family stability and income maximization issues. By providing holistic, culturally sensitive representation, AIDS Action attorneys directly address the individual and social factors that seem to lead to high rates of HIV infection, poorer health outcomes for those already infected, and death among marginalized, minority populations. Without legal advocacy, AIDS Action clients would lose their housing, children, income, and be subject to discrimination/stigmatization.

One segment of AIDS Action’s client population is poor women of color. In the last ten years, the HIV epidemic has shifted dramatically as a result of marked increase in HIV infection rates among women of color. According to the Centers for Disease Control and Prevention (CDC), among racial/ethnic groups, African Americans face the most severe burden of HIV and AIDS in the nation. The CDC also reports that HIV incidence rate for black women is nearly 15 times as high as that of white women, and nearly four times that of Hispanic/Latino women. HIV and AIDS were originally thought to affect mostly gay men. However, women have always been affected too. And even though more men than women in the United States presently have HIV, women are catching up. In fact, if new HIV infections continue at their current rate worldwide, women with HIV may soon outnumber men with HIV.

AIDS Action’s legal department has represented many poor women of color living with HIV/AIDS. In the last year, AIDS Action represented almost twice as many women as men. Because women tend to be or want to be the primary caretakers of children, much of AIDS Action’s legal representation has been in the family courts representing clients in custody/visitation matters between biological parents, guardianship of minors who are biologically the offspring of the HIV-positive client but who are in the custody of someone else, and matters involving the financial support of children who are living with or not living with the HIV-positive parent. AIDS action has also represented women who are survivors of domestic violence.

One such trial at AIDS Action involved a woman who had been abused by her spouse. The client, an African-American, Christian woman had filed a divorce complaint in the family courts requesting that the court order her divorced because her husband was cruel to her and abused her while they were married and living together. She like many African-American, Christian women had tried to make her marriage work for God and so she wouldn’t be a sinner. In her family and community, one stays married for life. Prior to arriving at our offices she was denied legal counsel from reputable legal services non-profit. Her husband had, in response to her initiating the divorce case filed a counterclaim requesting that the court order the marriage annulled. The legal standard for getting a marriage annulled in Massachusetts is really high. My client had been was pushed down stairs, cut with a machete, threatened to tell her friends and family about her serostatus, her spouse made them lose their home because he would steal money from their joint checking account. Yet, my client was denied services from this other nonprofit, presumably because being they questioned whether she had a case that they could win, given that judges can and do often discriminate against women living with HIV/AIDS, particularly when the other party is male, HIV negative and accusing her of lying to him about her status. AIDS Action took her case, worked with her, sensitive to her cultural background, involved her therapist, and sought the assistance of her doctors to develop her case. Not only did the judge order her divorced and not order her marriage annulled, but also awarded the client $6000 in damages for the abuse she suffered.

In another case, AIDS Action represented a fifty-five year old African-American woman living on public benefits who in the context of representing herself in a divorce entered into a court-ordered separation agreement that gave her no rights to see her daughter. She had been an active crack cocaine addict and sex worker at the time of the divorce. When she put together a few months of sobriety and had quit “working the streets” she came to our legal department seeking assistance with changing the court’s order. In the context of representing this client, issues arose with drug testing and her medication. The client had been court ordered to be tested and was being tested on a randomized schedule by the family services office at the court. On a few occasions, her tests came back positive for Tetrahydrocannabinol (THC) a chemical compound most commonly associated with
marijuana use. The client’s healthcare provider informed the family services office that when the client was
tested at their facility, her tests showed negative for the chemical, which led her provider to believe that the
positive test results were most likely caused by one of the many prescription medications that the client took
for HIV-related illness. The family services officer concurred with this and agreed that the client could and
should be tested by her healthcare providers who had access to different tests than the courts. Opposing
counsel and the opposing party (my client’s ex-husband) balked at the proposal, demanding that my client
admit that she was “smoking weed” and refused to comply with the court’s most recent order that permitted
my client visits with her daughter. Knowing the tenuous nature of my client’s sobriety, being ever mindful of
how she as a former addict and prostitute was likely being perceived by the other side and the courts and by
taking strong, decisive action, on behalf of a vulnerable minority and recovering addict who always sees herself
as the weaker party, not owed anything, I filed a contempt complaint against her ex-husband. My client won.
The court ordered that visits resume immediately.

Best Practices

In traditional civil legal practice lawyers work on building cases. The goal is to remove the threat of legal
jeopardy, not ameliorate any larger issue. Unfortunately, within these clearly defined limits, lawyers seldom
develop the skills to delve more deeply into the lives of their clients or to work collaboratively with them on
issues that are “outside the scope of their representation.” Part of the problem is lack of resources and time.
Part of the problem is the legal culture’s bias against investing any more than what’s needed to win a case
based on the legal standard; holistic representation addresses both of these shortcomings by incorporating
collaborations with service providers, community members and family. In the examples above AIDS Action
attorneys worked intimately with clients, their health care providers, family members and court personnel to
ensure that the clients won their cases because their cases were well developed and presented to the court.
Using a client-centered approach that recognized clients’ perspectives and experiences, AIDS Action’s Legal
Department was able to integrate cultural information into providing the highest quality legal advocacy for our
poor, female clients of color.

Recommendations

- Recognize ways in which culturally based beliefs, values, attitudes and practices can affect one’s
  understanding of the law and a particular case, as well as clients’ expectations as far as outcomes.
- Identify value orientations inherent in the culture of law in their country and in general.
- Identify systemic bias, and cultural conflicts in the legal encounter.
- Use a client-centered approach to integrating cultural information into legal representation, strategy and
  advocacy.

21 USA

U.S. Positive Women’s Network (PWN) HIV Human
Rights Attorney WORLD (Women Organized to Respond
to Life-threatening Disease)

Thirty years into the HIV/AIDS epidemic life-saving milestones have been reached through effective legal and
public health policy reforms. Yet for women living with HIV in the U.S., barriers to leading a quality life remain.
HIVpositive women experience many of the same forms of discrimination and neglect as the larger HIV
community including underfunded health care systems, discrimination in the work place, discrimination in or
lack of affordable housing, and HIV-specific criminalization. In addition, women living with HIV face violations of
their sexual and reproductive rights to choice and information, as well as their right to parent.

The mission of the U.S. Positive Women’s Network, a project of WORLD, is to prepare and involve HIV-positive
women, including transgender women, in all levels of policy and decision-making to improve the quality of
women’s lives. We offer a unique perspective on how U.S. law and policy affect the human rights of women living with HIV because our broad national Network allows us to keep our finger on the pulse of women’s lived experiences.

This submission will focus on aspects of U.S. law and policy that uniquely affect women living with HIV in the U.S. — namely, the violations of HIV-positive women’s sexual and reproductive rights in the U.S.

**International Law and women’s sexual and reproductive rights**

The following United Nations human rights bodies have acknowledged sexual and reproductive rights as a fundamental human right: the Committee against Torture; the Committee on Economic Social and Cultural Rights; the Committee on the Elimination of Discrimination against Women; the Committee on the Elimination of Racial Discrimination; the Committee on the Rights of the Child; and the Human Rights Committee.

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continue to suffer from violations of their rights to be sexual and reproductive beings.

HIV specialist and general medical practitioners routinely fail to educate HIV-positive female patients about their fertility, conception and contraception options. The lack of information provided to women living with HIV about their reproductive options limits their full range of reproductive choice and violates their sexual and reproductive rights under both international and domestic law.

Reproductive options for women living with or affected by HIV and AIDS

HIV-positive women are able to live long and healthy lives and give birth to healthy children. There are a number of medical options for sero-different couples and HIV-positive mothers, greatly minimizing the risk of HIV transmission and making a healthy pregnancy and the birth of a healthy child possible. Some options for sero-different couples include sperm washing, artificial insemination, and unprotected sex when both partners have been screened and treated for any secondary sexually transmitted infections and the HIV-positive partner is on HIV treatment and has a low to undetectable viral load. Antiretroviral therapy during prenatal and postnatal care is an effective prevention strategy to protect the child. To take advantage of these options successfully requires ongoing counseling, support and treatment by well-informed medical professionals.

Despite the reproductive options available in the U.S., women living with HIV and AIDS frequently suffer from judgment, lack of, or mis-information, and discrimination when inquiring into their sexual and reproductive choices or attempting to exercise their sexual and reproductive rights. A 2007 Foundation for AIDS Research (amFAR) survey of Americans found that one-third of Americans would not support an HIV-positive woman’s choice to become pregnant despite antiretroviral therapy to prevent mother to child transmission and only 14% believed HIV-positive women should be able to have children.

The U.S. Positive Women’s Network (PWN) conducted a survey and issued a report, Diagnosis, Sexuality, Choice, on HIV-positive women’s experiences with reproductive health choices, and found discouraging results. The survey indicated that many doctors are either uninformed about HIV-positive women’s reproductive options, choosing to forego any conversation about reproductive options or care for HIV-positive women, or are entirely unsupportive of an HIV-positive woman’s right to reproductive choice, which includes the right to have a child. One woman reported that:

My primary care doctor looked at me like I was sick for even thinking of becoming pregnant. I just felt that the consensus was that I should not, that I was selfish and irresponsible for even thinking about it.

Another woman reported that:

I seemed to be the educator in most of these areas. I was more up to date on any of the information than any doctor I found. My doctor had little context or experience so it was up to me and the internet. Searching for an OB/GYN who was supportive was even more difficult. I was even offered an abortion by one OB.

Some respondents experienced outright stigma and discrimination, as in this case:

I was told by several doctors to abort the pregnancy. I was almost in my 2nd trimester before I knew I was pregnant. I ran out of many a doctor’s offices in tears after being told I was “selfish” or “if that were my wife, I’d make her have an abortion.”

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8 Women, HIV, and Stigma: Results from a National Survey, American Foundation for AIDS Research (amFAR), 2007.
A study conducted in 2008, *Gynecologic issues in the HIV-infected woman,* of 181 HIV-positive women of reproductive age in urban health clinics, confirms some of the PWN’s findings. Namely, only 31% of the women had discussed their reproductive options with health care providers. Of those 31%, 64% had initiated the conversation with the health care provider herself. Yet “between 25% and 45% of HIV positive individuals of reproductive age report wanting to have a baby in the future, compared with about 35% in the general population.”

On top of provider attitudes, the costs of reproduction—sperm washing, artificial insemination—are high, and are often not covered by health insurance plans. This makes safe reproduction for some HIV-positive women altogether unattainable.

**Parental rights of women living with HIV**

Women face abrogation of their parental rights based on HIV status. These violations include loss of child custody based solely on their HIV status—often a result of un-checked judicial attitudes and assumptions about HIV, poverty, and accompanying factors—but also result from prosecutions under HIV-specific criminalization laws. Women who are prosecuted under these laws find it difficult to impossible to regain custody of children once released from prison sentences.

Additionally, there has been a rise in cases where the custody of women’s existing children is threatened by child services agencies when an HIV-positive woman becomes, or expresses the desire to become, pregnant. These instances are especially hard to document because the coercion often takes place off the record.

**Conclusion**

Women living with HIV in the U.S. continue to experience violations of their sexual and reproductive rights, international human rights, and domestic anti-discrimination protections when seeking to exercise their fundamental right to choose when and whether to have a child. It is our hope that the Commission will provide guidance on how the U.S. and state governments can comply with international human rights norms as well as our own domestic legal protections in order to create an environment that reflects the evidence-based advances made in HIV and sexual and reproductive healthcare for women, while taking into account the financial barriers to care faced by many women. Care systems serving women with HIV must truly adopt sexual and reproductive rights as a framework and train providers to ensure that those rights are upheld.

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10 Id.
HIV, policing, and state-involvement of minors participating in the sex trades

This brief was submitted to the UN Global Commission on HIV and the Law “High-Income” Countries Dialogue of 2011 on behalf of Streetwise and Safe (SAS), a leadership development initiative aimed at building knowledge, leadership, and power among LGBTQQ youth of color who experience gender and sexuality-specific policing such as police sexual harassment and abuse, policing of “quality of life” offenses, sex work, and trafficking, and unlawful searches and unsafe placement of transgender youth in police custody. SAS youth develop “know your rights” materials tailored to their experiences, engage in peer education and organizing, and present policy perspectives to government agencies.

While in recent years much has been achieved in identifying the effects of the law upon specific populations’ vulnerabilities to HIV and AIDS (e.g., women’s ability to negotiate safe sex, refuse unwanted sex, and report domestic violence), veritably little has been accomplished at the intersections. This policy brief addresses just such a neglected intersection—the vulnerabilities to HIV faced by minors involved in the sex trades under current international and domestic criminal law—and presents actionable policy recommendations for reform.

The international legal framework for reform is already in place under the Convention on the Rights of the Child and related treaties. What is needed is a more muscular interpretation of the international mandate, and a change in emphasis from “End Demand” enforcement toward: (1) the full decriminalization of youth involvement, (2) reorientation from court-mandated “rehabilitation” and secure detention to the rights-based approach of voluntary, client-centered services, especially shelter and living wage alternatives, and (3) implementation of No-Condoms-As-Evidence policies.

Background

In high-income countries, HIV still remains concentrated in hard-to-reach populations such as MSM, IDUs, sex workers, and migrants. Globally, in 2003, young people aged 15 to 24 accounted for over half of new HIV infections. The collection of accurate HIV prevalence data specific to vulnerable young people, however, faces a number of obstacles, including a lack of age-disaggregated data and honest research about involvement given high levels of policing and stigma. However, in the few studies conducted, high prevalence is reported. In one study in India, 12.5% of younger sex workers (under 20) were living with HIV compared to older age groups, at 5.4%, and professional immaturity with customers was cited as a contributing factor. In addition, among those youth populations identified as most vulnerable to HIV, all report high involvement in transactional sex: e.g. in New York City, street-involved and homeless youth (30 to 50%), young men who have sex with men (35%), and transgender minors (350% more likely to be involved). Yet, far too large a portion of global funds are directed to young people in the “general population,” typically older males (above 20) who are unmarried and have involved parents, housing, and are enrolled in schools.

1 “Minors” are persons under the legal age of majority. According to most State Parties the age of majority is 18, and persons under this age are referred to as “children” or, for the purposes of this article, “minors.” I refer to minors and not children in order to respect young people’s resiliency and capacity for choice, even among limited economic and social choices, and to recognize the fundamentally legal nature of the distinction.

2 Recently, there is also a reported increase in the U.S. and Europe in the number of diagnoses of women who contract HIV as a result of heterosexual sex, but not enough has been done to isolate accompanying factors, such as street-involvement, levels of policing, engagement in sex work, and services access. See Center for Disease Control and Prevention (CDC). (2010). Diagnoses of HIV infection and AIDS in the United States and Dependent Areas, 2008. Vol. 20.


5 Notably, among the identified behavioral risks was professional immaturity with clients

This lacuna of services for vulnerable youth is accompanied by obstacles to services access as a result of high levels of policing and placement in state custody. This “state-involvement” may include secure detention or involuntary commitment to group homes, foster care, and “rehabilitation” centers, and is especially common for minors involved in the sex trades.

For instance, a minor involved in transactional sex in New York City has, on average, been arrested 2.5 times. Importantly, the arrests are not merely for crimes with “prostitution” in the title, which account for 17.6 percent of charges for minors involved. While the New York Safe Harbor Act has been widely lauded for purportedly decriminalizing minors’ involvement, it currently extends only to prostitution and to youth aged 7 to 16, excluding 93 percent estimated to be involved. Therefore, reform must take compound criminalization into account and extend protection to minors arrested under “proxy” charges such as loitering, false personation, criminal nuisance, etc. Additionally, among this larger category of sex-trading minors, certain groups face disproportionate policing, with 81 percent of young MSM and 63 percent of transgender youth reporting prior arrests. In a study of transgender youth in New York City, participants reported profiling by police and verbal and sexual harassment and violence, including the extortion of sex in exchange for release from custody.

There are available solutions to the high HIV rates of sex-trading minors. Youth at risk of HIV through sex or injecting drug use often lack access to basic information and services to prevent HIV, in addition to independent access to testing, counseling, condoms, and treatment. But information and independent access to services will only be achieved when being arrested is not a prerequisite for access, and law enforcement are not the referees. Furthermore, policymakers must recognize that for every minor mandated to services, there are many more who return to trading sex. For those minors, safer working conditions are the only hope for safer living. Both outcomes—exit for those who desire it and safer working conditions for those who inevitably remain—may only be achieved by fully decriminalizing minors’ involvement in the sex trades, as arguably required by the following framework of international legal documents.

**International Law on State Custody of Minors Involved in the Sex Trades**

The second Optional Protocol on the Sale of Children, Child Pornography, and Child Prostitution (“OPSC”) to the Convention on the Rights of the Child (“UNCRC”) entered into force on January 18, 2002, appending a specific concern for minors involved in the sex trades to the most widely ratified treaty in the history of the world. The OPSC’s 17 articles primarily set out a blueprint for international enforcement of criminal laws against consumers and procurers. The OPSC is not unique in its approach to the “sale of children,” but instead inherits its classification of “children” in the sex trades from definitional analogues in the Convention on the Rights of the Child, the Worst Forms of Child Labour Convention articles 2 and 3, article 3(c)-(d) of the Palermo

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8 Id., p. 92.


10 Curtis, supra note 7, p. 92.


13 In the technical sense, a protocol to a treaty is ‘optional’ in that it is not automatically binding on the states that have already ratified the treaty. See generally “Key Terms,” *United Nations Treaty Reference Guide*.


16 Id. Preamble. ¶ 1.

17 The UNCRC defines “child” to be inclusive of all persons under 18 years of age, unless a treaty party recognizes an earlier age of majority, with exceptions for enumerated benchmarks (e.g., compulsory education through primary school, prohibiting capital punishment and life imprisonment for those under 18).
Trafficking Protocol, and prior legal documents. In pertinent part, the OPSC adopts a presumption of victimhood for minors involved in the sex trades as encompassed by these prior agreements, and so also distinguishes this presumption from the standard of proof required for adults as defined by the Palermo Protocol, that is, proof of force, fraud, or coercion. The OPSC also inherits protections from the UNCRC, such as the article 3 best interests and article 37(b) minimum intervention principles. However, many State Parties have not fully implemented this presumption.

