## Country

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

The issue of access to essential medicines is one of the great concern to developing countries whose health care system are often overwhelmed by HIV/AIDS and other diseases and a wide gap of income is major problem of these countries. However, the reluctance of developing countries governments to introduce TRIPS flexibilities to improve access to essential medicines reflects the awareness of the relatively weaker power they command, when compared with industrialised nations and multi-national drug industry.

As we know that Thailand has been a global leader in lawfully using domestic and international IP and trade laws to gain access to more essential medicines including antiretrovirals (ARVs). The Government of Thailand introduced public use of patents for seven medicines in 2007 and 2008, including for efavirenz and lopinavir/ritonavir. This action prompted strong support along with opposition by key stakeholders around the world. After that, the price of ARVs dropped by two to five times, resulting in the higher number of patients access to ARV medicines. Therefore, the government use of patents issued by the Thai government significantly decreased the price of ARVs in Thailand, and greatly expanded access to ARV treatment for Thais living with HIV/AIDS.

In 2008, we conducted a research entitled ‘Impacts on access to medicines and health from Thai-US Free Trade Agreement’ that was granted by Thai FDA. This study’s aim was to calculate the impact of American trade conditions on Thailand’s access to medicine and health during negotiations for a Thai-US Free Trade Agreement (FTA). The trade restrictions sought by the US examined in the study emerged when discussing Intellectual Property rights in the 6th round of Thai-US FTA negotiations. One more important aim of this study was to develop the negotiation strategies to be used in the Thai-US FTA, and to develop the strategies to address the negative consequences of the US conditions as it affects access to medicine.

This study calculated the impact on the access to medicine and health resulting from the extension of patent term for 2, 5, and 10 years and the data exclusivity for 5 and 10 years. The extension of the patent period could be from the delay of patent approval, drug registration, or linkage between patent and drug registration. The analysis on the impact on health was based on Markov modeling of the use of antiretroviral therapy among HIV/AIDS patients in hospitals in Thailand. This Markov model was primarily constructed based on real data of more than 400 Thai HIV patients and generated a HIV/AIDS medication progression through 4 states: 1st regimen, switching to the 2nd regimen, switching to the 3rd regimen, and then death. Switching to a 2nd or 3rd regimen was dependent on development of complications during treatment such as moderate or severe adverse drug reactions, or opportunistic infections. Cycle lengths of 1-year for the full health states and one or two months for the sub-states were used for the analysis. The lifetime total costs of treatment and their quality of life of HIV/AIDS patients were calculated comparing between base-case scenarios and in the case of patent term extension due to US-Thai FTA.

The results from the analysis of the impact of access to medicine and health from Thai-US FTA on HIV/AIDS drug
patents in Thailand were as follows. Under the extensions of market exclusivity, the total cost of treatment during the lifetime of HIV/AIDS patients will increase, resulting in the increase of government expenses. If the government can issue a CL, have generic drugs available as soon as the patent expires, and face no additional barriers from the Thai-US FTA, then the cost of lifetime treatment for HIV/AIDS will substantially decrease. If the patent term is expanded to 10 years, after which the government could procure a generic drug that is five times cheaper than the original product, the results indicated that the total cost would be 1,031,299 Baht. This cost is one hundred percent higher than if the government issued a CL, which would only cost 586,564 Baht. The impacts on health were evaluated in terms of life-year gained (LY gained), and disability-adjusted life-year (DALY) averted. Assuming that the government had a fixed budget of 3 billion Baht for 120,000 HIV/AIDS patients, the study reported the impact from patent extension. The longer the patent extension, the greater the limitation on access to medication, resulting in the decrease of LY gained and DALY averted. In base-case scenario having ARV treatment yielded LY gained for 16.2 years, and DALY averted for 4.5 years. In case of CL was issued, at the initial treatment, the highest LY gained and DALY averted were 26.7 and 7.4 years, respectively then decrease to 9.4 and 2.6 years after 25 years of treatment. In the case of 10 years patent term extension, at the initial treatment, the highest LY gained and DALY averted were 22.4 and 6.2 years, respectively then it were decreased to 8.3 and 2.3 years after 25 years of treatment.

The scenario in which access to medicine was the hardest when extending market exclusivity for 10 more years while having a generic drug that costs five times less than the original product. Although the patents of ARV drugs have expired, the government will not be able to provide the ARV program that could cover all HIV/AIDS patients. Due to drug resistance, HIV/AIDS patients need access to the third line ARV regimens, which are more expensive than the first and second line ARV regimens. The substantially higher costs of the third line ARV regimens result in higher total lifetime costs of treating HIV/AIDS patients, which is also more than the government budget.

The negotiation strategies to be used in the Thai-US FTA include informing interested organizations about the impact of the FTA; preparing negotiators who have knowledge regarding the impacts on the access to medicine and health; and preparing the patent database containing the completeness of patent status. Additional strategies include establishing cooperation between the Intellectual Property Department and the FDA. The negotiation process must be transparent and must be open to the public. Strong evidence should be used for FTA negotiations with the USA.

The strategies associated with drug patent include: (1) the measures to improve the mechanism to monitor patent status, and to examine the correctness, reliability, and appropriateness of the patent; (2) the development of guidelines for IP staff to examine the patent applications; (3) the improvement of the drug patent database that can identify patent status easily, rapidly and completely; and (4) the amendment of the patent act to expedite the access to medicine.

The strategies to address the negative consequences from the FTA that affect the access to medicine were based on the four elements of the drug system including drug selection, drug procurement, drug distribution, and drug use. The impact on patients and their participation should be considered and included in the following strategies. The six strategies are: (1) strategy on pharmaceutical research and development; (2) strategy on drug pricing; (3) strategy on the local drug manufacturing; (4) strategy on rational drug use; (5) strategy to support the gathering of patients who have the same illness; and (6) strategy to network with the advocacy groups for access to medicine.

We would like to personally thank the Global Commission on HIV and the Law for this opportunity to submit this information to present the impacts of patent term extension on access to medicines and also on the quality of life of HIV/AIDS patients.

Best Regards

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TRIPARTITE FRAMEWORK (government-employer-worker) for the response to HIV / AIDS and co-infected TB / HIV IN BURKINA FASO

In Burkina Faso, resource-limited countries, HIV prevalence is relatively high, though steady decline (7.17% in 1997 and 4.2% in 2001 and 1.6 in 2007), placing Burkina among the countries most affected in the West African sub region.

In response to the problem of development, the country has initiated several actions including the development of strategies for the fight against AIDS and sexually transmitted infections (STIs), to coordinate and intensify the fight against this scourge. The Multisectoral Strategic Framework takes into account the world of work in its specificity.

In this context, the Ministry of Labour and Social Security, employer organizations represented by the National Council of Employers Burkinabe (CNPB) and workers' organizations represented by the General Confederation of Labour of Burkina (CGT -B), with technical and financial support of the International Labour Office (ILO), have been collaborating since 2005 for the implementation of an education project on HIV / AIDS in the workplace in Burkina Faso.

The project aims to reduce the spread of HIV and AIDS in the workplace and its adverse consequences on human resources and business and economic development, social and professional.

Focused primarily on the action at the world of work, the project involves the Government, unions of workers and employers to ensure a legal and policy framework conducive to national prevention and protection of workers' rights in connection with HIV / AIDS in the workplace.

Thus, a National Tripartite Declaration, inspired by the ILO Code of Practice on HIV / AIDS and the workplace was signed July 3, 2006 between the Government of Burkina Faso, unions of workers and employers to express their commitments in the fight against HIV / AIDS and raise regulatory bases for the response.

The ILO / AIDS has affected more than 15,000 workers in 27 companies, including two of the informal sector. These actions have helped:
• 54 representatives aware of the tripartite constituents on issues HIV / AIDS and the workplace;
• Train 92 representatives of employers, unions and government employees work on the ILO Code of Practice on HIV / AIDS and the world of work that have become resource persons on issues concerning the taking management of HIV in the workplace. The achievements of these programs have enabled constituents to engage in a national tripartite declaration on fundamental principles contained in the ILO Code of Practice on HIV / AIDS and the workplace;
• Train 24 judicial officers and 25 inspectors and supervisors of work, responsible for ensuring compliance with legislation on labor, to enable them to better integrate HIV / AIDS in the workplace in their functions;
• Train 18 resource persons who have in turn supported the technical team of the ILO,
• Train 154 members of works councils in the fight against HIV / AIDS peer educators and 782 company to develop and implement policies and programs against HIV / AIDS and Communication Strategies for Behavior Change .
• Support more than 27 companies for the development of policies and program against HIV, communication strategies for behavioral change, the design and implementation of specific communication media.

To sustain these good practices and enhance coordination of all these actions in the workplace, the ILO and UNAIDS supported the establishment of a Tripartite Framework for the Fight against HIV, AIDS, STIs and Tuberculosis in the Workplace (CTLS / MT) that was created by Ministerial Order No. 2010-001/MTSS/CAB. The Framework is an industry guidance, coordination and supervision of action against HIV, AIDS, STIs and TB in the workplace and its role is the leadership, coordination and monitoring evaluation action against HIV / AIDS in the workplace.
In the same vein, the development of a strategy (policy) sector in the fight against HIV / AIDS in the workplace in 2010 is one of the final stages of the achievements of the Tripartite Framework. This sector strategy should provide a framework for action to governments, organizations of employers and workers, occupational health services, specialists of issues related to HIV / AIDS and all other stakeholders in the fight against pandemic in the workplace.

The strategy applies to all workers and all employers who operate business in Burkina Faso, either in the public sector, the broader public sector and the private sector or the informal economy. Its objective is to contribute to the fight against HIV and AIDS in the workplace, to reduce the impact of the pandemic on economic, social and professional in Burkina Faso. It is part of the National Strategic Framework for the Fight against HIV / AIDS and STIs 2011-2015 and is based on a legal and institutional framework.

The implementation of the strategy (policy) sector is based on five priority areas, a legal and institutional framework of the fight against HIV / AIDS-STD, TB and malaria in the world of work. These five areas are:

1. Strategic Thrust 1: Enhancing measures to prevent transmission of HIV / AIDS and STIs, and VCT promotion board;
2. Strategic Thrust 2: Enhancing access to health care and medical care and community of PLWHA;
3. Strategic Thrust 3: Strengthen the protection and support to PLWHA and people affected by HIV / AIDS and other specific groups;
4. Strategic area 4: Strengthening the partnership, coordination and resource mobilization;
5. Core Strategy 5: Strengthening surveillance of the epidemic, monitoring evaluation and promotion of research.

Lessons Learned

With this mobilization tripartite workers participate more confidently in prevention activities and adhere to voluntary testing sessions. This mobilization of the social partners also significantly reduced stigma and discrimination. Workers living with HIV have confidence in joint committees and business can benefit from early treatment. Excellent cooperation between business leaders, worker representatives, health workers and labor inspectors as part of the response to HIV / AIDS.

Recommendations

- Strengthen the extension and the appropriation of the ILO recommendation 200 on HIV / AIDS and the workplace for efficient application of its provisions;
- That the Tripartite framework of the fight against HIV / AIDS and tuberculosis in the world of work consolidates and make more visible the achievements of the response of the players in the world of work.

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3  Australia  Nossal Institute for Global Health, University of Melbourne

Arresting HIV: Law Enforcement’s Role in Stopping HIV

The importance of police as agents of change

Enabling legal and policy frameworks are critically necessary to providing the context in which HIV prevention and
care programs can operate optimally, but by themselves they are not sufficient: it is how policy and law are implemented that determines impact on the ground. Examination of law without examination of law enforcement will ultimately be unproductive; reform of law without reform of police practice will be self-defeating.

In the creation of enabling environments for tackling HIV, police are critical. They are too often seen and treated as barriers to or enemies of HIV prevention, on the one hand, and as passive translators of the existing law on the other.

Police must be better engaged as allies in the fight against HIV, or even leaders. Police create their own cultures, and their practices respond to drivers other (and, for police, more contingent and powerful) than HIV prevention – or, in many societies, than the law itself; and if legal reform is to mean anything, police cultures and practices must be concordant with goals of decreasing HIV vulnerabilities. It is the behaviours, practices and roles of police and their operational cultures that ultimately increase or decrease HIV vulnerability among these marginalised communities, through their roles in interpretation and application of laws (or in many cases behaviours without references to the law), and in the frontline policing of the space between HIV programs and their clients. If we get these police cultures and practices right, police can not only be supportive, or allies – they can be effective leaders in tackling HIV; the optimum situation. In many communities, police are opinion leaders; in many societies, police wield enormous influence over the political process. We need to become much more expert at bringing them on side.

“Police can be your best friend or your worst enemy”
There is a large body of evidence documenting the negative impacts that police and policing practice have on the HIV prevention, treatment and care programs working with marginalised groups vulnerable to HIV, including people who inject drugs (PWIDs), sex workers, men who have sex with men (MSM), migrants, prisoners and detainees. Unfortunately, much of the focus on law enforcement in relation to HIV has remained on this highlighting of abuses and barriers; there has been far too little concentration on how to work with law enforcement to achieve effective collaborations.

Successful solutions to the challenge of working with police need to be identified so that effective HIV responses can be scaled up. As public health advocates we do not adequately know or understand what governs police practice, what their self-interest is, and how to tap into it; therefore by definition we do not adequately know or understand how we can change police practice. Historically, advocacy to police concerning HIV has largely sought to convince police to help us, the public health community, reach our goals. Very often we have asked police to change their behaviour in ways that interfere with the achievement of their goals, and we have failed to recognise either that their goals differ from ours (e.g. catching criminals, reaching arrest quotas, supplementing inadequate incomes – as opposed to using discretion to allow vulnerable communities to protect themselves from HIV) or that, in their frame of reference, their goals are legitimate.

We do know, however, that we must put as much effort into changing police culture as into changing law and policy. In fact, changing police culture in some situations might be all that is necessary, and it may be easier than addressing the law: there is evidence that police practice can change without changes in existing law. A striking example of this is secondary distribution of sterile needles and syringes in Australia, where PWIDs collect sterile syringes from programs to distribute to people in their injecting networks who may not access programs, thereby vastly increasing the reach and coverage of such programs. This practice remains illegal in all jurisdictions but is common and widely promoted, and police do absolutely nothing to discourage it.

“What’s in it for them?”
Through our long-standing work with police and harm reduction, it is increasingly clear that ongoing cultural change within police forces, influencing police practices, needs to be driven by the police themselves. It requires not only leadership from the top levels of police management but an ongoing commitment to operational and
cultural change within the law enforcement community. This needs to be maintained through a process of continual learning: not just through basic training on enrolment into the police: "what you learn in the academy stays in the academy, most learning goes on from your more senior peers". Learning and professional development has to be career long, integrated into normal police learning processes, valued and rewarded professionally as any other aspect of policing.

Further, we need to recognise that just as behaviour change among marginalised communities is not simply a matter of education but also of changing cultures and promoting enabling environments, police are no different: their interests must form the basis of sustainable behaviour change. And again, police form their own relatively closed culture, just as do heroin users or men who have sex with men – and, just as with them, peer education is the only truly effective educational approach, so it is with police. Police only really listen to and learn from other police.

A major difficulty in the intersection of law enforcement and HIV related issues is the inadequate characterisation and legitimisation of the role of law enforcement agencies in protection or promotion of the public health. Most law enforcement agencies at most times do not construct their identity in this way, despite having an active and integral role in many aspects of public health and health protection and promotion. This and the inadequate concentration on developing effective and sustainable relationships between the law enforcement and public health programming sector impairs the ability of the community to achieve optimum responses to not only HIV prevention, treatment and care but a range of complex issues involving mental health, alcohol and other drugs, and intra-community conflict including violence.

The Intersection of Law Enforcement, Marginalised Groups and HIV

There is no doubt that there frequently exist conflicts between the aims of public health policies seeking to reach out to marginalised at risk populations, on the one hand, and law enforcement policies and operations which seek to marginalise and prosecute them on the other. Public health policies and interventions can conflict with the laws (or just as often the interpretation of the laws) that marginalise these groups; the provision of condoms to MSM and sex worker organisations or the provision of clean syringes to PWIDs are examples of effective HIV prevention measures that may be prohibited either by direct legislation or by the interpretation of laws by local law enforcement agencies.

Again, without looking at the police perspective, strategies for change will be ill-founded. In many situations police routinely extort money, drugs or sexual favours from the powerless and marginalised: sometimes on the basis of the law (i.e. with the bribe one is freed from the threat of criminal action, at least for this occasion), often simply on the basis of their powerlessness. In no way excusing these behaviours, they will not change, nor will our strategies to change them be effective, without recognition that they have their roots in custom (as part of culture, re-created with each new generation of police), in inadequate pay and conditions for police in much of the world, and in the reflection of a wider socially accepted discrimination by police.

Such disparities between law, interpretation of the law, and the law’s discretionary enforcement, highlight the need to investigate law enforcement’s involvement in addressing the HIV epidemic, as separate from the law. We canvass here very briefly the relationship of law enforcement and vulnerable populations, in relation to HIV.

PWIDs: Many authors have noted that law and law enforcement reform can facilitate HIV prevention efforts targeting PWIDs, in a variety of ways. For example, the decriminalisation of aspects of injecting drug use such as the possession of syringes enables HIV prevention programs targeting PWIDs to conduct effective interventions without fear of breaking the law. Partnerships between law enforcement and harm reduction programs may help facilitate cultural change within law enforcement organisations and reduce the stigma directed towards PWIDs. Legislation preventing police access to drug registries and giving health officials and PWIDs rights to privacy would facilitate the efforts of harm reduction and HIV prevention programs targeting PWIDs. Ultimately, drug law and drug enforcement need to have their public health impact taken into consideration to make harmonisation of
public health and law enforcement strategies more than idealistic rhetoric; the essential policy distinction is to view drug dependence as a health issue; the essential change in police culture is for them to see their role as in any other health issue.

**SWs:** The law has a powerful role to play in addressing HIV prevalence in sex worker populations. The decriminalisation of aspects of sex work allows regulatory steps to be taken that address risky behaviour that can contribute to the HIV epidemic. Legislation that allows sex workers to access health services without fear of arrest or police harassment should be the norm. There is increasing evidence in some settings of violence towards sex workers being perpetrated by law enforcement officials. Furthermore, there is also evidence that some police extract sexual favours or demand bribes in exchange for not arresting sex workers. As such, legislation alone may not be enough to significantly alter police behaviour. Education and training programs run by law enforcement agencies for law enforcement agencies combined with partnerships between law enforcement and HIV prevention programs should create a more harmonious relationship between law enforcement and HIV prevention efforts.

**MSM:** HIV infection is widespread amongst some MSM communities, particularly throughout Asia. MSM are often subjected to laws against their sexuality and are often marginalised at the hands of law enforcement officials. The law and its enforcement can act as a powerful force in the success or failure of HIV intervention programs targeted at MSM. Law reforms aimed at decriminalising homosexual intercourse and the training and education of police to facilitate cultural change in the police force are frequently suggested as means to facilitate effective HIV responses. Collaboration between MSM groups, HIV programs and law enforcement should increase the effectiveness of HIV programs aimed at MSM. Unfortunately there is a lack of literature documenting positive examples of how law enforcement operations can increase effectiveness of HIV programs targeting MSM.

**Migrants:** Laws and law enforcement can play a powerful role in facilitating or hindering efforts to deal with HIV in migrant populations. As migrants are frequently subjected to discrimination and often lack access to basic human rights they are a population vulnerable to HIV. Police and officials may often have a degree of control in illegal migration. An understanding that the law enforcement sector may be involved in activities that do not act in harmony with written legislation is required to adequately deal with questions of law, law enforcement and HIV vulnerability for migrant populations.

**Closed settings:** Detention centres and prisons are incubators of infectious disease as they frequently have a high prevalence of HIV infection among inmates, risk behaviours are highly prevalent and there is often a lack of access to preventative measures. There are many effective methods of reducing HIV risk behaviours in prisons that have been suggested including condom distribution programmes, needle and syringe programmes, opioid substitution therapies, voluntary HIV testing, education and counselling and antiretroviral treatment for HIV-positive prisoners. Public health advocates continue to push for law reform, policies and programs that would initiate HIV interventions or take these interventions to scale but are too often disappointed at the lack of uptake or interest from law enforcement authorities. Changes in the law can facilitate many of these programs that aim to reduce HIV prevalence in prisons and detention centres but without cultural reforms at the prison management level and ongoing training of law enforcement officials involved in the management of any form of incarceration, these interventions will continue to either be blocked or compromised.

**The research agenda**

After thirty years of the HIV epidemic, our understanding of the legal, medical, individual and social interventions required to prevent and treat HIV have become increasingly sophisticated. We however cannot yet lay claim to having re-characterised law enforcement officials as meaningful public health actors, or even leaders, in the prevention and treatment of HIV. Much of the literature expresses a need for increased research on the interaction between law enforcement and HIV programs. Documenting rights violations perpetuated by law enforcement agencies in the context of HIV can no longer be the only research agenda pursued by public health advocates, human rights groups or the people that work with or are assisted by HIV programs. Documenting law enforcement best practice, eliciting and understanding underlying principles of successful partnerships, building meaningful and sustained collaborations between police and programs at the local level and working with police management and training institutes — all are equally important and increasingly sophisticated ways of addressing this complex intersection.

**Identifying Opportunities, Documenting Solutions and Bringing Sustained Change to Police Operations**
The Nossal Institute is conducting research exploring the experiences of law enforcement agencies working with harm reduction programs in South East Asia\(^1\); this research is the first to look at the impact of harm reduction policies and programs on police policy and practice. This research is beginning to provide better understandings of how harm reductions programs interact with police, as much as we understand how police interact with harm reduction programs. A LEHRN seminar held in Phnom Penh highlighted the initial recommendations (see Box) coming from this research.

Much of this work builds on ground-breaking work of AusAID’s regional harm reduction programs 2000-2004 (Asia Regional Harm Reduction Project, ARHP) and 2007-15 (HIV/AIDS Asia Regional Project, HAARP), which actively build partnerships at the local level across South East Asia, and where training on harm reduction was provided to police by police. In combination, these efforts are beginning to match the kind of efforts and attention harm reduction programs need to make with not only high-level law enforcement but street level police as well.

**LEAHRN:** [www.leahrn.org](http://www.leahrn.org)

We are building an international network of police and ex-police who are supportive of harm reduction, the Law Enforcement and Harm Reduction Network (LEAHRN). The organizational structure of LEAHRN has many current or retired police officers on the board and is implementing a range of activities designed to significantly increase the numbers of police involved with LEAHRN, broaden its reach, vastly increase its resources and therefore engage the critical mass of law enforcement officials required to ultimately make the cultural changes required to police operations and culture.

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\(^1\) the Law Enforcement and Harm Reduction project at the Nossal, (LEHRN)
As we continue to delve further into the culture of operational policing around harm reduction and build up a network of interested and active police, we are realizing that the role of police across the range of HIV programs has not been nearly adequately documented or explored. To begin to address this, we have organized sessions at the upcoming ICAAP conference in Korea with support from UNAIDS, UNODC and AusAID entitled, “**Arresting HIV: programs that work with police to reduce HIV**”. At this session we are bringing together six programs that work with PWIDs, sex workers and MSM together with the police with whom the programs collaborate. A symposium will highlight and document how positive collaborations have been built between HIV programs and law enforcement at the local level. The session will be followed by a skills building workshop designed to explore the principles behind successful collaborations, and to give police and programs methods and strategies for building strong collaborative partnerships. A rigorous documentation and research effort will accompany both the session and the skills building effort so that lessons learned can be highlighted, eliciting the main common factors inherent in these program partnerships of real life best practice across a range of programs and countries.

This process will set the scene for an ongoing program of research, documentation and dissemination, producing concrete guidelines and training curriculums that can be tailored and implemented across all HIV programs and all police training institutes around the world.

In November 2012, we are hosting the first ever International Conference on Law Enforcement and Public Health in Melbourne, jointly auspiced by the Australian Institute of Police Management and the Australian and New Zealand Public Health Association. While arresting HIV will be one of the major themes of the conference, its ultimate aim is to continue to bring together police and public health sectors from around the world in partnership for the betterment of public health. Building a platform where rigorous academic investigation can accompany sound collaborations will allow us to develop evidenced based approaches to partnership building across these two sectors. Importantly it will also build the critical mass of police and public health actors who are not only willing to work together but have the tools at their disposal from which to do so.

**Conclusions**

Many of the law enforcement outcomes in relation to HIV vulnerabilities are driven by police culture and operations, not solely by legislation. The distinction between law and law enforcement needs to be acknowledged so that measures that seek to facilitate a cultural and operational change in law enforcement can be employed, from within. Police in particular need to be recognised as active in constructing their own cultures, and key actors in creation of enabling environments for scale-up of HIV prevention programs.

Rigorous outcome based assessments can be conducted and documented to produce best practice guidelines for HIV programs working with police and it is this process that can facilitate the scaling up of such partnerships. Relationships need to be built between public health and law enforcement agencies to improve the effectiveness of public health outcomes.

A comprehensive review of partnerships between law enforcement, health organisations and community organisations is required so that best practice guidelines for HIV programs working with police can be created and implemented. Ultimately, policies and programs will need to appeal to and understand both law enforcement and public health approaches to facilitate the success of effective HIV responses.

The key principles upon which our ongoing work is based are:

- The law enforcement sector is key to the success of attempts to control the HIV epidemic among and from vulnerable groups including illicit drug users, sex workers, MSM, prisoners and detainees and migrants
- Law enforcement can be a major barrier or a major ally in the fight against HIV: the HIV program and community must engage effectively with law enforcement if there is to be effective change.
There is a need to increase efforts for better understanding of factors which might provide incentives for law enforcement to have a greater stake in HIV programs. Partly this relates to better documentation and consideration of current experience, measuring outcomes against strategies – for instance, the impact of engagement versus confrontation of police – but it also requires new and innovative approaches to partnership building.

It is of particular importance that police feel supported by government in their commitment to HIV prevention among vulnerable groups; conversely, government needs to have the support of police in developing holistic HIV prevention and care programs. These holistic approaches require the development of consensus among all sectors – or at least a willingness to work together towards a consensus approach - especially clear indications and agreements of the police role in the community partnership, and of what is expected, matched by resourcing particularly in areas that reduce harmful risks to police themselves. They must also take into account the many internal and external factors impacting law enforcement work.

Even where the desire exists to move away from reliance on a unidimensional law enforcement approach to marginalised groups or behaviours— as is increasingly the case – a major impediment to such a move is the lack of community-based services to which to transfer or refer people. Recognition of the adverse role of law enforcement in its contribution to increasing HIV risks and vulnerabilities must be matched by recognition of the legitimate role police and other law enforcement agencies have in relation to public health.

Working with police to change cultures and enhance their ability to work collaboratively and community-wide to protect all members of a society from preventable ills is critical in stopping HIV epidemics among and from vulnerable groups.

Getting the law right is only half the job ...

Addressing Gender Inequality for Controlling HIV/AIDS among Nigerian Women

HIV/AIDS is not a gender-neutral disease. Women are biologically at twice the risk of HIV infection as men. But it is their relative lack of decision-making power, education, and economic independence that amplify their risk of exposure to HIV/AIDS. They are often vulnerable to coercive or transactional sex and burdened with expectations to care for younger siblings or ill relatives rather than go to school or work. Early marriage and harmful traditional practices, such as female genital cutting, add to the risk of transmission, during both sexual intercourse and birth. HIV-positive women are more vulnerable to abuse or abandonment than women who are not, and they are likely to lose their inheritance without legal recourse in many countries. Without addressing the many ways in which these conditions fuel women’s increased vulnerability— including supporting women living with HIV/AIDS to live as well and as long as possible—PMTCT and HIV prevention efforts will have only limited success.

The 1999 Constitution of Nigeria prohibits discrimination on the grounds of gender, but customary and religious laws continue to restrict women’s rights. As Nigeria is a federal republic, each state has the authority to draft its own legislation. The combination of federation and a tripartite system of civil, customary and religious law makes it very difficult to harmonise legislation and remove discriminatory measures. Moreover, certain states in the north follow Islamic Sharia law, which reinforces customs that are unfavourable to women. The government has established a National Committee on the Reform of Discriminatory Laws against Women, which has drafted a decree for the abolition of all forms of discrimination against women. The decree is under discussion in the National Assembly.
Nigerian women in the family are not sufficiently protected: several inequalities remain because of tradition. There are three forms of marriage in the country: monogamous marriage registered under the civil marriage law, customary marriage and Islamic marriage. In southern Nigeria, the minimum legal age for marriage is between 18 and 21 years of age, depending on the region; in the north it ranges from 12 to 15 years. In some regions, customary law allows girls to marry from the age of only nine years; such marriages are banned in two states, but remain common overall. The incidence of early marriage is high in Nigeria: a 2004 United Nations report estimated that 28 per cent of girls between 15 and 19 years of age were married, divorced or widowed.

Polygamy is prohibited in civil marriages, but authorised under customary and Islamic law. The practice is widespread: more than one-third of Nigerian women are in polygamous unions. In civil marriages, parental authority is shared by the mother and father, but in two-thirds of Nigerian households, husbands alone make decisions about the health and education of their children. Customary law seldom recognises women’s rights to inheritance. In many instances, the family of a deceased husband will claim rights to the couple’s property, leaving the widow destitute. In civil marriage, widows are guaranteed the right to inherit at least 30 per cent of the couple’s property.

Physical integrity
Women’s physical integrity is not sufficiently protected in Nigeria. Only one Nigerian state has a law in place to address violence against women, and the country’s Penal Code grants husbands permission to beat their wives, provided the violence does not result in serious injury. Domestic violence is common, particularly in polygamous families, and affects one-fifth of couples. According to a 2003 Demographic and Health Survey, 64.5 per cent of Nigerian women consider it normal to be beaten by their husbands – even for infractions as minor as burning a meal or failing to have dinner ready on time. Rape is punishable by life imprisonment in Nigeria, but there are no sanctions in the Penal Code against spousal rape.

Female genital mutilation (FGM) is prohibited in several Nigerian states, but such laws are difficult to enforce. On a national scale, FGM is widely practised: one-fifth of women aged between 15 and 49 years have been subjected to it. The incidence of FGM differs considerably by region, and is twice as common in rural communities as in urban areas. The older a women is, the more likely she is to have been subjected to FGM; this suggests that the practice has less support among the younger generation. There is evidence to suggest that Nigeria may be a country of concern in relation to missing women.