**Pass “No Condoms as Evidence” Legislation**

Finally, under current law in New York City, San Francisco, and Washington, D.C., among other cities in “high-income” countries, police and prosecutors use condoms to prove prostitution-related offenses despite these metropolitan areas having some of the highest HIV prevalence rates in the nation. This practice further criminalizes youth for using one of the few tools they have left for their self-protection. Seventy six percent of minors involved in the sex trades report always practicing safe sex. Yet, the use of condoms as evidence in prostitution prosecutions threatens to reverse this trend.

Dear Members of the Global Commission on HIV/AIDS and the Law,

We at Women with a Vision are pleased to submit this letter in relation to the Regional Dialogue for High-Income Countries. We believe strongly that law reform is necessary in our home state of Louisiana in order to reduce the alarming rates of HIV infection and deaths from AIDS, rates that have particularly impacted communities of color.

Women with A Vision was founded in 1991 with a mission to improve the lives of marginalized women, their families, and their communities by addressing the social conditions that hinder their health and well being. We accomplish this through relentless advocacy, health education, supportive services and community-based participatory research. We have committed ourselves to activism and advocacy for law reform out of necessity where unjust and misguided laws and policies increase the vulnerability of women of color and undermine their human rights. For example, we recently filed suit against the state of Louisiana challenging a law that required persons charged with soliciting anal or oral sex to register as sex offenders. After the suit was filed the legislature responded by repealing this 205-year old law.

HIV in Louisiana is a serious public health issue. Louisiana has more than 18,000 people living with HIV, 55 percent of who have been diagnosed with AIDS. Louisiana ranks 5th in the U.S. in estimated AIDS cases, while Baton Rouge ranks second among U.S. metropolitan areas and New Orleans ranks 9th in AIDS cases as of 2009. The death rate from HIV/AIDS in Louisiana is almost 3 times higher than the national average. 74 percent of new HIV and 78 percent of new AIDS cases are among people of color, with women comprising 28 percent of new HIV infections.

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18 See Convention Concerning the Prohibition and Immediate Action for the Elimination of the Worst Forms of Child Labour, adopted June 17, 1999, ILO No. 182, arts. 2–3.
21 Curtis et. al., supra note 7, p. 96.
In our view, top law reform issues in Louisiana include:

- Decriminalizing the failure to disclose one’s HIV status to one’s partner. Louisiana’s law (Louisiana revised statute 14.43.5) requires neither the intent to transmit HIV nor actual transmission to impose as much as a ten year prison sentence. HIV-specific statutes are not necessary as the criminal laws already cover assault and battery. Punishing those who know their HIV status undermines the public health objective of encouraging HIV testing. The statute also includes as punishable acts spitting and other behaviors which are not scientifically associated with HIV transmission, thus promoting misinformation among the public. Laws that single out people with HIV for criminal prosecution serve no public health purpose and increase HIV stigma which is a serious concern in Louisiana. These statutes also have been used as an “aggravating factor” to greatly increase the sentences of women charged with solicitation.

- Decriminalizing syringe access. Louisiana’s drug paraphernalia laws (Louisiana revised statute 40:1031) make it a crime to possess or use a syringe for injection of controlled substances, and syringes with drug residue may be used as evidence of a crime. These laws limit the expansion of needle exchange programs throughout the state, despite well-established evidence that access to sterile syringes reduces HIV transmission among injection drug users. Injection drug use has contributed to the alarming rates of new HIV infection in the cities of Baton Rouge and New Orleans.

- Pass comprehensive sex education in the schools. Current Louisiana law (Louisiana revised statute 17:263,279,281) does not require that sex education be taught in the schools at all. However, if it is taught the law requires that it emphasize that abstinence-only until marriage is the “expected standard” for all school-age children. Recent efforts to pass comprehensive sexuality education for Louisiana failed in the state legislature. In Louisiana, 5 percent of people living with HIV/AIDS are young people ages 13-24, and disturbingly, many of these young people were diagnosed very late in the disease, with nearly 20 percent diagnosed with AIDS within 6 months of their positive test. This suggests a lack of information and knowledge about HIV and AIDS that may be a direct result of the failure to provide HIV information in the public schools.

There are other law reform issues that affect HIV in Louisiana, including our public officials’ opposition to implementing national health care reform, despite its increased provision of health care coverage to many low income people, including many with HIV/AIDS. We appreciate this opportunity to highlight some of the legal and policy issues that urgently need change in Louisiana, and please do not hesitate to contact us for further information.
Dear Members of the Global Commission on HIV/AIDS and the Law,

We at the North Carolina Harm Reduction Coalition are pleased to submit this letter in relation to the Regional Dialogue for High-Income Countries. We believe strongly that law reform is necessary in our home state of North Carolina in order to reduce the alarming rates of HIV infection and deaths from AIDS, rates that have particularly impacted communities of color.

North Carolina Harm Reduction Coalition (NCHRC) is North Carolina’s only comprehensive harm reduction program. NCHRC engages in grass-roots advocacy, resource development, coalition building and direct services for law enforcement and those made vulnerable by sex work, drug use, overdose, immigration status, gender, STIs, HIV and hepatitis. This submission will focus on reforms in laws and policies that affect access to harm reduction for the residents of North Carolina.

HIV in North Carolina is a serious public health issue. North Carolina has approximately 35,000 people living with HIV, of whom more than 9,000 have been diagnosed with AIDS. The rate of new infections in North Carolina is 41 percent higher than the national rate. 1 out of 4 newly diagnosed people are diagnosed with AIDS, indicating that people are not seeking testing or care until they are very sick. Consequently, the death rate from AIDS in North Carolina is significantly higher than the national average (4.1 vs. 3.7 per 100,000). 67 percent of people living with HIV/AIDS are African-American, though blacks comprise only 21 percent of the state’s population. North Carolina has an estimated 50,000 injection drug users and over 171,000 crack users. In North Carolina, 22.7 percent of people with HIV acquired it by injection drug use since the beginning of the epidemic, one of the highest rates in the country.

In our view, top law and policy reform issues in North Carolina related to harm reduction include:

- Decriminalizing syringe access. North Carolina’s drug paraphernalia laws (NC Rev. Statute 90.113.20) make it a crime to possess or use a syringe for injection of controlled substances, and syringes with drug residue may be used as evidence of a crime. These laws limit the expansion of needle exchange programs throughout the state, despite well-established evidence that access to sterile syringes reduces HIV transmission among injection drug users. North Carolina has an estimated 50,000 injection drug users who are at risk for HIV and Hepatitis B and C from sharing non-sterile needles. There are five syringe distribution programs in the state, but these vital programs are limited, underground, and unable to expand due to the current state of the criminal law. The federal ban on needle exchange was lifted in 2009, but North Carolina is unable to apply for federal funding that would permit expansion of these programs.

  - North Carolina law permits pharmacists to sell syringes, but permit pharmacist discretion in the transaction. Thus many drug users are rejected when they try to purchase clean needles. A study by the Research Triangle Institute also indicated that African-Americans were less likely than whites to be sold syringes at commercial pharmacies. These conditions are denying access to life-saving materials to the very groups at highest risk for acquiring HIV.

- Increase access to treatment services. Many people with HIV are also experiencing problems with drug dependence. Legal barriers make it difficult for low income people with drug dependence to access affordable and evidence-based drug treatment. While Medicaid in North Carolina covers some drug dependence treatment, eligibility is very limited. In North Carolina, non-elderly, non-disabled adults without children are categorically excluded from Medicaid coverage.\(^1\) For working parents and their children to be eligible for Medicaid, annual family income must be no more than 49% of the federal poverty level,\(^2\) or

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This leaves many people in North Carolina, where 1 out of 6 residents live below the federal poverty level, without access to drug treatment. Because many community mental health centers will not take clients who are uninsured, many people are unable to access drug treatment in the state, thus leaving them vulnerable to acquiring HIV or the inability to manage the disease if they are already infected. North Carolina’s budget cuts have already impacted what little mental health services do exist for low income people, and more cuts are threatened. With restrictive Medicaid policies and treatment centers turning away the uninsured and patients with co-occurring conditions, many North Carolinians are being denied access to affordable, evidence-based treatment.

- On a policy level, public health officials in North Carolina should promote and support harm reduction services including:
  - Promoting syringe distribution through syringe exchange, pharmacy sales, peer distribution and decriminalization.
  - Making Naloxone more available for overdose prevention. This prescription drug is proven to save lives in case of opiate overdose but has limited distribution in North Carolina, while in other states such as New York, California and New Mexico it has been promoted by the health departments for peer distribution and training.
  - Promoting amnesty for those who make 911 emergency calls in case of drug overdose, as users are reluctant to contact authorities for assistance for fear of arrest.

We appreciate this opportunity to highlight some of the legal and policy issues that urgently need change in North Carolina to increase access to harm reduction services. Please do not hesitate to contact us for further information.

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I am X; I am a transgender woman living with AIDS. I am a former sex worker and survivor of sexual abuse. I am an advocate for transgender rights and people living with HIV and AIDS (PLWHA).

To effectively reduce HIV transmission and connect PLWHA to care and, where appropriate, anti-retroviral treatment, we must prioritize the fight against HIV-related stigma, discrimination and criminalization. This is true with all populations of PLWHA, but especially so with transgender women.

_Injustice at Every Turn: A Report of the National Transgender Discrimination Survey_ is the nation’s most comprehensive survey of the lives of transgender people in the United States. According to the report, the HIV sero-prevalence among transgender women in the U.S. is more than seven times the national average. The HIV infection rate of the general population is 0.6%; the infection rate for transgender participants in the report’s survey was an astounding 2.6%, with rates for transgender women at 4.28%. The report also found that the infection rate increases to 15.3% for transgender individuals that engage in sex work.

Yet transgender women, who are at such dramatically greater risk of acquiring HIV, often encounter significant

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issues with criminal justice systems, law enforcement and penal institutions, issues that contribute to further transmission of HIV because they perpetuate stigma and criminalize transgender women.

**Criminalization of Condoms**

Condoms have been proven to be the most effective prevention strategy in the fight against HIV/AIDS and other sexually transmitted diseases. Under international human rights law, governments are obligated to promote public health and ensure access to information and services for preventing the spread of HIV and sexually transmitted diseases without discrimination. Logically, this should extend to the distribution of condoms to the public at large, including people engaged in sex work. Sadly, the current practice by law enforcement officers in most jurisdictions in the United States does not follow this logic.

In major cities such as San Francisco, New York and Washington, D.C., there are frequently reports of police “profiling” transgender women as sex workers. This leads to some of the community members at the highest risk of acquiring or transmitting HIV becoming reluctant to accept condoms from outreach workers for fear, that simple possession of condoms will be used as evidence against them in a criminal proceeding.

To interfere with one’s ability to protect one’s health is not only inconsistent with human rights law but it is bad public health policy. Further, according to *Injustice at Every Turn*, 22% of survey respondents have been harassed by police officers. The rate of reported harassment is even higher among respondents of color.

**Transgender Women in Detention**

Many in the transgender and PLWHA community believe that, like efforts to advance LGBT equality, overcoming abuse and discrimination in prisons and other detention facilities represents a defining domestic human rights issue of our time. People living at the intersection of these issues face a human rights crisis.

Transgender women who are routinely placed in men’s prisons and jails are 13 times more likely than their fellow inmates to be sexually abused in prison. All transgender people are at risk of much higher rates of incessant harassment, prolonged isolation, and denial of necessary medical care in most every detention facility in the United States. The same is true for transgender youth in juvenile facilities.

For example, denial of necessary medical care -- such as hormone therapy -- is a common reality for most transgender detainees. Such denial carries risks ranging from hypertension and diabetes to attempted self-castration and suicide. In addition, juvenile facilities often punish transgender youth simply for being themselves and frequently subject transgender youth to intensive gender and sexuality policing, literally forcing gender conformity on them in the guise of a treatment plan.

The courts and the major medical associations have condemned the denial of care for transgender inmates. These problems are pervasive in local, state and federal prisons and jails, juvenile facilities, and immigration detention. For the individuals involved, they are often life and death issues.

Immigration and Custom Enforcement’s (ICE) Office of Detention Policy and Planning has shown some receptivity when these issues have been raised by its NGO Advisory Group. However that receptivity has not translated into improved conditions. To make matters worse, national standards addressing prisoner sexual abuse are currently not applied to immigration detention centers by the Department of Justice (the body required to adopt the standards). In early 2011, the National Immigrant Justice Center filed coordinated complaints with the Department of Homeland Security’s Civil Rights Division on behalf of LGB and T immigrant detainees on a range of human rights violations, including isolation, abuse and denial of hormone treatment:

- Victoria Arrellano, a transgender woman died in ICE custody in 2007 after being denied treatment for HIV;
- Esmerelda Soto, a transgender asylum-seeker, was brutally assaulted by a federal ICE officer in 2003;
These are but two examples; civil rights groups and monitors tell us conditions for transgender people in these centers are horrific. We need to see strong action from ICE to prevent further incidents.

The horrific conditions of confinement that transgender youth and adults face in the US are a serious concern for our community. As part of the Prison Rape Elimination Act of 2003, the National Prison Rape Elimination Commission (NPREC) recommended strong national standards in its 2009 report. The DOJ was then statutorily required to adopt national standards to end prison rape within a year. We are currently more than a year past that statutory deadline and national standards have yet to be adopted.

Each day without these life-saving standards means more transgender people are exposed to the cruel and unusual punishments of sexual violence in detention facilities across the United States. This horrific treatment puts our community at heightened risk for HIV, Hepatitis, other STDs, physical harms and emotional trauma:

- Alexis Giraldo, a Puerto Rican transgender woman who was repeatedly raped her two cell mates between January and March 2006 at Folsom State Prison;

- Jennifer Lynn Sutton, a transgender inmate with HIV and hepatitis C, who had written about her lack of access to compassionate treatment and medical care at Corcoran state prison in California, died early Friday morning, May 3, 2002, of kidney failure.

In addition to these two examples, the most recent incidence happened recently to Jovanie Saldana, 23-year-old transgender woman in Philadelphia who has been spent 14 months incarcerated at Riverside Correctional Facility, the city’s only prison for women. She is now being moved to the men’s prison after she complained that a correctional staff forced her to perform oral sex.

A prison sentence should not be a sentence to be raped, brutalized, tortured or denied medical care. The neglect of these horrific human rights abuses—that so directly relate to further transmission of HIV—is a national disgrace, a national shame and demands the attention of global human rights advocates.

**Recommendations**

We must decriminalize HIV/AIDS by elimination of HIV-specific criminal statutes and sentencing enhancements. Transgender women, when it comes to carrying condoms, face the horrific choice between protecting themselves or providing ammunition to police and prosecutors. Criminal prosecution of people who know they have HIV for behaviors that are unremarkable for others is a further disincentive to transgender women to get tested and into care. “Take the test and risk arrest” is increasingly heard on the street; sending that message to communities most at risk is dangerous indeed.

We must urge the U.S. Department of Justice, including through pressure and scrutiny from global human rights and public health advocates, to adopt effective, enforceable standards which apply equally to all prisons, jails, and immigration detention facilities. The NPREC spent five years collecting data and testimony from all sectors of society in order to develop its proposed standards. The DOJ has no justifiable reason for taking so long in adopting national standards based on those generated by NPREC.

These steps will not, in and of themselves, end HIV transmission among transgender women. However, taken together with other practical, effective recommendations, these vital steps will go a long way towards bringing down the risk of infection and elevating the dignity and equality of transgender women.
HIV criminalisation: the negative impacts of the criminalisation of people living with HIV for non-disclosure, potential exposure and non-intentional transmission during otherwise consensual sex.

Background

I am British-born journalist, advocate and policy consultant currently based in Berlin, Germany. I have been aware that I have been living with HIV since 1988.1

Since 2007, I have been reporting on and analysing HIV criminalisation in my blog Criminal HIV Transmission. The blog has become an important global resource for advocates, academics, civil society and other stakeholders who are dedicated to both ending new infections and supporting the human rights of people living with HIV by highlighting:

- individual cases and judicial decisions from around the world;
- existing, proposed and new HIV-specific criminal laws;
- media reports and public opinion of such laws and prosecutions;
- and – increasingly – case studies of anti-criminalisation advocacy.

This abstract focuses on how HIV criminalisation affects people living with HIV (PLHIV) based on my own observations and those of my readers.

10 Myths about HIV and PLHIV

HIV criminalisation is primarily the result of HIV-related stigma.2 Arrests, prosecutions and media reporting exacerbate this, adding further misinformation, resulting in unintended harm to public health messages and negative perceptions of people living with HIV. Such policy, practice and reporting has resulted in the following ten 'myths' about HIV and people living with HIV:

1. Only the people most responsible for “spreading HIV” are arrested and prosecuted.
2. If you have sex just once with someone who has HIV you are incredibly lucky if you aren't infected.
3. Having unprotected sex with someone with HIV is like playing Russian Roulette.
4. People with HIV are potential lethal weapons or terrorists, or both.
5. HIV = AIDS = death sentence.
6. It is the easiest thing in the world to tell someone you have HIV.
7. People with HIV who don’t tell their sexual partner(s) they have the virus are selfish, evil monsters.
8. Scientific tests can easily tell who infected whom.
9. Scientific tests can easily tell when someone was infected.
10. The criminal law can protect you from HIV.

Much of my professional work about HIV criminalisation relates to dispelling these myths through better knowledge of HIV-related science. For example, I was recently lead author of a report for UK NGO NAT that explores the implications of tests to estimate timing of HIV infection for criminal prosecutions3, and am currently working as a consultant for UNAIDS on a project that uses HIV-related science to inform the legal and human rights aspects of HIV criminalisation.4

Divisive and emotive

1 For more about my personal history and motivations see: edwinbernard.com/about/history.html
2 I have written extensively about the connection between HIV-related stigma and punitive laws and policies, notably in the Fundamentals chapter of ‘HIV and the Criminal Law’: aidsmap.com/resources/law/Fundamentals/page/1410518/
HIV criminalisation is an emotive issue that is often conflated with perceptions of responsibility for HIV prevention. This anonymous comment on a blog post\(^5\) is illustrative of how a significant minority of PLHIV think that people who do not disclose before potentially exposing their sexual partners to HIV are “monsters”.

I hate to say it but I think it is outrageous for people to believe there should not be criminal laws preventing these monsters from spreading HIV to unsuspecting people. I think sometimes that there are those people with HIV who believe they should be able to infect whoever they want without any consequences. There are so many of us who have this disease who would not dream of exposing another person to such a horrible thing as AIDS. I was infected by a man who I dated for three years. I trusted him when he told me that he had been tested and was negative. He watched me get sicker and sicker and never said a word all the while, he continued to expose me again and again. How can anyone say that this is acceptable behavior? How can anyone think that this should not be criminal? Those people who think that society will not hold these people accountable for their actions are crazy! These monsters are better off with a law that punishes them otherwise they may face a much more severe punishment from those they infected.

The impact of HIV criminalisation on people living with HIV is ultimately destructive and divisive, creating a sense that there are ‘good’ HIV-positive people versus ‘bad’ HIV-positive people. The people who complain to the police, supported by the criminal justice system, believe that they should be warned when their sexual partner is HIV-positive. Never mind the incredible difficulties we might have disclosing this very sensitive information to people who we don’t trust; the deep denial we often face earlier on in our diagnosis; the difficulties we have negotiating or using condoms; or the fact that those of us on effective treatment are going to be far less infectious than people who are undiagnosed and who couldn’t possibly warn their partner.\(^6\)

The criminal justice system thinks that by picking out a few unfortunate people who come to their attention in a completely random way, and prosecuting them, it will scare the rest of us living with HIV to keep the virus to ourselves. Actually, most of us already do that, and the law doesn’t help those who can’t or won’t share their status with their partners – or use condoms to protect them. Support, not punishment, is what is needed.\(^7\)

For example, woman living with HIV from the United Kingdom wrote, in response to a blog posting about her husband’s conviction for breaching a Sexual Offences Prevention Order after he had previously been imprisoned for ‘reckless’ HIV transmission,\(^8\)

Prison is no good for him. He needs to be in a special hospital.

Isolating, frightening and daunting

I often receive emails and comments on my blog from people living with HIV who tell me about the impact HIV criminalisation is having on their lives. The first testimony is from a British man in Malta who was arrested after being (apparently falsely) accused of raping and infecting a female friend.\(^9\)

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\(^5\) US: Maryland man, previously convicted of HIV exposure, arrested again 1 May 2009.

\(^6\) For a detailed examination of responsibility for HIV prevention, and disclosure, see the Responsibility chapter of ‘HIV and the criminal law’. Available at: www.aidsmap.com/page/1441686/

\(^7\) I have also worked as a consultant on an alternative framework, known as Positive Health, Dignity and Prevention, that is proposed by the Global Network of People Living with HIV and UNAIDS. Available at: www.gnpplus.net/en/resources/positive-health-dignity-and-prevention/item/109-positive-health-dignity-and-prevention-a-policy-framework

\(^8\) UK: Man previously convicted of reckless HIV transmission jailed again 11 May 2009.

\(^9\) Malta: British man accused of rape, HIV transmission 10 June 2009.

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with the same contempt of the 80s - the laws are unclear and I face a long agonising wait for trial [for] which many people already seem to have found the answer. I [am] angry how people judge. [But] I am on treatment and doing OK. This is a very small-minded country and a fair trial might be blinded just because I have HIV. Obviously I can't talk about the accusation, but I'm angry just because I have HIV how I've been treated...I do have a lawyer who seems keen to take the case on. A very rare case like this is good for her profile and bank balance. We have had to put our house up for sale and my Maltese girlfriend [who] was there [when the alleged acts took place] is behind me 100 per cent. These people [who accused me] were my work colleagues and best friends and since my release on bail no one will employ me, or even talk to me. On a small island, this is very depressing.

The second testimony is from a person in the US military who responded to a blog post about a recent HIV-related court martial.10

I’m an active duty male with 21 years and going through the same thing – I must plead guilty to save my retirement. But mine is a bit different, a jilted lover who knew my status reported non-disclosure. But as you posted, one cannot consent in the military to aggravated assault.... I have been positive for 20 years, and undetectable for years, but I don’t wish to fight the military now, I need the retirement [to pay] for meds. I have got a pre-trial agreement that gives me retirement in lower pay-grade [and] 16 months confinement. I just want to get past this. I get sentenced this month...Just thought I would let you know it’s not just in the civilian world and add that fear and ignorance rules here also.

Feeling unsafe, victimised, criminalised

The final two testimonies are illustrative of how the impact of HIV criminalisation goes far beyond the individuals who have been prosecuted.

I moved from San Francisco back to my hometown in the Midwest ten years ago, a city of around 1 million people. I have been as responsible as a person can be with my HIV status [but it] seems the more open and honest a person is, the more they are subjected to rumors. [The gay men here seem to be in denial about the HIV risks they run but] revealing my status seems to break through this denial and I am seen as a predator...I’ve told friends that I don’t feel safe here but I can’t quite place my finger on it, after seeing this trend in criminalization, perhaps those fears are warranted.11

I’m not a big fan of the word injustice... But [Norway’s] Paragraph 155 criminalizes me for wanting to live a full life – and that includes a sex life. Me - who has studied law just because everyone said I was always so fair and wise. I feel like a victim, even though I often criticise the role of the victim. A victim of this discriminatory law that criminalises the sexuality of people affected by HIV.12

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10 US: Military court sends Naval officer to prison for unprotected sex with disclosure 7 October 2009.
11 “02Dave12345” responding to Canada: Xtra publishes its anti-criminalisation piece-de-resistance 2 October 2009.
12 This is just an except, the full testimony can be read at: Tell your story - how are you impacted by HIV criminalisation? 4 August 2011.
The nature and impact of the criminal law and its impact on the response to HIV is neither well documented nor well understood. But it risks further marginalizing people already vulnerable to HIV infection, including women, men who have sex with men, migrant communities, sex workers and people who use drugs. Legislation and legal practice is different in every country around the world, and collectively we need to become more conscious of the impact of both the criminal law and its implementation on national responses to HIV.

Timely concern: The criminalisation of HIV transmission or exposure

Internationally, the last decade has seen a concerning trend to apply the criminal law (prosecuting HIV transmission or in some cases also exposure) as part of national responses to HIV and to promoting public health (OSI, 2008; IPPF, GNP+ and ICW, 2008). Imbued with the ability to fuel stigma, the application of the criminal law to HIV transmission and/or exposure can undermine all our hard won gains in the response to HIV over the last thirty years. One of the founding sociologists of law, Emile Durkheim, suggested that the criminal law is a barometer of the collective consciousness:

“[One] should not say that an act offends the common consciousness because it is criminal, but that it is criminal because it offends that consciousness. We do not condemn it because it is a crime, but it is a crime because we condemn it.”

Regardless of whether or how prosecutions may take place, the simple application of the criminal law to issues relating to HIV transmission perpetuates stigma by delineating the boundary of social consciousness.

External stigma and discrimination, misconceptions, internalised stigma, are all exacerbated by criminalization (particularly the media coverage of criminalization), and all serve to discourage disclosure. This in turn makes individuals more vulnerable to prosecution, trapping often vulnerable people in a vicious cycle of secrecy and fear. Criminalizing the transmission of HIV harms already marginalised communities at particular risk of HIV infection including migrants, women, men who have sex with men, sex workers and people who use drugs, and the harms far outweigh any perceived benefits. It fails to take into account the external and internal barriers to disclosure, nor indeed the shared responsibility for consensual sex. Promoting safer sex choices for everyone, whether positive or negative, will have a far more significant impact on the reduction of HIV transmission than attempts to criminalise a virus.

By fuelling stigma, criminalization undermines efforts to prevent, treat and care for HIV. This is potentially even truer in high income countries where to date there have been higher numbers of prosecutions for HIV transmission or exposure.

The ‘Criminalize Hate Not HIV’ campaign

Launched at the International AIDS Conference in Vienna, July 2010, ‘Criminalise Hate Not HIV’ was for some an unexpected campaign for an international federation of essentially health-service providers. The International Planned Parenthood Federation (IPPF) launched the campaign that has been taken up in almost half of its member organisations including those in Europe, North America, and Australasia with the highest rates of prosecution of HIV transmission or exposure.

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1 Although difficult to know exactly, and specific research into national legislation and policy frameworks is currently underway, recent reviews indicate that 58 countries worldwide have laws that criminalize HIV or use existing laws for the prosecution of people for HIV transmission or exposure and another 33 countries are considering similar legislation (IPPF, GNP+ and ICW, 2008; Chenge, 2008). See www.criminalisationscan.org, and initiative of the Global Network of People Living with HIV (GNP+) to document the situation in many countries around the world and their legislation relating to prosecution of HIV transmission or exposure.
As an organisation focusing on sexual and reproductive health and rights, IPPF has been concerned with legal and policy matters that may restrict access to health services and impede the realisation of the human right to health—such as the criminalisation of HIV transmission or exposure—for many years.

The IPPF submission includes reflections on how the Federation, primarily a union of sexual health care providers around the world, has adopted and responded to development of a controversial and timely international campaign against the criminalisation of HIV transmission. In 2010, 46% IPPF Member Associations (72 organisations) and specifically 39% of those in Europe (11 organisations), engaged in a form of national advocacy against the criminalisation of HIV transmission.

It will highlight examples of successes and challenges on advocating on these issues internationally as well as through a catalytic regional campaign in Europe 2010 - 11. It will also explore the implications for the Federation’s way of working, international HIV workplace policies, and referrals and support for HIV positive staff and volunteers. The submission includes a 2 minute campaign video, viewed all over Europe, North America and Australasia, as well as some of the debates and dissenting responses the campaign has generated. Specifically in high income countries, recent efforts have focused on advocacy, awareness-raising among people living with HIV and institutional partnerships with national organisations to facilitate collaborative efforts to speak out against the criminalisation of HIV at the national level. These have included:

- **In Sweden**, the European country with the highest number of known prosecutions relating to HIV transmission or exposure, the national family planning association (RFSU) has partnered with HIV Sweden and a national LGBT network to build a centre of excellence on these issues and enhance their collective capacity to advocate effectively with politicians and through the media.

- **In the UK**, second to Sweden as the country with the highest known number of criminalisation cases, IPPF supported the rollout of *The People Living with HIV Stigma Index* in 2009-11 that included a focus on understanding the experiences and impact of the criminal law for people living with HIV as well as informing community-based activism responding to the issues identified.

- **In New Zealand**, as part of a global collection of stories about the impact of the criminalisation of HIV on individuals (such as doctors, lawyers, journalists and people living with HIV), the personal story of Marama Pala documents the contradictions in the law, the power of the media, and changes of attitudes over time. The collection is called ‘Behind the Bars’ ([http://www.ippf.org/en/What-we-do/AIDS+and+HIV/Behind+bars.htm](http://www.ippf.org/en/What-we-do/AIDS+and+HIV/Behind+bars.htm)).

The evolving campaign builds on both IPPF’s HIV policy which does not support the criminalisation of HIV and on IPPF’s *Declaration of Sexual Rights*. IPPF invites the Commission to review and reflect on the submissions from *The People Living with HIV Stigma Index UK Team*, and the Swedish national partnership; to read the reflections included in the ‘Behind Bars’ collection, and to show two advocacy films relating to the campaign and the promotion of the Declaration of Sexual Rights:

1. **Criminalize Hate Not HIV**—a 2 minute campaign film. Upholding GIPA principals, members of the UK Stigma Index team (non-professional actors!) produced and directed the film to show the humanness of sex, intimacy, relationships and of HIV. The film alludes to the laws criminalizing HIV transmission and exposure but also laws criminalizing behaviours associated with HIV transmission (including mother to child transmission, drug injection, sex work, and sex between men). This film has since been produced to broadcast quality in 15 language versions, including English, French, Spanish, Swahili, Russian, Arabic, German, Portuguese, Swedish, Dutch, Tamil, Hindi, Telugu, Siswati and Amharic.

2. **Verdict on a Virus**—a 12 minute in-depth policy film. Further research and concern for criminalization of HIV transmission in the UK led to a UK focused documentary featuring interviews with a host of experts...
Sexual rights: An IPPF Declaration: Sexual rights - including for people living with HIV - are a component of human rights, they are an evolving set of entitlements related to sexuality that contribute to the freedom, equality and dignity of all people, and they cannot be ignored. Full length and pocket size versions of the Declaration are available in over 24 languages. http://www.ippf.org/en/Resources/Statements/Sexual+rights+an+IPPF+declaration.htm

Both films are available online and we would be delighted if you would review and screen these as a result of this submission. http://www.youtube.com/user/IPPFHIV

28 USA

Sex Workers Project, Urban Justice Coalition

We work in various capacities with sex workers in the U.S. whose lives are criminalized and whose human rights are violated. In our country, sex workers live with the threat of double prosecution under one set of laws criminalizing sex work and another criminalizing HIV exposure or transmission. We present our observations here to illustrate how the criminalization of sex work – especially when overlaid with this second legal layer – promotes stigma and compromises the health of sex workers. This synergy both increases sex workers’ vulnerability to HIV and undermines the ability of those living with the virus to access to treatment, care and support.

Thirty-six U.S. states and territories have either created laws designating HIV-specific crimes or enhanced the penalties applied to HIV positive people convicted of other offenses.¹ In fifteen of these, penalties are further enhanced for those convicted of selling (and, infrequently, buying) sex while HIV positive.

The U.S. leads the world in the number of people convicted of willfully exposing others to HIV, with 205 convictions as of 2009.² The new National HIV Prevention Strategy discourages states from adopting laws criminalizing HIV transmission but it does not call directly for their repeal.

Sex work is criminalized via a patchwork of laws across the U.S. except in parts of Nevada, where it is tightly regulated. Those suffering most from this state-enforced stigma are street-based sex workers. Whether female, male, or transgender, street-based sex workers are frequently impoverished people of color. They are at high risk of violence from clients and the police, as well as homelessness, addiction, and HIV. Because they can be arrested at any time, negotiations with clients regarding prices and condom use are often hastily conducted, to facilitate getting off the street before being observed and arrested. This not only leads to less enforceable agreements with clients but also reduces the time a sex worker has to “size up” the situation regarding potential violence or risk.

Since self-disclosure as a sex worker often leads to discriminatory treatment in health centers and other social services agencies, street-based sex workers also tend to experience little or no access to HIV prevention, care, and treatment services.

The lived experiences of sex workers, drug users and LGBT (lesbian, gay, bisexual and transgender) people show the impossibility of governments stigmatizing people on one hand while simultaneously actually helping to reduce their risk of HIV transmission or exposure on the other. As the Urban Justice Center’s Sex Workers

Project noted in 2007, “[t]he real hypocrisy here is that people who need healthcare and services, and who need their rights protected, are being denounced by those whose mission it is to help them.”

Some real life examples illustrate this core contradiction:

In some states, possession of condoms can be used as evidence of intent to engage in sex work. There is no legal limit to the number of condoms an individual can carry, but reports from three major cities (New York, Washington DC, and San Francisco) document that law enforcement officers routinely confiscate condoms from suspected sex workers, sometimes submitting them as “evidence” and sometimes arresting people based solely on their possession of condoms. Transgender women, homeless women of color, and others commonly profiled as doing sex work are especially targeted by this practice.

In addition to abusing the rights and safety of sex workers – most of whom are determined to protect their own health and that of their clients -- these policing practices directly undermine publicly funded HIV prevention efforts.

In New York, S323/A1008 is a bill in the legislature that would provide “that possession of a condom may not be received in evidence in any trial, hearing or proceeding as evidence of prostitution”. Prior versions of this bill were introduced in each of New York’s last five legislative sessions. Each time, they remained trapped in a legislative committee and failed to reach the full legislature for debate or a vote. Sex workers’ advocates have amassed a large coalition of civil rights groups, reproductive justice groups, HIV prevention groups, and healthcare providers that is working hard to move this session’s bill forward.

The state of Louisiana has taken vilification of sex workers to new heights by using an 1805 law to enhance sex worker prosecutions. The law bans oral and anal sex as “crimes against nature” and The Louisiana Weekly reported that “sex workers convicted of breaking this law are charged with felonies, issued longer jail sentences and forced to register as sex offenders. They must also carry a driver’s license with the label ‘sex offender’ printed on it.”

Sex offender registries are generally comprised almost entirely of men but, because fellatio is commonly sold by sex workers, three quarters of those on Louisiana’s registry are now women. Most (80%) of these women are African American. The HIV risk associated with receiving fellatio is microscopically small, but being convicted as a sex offender for performing consensual fellatio may substantially increase one’s HIV risk. Here’s why. Sex offenders remain on the registry for a minimum of ten years. During this time, they are barred from certain kinds of employment and most other employers are unwilling to hire them. As felons, they do not qualify for public housing assistance or educational loans in Louisiana and are ineligible for food stamps under some circumstances. These factors combine to make it extremely difficult for women on the registry to find legal ways to support their families, increasing their likelihood of having to continue to do sex work, live in poverty, and be deprived prevention and sexual health options, all risk factors for HIV.

A relentless coalition of civil rights and health activists called NO Justice, led by Deon Haywood of Women with a Vision, mounted a two-year public campaign that finally resulted in the 2011 passage of state legislation overturning this policy.