The way forward
Although Nigeria has ratified the main international and regional women’s rights protection instruments, discrimination against women still persists widely both in law and practice. Particular attention should be generated to the following violations of women’s rights in Nigeria: persistence of discriminatory laws; lack of harmonisation between statutory and customary laws and application of Sharia laws in the northern states; violence against women, including widowhood rites; and obstacles to access to employment, decision-making positions and health services. I acknowledge the adoption of several laws and policies aimed at improving respect for women’s rights, including: The passage of the Gender and Equal Opportunities Law 2007 by the states of Anambra and Imo, providing for affirmative action measures to redress under-representation of women in appointive and elective positions and prohibiting discrimination in areas such as education and employment. The adoption of laws protecting the rights of widows in several states: Enugu (2001), Oyo (2002), Ekiti (2002), Anambra (2004), and Edo (2004). However, implementation of these laws remains inadequate.

Nigeria is a federal republic with 36 states, which each adopt distinct federal laws. Nigeria has a tripartite legal system consisting of statutory, customary, as well as, in the northern states, sharia laws. The three bodies of law create contradictions and inconsistencies and discriminatory provisions are widespread within each source of law particularly in the areas of family and property law.

Discriminatory **statutory laws** include:
**Constitution:** Article 26(2) limits the rights of Nigerian women to transmit their nationality to foreign spouses. Article 29(4) deems a woman to be of full age upon marriage, which lends support to early marriages and contradicts the minimum age requirement (18 years for men and women) set by the Child’s Right Act 2003.

**Criminal Code:** Very strict evidential requirements are imposed to prove the crime of rape, making convictions almost impossible (s. 358, requirement of corroborative evidence). Abortion is criminalised (ss. 228-230).

Discriminatory **customary and religious laws** include:

**Marriage:** In the southern region, customary laws allow marriage of girls between 12 and 15 years, while in other regions marriage is authorised from 9 years. A 2004 United Nations report estimated that 28% of girls between 15 and 29 years were married, divorced, or widowed. Polygamy is authorized and widely practiced under both customary and Sharia laws. Nearly one third of Nigerian women are in polygamous unions.

**Divorce:** Sharia law recognizes four main types of divorce. The *talaq* procedure can only be initiated by the husband. It allows him to repudiate the marriage by announcing out loud that he intends to divorce his wife. The *khul’u* procedure allows a woman to request a divorce by paying a “ransom” to her husband in order to terminate the marriage. The *khul’u* is settled in court. The *tafriq* and *faskh* procedures also require court intervention. Divorce is pronounced following an investigation into the truth of the wife’s accusations.

**Violence:** Under the Penal Code of Northern Nigeria, husbands are permitted to beat their wives provided it does not rise to the level of “grievous hurt” (s. 55). Under Sharia law, the husband can withdraw maintenance if his wife refuses sexual intercourse. Under Sharia law (eg. Kano State Sharia Penal Code), a woman alleging rape must produce 4 witnesses to the rape. If the rape is not proved she can be punished for adultery with a prison sentence or flogging.

Despite intensive lobbying efforts of women’s rights organisations in Nigeria, the legislature has yet to pass into law 9 draft bills on violence against women, including bills prohibiting domestic violence, female genital mutilation, and sexual offences. Domestic violence is extremely prevalent in Nigeria. It is estimated that 20% of women are victims of domestic violence and such violence is generally condoned by society. There is no specific legislation sanctionning domestic violence and marital rape is not criminalised. It is almost impossible to obtain convictions for rape due to strict evidential requirements. In addition, women tend not to report rape for fear of shaming themselves and their family members, and aware that the authorities generally refuse to file their complaints. When complaints are filed, investigations are often abandoned.

Despite the passage of laws in several states prohibiting female genital mutilation (FGM), and the adoption of a National Plan of Action aimed at reducing the prevalence and incidence of FGM, the practice remains widespread. A 2007 World Health Organization study reported that FGM is practised in the vast majority of Nigerian states. It is estimated that across the country 20% of women aged 15 – 49 have undergone some form of FGM and the areas with the highest prevalence are southwestern Nigeria (56.9%), southeastern Nigeria (40.8%), and southern Nigeria (34.7%).

**Authority of Nigerian should reform or repeal all discriminatory statutory laws** in conformity with CEDAW and the Maputo Protocol, including provisions within the Constitution and the Criminal Code.

**Harmonise statutory, customary, and religious law in conformity with international and regional instruments on women’s rights** and ensure that where conflicts arise between formal legal provisions and customary law, the formal provisions prevail.

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**Inadequate Access to ARV Drugs among People Living With HIV/AIDS in Nigeria**
In Nigeria, an estimated 3.6 percent of the population are living with HIV and AIDS (UNGASS, 2010). Although HIV prevalence is much lower in Nigeria than in other African countries such as South Africa and Zambia, the size of Nigeria’s population (around 149 million) means that by the end of 2009, there were 3.3 million people living with HIV (UNAIDS, 2010). Approximately 220,000 people died from AIDS in Nigeria in 2009 (UNAIDS, 2010). With AIDS claiming so many lives, Nigeria’s life expectancy has declined significantly. In 1991 the average life expectancy was 54 years for women and 53 years for men (WHO, 2008). In 2009 these figures had fallen to 48 for women and 46 for men (CIA World Factbook, 2010).

When antiretroviral drugs (ARVs) were introduced in Nigeria in the early 1990s, they were only available to those who paid for them. As the cost of the drugs was very high at this time and the overwhelming majority of Nigerians were living on less than $2 a day, only the wealthy minority were able to afford the treatment. In 2002 the Nigerian government started an ambitious antiretroviral treatment programme, which aimed to supply 10,000 adults and 5,000 children with antiretroviral drugs within one year. An initial $3.5 million worth of ARVs were to be imported from India and delivered at a subsidized monthly cost of $7 per person. The programme was announced as 'Africa’s largest antiretroviral treatment programme'.

By 2004 the programme had suffered a major setback as too many patients were being recruited without a big enough supply of drugs to hand out. This resulted in an expanding waiting list and not enough drugs to supply the high demand. The patients who had already started the treatment then had to wait for up to three months for more drugs, which can not only reverse the progress the drugs have already made, but can also increase HIV drug resistance. Eventually, another $3.8 million worth of drugs were ordered and the programme resumed.

ARVs were being administered in only 25 treatment centres across the country which was a far from adequate attempt at helping the estimated 550,000 people requiring antiretroviral therapy. As a result, in 2006 Nigeria opened up 41 new AIDS treatment centres and started handing out free ARVs to those who needed them (Reuters Limited, 2006). Treatment scale-up between 2006-7 was impressive, rising from 81,000 people (15% of those in need) to 198,000 (26%) by the end of 2007.

Resources needed to provide sufficient treatment and care for those living with HIV in Nigeria are seriously lacking. A study of health care providers found many had not received sufficient training on HIV prevention and treatment and many of the health facilities had a shortage of medications, equipment and materials (Physicians for Human Rights (2006). The government's National HIV/AIDS Strategic Framework for 2005 to 2009 set out to provide ARVs to 80 percent of adults and children with advanced HIV infection and to 80 percent of HIV-positive pregnant women, all by 2010 (WHO, UNAIDS and UNICEF 2007). However, only 31 percent of people who needed treatment for advanced HIV infection received it in 2009. According to the latest WHO guidelines (2010), which advise starting treatment earlier, HIV treatment coverage is only 21% (WHO/UNAIDS/UNICEF (2010). As a result of this slow progress the treatment goals were set back to 2015 in the revised framework (2010 to 2015) (National Agency for the Control of AIDS (NACA), 2009)

It has been estimated that the Nigerian government are contributing around 5 percent of the funds for the antiretroviral treatment programmes (Health Reform Foundation of Nigeria (HERFON), 2007). The majority of the funding comes from development partners. The main donors are PEPFAR, the Global Fund and the World Bank. In 2002, the World Bank loaned US$90.3 million to Nigeria to support the 5-year HIV/AIDS Programme Development Project (Health Reform Foundation of Nigeria (HERFON), 2007). In May 2007 it was announced that the World Bank were to allocate a further US$50 million loan for the programme (World Bank, 2008). Through PEPFAR (the President's Emergency Plan for AIDS Relief) the United States has allocated a large amount of money to Nigeria. In 2006 PEPFAR provided approximately US$448 million to Nigeria for HIV/AIDS prevention, treatment and care (PEPFAR, 2008), the third highest amount out of PEPFAR’s 15 focus countries. By the end of 2008, the Global Fund had disbursed US$95 million in funds for Nigeria to expand treatment, prevention, and prevention of mother-to-child transmission programmes (The Global Fund (2009). Much of this was given to the Nigerian government to fund the expansion of antiretroviral treatment.
Conclusion
Increased uptake of ARV drug in Nigeria will prolong and improve the quality of life of HIV/AIDS patients in the country. For instance, the survival data of 2009 shows that about 68.3% of adults and children that were on treatment are still alive and healthy after 12 months. Laws can be used to scale up adequate access to ARV drugs by making it compulsory for existing public health services especially those at the grassroots level to include ART service as part of their service plan for the community they serve. This will further increase access to ARV drugs and thereby prolonging life of PLWHA.

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

Discrimination on transgenders

1. Difficulties in legal gender recognition of transgenders
There is no special law for legal gender recognition of transgenders. A special bill on legal gender recognition was brought before the National Assembly in 2006, but the bill did not pass the assembly. However, that same year, Korea's Supreme Court handed down a first decision admitting legal gender correction of transgenders and enacted <Administrative Guideline for Applications for Legal Gender Correction of Transgenders> as a Supreme Court Established Rule in September 4, 2006. But the Supreme Court strictly regulates the requisites for legal gender recognition. It states that the applicant should have no prior marriage experience, have no children, have sex reassignment surgery including external genitalia completed, and be over the age of 20. As the Supreme Court strictly regulates the requisites for legal gender recognition in its guideline, it still remains a high barrier for transgenders. Consequently, their employment, education, and other social activities are restricted.

2. Uncovered insurance on sex reassignment surgery and hormone therapy
There is no systematic medical guideline in sexual transition process. Thus, most transgenders' access to medical information is rather limited. On average, transgenders pay approximately 21,300,000 won, approximately 20,000USD, for sexual reassignment surgery and it is not covered by national health insurance (based on the research on current condition of transgenders' right in 2006). GDP per capita of South Korea in 2006 was 18,391USD. Transgenders in poverty or in unstable employment are unable to afford the surgery due to its high cost. As a result, their sexual transition period gets extended. Those who could not have the surgery completed obviously cannot change their legal gender status and would be caught in a vicious cycle of being discriminated in their employment and their social life. Hormone therapy is not also covered by national health insurance.

Army and AIDS
Korean Army has a draft system. Every year approximately 350,000 Koreans take physical examination to check their suitability in performing their military service. According to their exam result, they receive the notice of duty. Once they are enlisted, there's another physical examination for them to take. The physical examinations include mandatory HIV test without pre-informed consent and counseling. If turn out to be HIV positive, they cannot perform their military service and have little or no freedom of career choice for military officer.

1. Draft physical and mandatory HIV test
Since 2007, the first inspection division of Seoul office has run HIV tests during draft physical on a trial basis. The draft physical has included HIV test for all examinees since February 16, 2009. There is no legal regulation about the Draft physical and mandatory HIV test. According to Article 12 (1)-3 of the Military Service Act(evaluation of
physical classification), those who are incapable of completing military service due to any disease or mental or physical disability shall be placed in Grade 6. Article 14 (1)-3 states that a person whose physical grade is in 6 shall be exempted from military service. According to Regulation on physical examination [attached table 2] the criteria for evaluating the degree of any disease or mental and physical incompetence, HIV-positive persons shall be judged in Grade 6 in draft, and be discharged from military service.

2. Enlistment physical and mandatory HIV test
AIDS Prevention Directive of the Ministry of National Defense (Directive 1011) was amended in December 31, 2008. Amended Directive reinforced the obligation and forcibleness by changing the phrase 'under each individuals consent, HIV test in enlistment physical may be conducted' into 'must be conducted'. Persons diagnosed with HIV-positive in enlistment physical are sent to hospital to confirm the diagnosis. On confirmation, they are to be exempted from the military service, blocked from rejoining the army and to be treated by Public Health Clinic after the diagnosis is reported to the minister of National Defense and the director of Korea Centers for Disease Control and Prevention.

※ Current status on those who were exempted from military duty due to being diagnosed HIV-Positive

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<td>15</td>
<td>22</td>
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3. Military officer
According to article 53 of Enforcement Rule of the Military Personnel Management Act (the criteria for being discharged etc.), any commissioned officer, warrant officer and deputy officer, whose degree of mental and physical incompetence is categorized in between Grade 1 and 7 and whose incompetence is not from injury sustained in action or on duty, shall be discharged or dismissed from the army through discharge deliberation committee. If he is placed in Grade 8 to 9, he shall go into the reserves. According to the table of grading mental and physical incompetence of Enforcement Rule of the Military Personnel Management Act [attached table 1], HIV-positive person shall be judged in Grade 8 and assigned to the armed reserves. It is likely that HIV-positive person with other mental and physical incompetence shall be judged under Grade 7 and be discharged or dismissed from the army. That is, all military officers shall go into the reserves or shall not serve under active duty if he is found to be HIV-positive.

<Discrimination on homosexuality>

1. Homophobia and ‘normal family' logic
1) Homosexuals cannot reveal their identity and even existence due to social discrimination and stigma referred as 'abnormal' and 'immoral'. When their sexual orientation is revealed, they face harassment, dismissal, hated and violence from family, friends, school and their everyday environment. Public Opinion Survey by Network for Supporting Single Mom and Women’s Policy Institute in 2009 shows that homosexuals are the most discriminated group in Korea. But no anti-discrimination law exists. Because of the absence of Anti-Discrimination Act in S. Korea, homosexuals cannot be protected by any judicial systems. Although the National Human Rights Commission Act states every individual cannot be discriminated by his or her sexual orientation, the commission can’t take any other actions but investigation and recommendation. There was an attempt to put forward Anti-Discrimination Act in 2007, but the attempt was blocked by the strong opposition of conservative organizations and religious groups against homosexuality. Ministry of Justice accommodated their objection and removed 7 categories from the Anti-Discrimination Act, including diseases, nationality and sexual orientation. Ministry of
Justice even ignored that the Anti-Discrimination Act fell into disuse without any deliberation. By neglecting behavior of duty, in November 2009 Ministry of Justice was recommended by UN Committee on Economic, Social and Cultural Rights due to the removal of those categories in the Anti-Discrimination Act. Since 2007, social movements of CSOs for the Anti-Discrimination Act in S. Korea have been continuing, but Ministry of Justice has not changed its position.

2) Korean society defines "normal family" to be heterosexual marriage-oriented and blood relation-oriented. This 'normal family' ideology has not only restricted family configuration right for homosexuals, but it also leads to inaccessibility to designate a recipient in public and private insurance, inability to adopt or hold custody, and exclusion from other social benefits. There are no policies or legal resources for homosexuals to secure them family configuration right.

2. Article 92 (5) of the Military Criminal Act prohibiting sexual touching between male soldiers
According to Article 92 (5) of the Military Criminal Act(infamous conduct), a person who engage in sodomy or commit other indecent acts shall be punished by imprisonment for not more than 1 year. It uses degrading word "gyegan"(verbatim meaning is sex between chickens) to describe sexual touching between men, and it unquestioningly represents it as 'harassment'. “Gyegan” refers to sex relationships between men. It also takes no notice of sexual behaviors in between women or/and heterosexual officers.

The article does not question the existence of neither consent nor coercion in the sexual conduct. As it only covers 'infamous conduct, etc.', it isn’t certain as to whether the article is limited to non-coerced indecent act without assault or intimidation only or whether it also punishes indecent act by compulsion such as 'indecent act by force' in the Criminal Act.

The article also prohibits any sexual intercourse in between male officers regardless of the pre-existing relationship between them, the place or the situation it takes place. It is open to interpretation whether the doers are in a dominant-subordinate relationship, or the fact that they may belong to the same unit, where the sexual intercourse takes place, or intercourse in secluded place in the camp is punishable. That is, Article 92 (5) of the Military Criminal Act punishes any sexual intercourse in between men without any restriction on the actor and the time and place or the way of action. It determines the target of punishment only through the arbitrary interpretation of the Act, which violates the right of sexual self-determination.

3. Unit Management Directive of the Ministry of National Defense prohibiting sexual intercourses only between homosexuals
Article 236(fundamental principles) of Part 4, Chapter 5 of Unit Management Directive of the ministry of National Defense(act of homosexual military member) states that "Any sexual intercourses in between homosexual officers in the camp shall be prohibited. Any person who violates the directive shall be criminally punished or disciplined."

It can be assumed from the context that 'heterosexual' officers are permitted to have sexual intercourse. It also describes that homosexual officers are likely to violate and commit the sexual violence. There is no knowing when 'homosexual' officer would be the subject of the article if his sexual orientation was 'homosexual' before enlistment or if 'heterosexual' officer changed his sexual orientation in the army. Therefore, it is not clear. It is vague as to what 'any sexual intercourse' prohibited in the article means.

According to the Research on the current condition of sexual violence in the military in 2004(National Commission on Human Rights), there’s has not been a case where homosexual was the assailant or the attacker of a sexual violence in the military. In fact the assailants are heterosexuals and they commit these acts as a way of showing their power and hierarchy to the other men.

As Part 4, Chapter 4 of Unit Management Directive of the ministry of National Defense(sexual discipline and accident prevention) and Part 15 of the Military Criminal Act(crime of rape and infamous act) already cover the cases where homosexual members committed sexual violence, this particular Directive is unnecessary. Even so, homosexual officers are being discriminated by this Directive. There is a high risk of prejudice and unnecessary surveillance on homosexual members who are exposed to the discrimination and human rights violation.

4. 'Blood donation record card' prohibiting collecting blood from those who had sexual contact between men
In 'Blood donation record card'[Notification no. 2009-57 of the Ministry of Health and Welfare and Family Affairs], there is a question confirming whether one has experienced sexual contact with unspecified opposite sex or with another man if he is male within last year. As this inquiry is specifically questioning the sexual preference, it is discriminatory. Although it could be revised as ‘I’ve had unsafe sexual intercourse with unspecified person without using condom, etc.’, the existing notification provides that sex in between men might be the cause of HIV/AIDS whether it is ‘specified’ or ‘unspecified’, ‘safe’ or ‘unsafe’. This explicitly discriminates homosexuality of men. Such blood donation inquiry spreads the misconception that sexual intercourse in between men is unquestioningly dangerous and homosexuality is bad. Homosexual men unnecessarily experience rejection from society, and are deprived of freedom or right to donate blood. Moreover, the inquiry details are based on misunderstanding on HIV/AIDS and it can’t be of any help to HIV/AIDS prevention.

5. Others
1) According to Regulation on physical examination, etc.[attached table 2] the criteria for evaluating the degree of any disease or mental and physical incompetence, Enforcement Decree 728 of the Military Service Act, all examinees’ physical grades shall be evaluated become the criteria for evaluating their suitability in performing military service. ‘Sexual identity disorder/sexual preference disorder’ is included in the psychological section. [attached table 2]. It is unclear as to whether such disorder exist or not, it has tendency to classify homosexuality into sexual preference disorder and transgender into sexual identity disorder.

2) Among the psychological section of the table of evaluating mental and physical incompetence of Enforcement Rule of the Military Personnel Management Act [attached table 1] ‘sexual identity disorder’ and ‘sexual preference disorder’ are covered in ‘85. Adult behavior disorder’. Article 49 (1)-2 of Enforcement rule of the Military Personnel Management Act [attached 1](discharge of person unsuitable for active service), ‘a person who is found improper to continue his active service due to a defect in his character’, is also defined in Article 56 of Enforcement Rule of the Act(the criteria for evaluating an ineffective), which includes ‘sexual pervert’. The concept of sexual pervert is so ambiguous that it is open to interpretation as homosexual military officer. Then this would restrict their freedom of choose an occupation of their choice.

<Inmates and AIDS>

1. Mandatory HIV test

1) Mandatory HIV test when entering a correctional institution
Article 7 of Health Care Guideline for correctional institution inmates(Administrative Rule No 971 of Ministry of Justice) provides that every new inmate should take syphilis and HIV test. HIV test is not fully notified to the inmates during the process. Since 1997 for 10 years, the juvenile reformatories have also taken blood samples of all youths including detainees yet not to be convicted and made it mandatory to take these tests. HIV test has been notified as a mere STD(sexually transmitted disease) test.

2) Mandatory HIV test during detention
According to Article 8 of Health Care Guidance for correctional institution inmates, inmates over 19 have been checked-up once a year and inmates under 19 and over 65 have been checked-up once in every 6 months. Check-ups include HIV test without any notice or consultation, which have no specific legal basis for it.

3) The amendment on Administration and Treatment of Correctional Institution Inmates Act
Even though it is rare, it is possible for inmates entering an institution to deny the mandatory examination. It is due to the fact that only the warden must go through the medical examination according to Article 16 of the Administration and Treatment of Correctional institution Inmates Act. But Ministry of Justice announced an amendment in April 14 2011, imposing an obligation on new inmates to take the medical examination so as not to let them to deny the examination. Inmates will not be able to refuse to take
the mandatory medical examination including HIV test when the amendment is passed.

2. Isolated accommodation
Article 15 of Health Care Guidance for correctional institution inmate makes isolated accommodation mandatory regardless of the will of the infected person and includes the inmates suspected to be infected HIV as the subject of isolated accommodation.

3. Lack of perception for confidentiality
Although it is clearly stated in the Article 7 of Prevention of Acquired Immunodeficiency Syndrome Act <Research on the current medical condition in correctional institutions and for the right to medical treatment by National Human Rights Commission in 2002 >that medical record is to be kept confidential, every institution that was visited did not follow this procedure. Many institutions often revealed the current status of PLHIV to the investigator of this report, and it was clear that they lack the awareness of the importance of the confidentiality. There were cases where their files have been neglected and misplaced, and thus PLHIV’s privacy have been violated.

4. Other discriminative treatment
Article 24 of Health Care Guidance for correctional institution inmate explicitly excludes the PLHIV from the subject of hemodialysis who shall be transferred to hemodialysis agency, which deprives the infected person of the right to be treated.

<Criminalization of Sex Worker and Mandatory Test>

1. Criminalization of Sex Worker
It is noted in the Act on the Punishment of Acts of Arranging Sexual Trafficking, Article 21(Penal Provisions) (1) that anyone who engages in the prostitution shall be punished by imprisonment for not more than one year, by a fine not exceeding 3 million won, by penal detention or by a fine for negligence. However, as set out in Article 6(Exemption of Punishment of Victims of Sexual Trafficking and Their Protection), any victim of the sexual trafficking listed in article 2-anyone who is coerced to having sexual intercourse under duress or under the influence of narcotics or psychotropic drugs, and who is the victim of the human trafficking shall not be punished. Yet, regulation for exemption is not comprehensive enough to cover sexual victims in reality.

2. Mandatory Test on Sex Worker
Korea’s regulation on prostitution has adopted both prohibitory and controlled system. In 1961, Korea enacted Prevention on Sexual Industry and also enacted Prevention on Prostitution in 2004. Thus made prostitution illegal under the law. However, the government conducts mandatory STD tests to sex workers. Mandatory STD and HIV test stems from Japanese colonial era and U.S military government in Korea, when sex workers were regarded as useful source of government revenue. Because of Korean prostitution policy, even though the HIV infection rate of sex workers was not high, sex workers had to take mandatory HIV test. A person who shall undergo medical examinations for STD and HIV regularly is provided by Prevention of Contagious Diseases Act Article 19, under the Prevention of Acquired Immunodeficiency Syndrome Act, article 8(2), subparagraph 2 and its enforcement decree article 10. As such, types of workers subjected to regular mandatory testing for STD and HIV-e.g. HIV every six month- include female worker at Korean cafe in Enforcement Decree of Juvenile Protection Act, article 3(Entertainment establishments harmful to juveniles), paragraph 4, subparagraph 1; woman who drinks with customers or entertains customers by singing or dancing at entertainment establishment in Enforcement Decree of Food Sanitation Act, article 22(range of workers at entertainment establishment); female worker at massage parlor in Municipal Decree on masseur, article 6(establistments standards for massage parlor); and a person who may no doubt become a transmitter of STD or HIV as is deemed by the local governor. A person who fails to comply with HIV test shall be punished by imprisonment for not more than a year or a fine not exceeding 3 million won in accordance with Article 27 (Penal Provisions), paragraph 2 of Prevention of Acquired Immunodeficiency System Act.
Ministry of Justice in 2010 amended its internal guidelines so as not to regulate immigration of foreigners with HIV and mostly removed the obligation for the submission of HIV test result upon applying for visa issuing and alien registering after amending enforcement regulations of Immigration Control Act. However, some of aliens are forced to submit HIV test result by Ministry of Justice. There are no changes on the Immigration Control Act especially for those with contagious diseases.

1. Mandatory test in Prevention of acquired immunodeficiency syndrome act and enforcement decree of the immigration control act

According to Section 3 in Article 8 (examination) of the Act of Acquired Immunodeficiency Syndrome Prevention and Article 10 (Examinee) of Enforcement regulation of the Act, applicants for E6 visa (Art and Entertainment) who are entering Korea from abroad and staying more than 90 days are obligated with the submission of HIV-negative certificate. Those who refuse HIV test are punished with imprisonment of not-more-than-a-year or a fine not exceeding 3 million won by Article 27 (penal provision) of the Act. Ministry of Health and Welfare initiated amendments of this provision including abolishment of mandatory test, the cabinet meeting held off resolution of the amendment in December 28, 2010.

In accordance with article 76 of enforcement regulations of the immigration control act, foreign language teacher who falls under E2(Language instruct) visa shall submit the Examination of Physical Condition in Recruitment when applying for alien registration for long sojourn. Medical institution conducting the Examination of Physical Condition in Recruitment shall include drug screening and HIV testing accordingly. The regulation on health checkup for E2 shall also apply to E7(special activities) visa.

Immigrants living in Korea for the purpose of marriage who need F2(residence) visa shall present medical certificate. Medical certificate should include checklists about venereal disease, mental illness, AIDS and etc.

2. Immigration Control

From 1985 to 2008, among 751 foreigners with HIV, 600 HIV infected foreigners were deported. The legal basis for the deportation lies in Immigration Control Act. National Human Rights Committee had ventilated their position in February 2008 that ‘such deportation violates the international human rights norms and it also violates right to live in Korea and equal rights by denying the right of residence of the people with illnesses’. In the April of the same year, Seoul Administrative Court judged to withdraw departure command with ordering that it is unclear to accomplish the public good of contagious disease prevention, whereas it is obviously clear to give threats to the happiness of family gathering, possibility to be cured, and freedom of residence.

Immigration Control Act, Article 11(Prohibition, etc. of Entry) notes that a contagious patient is prohibited from entering the Republic of Korea. AIDS is in group 3 and can fall into categories of the ‘contagious disease’ stated above. Also, a person who is found to fall under or is subjected to grounds for prohibition of entry falling under Article 11 after entry shall be deported or get departure orders from the office of foreigner internment camp in accordance with Immigration Control Act, Article 46 (persons subject to Deportation) and Article 68(Departure Orders).

Ministry of Justice stated that it has amended their internal guidelines in order not to prohibit immigration of aliens simply because of their HIV status. However since the Immigration Control Act still implies the article stipulating regulations of immigration control targeted at people with contagious diseases, PLHIV could have situational confrontation with prohibition of entry and/or forced evictions.

3. Support for Treatment and Treatment Expenses

If fall under these following categories; PLHIV foreigners who holds F5 Visa with a Korean spouse, their minor
children who stayed in Korea over 2 years, F2 visa holders with a Korean spouse, their minor children, accepted refugees, general/summary naturalization applicant, other authorized sojourner, those who need constant consultation and support, can have medical fee support like Korean citizens do. Apart from them, other foreigners with HIV get no support and must pay without any insurance or discount. Medication alone cost at least one million won (approx. 940 USD) for an adult per month. Therefore, PLHIV foreigners feel it’s necessary to go back to their home country due to the hospital expenses even if they are not deported.

<Restriction on Labor rights of PLHIV>

1. Labor rights in Prevention of Acquired Immunodeficiency Syndrome Act

1) It is articulated in Prevention of Acquired Immunodeficiency Syndrome Act, Article 8 (Restriction on Employment) that (1) "No infected person may be employed to work at an establishment where the employees thereof are required to have regular medical examinations under Article 8 (1); (2) "No person who operates an establishment referred to in Article 8 (1) shall have an infected person or a person who has not had a medical examination work at his/her establishment." As set out in Article 26 (Penal Provisions) and Article 27 (Penal Provisions), any person who violated Article 8 (2) and (1), shall be punished by imprisonment for not more than three years or a fine not exceeding ten million won.

Types of workers subjected to medical examination regarding STD and HIV who falls under article 8(1) are listed in Regulation for medical examination for sanitary workers, Article 3. (Refer to <Criminalization of Sex Worker and Compulsory Test> for details.) PLHIV cannot be employed to establishments pertaining to this act, such as coffees hops and massage palour regardless of type of work they do in the establishments. It is applicable to business operator not to employ infected person in their establishment.

2) In March, 2008, it is newly established in Prevention of Acquired Immunodeficiency Syndrome, Article 2 (5) that "Any employer may not put a worker at a disadvantage or threat him/her with discrimination in labor relationship except that prescribed by the Act on the grounds that such worker is an infected person." Regulation, however, does not ensure labor rights of PLHIV because it does not have any penal provisions for violation, and does not elaborate types of discrimination such as HIV examination in workplace. It still remains as a proclamatory clause, without providing any concrete and effective measures against discrimination.

2. Qualification for Occupations and HIV Test

Due to its vagueness and comprehensiveness, law pertaining to qualifications for occupation undermines chances of PLHIV’s employment, even it deprives PLHIV of right to acquire license for several occupations. Moreover, Public official, cook, and nutritionist with license could get disqualified after their infection to HIV. Therefore, anxiety still exists in PLHIV's lives because revealing HIV status could lead to dismissal.

1) Public Official

‘Regulation on Examination of the Physical Condition in Public Official Recruitment’ articulates that anyone disqualified by whether or not physically or mentally disable, and having disease and degree of it shall not be employed as public official, teacher, and judicial officer. Article 4 (Grounds for Disqualification) sets out in subparagraph 1 ‘General Defects’ that anyone who has infectious disease designated by law without getting effective and appropriate treatment and still contagious regulated vague and comprehensive. PLHIV can be restricted by the Act given that AIDS pertains to a disease legally designated as an epidemic group 3.

2) Pilot

As set out in Pilot Act, Article 31 (Certification of Medical Examination for Aircrew), anyone among those holding certification of qualification must obtain certification of a medical examination for aircrew by certification of qualification or the certification of qualification will be subjected to revocation of license. In accordance with Enforcement Rule, Article 95 (Standard and Validity Term for Medical Examination for Aircrew, etc.), Attached Table 15 (Standard for Medical Examination for Aircrew), airline transport pilot(Type 1), commercial pilot(Type 2),
private pilot (Type 3) shall not have AIDS, and if HIV positive, shall not have any related disease.

3) Cook
Food Sanitation Act, Article 54 (Grounds for Disqualification) states that any patient suffering from a contagious disease under Article 2 (13) of the Prevention of Contagious Diseases Act, excluding patients with hepatitis B, shall not acquire cook license. Given that the scope of infectious person is comprehensive, PLHIV shall not acquire cook license.
Also, as listed in Food Sanitation Act Enforcement Rule, Article 50 (types of disease prohibited from operation), anyone infected by designated disease shall not engage in any operation regarding food in accordance with Food Sanitation Act, Article 40 (Medical Examination), which Acquired Immune Deficiency Syndrome also falls under. However, it only pertains to workers at the establishment which needs medical check-up regarding STD as set out in Prevention of Contagious Diseases Act, Article 19. Thus, regardless of cook license, PLHIV shall not work at entertainment facilities.

4) Nutritionist
Likewise, PLHIV shall not acquire nutritionist license with their disease confirmed and reported in accordance with Public Nutrition Act, Article 16 (Grounds for Disqualification), in Article 2, subparagraph 13, which provides that infected person listed in its Decree of Ministry of Health and Welfare cannot acquire nutritionist license.

3. HIV test in Workplace checkup
National Health Insurance Act, Article 47 (Restriction of Benefits) and its enforcement decree, Article 26 (Medical Examination) articulates that health checkups shall be conducted after they are classified into general health checkup, cancer checkup, and infant and child health checkup, and it categorizes employment-provided policyholder into general checkup in its subparagraph 1, and it also states that "health checkups shall be conducted not less than once every two years, and for employment-provided policyholders who do not work at a desk, health checkups shall be conducted once a year" in its paragraph 3. Occupational Safety and Health Act, Article 43 (Health Examination), paragraph 1, states that "a business owner shall arrange for institutions designated by the Minister of Employment and Labor or institutions to be charged with conducting the health examination provided by the National Health Insurance Act to conduct the health examinations for workers in order to protect and maintain the health of his/her workers". In other words, business owner shall conduct general checkup, so-called workplace checkup, for their employees in accordance with National Health Insurance Act and Occupational Safety and Health Act. General checkup does not force to include HIV test.

* Regular health check-up entries. Standards of Regular health checkups and Cancer criteria [Ministry of Health and Welfare Notification No. 2007-129

<table>
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<tr>
<th>Inspection Items</th>
<th>Related Diseases</th>
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<td>Postural tests</td>
<td>Height, weight, waist measure, obesity, vision, hearing,</td>
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<td>blood pressure</td>
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<td>Urinalysis</td>
<td>Glucose, Urine Albumin, occult hematuria, urine ph</td>
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<td>ALT, γ-GTP</td>
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<td>Chest X-rays</td>
<td>Tuberculosis, Chest Diseases</td>
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<td>ECG</td>
<td>Hypertension, hyperlipidemia, myocardial infarction</td>
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<tr>
<td>Oral examination</td>
<td>Oral Diseases</td>
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<td>Hepatitis B</td>
<td>Insurer inspects hepatitis B antigen and antibody tests</td>
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However, business owner can choose health checkup program with HIV test, which actually happened. (refer to case 1, 2, and 3 below). As a matter of fact, health check-up at a medical facility or hospital contains often HIV test in the check-up list, and employers can select health check-up package of hospitals, as they want. Under this
circumstance employees are hardly aware of whether they are being taken HIV test or not, and when the test result is confirmed as positive status, they could confront discrimination at work.

In accordance with Article 8-2 (Notification of test result), subparagraph 3 of AIDS prevention Act, it is specified that employers do not ask employees for HIV test result. And enforcement regulation of occupational safety and health act, Article 105 (Report of health check-up result) states that health check-up facility has to give individual result of checkup to worker directly. However, employers can check employees’ health checkup result under their consent as employers are given responsibility for caring employees’ health in accordance with occupational safety and health act. It is difficult that employees refuse consent that employer requests.

Considering Korea’s low HIV infection rate, workplace checkup does not have to include HIV test, which is the case in general checkup. It only evokes PLHIV constant anxiety, and revealing HIV status even leads to discrimination such as dismissal, dismissal inducement, advice to resign, marginalization, relegation to petty job, etc. Furthermore, if needed, HIV test is available at public health center free of charge. HIV test should be changed to be included only when requested by worker, with result in confidential.

[Three workplace medical examination documents omitted, which include HIV testing: Workplace Checkup 1: July, 2011, Item 18, Serum Immunity Test includes HIV Test. Workplace Checkup 2: April, 2009, STD Test includes HIV Test. Workplace Checkup 3: November, 2008, Item 9 includes HIV Test.]

**<Blood Management Act>**

Korea Centers for Disease Control and Prevention has provided Republic of Korea National Red Cross with the list of malaria patients since 2004 and personal information on AIDS infected person even earlier. In 2005, the Ministry of Health and Welfare decided to share information on malaria, creutzfeldt-jakob disease, babesiosis, brucellosis-infected person including PLHIV with National Red Cross. National Human Rights Commission advised that it has no legal ground and that it violates human rights. But a new clause enabling them to get information on infectious disease patients was introduced in Blood Management Act in March 2008.

According Article 7 of Blood Management Act (Identity Verification, Health Examinations, etc. of Blood Donors), when deemed necessary for securing the safety of blood, the Minister of Health and Welfare may request the head of the relevant central administrative agencies or the head of the relevant public organization to provide them with the relevant information on patients with an infectious disease, patients who are on medication, etc. Article 6 of Enforcement Rule of the Blood Management Act (Health examination, etc. of Blood donors) provides the range of information blood centers get-personal information of infectious disease patient and patient taking medication, the result of diagnosis or the name of prescribed medicine, the date of diagnosis or prescription.

Rather than providing human resources, technologies, equipment and systems to conduct HIV selective examination on all the blood gathered, passing information on infectious disease patient which has already been reported in real name infringes on the informative human rights of patients, shifts the responsibility of blood management to patients, which is not effective. It also grants excessive discretion to the minister of Health and Welfare by making it 'deemed necessary'.

**<Prevention of Acquired immunodeficiency syndrome Act>**

The main purpose of Prevention of acquired immunodeficiency syndrome Act, which was enacted in 1987, is to monitor and control the PLHIV.

1. **Using their real name in examination, report and management/control**
   
   Article 5 of the act (reports by doctor or medical institution, etc) requires any doctor or any medical institution that has diagnosed an infected person to immediately report such diagnosis to the Public Health Clinic, which shall be reported to the Minister of Health, Welfare and Family Affairs through local authorities. Article 5 and Article 2
of enforcement rules of the act do not require the report to be in their real names excluding report in case of death. However, AIDS control Guidelines differs. Real name report and control is practiced in (1) Interview with the infected person and inquiry into blood-donation records of public health clinic, (2) Linked process in supporting hospital expenses.

1) Mandatory epidemiological investigation and real name report in public health clinic interview with PLHIV
If a person is diagnosed with HIV-positive, public health clinic should conduct an epidemiological investigation through an interview with him. PLHIV is registered to the residence district public health clinic, reported to centers for disease control and prevention through HASNet in case of moving, and is managed by public health clinic until death. Article 10(Epidemiological Investigation) states that medical examinations shall be conducted for AIDS or epidemiological investigations purposes, etc. transmission routes with respect to PLHIV and persons with good grounds to be suspected of infection. Article 27 has empowered epidemiological investigation by stating that any person who fails to comply with an epidemiological investigation shall be punished by imprisonment for no more than 1 year or a fine not exceeding 3 million won.

Under the provision, public health clinic identifies him immediately and contact him directly to investigate when medical institutions report PLHIV to be found. The clinics report the result of investigation to Centers for disease control and prevention through HASNet. In the investigation report, infected person number is reported instead of his real name, resident registration number, etc. Their identity is confirmed by his identification card during interview and his personal information(name, resident registration number) is reported to Centers for disease control and prevention through network. After public health clinic reports personal information(name, resident registration number) to the center, National Red Cross check the blood donation records of the infected person.

2) Relationship between real name report and hospital expenses support
The government argues that the reason for the necessity of real name report is so that they may support the PLHIV. The local government reimburses the medical expenses of PLHIV when they submit the receipt to the district public health clinic. Such system is used for the district public health clinic as a means of management and control to secure the attendance of the PLHIV, and is advertised as the necessary way to maintain the existing real name report system.

3) Transition of anonymous medical examination to real name examination
Article 8 of the Act(medical examination) mentions both real name examination and anonymous examination. When PLHIV gets a medical examination under his name, he gets reported in his real name in the procedures. It is provided that information on PLHIV shall be managed anonymously in case of anonymous medical examination, but real name report associated with medical expenses support is recommended. 'Anonymous' examination in the 'real name' report system is just nominal, which only leads to the management and control system of government. It just deceives the examination applicant with a sugar coating of 'anonymity'.

2. Notification to the spouse of the infected person and Mandatory examination
Method of notification to the spouse of the PLHIV is not mentioned in the law when they are bound to find out that their spouse is infected through Article 8 (medical examination) and Article 10 (epidemiological investigation). Article 8(medical examination) (2) states that medical examinations for AIDS shall be conducted to the spouse or sexual partner of the PLHIV and other persons Ministry of Health Welfare and Family Affairs believes it is necessary for the prevention of AIDS. Article 27(penal provisions) made it mandatory to conduct medical examination for AIDS on the spouse or sexual partner by stating that any person who fails to comply with an epidemiological investigation shall be punished by imprisonment for no more than 1 year or a fine not exceeding 3 million won. The subject of 'mandatory' epidemiological investigation includes 'any person with good grounds to be suspected of infection.' It is an ambiguous regulation with high risk of arbitrary application, which is applied to his partner and family members.
AIDS control Guidelines recommend that PLHIV instantly notify their spouse that they have been infected. It also states that the head of public health clinic may notify it to his/her spouse with written consent of PLHIV if they do not let their spouse be aware of the situation. When there’s a danger of infecting the spouse without their knowledge, the head of clinic shall notify it to the spouse without written consent of PLHIV.

3. Prohibition of committing infectious act
According to Article 19 of the Act, PLHIV shall not perform any infectious act to another person intentionally through blood or bodily fluids. Article 25(penal provisions) states that any person who violates the law shall be punished by imprisonment for not more then 1 year. Acts that can be seen as infectious such as 'Sexual intercourse without using condom' or 'blood donation' should be prohibited through educating and supporting PLHIV. Simple prohibitory clause cannot be a practical way of preventing HIV spread. It only promotes the stereotypes of the PLHIV being a hotbed of propagation. One may still be punished even if sexual intercourse did not infect the partner or notified the other in advance of the possibility.

4. Treatment and protection
Article 15(Measures for medical treatment and Protection, etc.) states that among PLHIVs those who refuse to be treated and has a high risk of infecting others shall be forced to take medical treatment and protection. According to Article 27, any person who fails to comply with an epidemiological investigation shall be punished by imprisonment for not more than 1 year or a fine not exceeding 3 million won. The clause of 'any person with high risk to infect others taking account of the ability of attention, surrounding environment, etc' is an ambiguous regulation with high risk of arbitrary application.

II. Laws and practices that mitigate or sustain violence and discrimination as lived by women;

< Support for infected infants >
In a very rare possibility, there are vertically infected babies. However, the medicine registered with national health insurance for PLHIV infants is only Zidovudine syrup. Usually parents grind a medicine-for-adult and use it for the babies. There is not even a guideline. Of course there is neither consultation nor education for the babies and parents.

<Support for female PLHIV>
There is a recent story that a female found herself HIV positive after giving a birth. Right after that, she committed suicide. In October 2010, there was another story about a runaway girl infected with HIV and her prostitution afterwards. But the Korean media released lewd articles for this story, using terms like 'indiscriminate sex', 'shock', 'horrifying'. None of the media was interested in other factors of this incident, such as why this teenager girl began to start prostitution, why she ran away from home and why male sex partner refused to use a condom despite of her recommendation. These incidents and the response of the media reflect the reality that women with HIV are confronting in the Korean society. Fewer than one out of ten PLHIV in S. Korea is female. The only way to protect and understand those minorities is to give protection by law. Within the conservative Korean society equipped with severe discrimination and prejudice against PLHIV, women with HIV are much more vulnerable and easily blamed for transmission, while there is no social protection for their livelihood and sustainability.

III. Laws and practices that facilitate or impede treatment access:

< Drug-supply rejection of Trans-national pharmaceutical companies and nothing more we could do>
Fuzeon(enfuvertide) was registered with Korean national health insurance on the condition of supplying at approximately USD 18,000 per year in November 2004. However, Roche was dissatisfied with the price of insured medicines and several times asked an increase of the insured price. Until today, Roche has not been providing Fuzeon through the insurance registration. In the last, PLHIV communities and CS movement groups filed the request for the compulsory license of Fuzeon’s patents on the basis of Article 107 of patent law specifying
‘especially-necessary case for the public good or benefit’ in December 2008. Right after this request, Roche came to notify free-supply for Fuzeon through ‘compassionate access programme’ in February 2009. Free-supply, as Roche stated by itself, was no more than a ‘temporary measure’, and the programme was ‘as-Roche-please-programme’ itself which never expects when it stops for Roche’s own interest. In June 2009, the Korean Intellectual Property Office (KIPO) agreed on that Fuzeon supply is considered as a necessary action for the public good and benefit, whereas KIPO dismissed the compulsory licensing claim with saying ‘the compulsory licensing on Fuzeon patent is hardly regarded as a especially-necessary case for the public good and benefit’.

< Unreasonable increase in prices of insured medicines >
Janssen Korea and National Health Insurance Corporation reached an agreement to supply Prezista (Darunavir) at 3,480KRW(USD3.50) per tablet of the insured price (USD5,100 per year) on May 26 2008. At the moment of negotiation, the offered price by Janssen was 6,150KRW(USD6.30) per tablet. Janssen Korea, However, called on re-negotiation on insurance pricing for Prezista to the Ministry of Health and Welfare. Janssen Korea determined to supply Prezista for free (not supply by insurance registration) as the Ministry of Health and Welfare had refused to renegotiate the insurance pricing. Janssen Korea was ill-affected about insurance pricing and thus disregarded Pharmaceutical Pricing Policies of Korea. In November 2011, Prezista was registered with national insurance at 41% increased price without any reasonable grounds.

< Korea-US FTA>
In February 2011, Ministry of Health, Welfare and Family (MoHWF) announced to legalize the amendment on the Pharmaceutical affairs law with the purpose of adopting Approval-Patent linkage policy before the Korea-US Free Trade Agreement was ratified by the National Assembly. The National Assembly even manages to push through ratification on the Korea-US FTA in August or autumn 2011. IF the Korea-US FTA would be ratified, including Approval-Patent linkage, data exclusivity, independent review process, medicines & medical devices committee, investor-state dispute, it would be distinctly not only causing a spurt in prices of medicines by delaying generic version, but also paralysing independent policy establishment process over insurance pricing decision and national health care system.

6 Nigeria Individual(s)

Poor Coverage of PMTCT in Nigeria: Implication for HIV Infection of Infants
Nigeria has the second highest number of people living with HIV in the world after South Africa. UNAIDS estimated 33.4million people living with HIV in 2008 in the world. Nigeria, with about 2.98million people living with HIV, makes about 9% of the global HIV burden. However, there is gender inequality in the distribution with males accounting for 1.23million and female accounting for 1.72million in the HIV estimates and projections for 2008. Women are more affected in the defining feature of the epidemic with policy implications for prevention of mother to child transmissions.

Percentage of HIV infected infants born to HIV-infected mothers is 29.1% from Spectrum. Data collected from Federal Ministry of Health (FMOH) had 13.1% of infants born to HIV mothers infected. Nigeria needs to strive towards improving the impact of PMTCT service. Operations research in the area of PMTCT is needed to improve the quality of services, and scale-up of coverage so that more HIV positive mothers could benefit from.

USAID estimates that 630,000 babies became infected with HIV through Mother-To-Child Transmission (MTCT) in 2004, and in 2005, nearly 570,000 children died of AIDS-related causes. The overwhelming majority of these children are born in the developing world, primarily in sub-Saharan Africa. Without intervention, 25 percent to 35 percent of pregnant mothers living with HIV/AIDS will transmit the disease to their children during pregnancy, labour and delivery, or through breastfeeding. The limited, primarily facility-based Prevention of Mother-To-Child Transmission (PMTCT) programs that do exist in developing countries have not reduced transmission significantly.
The numbers of mothers that can be supported appropriately with formula and all its requirements are few. There are too many missed opportunities to prevent MTCT through community strategies complementing facility services.

**Recommendation**

The integration of PMTCT into sexual, reproductive, maternal, and child health or home based care programs is the best way to use existing services and providers, and to reach the maximum number of people living with or affected by HIV/AIDS. While strong, comprehensive, quality facility services are the foundation of a successful PMTCT program, these services must be linked to community-based resources and initiatives for maximum coverage and impact—especially home-based care, faith-based programs, traditional practitioners, PLWHA support groups, and adolescent-friendly services and information. PMTCT is an issue that can serve to increase awareness and understanding of HIV/AIDS and therefore increase behaviour change and prevention. It can also inspire and promote volunteerism to promote the community’s health.

Community-level entities and organizations can advance healthy practices around PMTCT by promoting breastfeeding and its benefits to the baby. Breastfeeding must not be undermined in general because of an association with HIV/AIDS transmission, particularly since the use of infant formula is often not a feasible alternative. The vast majority of women living with HIV/AIDS do not have the financial means or the social resources (such as clean water) to safely replacement feed their babies. Unless all necessary means of safe replacement feeding are provided, it is unethical for providers to direct these mothers away from breastfeeding and its protective benefits. CBOs and NGOs can also advocate with governments and the private sector for ongoing ARV supplies for both the newborn baby and the mother. In addition to preventing HIV transmission to children, the life long care and support of the mother must be considered an equal priority.

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**Protection for the Legal and Human Rights of AIDS Orphans in Nigeria**

AIDS is responsible for leaving vast numbers of children across Africa without one or both parents. In some countries, a larger proportion of orphans have lost their parents to AIDS than to any other cause of death—meaning that, were it not for the AIDS epidemic, these children would not have been orphaned.

**The problems faced by AIDS orphans**

**Emotional impact**

Children whose parents are living with HIV often experience many negative changes in their lives and can start to suffer neglect, including emotional neglect, long before they are orphaned. Eventually, they suffer the death of their parent(s) and the emotional trauma that results. They may then have to adjust to a new situation, with little or no support, and may suffer exploitation and abuse. In one study carried out in rural Uganda, high levels of psychological distress were found in children who had been orphaned by AIDS. Anxiety, depression and anger were more found to be more common among AIDS orphans than other children. 12% of AIDS orphans affirmed that they wished they were dead, compared to 3% of other children interviewed. These psychological problems can become more severe if a child is forced to separate from their siblings upon becoming orphaned. In some regions this occurs regularly: a 2002 survey in Zambia showed that more than half of orphaned children no longer lived with all of their siblings.

**Household impact**

The loss of a parent to AIDS can have serious consequences for a child’s access to basic necessities such as shelter, food, clothing, health and education. Orphans are more likely than non-orphans to live in large, female-headed households where more people are dependent on fewer income earners. This lack of income puts extra pressure on AIDS orphans to contribute financially to the household, in some cases driving them to the streets to work, beg or seek food. The majority of children who have lost a parent continue to live in the care of a surviving parent or
family member, but often have to take on the responsibility of doing the housework, looking after siblings and caring for ill or dying parent(s). Children who have lost one parent to AIDS are often at risk of losing the other parent as well, since HIV may have been transmitted between the couple through sex.

**Education**

Children orphaned by AIDS may miss out on school enrolment, have their schooling interrupted or perform poorly in school as a result of their situation. Expenses such as school fees and school uniforms present barriers to school attendance if orphans’ caregivers struggle to afford these costs. Studies suggest that the impact of orphanhood on a child's education is closely interlinked with other factors such as poverty. For example, a multi-country study released in 2010 found that orphanhood itself was not directly associated with lower school attendance (when measuring school attendance orphans are defined as children who have lost both parents while non orphans are defined as children both of whose parents are alive). Instead, other factors such as greater household wealth were more likely to result in increased school attendance for both orphans and non orphans. However, the loss of a productive family member is likely to be a financial burden and might push a family into poverty, increasing the likelihood that a child orphaned by AIDS will miss out on school. Moreover, most orphans and their caregivers still do not receive any type of external support in the form of healthcare, nutrition, or psychosocial support. Ensuring that households where a child has been orphaned by AIDS receive external care and support is therefore essential to ensure that the increasing number of AIDS orphans attend school.

Figures released in 2010 revealed that in most countries in sub-Saharan Africa the gap between school attendance by orphans and non-orphans has narrowed although progress varies across the region. Despite this, orphans, particularly those from poorer households still remain less likely to attend school compared to non orphans. Outside of school, AIDS orphans may also miss out on valuable life-skills and practical knowledge that would have been passed on to them by their parents. Without this knowledge and a basic school education, children may be more likely to face social, economic and health problems as they grow up.

**Stigmatisation**

Children grieving for dying or dead parents are often stigmatised by society through association with AIDS. The distress and social isolation experienced by these children, both before and after the death of their parent(s), is made worse by the shame, fear, and rejection that often surrounds people affected by HIV and AIDS. Because of this stigma, children may be denied access to schooling and health care. Once a parent dies children may also be denied their inheritance and property. Often children who have lost their parents to AIDS are assumed to be HIV positive themselves, adding to the likelihood that they will face discrimination and damaging their future prospects. In this situation children may also be denied access to healthcare that they need. Sometimes this occurs because it is assumed that they are infected with HIV and their illnesses are untreatable.

**Family structures**

In African countries that have already suffered long, severe epidemics, AIDS places pressure on families and communities. Traditional systems of taking care of children who lose their parents, for whatever reason, have been in place throughout Sub-Saharan Africa for generations. But HIV and AIDS are eroding such practices by creating larger numbers of orphans than have ever been known before. The demand for care and support is simply overwhelming in many areas. HIV reduces the caring capacity of families and communities by deepening poverty, through medical and funeral costs as well as the loss of labour.

**The Way Forward**

**Support for carers**

In the early days of the AIDS orphan crisis, there was a rush by well meaning non-governmental organisations to build orphanages. Given the scale of the problem, though, this response was unsustainable, as the cost of maintaining a child in such an institution is much greater than other forms of care. Most people now believe that orphans should be cared for in family units through extended family networks, foster families and adoption, and that siblings should not be separated. Studies in sub-Saharan Africa
have repeatedly demonstrated that growing up in a family environment is more beneficial to a child than institutional care, which should be considered a temporary option or a last resort. Ultimately, though, the extended family can only serve as part of the solution to mass orphanhood if adequately supported by the state and the community, as well as other sectors of society. The community needs to be supportive of children when they are orphaned, making sure that they are accepted and have access to essential services, such as health care and education. This means improving existing services and reducing the stigma surrounding children affected by AIDS so that they do not face discrimination when trying to access these services.

**Keeping children in school**

Schools can play a crucial role in improving the prospects of AIDS orphans and securing their future. A good school education can give children a higher self-esteem, better job prospects and economic independence. As well as lifting children out of poverty, such an education can also give children a better understanding of HIV and AIDS, decreasing the risk that they will become infected. Schools can also offer benefits to AIDS orphans outside of education, such as emotional support and care.

**Empowerment for children**

If AIDS orphans are as active members of the community rather than just victims, their lives can be given purpose and dignity. Many children already function as heads of households and as caregivers. They are a vital part of the solution and should be supported in planning and carrying out efforts to lessen the impact of AIDS in their families and communities.

**Protection for the legal and human rights of orphans**

Much can be done to ensure the legal and human rights of AIDS orphans. Many communities are now writing wills to protect the inheritance rights of children and to prevent land and property grabbing, where adults attempt to rob orphans of their property once they have no parents to protect their rights. “You find that the parents have been productive and have left assets for the children but immediately after their deaths, the relatives squander everything. Those that are left without anything are just being used for the food rations.”

Children orphaned due to AIDS may face exploitation in other areas of their lives as well. For instance, evidence suggests that there is a relationship between AIDS orphans in sub-Saharan Africa and increased child-labour.

**Meeting emotional needs**

The physical needs of orphans, such as nutrition and health care, can often appear to be the most urgent. But the emotional needs of children who have lost a parent should not be forgotten. Having a parent becomes sick and die is clearly a major trauma for any child, and may affect them for the rest of their life.

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**Nigeria Law that Mitigate Rape Violence: Implication on Rising HIV Prevalence among Women**

Rape is a common sordid phenomenon in Nigeria, and some observers have blamed laws, societal attitude which tend to heap blames on victims rather than on perpetrators, as partly responsible for the upsurge and the contempt with which perpetrators view their conducts. The emerging trend has also shown that soldiers are not the only perpetrators of rape of women and even minors. In recent times, the rape of children appears to be on the increase. Early this last month, a girl of 12 was raped by a teacher in Bauchi which is one of the States in Nigeria. The perpetrator was a man living with HIV. He was said to have consciously infected the 12 year old girl with HIV. The accused unfortunately was left off the hook by the state police command and the law court. Rights groups have accused the police of treating cases of rape with kid gloves. One Margaret, a teacher in Kwara State on reporting an incident of rape in a police station, the investigating police officer IPO asked her if she had living witnesses. In another instance, a middle aged woman in Lagos late last year, stripped herself naked in the premises of the Ikeja police station alleging that she was raped by a police officer who was investigating a case of
theft she had lodged. The state police command said she was a case of ‘mental problem’ apparently without official investigation of the incident. In other instances, desk officials at police stations have been sighted mocking victims of rape.

Community Peoples Action Against AIDS, COPE AIDS, wrote a petition to the Nigerian Judicial Council, NJC seeking justice for the infected 12 year old girl that was raped in Bauchi. On the face value, rape is a grievous offence by the dictates of the Nigerian constitution. Section 357 cap 38 of the Criminal Code imposes life sentence on person who commits rape while the same section imposes two years imprisonment on perpetrators. Rape is defined as having forceful carnal knowledge of a woman or having carnal knowledge through forceful or fraudulent means. However, there has been a long standing controversy on the procedure for a victim to ascertain the veracity of claims. For instance, under the procedure to establish a rape case, a victim must produce a witness. Rights activists have kicked against this particular aspect, saying that it smacks of colonial mentality. ‘The law on rape protects men from being arrested and effectively prosecuted in the law courts because it emphasises the need for the victim to produce witnesses whereas, we all know that rape is carried out mostly without witnesses. The bizarre nature with which rape is committed in Nigeria and mostly with impunity is partly as a result of a legal framework that generally fails to protect the weak from the ferocious onslaught of the strong.

Nigerian women’s low status in marriage also makes them vulnerable to violence from their husbands. When men beat up their wives, there are no reprisals. Marital rape must be suffered in silence. Fear of beating and rape keeps many women from questioning their husbands’ sexual escapades. And submission frequently reaps a death sentence: many women contract AIDS as a result of coerced sex. For unmarried girls, the situation is even worse. If a rape is reported, it is the girl who suffers the shame, and all chance of future marriage. Under such circumstances, women’s ability to protect themselves is minimal.

AIDS has added a further, nasty dimension to this situation. Odion tested positive to HIV/AIDS in the city of Lagos. He went to his hometown of Igueben from Lagos and raped eight girls there within a month, after which he prepared a notice entitled ‘HIV Carriers in Igueben’, typed out their names, and pasted copies on signposts all over the town. Odion and the eight girls were arrested immediately. On interrogation, Odion explained that he didn’t want to die alone and that he wanted to enjoy himself before he died. The girls tested positive to HIV. In tears, they described how fear of shame and rejection had prevented them reporting the rape. While rape continues to thrive, checking the spread of HIV/AIDS becomes a Herculean task.

Current rape incidence in Nigeria
A housemaid, Yetunde Olayemi was recently raped by Oshinowo in Lagos, Nigeria. She narrated her experience “I lived with my mother in Sango-Ota before I moved to Lagos. Presently, I work as a housemaid to my guardian; she works with the United Nations,” Olayemi resisted all attempts to make her reveal her guardian’s identity.

“My guardian travels often; she doesn’t reside here with her family. Each time she travelled out of the country, she would ask her elder sister to come and stay with me so that I wouldn’t be all alone,” Olayemi recalled. Unknown to Olayemi’s guardian, her elder sister’s daughter, Faramade, often came to her two-bedroom flat in her mother’s place with her boyfriend, Oshinowo. “At first, I protested this development to my guardian’s sister, but she cautioned me and advised that I allow Oshinowo stay in the flat whenever he came with Faramade. Meanwhile, she (the guardian) was never around except on weekends,” Olayemi said. She added that her guardian had a room to herself, which was always locked.

“I used the second bedroom, which I had to vacate for Faramade and Oshinowo whenever they were around; I would have to make do with sleeping in the parlour then,” Olayemi, 21, added. On July 12, 2011, Oshinowo showed up at Olayemi’s house “I didn’t think there was anything to worry about it because Oshinowo was a frequent visitor to our flat. He gave me the impression that he was expecting his girlfriend, Faramade, and I went about my normal duties,” Olayemi said. In the end, Faramade did not show up. Oshinowo eventually passed the night in Olayemi’s room, while she slept in the parlour.
“I was startled when I was awakened in the middle of the night by a hand around my throat; it was Oshinowo. He threatened to harm me with a knife if I did not let him have his way with me. We were both alone in the flat and I was so scared. He raped me and when he was through, warned me against screaming while he went to take his bath,” While Oshinowo was in the bathroom, Olayemi ran out of the flat and went banging on the door of her neighbour’s flat opposite hers, screaming for help.

The neighbour told CRIME DIGEST that he was awakened in the middle of the night by Olayemi’s screams. “She kept screaming that there was someone in her flat that was threatening to take her life. I quickly called the police because I initially thought it was a case of armed robbery,” the neighbour said. Police officers responded almost immediately but when they got to Olayemi’s flat, it was empty. “Oshinowo had jumped downstairs (it is a one-storey building) and hid himself within the compound,” the neighbour explained. After Olayemi reported the matter to the police, a search was immediately conducted and Oshinowo was fished out from his hiding place and arrested.

Presently, Olayemi, and even her guardian, who was eventually contacted, are insisting that Oshinowo be prosecuted, but Faramade’s mother is pleading for an out of court settlement as she claims Oshinowo is the father of Faramade’s unborn child and that they are due to be married presently. Faramade’s mother was not available for comments. The Executive Secretary of the Child Dignity Foundation, Amaka Awogu, said her organisation had taken up Olayemi’s cause and would see it to a logical conclusion. “We were informed of Olayemi’s plight by some of her concerned neighbours who did not trust the police to do a thorough job. You know Olayemi has no relative in Lagos and her guardian is currently out of the country, so it was important that the matter was not swept under the carpet. “We were able to get medical evidence that Olayemi had indeed been raped; she underwent several tests,” Awogu said. “She still has to go back to the hospital in another six months to ascertain her HIV status because Oshinowo did not use any protection.