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Twenty states in the U.S. now do mandatory HIV testing on people arrested or convicted on charges of prostitution, solicitation or pandering. In nine of these, the state is not required to provide any accompanying HIV counseling, education, treatment, or services for those testing HIV positive. Positive test results may be released without consent—depending on the state—to the person with whom the accused had sex, the district attorney, the Mayor (in the case of the District of Columbia), state agencies, and/or the courts.

When a sex worker in Ohio died of a drug overdose in September, 2010, local newspaper coverage of her death printed her full name under her photograph and disclosed that she had been incarcerated for two years after soliciting while HIV positive in 2003. The story was news not because of the tragedy of her suffering and untreated conditions but because “she escaped similar charges after six soliciting arrests from December 2008 to October 2009”.

The Denver Post similarly published a 2009 story under the banner, “[Defendant’s Name] Charged With Prostitution With Knowledge Of AIDS”. This former sex worker, also pictured, was charged with felony prostitution because she was HIV positive. The article noted that she had also “pleaded guilty in 2000 and 2008 to attempted prostitution with knowledge of AIDS”. Colorado is one of the states conducting HIV testing (presumably imposed on this defendant in 2000) without any accompanying counseling, education, treatment or services.

Nonconsensual public disclosure of a person’s HIV status is a human rights violation. Thousands of sex workers in the U.S. are subjected to mandatory HIV testing without any kind of informed consent or appropriate medical or social supports. The fact that the women convicted in both cases above returned to sex work underscores that this practice does not enlarge people’s options.

The above are just a few of the ways in which criminalizing sex workers and doubly prosecuting them in the name of “HIV risk” flatly contradict stated governmental commitments to human rights and public health. These policies also constrain or deny sex workers’ access to appropriate medical, legal and social services. As a result, many sex workers are effectively locked into their current situations by state-enforced stigma. Despite—not because of—these policies, we are inspired by the perseverance of the sex workers we work with, who insist on condom use to protect themselves and their clients.

Human rights are violated and HIV spread is facilitated: every time the police take condoms away from a sex worker, every time a massage parlor or brothel manager refuses to have condoms on the premises for fear that they will be used as evidence, every time someone becomes a felon simply by engaging in consensual sex for money, and every time forced HIV testing breaches the bounds of informed consent, bodily integrity, and privacy.

Criminal justice approaches to sex work and HIV are ineffective, inhumane, and wrong. These statutes and policies embody a vicious contradiction that undermines both human rights and best practices in public health. State and federal tax dollars are funding these prosecutions and, thus, supporting state-enforced stigma.

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7 Shkordoff L., legal research conducted for the Sex Workers Project, publication pending.
8 The Columbus Dispatch. “Prostitutes’ HIV Status Overlooked in Charges”. 13 September 2010
The United Kingdom (UK) is one of the world’s eminent donor countries and development partners in the international response to HIV. The policies to address HIV and strengthen health systems are based on principles of human rights and equal opportunity, and the Department for International Development (DFID) has identified addressing stigma as one of the priorities in the response to HIV throughout the last decade. The UK is signatory to the main international human rights treaties and conventions, including the Universal Declaration of Human Rights (1948), European Convention on Human Rights (ECHR, 1953), International Covenant on Economic Social and Cultural Rights (IESCR, 1966), and specifically in relation to HIV, the UK endorsed the Declaration of Commitment on HIV/AIDS from the United Nations General Assembly Special Session dedicated to HIV/AIDS (UNGASS) (2011).

Yet domestically, within the UK, the law is fighting against itself in terms of its role in the national response to HIV. On the one hand, national human rights laws and provisions include the Disability Discrimination Act (DDA, 1995, 2005) and the Human Rights Act (HRA, 1998). On the other hand, laws that criminalise HIV transmission are perpetuating stigma and confusing many groups of people particularly vulnerable to or living with HIV about their health seeking behaviour and human rights. In England and Wales, HIV transmission has been prosecuted under The Offences Against the Persons Act (OAPA, 1861) and in Scotland, a separate legal jurisdiction, as a common law offence of ‘Reckless and Culpable Conduct’. To date there have been at least 20 prosecutions in the UK since 2001.

”The really, really frightening thing about criminalization is that it is driving people underground... (They are) not disclosing.” Leicester, Male, September 2010

”Basically about the law, I think people living with HIV don’t know what’s legal and I think it is important that they should”. Glasgow, Female, August 2010

**Consideration:** The nuanced contradictions of the role of the law as part of the response to HIV in the UK—from the perspective of particularly vulnerable to HIV and people living with HIV—has an impact on promoting health seeking behaviours and promoting an enabling environment that safeguards human rights and addresses HIV–related stigma. We outline some of the main findings from the implementation of The People Living with HIV Stigma Index in the UK in 2009-10 as well as two specific advocacy initiatives seeking to respond to some of the concerns identified.

**Findings from The People Living with HIV Stigma Index: UK**

Between May and September 2009, 35 community researchers interviewed 867 of their peers as part of The People Living with HIV Stigma Index rollout in the United Kingdom. This was the first full implementation of the tool in a high income country. In 2010, 61 people living with HIV were interviewed in 12 focus groups UK wide as follow-up from the quantitative results from 2009. The initiative indicated that the nature and impact of the

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1 The UK government has been identified as the second biggest bilateral donor in the global response to HIV. [http://www.avert.org/aids-funding.htm](http://www.avert.org/aids-funding.htm)
4 The Stigma Index team was made up of a diverse groups of 35 People Living with HIV and a host of more than 40 domestic organizations from across the UK including national organizations such as the Terence Higgins Trust (THT), African HIV Policy Network (AHPN), Positively Women (PW), PozFem and the International Community of Women Living with HIV (ICW) and HIV Scotland as well as local groups such as Body Positive North West; George House Trust; Positive East and Waverley Care. Efforts were also made to work alongside charities working with people with disabilities, the national network of sex workers, and charities working with homeless people. Research guidance was provided by The Office of Psychosocial Research in Glasgow. Further details and publications available at [www.stigmaindex.org](http://www.stigmaindex.org).
criminal law and its impact on the response to HIV is neither well documented nor well understood.

Three of the main findings:

1. Repeated rejection and stigma has an impact on sexual confidence, disclosure and HIV prevention – especially for young people.

The results indicated that in the most intimate spaces, the experienced and perceived stigma relating to sexual rejection was high and may perhaps affect to whom or how a person living with HIV chooses to disclose.

More than two-thirds of participants feared someone would not want to be sexually intimate with them because of their HIV status (66%), and this was higher for men than women (70% men, 58% women). Almost half or all participants reported that this had occurred (39%), again higher for men than women (46% men, 29% women) and higher than the average for those who identified as MSM, gay or lesbian (45-47%). In addition, many participants chose not to have sex (36%) in the previous 12 months.

It is perhaps then not surprising therefore that participants reported that disclosure can be (55%) but is not always an empowering experience.

“...and it should not always be the positive person... to take responsibility. Some people are not responsible that’s for sure, it’s going to happen, so everybody, regardless of their status, should be responsible about their own sexual action”. Glasgow, Female, August 2010

“It’s up to you both to take precautions, it shouldn’t be down to one person”. Leicester, Female, September 2010

2. Knowledge of HIV-related national legislation and legal redress is low.

Just over half of people living with HIV (56%) had heard of the Disability Discrimination Act (DDA) and even fewer (40%) having heard of the UNGASS Declaration of Commitment – for both this was slightly higher among men and than among women (DDA: 58% men, 39% women; UNGASS: 39% men, 31% women) and lower than average for refugees or asylum seekers (DDA: 43% and UNGASS: 32%).

“There is a need to educate about people’s rights. For one to identify that they have been discriminated against they need to know their rights” Female researcher, London, May 2009

Even though many reported direct experiences of discrimination (19%), only 6% sought legal redress. This was slightly higher in women than men (4% men, 9% women), slightly higher for refugees or asylum seekers (8%); and average for MSM, gay or lesbian (5%).

The results indicate that more effort is needed to strengthen awareness and impact of legal mechanisms—and the corresponding accessibility of legal services—to protect the rights of people living with HIV. Awareness of the laws such as the Offences Against the Persons Act (OAPA, 1861) and its impact on the lives and choices of PLHIV and their caregivers needs to be critically assessed to determine its impact on and cost for mainstream HIV prevention efforts.

3. Stigma can influence perceptions of shared responsibility for sexual health

The results show almost unanimous agreement (92%) that both partners, regardless of HIV status, share equal responsibility for preventing HIV transmission and for the sexual health of both partners. Yet even so, in
response to a question about whether the transmission of HIV should be a criminal offence, the responses were split between no (the majority, 41%), yes (26%) and not sure (26%).

Perhaps this disparity can in part be explained in light of the results relating to internalised stigma, where 44% of participants indicated that they felt shame relating to their HIV status in the previous 12 months, and 43% expressed they experienced guilt.

Because crime and punishment in relation to HIV have prominence in the formation and regulation of moral norms, they link with connotations of stigma and values—not only for the individuals who are accused or perpetrate crimes, but also as benchmarks that have symbolic significance in demarking and controlling wider social standards.

“(As) Positive people, we can’t carry the baggage of telling people we are HIV positive, people should be responsible for their (own) sexual life”. Leeds, Male, September 2010

Overall, the results from The People Living with HIV Stigma Index in the UK highlight that the role of the law in the national response to HIV in the UK can be paradoxical and perplexing for people living with HIV. People living with HIV need greater support and outreach to access legal services and knowledge relevant for protecting their human rights (in terms of health as well as cross-cutting issues such as housing, immigration, employment and social welfare benefits).

People living with HIV need support not suspicion. Once a trial is over, once a legal judgement has been made, and once the press have left the gallery, in cases where HIV transmission has occurred the ‘victim’ of crime is still vulnerable to these very same social attitudes and processes of devaluation.

Consideration: A mainstream HIV prevention/PSA campaign is needed to raise awareness of HIV within a context of human rights. In partnership the PLHIV Stigma Index team/UK has been involved in the development of a new media campaign to address some of the issues raised about the role of law and HIV in the UK.

“One of the biggest stigmatizing things I think is the way the media presents those criminalization cases. The whole issue is turned into innocent victim horror, you know horrid evil character who is going out and doing it”. Edinburgh, Male, July 2010

The UK Stigma Index Team are committed to increasing awareness and a program of advocacy and activism with regard to Criminalization agenda in the UK and to that end have generated two new pieces media to support the Global Criminalize Hate not HIV campaign.

- **Criminalize Hate Not HIV**—a 2 minute campaign film. Upholding GIPA principals, supported by the International Planned Parenthood Federation (IPPF), members of the UK Index team (non-professional actors!) produced and directed the film to show the humanness of sex, intimacy, relationships and of HIV. This film has since been produced to broadcast quality in 15 language versions, including English, French, Spanish, Swahili, Russian, Arabic, German, Portuguese, Swedish, Dutch, Tamil, Hindi, Telugu, Siswati and Amharic.

- **Verdict on a Virus**—a 12 minute in-depth policy film. Further research and concern for criminalization of HIV transmission in the UK led to a UK focused documentary featuring interviews with a host of experts and stakeholders speaking on criminalization, including the National AIDS Trust,

Both campaign films and messages are available online and we would be delighted if you would review and
screen these as a result of this submission.

http://www.youtube.com/user/PLHIVStigmaIndex?feature=mhee#p/a/u/2/nPWw-1A9LAE

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<td>Joint submission on behalf of Best Practices Policy Project and for Kiesha McCurtis, Sharmus Outlaw and Cristine Sardina of the Desiree Alliance</td>
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The following information is submitted by the Best Practices Policy Project (BPPP) and the Desiree Alliance. Both organizations were founded in 2005 to be part of a re-emerging movement for sex worker rights in the United States. Both groups prioritize sex worker leadership in issues of concern to them and strive to ensure social justice through anti-oppression/anti-racism work. The Desiree Alliance has worked since its inception to speak to the concerns of the wide range of people—including lesbian, gay, bisexual and transgender communities—who engage in sexual commerce (such as street sex work, escort work, informal sexual negotiations for basic income). The Best Practices Policy Project is dedicated to building excellence amongst organizations working with sex workers and related communities of people also affected by anti-prostitution policies (such as transgender people, youth, low income people of color and immigrants) so that collectively we can build a society in which these communities can enjoy their health and rights.

Recently the Desiree Alliance and Best Practices Policy Project produced a national report on human rights abuses experienced by sex workers and people in the sex trade that was submitted to the Human Rights Council at the United Nations for consideration during the Universal Periodic Review (UPR) of the human rights record of United States.¹ This report and related advocacy led to UN Recommendation 86 that the U.S. “...ensure access to public services paying attention to the special vulnerability of sex workers to violence and human rights abuses” and subsequently the first ever acknowledgement of the rights of sex workers by the US government in March 2011. The information provided in this statement is drawn from materials developed during the UPR process, other reports on HIV/AIDS produced by BPPP,² and our experiences as sex workers and allies working for social justice for communities of sex workers in the U.S.

**Overview of the laws and policies affecting sex workers and related communities**

Criminal prohibition of sex for money and surrounding activities exists in almost all states of the United States (with the exception of some counties in the state of Nevada). Some forms of sex work, such as exotic dancing, may not be prohibited by state legislation but they are always regulated by state and municipal policies. Sex work that occurs in public spaces is also often policed under legislation prohibiting loitering, public nuisance, trespassing or “failure to obey” a police officer’s directive to move along. Some states in the U.S. mandate minimum sentences so that judges are required to incarcerate people convicted for prostitution-related offenses. Some states have sentencing guidelines and judicial practices making a third charge for prostitution-related offenses a felony. People arrested for solicitation or other prostitution charges in many jurisdictions in the United States are mandated to test for HIV and people testing positive can face significant penalties and incarceration because of their HIV status.

Different forms of U.S. anti-trafficking legislation and policies affect sex workers in the United States and globally. Federal U.S. anti-trafficking policies undermine the health and rights of sex workers both domestically and internationally by requiring that organizations seeking funding adopt a policy against sex work (“Anti-Prostitution Loyalty Oath”). This requirement is applied to international and almost all U.S.-based organizations

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seeking funds from the President's Emergency Plan for AIDS Relief (PEPFAR). Organizations within the U.S. have also been subject to the pledge under the Trafficking Victims Protection Reauthorization Act. These restrictions mean that many organizations are confused about what kinds of services they can provide to sex workers and have, in some situations, lead to excellent harm reduction services being shuttered. New forms of state level legislation to end “domestic trafficking” focusing on “ending demand” for prostitution have been proposed and/or adopted in many U.S. States intensifying policing of sex workers and their clients.

**Specific issues of concern regarding HIV, laws, policy and sex work**

The following issues affect sex workers, people in the sex trade and people who are often profiled as prostitutes by the police even if they are not engaged in sex work (such as transgender people, immigrants, low-income people of color, youth of color).

- The policing of anti-prostitution laws, related policies and by-laws across the United States directly undermines the ability of sex workers to protect them from HIV infection and, in a broader sense, alienates these communities from the support needed to defend their health and rights. Sex workers, and people the police assume to be sex workers, are harassed, assaulted, sexually assaulted, extorted, and falsely arrested by police. The law enforcement practice of using condoms as evidence and/or destroying condoms and safe sex materials directly contravenes efforts to halt the spread of HIV in the United States. People of color, transgender people, immigrants, homeless people and youth of color are disproportionately affected by these law enforcement activities.

- Mandatory HIV testing of people arrested on prostitution and prostitution related offenses violates the human rights of many and the imposition of higher penalties (including felonies) on people who are said to be engaging sex work while living with HIV punishes already vulnerable communities. In some states, people testing positive face significant penalties and incarceration for their engagement in sex work while positive, even if they used condoms and engaged in less risky forms of sex with their partners. Information about their HIV status (sometimes accompanied by photographs of them) is often distributed widely in the media and local communities placing them at great risk of retaliation and other abuse. Sharmus Outlaw, co-coordinator of the Desiree Alliance and advocate for both sex workers and transgender people, commented during our development of this statement that these kinds of laws reinforce deeply held prejudices. “Many in society already incorrectly fear that sex workers spread disease,” she noted, “Using these laws to arrest people living with HIV whips up fear against sex workers, transgender people and men who have sex with men.”

- Anti-prostitution laws and policies are used as a tool to arrest migrants and deport them. Migrant sex workers are therefore more likely than other groups of sex workers to avoid public services and are therefore much less able to access safe sex supplies, health services, and medications. Immigration policies prohibiting people who have engaged in sex work and drug use from entering the U.S. also mean that the International AIDS Conference to be held in Washington, D.C. in 2012 will not have a full complement of civil society participants.

- Sex workers are not a priority in the National HIV/AIDS Strategy (released in July 2010). In fact the National HIV/AIDS Strategy makes no mention of sex workers at all. The document emphasizes targeting resources to “vulnerable populations,” but this emphasis refers to gay and bisexual men, African-Americans and Latinos. The plan acknowledges issues confronted by drug users and mentions (but does not explicitly prioritize) the importance of access to safe injecting equipment; prioritizes the prevention needs of gay and bisexual men and transgender people; and highlights the importance of racial and other disparities in the United States as important drivers of the epidemic. In terms of reducing stigma and discrimination, the plan recommends that policy makers “ensure that laws and policies support our current understanding of best public health practices for preventing and treating HIV.” However, the plan makes no mention of the barriers faced by sex workers and people in the sex trade, nor is these groups listed in prevention and treatment priorities.

- Globally US policies, such as the “Anti-Prostitution Loyalty Oath” and the failed “war on drugs,” undermine

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3 See for example, the Illinois Safe Children Act adopted August 20, 2010 and legislation passed this year in Colorado which increases penalties against clients of sex workers.
I am the HIV Project Director at Lambda Legal.