**Conclusion and Recommendation**

Despite the violent description given to rape, it is unfortunately, said to be on the increase. Ironically, the prosecution of the offenders of this heinous crime has remained relatively low as many rapists are going all over the society scot free due to the disheartening fact that the existing rape laws have not been a deterrent to the perpetrators of the crime which tends to encourage them to molest girls.

It is therefore important to strengthen legislation and other measures to protect women from violence and support victims, including by adopting specific legislation to criminalise domestic violence, marital rape and other crimes of sexual violence; and reforming the evidence requirements to prove rape; removing obstacles to victims’ access to justice; ensuring effective prosecution and punishment of offenders; implementing training for all law enforcement personnel; and establishing shelters for women victims of violence..

**Early marriage in Nigeria: Implication for the spread of HIV**

Early marriage is recognized as a violation of human rights and a critical social problem with multifaceted consequences - particularly for women and children. The practice is also recognized as a barrier that inhibits young girls from attaining education that would otherwise have a lasting positive impact on their life and well-being.

A combination of biological, socio-economic, cultural, and political factors put young women at greater risk of HIV infection than males. A girl is physiologically more prone to contracting HIV/AIDS, as her vagina is not well lined with protective cells and her cervix may be penetrated easily. A global analysis of the epidemic shows that the
Prevalence of HIV infection is highest in women aged 15–24 and peaks in men between five to ten years later.

Marriage can increase married girls’ exposure to the virus, especially as older husbands may engage in unprotected sexual relations with other partners. The risk of HIV infection is higher among the poorest and most powerless in society, and, as such, married adolescent girls will be more at risk of infection than unmarried girls who are not having sexual intercourse.

Married adolescent girls’ inability to negotiate safe sex and other social pressures represents a critical channel of vulnerability. These girls are too young and lack the courage to persuade their partners to learn their own sero-status. In general, early marriage of girls impairs the realization and enjoyment of virtually all of their rights. The imposition of marriage on children or adolescents who are in no way ready for married life deprives them of freedom, opportunities for personal development, health and well-being, education, and participation in civic life.

Many Nigerian societies have norms that limit the age of young girls to enter into marriage, but in some cases the age limit does not take into consideration their physiological readiness for childbearing. Marriage often takes place at ages much earlier than the legally ratified minimum age. Early marriage is the marriage of children and adolescents below the age of eighteen.

Among those marrying early, some are forced into this union, others are simply too young to make an informed decision. Because the child does not have the opportunity to exercise her right to choose, early marriages are also referred to as forced marriages. In its most extreme form, forced marriages are the result of abductions.

In Nigerian, particularly in the Northern part, deep-rooted traditions compel families to continue the practice of early marriage despite its consequences. Some of the most important reasons reported for the practice of early marriage relate to maintaining family status in the community, which is closely bound up with the success of children. A daughter’s marriage represents her success. There is an old traditional concern that a girl will become too old for marriage, which will represent a failure on the part of her parents. Of major importance is creating a bond with the bridegroom’s family, as well as ensuring the girl marries while she has her virginity. It was reported that enforcement of the legal age of marriage by authorities was inadequate.

When women are able to control their sexuality and fertility they are better able to take advantage of opportunities, including education and income-generating activities, that could mitigate gender-based barriers that make them vulnerable to poverty. Health, including sexual and reproductive health, ensures the capacity for personal development and economic security in the future. Health is the basis for productivity, the capacity to learn in school, and the capability to grow intellectually, physically, and emotionally.

Many believe that an exemplary marriage is characterized by the mutual understanding and respect the couple has for each other. This normally happens when the couples have entered into the marriage willingly and without the influence of a third party. Willingness reflects the individual’s commitment and readiness to keep the marriage intact. In line with this, effort was made to see if respondents entered the marriage with or without the influence of a third party.

Although the risk on HIV increase is not directly related to youth, instability is very common in early marriages, since the women enter the union by force and lack commitment and love to maintain the marriage. They run away back to their parents or to towns in search of a better livelihood, getting employed as housemaids or sex workers. This increases their vulnerability to HIV/AIDS and other STIs.

Case review

Rahmoh, who is twenty three years old, was married at the age of eleven and gave birth at twelve to a son. However, the trauma of her early delivery was too much for her young and delicate body and the whole left side of her body remained paralyzed. As a result, her husband sent her back to her parents, eventually abandoning her
completely and taking another wife. After years of suffering, her health improved but she found life extremely difficult. Leaving her son with her parents, Rahmoh moved to a town and ended up as a sex worker. Now, she is HIV positive.

Existing Law in Nigeria
The Child Rights Act, passed in 2003 and the convention on the Right of the Child (CRC), established 18 years as the legal age of consent to marriage and that if the timing of marriage does not change, over 100 million girls will be married as children in the next ten years. However, federal law may be implemented differently at the state level, only a few of the 36 states in the country have begun developing provisions to execute the law. Further on this, Nigeria has three different legal systems operating simultaneously civil, customary, and Islamic. Federal and state governments have control only over marriages that take place within the civil system.

Recommendation
A more rigorous enforcement of existing laws and policies is required to discourage early marriage. Allow anonymous reporting, work with the police and other law enforcement agencies, and make it clear that early marriage is a major violation of the rights of children.

Check and monitor the extent to which courts are implementing the existing relevant laws regularly. Despite the laws, most parents do not feel threatened by government intervention if they marry their daughters at a young age. But in some areas, recent reductions in the practice of early marriage are attributed to strong measures taken by law enforcement (the police and courts). Hence, it is important that the initiatives and commitments manifested in this area are maintained and further enhanced.

Strengthen law enforcement bodies to enable them to effectively discharge their duties and responsibilities, with due attention to the implementation of the family law and respect for children’s rights.

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Inadequate access to Treatment among Children Living with HIV/AIDS In Ede, Nigeria

Background
In high-income countries, children can be tested soon after birth using polymerase chain reaction (PCR) tests and other specialist techniques. Where this technology is available, the longest a mother will have to wait for an accurate result is usually around six weeks. In Nigeria, PCR testing is generally unaffordable or unavailable; a mother may have to wait up to eighteen months after giving birth before antibody tests (which are used in adults, and are more commonly available) can be used to accurately diagnose her child.

In some resource-poor communities like Ede town, ‘dried blood spot’ testing has been introduced. This is where a small sample of blood is taken from a child, dropped on a paper, and sent to a laboratory where it can be tested. Since these samples do not need to be refrigerated and are easy to transport, they will then be sent miles away to places where PCR is available which is always the Teaching Hospital in the State Capital, Oshogbo. However, dried blood spot testing is expensive and take a long time for test results to return. There is evidence that when the drug nevirapine is used to prevent mother-to-child transmission of HIV, dried blood spot testing doesn’t always detect HIV in the first few days of the child’s life.

Problems with testing
In 2010, only six percent of children born to women living with HIV who delivered in hospitals were tested within two months of birth in Ede. A number of factors prevent children from being tested. Health authorities’ lack of technical ability, poor systems for laboratory analysis, problems with transportation of specimens and results, and little confidence in caring for children are all significant factors. Furthermore, parents unwilling to take their child for an HIV test for fear that the child will face prejudice once diagnosed. A lack of knowledge about testing and the fact HIV can be effectively treated could also lead to poor testing rates. Mothers who have not yet been
tested may also be fearful of discovering their child been infected as this would likely mean they are infected also. Hospitals or clinics providing testing in Ede were not readily accessible and lose contact with HIV-exposed children for follow-up tests. Mothers have to travel long distances to reach the nearest health service that can test her child, and this may be impractical and expensive.

Adherence to Treatment
A self follow up of 15 cohort children in Ede who were living with HIV and on treatment found that treatment adherence ranging from 10-30%. The socioeconomic status of the children, whether or not they have disclosed their status was identified to affect their adherent to treatment. Out of the fifteen children I followed up, only 2 of them disclosed their status and this awareness of their positive status by community members has made them to be stigmatized and denied access to education by schools in this community. Stigma surrounding HIV is a major adherence problem and that is why parents and caregivers are unwilling to make it publicly known that the child in their care is HIV-positive. For instance, carers interviewed said they feel reluctant to fill out prescriptions in their local community and did not make a child’s school aware of their condition, which has led them to missing out on drug doses during the school day. They added that they are also always hesitating to administer ARVs if other people are present when a child is due to receive them.

Among older children and adolescents, a variety of social factors such as fear of stigma and discrimination, stress and anxiety and peer relations impact treatment adherence. Side effects, and the need to take treatment at different times of the day, also explain why adolescents may find it difficult to adhere to their treatment regimens. Some of the responses of the interviewees were as follows:

“We usually go for treatment during the weekdays which I cannot go because of my school and I cannot get permission from school because I don't want them to be aware that am HIV positive because my friends would leave me”. High school 2 student

“My parents abandoned me here with my grandparents because am positive to HIV which I was told to contracted through circumcision. I was not given the opportunity to go to school and everyday my grandmother would asked me not to go out and I have heard my grandparents saying it that I would soon die. When asked if she’s on any treatment she said no” twelve years old girl

“My parents died of AIDS and I was told I got this disease from my mother. People living with HIV in this community usually contribute money to hire a bus whenever we are going for treatment because we go in group because the hospital we go for our treatment is far and when I don’t have money I would be dropped because am a beggar and most times I don’t make more than 250-300 naira daily ($2) and that is what I use to sustain myself. I wish I have a relatives to care for me and send me to school. I pray for death everyday”. Fourteen years old boy

Lack of appropriate treatment
Many of the drugs that are conventionally used to treat adults living with HIV are not available in an appropriate form, or licensed/approved for use in children. Those that are available are often unaffordable in the areas where they are most needed. In the study area for instance, no treatment is available for children and whoever in need of treatment have to travel to state capital before they could access treatment. When their parents/caregivers were asked on the treatment of their children, they said

“My child is not receiving any treatment for this disease likewise myself because I don’t want people in this community to be aware of our status that is why we don’t go for treatment and even if I decide to take him for treatment I cannot afford the transport fare since my husband has dead of this disease but I make sure I take him regularly to my pastor for delivery prayer and I know my God will cure him one day”. Mother of a 3 year old child who herself is positive

My child was tested positive to HIV and I know she got this disease through circumcision. I cried with nobody to console me and have been warned earlier not to take her for circumcision but I believed if I don’t she might be
promiscuous. Now she is seriously sick because I don’t want people to know that she is HIV positive and I also don’t know if treatments are available for children. This is a lesson for me and other mothers in my community, I need to speak against circumcision in this community because it is the order of the day here. My husband who is the initiator of the circumcision abandoned me and the baby. Mother of a 5 year child living with HIV

The paediatric formulations that are available can be significantly more expensive than adult equivalents and therefore an expansion of the development of cheap, fixed-dose combinations for children is greatly needed. A lack of appropriate treatment is one of the main reasons that treatment failures occurs in children. The wider provision of cheaper, simplified drug formulations, fixed-dose combination tablets and low-cost generic versions of paediatric drugs would all have immense benefits. Although developments in paediatric HIV drugs are urgently needed it has also been observed that “children are often a low priority when it comes to drug development and financing.

Discussion/Conclusion
As HIV-related stigma and discrimination can affect children's testing and treatment, adherence due to the unwillingness of some caregivers to reveal a child's HIV status and negative attitudes towards those living with HIV need to be tackled. General improvements in the health systems of local communities in Nigeria would allow for greater resources to be allocated towards treating children. Most clinics in Nigeria lack the resources and capacity needed to help children living with HIV, and suffer from a shortage of healthcare workers that are trained to test and treat children.

SUBJECT: SPECIALIST CALL FOR SUBMISSION

INTRODUCTION
As a researcher and social worker in the field of HIV and gender justice, I feel honored at the possibility of contributing to the work of the Global Commission on HIV & Law as a ‘Specialist’. The scope of my work includes: Gender Violence, Rights of PLWHAs, acid victims and marginalized groups (Sex workers, Transgendered, IDU’s and sexual minorities). I am well acquainted with the work of the Commission and I have been part of the Asia-Pacific Regional Dialogue hosted by the ‘Global Commission on HIV and the Law’ (annex A). Recently, I have also facilitated as an expert the ‘Consultative Session of Positive Women’s Network’ hosted by SAARC and supported by UNDP. (annex B).

THE WORK WE DO
Friends for Progress, the welfare organization which I am a co-founder of has set-up a centre to promote HIV&AIDS/STIs information and prevention. We work extensively with high risk group including IDU’s, sex workers (female & male) as well as transgendered community in Pakistan. We have established two centres (1) in the Red Light area of Lahore and (2) in F-10, Markaz, Islamabad, which have a lawyer (volunteer on part time basis), doctor and female Psychologist (full time) who provide (i) information legal rights of a victim of sexual abuse / violence, (ii) Facilitating access to treatment for HIV/AIDS positive persons (iii) Training for Law Enforcers / Medical Practitioners and (iv) reproductive health. In addition free condoms and disposable syringes are also available on demand. The services of our Organization have been recognized at the national as well as international level. In the near future, we plan to launch a toll-free phone HELP-LINE in 05 local languages which would provide (i) basic legal advice to victims of Sexual Abuse / Violence, (ii) HIV / STIs, (iii) Psychological counseling and (iv) how to report a rape and where to seek help from.

How the law can be used to scale up effective HIV responses
The law and its application can have a great impact on the lives of people, especially those who are marginalized
and disempowered. The law is a powerful tool to counter discrimination, promote better health and safeguard human rights. There is a lot to learn on the interactions between the law, legislative reform, law enforcement practices and public health responses.

There is a need for lawmakers to effectively deploy legislation as a tool for ensuring universal access to HIV services. In Pakistan, the law is not serving those most susceptible to HIV – sex workers, men who have sex with men, transgender people, injecting drug users. Due to lack of understanding on part of Law Makers as well as Law enforcers, these populations are out of the reach of essential services and condemned to be ostracized forever. The silence of the Law and its archaic application has become a cause of increase in new HIV infections. There is great need to counter this silence of the Law and make favorable changes to help prevent stigmatization and risky behavior.

State of the Epidemic in Pakistan
Having an estimated total population of about 172 million and an average annual growth rate of 1.9%, Pakistan ranks as the sixth most populous nation in the world. Current data suggests that Pakistan has a concentrated epidemic among injection drug users in most cities and among male sex workers in a few cities. HIV prevalence has reached more than 7% among injecting drug users (IDUs) in at least eight major and among Hijras sex workers in at least one city. At the end of 2009, it was estimated that there were 97,400 people living with HIV and AIDS, with only 2,917 patients registered across the country, among which 1,320 are on antiretroviral drug therapy. This gap between those infected viz-a-viz those who are seeking help represents and a latent threat of the infection spiraling out of control. In the past, the majority of reported cases were among repatriated Pakistanis who had acquired HIV abroad, but currently most HIV infections are acquired indigenously – especially among the key populations at higher risk comprising IDUs, sex workers, and prison inmates. Although HIV infection rates among female sex workers (FSWs) remains low at just under 1%, there is evidence of sexual networking between FSWs and IDUs. Thus, the rising number of HIV prevalence among IDUs increases the risk of spilling over into the network of FSWs and their clients.

LOCAL LAWS THAT REPRESENT BARRIERS TO ADEQUATE HIV RESPONSE

a) The Control of Narcotic Substances Act, 1997 criminalizes drug use and possession;

The realization that the criminalization of drug users is a significant factor in the spread of HIV/AIDS is only emerging in the Pakistani Society. With about 6 million drug users in Pakistan, their criminalization has prevented drug users from accessing AIDS education and health services. Criminalization and police abuse have impeded efforts to encourage injecting users to use clean needle and syringes rather than sharing needles. Unfortunately, there is no debate on the concept of “harm reduction”, that would be much better to focus on reducing the harmful effects of drugs instead of advocating total abstinence which is generally unrealistic and unachievable. Pakistan, has failed to control the spread of HIV among injecting drug users due to continued criminalization of drug possession (even for personal use) and systemic harassment of drug users by law enforcement. Drug use and related offences: Drug control is enforced through the Prohibition (Enforcement of Hadd) Order, 1979 and Control of Narcotic Substances Act, 1997. Consumption of intoxicants including alcohol and narcotic drugs is forbidden under the Hadd order.

Treatment: Theoretically, drug users are required to register with the provincial government and carry registration cards, however, this is almost never the case. Federal and provincial governments are jointly responsible for treatment, care and follow up. Harm Reduction: Supplying of injecting equipment to an IDU may be punishable as abetment of an offence under the Hadd order. Oral substitution may also be in contravention of the law, unless permitted within the exception of supply for medical treatment. Pakistan is considering the HIV & AIDS Prevention and Treatment Act, 2007. The National HIV and AIDS Strategic Framework, 2007-2011 earmarks strategies for prevention of drug related HIV including needle exchange programmes and referral to drug treatment services and encourages co-ordination between drug demand reduction and HIV prevention programs.

Criminalization of people using drugs
Despite certain theoretical advances due to the active work of UNAIDS and other donor funded programs, the
situation on the ground is that, Police raids on IDUs disperse them underground, out of our reach and into the general population, thereby increasing the risk of spread. Criminalization of drug use is universal; penalties for consumption are either standard or vary according to the nature of drug. Penalty may also be linked to intent (with intention) to sell attracting stringent measures. Some laws distinguish between and specify small from commercial quantity, which indicates what the drug was meant for. Under Pakistani law, possession of more than the specified amount creates a presumption that the drug was meant to be trafficked. In Pakistan, possession of less than 100 grams of an illegal drug is considered possession for personal use, anything greater is presumed to be for sale, punishable with penalties up to life imprisonment, death and confiscation of property.

**Issues to explore:**
- How are charges of consumption and possession applied? Individually and/or in conjunction?
- Are drug dependent persons able to avail exemptions for medical use?
- What is the impact of arrest and incarceration on drug users’ health, especially access to harm reduction services?
- Have graded penalties according to substance and quantity proven less burdensome for drug users?

**Treatment for drug dependence**
Almost all laws provide some form of treatment either within penal or civil institutions or both. Treatment is available to ‘addicts’ – which generally excludes occasional users or those without manifest signs of dependence. Where defined, treatment is given a restrictive meaning, usually to be ‘free from drugs’. Several countries including Pakistan mandate reporting of ‘addicts’ to authorities by physicians, family or the user her/himself. Users can be forced into ‘treatment’. Some statutes also authorize users’ detention in treatment and/or rehabilitation centres. Successful completion means ‘coming out’ and ‘remaining clean’ for years together. Where offered as an alternative to imprisonment, relapse can result in enhanced sentencing.

**Issues to explore:**
- What policy mechanisms can be applied to give treatment a ‘real’ meaning?
- Are there differences in drug users’ experience of treatment in civil facilities as opposed to treatment routed in the criminal justice system?
- Do prosecution/ Courts invoke treatment provisions?
- What evidence is needed to reform/reject mandatory reporting and forced treatment?
- Can treatment be offered with safeguards against loss of civil rights and liberty?

**Harm reduction / Needle syringe provision**
While Pakistani law does not penalize possession of injection equipment. Yet, providing, distributing and dispensing clean needles to drug users with knowledge and intent that such needle will be used to inject illicit drugs, may attract penalty for inciting, aiding or abetting an offence.

**Issues to explore:**
- Does carrying needles increase risk of identification and arrest for drug users?
- Does shaky legal ground for needle syringe programs affect coverage?
- How can international and national regulations for Buprenorphine and Methadone procurement be simplified and made operational?
- How can policy commitments on HIV and harm reduction provide impetus to drug law reform?

b) **The Hudood Ordinance of 1979; The (Punjab and West Pakistan) Suppression of Prostitution Ordinances 1961, and the Pakistan Penal Code 1860 criminalize activities of MSM & FSW.**

Sex work is illegal in Islamic Republic of Pakistan, but has a long history and is a thriving industry in the country. Over the past three decades, sex work has evolved from a predominantly brothel-based culture to a more diverse and dispersed pattern where women, men and transgenders (Hijras) sell sex. Male sex workers (MSWs) and Hijras
mainly operate in public areas such as parks or streets. Prostitution has no legal recognition in Pakistan. Moreover, despite growth of male prostitution and gay prostitution, homosexuality is outlawed in the nation. Under Section 377 of the Pakistan Penal Code, whoever voluntarily has "carnal intercourse against the order of nature with any man, woman or animal" shall be punished by 100 lashes and from 2 years to life imprisonment. While arrests are not common for homosexuality, the law is used as a tool to blackmail. Police frequently take money or sex from people they know to be involved in commercial or non-commercial homosexual relationship. Pakistani law is greatly influenced by the Penal Code drawn up by the British in 1892. This remains a major element of the current Pakistani law.

Section 371A and section 371B of the Pakistan Penal Code states:
c) 371A. Selling person for purposes of prostitution, etc.—Whoever sells, lets to hire, or otherwise disposes of any person with intent that such person shall at any time be employed or used for the purpose of prostitution or illicit intercourse with any person or for any unlawful and immoral purpose, or knowing it to be likely that such person will at any time be employed or used for any such purpose, shall be punished with imprisonement which may extend to twenty-five years, and shall also be liable to fine. Explanations.—(a) When a female is sold, let for hire, or otherwise disposed of to a prostitute or to any person who keeps or manages a brothel, the person so disposing of such female shall, until the contrary is proved, be presumed to have disposed of her with the intent that she shall be used for the purpose of prostitution. (b) For the purposes of this section and section 371B, "illicit intercourse" means sexual intercourse between persons not united by marriage.
d) 371B. Buying person for purposes of prostitution, etc.—Whoever buys, hires or otherwise obtains possession of any person with intent that such person shall at any time be employed or used for the purpose of prostitution or illicit intercourse with any person or for any unlawful and immoral purpose, or knowing it to be likely that such person will at any time be employed or used for any such purpose, shall be punished with imprisonement which may extend to twenty-five years, and shall also be liable to fine. Explanation.—Any prostitute or any person keeping or managing a brothel, who buys, hires or otherwise obtains possession of a female shall, until the contrary is proved be presumed to have obtained possession of such female with the intent that she shall be used for the purpose of prostitution.
e) Sexual relations between two consenting adults was not a crime in Pakistan before 1979. Only the involvement of minors in prostitution was prohibited by law. Later the Hudood Ordinance was enacted and extramarital sex became a criminal offence.
f) The Hudood ordinance categorizes FSWs and MSMs a quasi-legal population making service delivery difficult.
g) All sex workers and MSM fall into the category of a quasi-legal population which naturally makes steady, consistent service delivery a difficult task, thereby diluting the impact of our activities.
h) Stigma, especially against the Hijra community is high, inhibiting entry into treatment centers without fear of discrimination. Hijras, as a lifestyle, opt for voluntary castration which is not supported by our centers forcing them to opt for traditional methods that are unhygienic and dangerous. Human Rights issues in general are itself an enormous challenge in Pakistan.

EXPERIENCE(s)
Our experience of working with vulnerable individuals during the last five years has exposed a fatal synergy between the pandemics of Violence against Women (VAW) and HIV&AIDS. Women who are HIV-positive tend to have a higher degree of exposure to violence. And women in violent situations experience heightened vulnerability to HIV transmission. The individual stories are heart wrenching. In the displacement following the 2005 catastrophic earthquake in Pakistan, (28 years) was gang-raped by a group of looters. She reported the rape to her husband but he felt powerless to help her due to his own injuries and poverty. A few months after the rape, Shazia began to feel ill, and discovered first that she was pregnant and then that she was HIV-positive. Her husband abandoned her and her twin sons. (32 years) an illegal immigrant from Afghanistan living on the outskirts of Peshawar also underlines the link between violence and HIV&AIDS as she describes her treatment at the hands of an abusive husband who had 2 other wives: “He would beat me to the point that he was too ashamed to take me to the doctor. He forced me to have sex with him and beat me if I refused. This went for all his [wives]. Even when he was HIV-positive he still wanted sex. He refused to use a condom.”
Despite the abundant nature of such chilling stories from across Pakistan, most HIV & AIDS prevention strategies fail to integrate effective measures to address violence as a crucial transmission channel for the AIDS virus.

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

**Research for Reform must be Ongoing …**

HIV and attendant health concerns have given momentum to advocacy and policy reform in many areas including drug use. Some typologies for legislative change are already available. It is hoped that international drug policy and its domestic equivalent – narcotic legislations will be subject to rigorous debate and analysis. Matters that affect the health and lives of drug users must be placed high on legal research and reform agendas.

**The need for strengthening of legislation**

A National response to control the HIV epidemic calls for a multisectoral involvement and an enabling environment ensured by an adequate legislation in all sectors. Our Organization (Friends for Progress) and NACP has started to work propositions to revise the legislation regarding public health. But this effort must be joined by all sectors. The following examples illustrate the need for such an act:

- The high levels of stigma and discrimination for PLWHAs and high risk groups within society and even within families,
- Lapses in confidentiality and the lack of codes of conduct, with numerous examples of name and photos of PLWHAs published in media, misbehaviors with PLWHAs by health professionals,
- The boycott of PLWHAs businesses, and discrimination in working places,
- The right to privacy and family life for PLWHAs,
- The vulnerability of women in particular to protect themselves when the husband is HIV positive or engaged in high risk behavior, to access services dependant on decision by male.

In Pakistan, for the moment no HIV/AIDS specific act of legislation ensures that individual rights are guaranteed to protect vulnerable persons, PLWHAs and their families. The report of the “National Consultation on HIV/AIDS and Human Rights” held in Islamabad stressed that:

- “It was crucial that certain individual rights are guaranteed by law to protect PLWHAs and their families from discrimination and stigmatization”
- “Those countries without any existing legislation must enact a comprehensive national HIV/AIDS prevention law and systems must be in place to ensure effective implementation as well as effective action in respect of violations or noncompliance”.

Moreover, the fact remains that high risk groups have doubtful legal status in Pakistan and are hence often liable for prosecution and persecution. This raises the question of how to define their legal human rights in accessing specific services. This can be partially answered through pursuing the enactment and enforcement of appropriate legislation. With regard to HIV/AIDS, any legislation needs to draw on a clear understanding and awareness of the status of the HIV epidemic in Pakistan now, as well as future projections, so that it remains relevant. The legislation has to take into account the urgent need for comprehensive interventions, to weigh their pertinence in view of their benefits, now and in the future, and to protect their implementation. The specific issues that the legislation should try to address are as follows:

**Public health:**

- Voluntary testing and counseling with prohibition of mandatory and compulsory HIV testing,
• Confidentiality of information/ notification of test results to the public health authorities
• Universal precautions control
• Blood safety
• Access to the means of prevention

Treatment, therapeutic goods and ethical research
• Access to affordable HIV/AIDS medication
• Access to care
• Ensuring safe and efficacious therapeutic goods
• Quality of HIV test kits and condoms
• Ethical human research

Anti-discrimination, privacy legislation, equality and communication
• Protection of vulnerable groups against discrimination with wide jurisdiction
• Privacy protection for HIV related data
• Conditions allowing the partner notification
• Administration of anti-discrimination and privacy protections
• Equal legal status of men and women (property, finances, relationships and work)
• Assembly, association and movement rights
• Expression rights and censorship/broadcasting

Employment law
• Prohibition of HIV screening
• Lack of exclusion of HIV positive workers
• Complaints against health professionals
• Employment security and social security
• Confidentiality in the place of work

Criminal laws
• Laws related to drug abuse, rehabilitation and harm reduction
• Protection against sexual and other violence
• Right to legal representation
• Conditions allowing restriction on living circumstances and detention

Sexual offences and sex industry
• Protection of SW from trafficking
• Regulation of health and safety of SW

Prisons/correctional laws
• Availability of means of prevention in prison
• Parity of access to prevention and care in prisons
• Lack of compulsory testing and segregation
• Protection against involuntary acts
• Confidentiality of information
• Compassionate early release or diversion on health conditions

Advancing Equality to Promote Gender Equity
There are many inequalities that women face, such as in accessing basic facilities and opportunities, inequalities at the workplace, within households, and in inheritance and property ownership as highlighted earlier. Policies should be in place for law enforcement and legal agencies to support women who are victims of violence including marital rape. HIV cannot be fully countered only through public health measures. There is a dire need
to shift the dynamic of gender relations. Community-based initiatives that address damaging norms of masculinity and femininity and reduce the acceptability of violence against women must be supported and scaled up. Simultaneously, we must implement legislative, policy and programmatic measures to promote gender equality and the empowerment of women and girls. These should include the enforcement of laws to grant women equal property and inheritance rights and allow them to make independent decisions regarding marriage and divorce. Policies need to be implemented that increase women’s access to economic opportunities and formal employment. We should step up efforts to ensure that girls complete secondary education and have livelihood alternatives, and put in place programmes to increase women’s access to sexual and reproductive health services.

These interventions need to be supported by an enabling environment, hence the need to begin to address the structural determinants of Intimate Partner Transmission of HIV, such as profound gender inequality in law, custom and practice and unfavorable legal frameworks to address HIV comprehensively.

In this context, it is important to have a periodic review of policies and reform of the legal systems that govern women and vulnerable populations, including the review of laws that criminalize sex work and homosexuality.

Addressing Underlying Structures
In order to support effective preventative measures and interventions, it is important to address the underlying structural causes that put women at risk and increase their vulnerability to HIV in long-term and stable sexual relationships. This will substantially enhance the effectiveness of the efforts to reduce the HIV risk of sex workers, MSM, and IDUs, and would also help break the link between their risk and that of their regular sexual partners. Legal frameworks that continue to pose significant challenges to universal access, prevention treatment and care need to be improved and integrate the gender equality and human rights obligations made by the Pakistani Government in line with international commitments. Measures and programmes that promote and enhance women and girls’ economic empowerment is another broad area of structural intervention that has proved important in decreasing women’s vulnerability to gender based violence and increasing their ability to negotiate safe sex. Community based initiatives that address damaging norms of masculinity and femininity, promote positive models of masculinities among men and boys and reduce the acceptability of violence against women must be supported and scaled up. Similarly, it is critical to put in place a system to address the factors that make migrants vulnerable to HIV throughout the migration process. A reintegration programme for migrant workers who are sent back from the host country after being infected with HIV should also be worked out.

There is a need for scaling up lobbying activity to ensure that legal and social reform to safeguard the rights of women (especially against violence) remains high on the list of government priorities. Civil society groups can play an important role in this regard. However, sustainable progress to eliminate GBV depends ultimately on; the ability of a society to make advances on other development objectives, as enshrined in the MDGs. Sensitization of front line personnel (police personnel, for example) is of critical importance in improving law enforcement related practices in the context of GBV. A key challenge faced by women infected and affected by HIV in Pakistan and this region is the denial of their right to inheritance and properties. Reports from networks of women living with HIV, as well as academic research in the region, show that it is a crucial factor in reducing women’s vulnerability to violence and HIV, as well as empowering women to cope with the social and economic impact of the epidemic at the household level.

Laws, customs and ‘traditional’ practices often legitimize the allocation of community and family property to males over females. Patrilineal customs demand that inheritance of the family name, the membership of the community and property should all be channeled through the male. Women who are widowed or abandoned by their husbands, and returned to their maternal homes are often forced to survive as full dependents on the fringes of their family.

STATE OF WOMENS RIGHTS IN PAKISTAN
The Married Women’s Property Act, 1874, entitles married women to separate property. Similarly, the Transfer of Property Act, 1882, confers equal rights upon women to engage in sale, mortgage, lease, gift and transfer deals of immovable property. However, gender inequality in ownership is the norm: In reality, Pakistani women are
deprived of their legitimate property rights. A combination of factors such as harmful customary practices, social inhibitions, distorted version of Islamic provisions on inheritance and unequal power structures prevent Pakistani women from exercising their due rights. For most of the population, inheritance practices are largely governed by Islamic Sharia law. Women’s share is generally smaller than to which men are entitled. A daughter in a family inherits half the share of a son in the property.

**LOCAL SITUATION**

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

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

**ADVOCACY EXPERIENCES**

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

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

**BUILDING A LONG TERM STRATEGY**

In our recent presentation at ‘Pakistan Human Rights Forum’, we stressed on policy makers and civil society that Police must be made to be accountable to communities and protect and serve all individuals, including sex workers. But participants noted that police are often the primary perpetrators of abuse. In Pakistan, the police go beyond their mandate of law enforcement to impose their own conceptions of morality, such as the idea that women shouldn’t be in control of their sexual behavior. Participants discussed risks confronted by NGOs that try to work with police. Some are co-opted into informing on sex worker communities or facilitating enforcement of prostitution law. Or conversely, NGO staff may be attacked or arrested for the work they carry out with and on behalf of sex workers and other marginalized groups. Participants stressed that the strategies used to address policing tactics must vary according to local realities. For example, lawyers may be useful in some places to contest police abuse. However, laws and courts are irrelevant in many places, and collective action may be the best way to restrain police. Others stressed that pragmatic reforms work best, such as working against police corruption by advocating for better police training, internal accountability and higher police salaries.
Finally, I believe the rights situation in Pakistan for those suffering with HIV and vulnerable to HIV is far from ideal. Significant efforts are needed to educate the public and reform legislation to improve the rights of marginalized segments of society that are most vulnerable to exploitation and HIV infection. I would also like to state that irrespective of the outcome of my humble submission, I would like to remain in contact with the Commission, as I strongly feel that we have a common agenda and face common challenges.

Yours faithfully,
FRIENDS FOR PROGRESS

Introduction

Sigma Research welcomes the opportunity to respond to the call from the Global Commission on HIV and the Law to submit specialist evidence about the impact of legal systems on the HIV response. Sigma Research is a semi-autonomous research unit that is part of the Department of Social and Environmental Health Research within the London School of Hygiene and Tropical Medicine (LSHTM). We undertake social, behavioural and policy research related to HIV and sexual health among those groups that are most affected, and in the UK this means a focus on gay and bisexual men and other men who have sex with men (MSM), as well as people of Black African ethnicity, no matter what their sexuality. Our research values commit us to a grounding in community-based research that is guided by our focus on human rights and equity for the sexually and socially marginalised, and we also aim to ensure that the knowledge base that we contribute to is translated into action at local, national and international levels.

We acknowledge and support the deliberately wide scope of the call for submissions as set out by the Global Commission. In anticipation of the fact that many UK organisations will have already made submissions covering a wide array of legal issues affecting the lives of people with HIV, as well as the those in HIV prevention need (including: criminal legislation governing sex work, immigration law, regulations about access to ARVs for irregular migrants, healthcare and prevention policy in detention settings, etc.), we have chosen to focus our submission on criminal prosecutions for HIV transmission and exposure in the UK, as this is an area within which Sigma Research has collected a sufficient body of evidence.

A decade has now passed since people with HIV in the UK have been successfully prosecuted for HIV transmission under criminal law in Scotland as well as England and Wales (we are unaware of any prosecutions in Northern Ireland). Sigma Research has been steadfastly involved in contributing to the community, policy and research response to these prosecutions. In addition to the production of a policy briefing on the topic designed for the domestic HIV sector (Dodds et al. 2005), we have also systematically collected data on how such prosecutions are regarded among the groups most affected by HIV in the UK (MSM and Black African people).

Despite a dramatic slowdown in prosecutions in England and Wales since the central implementation of Crown Prosecution Service prosecutorial guidelines on such cases accompanied by the case of R v Collins 2006 where it was demonstrated by testimony from Dr Anna-Maria Gerretti that virological evidence alone is unable to prove the direction or timing of transmission, we feel that the impact of criminal prosecutions continues to hamper the lives of people with HIV in the UK, as well as those most at risk of acquisition. Police investigations, arrests, and early guilty pleas all continue to gain widespread and misinformed national media attention. For this reason, most members of the public including people with HIV, healthcare providers, and frontline staff in HIV support and prevention organisations have no reason to understand that there has been any significant change in the rates of...
successful prosecution. We believe that in both subtle and direct ways, the harm done by criminalising HIV transmission in the UK continues, even while successful prosecutions continue to ‘wither on the vine’.

This submission will summarise three different pieces of research we have undertaken in the past decade, each with different groups of people and framed within very different research questions, approaches and methodologies. The reference list at the end of this document gives the full bibliographic details of the research reports and papers on which this submission is based. We aim to demonstrate not only the range of evidence on criminalisation over time, and across sub-populations, but in summarising them together we want to present a picture of the impact this has had on the lives of those closest to the epidemic. In doing so, this submission aims to respond to the second of the two questions posed in the call for submissions by the *Global Commission*, namely: *How can the law be a ‘game-changer’ - i.e.: substantially change the trajectory of the HIV epidemic?*

2003 Data

The Outsider Status project (Dodds *et al.* 2004) was a study of the impact of HIV-related stigma and discrimination on people with diagnosed HIV undertaken in England in 2003. We were able to explore responses to the first criminal conviction for HIV transmission in England as it emerged during the fieldwork. The responses were collected during 20 focused group discussions (consisting of 5-12 participant each) with a community and web-recruited panel of heterosexual African men and women, and gay and bisexual men (n=125) living with diagnosed HIV in London, Manchester and Brighton. Criminalization of reckless HIV transmission was discussed in 16 of the 20 groups (the subject was raised by participants in eight groups and prompted by the facilitator in eight groups).

A detailed review of all annotations and transcripts revealed 188 separate comments or exchanges on this subject. A reflexive thematic content analysis of this sub-sample yielded 12 thematic categories into which comments were then coded (see text box below).

The vast majority (90%) of comments made by participants were critical of the implementation and impact of criminalisation. In particular, respondents expressed concern about the way in which criminal convictions conflicted with messages about shared responsibility for ‘safer sex’, and the extent to which such cases exacerbate existing stigma and discrimination related to HIV. Most felt that the successes achieved by human rights approaches to HIV prevention, treatment, and care were placed under threat by the growing culture of blame encouraged by criminal prosecutions.

The data allowed us to examine the extent to which people living with HIV regard the issue of criminalization as one that affects them personally, as well as how they assess the broader impact of such prosecutions. The analysis demonstrated that there were core issues of concern among this population with direct relevance to public health outcomes and, in turn, the longer-term development of prosecution policy.

**Thematic categorization of respondents’ positions on criminalization (ordered by number of times the comment was made)**
1. *Shared responsibility* (n=49) Responsibility for HIV transmission is shared, it is not the sole duty of the person with diagnosed HIV to ensure that consensual sex is protected
2. *Increased stigma* (n=34) Criminalization exacerbates the stigma that is already associated with HIV by strengthening the culture of blame surrounding infection
3. *Questionable veracity of evidence and reliability of witnesses* (n=17) The veracity of the evidence in such cases is questioned due to a lack of detail in press coverage (i.e. was it determined who was infected first, or if the complainants might have been infected by a different partner?)
4. *Behaviour change implications* (n=16) Sexual practice will need to change – untested people need to exercise more caution, and those diagnosed with HIV will need to disclose. Those making such comments were sometimes, but not always in support of criminalization
5. *Perception of racial bias in the judiciary* (n=14) These cases are seen to be indicative of a racist judicial system
6. *Negative press impact* (n=13) The press has perpetuated inaccuracies and misinformation about HIV in relation to these cases (i.e. HIV as an immediate death sentence)
7. *Criminalization may be the best way forward* (n=11) There are valid occasions when people should be convicted for not disclosing their HIV status, this might encourage some people to think twice before they act
8. *Renewed imperative to resist stigma* (n=8) There now exists an even greater imperative to actively resist stigma as a result of criminal cases
9. Invisibility of large HIV organizations on this issue (n=8) HIV organizations have not made an effective response on this issue – Some wondered if this reflects their lack of support for migrant Black African men with HIV?

10. Negative public health outcomes (n=6) Criminalization will ultimately result in worsening public health outcomes (i.e. fewer people will come forward for testing)

11. Most people living with HIV have safer sex (n=7) Most people living with diagnosed HIV are responsible when it comes to sexual risk-taking, and as such, those being prosecuted are not representative of the HIV-positive population as a whole.

12. Gender disharmony (n=5) This issue pits women against men in a way that is unproductive and disempowering

Many felt that limiting responsibility for HIV transmission to the persons who know that they are infected runs counter to the goals of ‘safer sex’ interventions that target populations at highest risk. The issue raised most often by respondents was their concern that criminalization had weakened the message that sexual health should be the responsibility of both consenting partners during sex.

There is something called collective responsibility. I think they [the complainants] should be responsible for their lives in the first place. (female African respondent)

In addition to this, the experiences and opinions of respondents make it clear that criminalization has a broader social impact that ultimately increases stigma related to HIV. That is, fear of persecution inhibits people’s ability to live openly with HIV infection.

Once you talk about this, you fear everybody! You can’t do this or that. (male African respondent)

This can significantly reduce the quality of life of those living with HIV. There is also evidence that stigma detracts from the aims of HIV prevention work because it increases the difficulty of disclosing an HIV-positive status in sexual settings, and provides a disincentive for those at risk of exposure to reflect on their behaviour and come forward for testing.

2006 Data

While undertaking the national Gay Men’s Sex Survey in 2006, we were able to ask a large number of gay men and bisexual men about their views on criminal prosecutions for the sexual transmission of HIV infection in order to better understand how this might impact on their sexual risk behaviour. The survey is an annual community-based collaborative action research intervention that was also used to give men some facts about HIV and prosecution. During the period of fieldwork, there was a significant amount of national press coverage of a London woman prosecuted for the reckless transmission of HIV. That same summer brought news of the first conviction where the defendant and complainant were both gay men. Thus, the issue was very current in the mainstream press and the gay press at that time.

The Gay Men’s Sex Survey (GMSS) is an annual self-completion survey of men living in the UK who have sex with men. The questions include demographics, HIV status indicators, HIV risk and prevention behaviours, HIV prevention needs, use of settings in which health promotion can occur and access to interventions. GMSS recruits using two methods: online and through the distribution of seal-and-return booklets by agencies working with gay and bisexual clients. A wide range of questions on criminal prosecutions were asked in both the online and booklet versions of the survey, and findings from most of these questions are in the main survey report (Weatherburn et al. 2008).

Following on from the main survey report, the Sexually Charged report (Dodds et al. 2009) summarised below concerned additional exploratory questions in the online version of the survey only. In the online version of the survey, all men were asked: Do you think it is a good idea to imprison people who know they have HIV if they pass it to sexual partners who do not know they have it?. The response options were: Yes; No; Not sure. Whatever their answer they were then asked: Why do you say no / yes / not sure? They were provided with an open box within which to type an answer. There were 8,286 men who completed the survey online, and of these, 8,252 answered the first close-ended part of the question, and 6,718 (81%) went on to provide a response to the open-ended question. More than half (57%, n=4676) of all respondents said yes, they think it is a good idea to imprison people who know they have HIV if they pass it to sexual partners who do not know they have it. About a quarter
(26%, n=2120) were unsure and the remainder (18%, n=1456) thought it was not a good idea.

By far the strongest association with agreement on criminal prosecutions was with numbers of male sexual partners in the last year. Disagreement with prosecutions increased with increasing numbers of partners. When asked to describe why they agreed or disagreed with prosecutions, men’s responses fell into one of five major themes: Responsibility, contingency, appropriateness of using the criminal process, harmfulness of HIV transmission, and HIV prevention impact. The Sexually Charged report (Dodds et al. 2009) describes in detail how these themes emerged variously in responses given by men who agreed, disagreed, or were not sure about prosecutions.

Among men who supported prosecutions, a substantial proportion felt that HIV transmission represents a substantial infliction of harm (49%) – with many considering HIV to be a fatal disease, the transmission of which they represent as being akin to murder. Rather than being ‘complacent’ about HIV, this demonstrates how very seriously most men treat the possibility of HIV infection. At the same time, equating HIV with ill-health and death means that many have overlooked the positive benefits of anti-HIV treatments, which in itself indicates HIV prevention need. Men focused on the harm caused, considered the consequences of infection, the conduct of the transmitter, and his moral culpability. Those who focused instead on responsibility (37%) were almost uniformly of the view that it is the exclusive responsibility of the person with diagnosed HIV to avoid participating in sexual exposure and transmission.

Most men who were not in favour of imprisonment gave a reason that related to responsibility (42%). This was the one major thematic category that pervaded the open responses, regardless of men’s position on prosecutions. Unlike those who agreed with imprisonment (described in the paragraph above), men who disagreed with prosecutions did not hold a unified view of responsibility. Instead, there was a divide – between those who regarded sexual contact as a shared undertaking with shared responsibility and those who felt that the person who acquires HIV is responsible for his own infection. Some of these latter responses blamed the (previously) uninfected partner, which is similar to those men that agreed with imprisonment and blamed the man transmitting HIV. Others (25%) felt that even where people’s actions were morally dubious, they did not feel that being in prison would do anything to improve future outcomes for that individual or the population as a whole. A final group (12%) took a broader view, by setting the population goals of HIV prevention as the primary measure against which all interventions are assessed. By their reckoning, criminal prosecutions caused more harm than good.

Where men who were not sure about prosecutions gave reasons for their response, answers tended to be longer and more equivocal than those given by men who clearly agreed or disagreed with prosecutions. In the main (42%), they felt that forming an opinion would depend on particular aspects of a case, including risk reduction, shared understandings and intent (despite the highly contested meanings that this notion is shown to have). Given all of these possible contingencies, many felt it was not feasible to offer a single definite answer. Where responsibility was raised by men who were unsure about prosecutions (17%), the perspectives were more diverse than among men who were sure of their position. Among men who agreed with imprisonment, the vast majority were concerned with the responsibility of the diagnosed partner, and among men who disagreed with imprisonment, there was a divide between responsibility shared by both partners, or just the person acquiring HIV. Among men who remained unsure about prosecutions, all three responsibility sub-themes were rehearsed by different respondents in different ways while simultaneously expressing grave doubt about prosecutions. Others (17%) considered imprisonment to be an inappropriate response to such cases.

Whereas it is often difficult to find a useful means of interpreting what survey respondents mean when they say they are ‘not sure’ about a particular question – in this particular instance, it is the men who answered ‘not sure’ who are perhaps the most interesting. They are men who want to know more about an event before they are prepared to judge it, and they are men who can be seen to be actively weighing up the balance of what they may regard as an immoral act, on the one hand, with a potentially problematic response, on the other.
Responsibility emerged as the most significant theme for all men responding to the open-ended question, regardless of their views on prosecution. For a significant proportion, their beliefs about the exclusive and primary responsibility held by those with diagnosed HIV centered on the obligation to disclose their HIV infection. This is not surprising given that prior research demonstrates that most gay and bisexual men think men with HIV should disclose their status before having sex and that men who do not disclose are by default not infected. Patterns of support for prosecutions follow patterns of disclosure expectations. In HIV prevention terms, men’s strong beliefs about how people should behave toward one another informs their understanding of how people do behave. Where respondents have expectations that all men with diagnosed HIV should tell their sexual partners in advance, they will also apply this expectation when having sex themselves. The expectation that people with HIV will disclose their infection to all sexual partners prior to intercourse carries the implication that HIV diagnosis itself confers a contingent element of culpability. From this perspective, knowledge is accompanied by an automatic obligation to warn others of the possibility of infection, and where disclosure does not occur, that default culpability is affirmed. Furthermore, the twin assumptions that all men with HIV will both know about their infection, and that they possess the desire and skills to disclose to all their potential sexual partners presumes that men without HIV have no part to play in protecting themselves from infection.

The responses of many men who support imprisonment demonstrate little appreciation of the possibility of living well with HIV, and a clear indication that they blame men with diagnosed infection for any subsequent transmission they are involved in. Such views support HIV-related stigma, and provide evidence of pervasive HIV prevention need. For instance, those who do not appreciate that most people with HIV on treatment live full and active lives will be less likely to consider whether some of their own sexual partners have HIV. If we expect people with HIV to look thin and sickly we are unlikely to appreciate that a healthy and attractive sexual partner might have HIV. Among men who have not tested HIV positive, ignorance of this kind is associated with viewing HIV transmission risk as theoretical unless directly confronted with a positive disclosure.

Those who lack the knowledge, the will or the power to reduce the risk of acquiring HIV, or the capacity to implement risk reduction during a sexual encounter, are ill-equipped to deal with a positive disclosure when it occurs. In addition, where men with diagnosed HIV have experienced rejection and recrimination as a consequence of prior disclosures to potential sexual partners, their likelihood of maintaining a strategy of universal disclosure is substantially diminished. These needs were not caused by the emergence of criminal prosecutions for sexual HIV transmission. However, legal developments maintain and possibly exacerbate them by fostering unrealistic expectations and encouraging blame. Those with unrealistic assumptions of sero-concordancy and positive disclosure may welcome what they regard as a further layer of protection from the criminal legal system. Instead, the opposite is the case. They will continue to take risks, naive to the possibility that current and future sexual partners could have diagnosed HIV and not tell them. What blame tends to do, is to further entrench two flawed positions, between men who feel that those who acquire HIV ‘should have known better’, and those who feel that men who transmit HIV ‘should have acted more honourably’. This need to locate blame for HIV transmission undermines HIV prevention needs of men on both sides, as it reinforces the pervasive assumption that all men think and act in the same way.

While we have reported elsewhere (Dodds et al. 2004) the propensity of both gay and bisexual men, and African people, to stigmatise members of their own communities on the basis of known (or assumed) HIV infection, the degree to which the reality of living with HIV is misunderstood, and the fear and loathing with which men characterise those “other” gay men and bisexual men with HIV is clearly evident in the findings presented here. The othering of HIV continues to be the largest underlying challenge to our HIV response.

2008 Data
The final set of findings to be summarised in this report are taken from data collected during a project called Relative Safety II. The study involved in-depth interviews undertaken with 42 men recruited by 10 community-
based agencies in England and Wales in 2008 to investigate experiences of unprotected anal intercourse amongst homosexually active men with diagnosed HIV. A full description of the methods and wider findings of that study are reported elsewhere (Bourne et al. 2009). There was an even distribution of men living in high and low HIV prevalence areas, and those who had been diagnosed for longer and shorter periods of time. To be eligible to participate, men were required to have received an HIV diagnosis, and to have participated in unprotected anal intercourse with a man in the last year. Interview questions covered a range of topics about respondents’ sexual decision-making and risk assessment, also enquired about their awareness and assessment of the personal impact of criminal prosecutions for the reckless transmission of HIV in the UK. Interviews lasted 1-2 hours and took place in Bristol, Exeter, Leeds, Liverpool, London, Stoke-on-Trent, Manchester and Swansea. Each interview was digitally recorded and transcribed verbatim.

Almost all (37 of 42) respondents gave information about their understanding of prosecutions after being asked: Did you know that in the UK, and elsewhere, people have been prosecuted and convicted for transmitting HIV to another person? … Can you tell me what you understand about these cases and about criminal prosecution for HIV transmission?

Twenty-nine of the 42 talked about the extent to which criminal cases had caused them to reflect on or change their sexual behaviour after being asked: Does the possibility of criminal prosecution make any difference to the type of sex you have?

About a third of the men in the sample articulated awareness of, and accurately expressed, the matters which the prosecution has to prove. Nonetheless, their understanding commonly contained key flaws and some substantial misunderstandings. For instance, most of the men were aware of black African heterosexuals in the UK facing prosecution but did not know that sexual HIV transmission between men could also be prosecuted. Another frequent assumption was that for those with high numbers of concurrent partners, evidence to support a prosecution would be impossible to collect. Perhaps the most profound confusion was among those who wrongly believed that only those who had a premeditated intent to cause HIV transmission risked prosecution.

Of the 29 men who reflected on personal impact, almost half felt that prosecutions had not influenced their sexual behaviour in any way. The rest said they had, or planned to, behave and communicate differently with sexual partners as a direct result of concern at the prospect of legal intrusion into their sex lives. Awareness of criminal prosecutions had furthered some respondents' pre-existing moral position on the need to be open and unequivocal about their own HIV status with sexual partners. A few said they disclosed their HIV status more regularly since hearing about criminal cases, to minimise the likelihood of having unprotected anal intercourse with an uninfected man, thereby also reducing the risk of prosecution.

However, adaptation of behaviour attributed to criminal prosecutions was not always in a more protective direction. In direct contrast to the men described above, five men responded to the risk of criminal prosecutions by maximising their anonymity, and being less open about their HIV status. They felt that being publicly identifiable as a man with diagnosed HIV placed them at too much risk of prosecution, and were concerned about previous openness about their own HIV status within social networks. Concern about the lack of control they now exercised over that personal information meant they were now rarely open about their HIV status among friends and acquaintances.

Most respondents with higher number of sexual partners considered anonymous sexual settings (such as saunas or bathhouses) as places where HIV exposure carried a lower risk of prosecution. Firstly, they believed people in such environments knew and accepted the risks, and secondly, the transitory nature of such interactions would make the establishment of culpability impossible anyhow.

Nearly half of the 29 respondents who said that prosecutions had not influenced their sexual behaviour were not concerned about the possibility of criminal prosecution. The reasons for this often
related to their existing practices, which they felt limited the possibility of a successful case being brought against
them. Some of these practices could reduce the likelihood of a criminal complaint being made; yet it was clear
that in other cases, existing practice carried a considerable risk HIV transmission and subsequent prosecution.

Analysis revealed that few men disclosed their status in a clear and explicit manner. Thus, men's statements of
belief about the safety of their sexual activity with regard to criminal prosecution were very often belied by the
vagaries of sexual negotiation and assumption-making they reported during the same interview. Due largely to
the fear of rejection or other negative reaction, many respondents made what they felt to be a disclosure of their
status, but which had the potential to be misunderstood by sexual partners.

Just as disclosure was sometimes ambiguous, so were the practices that men described as “ensuring” they knew
whether their sexual partners also had HIV. Actually, gaining unequivocal understanding of sexual partners' HIV
infection was rare. What was more common was for men to rely on subtle cues or inferences from their sexual
partners regarding HIV status. Many others made assumptions of partners' serostatus based on the type of sex
that was requested or observed. Consistent disclosure of HIV status in all
sexual contexts was regarded by many respondents as unrealistic – which in many cases turns such respondents
certainty about their invulnerability to prosecution on its head. Some rationalised this by contending that this was
not expected by sexual partners and therefore, there was little reason to expect criminal investigation as a result.
Men may feel that adapting behaviour in light of criminal prosecutions is unnecessary. However, given the type
of sex these respondents describe, the possibility that they might transmit HIV to another individual remains. So
too does the possibility of criminal prosecution for reckless transmission.

While not all of the news about the impact of criminalisation is bad, there is a need to consider how this stacks up
against reduced openness and the failure of criminalisation to address the deeply flawed risk assessments made
by many of the men described here.

Summary
The evidence summarised in this submission collected across three different time periods in the past decade
demonstrates that on balance, criminal prosecutions for HIV transmission have a directly deleterious impact on
the goals of HIV prevention given that they result in increased stigma, decreased openness about HIV positive
status among some diagnosed people, and they contribute to an increased expectation that HIV will make itself
known prior to sexual encounters that carry the risk of transmission / or conversely that consent to the risk of HIV
transmission is present during anonymous unprotected anal intercourse. It should be acknowledged that for
some people, the existence of criminal prosecutions for the transmission of HIV will encourage them to take
measures that are likely to reduce the chance of HIV being transmitted. However, this is likely to be tremendously
outweighed by the deleterious effect that this use of the criminal law has on the goals of HIV prevention. To this
extent, such prosecutions represent a ‘game-change’ that directly opposes the cautiously won behavioural and
attitudinal changes necessary in combating ongoing HIV transmission, particularly those aiming to increase
awareness that our sexual partners may not share our own HIV status or our understanding that a particular
sexual encounter may carry a risk of transmission.

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Dear Commissioners

I am writing to you on behalf of the UNAIDS Advisory Group on HIV and Sex Work. The Advisory Group has been
set up to support and advise the UNAIDS family on effective policy, programme, advocacy and capacity-building
activities in relation to HIV and sex work. The group includes representatives of UNAIDS Co-sponsors and the
Secretariat, representatives of organisations affiliated with the Global Network of Sex Work Projects, and independent experts from academia and civil society organisations.

We note the two key questions posed in this submission, namely;

• How can the law be used to scale up effective HIV responses?
• How can the law be a ‘game-changer’ – i.e. substantially change the trajectory of the HIV epidemic?

The Advisory Group is well aware of the regional dialogues that have taken place so far and members have participated in supporting sex work organisations around the world to contribute to these events. The feedback from the sex work organisations that have participated is that the Commission have been highly respectful and interested in their evidence.

To further support the input from sex work organisations we also attach for your information and attention 3 papers prepared by the Advisory Group which now form an integral part of the UNAIDS Guidance Note on HIV and Sex Work 2009. The 4th and final annexe to the Guidance Note is currently in the final stages of review by the Advisory Group and will be submitted to you at the earliest possible opportunity.

The focus of these Annexes is much broader but we hope you will find them worthy of incorporating into your analysis. The Annexes are as follows:

• The impact of legal and policy environments on sex workers and some policy options for protecting the rights of sex workers (to be submitted);
• Differentiating sex work and trafficking;
• Reducing the demand for unprotected paid sex; and
• Economic empowerment.

The Advisory Group strongly affirms that sex workers and their organisations play a crucial role in confronting HIV and AIDS and in many places have an outstanding record in helping to achieve universal access. However, sex workers often face widespread and interconnected human rights violations which impede both their effective participation in HIV responses and their right to access HIV and other health and social services. Stigma and discrimination within society results in repressive laws, policies and practices against sex work, and the economic disempowerment of sex workers. Policies and programmes to reduce the demand for sex work, designed ignoring the voices of sex workers, often result in unintended harms including increased HIV risk and vulnerability for sex workers and their clients, and diverting attention from protecting sex workers’ rights.

One of the basic principles contained within the UNAIDS Guidance Note states that:

In many countries, laws, policies, discriminatory practices, and stigmatising social attitudes drive sex work underground, impeding efforts to reach sex workers and their clients with HIV prevention, treatment, care and support programmes … Stigma and discrimination must be effectively addressed; violence and abuse of sex workers must be reduced; and legal barriers to participation should be revised. Achieving the changes in social and legal conditions that limit access to those services will take time, but it is critical to implement needed legal and policy reforms now. ¹

Removing the legal barriers that exist to access to HIV prevention, treatment, care and support as well as ensuring the legal protection of the rights of those vulnerable to HIV infection are areas of paramount importance. This principle is well documented and recognised by international organisations, states and civil society groups. For example, the UN Human Rights Council in 2009 urged states to work towards the elimination of criminal and other laws that are counterproductive to HIV prevention ². The first of the Annexes listed above, ‘The impact of legal and policy environments on sex workers and some policy options for protecting the rights of sex workers’, outlines in some detail how law and law enforcement impacts sex workers though criminalisation and regulation, as well as affecting their vulnerability to HIV.

The law can be used productively by developing frameworks that enable safer sex work, support sex workers to claim their human rights and protect the health of sex workers, their clients and the wider community. However, these frameworks require accurate local data about domestic laws, policies and enforcement practices and their impact, intended and unintended, on the health of female, male and transgender sex workers, and their clients. There needs to be consistent use of well-defined terminology to describe different possible legal and regulatory environments for commercial sex, as well as their possible positive and negative effects.
The persistent confusion and conflation between trafficking in persons and sex work leads to laws and interventions that negatively impact sex workers, and at the same time undermine efforts to stop trafficking. In some cases, this conflation results in legislation and interventions that criminalise sex work and target the sex industry as a whole, resulting in harmful outcomes for sex workers, including increasing their HIV risk and vulnerability to abuse and exploitation.

States must have a legal obligation to protect, respect and fulfil the human rights of everyone, including female, male and transgender sex workers, regardless of whether sex work remains criminalised. States must take steps to protect sex workers from violence and exploitation, prevent illegal police practices against them, provide them with equality before the law and due process, and implement measures to ensure that they are able to access health services including HIV prevention and treatment in a non-discriminatory, confidential and voluntary manner, including protection from mandatory testing.

In order to effectively address HIV, states must reform the laws governing sex work in a manner that is cognisant of the variety of forms that commercial sex may take, and the range of individuals who perform roles associated with the conduct of commercial sex other than the physical provision of sexual services. These include brothel owners, managers, and cleaners, drivers, cooks and other support staff.

Another option, chosen by some States, is to move further away from criminalisation, prohibition and penalisation, to create regulatory frameworks for commercial sex that recognise sex work as a legitimate occupation and regulate safety and health within that occupation. Such regulatory frameworks can:

• Enable sex workers to be recognised as persons before the law capable of holding and exercising all human rights, including the right to mobilise and form representative bodies to advocate for further social and legal reforms;
• Ensure that sex work can take place under healthy and safe conditions;
• Guarantee sex workers’ access to health and social services; and
• Provide protection from violence, exploitation, coercion, abuse and discrimination.

Sex workers around the globe are disproportionately affected by HIV. However, eradicating sex work is neither feasible nor an appropriate goal for public health programmes. Effective approaches to HIV prevention in the context of sex work are those that recognise the realities of sex work and enable sex workers to protect themselves from the risk of HIV transmission.

We hope you find these points, and in particular the Annexes attached to this letter, useful and constructive.