Founded in New York in 1973, a few short years after Stonewall, Lambda Legal is a national organization dedicated to protecting and enhancing the civil rights of the LGBT community and people living with HIV through impact litigation, policy work and public education. As an advocacy organization whose primary initial mission was the repeal of sodomy laws—a goal that Lambda Legal achieved nationwide in 2003, when it successfully litigated *Lawrence v. Texas* to the U.S. Supreme Court—Lambda Legal has a unique perspective and expertise to offer regarding continuing attempts to criminalize the lives of gay, bisexual and transgender people through laws related to HIV and its potential transmission.

This testimony will provide a snapshot of HIV criminalization laws and prosecutions across the United States and then briefly address the relationship of these laws to predecessor laws that criminalized the sex lives of LGBT people. The attached poster, created in conjunction with the Center for HIV Law and Policy, will be used to provide a snapshot of the legal landscape as of the end of 2010.

The 26 states colored red have both an HIV-specific statute and at least one HIV-related prosecution under that statute in the previous two years. As an example of an HIV-specific statute, under Florida law: “It is a third-degree felony, punishable by up to five years in prison and/or a $5,000 fine, if an HIV-positive person (1) knows that she/he is HIV positive, (2) has been informed that HIV may be transmitted during sexual intercourse, and (3) has sexual intercourse with any other person without disclosing her/his HIV status.” It becomes a first degree felony, with a sentence of up to thirty years, if intercourse occurs on multiple occasions.

The 6 states colored in orange do not have an HIV-specific statute but nonetheless have had at least one HIV-related prosecution or sentence enhancement in the past two years. For instance, while Texas may not be able to prosecute someone under a statute that specifically references HIV as an element of the crime, Texas has used aggravated assault laws to prosecute people with HIV for engaging in behaviors that would otherwise be lawful if the person did not have HIV. And in other situations, where unlawful conduct has been involved, simply having HIV has elevated the charges to, for instance, attempted murder or aggravated assault, under the theory that a person with HIV is carrying a “deadly weapon.”

In addition, the 7 states colored in yellow have an HIV-specific law, but there have been no prosecutions in the past two years, at least none of which we are aware. However, regardless of whether such laws are being regularly enforced, simply having them on the books sends the same harmful messages regarding people with HIV, responsibility for engaging in safer sex and the consequences of becoming aware of one’s HIV status.

Finally, a word of caution about the 11 states colored gray. Because there is no uniform or comprehensive method of tracking HIV-related prosecutions, this map may have been created based upon incomplete information. If we had perfect information, any (or all) of the 11 gray states might properly be colored orange and/or the 6 yellow states colored red. The important thing to understand is that this map represents the “best case” scenario in terms of the actual number of HIV-related prosecutions in the United States over a two-year period.

The following specific examples of HIV-related prosecutions help sketch the contours of the problem and show exactly how many of these prosecutions have become:
- A Texas man is serving a 35-year sentence for spitting at a police officer while having HIV, an activity that medical experts agree is not a method of HIV transmission.

- In Oregon, a 23-year-old man was sentenced to over 7 years in prison after pleading guilty to unprotected sex without disclosure of his HIV status to a man he met on Manhunt.com.

- A man in Ohio is serving 40 years for failing to disclose to his girlfriend that he was HIV-positive, despite his contention that she knew he was positive and only went to the prosecutor after he stopped dating her and moved in with another woman.

- In April 2009, a young gay man in Iowa was sentenced to twenty-five years in prison after he failed to disclose his HIV status to a one-time sexual partner he met online, despite using a condom during sex. Though his sentence was later reduced to probation, the requirement that he complete a sex offender treatment program and register as a sex offender severely restrict his activities and prevent him from spending unsupervised time with his niece and nephew – even though his purported crime involved consensual sex with another adult.

- In Georgia, a woman was sentenced to eight years in prison, despite publication of her HIV status on the front page of the newspaper and the testimony of two individuals that her sexual partner was aware of her HIV status.

- In Michigan, a man, who allegedly had HIV, was charged under the bioterrorism law because he was involved in an altercation with his neighbor during which biting occurred, under the theory that having HIV is the same as possession of a biological weapon.

The HIV-criminalization laws are not uniform, but there are a few things that are generally true about them:

1) The requirement of intent has been lost. Many of these laws were supposedly created to provide a way to prosecute people for intentionally transmitting—or attempting to transmit—HIV. However, in practice, many of the laws simply allow the human sex drive to substitute for the intent to do harm.

2) An actual risk of transmission is also not required. Under many of the laws, activities that pose no risk or almost no risk are still prosecutable – among such activities are: spitting, biting and performing oral sex on someone who is HIV-negative.

3) While disclosure followed by consent is a defense under at least some of these laws, it is generally an affirmative defense, which means the defendant has to be able to prove that there was both disclosure and consent. In these types of intimate situations, unless a person gets his or her potential partner to sign a document before engaging in sexual relations, it is almost always going to result in a situation involving one person’s word against the other.

4) Finally, many of these laws do not make using protection, such as a condom, a defense. So the very behavior we should be encouraging for everyone — safer sex — is not even mentioned, much less encouraged, by these laws. Instead, we send the message that a person can rely on their partner to reveal his or her HIV status and that decisions about engaging in sexual contact and/or using safer sex practices can be based on whether your partner tells you he or she has HIV.

The parallels between the sodomy laws that Lambda Legal fought to eliminate and the HIV criminalization laws as they pertain to sexual exposure are quite obvious. Both are governmental attempts to regulate private and intimate personal relationships and to define acceptable—and “unacceptable”—behavior within these most complex and delicate of relationships; like the sodomy laws before them, the HIV criminalization laws (for the
most part) prohibit conduct that is consensual in nature; and, as with the sodomy laws as applied to two consenting adults, most of the HIV criminalization laws in this country contain no requirement that an actual harm occur to the complainant (i.e., transmission of HIV is not an element).

Proponents of these laws, however, claim that this is where the similarities end—and that the state has a legitimate interest in regulating these intimate personal relationships to protect the public health.

However, two features of the manner in which the HIV criminalization laws have developed—the loss of any requirement of intent to harm and the lack of proportionality in sentencing—demonstrate that something other than the mere goal of protecting public health is at work here. While perhaps some portion of these developments can be attributed to ignorance regarding HIV and the hysteria that accompanies that ignorance, these features of current law also evince lawmakers’ fundamental distaste and moral disapproval of gay sex. For this reason, the connection between the HIV criminalization laws—many of which were instituted when HIV was still considered a “gay disease”—and the sodomy laws, many of which are still on the books, is undeniable.

Though Lambda’s mission on behalf of people living with HIV is not confined to gay, bisexual and transgender people living with HIV, we will continue to draw upon our knowledge and experience advocating on behalf of these marginalized groups to inform and support the work we do on behalf of all people living with HIV.

32 Norway

### Barriers to Rights and Health: The effects of regulation, legislation and law enforcement on prostitution in Norway

#### About PION

PION - Prostitutes’ interest organisation in Norway was founded in 1990. The organization is a political voice for female, male and transgender sex workers and we are working to promote sex workers’ rights and health. In addition, we work with preventive health and educational work among sex workers and offers individual legal advice and assistance. We are also working to combat social stigma and condemnation of sex workers in society. Our work is funded by financial grants from the Health Directorate and the Ministry of Justice and Police.

#### Introduction

Over the last decade there has been a radical change in the political approach to prostitution in Norway. It used to be seen as mainly a social problem which should be met with social services and harm reduction programs, but with an increasing focus on human trafficking and the implementation of an “end demand model” – the criminalizing of the clients of sex workers in January the 1, 2009, focus has now moved to crime control. The purpose of the new regulatory regime is to combat human trafficking which has changed the law enforcement of paragraphs 202 in the penal code – the so called pimp paragraph, and the implementation of the new bill, paragraph 202a, the prohibition of purchase of sexual services.

Within this new paradigm sex workers are regarded as victim and the official policy in Norway has been based on harm reduction regarding services directed towards sex workers. Attention is now primarily on third party and the buyers of sexual services while recruitment for prostitution is individualized and reduced to a matter of cynical criminals and the men's demand for buying sex. Which also means that social and societal factors that contribute to that many people choose to sell sexual services are overlooked and underexposed.
Prostitution

The prostitution market in Norway is characterized by high degree of transnational prostitution and cross-border mobility, with many different nationalities represented (PION Annual Report 2010). According to the Norwegian government the ban of purchasing sex has reduced the demand side and resulted in a decline of the market. There is no evidence based knowledge or research supporting this statement. The total number of sex workers (female) in Norway is estimated 2,200 people (Pro Centers Annual Report 2010). This is the survey of street walkers and sex workers advertising on the Internet. There is reason to believe that the figure is higher because we know that there are also other venues for establishing contact with clients. The figure includes neither male nor transgender people who sell sex. The number of sex workers have in the past decade, been estimated to be from 2500 to 3500 in total per year, and the estimated number shows that the market has not changed significantly after the implementation of the ban of purchasing sex. From our point of view the government is not taking into consideration that the political agenda in itself is harmful for sex workers and that the new regulatory regime and the law enforcement badly affect sex workers right and health as well as harm reduction work among sex workers.

Law enforcement and harm reduction

Police are using different methods. They chase women in street prostitution claiming that they encourage criminal acts. They control and persecute sex workers as means to identify clients. They inform landlords about possible prostitution and threaten the land lords with prosecution for pimping unless the rent agreement of apartments etc. is not terminated immediately. Police raid apartments, massage institutes, studios and hotel rooms. They collaborate with the private sector such as hotel management, and exchange sensitive information about potential sex workers.

Prostitution has become more invisible leaving sex workers more isolated and stigmatized which negatively affects their risk assessment while working. The result is that sex workers are more isolated and are facing worse and more dangerous working conditions. Sex workers have been forced to work alone, visiting the client at home or at a hotel. They report to have less control over the relation to the clients and less negotiation opportunities about the price and about using condoms. They also report of having lost control over the hygienically conditions and the ability to assess the risk.

Use of protection has become a bargaining issue with clients that offer a higher price or claims that others sell sex without a condom. Sex workers who are most dependent on income from prostitution are more vulnerable to pressure from customers who don’t want to use condoms. According to health services in Norway, there has been an increase among migrant sex workers of sexually transmitted infections and pregnancy.

Law enforcement has also turned harm reduction measures such as condoms and lubricant, into evidence of crime. The result is that sex workers are more reluctant to take precautions that could be used as evidence of prostitution, such as condoms, lube, information about social services etc. Condoms are also being stored, or more correctly, hidden in ways which might be harmful and destroying, such as in the freezer.

Sex workers are also reluctant to seek out social workers and social services directed towards prostitution because they are afraid that social workers cooperate with the police, or that contact with social services can make them more visible for the police.

The criminalization of prostitution contributes to maintain the invisible of LGBT- sex workers. In recent years the commercial sex market of men who sell sex to men and transgender people has increased and the market is also characterized by high degree of transnational prostitution and cross-border mobility.

From our point of view it seems like sex workers are perceived as lawless having to accept discrimination and
the lack of rights other citizens are taking for granted. The police carry out raids in the streets and studios etc with media coverage where sex workers face are exposed to the public. Journalists dial numbers in advertisements and shows pictures from the ads where neither voices nor photos are sufficiently unrecognizable.

Legal policy and social changes

Despite the fact that sex workers are regarded as victims, the new regulatory regimes fail to addresses the impact of the policy on sex workers rights, health and safety. In our opinion, there is also reason to look critically at what we experiences as an increased focus on exit measures where the goal is to leave prostitution and a tendency where the purpose of harm reduction measures seems to be regarded as a preparation for the exit. It is also important to note that the change in services provided has not come as a result of developments in the prostitution market or the needs among sex workers it is rather a result of contemporary overall policy.

The need to address health and rights

Above, we have described our experiences of how the new regulatory regimes and the law enforcement create barriers for sex workers in Norway to enjoy their rights as well as barriers to do harm reduction work and HIV prevention among sex workers in Norway. We think that there is a strong need to raise the health and rights perspective in the political approach to sex work. We also think there is a strong need to look at how regulation/criminalization of prostitution as anti-trafficking measure overlook and underexpose other issues such as social and health problems among sex workers. There is also a need to critically assess how anti-trafficking measures creates problem for a well-targeted preventive HIV/ Aids work among sex workers. And last but not least is the need for external control of police methods and enforcement to ensure that sex workers' fully can enjoy their rights in Norway.

Switzerland: strategies for decriminalization of HIV exposure/transmission

Context and issues

For HIV-positive people in Switzerland, one sexual intercourse without a condom, even with the consent of the partner, is enough to constitute a criminal offense which can lead to imprisonment. New data on the preventive effect of HAART, published by the Swiss Commission for HIV/AIDS in 2008, has had a great impact on the criminalization of HIV exposure and has resulted, in 2009, in the first acquittal of an HIV-positive person in Geneva.

After having been sentenced to 18 months of imprisonment for exposing two women to HIV (sexual intercourse without condom after which no transmission occurred), an HIV-positive man appealed to the Geneva Court of Justice. In the appeal process, the defendant’s lawyer presented the conclusions of the Swiss Commission for HIV/AIDS stating that an HIV-positive person under effective HAART can, under specific conditions, become non-infectious and have sexual intercourse without condom without endangering his or her partner. It was actually confirmed that the convicted had undetectable viral load when the events took place and was therefore not able to transmit the virus. In view of this new paradigm, the deputy coroner (public accusation) requested acquittal of the defendant, who was then immediately released from jail.

This acquittal in Switzerland on the basis of the undetectable viral load of the accused was a first at the international level. Since then, the "Swiss statement" on the preventive effect of ART has been widely
acknowledged by world experts. But HIV-positive people are still criminalized for exposure to HIV worldwide.

Undeniably, the preventive effect of effective HAART should impact HIV-specific legislations, in particular those who criminalize HIV exposure in countries where state-of-the-art antiretroviral therapies are available. Recommendation is to advise justice courts and legislative stakeholders in that matter, as relevant information has a great potential impact on prosecutions.

**Strategies and outcomes**

Since the 2009 acquittal our advocacy activities for decriminalization of HIV exposure have focused on three strategic areas:

1- Magistrates
2- Legislators
3- Media

Below are illustrations of some recent experience and effective outcomes of this combined strategy we would like to share with the Global Commission on HIV and the law.

**1- Magistrates**

In June 2011, a HIV-positive man was arrested and put in custody in Geneva after his former partner, a recently-diagnosed HIV-positive woman, had pressed charges against him for HIV transmission. He was to remain in remand for a month, and the prosecutor asked that this custody be prolonged because of three alleged risks she defined as the risk of getaway (fuite), the risk of subsequent offense (récidive) and the risk of collusion. The lawyer defending the accused argued against those risks and against the prolonged detention. The accused is now under HAART with an undetectable viral load but it has not been determined since when and if he actually has transmitted HIV to his partner or not. The partner has acknowledged sexual intercourses with other men without the use of condoms.

Groupe sida Genève contacted the prosecutor who had acquitted and released the HIV-positive man in 2009 on the basis of the "Swiss statement". He agreed to speak with his colleague prosecutor, in charge of this new case, and sensitize her to the principle of non-transmission of HIV under effective HAART. After this conversation, the remand custody of the accused was lifted and the accused was released and is now in wait for the investigation results.

**2- Legislators**

In 2011 began the process for revision of the Swiss national Law on epidemics. A modification of art. 86 of this law would have an impact on art. 231 of the Swiss Penal code which criminalizes HIV transmission and exposure. Therefore, a project was submitted and approved by all experts which recommended to criminalize only intentional and malevolent transmission. However, a counter-project was submitted to parliamentaries by the Swiss Department of Justice.

Driven by the Swiss Commission for HIV/AIDS and Groupe sida Genève, a special task force was subsequently created to oppose the counter-project. A hearing with the chamber’s Social Security and Public Health Commission was requested by the Swiss Commission for HIV/AIDS and took place on June 23\textsuperscript{rd}. Subsequently, the Social Security and Public Health Commission agreed to begin consideration of the bill article by article during the autumn session of the federal chambers beginning in September. Given this new opportunity, returning the rider to its original formulation will be the focus of our lobbying efforts from September onwards.
We believe sensitizing public opinion through the media is a cornerstone for decriminalization. Groupe sida Genève has therefore extensively raised the decriminalization issue in the media over the years, stressing the impact of the "Swiss statement" and restating that criminalization of HIV transmission is also advocated against by UNAIDS, WHO and Swiss public health experts. Since 2009, this has given excellent results with no less than 90 media coverages.

Stella is a health and social service organization run by- and for- female and transgender sex workers in Montreal, Canada that has existed since 1995. We run a drop-in center, a help line, a legal clinic, a medical clinic and a human rights documenting project. Our outreach team of 6 provides direct services- often with a street nurse from Doctors of the World- on the street, in drug venues (i.e. “crackhouses” and “shooting galleries”), provincial and federal prison, in strip clubs, erotic massage parlours and escort agencies. We average between 4000 and 6000 contacts with sex workers every year. Generally, around 1000 of these contacts every year are with sex workers we are meeting for the first time. We have received the Québec government’s prize for excellence in health and social services and the prestigious “Aids Action Award” from Human Rights Watch and the Canadian HIV/AIDS Legal Network.

Stella’s human rights documenting project “Stella Deboutte” is currently documenting sex workers’ experience of sex work laws and policing through a community-based research project.

In the Canadian context, sex workers are a very diverse group and to date there is no reliable and generalizable data on HIV-prevalence for sex workers as a whole based on a representative sample. In Vancouver, sex workers who inject drugs working in the Downtown East Side were estimated to have an HIV-prevalence of 26%. In Montreal, data dating from 1989 and 1992 among female prisoners sex workers who did not inject drugs had an HIV-prevalence of 5.2% (1989) and 0% (1992). Sex workers who injected drugs had a prevalence of 12% (1989) and 16% (1992). Though the latter were slightly higher than women who injected drugs over all, a multivariate analysis determined that sex work was not a significant HIV-risk factor among women who inject drugs.