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Introduction to the Annexes

These four annexes were prepared by the UNAIDS Advisory Group on HIV and Sex Work to accompany the UNAIDS Guidance Note on HIV and Sex Work (2009). The Advisory Group includes representatives of UNAIDS Cosponsors and the Secretariat, representatives of organisations affiliated with the Global Network of Sex Work Projects, and independent experts from academia and civil society organisations. The Advisory Group was constituted in 2009 by the Executive Director of UNAIDS to provide advice and guidance to UNAIDS on matters related to HIV and sex work, while paying particular attention to the human rights of female, male, and transgender sex workers and the goal of universal access to HIV prevention, treatment, care and support for sex workers.

Among its first tasks, the Advisory Group prioritised the development of annexes to the 2009 Guidance Note. In a meeting in May 2009, UNAIDS Executive Director Michel Sidibé, UNAIDS Cosponsors and the Secretariat, and representatives of the Global Network of Sex Work Projects agreed on four themes on which further clarification was needed. These four themes, corresponding to the four annexes presented here, are as follows: (1) the legal and policy environment for sex work, including criminal and other laws affecting sex workers; (2) shifting the strategic focus from reduction of demand for sex work to reduction of demand for unprotected paid sex; (3) the problematic conflation of sex work and trafficking; and (4) economic empowerment of sex workers.

The Advisory Group strongly affirms that sex workers and their organisations play a crucial role in confronting HIV
and AIDS and in many places have an outstanding record in helping to achieve universal access. However, sex workers often face widespread and interconnected human rights violations which impede both their effective participation in HIV responses and their right to access HIV and other health and social services. Stigma and discrimination within society results in repressive laws, policies and practices against sex work, and the economic disempowerment of sex workers. Policies and programmes to reduce the demand for sex work, designed ignoring the voices of sex workers, often result in unintended harms including increased HIV risk and vulnerability for sex workers and their clients, and diverting attention from protecting sex workers’ rights. The frequent failure of policy-makers, religious leaders and society to distinguish sex work from human trafficking has sometimes led to involuntary displacement, harassment or detention of sex workers. Violence against sex workers is too often committed with impunity by state and civilian actors, exacerbating sex workers’ HIV vulnerability. Sex workers are often excluded from access to benefits and financial services available to the general population and prevented from forming organisations that enable economic empowerment and social inclusion.

The Advisory Group offers these annexes to contribute a greater understanding of the situation of sex workers—an understanding that is necessary to address the abuses they face and to ensure they have universal access to HIV services. Every effort has been made in these annexes to highlight both good practices that enhance human rights protections for sex workers and practices that create barriers to universal access to HIV prevention, treatment, care and support. The hope of the Advisory Group is that the information presented here will help shape programmes and policies on HIV and sex work that are truly human rights-based.

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**Differentiating sex work and trafficking**

**What are the issues?**

The United Nations Trafficking in Persons Protocol requires States parties to criminalise and comprehensively tackle trafficking in persons in all its forms. Under these treaty obligations, states often pass laws or take action to end such trafficking. However, anti-trafficking laws or actions often encourage the assumption that all, or at least most, trafficked persons are trafficked for commercial sexual exploitation, and that all or most sex workers are trafficked into sex work against their will. In reality, trafficking and sex work are two very different things. Trafficking involves coercion and deceit; it results in various forms of exploitation, including forced labour, and is a gross violation of human rights. Sex work, on the other hand, does not involve coercion or deceit. Even when it is illegal, sex work comprises freely entered into and consensual sex between adults, and like other forms of labour provides sex workers with a livelihood.

The persistent confusion and conflation between trafficking in persons and sex work leads to laws and interventions that negatively impact sex workers, and at the same time undermine efforts to stop trafficking. In some cases, this conflation results in legislation and interventions that criminalise sex work and target the sex industry as a whole, resulting in harmful outcomes for sex workers, including increasing their HIV risk and vulnerability to abuse and exploitation. Whether sex work is legal or illegal there is an urgent need for States, the UN system, law enforcement agencies, and civil society to understand and differentiate between trafficking in persons and sex work.

Several examples from around the world show how anti-trafficking legislation and law enforcement have been used to attempt to eradicate or disrupt the sex industry. This has been done without consideration of the negative impact such legislation has on human rights and health, including the lack of impact on eradicating trafficking. These have resulted in sex workers being arrested and detained in an attempt to eradicate trafficking.

Through the conflation of trafficking and sex work, local and migrant sex workers in several countries have been subjected to the following: (a) arbitrary and aggressive anti-trafficking interventions (often involving the “raid and rescue” model) which fail to take into consideration the stated wishes of the individual being targeted, who does
not need to be or want to be “rescued”; (b) indiscriminate arrest and incarceration of sex workers; (c) sex workers being beaten and raped by formal and informal law enforcement agents while in detention (this is not part of anti-trafficking legislation, but has escalated in countries with inappropriate anti-trafficking and related laws and regulations); and (d) sex workers being denied their freedom of movement.

What is sex work and what is trafficking?

Sex work
Sex worker organisations globally, and locally, understand sex work as a contractual arrangement where sexual services are negotiated between consenting adults, with the terms of engagement having been agreed upon between the seller and the buyer of sexual services. By definition, sex work means that adult female, male and transgender sex workers who are engaging in commercial sex have consented to do so (that is, are choosing voluntarily to do so), making it distinct from trafficking.

For sex workers, working in the sex industry is not usually a result of coercion or an irrational act of desperation arising from their economic or social vulnerability. On the contrary, men, women and transgender people who sell sex are exercising their agency to make a realistic choice from the options available to them. A woman deciding to sell sexual services in order to support herself or her family is not a trafficked person. A man deciding to sell sexual services to fund his drug use is not a trafficked person. A transgender person deciding to sell sexual services because of lack of employment options is not a trafficked person. There may be people in sex work who might prefer to be in another form of employment, but do not have many alternatives—a situation that many people in other employment sectors are in. They should not be deemed as being coerced into sex work, as trafficked persons are.

Trafficking in persons

According to international treaties, trafficking in persons is defined as “the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation”. In this definition, exploitation includes the exploitation of the prostitution of others or other forms of sexual exploitation; forced labour or services; slavery or practices similar to slavery; servitude; or the removal of organs.

Trafficking for the purposes of commercial sexual exploitation involves adults or children providing sexual services against their will, either through direct force or through deception, violating their fundamental freedoms. As such, it violates the rights and removes the agency of trafficked persons.

However, it is important to understand that being trafficked is often a temporary situation: people who are trafficked do not necessarily remain in situations of powerlessness and coercion. For example, individuals who have been trafficked into the sex industry, or those who find themselves tricked or coerced once within the sex industry, can find their way out of situations of coercion but remain in sex work operating more independently and usually with support from their fellow sex workers, their clients, their intimate partners and their managers or agents. Clearly, care has to be taken to ensure that the individuals concerned are able to freely assess the situation for themselves and, as with all sex workers, empowerment opportunities should be provided.

Understanding the differences between sex work and trafficking in persons for the purpose of sexual exploitation

The UNAIDS Guidance Note on HIV and Sex Work clearly states that trafficking in persons for the purposes of sexual exploitation is a gross violation of human rights. At the same time, the Guidance Note strongly and clearly states that trafficking in persons for any distinct purpose, including commercial sexual exploitation, should never be implicitly or explicitly conflated with sex work. This is because, as the definitions given above show, they are
clearly not the same. Sex work implies consent of sex workers and their capacity to exercise that consent voluntarily. The exercise of agency—that is, people determining for themselves what they want to do and when—is central to the definition of sex work. Trafficking, on the other hand, involves coercion and deceit, resulting in loss of agency on the part of the trafficked person.

One of the reasons for the conflation of sex work and trafficking is that some people believe sex work to be inherently harmful and exploitative. However, many sex workers work in situations where there is no greater exploitation than that experienced by many other workers. Moreover, the harm and abuse that do occur in contexts of sex work often have nothing to do with trafficking. For instance, a major source of violence and extortion against sex workers is law enforcement officials, who are supposed to be preventing rather than causing harm.

The unwillingness or inability of people to recognise that people can freely decide to engage in sex work means that sex workers are often automatically labelled as victims of trafficking when they are not. Often sex workers are portrayed as passive victims who need to be saved. Assuming that all sex workers are trafficked denies the autonomy and agency of people who sell sex. Moreover, such perspectives mean that anti-trafficking efforts typically ignore the possibility of engaging sex workers as partners in identifying, preventing and resolving situations that do involve trafficked people. Sex workers themselves are often best placed to know who is being trafficked into commercial sex and by whom, and are particularly motivated to work to stop such odious practices.7

What does it mean for HIV?

Anti-trafficking measures often concentrate on getting people out of sex work, without considering whether they are trafficked, or whether the efforts will disrupt the access sex workers have to services that safeguard their health and well-being, and that create opportunities for them to share information and seek assistance for individuals they are concerned may have been trafficked. Many projects that focus on rescuing trafficked persons interrupt and undermine efforts to provide sex workers with access to HIV prevention, treatment, care and support.

Many countries are failing to address the actual violence and abuse experienced by sex workers, and by trafficked persons, at the hands of state officers implementing anti-trafficking measures—for instance, unlawful arrest, incarceration, harassment, physical and sexual assaults, rape and even murder by law enforcement and detention officers. The vulnerability of sex workers is increased as a result of having to pay bribes to avoid arrest or detention, or to be released from prison or rehabilitation centres, often requiring them to take out loans that potentially increase their burden of debt.8

There is a growing body of evidence that “raiding” sex work venues and forcibly “rescuing” or “rehabilitating” sex workers results in increased displacement of sex workers, mobility of sex work venues and migration among sex workers; it also has a direct impact on HIV risk.9 Forced rescue and rehabilitation practices lower sex workers’ control over where and under what conditions they sell sexual services and to whom, exposing them to greater violence and exploitation. In turn, this leads to social disintegration and a loss of solidarity and cohesion (social capital) among sex workers, including reducing their ability to access health care, legal and social services. Low social capital is known to increase vulnerability to sexually transmitted infections among sex workers and therefore has a detrimental impact on HIV prevention efforts.10

The conflation of sex work and trafficking directly limits the ability of migrant sex workers to protect themselves from HIV, since they are often assumed to be trafficked. Migrant sex workers often live with the constant threat of being reported, arrested and deported which creates a real barrier to accessing health and welfare services. Female migrant sex workers are frequently assumed to be trafficked when “moral panics” around migration and sex work are created for populist political gain.
Such situations are counterproductive to creating enabling environments for sex workers to practice or promote safer sex and other HIV risk reduction strategies.

Additionally, the frequent overestimation and sensationalism associated with allegations of trafficking divert attention and important resources away from the much needed services that could have a real impact upon HIV prevention, treatment, care and support among sex workers and their clients, and on rights-based support mechanisms for trafficked persons. For instance, money for HIV programmes is either diverted away from sex work programmes as sex work is seen as a criminal law issue, or funds are spent on misguided “rehabilitation” programmes.

**Good practices**

Immediate and active consultation between sex workers, anti-trafficking advocates, governments, law enforcement agencies and civil society organisations is required to clarify the distinction between sex work and trafficking in persons for the purposes of commercial sexual exploitation. To achieve universal access to HIV prevention, treatment, care and support for sex workers, efforts should be refocused on the real and persistent risks that sex workers face, in terms of both human rights violations, and HIV risk and vulnerability. Such discussions should actively involve both sex workers and others directly involved in the sex industry, as well as people who have been trafficked, to benefit from their experience.

**Do no harm**

Anti-trafficking interventions should be reviewed and evaluations carried out to ensure that the human rights of both sex workers and trafficked persons are being protected. All anti-trafficking interventions should be monitored closely to ensure that sex workers are not targeted; and that on-going HIV prevention, treatment, care and support services are not disrupted or undermined.

**Involve sex workers in addressing trafficking in persons within the sex industry**

Sex workers’ organisations and sex work networks can, and do, play a significant role in addressing trafficking in persons, including the sexual exploitation of children. Sex workers know and understand sex work settings. They are in an ideal position to identify and gain the trust of those who may be trafficked for the purpose of sexual exploitation; and they are well placed to provide assistance, support and appropriate referral without further increasing their vulnerability. Organised groups of sex workers are also best placed to establish safe working norms within the sex industry, and influence other actors in the industry to ensure that trafficked adults and children are not retained in sex work. Some sex worker organisations, such as the Durbar Mahila Samanwaya Committee in India, have established models of self-regulatory boards that effectively address trafficking in persons from within the sex industry itself. These self-regulatory mechanisms, which are established, implemented and overseen by sex workers’ organisations can limit trafficking into the sex industry as well as the sexual exploitation of children. They also form a platform for addressing labour exploitation of sex workers.  

**Review anti-trafficking and sex work legislation and law enforcement practices**

National anti-trafficking legislation should be reviewed to ensure that it focuses on addressing trafficking of persons and is not misused to target sex workers. Exploitation that does not fall within the definition of trafficking in the Palermo Protocol should be regulated through national civil, criminal and labour laws and dealt with separately to any trafficking legislation. Similarly, laws on sex work should be reviewed to ensure that they do not conflate sex work and trafficking. Any conflicts between laws should be resolved to ensure that the rights of both sex workers and trafficked persons are respected and protected.

**Collate, generate and disseminate evidence**

There is a need to collect and analyse existing evidence and ensure that new research is undertaken to provide policy-makers with an accurate picture of the impact of anti-trafficking laws; conflating sex work with trafficking; the extent of trafficking for commercial sexual exploitation; the ways in which sex workers can lead effective
interventions to stop trafficking within the sex industry; and the sexual exploitation of children. Such research must be rigorous and ethically sound.

**Barriers to good practice**

No form of legislation, whether it be related to trafficking or sex work, should be used as an excuse to withhold health care and access to other support services from any member of the population. Many of the abuses and problems that occur in the context of anti-trafficking initiatives and legislation also occur in the context of laws that criminalise sex work. Whatever the legislative framework, it is essential to challenge the behaviour of law enforcement and justice officials to ensure that due process is followed and abuses of power do not take place.

**Conclusion**

This annex urges all stakeholders to combat the persistent confusion and conflation between trafficking in persons and sex work. To improve effectiveness, anti-trafficking legislation, and law enforcement initiatives should be reviewed, in partnership with sex workers and people who have been trafficked, to ensure their rights are respected and protected, and that HIV prevention, treatment, care and support services are not undermined.

“In the end, simplistic approaches that equate all migration for sex work with ‘trafficking’ and exploitation only complicate efforts to provide appropriate health and social services to meet the immediate needs of sex workers. Increased efforts to abolish the sex industry can force it underground, making access to sex workers in need all the more difficult.”

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**Economic empowerment**

**What are the issues?**

HIV epidemics spread rapidly in settings of economic and social vulnerability. Unprotected sex in the context of sex work, particularly in settings of high population mobility and poor provision of health information and services, has been identified as a major factor in rapid epidemic growth. Sex workers can and should play a key role in efforts to reduce the spread of HIV.

Sex workers face multiple risks, including social marginalisation, violence, and poor health. These overlapping and mutually reinforcing factors have been shown to restrict sex workers’ ability to improve their living and working conditions, and achieve economic security. They are also among the most frequently cited factors affecting the ability of sex workers to adopt safer sexual practices and condom use.

Furthermore, sex workers, like other people working in informal economies, commonly report a lack of access to bank accounts, saving schemes, loans and legal forms of credit, insurance, pensions and other employment benefits. Stigma and discrimination aggravate economic disempowerment, restricting sex workers’ access to financial services. This further compromises their ability to manage and plan their finances.

Efforts to empower sex workers as a way of improving difficult working conditions have resulted in measurable improvements in sex workers’ quality of life, self-confidence and agency. Studies have documented good social and economic outcomes, increased social capital, high rates of condom use.

However, some programmes that aim to empower sex workers fail to do so; this is particularly common in the case of “economic empowerment” programmes which aim to provide alternative incomes and to exit people from sex work. Actions aimed at “rehabilitation” through training and steering sex workers toward alternative
employment or income generation often incorrectly assume that sex workers want to be rehabilitated or want to leave sex work. While in many countries HIV programmes offer income-generating activities, training and credit to sex workers, their aim is often to encourage sex workers to leave sex work, rather than to provide them with increased choice and reduced risk and vulnerability. As a result, access to these programmes can even be conditional on leaving sex work. Moreover, income generation, training and credit schemes are not always based on current markets and opportunities—and unsuccessful ventures risk disempowering sex workers further, since they often entail debt and the stigma of failure.

Nonetheless, economic empowerment can be an important strategy to improve sex workers’ living and working conditions. By increasing economic options, sex workers can achieve greater financial security, which makes it easier for them to make important decisions that affect their lives. These include their choice of work and their capacity to save and plan for the future for themselves and their dependents. Improving economic options also helps sex workers to reduce the likelihood of having to accept clients’ requests for unprotected sex or that they will be put in situations that inhibit their ability to negotiate with clients and reduce the risk of violence or abuse.

Economic empowerment means equality and equity within the financial system. There are considerable advantages in recognising that sex work is work, as this provides a framework within which sex workers can benefit from the same protections, including the same access to services and freedom from discrimination as other workers. The ILO’s new labour international standard, the Recommendation concerning HIV and AIDS and the World of Work, 2010 (No. 200) applies to sex workers. Delegates to the HIV/AIDS Committee, the tripartite body responsible for finalising the text of Recommendation No.200 submitted to the International Labour Conference for adoption at its 99th Session in June 2010, proposed a specific amendment to the text of the Recommendation proposing that sex workers be explicitly mentioned. The delegates discussed the importance of bringing the needs of sex workers into the mainstream of HIV prevention, care and treatment, noting that if this critical group were to be excluded, it would undermine HIV prevention efforts. Ultimately, the delegates agreed that the broad scope of application in paragraph 2 of the Recommendation implicitly covers sex workers for purposes of the Recommendation.

If sex work is recognised as work, this would also imply that sex workers have the right to choose whether to remain in or leave sex work. Knowing how to manage one’s financial resources, being able to cope with financial crises and being able to change employment are also important aspects of this choice.

Initiatives for economic empowerment of sex workers can operate at individual and collective levels. These are potentially complementary and mutually reinforcing. At the individual level, they can include assistance to individual sex workers in savings, credit, education and training. At the collective level, empowerment activities can strengthen the capacity of organisations led by sex workers to improve economic and social conditions for all sex workers in a given community.

What does it mean for HIV?

Many positive benefits can result from both individual and collective initiatives to support the economic empowerment of sex workers, including access to HIV- and sexual health-related services.

The effects of adding micro-enterprise services to sex worker-led HIV interventions were assessed among 227 female sex workers in Kenya over two years. Two thirds of the women had operational businesses at the end of the period. More than half chose to remain engaged in sex work. A number of benefits were measured including reduction of the mean number of sex partners and more consistent condom use with regular and casual partners.

The USHA sex worker cooperative in West Bengal, India, has more than 13 000 members who are able to access official loans through the cooperative credit union. A study

- increased knowledge of sexually transmitted infections and condom use to prevent HIV infection; A study
reported tangible improvements in sex workers’ lives in five areas:
• reframing of sex work as valid work and increasing aspirations, reflected in a desire for more education or training;
• improved skills in sexual and workplace negotiations reflected in more successful condom use negotiations and increased ability to change workplace and contractual arrangements;
• building social support by increasing social interactions outside work, social function participation and helping other sex workers; and,
• addressing economic vulnerabilities by increasing savings, credit and supplementary income sources.

The results of a study in Andhra Pradesh, India, illustrate the importance of sex worker control over work and access to economic resources. Among the 803 sex workers interviewed, involvement in economic independence programmes was positively associated with control over both the type and cost of sexual services provided and with consistent condom use. Among respondents who reported both programme exposure and high levels of collective agency, consistent condom use was significantly higher than among other sex workers.

In Brazil, sex work is decriminalised. Sex workers are able to register their occupation and have the same rights as other workers. Such high-level policy change is in line with an approach that considers sex work as work. The International Labour Organization HIV and AIDS Recommendation, 2010 (No. 200) applies explicitly to all workers in the formal and informal economies.

An example of a successful initiative for sex workers was set up by DAVIDA, a sex worker-led organisation in Rio de Janeiro. DAVIDA established the fashion company DASPU, which manufactures a range of clothing and organises fashion shows to promote not only the clothes, but also respect for sex workers and their human rights.

Good practices

Evidence strongly supports the benefits of empowering sex workers so that they may enjoy improved working and living conditions, and at the same time, reduce their HIV risk and vulnerability. Policy-makers and service providers working on the economic empowerment of sex workers should take steps to achieve the following:

Ensure compliance with the International Labour Organization’s HIV and AIDS Recommendation, and apply the principles established in the standard to sex workers in both the formal and informal economies to ensure access to prevention, treatment, care and support;

Support the development of sex worker-led organisations that advocate for, and implement, programmes to reduce sex workers’ economic and social vulnerability;

Ensure that access to economic empowerment programmes is not conditional on leaving sex work or reducing involvement in sex work. The outcomes of such programmes should be measured primarily in terms of improvements of economic independence.

Develop economic empowerment initiatives, taking the views of sex workers into account, to:

• increase options for savings and reduce debt
• expand earning potential and economic choices
• develop capacity and skills;

Ensure that access to financial services including savings schemes, access to bank accounts, insurance and loans are non-discriminatory and accessible to sex workers, their families and community organisations;

Ensure that access to credit includes assistance in financial planning and business management to achieve goals;

Ensure that educational opportunities are relevant, of good quality, acceptable to sex workers, non-discriminatory and available without being conditional on leaving sex work;

Options for increasing and diversifying earning potential should be nondirective, supportive of sex workers’ decisions about how they earn their living, and designed to increase choices and reduce economic and social
marginalisation.

Community initiatives should be sex worker-led and provide:
• opportunities and choices valued by sex workers;
• training in areas prioritised by sex workers themselves, which often include entrepreneurial skills and financial management;
• capacity building to diversify earning potential or facilitate transiting;
• safeguards and flexibility to prevent debt accumulation;
• improved functional literacy.

Economic empowerment programmes should include support to sex worker organisations to open and operate sex worker-led cooperatives, credit unions and collectives, and lending and savings schemes. Economic empowerment approaches should consider the needs of all sex workers—female, male and transgender—with attention to the special needs of older sex workers and those with HIV or other illnesses or disabilities. There are a number of jobs that such sex workers can do within the sex work community, enabling them to remain attached to their community, friends and networks.

Sex workers from Ashodaya Samithi, a collective working in several districts of Karnataka, India, have initiated several ventures to enhance their economic security, and meet specific needs identified by sex workers themselves. Hotel Ashodaya is a restaurant initially set up to meet sex workers’ needs for affordable meals and now attracts a wide range of customers, generating funds to support activities for the sex worker community.13 The Care Home managed and run by HIV-positive sex workers, addresses basic care, shelter and nutritional needs of sex workers and others living with HIV.

Experiences from the Wonetha Association in Uganda and Danaya So in Mali highlight similar benefits to sex workers from programmes that build on basic health interventions. These include collective action to improve living and working conditions, access to bank accounts and loans, capacity-building, income-generating activities, health insurance, and support for sex workers’ families.

Barriers to good practice

Programmes that have the sole aim of getting sex workers out of sex work, rather than having an aim of empowerment, have had little success; moreover, there is little evidence that they have an impact on the scale of the sex industry or vulnerability to HIV. Economic empowerment should not be a stand-alone intervention, but should be combined with a range of measures that empower sex workers and provide them with supplementary incomes rather than focusing on creating alternative incomes or livelihoods.

In addition, unsuccessful empowerment programmes have often targeted the wrong groups of people, such as those who are not interested in the support or who have less of a need or capacity to benefit. For example, microcredit schemes are often targeted toward younger sex workers, but the available evidence shows that older sex workers (who often have less earning potential and negotiating power and who may be planning to leave sex work) benefit more from such schemes.

Conclusion

Economic empowerment is a critical component of initiatives to reduce vulnerability and empower sex workers to gain greater control over their lives. As such, initiatives should aim to involve sex workers, reduce harm, increase options and respect choice – initiatives must be voluntary and available to sex workers without any conditions that they stop or reduce their involvement in sex work. Economic empowerment should emphasise both individual opportunities and collective action through support to sex worker-led organisations and networks. The potential benefits of such initiatives are numerous—both for sex workers themselves and for the larger community, in terms of poverty reduction, women and child welfare and public health. Economic empowerment initiatives
should be provided in the context of broader empowerment and HIV-prevention efforts designed with and for sex workers.

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**Reducing the demand for unprotected paid sex**

**What are the issues?**

Sex workers around the globe are disproportionately affected by HIV. However, eradicating sex work is neither feasible nor an appropriate goal for public health programmes. Effective approaches to HIV prevention in the context of sex work are those that recognise the realities of sex work and enable sex workers to protect themselves from the risk of HIV transmission. One of the key aspects of this is to enable sex workers to protect themselves every time they have sex with a client.

Sex in and of itself—whether paid for or not—does not cause HIV infection. Rather, unprotected sex between HIV sero-discordant partners can result in the transmission of HIV from one infected partner to the other. Penetrative sex is an HIV-infection risk for sex workers and their clients when condoms are not used—particularly in countries where people have a low perception or knowledge of the risk factors involved in HIV transmission. Correct condom use during penetrative sex is an effective way of reducing transmission of HIV and other sexually transmitted infections. However, in many settings, issues such as poor availability of condoms and water-based lubricants, police harassment and arrest of sex workers when they carry condoms, condoms being used as evidence of brothel keeping, and clients' lack of knowledge about condoms and preference for sex without condoms are barriers to consistent condom use.

UNAIDS has recommended that criminal laws and punitive policies around sex work, which are barriers to universal access to HIV prevention, treatment and care, should be removed and that supportive policies should be enacted to empower and “protect sex workers and their clients, including safe sex during sex work”. Similarly, the UNAIDS Joint Action for Results Outcome Framework states that HIV prevention activities should promote the empowerment of sex workers to protect themselves from HIV infection, and that law enforcement agencies and the judicial system should protect the rights of sex workers.

The term “end demand” is often used to mean policies, strategies and legal efforts to target the clients of sex workers in an effort to reduce or eliminate sex work altogether. In countries where buying or seeking to buy sex is illegal, such “end demand” efforts can include arresting and prosecuting clients, and imposing fines, jail or rehabilitation programmes on convicted clients; impounding or seizing clients’ vehicles; and publishing clients’ names on billboards, on websites or in newspapers. Furthermore, well-meaning but ill-informed service and healthcare providers and policy actors from community-based organisations, nongovernmental organisations, donors, international organisations and government agencies believe that they are helping sex workers by calling for criminalisation of clients. However, there is no evidence that these “end demand” initiatives reduce sex work or HIV transmission, or improve the quality of life for sex workers. “End demand” initiatives are often either the product of punitive laws criminalising sex work, or the approach used by those wishing to see punitive laws introduced. These laws do not reduce the scale of sex work, but they do make sex workers more vulnerable.

The generally negative attitudes to sex workers and clients that characterise efforts to end demand also contribute to the neglect of evidence-informed HIV prevention programmes and services. These attitudes also encourage law enforcement officials and local authorities to enforce laws in ways that increase HIV vulnerability among sex workers—for instance, by using condoms as evidence of involvement in sex work and thus as grounds for arrest or detention, which discourages condom use.


Activities to ensure that clients take responsibility for their own sexual behaviour, thereby protecting themselves and all their sexual partners from HIV infection, must be developed and supported. Clients’ negative attitudes
towards, female, male and transgender sex workers and towards condom use need to be addressed and challenged. Expanding and ensuring condom use by sex workers and their clients is feasible: it has been achieved in many settings. More needs to be done to ensure consistent protected sex. Permanent availability of both male and female condoms and water-based lubricant, empowerment of sex workers to demand condom use, and increased acceptance of condom use by clients are all issues that require urgent and immediate action.

What does it mean for HIV?
Empowering sex workers to have greater control over their working conditions, rather than “end demand” approaches, should be the focus of HIV prevention efforts. Additionally, reducing exploitation of, and violence against, sex workers is a key strategy in HIV prevention and comprehensive workplace-related health and safety for all sex workers. When sex workers can successfully ensure that their customers use condoms, sex workers are less likely to become infected by HIV. As condom usage in sex work settings becomes normalised, and unprotected sex is seen as undesirable, clients will adapt their expectations and not insist on sex without condoms, effectively reducing the demand and extent of this risk behaviour. Moreover, when customers of sex workers actively participate in and facilitate the use of condoms with all sex encounters (paid and unpaid), HIV transmission will be substantially reduced. The aims of programmes in the context of sex work and HIV prevention should be to:
- reduce the demand from clients for unprotected sex;
- reduce exploitation of sex workers of all genders;
- change the power dynamics within sex work so that sex workers are able to exercise control over the use of condoms and so that these decisions are not put in the hands of clients or managers;
- ensure that male and female condoms and water-based lubricants are available, and that sex workers are not penalised for possession of condoms; and
- increase the ability of sex workers of all genders to demand the use of condoms with clients.

The key issue for HIV prevention should be on changing clients’ attitudes to women, men and transgender sex workers, and to condom use. Increasing clients’ responsibilities and role in reducing HIV infection goes hand in hand with improving the status of sex workers. Challenging stereotypes and norms that disadvantage sex workers—legally, economically, politically, socially and culturally—provides greater autonomy and thus choices for sex workers, and reduces the pressure to engage in sex with clients who refuse to use condoms. Efforts and messaging that aim to reduce HIV risk and vulnerability associated with sex work need, in particular, to address the demand for unprotected paid sex.

Typically, commercial sex acts involve two people. Both have responsibility for practicing safer sex, although it is also important to recognise that power dynamics in commercial sex encounters tend to favour clients—particularly if clients are prepared to pay more money for sex without a condom. Clients of sex workers need to take responsibility for their own sexual behaviour: they have a responsibility to insist on protected paid sex. Clients also have a responsibility to not compromise the health and safety of sex workers by demanding unprotected paid sex. In this way, they take responsibility for protecting themselves and their partners from HIV infection and other sexually transmitted infections.

Communication strategies addressing clients are unlikely to succeed if they are moralising or blaming, or if they depict clients as perpetrators of exploitation or as immoral. Clients are people. Clients also deserve HIV prevention services, including education about condom usage with paid partners. Moreover, when programmes adopt judgemental approaches, they fail to address the reasons many clients are reluctant to use condoms—such as low perception of risk for HIV infection, lack of knowledge and lack of availability of condoms and water-based lubricant.