Female-to-male transsexual and transgender sex workers face significant risk for HIV-infection in Québec. In 1996, of a sample of 43 young transgender sex workers in precarious situations in Toronto 81.4 % were HIV-positive. In 1995, of transgender sex workers who frequented a Montreal needle exchange that provided free condoms over a quarter were HIV-positive.

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Much of the available prevalence information for sex workers in Québec is out-dated. It is worth mentioning that certain risk factors have changed since the 1990s. In the 2000s, Stella witnessed deterioration in working conditions. As the “GFE” or “Girl Friend –Experience” became mainstreamed as a service, most clients and escort agencies came to require that workers perform oral sex without condoms, a trend that has in some instances spread to the street. Since the mid-1990s, Montréal has also been the site of a porn boom. Most porn productions do not require condom use for penetrative sex, porn actors also frequently film in other countries. There has also been a large upswing in crack consumption in the past 10 years, primarily on the street but on occasion among escorts. It is also worth noting that although crack-cocaine use has greatly increased among drug-users in Montreal, most cocaine users still inject either cocaine or prescription opiates.

It is not known at the current time if any of the above-mentioned risk factors have affected HIV-incidence among sex workers.

However, it is clear that sex workers continue to face HIV-risks. It is also clear that among that sex workers using drugs continue to be among those facing the highest risks of HIV transmission. Their intersecting risks include unsafe sex with a male partner (many of whom are IDUs or former prisoners); shared injection with male partners; sexual violence within crack houses/piaules; sexual violence from aggressors targeting women on the street; unsafe sex with clients due to the financial pressure of dope debts (and their attendant violence) or withdrawal symptoms; shared injection due to a lack of clean needles in prison.

Male sex workers also face very important risks of HIV, particularly if serving a male clientele. They also face very high levels of violence and discrimination. However, given Stella’s mandate and representation, addressing the specific issues faced by male sex workers goes beyond the scope of this submission. Nonetheless, it is important to note that many of the issues that will be addressed, and in particular, how laws fuel and foster violence and discrimination, also apply to male sex workers.

**Criminalization of Sex Work**

Because the exchange of sex for money is in itself legal in Canada, many erroneously consider sex work to be legal or not criminalized. The reality is that sex work remains criminalized, though indirectly, through provisions of our criminal code (s. 210 to 213) against being found in a bawdy-house, running a bawdy-house, living on the avails of prostitution and communication for the purposes of prostitution.

The laws effectively criminalize sex workers on the street, sex workers working indoors from the same location more than once and sex workers moving from venue to venue who communicate their services over the phone or in public. The most common application of the law is against sex workers on the street, but women working in massage parlours or in-door venues are also occasionally criminalized.

The laws effectively criminalize brothel-owners or agency-owners. They also criminalize sex workers working together where one (or more) sex workers have their names on the lease or bills.

The laws effectively criminalize clients on the streets, in indoor venues that are used more than once for sex work and potentially for clients of escorts who communicate their desired services. In application, clients on the street are the most commonly criminalized.

These laws are currently being challenged by sex workers in Ontario (Bedford v. Crown) and in British Columbia.

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8 Idem. For information on the crack epidemic in terms of drug users overall see Élyse Roy et. al. (2011) cited below.
10 See for instance the mischaracterization of sex work as not criminalized in Canada in the 2010 UNFPA/UNAIDS review of punitive legislation poster.
by Sex Workers of the Downtown Eastside United Against Violence (SWUAV v. Crown) due to their infringement on sex workers’ constitutional rights to liberty and security of the person. A judgment at the Superior Court Level in Ontario found, based on 83,000 pages of national and international evidence, that the laws criminalizing brothels and communicating for the purposes of sex work forced sex workers to choose between their liberty and security and increased sex workers’ risk of violence. The conservative government has since appealed the judgment.

Sex work is also criminalized indirectly through “social profiling” such as discriminatorily targeting sex workers for tickets using archaic municipal by-laws (i.e. loitering, taking up more than one space on a public bench, spitting on the sidewalk) or the highway safety code (i.e. soliciting on public roads). Such targeting is highly gendered (primarily women sex workers including trans women) and racialized (often primarily Black and Indigenous women). Sex workers on the street who use drugs are disproportionately targeted for drug possession infractions. For example, a police chief explained that 2010 raids that led to the arrest of 45 people, including a number of sex workers who are participants in Stella, on drug-related charges in the Hochelaga-Maisonneuve area were undertaken in part due to residents’ complaints of prostitution.11 Ironically, these same raids were later justified by the same police chief as going after drug-traffickers who preyed on prostitutes.12

Finally, police use pre-trial and release conditions known as “quadrilatères” that prohibit sex workers from simply being present in large cores of downtown, residential areas or the whole island of Montreal then routinely detain sex workers for “breach of conditions” in line with political orders to “clean” up given areas for tourism or for political optics.13

The Links Between Criminalization, Violence and Other Human Rights Abuses

1. Criminalization of sex workers

The criminalization of sex workers places sex workers at higher risk of violence and HIV transmission.

Police repression on the street and around drug venues displaces sex workers into more hidden and isolated areas where they are in more danger if they are attacked and where they have less access to essential health, social and harm-reduction services. As was found in a Vancouver study14, Stella’s experience is that displacement due to police repression is highly correlated with increased violence.

By prohibiting sex workers from entering entire zones of the city, pre-trial and release conditions known as “quadrilatères” prevent sex workers from accessing their homes, harm-reduction services, methadone treatment, medical and social services, social network or safer sex working zones (due for example to a group of sex workers who watch out for each other). Sex workers who break these conditions face immediate detention and further conditions.

Incarcerations places sex worker at extremely high risk for HIV or Hepatitis C transmission. Drug use, including injection drug use continues in prison but without benefit of access to sterile injecting equipment and within a community with exceedingly high rates of HIV and HCV.15 Incarceration often leads to homelessness and family separation. Loss of safe and secure shelter puts women at higher risk of violence.

The criminalization of sex workers places sex workers wishing to report a violent attack in the position of risking

12 http://montreal.ctv.ca/servlet/an/local/CTVNews/20100430/mtl_eraser_100430/CTV%20Movie:%20ELIJAH “(Some prostitutes) are sick people. They need support. They’re not criminals, but they have these guys supplying them with (drugs). So hopefully this is going to help,” said (Commandant) Cayer. 04/30/2010
13 See for example STELLA “Actions répressives envers les travailleuses du sexe et sans-abris durant les Outgames”, La Presse, June 6, 2006
15 See "Sous la Peau/Under the Skin" by Canadian HIV/AIDS Legal Network.
arrest either for sex work-related charges, because they are in breach of conditions barring them from parts of the city or have outstanding warrants for sex work or drug-related crimes. They also risk being arrested in the future if they are known to police as sex workers. Indeed, we have the copy of one charge given to a sex worker where the police indicated that it was given because the woman was a “known prostitute.” The laws mean that sex workers must choose between their safety and their freedom and right to earn an income. The result is a climate of impunity for violence against sex workers, and a situation in which a number of serial predators have specifically targeted sex workers in Montreal in the past 5 years.

To evade “bawdy house charges” from indoor venues and “communicating charges” from working on the street, many sex workers work as “escorts” meeting clients where they wish. The result is that they go to unknown venues with few safety protections.

2. Criminalization of Clients

The criminalization of sex workers places sex workers at higher risk of violence and HIV transmission.

Police repression against clients happens almost entirely on the street. Sex worker are no longer able to earn money on the main thoroughfares where police crack down on clients. As a result, in the same as with criminalization of sex worker, women are displaced to more isolated and dangerous areas placing them at higher risk of violence and out of reach of essential health, social and harm-reduction services.

In 2001, the police undertook a large highly publicized 2-month series of raids of clients of street prostitution. Street-based sex workers reported to Stella that as a result, most clients were displaced to off-street sex work venues. However, those who due, to drug use or precarious life circumstances were unable to, were left with a smaller pool of clients. Many spoke of taking clients they would otherwise refuse because they were drunk or aggressive in order to attempt to maintain their revenue. These sex workers were often displaced off of main thoroughfares to residential side streets or industrial areas where clients were less likely to be arrested- and where sex workers were at much higher risk of violence, either from residents angry about prostitution near their homes or aggressors targeting sex workers. During that 2-month period, sex workers reported 3 times the average number of violent incidents to Stella and 5 times the number of violent incidents with a deadly weapon. The peak in violence as well as the displacement of sex workers and their being cut off from health services was publicly denounced at the time in a press conference by Stella, the Montreal Public Health Agency and the Federation of Quebec Women (La Fédération des femmes du Québec).

In 2010, even police conceded that anti-client raids hadn’t ended sex work in Montreal’s east end but led to women standing on the street for much longer waiting for clients. This in turn aggravated residents distressed by visible prostitution who had triggered the client raids in the first place.\(^\text{16}\)

Despite, appeals to arresting clients in the name of women’s equality advanced by fundamentalist-feminist and other anti-sex worker groups, such measures have at worst fueled violence against sex workers and at best, made it harder to stop it.

The criminalization of clients places sex workers wishing to report an attack from an aggressor in the position of risking that if she is identified to police as a sex worker or her home or workplace are identified as sex work venues, in the future, police may choose to target her clients. This places sex workers in the position of choosing between their safety and their ability to earn an income.

Furthermore, when sex workers are experience the most extreme forms of coercion and are confined by an

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\(^{16}\) Rénaud, Daniel. "La police ouverte au centre de répit pour prostituées." Rue Frontenac. 8 Novembre 2010: «Les prostituées, qui restaient auparavant seulement trois ou quatre minutes sur le trottoir, se sont mises à errer durant 50 minutes avant de quitter avec un client. Les résidants les voyaient plus longtemps, et on a reçu encore plus de plaintes», décrit le commandant du PDQ 23, François Cayer.
abuser, clients are often the only people they are able to have contact with to ask for help. Criminalizing clients places clients in the position of self-incriminating if they report such abuses to the police. In so doing, one of the last points of exit, for women in the most abusive circumstances, is cut off.

3. Criminalization of Third Parties (Brothel-owners, Managers, security Personnel, Other Staff)

The criminalization of third-parties and brothel-owners places sex workers at higher risk of violence and HIV transmission.

A number of women prefer to work for an employer in an establishment with security personnel or systems, other women and a client base such as a “massage parlour”, a strip club offering “extras” (“clubs à gaffe”), or a brothel. Owners of such establishments try to evade bawdy house charges by masking their activities and prohibiting having condoms on the premises for fear they can be used as “evidence” of prostitution. As a result, sex workers often engage in unprotected high-risk sexual activity. Sex workers who choose such venues for their safety protections are thus forced by the laws, to compromise their health.

Sex workers who would like to protect both their health and safety by working indoors alone or together with a security system and HIV-prevention materials are also stymied by the laws. Firstly, the criminalization of “living off the avails” and of “bawdy-houses” makes it extremely difficult for sex workers who are openly engaging in sex work to hire their own security personnel, given the heavy criminal charges the latter face. When sex workers work together, in order to better protect themselves, as mentioned above, the sex worker(s) with her (their) name on the lease often face brothel-running charges.

Landlords who know of sex work taking place in their properties may be liable for bawdy-house charges. Furthermore, if criminal activity is occurring in one of their rental properties (such as someone “being found in a bawdy house”), landlords have grounds to terminate a lease immediately. As a result of the criminalization of brothels, sex workers working from home face precarious housing situations. A record of eviction can further impede finding new housing. A lack of secure and stable housing is a major factor in increasing women’s risk of violence and impeding efforts to move away from violent situations or relationships.

Bawdyhouse laws, drug laws and tenancy laws mean that many women are evicted or live in fear of losing their social housing due to their sex work and/or drug use. (Women who do sex work/use drugs are also flat out refused by many shelters or turned away if they cannot make curfews that are impossible given their living/working conditions. The criminalization of sex work and drug use is often the pretext for such exclusions.). And yet it sex workers who use drugs who are at the highest risk of violence and HIV and would most benefit from safe shelter. Sex workers who use drugs who lose their homes generally pay a small fee (7$ or so a night) to sleep in a crack house/shooting gallery/piaule. Women are often physically assaulted, sexually assaulted and robbed when they are sleeping in the crack houses/shooting galleries/piaules. If they have not fully reimbursed drug debts, their chances of facing violence in the crack houses/piaules are extremely high. If they do not have a home and seek to evade potential violence at the crack houses/shooting galleries/piaules their remaining options are to sleep in the streets or public parks where they again, are often physically assaulted, sexually assaulted or robbed or to sleep with a client, which presents again, its own safety risks.

The laws against bawdy-houses preclude opening a non-profit center where women working in the most dangerous conditions (the street, the crack houses/shooting galleries/piaules) could bring their clients and provide services in a safe place with functioning security and social workers and nurses on-site available if women need assistance or support. Such locales exist in New Zealand. An Aboriginal street sex worker in British Columbia named Jamie Lee Hamilton opened one such venue at the height of the Pickton murders. named

17 Pickton is a serial murderer found guilty of murdering 6 street-based sex workers from Vancouver but who confessed to an undercover police officer to having murdered 49 sex workers most of whom were Aboriginal and most of whom were drug-users. One sex worker survived one his attempts to kill her early on and reported it to the police. Prosecutors declined to press charges.
“Granny’s House” that first operated out of a church basement. It was shut down and she was charged with “bawdy house charges”.

Bawdy-house laws also preclude developing adequate short-term and long-term housing options for women who do sex work and use drugs. Projects based on the “housing first” model have shown that safe shelter is crucial to support people to stabilize their lives, access treatment and work towards safer and healthier living conditions. Such models are not possible under our laws, unless authorities specifically choose to disregard them.

Positive Policy

- **Housing First: Not Applying Harmful Law**

  In one Canadian city, some social housing authorities have refused to evict women for their sex work and/or drug use. They have notified police who actually support them in doing so given the safety risks the women would otherwise face and have as of yet, not charged them or the women with bawdy house charges. However, due to the presence of a strong local anti-sex worker fundamentalist-feminist group they cannot publicly share that they have adopted this policy- or its results- for fear of being shut down.

- **Fighting Violence First: Not Applying Harmful Law**

  At Stella, we document an average of 60 violent attacks on sex workers in Montreal every year. In the past 10 years, 15 sex workers that we know of have been killed in our province, 12 of these in Quebec. We are constant witnesses to the human toll of the climate of impunity for violence against us.

  Due in part to Stella’s many years of sensitizing police officers, the organization has been able to find certain contacts within the major crimes and sexual assault units in Montréal that take sex workers’ reports of violence respectfully. In the course of doing so, they do not arrest sex workers for sex work, broken quadrilatères, or outstanding warrants for sex work/drug use or minor crimes; do not arrest sex workers’ clients (unless they are the perpetrators of violence); do not arrest sex workers’ bosses, managers, support staff or sex worker colleagues (unless they are the perpetrators of violence).

  For sex workers, the knowledge that they, their clients or their place of employment will not be criminalized if they come forward, has created a sea change in women willing to report violence. In the past 3 years, we have accompanied sex workers in reporting violence in the cases of 4 alleged and convicted serial aggressors of sex workers to police. The latter faced or are facing charges ranging from murder, attempted murder, confinement, sexual assault and death threats.

  This model has given us what we call an “avant-goût” of decriminalization, a small taste of what it could mean if the sex work laws were repealed and the climate of impunity for violence against us no longer existed.

  However, focusing on criminalizing violence in lieu of criminalizing sex work is not official policy. We cannot guarantee in any way that a woman, who goes directly to police, will receive the same reception. We cannot guarantee that higher-ups within the police force or politicians won’t over-ride it. The latter alone is reason enough for many sex workers to still avoid reporting violence out of fear. Added to that, when their only and habitual interface with police is with patrollers who arrest, harass, intimidate or assault them- often unlawfully- due to the criminalization of sex work and drug use, women have little reason to trust that it is worth reporting

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18 We actually supported sex workers attacked by a total of 7 alleged and convicted serial aggressors targeting sex workers during this same period. Chevalier plead guilty in 2011 to sequestering, raping, assaulting and threatening to kill 5 women, 4 of whom were sex workers. Larouche was found guilty of a separate murder in 2011 and still faces charges for the attempted murder of a sex worker. Papillon, D’Amico, Rijba and Chemama are currently facing trial for serial attacks on sex workers. Although no women were interested in coming forward, Stella offered support to sex workers who had been attacked by Harmelin. The latter pled guilty to the murder of a sex worker in 2010.
violence to police.

Recommendations

- **Governments must decriminalize sex work under a process of sex worker-led law reform.**

This means the decriminalization not only of sex workers, but just as crucially, of their clients and of third-parties, such as brothel-owners, managers, security personnel or attendant staff. In light of evidence that even partial criminalization of sex work impacts negatively on sex workers’ health and rights, there is no other rights-based option.

- **Governments must increase their financial support of sex worker-led organizations working for sex workers’ health and rights.**

Organizations like Stella are able to accomplish the work we do to the extent that we are funded to do so and to the extent that we are led by the community we serve. This applies also, and in particular, to organizations by and for male and transgender sex workers. Governments must specifically found short and long-term housing options for sex workers and/or drug users. They must also financially support the creation of safe non-profit spaces for women to bring their clients and be able to access health and social services.

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Dear Secretariat of the Global Commission on HIV and the Law,

This submission, on behalf of the National Women and AIDS Collective (NWAC), is in response to the Global Commission on HIV and the Law’s call to address, “... some of the most challenging legal and human rights issues in the context of HIV, including criminalization of HIV transmission, behaviors and practices such as drug use, sex work, homosexuality, and issues of prisoners, migrants, children’s rights, discrimination and violence against women, and access to treatment.” This submission also provides a framework for, “develop[ing] actionable, evidence-informed and human rights-based recommendations for effective HIV responses that protect and promote the human rights of people living with and most vulnerable to HIV, [particularly women living with HIV/AIDS.]”

The National Women and AIDS Collective (NWAC) is a national network of women-led organizations and programs working on behalf of women living with and affected by HIV/AIDS. NWAC’s mission is to create support and advocate for policies and programs to improve the lives of women living with and affected by HIV/AIDS in the US. Thus, it fits within the category of, “[an] academic or advocate who contributes to the evidence-base on legal and human rights issues in the context of HIV through research and advocacy work.”

NWAC utilizes its policy position papers as advocacy tools to address gender specific social and health disparities in HIV/AIDS in the United States. NWAC believes that greater improvements in population health outcomes can be achieved by addressing both social determinants (of health) and individual-level risk factors. For the purposes of this submission, NWAC will be addressing poverty and how this important social determinant leads to increase susceptibility to HIV infection among, especially women of color.

HIV/AIDS represents a severely disruptive life event. Once diagnosed with HIV, health and social implications come to bear, from troublesome symptoms to severe illness, from precipitous drops in employment and socioeconomic status to stigmatizing social encounters. For women of color diagnosed with HIV/AIDS the disruption is fierce. The physical, social and economic conditions that women of color experience often pre-determines: 1) their vulnerability for HIV infection, 2) the success of HIV prevention and care programs in
addressing their vulnerability and needs, and 3) their ability to care for themselves and successfully live with this disease.

HIV was the third leading cause of death for all women ages 35-44, and the first leading cause of death for African American women ages 25-34. Although HIV may be the primary reason for death in these women, the social determinants these women face also allows HIV to flourish and rob them of their health, productivity and lives. Thus, one of the most important social determinants for women vulnerable to and living with HIV/AIDS is poverty.

Women, as a population group in the US, suffer from economic disparities. In the U.S., women are more likely than men to live in poverty, earn less money for the same work, are more likely to be victims of intimate partner violence and rape, and have less of a political voice. In 2009, women still do not receive equal pay for equal work, let alone equal pay for work of equal value. For full-time, year-round workers, women are paid on average only 78 cents for every $1.00 earned by men. For women of color, the gap in equal pay is significantly wider. In comparison to men’s dollar, African American women earn only 69 cents and Latinas just 59 cents.

The gap widens for women living with chronic diseases and disabling conditions, such as those resulting from HIV infection. Women with chronic diseases and disabling conditions are one of the poorest population groups, next to children, in our society. It is worth repeating that, the most inescapable reality for women with chronic diseases and disabling conditions, such as HIV/AIDS, is poverty. In 2008, in the United States, a quarter of people diagnosed with HIV were female, and three quarters of these women were infected as a result of heterosexual sex. Nearly two-thirds of women living with HIV/AIDS had annual incomes of $10,000.

It is within this framework that this submission seeks to address the economic conditions of women of color living with HIV/AIDS. Reducing HIV health disparity among women requires focusing on their economic and social position in society. There is an urgent need to challenge national laws and policies that perpetuate economic inequality and advocate for policies which will ensure that women of color living with HIV/AIDS, who want to return to work or school are not discriminated against and are treated in a fair and equitable manner.

**For all women vulnerable to and living with HIV/AIDS**

NWAC seeks and advocates for laws and policies which will lead to the creation of a comprehensive, gender-specific service continuum which incorporates the following the following services: 1) job training, 2) food banks, 3) housing assistance, 4) mental health services, 5) substance abuse treatment, 6) psycho-socio counseling and support services, 7) couples and family counseling and 8) family services, in order to reduce gender related HIV disparities.

**For women living with HIV/AIDS**

NWAC seeks and advocates for economic protective laws and policies which will enable women living with HIV/AIDS to access: 1) vocational rehabilitation services including education and job training programs; 2) employment creation such as entrepreneurship development initiatives and microenterprise programs; 3) return-to-work programs that protect health care entitlements, such as Medicaid, Medicare and disability benefits; and, 4) worker protection, including fair wages, and fair hiring and promotion practices. Such laws and policies will lead to greater self-sufficiency for women of color living with HIV/AIDS and eventually better overall health and social position. In addition, NWAC advocates for equity in HIV funding so that women led organizations and programs can continue to recruit and hire HIV-positive clients from the community in order to promote the economic advancement of these women and to deliver the most culturally and linguistically appropriate services to women of color living with and vulnerable to HIV.

NWAC believes that the incidence of HIV infection among women, especially women of color can be reduced by
confronting poverty and the employment related laws and policies that enable poverty to thrive in the US.

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### Legal Advisory Service from Human Rights Observatory of REDVIH

#### LEGAL ADVICE REPORT 2010: Legal advisory services from Human Rights Observatory of REDVIH

**Introduction**

The reality of people with HIV in Spain, although existing formal legal protection, sometime it shows marked by violation of basic/civil rights, which can range from loss of livelihood (work and therefore income) to gaps in health coverage or inability to ask for a home mortgage, among many others, personal or social, losses.

This violation of rights, sometimes appears accompanied by ignorance, from whom is involved or even from members of ngo’s, due to their ignorance about legal mechanisms available, recognizing the rights they have. To address this situation, in 2003 the Observatory for Human Rights and HIV/aids Community Network in Spain, was created. This Observatory is a statewide program that offers a holistic approach (legal, educational and informative), about such Human Rights issues. In turn, in a transparent and public manner, the Observatory publish on a year based report, cases on discrimination and violation of rights in Spain, based on data collected by its free legal advice public service. This report does not reflect all the work of the Observatory, because only addressed specific cases of discrimination (each one documented) with the intention of becoming an useful tool for all people here involve, working in the defense of Human Rights.

**Results**

From January 1 to December 31, 2010, the Service of Legal and Human Rights Watch HIV REDVIH received 168 enquiries, which represents an 18% increase over 2009. This report finds that it is still a reality that HIV people experience discrimination worldwide and Spain is not an exception. The basic rights of many people are violated in areas such as work, health or personal relationships.

All consultations reflected on this report, are specific about rights of HIV people. Other kind of consultations are not accounted in this report, because they are answered by technical team or transferred from REDVIH to other entities.

The main area of consultation remains employment (26%) which is held in absolute numbers, but lows in percentage due to the greater diversity of consultation’s reasons. Closely followed by healthcare (23%), Public Administration (10%), access to insurances (9%), welfare (7%) and family and life (7%). These are the main consulted areas.

Similarly, there remain a disturbingly significant number of queries labeled as “Criminalization” (8%), mainly referred to doubts about possibility to report a HIV transmission case. To approach this increasing aspect, the Observatory conducted last December 2010, the event “Ethics and Responsibility in HIV Transmission: Implications from a Legal and Public Health vision”. Where we reached a consensus among the ngo’s participants (over 30), in order to bring a common respond about such issue.

Demographically, 64% of queries are posed by men and 36% women, mean age 39 y.o. About 10% of consultations came from people living in Spain from abroad, with a clear predominance of Latin American countries (Colombia, Peru, Uruguay, Mexico, Argentina, Chile, Venezuela) and Europe (Ireland, Portugal, Germany, Netherlands).
As far as national geographical distribution is concerned, through 2010, we have been contacted by people from all over the Spanish country, with the exceptions of: Cantabria and Extremadura states, as well as the associated state of Melilla city. Highlighting a greater number of consultations from most populated states. Most people know the Observatory Free Legal Service through other ngo (51%), while internet (37%) has a high weight. The campaigns, the media, prior knowledge of service and mouth to mouth, added a respectable 20% of the total impact.

Another important aspect to facilitate full access to our service is to determine is who makes the decision to communicate with the Observatory, decided to report a case of discrimination or violation of rights. The vast majority of times is the person affected (67%) who contact us. But in many cases, professionals from others ngo’s (17%), friends or relatives (10%) or medical or social services (included in other 4%).

Conclusions

For an overview of the report, the data collected can be summarized as follows:

- Discrimination in work place (26%) is the main reason for consultation as in previous reports. Although health care (23%) not far away. Followed by discrimination in the Public Administration (10%) and insurance (9%).

- Most of consultations came directly from the affected user (69%), although professionals from others NGO’s (17%) or family and relatives (10%). More than a half came to the Observatory through another ngo (51%), while 27% found it by internet or heard about us through our media campaigns (8%).

- The Observatory has received cases from 15 Spanish states and one associate state. The majority of queries came from most populated areas (Catalunya, Madrid, Andalucia, Canary Islands and Valencia). The average age of users attended was 39 y.o., representing 36% female and 64% male and 10% of migrant population.

These data, together with our other daily work and effort, lead us to highlight some aspects such as:

- **Employment**: Stills as the main area of discrimination against people with HIV. To combat it is essential that the Central Spanish Government boost Recommendation 200 agreed by the International Labour Organization.

- **Access to insurance**: Actually, Spanish insurances companies are denying the possibility of contracting a life insurance to people living with HIV/aids, because this disease appears in exclusions tables prior to hiring. We believe that this denial is discriminatory. We propose that insurances companies eliminate such exclusions based on scientific evidence, finally covering also people with HIV, taking into account the circumstances of each, as they do, for example, with smokers, not basing the granting or denial of access to policy based on prejudice.

- **HIV cataloging**: Cataloging of HIV/aids as an infectious disease generates unjustified exclusions of certain goods and services (social services, elderly nursing homes, swimming pools...) which are also clear discrimination cases. We propose that the Ministry of Health, through it HIV Secretariat review such cataloging.

- **Criminalization**: The number of inquiries received and the impact of this issue in the media voices, denote an increase in national and global advocate for the criminalization on HIV transmission. That is, to attribute criminal character from either the judiciary or administrative. Therefore, the Observatory held a meeting with experts last December 2010, where emerged a Concensus Document signed by more than 50 Spanish...
Introduction

In the United Kingdom criminal prosecutions for reckless HIV transmission have taken place since 2001 in Scotland and since 2003 in England and Wales. In 2010 there was also the first conviction in Scotland for reckless exposure in the absence of transmission (three counts – the accused was also convicted of one count of transmission to another sexual partner). Exposure charges are not possible under the law in England and Wales. For details of all cases to date and more information on prosecutions in the UK and the HIV sector’s response go to the webpages at www.nat.org.uk on criminal prosecutions and police investigations.¹

NAT and other HIV organisations in the UK, in particular Terrence Higgins Trust (THT), have not attempted to secure new legislation to end prosecutions – it was felt the risk of getting instead even worse law was currently too great. Instead we have pursued a policy of ‘harm reduction’ at the heart of which is success in securing prosecution guidance for England and Wales (from the Crown Prosecution Service²) and police investigation guidance (drafted by NAT and the Association of Chief Police Officers). Both sets of Guidance have been used on numerous occasions to intervene to halt unfounded investigations and prevent pointless and harmful prosecutions.

The Guidance has also provided clarity to people with HIV as to the circumstances where criminal sanction was possible in relation to their sexual behaviour - this was an important human right in relation to the rule of law. The previous uncertainty as to what was prosecutable and what not caused great worry for many people with HIV and resulted in vexatious complaints and investigations, compromising on occasion individual confidentiality and resulting for those investigated in months if not years of distress on police bail before the case was dropped.

Prosecutions in particular have improved immensely as a result – and are compliant with the UNAIDS recommendations as to how to proceed should reckless transmission prosecutions continue. Police investigations are more difficult to align with the new Investigation Guidance because of the very disparate organisation of policing, with numerous often small but separate police forces across the country. But progress is being made and the Investigation Guidance is being disseminated and promoted.

We list below some of the harms identified from prosecutions and after each how NAT and others in the UK HIV sector have attempted to respond, with further reflections.

Miscarriages of justice arising from insufficient evidence of responsibility for transmission

In the early convictions in the UK phylogenetic analysis was misused in effect to claim that a virus match proved the responsibility of the accused for the infection of the complainant. On the basis of such misunderstanding people were persuaded to plead guilty and individuals convicted and imprisoned even though other sexual partners could conceivably have been responsible for the complainant’s infection. In other instances people have been convicted without any phylogenetic analysis taking place to demonstrate that transmission between complainant and accused is conceivable (phylogenetic analysis is most useful in excluding the possibility of transmission).

² For the CPS Guidance see http://www.cps.gov.uk/legal/h_to_k/intentional_or_reckless_sexual_transmission_of_infection_guidance
NAT has undertaken policy work to demonstrate the evidential value and limitations of both phylogenetic analysis and RITA testing in attempting to prove responsibility for reckless HIV transmission. The CPS Guidance includes advice on how carefully to interpret scientific evidence. This has resulted in a decline in the number of new prosecutions in the UK and increase in acquittals.

It is very hard to prove responsibility for HIV transmission where the complainant has over time had a number of sexual partners. Scientific evidence needs to be carefully handled and international standards agreed for this purpose. Scientific analysis should not be accepted in courts where this has not been undertaken under forensic conditions.

Miscarriages of justice arising from insufficient evidence of endangerment during ‘exposure’ to HIV
In the one conviction for exposure in the UK the number of acts of sex with the relevant partners was very low and it appears the accused was on treatment. NAT along with THT and other HIV sector organisations is currently challenging prosecutions for exposure in Scotland. It is hoped in the near future that prosecution advice will also be agreed with the Crown Office (the Scottish prosecution authority).

It is in fact also difficult to prove actual risk of transmission (‘endangerment’) in the absence of transmission actually occurring. The exposure charge was in reality a prosecution for having unprotected sex – NAT does not consider it to be ethically justified or an effective response to the epidemic to criminalise unsafe sex of HIV positive people when most HIV transmissions are from those undiagnosed and when ‘recklessness’ in the knowledge of safer sex advice is common amongst sexually active adults.

Miscarriages of justice arising from poor legal representation
In a number of instances individuals have accessed poor quality legal aid (they are often of limited means and do not have access to high quality legal support) – their cases which would have been dismissed had they been well represented, have instead resulted in convictions. Attempts to change guilty pleas midway through court proceedings (once the accused has realised they have been poorly advised) have been refused by judges.

Prosecutions have tended to be of socially marginalised persons or of people with few resources, and this to a degree reflect the wider epidemiology of HIV which disproportionately affects poorer people. In the absence of effective and consistent access to high quality legal aid it does not seem possible for people already stigmatised and much misunderstood to get access to justice as prosecutions spread round the globe.

Extreme selectivity in who is subject to criminal sanctions
The number prosecuted is very small compared with the many thousands infected every year, of which it is reasonable to assume a sizeable number (even if a minority) might conceivably be subject to criminal sanction if investigated. As, we understand, is also the case in many other jurisdictions, those prosecuted have tended to be the sexual partners of British-born heterosexuals. This is the least common transmission scenario in the UK but produces most charges - we assume one reason is the shock for the complainant of finding they were at HIV risk. There are clearly lessons for our HIV prevention work which has in recent years (and with good reason) targeted messages at communities most at risk (such as MSM, African migrant communities and IDUs) and not provided any advice on HIV prevention to the wider sexually active public.

The second factor 'skewing' prosecutions for transmission relates to the difficulty of proving responsibility for transmission if the complainant has had other sexual partners (since their last negative HIV test). This evidential issue means that for the most part the possibility of prosecution is only open to those with one or very few past sexual partners.

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This raises serious questions as to the possibility of providing consistent sanctions and justice for reckless transmission within a criminal justice framework. A law which can only be applied so rarely and selectively to the crime suggests that an alternative response, not relying on the criminal law, might be a better solution.

**Excessive sentences**

The maximum sentence for the crime of grievous bodily harm (the offence under which reckless transmission is prosecuted in England and Wales – s 20 Offences Against the Person Act 1861) is five years. Those convicted have all got high-end sentences approaching the five-year maximum, much more severe than the average sentences for assault. From transcripts of court proceedings these sentences can in part be attributed to poor understanding of the impact of HIV on someone in the era of treatment. Harmful side-effects of drugs, numbers of pills to be taken, and uncertainty of longer-term prognosis are all exaggerated in court proceedings. They also seem motivated by a stigmatising approach to HIV with the court sensationalising the horror of HIV infection (see NAT poster ‘Do judges understand HIV? www.nat.org.uk)

A more recent problem has been Sexual Offences Prevention Orders being used to require the accused always to use a condom and in another instance always to disclose their HIV status when having sex. We have persuaded the Crown Prosecution Service to amend its Guidance to prosecutors to help avoid such disproportionate measures.

More broadly, however, there is a need for further education of legal professionals on the modern realities of HIV. Whilst HIV remains a serious condition, it is not serious in the way and to the extent it is still conceived of in the courts.

A further issue is time off sentences for a guilty plea. For cases involving transmission there has been immense pressure on the defendant to plead guilty ‘at the earliest reasonable opportunity’ to get (in England and Wales) a third off their sentence. The difficulty is that whilst one might know the facts as to whether you have had unprotected sex and whether you have disclosed your status, it is not at all easy to know you were definitely the one responsible for someone’s HIV infection. We have with a measure of success emphasised the need to both prosecutors and Sentencing Council to take account of the fact that the earliest point at which the accused might have the evidence to plead guilty might be quite late on in the investigative/prosecution process.

**Increases in stigmatising media coverage of HIV**

Each case when conviction and sentencing occur, results in significant amounts of sensational and stigmatising coverage (with phrases such as ‘HIV Monster’ and ‘HIV Avenger’ used, for example). In the UK NAT has successfully used the self-regulatory process of the Press Complaints Commission to require media to publish corrections of incorrect reporting (incorrect reporting of charge/offence is common). We have also agreed Guidelines for journalists on reporting on HIV, supported by the National Union of Journalists and the Society of Editors, which has a section on reporting criminal cases. The Investigation Guidance agreed by the Association of Chief Police Officers includes advice on communications and media strategy emphasising the importance of not encouraging stigma and sensationalism.

A difficulty in the UK is that the cases remain rare which makes it difficult to secure media in-house experience of how to report these cases well.

**Wider public health harms?**

We do not have clear evidence that public health harms have accrued other than those associated with stigma around these cases (which of course is a serious harm). NAT’s work surveying public attitudes on a regular basis...
since 2000 suggests that in recent years progress in reducing levels of stigma has stalled. There are some anecdotal accounts of disincentive to test, of an encouragement to have more anonymous sex with a larger number of partners, and of unhelpful assumptions being encouraged about the HIV status of sexual partners in the absence of disclosure. But they remain speculative and in some instances questionable.