Good practices
HIV prevention programmes should work to empower sex workers to insist on protected and safe paid sex in their workplace. This approach would be in accordance with the emphasis placed by the HIV and AIDS Recommendation, 2010 (No. 200) of all modes of HIV transmission. Condoms and water-based lubricants should be made readily available to sex workers and in all sex work settings, and they should be accessible and affordable. Under no circumstances should the police or any other regulatory authority use possession of
condoms, discussions of condoms or safer sex, or any other evidence of condoms and safer sex practices (for example, signs requiring condoms or condom wrappers in trash receptacles) as evidence of sex work for arrest or prosecution purposes.


One critical issue is the involvement of brothel owners and managers in condom programmes. Brothel owners or managers can play a supportive role in ensuring that sex workers and their clients have access to condoms, and that condom use is the established norm within that setting. Alliances should be made with managers and agents of sex workers to encourage and support efforts to implement worker safety initiatives, such as requiring all customers to use condoms and posting signs to such effect. It is critical that all programmes follow a sex worker-led approach and enable sex workers to collectively determine what role brothel owners should play in HIV/AIDS intervention programmes.

Male and transgender sex workers have unique, as well as overlapping, challenges and needs in comparison to female sex workers engaged in commercial sex. It is important that HIV prevention programmes working with sex worker communities enable male and transgender sex workers to identify how to address their own specific needs.

In all cases, sex workers must have continuous access to both male and female condoms and water-based lubricants.

Specific examples of programmes that have improved sex workers’ ability to ensure condom use in their work include:

- In Mombasa, Kenya, the Population Council conducted an intervention to meet male sex workers’ health needs and promote behaviour change. Male sex workers were supported as peer leaders and educators in their communities to engage other male sex workers on condom use with clients. The project demonstrates the importance of engaging sex workers, using their existing access to the broader sex worker community and developing their ability to educate and support one another on health and safety matters in the industry; 5

- In Rio de Janeiro, Brazil, the Horizons programme conducted a study to document the process and effectiveness of integrating community development activities and interventions to prevent HIV and other sexually transmitted infections among female sex workers. Community development components, including social cohesion and mutual aid, were significantly associated with consistent condom use among sex workers and their paying clients in this study. More research should be done to evaluate the relationship between belonging to a community with shared values, norms and understandings and health behaviours and outcomes; for example consistent condom use and reduction of HIV/STI;

- In China the International Labour Organization is targeting men in the mining sector with comprehensive HIV/STI prevention interventions. Men working in industrial sectors that require them to work away from their families often engage in risky behaviours such as unprotected paid and casual sex. Consequences can include increased HIV/STI transmission among sex workers and the regular partners of these men. To address this, the International Labour Organization is working with large and medium-scale mining companies in southern China to promote responsible sexual behaviours among mine workers, including proper treatment of STIs, consistent condom use and elimination of violence against women, including sex workers. Preliminary results, assessed through qualitative and quantitative surveys, show significant increases in condom use and health-seeking behaviours, and increased reported condom use in paid and casual sex.

More generally, an essential component of any HIV prevention programming is the inclusion of sex workers in the development, implementation and evaluation of HIV programmes for sex workers. Merely consulting sex workers is insufficient; rather, strong programming should be based on the stated needs of the sex workers themselves in the area of the intervention. As needs, experiences and perceptions can change from region to region, local sex workers must be involved in the design of interventions to be implemented in their area.

Effective HIV programming with sex workers and clients also requires non-judgemental services from health care providers. Health systems need to build the capacity of health workers at all levels and strengthen condom
programming to make it more effective in protecting and promoting the health and human rights of sex workers. Condoms should not be the sole focus of HIV interventions for sex workers; they should be provided alongside access to non-judgemental health care, development of sex worker leadership, economic empowerment, strengthening collective identity, and the elimination of stigma and discrimination related to sex work and sex workers.

In terms of engaging clients, a growing number of studies indicate that men are disadvantaged by ‘masculinity’ norms such as machismo and other gender norms which entrench male dominance. Some of these studies show that men who adhere to rigid notions of manhood experience a range of poor health outcomes. For example, a 2009 article by Peacock et al. concludes that “men who hold traditional views about masculinity are more likely to have contracted a sexually transmitted infection (STI). They are more likely to view sexual relationships as adversarial, to have more negative attitudes toward condoms, and to use condoms less consistently”.

HIV prevention programmes should therefore explore ways of challenging these regressive norms.


**Barriers to good practice**

In general, demonising and marginalising clients are approaches that create major barriers to effective HIV programming with sex workers. Moreover, these approaches are often adopted with the aim of reducing sex work and also trafficking, but they have not been shown to be effective in achieving these aims. They should therefore be avoided, from both a public health and a human rights perspective.

Some programmes have been successful in helping to change the norms and practices around sex work by sex workers, with a subsequent effect on rates of HIV infection. The 100% condom use programme initiated in Thailand in the early 1990s is one such example. However, as these programmes have evolved and been replicated in many countries, they have not necessarily adhered to best practice.

In a review by SANGRAM (an Indian nongovernmental organisation working with sex workers) of 100% condom programmes implemented in South Asia, several challenges were identified in the implementation of those programmes as well as key recommendations that rights-based and empowerment models be employed in regards to sex workers. The authors cautioned against employing the police or other local government authorities to enforce 100% condom use in the sex industry. As they point out, “Sexual acts involve only two persons—the sex worker and the client—so successful rights-based programmes should focus on empowering sex workers to enforce condom use in their own way and on their own terms”.

Experience has shown that asking law enforcement officers, health professionals and sex establishment managers to take the lead on safer sex programming is counterproductive and can disempower and penalise sex workers. Sex workers and their clients should be the main implementers and decision-makers in making sex work safer. Other stakeholders can be useful partners but should not be given an authority role.

**Conclusion**

This annex aims at fostering a shift from an unrealistic approach that demonises clients and depicts them as criminals or exploiters, towards a more pragmatic approach that recognises that clients are involved in every commercial sex act, and therefore have a key role to play in both HIV prevention efforts and in protecting sex workers more generally. Programmes should work with both sex workers and clients to support their mutual responsibility in preventing HIV infection and other STIs.


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<td>“When I can work in safe and fair conditions. When I am free of discrimination. When I am free of labels like &quot;immoral&quot; or &quot;victim&quot;. When I am free from unethical researchers. When I am free to do my job without harassment, violence or breaking the law. When sex work is recognized as work. When we have safety, unity, respect and our rights. When I am free to choose my own way. THEN I am free to protect myself and others from HIV.”</td>
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Closing Ceremony XVth International AIDS Conference
Bangkok, Thailand, 11-16 July 2004
Empower Foundation read by Pornpit Puckmai

Sex workers in Thailand are one of the groups least protected by the law yet the most penalized and discriminated against by law enforcement. In Thailand, prostitution is the only sexual act between consenting adults is the subject of criminal law.

After failure of the 1928 law to regulate prostitution, the first Suppression of Prostitution Law was promulgated in 1960 by a military regime enacting a “Social Purification” campaign. A new Suppression and Prevention of Prostitution Act 1996 was designed to protect children and minors from commercial sexual abuse but criminalization of adult prostitution remained. Neither law considered the human rights or well being of sex workers, including our right to be safe from HIV. Both have failed spectacularly to suppress or prevent prostitution. Surely almost a century of legal persecution has shown that prostitution is not a moral problem that can be solved by punishing perceived immorality. Prostitution is not a legal problem that can be solved by criminal law. Prostitution is human rights problem that must be solved by sex workers being able to assert our human rights including having equal opportunities in society and to be treated with equal human dignity.

Punitive laws severely limit our ability to assert our basic human rights such as recognition as persons before the law; access to justice; safe fair working conditions; adequate health care; and equal access to social services. Migrant sex workers carry a double burden of criminalization that effectively threatens their right to a life of liberty and security. The legal and policy environment sex workers in Thailand endure is untenable with access to HIV prevention, treatment and care.

The first impact of being classed as a criminal is an attack on our self worth. In all other aspects of our lives we sex workers are law abiding productive members of society. We are the main family bread winner providing support for 5 - 8 other adults in the family. We take our religious, political social and cultural duties seriously. Our customers are respected members of society. We are good parents, neighbors and friends. The fact we are considered criminals before the law engenders a sense of shame. This shame and low self worth is continually reinforced by media, service providers and law enforcement. The resulting lack of self esteem and confidence leaves many of us feeling ambivalent about our own safety and well being, including feeling ambivalent about protection from HIV.

When sex work is a crime police are obliged to investigate and make arrests. However they are also obliged to prove the crime using evidence. What evidence is there that sexual services have taken place? There is nothing missing, no one hurt and no one is complaining. It is not surprising that police use condoms as the only tangible evidence at hand to provoke a confession. The use of condoms as evidence of the crime of prostitution naturally results in sex workers and owners of entertainment places being reluctant to carry or stock them. This is especially true for those condoms given to sex workers and entertainment venues by HIV projects, including Thai Public Health. The brand name adds weight to the police accusations of prostitution as these condoms are rarely found in other places.
Theoretically, we may have broken one law yet we still have rights under other laws. However, sex workers in Thailand are not seen as persons before the law. Sex workers are made vulnerable to wide ranging extortion by corrupt authorities. Sex workers are routinely threatened with arrest for a variety of crimes in addition to, or instead of prostitution offences e.g. public nuisance, loitering, drug abuse, immigration or traffic violations. This includes sex workers being threatened with arrest when needing to report even serious crimes like forced labor, child sexual abuse or rape. There is no access to justice for sex workers as long as we are deemed first as criminals, not people before the law.

Laws do not protect our rights. Law becomes a tool for corrupt police to get more money. All sex workers in Thailand pay police either directly or via lost income that the employer is obliged to reroute to the police. The more laws applying to us and our work the more money we have to hand over. The National Economic and Social Advisory Council found in a 2003 study that A go-go bar and massage parlor owners in Thailand pay a 3.2 billion baht (US$80 million) a year in police bribes. It has risen since then. The 2008 Anti-trafficking Law has created a new excuse for corrupt authorities to extort money from sex workers and our employers. Instead of just ordinary criminals, migrant sex workers have become translational criminals, or evidence of translational crime. Migrant sex workers tell how the daily bribes doubled and their salary dropped after the law was implemented. If sex work in itself was not a crime, if sex workers were not treated as criminals wherever they come from, even 10% of the informal “tax” the industry currently provides would fund many work place health and safety programs, including workplace HIV education and prevention.

Sex workers are criminals. Criminals are not treated the same as other people in society. We are not considered entitled to the same respect and the same services. Public health services dealing with sex workers are services dealing with criminals. They do not need to be polite or maintain the same standard of professional ethics with us as when they deal with a housewife or a University student or other “good” people. In addition sex workers have been having “dirty sex” we are considered immoral and diseased. This has become the culture of many government health providers. Who would want to visit a place where you know you will be insulted, examined roughly and humiliated even once, let alone return every 2 weeks. We sex workers want to take care of our health and protect society but should not have to sacrifice our dignity to do so. The Prostitution Law and attending public health policies reinforce this culture of stigma and discrimination. The law says to those health providers “Yes, you’re right. These are bad people doing bad things.” Of course they see as us criminals, after all we are the only people in society who are pressured or forced to have health checks by the police. A change of law may send a new message to them saying “These are human beings, not criminals” It will allow sex workers to help health providers improve their services so sex workers can have real access to sexual health treatment.

Sex work is against the law making it a criminal business. It should be no surprise that criminal businesses attract criminal businessmen. Criminals use the cover of Entertainment Places to carry out criminal business like money laundering, drug and arms trafficking etc. Respected business people don’t want to admit they own “dens of vice”. Honest business people don’t want people to think they are involved in criminal acts. While ever prostitution is criminalized, despite the neon flashing lights, sex worker workplaces remain dark places in society inaccessible to HIV programs. Legally Entertainment places fall under the 1966 Entertainment Place Act (Tabled for amendment 2003)The Act defines the various kinds of "Entertainment Places" and allows such places to operate under a license to be obtained from local police stations. There are no provisions under the Act that promote staff health and safety or labor protection. Under the Act all staff must be fingerprinted and have their history recorded on a police charge sheet. This abuse of the human right to privacy, protection of reputation and equal treatment under the law was finally recognized as such by the Thai National Human Rights Commission in July 2006, though no action has been taken.

With no enforcement of the Labor Law employers have been left to develop their own labor practices and rules which have become standard nationally over the years. Space doesn’t allow a full explanation but suffice to say these rules include requirements that markedly increase our risk of HIV. The “bar rules” inhibit our sexual autonomy by putting us in situations where unprotected sex is likely. The more controlled our work place, the less personal power we have, the higher our risk of HIV. If it is known that we become HIV positive we are dismissed. This means HIV positive workers don’t dare to seek treatment or even information and emotional support until they are very ill, often near death. If entertainment venues were recognized as work places they would be obliged
to comply with the same kind of regulations as other businesses and workplaces. Occupational Health and Safety Standards could be developed, implemented and enforced, along with the enforcement of the Thai Labor Law and the Social Security Act.

In 1996 Thailand began to explore policies to manage undocumented migrant workers. Many different systems have been trialed since then. Sixteen years on, to date, no government has ever included entertainment work in the categories available for migrants to find work in. This is despite the size of our industry and the numbers of migrant sex workers already employed. Thai sex workers and employers agree there are enough customers for all. However, instead of allowing migrant sex workers to obey the law and access our rights, the government keeps migrant sex workers as undocumented and doubly criminal.

Although a vital initial step, to just decriminalize sex work by amending the current Suppression and Prevention of Prostitution Act 1996 will not be enough. Sex workers must be recognized and protected as equal human beings and as workers. ABOVE ALL WE MUST ENSURE THAT SEX WORKER LEADERS AND THEIR ORGANIZATIONS HAVE MEANINGFUL PARTICIPATION IN ALL STAGES OF DEVELOPING REFORMS AND CHANGES

Recommendations
1. Decriminalize sex work (not legalize, no registration or mandatory health checks etc)
2. Apply existing Labor Law and Social Security Act to sex work
3. Develop implement and enforce OH&S standards for the entertainment industry
4. Allow migrant sex workers access to the same opportunities and rights as other migrant workers

Dear Commission Secretariat

Thank you for this opportunity to make a submission to the Global Commission on HIV and the Law.

By way of background, IDLO is the only inter-governmental organization entirely devoted to advancing the rule of law and its contribution to development. Over 27 years, IDLO has trained more than 20,000 lawyers and others in developing countries and transition economies. There are registered IDLO Alumni Associations in 46 countries. Many IDLO alumni now hold senior positions in government, civil society and private sector organizations.

The IDLO Health Law program started in 2009 with a focus on eight countries with core funds and support from the OPEC Fund for International Development (OFID). IDLO has undertaken ground-breaking work on HIV, law and development: pilot projects to expand HIV-related legal services; research on legal service models, and on the links between legal services and HIV prevention, treatment and care; and support for South-South dialogues and professional networking. In 2011 we will provide technical and financial support to strengthen and expand HIV-related legal services and rights in 17 countries. In 2009, IDLO hosted the first regional training seminar on HIV law and policy in Asia and the Pacific. This course was then adapted for IDLO’s online e-learning platform, and offered in English in 2010. The French version of the e-learning course will be offered in 2011, and the Spanish version in 2012.

IDLO has co-hosted regional consultations on HIV-related legal services and rights with local partners in Latin America, Middle East North Africa, and Sub-Saharan Africa. In 2011 IDLO and UNDP hosted the first national workshop on intellectual property law and access to medicines in Nepal.

With UNAIDS and UNDP, IDLO developed the publication: Toolkit: Scaling up HIV-related Legal Services. Over four thousand copies were distributed in English to government and civil society partners by UNAIDS and UNDP. In 2010 the Toolkit was disseminated in French and Chinese. In 2011 it will be published in Spanish and Arabic.
national version has been developed by partners in Burkina Faso. IDLO’s experience has proven that people living with HIV and key affected populations will seek and use quality legal services to address discrimination and other HIV-related legal issues, even in contexts where the rule of law is weak. From Benin to Papua New Guinea, our work has shown that legal services make a difference.

1. How can the law be used to scale up effective HIV responses?
The IDLO Health Law Program includes a focus on strengthening and expanding HIV-related legal services. It has long been recognized that discrimination against people living with HIV (PLHIV) and key populations impedes HIV prevention by discouraging HIV testing and limiting access to HIV prevention, care and treatment services. This discrimination often occurs in areas which are subject to legal regulation (e.g. employment, rental accommodation, education, health care and access to other goods and services). Law reform to prohibit discrimination is a central, but not the only, element of an enabling legal environment. The law cannot eliminate discrimination without accessible and affordable quality legal services. To provide such services, lawyers need to understand HIV, the relevant national and international law, and their clients’ needs. Legal services can also support evidence-based law and policy reforms by compiling accurate data on complaints received and legal and social outcomes.

The law can set normative standards which make HIV-related discrimination unacceptable. Legal education and interventions can help people living with HIV and from key populations to assert their rights, and social mobilization and publicity can deter discrimination against others.

Even in countries where mechanisms for legal action are weak, a government commitment expressed in law about the importance of addressing discrimination is an important component of the national response (e.g. Papua New Guinea’s HIV and AIDS Management Prevention Act 2003). Since the UN General Assembly Special Session on HIV/AIDS in 2001, there has been a heavy emphasis on the importance of law reform and the protection of legal rights in the context of HIV and AIDS. However law reform is often a lengthy process, and must include community education and enforcement mechanisms to be effective. In September 2008, UNAIDS published a technical guidance note on the role of the law in response to HIV (‘Addressing HIV-related Law at National Level’). While acknowledging the importance of law reform, UNAIDS suggests that we should also focus on community empowerment to access law, and appropriate law enforcement.

Research by the Nossal Institute for Global Health (‘HIV and Legal Empowerment’, 2009), suggests that legal services for people living with HIV and key populations can not only improve the quality of life for these groups, but can prevent HIV by increasing voluntary HIV testing, and improving access to HIV prevention, care and treatment services. Expanded HIV testing and treatment for people who are positive (which reduces viral load and infectivity) is increasingly seen as part of a national HIV prevention strategy. Other components include behavior change campaigns, the promotion of condoms, needle and syringe programs, and opioid substitution therapy. The legal environment also impacts directly on these programs, including through the criminal law and its enforcement. HIV-related legal services in developing countries and transition economies are largely ad-hoc, of limited coverage and variable quality. Aside from the rare cases of successful strategic litigation to address discrimination and improve access to prevention and treatment services, existing legal services can only have a limited impact on the HIV epidemic. They need to be evaluated and, where proven effective, scaled up.

2. How can the law be a ‘game-changer’ - i.e.: substantially change the trajectory of the HIV epidemic?
HIV-related legal services can change the trajectory of the HIV epidemic in two ways:

- By providing concrete, accessible, rights-based responses to the human rights abuses faced by people living with HIV and key affected populations; and
- By overcoming barriers to an enabling legal environments.

A. HIV-related legal services – a game changer through concrete, accessible, rights-based responses to HIV.
HIV-related legal services provide concrete, accessible, rights-based responses to the human rights abuses faced by people living with HIV and key affected populations. Ten reasons for HIV-related legal services to play a central role in the rights-based response to HIV are outlined below:
i. Informing people of their rights, while failing to provide ways to realize them, can be counterproductive and increase the burden on affected communities.

Many programs include human rights education for people living with HIV and key populations. We also need to offer concrete, practical and affordable ways to address the human rights abuses faced by people living with and vulnerable to HIV.

ii. Law reform is a long-term goal, while legal services can improve peoples’ lives right now.

Even in a hostile legal environment, lawyers can get better results for clients than if they are left to deal with employers, landlords, health authorities, and the justice sector on their own. Lawyers can intervene with police and other public authorities to achieve changes in the ways laws are implemented, such as guidelines on the discretion to prosecute.

iii. Taking legal action empowers individuals by affirming their right to recognition everywhere as a person before the law.

Whatever the outcome, legal support empowers individuals and groups to understand the legal context in which they live. Legal empowerment approaches also affirm dignity and self-esteem, which have other positive health and social benefits.

iv. Lawyers and paralegals can use a range of legal and non-legal tools to solve problems, including working with traditional legal systems and community leaders.

Formal justice systems can be slow, expensive and unpredictable. Lawyers and paralegals can use alternative dispute resolution mechanisms and support recourse to traditional legal structures such as community leaders.

v. Legal action requires all parties to state their case in an open, structured forum.

Many issues such as discrimination in employment and health care are complex. Employers (e.g. restaurants, airlines) complain about customer preference and safety. Medical personnel complain they lack basic resources such as latex gloves and sterilization equipment to prevent workplace infection. Legal action permits an open examination of these claims, and can allow for public policy and public health evidence as well.

vi. Legal services can also provide data on complaints and outcomes which can improve law and policy reforms.

Law and policy reform must be based on local realities as well as international law and best practice. Legal services can collect data on complaints and outcomes and provide these to policy makers, thus assisting the reform process.

vii. Engaging the legal profession and the courts in resolving HIV-related issues and disputes strengthens the rule of law and good governance more generally.

In contexts where the rule of law is weak, public protest may be the only way to bring crucial issues to the attention of governments. Strengthening the ability of the legal profession and the courts to deliver sound decisions on HIV-related issues also contributes to social harmony.

viii. Legal services can be delivered in multiple ways, including by engaging law students, peer counselors, and by using paralegals and other community educators for referral.
The Toolkit: Scaling up HIV-related Legal Services (IDLO, UNAIDS, UNDP, 2009) identifies eight ways in which HIV-related legal services are delivered in different countries and contexts. Working with law students, in particular, builds the capacity of future lawyers and community leaders to address HIV from a rights-based approach.

ix. The integration of HIV-related legal issues into existing access to justice and legal aid programs mainstreams the response to HIV for long term sustainability.

Although HIV-specific legal clinics may be appropriate in some contexts, scale up can often be achieved through integration of HIV concerns into mainstream legal aid programs.

x. Legal challenges combined with social mobilization can achieve policy reform and educate communities in ways which can have a huge impact nationally, and even globally.

The revolution in drug pricing for developing countries over the last decade was largely driven by strategic litigation in South Africa. Not only have prices for anti-retroviral therapies dropped, but pricing for medications for other diseases of public health significance in developing countries is now under examination. This is a huge contribution to global health and development.

See Ten Reasons Why Legal Services Must be Central to a Rights-based Response to HIV http://www.idlo.int/Publications/10reasonsWhyHIV.pdf

B. HIV-related legal services – a game changer by overcoming barriers to an enabling legal environments.

i. Barrier: Weak national capacity to access justice and lack of justice sector capacity to respond appropriately to HIV and related legal issues.

The inability to access to justice is the primary legal barrier to the human rights-based response HIV at country level. Even well-designed laws and regulations can have little impact if confidential, timely and affordable redress is not accessible to people living with HIV (PLHIV) and key affected populations (KAPs). For example, in Papua New Guinea, HIV-related discrimination is widespread. Few cases have been brought under the HIV/AIDS Management and Prevention (HAMP) Act, because both PLHIV and legal service providers are often unfamiliar with the law prohibiting such discrimination in PNG. To improve access to justice, these populations urgently need quality and affordable legal services.

HIV-related legal services are legal services for people living with HIV, people affected by HIV and key populations that directly relate to legal issues that affect their vulnerability to HIV and/or increase the impact of HIV in their lives. They may be delivered in a variety of settings, for example in conjunction with HIV prevention, treatment, care and support services, in conjunction with other legal services addressing other needs (not necessarily HIV-related) or on a stand-alone basis. (Toolkit: Scaling Up HIV-related Legal Services. IDLO, UNAIDS, UNDP, 2009)

Such services empower communities to utilize the tools and protections provided by legal frameworks, and help bridge the gap between national laws and their effective implementation. In the hostile legal environments in many developing countries region (e.g. where the criminal laws are applied inappropriately), quality legal services can obtain better outcomes for clients and communities, and generate data for appropriate law and policy reform.

Response: IDLO supports governments and civil society organizations in eight countries to design and deliver HIV-related legal services. These initiatives focus on improving access to justice through locally appropriate models, which include community outreach, legal hotlines, paralegal capacity building, and professional support and referral networks.

Recommendations:
Strengthen and expand access to justice for PLHIV and KAPs and support quality, affordable legal services by building the capacity of both government and nongovernmental facilities.

In consultation with national and local authorities, map existing HIV-related legal services, gaps and needs to identify priority areas for support, consistent with local epidemics.

Include costed proposals to strengthen and expand HIV-related legal services in national AIDS strategies and plans.

Include specific budget lines to strengthen and expand HIV-related legal services in national AIDS program budgets and/or national legal aid program budgets (as locally appropriate).

Build the capacity of national gatekeepers (e.g. Ministry of Health and Ministry of Justice staff, national AIDS program staff, Global Fund Country Coordinating Mechanism (CCM) chairpersons, UN and other agency staff) to program HIV-related legal services.

Include HIV-related legal issues in mainstream legal aid programs (e.g. Tamil Nadu (India) State AIDS Control Society (TANSACS) and Tamil Nadu State Legal Services Authority (TNSLSA); and Papua New Guinea Office of the Public Solicitor (from 2011)).

**ii. Barrier: People living with HIV and key affected populations lack of awareness of their rights under the law.**

In IDLO and other needs assessment studies across the eight countries a common theme has emerged - PLHIV and KAPs have limited awareness of their rights, little knowledge of the law and little understanding of how the laws work.

**Response:** IDLO has supported local partners to engage with positive communities and key affected populations, building awareness of rights and legal literacy.

**Recommendation:** Strengthen legal literacy of people living with HIV and affected communities. This should include specific information on local laws and policies, and where to access legal services, in addition to general human rights education.

**iii. Barrier: Lack of sensitivity, and awareness of the law relating to HIV, on the part of lawyers.**

Lawyers with little sensitivity to the lives and experiences of clients from positive communities or key affected populations are a substantial barrier to legal services. PLHIV and KAPs in IDLO project countries have reported negative experiences with lawyers. Individuals were treated in a judgmental manner, without sensitivity or respect, which deters people from seeking legal advice and representation.

**Response:** IDLO has supported local partners to implement seminars for lawyers on HIV and the law, building sensitivity and practical skills on managing clients from positive and KAP communities.

**Recommendation:** Capacity building for legal service providers (lawyers and paralegals) must include sensitization to the issues faced by PLHIV and KAPs and the impact of the law upon these groups, as well as the law applicable in a given context.

**iv. Barrier: Limited legal resources.**

Community and government legal aid services in developing countries are often stretched beyond capacity under their regular workload. This creates long waiting periods for all clients, including PLHIV and KAPs.

**Response:** IDLO has provided technical and financial support to legal service providers to enable them to engage additional lawyers and take on HIV-related matters.

**Recommendation:** Provide financial and technical support to suitable community legal aid centers and government legal aid bodies or community organizations with the capacity to develop in-house legal services.

**v. Barrier: Abuse of powers by police**

Police misuse of powers has a critical impact on the response to HIV. Key issues reported by IDLO partner organizations include: unlawful arrest, physical and sexual assault, verbal abuse, bribery, refusal to grant lawful
rights and entitlements in detention, and refusal to support access to anti-retroviral medication in detention.

Recommendation: Build police capacity to respect the rights of PLHIV and KAPs through training and the implementation of codes of practice and guidelines on issues such as harm reduction through condom distribution to sex workers and men who have sex with men, and needle and syringe exchange programs. Support programs to strengthen enforcement of the law and codes of practice within the police force. Educate communities on their rights on arrest and in detention, and provide practical tips on how to deal with the police and other justice sector authorities.

vi. Barrier: Police arrest quotas

In some developing countries, police are required to meet formal or informal weekly arrest quotas, which results in the unlawful arrest of key affected populations and interference with harm reduction programs (such as methadone maintenance programs).

Recommendation: The negative impact of such practices should be documented and government bodies alerted.

vii. Barrier: Lack of confidentiality in legal proceedings

In many developing countries, court practices do not provide for mechanisms to protect the identity of litigants in cases where public exposure could result in harm and deter legitimate legal action by people living with HIV and members of key populations. This represents a considerable disincentive to legal action to redress rights violations.

Recommendation: Document and share good practices and change court procedure to permit closed hearings and orders to protect confidentiality in such circumstances.

Examples of legal issues identified in specific countries

Burkina Faso - IDLO local partner: Initiative Privée et Communautaire (IPC) in Ouagadougou
- Property theft on the death of a person living with HIV
- Abandonment of children
- Breach of confidentiality regarding HIV status: unauthorized disclosure to spouses and partners
- Refusal of access to school education for children whose parents have died from AIDS
- Legal framework which prohibits sex work, so sex workers are reluctant to bring claims about other abuses.

Benin - IDLO local partner: Association Béninoise de droit du développement (ABDD) in Cotonou
- Problem inheritance and child custody
- PLWHA are deprived of their rights by their own families
- Population unaware of rights of PLHIV and key affected populations

China - IDLO local partner: Yunnan University Legal Aid Centre (LAC) in Kunming, Yunnan Province.
- IDU clients report obstacles posed by state bureaucracy and services. State-issued identification is required in order to apply for Methadone Maintenance Treatment (MMT). When identification documents are lost, individuals must go through a reapplication process which generally incorporates drug testing – this in turn may have repercussions for bail terms and compulsory detoxification sentences. The LAC helps clients obtain identification documents and hence avoid arrest and detention.

Egypt - IDLO partner: Justice and Freedom Organization
- Violations of the right to healthcare and treatment
- Violations of the right to work
- Arbitrary arrest related to personal status
- Security harassment
- Criminal prosecution.
**Indonesia** - IDLO local partner: Lembaga Bantuan Hukum Masayarakat (LBHM – the Community Legal Aid Institute) in Jakarta.

- IDUs report being framed by the police (drugs placed on the individuals’ motorbike or person) and unlawful arrest.
- PLHIV report discrimination in health care, education and employment settings. The national Human Rights Act defines discrimination broadly, arguably broadly enough to cover PLHIV, but this has not been tested.
- Transgenders report not being able to rely on the police to enforce their rights if they are physically or sexually assaulted. Transgenders report being openly ridiculed, shamed or assaulted by the police.
- LBHM uses a community legal empowerment model to support PLHIV and KAPs to understand the law and obtain justice through their own actions.

**Nepal** - IDLO local partner: IDLO Alumni Association (Nepal), Forum for Women Law and Development (FWLD)

- Legal aid programs are mostly centered in the capital and the needy key populations are out of service access.
- Key populations and communities are not aware of their rights.
- People living with HIV report eviction by their own relatives and guardians, violating property and inheritance rights.
- Violation of the right to education eviction for children living with HIV, including expulsion from school.
- Denial of health care services, the right at work, access to insurance due to HIV status.
- Capacity building on appropriate intellectual property law reform to ensure continuing access to medicines requested by government and civil society stakeholders.