It should, however, be added that recourse to criminal sanctions in an attempt (in our view misguided) to regulate behaviour has occurred at the same time as a failure of planning and investment in safer sex behavioural support in clinic and community settings. Criminal prosecutions do appear an ineffective distraction from the range of public health interventions which could make a difference to condom use and disclosure, and thus reduce reckless transmissions.

Public health powers
Public health powers have also been revised across the United Kingdom in response to the WHO 2005 International Health Regulations. The WHO’s ‘all hazards’ approach meant coercive public health powers were extended from a list of specified conditions to cover potentially any infectious disease where a serious threat to public or human health was identified. Thus magistrates could impose a range of coercive requirements at the request of a local authority on someone living with HIV. NAT intervened during the legislation to secure a number of protections in the legal process and then to secure Guidance from the Department of Health (see Department of Health, Health Protection Legislation (England) Guidance 2010) which made clear that apart from the most unusual of circumstances these short-term powers were not aimed at long-term conditions such as HIV.

We raise this given the interest in public health powers as an alternative to criminal prosecutions. In the UK we have taken a different approach, believing that such powers also run significant risks of abuse and disproportionate and intrusive control over the lives of people with HIV.

38 United Kingdom Terrence Higgins Trust

My name is X of Terrence Higgins Trust and I have been working with people accused of criminal transmission of HIV since the first English prosecution in 2003.

In that time, we have come a long way in England & Wales. The law used (the 1871 Offences Against The Person Act) has been clarified for prosecutors by Crown Prosecution Service Guidelines (http://www.cps.gov.uk/legal/h_to_k/intentional_or_reckless_sexual_transmission_of_infection_guidance/index.html) and police guidance (http://www.nat.org.uk/Our-thinking/Law-stigma-and-discrimination/Police-investigations.aspx for the full range of documents relating to police guidance).

Both of these, though owned by the Crown agencies concerned, were heavily influenced by people with HIV, clinicians and other HIV activists/organisations, in particular the National AIDS Trust (NAT) and ourselves (THT). Both sets of guidance were based on evidence of actual cases and problematical handling of them and both are subject to ongoing review involving community agencies.

Through the development of these guidelines, we have been able to obtain clarity about who can be prosecuted, what for and in what manner. This has radically transformed our ability to support and advise people with HIV, clinicians, the police and others in the justice system.

Currently charges of criminal transmission of HIV reaching Crown Court have been reduced to one or two a year. At the height of confusion and publicity for the charges, in 2006-7, THT’s helpline and specialist policy

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4 ‘HIV: Public Knowledge and Attitudes, 2010’ NAT 2011

service were logging a new case under police investigation every two weeks, on average. While many of these cases did not reach Crown Court, most took between 4 and 24 months of police investigation before being dropped or dismissed by the lower courts, representing a substantial waste of police time and a great deal of personal anguish to those accused. Due to poor levels of understanding of HIV and its transmission amongst police and prosecutors, many cases were investigated at length which had no realistic prospect of conviction. Now, in 2010-11, most cases with no realistic prospect of a charge are dropped much faster.

It should also be noted that other STIs can be (though rarely are) prosecuted; in recent years Hepatitis B and C and this week someone received 14 months in prison for passing on herpes.

Terrence Higgins Trust is aware of many negative impacts and injustices arising from the pursuance of such prosecutions within England & Wales.

- **Inequalities in who is prosecuted:** prosecutions reaching court are disproportionately of migrant heterosexual men. Only two women have been successfully prosecuted and despite over two thirds of onward transmission in the UK being between men who have sex with men, only one gay man has been successfully prosecuted. In all there have been 13 convictions in 18 individual cases (two men were prosecuted more than once due to appeals). Migrant heterosexual men are the least likely to test and the most likely to be diagnosed late, yet they are the most prosecuted.

- **Inequalities in access to justice:** legal aid is limited and this can affect the outcome of cases. In one case, an expensive private detective was employed to show that the accuser had had sex with other persons who had not been tested and eliminated; without the private funding for this, the case would not have been dismissed. In two cases, defendants were misadvised by inexperienced legal aid barristers to plead guilty on a misreading of the expert phylogenetic evidence and later unable to obtain permission to change their plea or their legal representation. One of those men died in prison and the other is expected to be deported to a country where he is unlikely to obtain antiretroviral treatment (ARVs). In several cases, expert phylogenetic defence witnesses have only been funded after long argument by the defence.

- **False statements prejudice cases and misinform the press and public:** because of the adversarial format of English courts, the prosecution is encouraged to maximise the impact of HIV transmission while the defence is often reluctant to challenge “sympathetic” prosecution witnesses. False statements have included that a woman with HIV can never have children; that HIV necessitated an abortion (in a separate case); that the average lifespan of someone with HIV is only a few years; repeated reference to HIV as “a death sentence”. These claims are often repeated and amplified by the popular press.

- **Loss of trust in clinical confidentiality:** because clinicians and clinical notes can be compelled in evidence, there is increasing reluctance on the part of some people with HIV to discuss difficulties in maintaining safer sex with doctors. Without honest discussions, people cannot be supported to avoid transmission. Additionally, examination of anonymised blood samples shows that one in four “undiagnosed” people with HIV attending for STI treatment also have ARVs in their blood, suggesting that, far from being unaware of their HIV, some people are not disclosing it in order to avoid giving evidence that could subsequently be used against them. (Savage, HPA, 2011)

- **Many people with HIV fear unfair or false accusations:** THT has experience of attempted extortion of money by people who threaten to report sexual partners with HIV to the police. A significant number of accusations are brought, not when the accuser is diagnosed but months or even years later when their relationship breaks up, as a form of revenge. In other cases, a newly diagnosed person will examine their past sexual contacts and try to bring a charge against someone known to have HIV, even though they may have had several other partners who remain untested.
- **Investigations which do not result in charges can cause significant damage to the accused.** In one case, a young man with no previous convictions was refused bail as “a danger to the public”, remanded in prison and subsequently given a bail curfew which made it impossible to do his job. He was suspended without pay for several months, forced to disclose his HIV status to his family, friends and work colleagues and almost lost both his job and his home. The charges were eventually dropped when belated phylogenetic testing showed no link with his accusers. THT has referred a substantial proportion of defendants it has worked with to mental health support due to the strain of investigations which have dragged on for many months.

- **Cases can also be damaging to those who bring charges.** THT has experience of people who bring charges, but who are not public about living with HIV, being promised anonymity by the police in court proceedings. However, once the case begins to be reported in the press, with the accused named and often photographed, the evidence reported has made it clear to their friends, family and workmates that they are the “ex-partner” who has brought the complaint. In at least two cases, where a complainant has tried to withdraw a charge after realising they will be identifiable, the police have threatened to charge them instead for wasting police time.

- **HIV stigma in the judiciary leads to disproportionate and inappropriate sentencing.** Analysis has shown that people found guilty of sexual transmission of HIV receive sentences at the top end of those given for such charges overall, higher than many for grave disabling injuries, despite HIV being a manageable condition in the UK. Additionally, in recent cases, judges have imposed Sexual Offences Prevention Orders (SOPOs) which require the accused to disclose before all future sexual contacts, regardless of whether there is any transmission risk, or to never have sex without a condom, regardless of sexual activity and risk. To date there has been little regard to whether these are appropriate or proportionate.

- **Sentencing pays no regard to supporting behaviour change in the future.** While all successful prosecutions have resulted in relatively long prison sentences for the charge, none have given regard to any form of support for behaviour change or rehabilitation. Indeed, some people (notably the two women prosecuted) have, upon release, been further pursued by the press and “exposed” as being an ongoing risk to the public.

Terrence Higgins Trust has supported many people involved in such cases, not only the defendants but also those making accusations and the police and lawyers. It is our firm view from this extensive practical experience that, while there may be a case for involving the criminal justice system where there is clear intent to harm or evidence of active deception leading someone to take a risk they would otherwise have avoided, in the majority of cases prosecution is counter productive. It can be conducive to behaviours which are more, rather than less, likely to lead to ongoing transmission of HIV through fear, ignorance, false expectations that people with HIV will disclose and stigmatisation of those known to be living with HIV. We believe that sentencing here is disproportionate and the use of the law fails to provide any positive outcomes. We believe that public health should be prioritised over vengeance when dealing with disease transmission and that people with HIV should not be subject to inequitable treatment under the law through stigma and fear.

| 39 | Norway | HIV Norge |

According to Norwegian law (Section 155 of the Norwegian criminal code) a person who, with intent or through negligence, exposes another person to the risk of transmission of a communicable disease that is hazardous to public health, inclusive HIV, can be persecuted. Section 155 has, as far as we know, so far only been applied to HIV and Hepatitis C.

It is not a condition that transmission actually takes place, exposing someone to the risk of transmission is a punishable crime in itself. In a recent court case a HIV positive person actually was convicted of violating Section 155, for several episodes where different partners were infected, and also one episode where the partner
wasn’t infected at all.

According to Norwegian law a person living with HIV is not obliged to inform his/her partners of their HIV positive status, unless they intend to marry. H/she is however, married or not, always obliged to prevent their partners from the risk of exposure of transmission of the virus. Pr. today it is regarded as a punishable crime even when the spouse/husband has consented to the risk of transmission. We have one courtcase where a HIV positive man was convicted although his wife was aware of his status as HIV positive and consented to sex (The case was prosecuted after they broke up).

**Laws and practises that facilitate or impedes HIV related treatment and access to treatment.**

A person residing in Norway, permanently or for shorter periods included illegal refugees, who is infected, or believes to be infected, with a communicable disease, inclusive HIV, has the right to testing, counselling and treatment. Testing, counselling and treatment, including medicine, is free of charge.

Persons infected by diseases that are hazardous to public health, inclusive HIV, also have the right to proper information about the disease, the treatment and what necessary precautions to take to safeguard her/his own health and how to avoid infecting others.

For the purpose of trace the source of transmission a person testing positive is under obligation to inform the doctor who established the diagnosis whom - if possible - the source of infection might be, and give names of those that s/he might have infected. Contact tracing can be done by the patient him/herself, or by the doctor. If left to the doctor it will be done anonymously.

People living with HIV are under no obligation to reveal her/his status to other health workers. To ensure that their status or the treatment they receive for HIV, do not have negative implications with regard to treatment they may get for other diseases, it is recommended to reveal the status as HIVpositive to medical doctor in charge of the treatment.

*Section 155 of the Norwegian criminal code applies to those exposing others to the risk of HIV infection regardless of transmission. The section applies to a set of communicable diseases that are hazardous to public health. It is not a prerequisite that transmission actually takes place, exposing someone to the risk is sufficient. As far as we know this section has so far only been applied to HIV and Hepatitis C.*

| 40 | USA | STD Control Branch, Californai Department of Public Health |

The mission of public health is to “fulfill society’s interest in assuring conditions in which people can be healthy”. It has been particularly challenging to address those conditions which may affect individuals’ sexual behaviors and risk. While considerable attention has been paid to studying and understanding social determinants, many of the interventions for reducing transmission of human immunodeficiency virus (HIV) and other sexually transmitted diseases (STDs) operate at the individual, and, increasingly, the biomedical level. This is in contrast to other fields of public health, such as tobacco, injury, and nutrition, where intervening on social determinants and environmental factors are central to public health strategies and are often accomplished through regulation.

HIV and STD preventionists have navigated several important areas of conflict as they have sought to reduce transmission in this highly charged policy arena.

This paper will examine two specific conflicts. First, we will examine efforts to balance society’s interest in reducing transmission and healthcare costs against the rights of patrons attending legal establishments, such as
bathhouses and sex clubs, also known as commercial sex venues (CSVs). In this example, we will illustrate how these efforts become even more complex when they involve the rights of a minority community – the gay community -- which has historically had fewer rights. While these venues play a less important role epidemiologically than they did at the beginning of the HIV epidemic, their history holds important lessons for both surveillance and prevention efforts.

Second, we will address efforts to balance, through regulation, the rights of performers in the adult film industry to be protected from exposure to sexually transmitted infections with the rights of the industry to operate freely to maximize profits.

**Regulation of commercial sex venues**

Advocates for and against regulating commercial sex venues rely on conflicting epidemiologic constructs to support their efforts. Both of these epidemiologic frames -- one, individual, and the other, structural -- reflect and support belief systems which in turn suggest different programmatic interventions.

In an individualist framework, epidemiologists focus on individuals’ risk. In the case of CSVs, public health regulation may pose a potential risk to individual freedoms. However, adopting a purely behavioral or educational public health approach in such venues may result in risk to the community’s health.

The interventions that are suggested by this paradigm typically include social marketing, outreach, and counseling. HIV and STD testing are also promoted. Risk is assumed to be at the individual level, and to the individual. Also, individuals are assumed to be completely empowered, able to act in their own best interest, and given complete freedom to take whatever level of risk they wish. When they do not act in their own best interest, it is assumed to be due to factors that may be addressed by behavioral interventions that are effective enough to reduce their risk behavior.

Evidence, however, suggests that, in practice, these interventions reach few individuals.

In contrast, structuralists believe that these venues are some of the riskiest places to be for uninfected lower-risk individuals. Thus, in addition to psychosocial factors, the environment emerges as an important factor that can increase risk of HIV transmission. Specifically, in the case of CSVs, two of the most important environmental variables that can affect mixing among those men at highest risk and those who take less risk are: the absence or presence of regulations forbidding high-risk (unprotected anal) sex, and the absence or presence of private rooms, which can make it easier or more difficult to enforce those regulations. These regulations can significantly affect the mixing that takes place between high and low-risk individuals that can in turn drive transmission.

Without any active advocacy efforts of their own, the highest-risk individuals (who also represent a number of total venue visits much greater than their individual numbers) are the de-facto beneficiaries of the lack of regulation in many cities. In part, this is because they can count on the support of advocates who are not at high risk or who do not even attend venues, but who, out of a belief that individual freedom is paramount, particularly when threatened by a majority, will support individuals’ rights to sexual expression in public venues.

We will review US cities’ attempts at regulating environments and lessons to be drawn from them. San Francisco gives owners partial responsibility for prohibiting unprotected sex in venues by removing the private doors. Los Angeles allows private rooms, and has attempted to require venues to provide testing. Despite New York regulations prohibiting sexual activity in venues, sexual activity does take place in private spaces, even though it is illegal, and clubs continue to operate. Thus, in this example nearly all responsibility for reducing transmission falls to the individual.
This difference in paradigms -- individual or structural -- has important consequences. Evidence regarding secondhand smoke was an important factor in developing policies that regulated smoking in public.\(^3\) The existence of secondhand risk of sexual transmission through networks is well accepted as part of the epidemiology of STDs. However, it has been difficult to operationalize this concept beyond partner notification.

The data surrounding environmental variables, and in particular the presence or absence of regulations, on sexual networks do not add up to a level of causation regarding the role of venues in affecting transmission that health policymakers are likely to feel confident relying upon when considering what, if any, regulatory action they should take. Causation is less clear than in other areas of public health, such as the link between tobacco smoking and cancer.

However, practitioners should remember that even greater certainty in determining the role of venues may not necessarily lead to greater action on the part of public health, or more regulation. There can still be considerable opposition from industry and from individuals. For example, in tobacco control, industry has frequently questioned the science behind studies, and supported their arguments by attributing all responsibility to smokers themselves. As a result, businesses will enjoy fewer costs, and those individuals with the highest level of risks will benefit.

**The Adult Film Industry**

While some performers in the Adult Film Industry are aware of occupational hazards of STDs, in general they lack an understanding of their risks or of their rights to a workplace free from such hazards, or their employer’s responsibility to protect their health and provide a safe and healthy workplace. Workers may also be reluctant to file a complaint, fearing they may lose their jobs.

After the 2004 HIV outbreak in the adult film industry, to improve performer awareness of the health risks and the production companies’ responsibilities to its workers, Cal/OSHA (the agency charged with occupational health) developed an online resource that outlined the workplace requirements and key elements of a model exposure control plan.\(^4\) Efforts to regulate the adult film industry have also included strategies to force the industry to assume a greater responsibility in protecting workers’ health. Non-governmental organizations have argued that:

Although workers in adult films should enjoy protections under the current phrasing of the regulation, as well as the Board’s [CalOSHA] determination that adult film workers are employees, the adult film industry has steadfastly refused to take any steps to protect its workers from diseases spread by bloodborne pathogens, resulting in thousands of employees becoming infected with STDs. Clarification and enhanced enforcement of the rules are called for.

Despite numerous hearings, it remains unclear as of this writing what steps will be taken to further regulate the industry.

Just as some venue owners have taken, independently of regulation, significant steps to avoid transmission; some adult film industry producers have as well and will not hire performers who have previously performed in films where unsafe sex takes place. However, other venue owners and producers have routinely avoided all responsibility and combatted any regulatory action.

**Conclusion**

The unintentional coalescing of forces of advocates for absolute individual freedom for sexual expression, and a strong business sector that can count on demand for its services, can provide formidable challenges to reducing HIV and STD transmission.
Public health acting alone has few tools to change those individuals who want to have unprotected sex, or to change the community cultural norms often promoted by businesses. It is unreasonable to expect that behavioral and low-scale structural interventions can bring down disease incidence without bringing the private sector into greater alignment with the public health’s interests.\(^5\) \(^6\)

Public health epidemiologists, researchers, and interventionists must not focus on individual risk alone, but also must carefully examine the relationships among individuals and the contexts in which those relationships flourish. In these two cases, the contexts are both physical and economic. Public health must carefully consider the interests of all the affected constituencies, including business owners, their employees, and their customers, as well as the communities in which they operate and which may suffer unintended consequences. This will require careful assessment and analysis, and a good deal of listening. It will also require leadership and forthright decision-making, and a commitment to fulfilling society’s interest in creating conditions in which people can be healthy.