**Papua New Guinea** - IDLO local partners: Igat Hope (National Positive Network) and Poro Sapot Project.

- Women are particularly vulnerable to domestic violence and sexual assault, placing them at increased risk of HIV. A combination of cultural norms, limited resources and weak rule of law mean that matters involving violence against women are often resolved outside the formal legal system, usually to the disadvantage of women.
- PLHIV report HIV screening in the employment process, although the HAMP Act (noted above) prohibits testing without consent and HIV screening in the employment process.
- PLHIV report widespread breaches of confidentiality in health care and employment settings. HIV test results are commonly delivered in public situations or to a related or unrelated person (again, contrary to the HAMP Act).
- The HAMP Act specifically criminalizes transmission of HIV, which opens up the possibility of misuse of the Act. Cases have been initiated under this provision, but none have proceeded to judgment, to date.
- Sex work, and sex between adult males in private, are criminalized under PNG law. This makes HIV prevention education more difficult because these populations are less accessible.

**Countries within the LA region:**
Colombia, Guatemala, Bolivia, Ecuador, Panamá, Paraguay, Nicaragua, Dominican Republic, Venezuela, Perú, Argentina, Uruguay & Chile

**Issues Identified:**

1. The absence of mechanisms to access justice and the judiciary's limited capacity to respond appropriately to legal issues related to HIV: The limited capacity and opportunities to access to justice is the main barrier for a response to rights-based HIV at country level.
   - In Latin America, IDLO supports civil society organizations in five countries to design and provide legal services related to HIV. These initiatives focus on improving access to justice through appropriate local models, which include community outreach, hotlines, capacity building for legal assistance, networking and professional support referenda.
   - **Recommendation:** To improve access to justice, quality legal services that are accessible are required. Experience has shown that legal services should be part of a response to HIV based on rights and central
element to ensure the protection against discrimination to obtain redress for violations of human rights and expand access to prevention and treatment.

2. It is necessary to advance the adoption of the *International Guidelines on HIV AIDS and Human Rights* and for harmonization of legislation at country level.
   - There are still gaps, constraints and obstacles in the application of laws or the definition of legal frameworks protecting human rights of PLHIV and key populations. In particular, it is necessary to harmonize national legislation with international guidelines in relation to HIV.
   - **Recommendation**: (i) Work with legislators from the region to strengthen their skills and knowledge related to HIV and human rights, (ii) generate useful evidence and tools for policymakers in the formulation of laws.

3. It is necessary to lower the cost of drugs and training in the use of TRIPS flexibilities to expand and ensure access to medicines.
   - Problems persist in the purchase, supply, distribution of medicines and lack of bargaining power for better prices.
   - **Recommendation**: In order for the different countries of the region to benefit from lower prices in medications, training is needed in the use of the flexibilities and safeguards provided in the TRIPS Agreement.

4. The protection and exercise of sexual and reproductive rights.
   - There are significant gaps in relation to the inclusion of HIV in an agenda of comprehensive sexual and reproductive health.
   - In the region, comprehensive health care, sexual and reproductive rights of women with HIV presents significant violations related to: the lack of emergency contraception, safe abortion options, post-exposure of prophylaxis to HIV, female condoms, violation of the right to decide on the number and spread of children, denial of enjoying a sexual life and no attention to sexual violence. Valuable comprehensive family planning advisors as part of HIV care, assisted reproduction and adoption by people with HIV are absent in national HIV programs in countries such as Bolivia, Colombia, Guatemala, Honduras, Nicaragua, Paraguay, Peru, Mexico.
   - Furthermore, the implementation of the Regional Ministerial Declaration Prevention through Education (2088) on sex education and differentiated access to sexual and reproductive health for adolescents and young people has had little progress in the region. More is needed to address gender-based violence and economic inequality that affects women and puts them in a position of vulnerability and increased risk of HIV infection.
   - **Recommendation**: Adapt the existing regulations and strengthen public policies and gender sensitive legislation to prevent any form of discrimination against women, promote and advocate for sexual and reproductive rights are an inherent part of human rights.

5. Protection against discrimination.
   - Stigma and discrimination associated with sexuality, gender, ethnicity and economic inequality and targeted in particular in vulnerable groups such as MSM, sex workers, indigenous people, LGBT, transgender people and drug users has negatively impacted the response to the epidemic. In particular, limited access to information, preventive services and timely care. In turn, hate crimes, harassment and threats against the LGBT community and the impunity with which these acts remain has revealed the discrimination of which these populations in particular are subjected to.
   - **Recommendations.** (i) Have mechanisms to record documenting and responding to cases of discrimination and violation of human rights for people with HIV and vulnerable groups, (ii) make these programs sustainable, particularly in civil society organizations, (iii) confirm the commitment of the government against the discrimination expressed in law, (iv) educate judicial officers in these issues.

6. Lack of awareness of their rights and legislation by the people living with HIV and key affected populations.
IDLO supports local partner organizations working with PLHIV and key affected populations in the legal empowerment and knowledge of human rights.

**Recommendation:** Strengthen the legal awareness of people living with HIV and affected communities. This should include specific information about local laws and policies, where access to legal services, in addition to the general education of human rights.

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To whom it may concern,

AIDS Action Europe (AAE) was established in 2004 and has grown to be one of the largest HIV-related networks in the region. Our network reaches beyond the borders of the European Union and covers all 53 countries in Europe and Central Asia. Our mission is to unite civil society to work towards a more effective response to the HIV epidemic in Europe and Central Asia. Members of our network comprise a diversity of about 400 NGOs, national networks, AIDS service organisations, activists and community based groups of people living with HIV. AAE also provides one of the two co-Chairs and some of the administrative support to the European Union's HIV/AIDS Civil Society Forum.

AAE has consistently engaged with issues of HIV and the law because legal matters have consistently been experienced as obstacles to an effective response to the epidemic by our members, and also on occasion as opportunities to improve the situation for people with HIV and affected communities. Activities have included an important seminar hosted with NAT (the National AIDS Trust) in the United Kingdom on 'Legislation and Judicial Systems in relation to HIV and AIDS' in 2007 (which included a pre-seminar survey),1 and presentations at the recent Vienna International AIDS Conference 2010 on legal obstacles for people with HIV in Europe, and on how we can use court cases to further the rights of people with HIV.

**Law as an agent of harm**

Our submission draws on the approach to law outlined by the UN ESC Committee, which has stated that:

- the law should respect
- the law should protect
- the law should fulfil
- the law should be accessible, available, acceptable and of high quality.

There is substantial evidence across the European region from our members of harms caused to people with HIV and those from affected communities by the law failing on all these fronts, harming instead of respecting, failing to protect from harm and failing to promote the good of these communities. Whilst the Commission asks for examples of the positive impact of law in scaling up an effective response to HIV, it must be noted that as urgent, probably more so, is that the law simply end its harmful impacts.

ECDC undertook an impressive monitoring exercise on implementation of the 2004 Dublin Declaration across Europe. The resulting report found that of respondent countries 63% reported legal, regulatory and policy barriers for IDUs accessing HIV treatment, care and support; 54% reported such barriers for migrants and the same percentage for prisoners; 33% reported these barriers for sex workers and 17% for MSM. Laws which for example deny HIV treatment to migrants or HIV prevention to prisoners need to be repealed to secure genuinely full, equal and universal access to HIV prevention, treatment, care and support. We single out two ‘legal harms’ for further comment – laws which prohibit harm reduction, and laws which criminalise HIV transmission.

**Harm reduction and IDUs**

The region showcases both the best and the worst of responses when it comes to harm reduction. In some
Western European countries especially harm reduction measures were robustly introduced at the outset of the epidemic, the result being very low rates of HIV infection amongst IDUs. In some Eastern European countries, however, such as Russia, laws –

- Criminalise drug possession, drug use and the carrying of drug paraphernalia
- Prohibit the 'aiding and abetting' of drug use - which is an effective deterrent to harm reduction services
- Prohibit the provision of Opiate Substitution Therapy (OST)
- Require registration of drug users
- Criminalise sex work, and
- Prohibit harm reduction in prisons.

Very simply, the repeal of these laws would allow harm reduction measures to be scaled up and a start made on reversing the serious and continuing epidemic amongst IDUs and their sexual partners in Eastern European countries.

To give more detailed examples of harms, in Russia people who enrol in publicly funded drug treatment programmes are added to a registry and this can lead to loss of employment, housing and even child custody. Criminalisation of both drugs and possession of drugs paraphernalia militate against safer injecting, as can be seen in the following quotation:

"Naturally, one tries to do everything as quickly as possible. Naturally, you wouldn’t want to waste time on boiling the solution [to dissolve the heroin], or start all this hassle with cottons shottons [to filter out impurities in the drug solute]. You just try to go quick, quick, quick, and you don’t give a damn whether it’s clean. You have to be quick, before the neighbours show up, or the police show up, or somebody calls someone." (Female, 22, Moscow)  
[Substance Misuse & Misuse 45:813-864 Sarang, Rhodes, Sheon and Page]

Even where some harm reduction measures are permitted there can be age restrictions on access to harm reduction which increase health harms to vulnerable young people.

AAE is a signatory to the Vienna Declaration calling for the decriminalisation of drug use as a key intervention to enable harm reduction amongst injecting drug users. It should be noted that in working towards this goal even where criminalization for drugs possession and use still exists laws can enable harm reduction measures - for example by permitting the distribution of clean injecting equipment (Misuse of Drugs Act in the UK) and by decriminalising the possession of such equipment. Comprehensive decriminalisation remains, however, an urgent need across the region if we are to address the epidemic.

**Criminalisation of HIV Transmission**

In response to a survey undertaken of members of the Civil Society Forum by the Fundamental Rights Agency, this was one of the most frequently cited legal harms. It should be noted that for every prosecution that gets to court there are in all probability many more investigations, very often with little or no probability of prosecution. Given stigma and ignorance around HIV, criminalisation will tend to be the occasion of significant harassment and intimidation of people with HIV, with people on bail or remand for extended periods, property confiscated and confidentiality of status in some cases compromised.

Stigma and/or ignorance not only fuel inappropriate investigations of people with HIV, they also distort court proceedings. Inaccurate understanding of clinical or scientific evidence has resulted in miscarriages of justice where it is wrongly thought that evidence proves responsibility for transmission or actual endangerment. Reading court proceedings it is also apparent that views of the consequences of HIV infection, and views of the sex lives of HIV positive people, are often misinformed and prejudiced and this is reflected in often harsh sentences. The cases also attract sensationalised and stigmatising media coverage.

The fact that defendants are often poor and marginalised also means that they can rarely afford or access good
quality legal representation.

In summary, the social context for HIV and for people with HIV make it inevitable that the application of criminal law in this area results in extensive harms. But it should also be noted that prosecutions in some jurisdictions fail to meet the minimal recommendations from UNAIDS where reckless transmission is an offence. In some jurisdictions, consent to risk of transmission is not a defence against prosecution. We have also seen people prosecuted who were not themselves diagnosed at the time of the alleged transmission.

The use of criminal law and public health law to place the responsibility to prevent HIV transmission on the diagnosed ignores the fact that the majority of transmissions are from the undiagnosed and the element of shared responsibility for the safety of sex between two people. The ‘recklessness’ we need to address is pervasive across the sexually active population and is effectively addressed by a range of structural, behavioural and technological interventions, not by the punitive use of law.

How can the law be used to scale-up effective HIV responses?

The positive function of law is a welcome focus of the Global Commission, and there are experiences across Europe of the law being an essential component of an effective response to the epidemic. Examples of the positive contribution of law provided by AAE members include:

EFFECTIVE ANTI-DISCRIMINATION LAW WHICH PROTECTS

- people with HIV from the point of diagnosis,
- their associates,
- those perceived to be HIV positive, and
- people from those groups most affected by the epidemic including MSM, women, sex workers, ethnic minorities, migrants and IDUs

Most European countries have some form of legislative protection against discrimination of people living with HIV, whether HIV-specific legislation, generic anti-discrimination legislation or disability/health-related legislation. It is important this legislation is comprehensive covering not only employment but the whole range of goods and services (including healthcare, housing and education). It is also important that different forms of discrimination are addressed including direct discrimination, indirect discrimination, instructions to discriminate, harassment, victimisation and hate crime, as well as rights to reasonable adjustment for those with a disability. When accessed, these rights have proved important for people with HIV. The difficulty, discussed further below, is accessing these legal rights in the first place. For example, with regard to the requirement that anti-discrimination sanctions are ‘effective, proportionate and dissuasive’, ‘few country experts currently predict that sanctions and remedies in their country will comply with this standard’ (see ‘Developing Anti-Discrimination Law in Europe’ Nov 2010 Executive Summary European Network of Legal Experts in the Non-Discrimination Field).

Discrimination remains in a number of jurisdictions in relation to particular professions, without any longer a clear rationale in an evidence-based view of risk – for example, armed services, healthcare workers. The recommendations of the recent ILO Recommendation on HIV and the World of Work need to be put into effect consistently in all countries. Another area cited is discrimination in insurance. Again the law has a role in requiring policy and practice to consider HIV risk according to what we now know of the effectiveness of treatment in reducing morbidity, mortality and transmission.

Similarly an effective response to the HIV epidemic requires strong anti-discrimination legislation to protect women, MSM and ethnic minorities. Within the EU good legislation exists at least on paper in all countries. Across the European region the picture varies with no effective protection from discrimination for MSM in Russia and Ukraine. This has an inevitably harmful impact on the response to the epidemic where, for example, Russian surveillance statistics consistently fail to recognise an MSM epidemic in that country. Sometimes laws can be used to prohibit HIV-related or sex education, especially amongst young people, for example recently in Uzbekistan
where an HIV worker, Maxim Popov, was convicted of a charge of ‘assault on minors without violence’ and another of ‘promoting homosexuality’ for providing relevant HIV information to young people. Recent vicious attacks on pride marches in certain European countries only intensify an atmosphere of fear in which it is more difficult to engage in health promotion amongst MSM.

We are not aware of anti-discrimination provisions in Europe relating to sex work, migration status as such, or injecting drug use. There are in some legal systems prohibitions against discrimination ‘on any other ground’ but there is little evidence as yet that such provisions have been effectively used to protect the rights of these persons in particular. The absence of legal protections against discrimination in employment and in provision of goods and services for these groups makes it much harder to address the inequalities and harms they experience.

More should be done to use law as part of a 'strategy for the positive and active promotion of non-discrimination and equal opportunities for all' ... 'there is a need to go beyond anti-discrimination policies designed to prevent unequal treatment of individuals' ('Non-discrimination and equal opportunities for all - a framework strategy' Commission Communication COM (2005) 224 final). There are some examples in European equality law of 'positive duties' on public bodies to promote equality (and address inequality) in their policies, practice and decision-making. If effectively and comprehensively implemented in relation to all those experiencing inequality, this has the potential to address some of the harms experienced both by people with HIV and by key groups such as MSM and migrants.

AAE members cite the importance and value of involvement of people with HIV in all aspects of decisions which affect them ('no decision about me without me'). This principle can be and in some countries is enshrined in law, and is another example of how law can move beyond addressing discrimination to actively promoting equality.

A number of AAE members speak very positively of the role national human rights institutions can play in securing, promoting and even litigating for rights of people with HIV and affected communities. The Belgian instance is one example often cited as effective - the 'Centre for Equal Opportunities and the Opposition of Racism' has addressed both individual and structural instances of inequality well. France has the HALDE with a similar function.

**LEGAL ESTABLISHMENT OF A RIGHT TO UNIVERSAL ACCESS TO HIV TREATMENT AND CARE (INCLUDING FOR UNDOCUMENTED MIGRANTS)**

Portugal and France have in recent years both been examples of jurisdictions where access for undocumented migrants to HIV treatment and care has been secured through law (it should be noted however that France may reverse this position).

How the law can usefully intervene to secure treatment access will depend on the nature of the health system. It can provide undocumented migrants to enjoy the same terms for access to healthcare as citizens; it can establish specific insurance mechanisms for those who are destitute; it can provide particular provisions for healthcare considered life-saving.

Despite the repeated international commitments to ‘universal access’ there is still a regrettable reluctance for the UN institutions to spell out explicitly and robustly the right of undocumented migrants and those without lawful residency status to access HIV treatment and care, as clinically recommended, on an equal basis with others. This seriously undermines the claimed ambition of universal access.

More generally universal access to HIV prevention, treatment, care and support should also be established through strong legal anti-discrimination provisions which should in particular be applied to health service planning and provision. Countries across Europe report discrimination experienced in healthcare settings, either relating to HIV positive status or to some other characteristics (for example there is often discrimination experienced by injecting drug users). ARV coverage amongst injecting drug users with HIV is very poor, for example, in Russia and
Ukraine (see IHRA 2010 Global Update Eurasia). In his 2010 Mission to Poland the Special Rapporteur on the Right to Health stated, ‘It is necessary to reiterate that medical services and goods are available and accessible to all on the basis of equality and non-discrimination, regardless of one’s health or other status’ – it is doubtful that there is a single country in Europe that fully meets this standard (though of course the extent of failure varies very significantly between countries).

We do not here address in detail here questions of national and international law as they affect drug pricing since this has not as yet been considered in depth by AAE itself. We have however expressed concerns through the Civil Society Forum at developments in free trade negotiations between the European Commission and India. Robust use of law on the international stage can and should be protected and promoted to ensure accessible drugs (including generic drugs) are available to secure universal access.

STRONG AND EFFECTIVE LEGAL PROTECTIONS FOR CONFIDENTIALITY OF HEALTH-RELATED INFORMATION

Breaches of confidentiality around HIV status are frequently cited in the region as a problem, and relate also to issues of discrimination in healthcare settings. Laws and rules in place are usually appropriate – the problem lies in some clinical practice, in poor knowledge of rights and ineffective means of redress. A lack of confidence in the confidentiality of healthcare settings deters both from testing and treatment. Law which effectively and consistently enforces appropriate confidentiality provisions in healthcare settings will transform the effectiveness of that healthcare system in dealing with HIV.

Confidentiality of health-related information can be seen as one aspect of the importance of consent in healthcare. Laws should prohibit any form of mandatory or non-consensual HIV testing (indeed this principle is established in the EU’s Charter of Fundamental Rights).

EFFECTIVE LEGAL AID AND A LEGAL SYSTEM WHICH IS HIV-LITERATE AND APPROPRIATELY RESPECTS CONFIDENTIALITY AROUND HIV STATUS

In the NAT-AAE survey and seminar on 'Legislation and Judicial Systems in relation to HIV and AIDS' there was extensive reporting of 'a huge disproportion between reality and what the law is in theory', in particular:

- Low levels of trust in and use of legal redress to protect rights
- Lack of legal aid; lack of confidentiality; lack of willing/competent lawyers to advocate; discrimination in the legal system
- Little or no engagement by the voluntary sector with the legal system
- Little HIV training for lawyers, judges and court staff
- Low knowledge of rights amongst people living with HIV.

If the law is to be a positive force in addressing the epidemic these failings have to be addressed and the law made protective rather than harmful. One example on an effective intervention around training is the work done in the UK with both prosecutors and police in relation to criminalisation of HIV transmission. Informing them of the biological facts around HIV, the value and limitations of scientific evidence on responsibility for transmission and the social and behavioural context, has significantly reduced the number of prosecutions and harmful investigations. In the NAT-AAE survey it appeared that when training of legal system personnel took place, it had a positive impact.

At the NAT-AAE seminar concern was also expressed at irrelevant references to HIV status in legal proceedings, as well as insufficient reporting/privacy protections around HIV status (even where the individual is a complainant).

Legal aid access in many countries is limited to mandatory defence cases in criminal law, and is not available for civil law (and thus for example for discrimination cases). Means testing criteria can be inconsistent and obscure and there can be no guarantee of presence of counsel during preliminary investigation (see 'Access to Justice in Central and Eastern Europe: Comparative Report' Public Interest Law Initiative).
At the NAT/AAE seminar and in submissions to the FRA repeated reference was made to the importance of educating people with HIV in their rights and of appropriate surveillance and monitoring of relevant laws and their application (where the work of the FRA and the stigma index were cited, as well as the criminalisation scan of GNP plus).

We hope central to the conclusions and recommendations of the Commission will be a vision for legal systems which protect and promote the rights of people with HIV and affected communities in practice and reality, with concrete proposals as to how to arrive there.

AIDS Action Europe
August 2011

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14 Switzerland South Centre

Dear Members of the Commission,

The South Centre is pleased to respond to the call for specialist submissions by the Commission on how can the law be used to scale up effective HIV responses and how can the law be a 'game-changer'.

In this submission we explain how intellectual property law and its implementation in national legislation may affect public health and access to medicines, including effective HIV responses. We forward some suggestions on how the flexibilities in the intellectual property system may be used by countries to promote public health objectives, particularly access to antiretrovirals (ARVs). This submission particularly focuses on the standards of patentability criteria and the use of compulsory licenses as key flexibilities necessary for developing countries' with respect to public health.¹

We note that the UNDP has been undertaking important work in this regard and we can only hope that this work continues.

I. The work of the South Centre on Public Health

The South Centre has a long experience in working with developing countries to facilitate informed approaches to address health implications of trade and globalization-related issues at the national, subregional and regional levels.

The South Centre strategy focuses on access to health care technologies relevant to all diseases, conditions or problems, as well as on research and development for areas diseases or conditions of significant public health importance in developing countries for which an adequate treatment for use in resource-poor settings is not available or affordable.

The South Centre’s work plan for health and development, focuses on four key interventions: 1) policy and technical guidance on health and development 2) training and enhancing capacity; 3) direct country support; and 4) monitoring and analysis.

The South Centre is highly aware that the law may be a game changer, and in that respect, undertakes research

¹ While this submission focuses on the patentability requirement and compulsory licenses, various other flexibilities under the TRIPS Agreement are also crucial with regard to public health objectives. These are: transition periods, public, non-commercial use (government use), parallel imports, exceptions to patent rights, and limitations on data protection. For a detailed analysis of how the TRIPS flexibilities can promote access to medicines, see, Sisule F. Musungu and Cecilia Oh, The Use of Flexibilities in TRIPS by Developing Countries: Can they Promote Access to Medicines? (South Centre and World Health Organisation, April 2006), available at http://www.who.int/intellectualproperty/studies/TRIPS_flexibilities/en/index.html
and provides policy advice to developing countries on issues related to public health, intellectual property rights
and innovation.

The South Centre develops technical and policy guidance in the form of technical publications, research papers
and briefing documents. These are available on the South Centre website at www.southcentre.org.

The South Centre organizes and facilitates training workshops for developing country policy makers, with a focus
on enhancing the capacity of trade negotiators, policy makers and institutions to understand and monitor the
impact of trade agreements, and to build negotiating skills.

The South Centre provides briefings and information to Geneva diplomatic missions and direct country support in
the review of national policy and legal frameworks. Such country support focuses on developing public health
sensitive patent legislation and incorporating the flexibilities of the Agreement of Trade Related Aspects of
Intellectual Property Rights (TRIPS) within the domestic legislation.

Furthermore, the South Centre monitors and analyses the impact of trade agreements on public health and access
to essential medicines, including the impact of new trends and developments.

II. The need for access to medicines and sustainable long term R&D for medicines on a needs basis

Of the 20 million people which the WHO, UNICEF and UNAIDS in their 2010 report consider should have received
a retroviral treatment, only 5.2 million had access to the therapy at the end of 2009. A third of the world's
population does not have regular access to essential medicines, and this ratio even reaches levels of half the
population in certain developing countries. Medicines are a key tool which society has in order to prevent, relieve
or cure diseases, and having access to them is a fundamental right of the citizens, it is a part of the right to health
as established by international treaties law, and even by the Constitution itself in many countries.

The financial burden of the expenditure in medicines in most of the developing countries falls on the individuals
and not on the health insurance (private or public), as occurs in the developed countries. In countries where the
per capita income (PCI) is less than 1,000 US dollars per year, individuals, as well as the State will not be able to
bear the cost of a second-line anti-retroviral treatment at a cost of 1,200 to 4,000 US dollars per year. According
to World Bank figures, one billion people currently live in extreme poverty (less than one dollar per day) and this
is precisely the population which has the most serious health problems.

In addition to the problem of access to medicines, there is a problem of insufficient innovation in medicines,
particularly to tackle diseases that mainly affect developing countries. While some governments are providing
incentives, and there a number of foundations’ and private firm initiatives, the fact remains that there is
insufficient funding for biomedical innovation to address the global burden of disease that disproportionately
affects developing countries.

A major challenge for sustainable financing of global health research and development, particularly for neglected
diseases, is that existing investments are primarily sourced from voluntary contributions from business and
private foundations, whose funding priorities are susceptible to change. Hence, there is no assurance of
sustainable financing of global health research.

Biomedical innovation for diseases that mainly affect developing countries is not taking place largely because
there is low purchasing power, by either the government or the patient, to create sufficient market-based profit
incentives for private pharmaceutical firms to invest in new products to treat such diseases. Developing countries
only account for 10% of global sales of pharmaceuticals (CIPIH 2007). Biomedical innovation also involves
substantial public sector support for upstream research, which developing countries have limited ability to fund.

One of the limitations of current initiatives to purchase and fund R&D in new medicines for diseases that mainly
affect developing countries is the question of their long-term sustainability, as most depend from voluntary
financial contributions from donors. With the current economic crisis, it is reported that donors have reduced
funding for public development partnerships (PDPs) and other related initiatives for health research. Moreover,
to date there is no global initiative that effectively works to improve biomedical innovation in parallel to
improving access to existing medicines. It is thus necessary to examine alternative mechanisms that would ensure
sustainability of R&D.
A priority in increasing biomedical R&D to address the global burden of disease is to increase the involvement in R&D by developing countries. Given the advantage of lower labor and other fixed costs and increased R&D capabilities in some countries, there is significant potential to do so.

In 2008, countries agreed at the World Health Assembly of the WHO to a Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property (GSPOA). The Global Strategy recognizes the urgent need to explore and promote new thinking on innovation and access to medicines, including the possibility of an international agreement or convention, as an alternative or complementary form of funding R&D for pharmaceutical products. A Consultative Expert Working Group on Research and Development: Financing and Coordination (CEWG) was set to "examine current financing and coordination of research and development, as well as proposals for new and innovative sources of funding to stimulate research and development related to Type II and Type III diseases and the specific research and development needs of developing countries in relation to Type I diseases." (WHA Resolution 63.28). At its second meeting that took place on 7-8 July 2011, the CEWG made two important preliminary recommendations: to strengthen global financing and coordination mechanisms for R&D for health needs of developing countries under the auspices of WHO, and that formal intergovernmental negotiations should begin for a binding global instrument for R&D and innovation for health.


Today, it is recognized that intellectual property law has a significant impact on the entire pharmaceutical sector, and more specifically on medicine prices, to the extent where it may even hamper access to medicines by the poor populations of the Southern countries. It is also alarming that rules which are included in the Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS) are not necessarily appropriate for those who are making an effort to meet health and development needs.

In its 2002 report, the United Kingdom Commission on Intellectual Property Rights (CIPR) recommended countries to "ensure that their IP protection regimes do not run counter to their public health policies and that they are consistent with and supportive of such policies." Patents are a key factor in the determination of the prices of medicines, and the TRIPS agreement imposes that all WTO member countries grant exclusive patent protection for a period of 20 years from the filing date of patent application. Even though the TRIPS agreement obliges WTO members to provide patent protection for medicines, it also allows them to take certain social interest measures, such as compulsory licenses, parallel imports, exceptions to patent rights, and the rigorous definition of patentability criteria. These flexibilities can be implemented as a means to balance patent rights with public interest, stimulate competition, protect consumers, and in the case of pharmaceuticals, allow the substitution of branded by generic medicines so as to encourage access there at prices affordable to governments and consumers.

In 2006, the WHO report on "Public Health, Innovation and Intellectual Property Rights" stated that "the TRIPS Agreement allows countries a considerable degree of freedom in how they implement their patent laws, subject to meeting its minimum standards including the criteria for patentability laid down in TRIPS. Since the benefits and costs of patents are unevenly distributed across countries, according to their level of development and scientific and technological capacity, countries may devise their patent systems to seek the best balance, in their own circumstances, between benefits and costs. Thus, developing countries may determine in their own ways the definition of an invention, the criteria for judging patentability, the rights conferred on patent owners and what exceptions to patentability are permitted (...)."

Countries may, hence, use certain flexibilities contained in the TRIPS Agreement, which were approved and confirmed in different international fora. However, developing countries that applied them have been subjected to bilateral pressures. These flexibilities have also been eroded by TRIPS-plus obligations in free trade agreements (see below). The Global Strategy on public health, innovation and Intellectual property, approved by the World Health Assembly in May 2008, recognizes this problem and proposes technical assistance as one of the elements to overcome this obstacle: “International intellectual property agreements contain flexibilities that could facilitate
increased access to pharmaceutical products by developing countries. However, developing countries may face obstacles in the use of these flexibilities. These countries may benefit, inter alia, from technical assistance.\textsuperscript{2}

III.1. Patentability requirements

Although the ordinary meaning of ‘invention’ evokes an intellectual activity leading to unexpected or surprising outcomes, the large majority of patents granted in the world protect mere incremental changes to existing products and processes. Protected inventions are often the result of routine production or development activities that do not require significant investment. The pharmaceutical sector is a paradigmatic example of the proliferation of patents of low or inexistent inventive step.

While the number of new chemical entities of therapeutic use developed and tested per year has drastically declined in the last decade, the number of patents relating to pharmaceuticals has grown significantly. They cover formulations, combinations, doses, salts, ethers, polymorphs, isomers, etc. of existing drugs, the development of which in most instances does not require any inventive activity.

Why are patents on these minor developments -sometimes called ‘secondary’ patents- applied for? Acquiring them allow pharmaceutical companies to delay the entry of generic products and thereby artificially extend exclusive rights on a particular drug. There is increasing evidence on the use of patents as a strategic tool to exclude competition rather than as a means of obtaining a reward for genuine innovation. An investigation carried out by the European Commission, for instance, identified a number of strategies with that purpose, such as filing for up to 1,300 patents EU-wide in relation to a single medicine (so-called “patent clusters”), engaging in disputes with generic companies leading to nearly 700 cases of reported patent litigation, and concluding settlement agreements with generic companies to stop generic entry. The additional costs caused by these practices was estimated for a sample of drugs at 3 billion Euros for 2000-2007. The report also found that ‘originator companies develop and practice defensive patenting strategies primarily in order to block the development of new competing products. This can lead to obstacles to innovation, in form of higher costs for competing pharmaceutical companies (e.g. for royalties) or in delays\textsuperscript{3}. A previous study by the Federal Trade Commission in the USA had also found evidence on the misuse of patents to block or delay generic competition\textsuperscript{4}.

Most patent laws in the world do not define what an invention is. The concept of ‘invention’ as applied in various countries significantly differs. The TRIPS Agreement does not interfere with such diversity. The wording of Article 27.1 indicates that WTO Members have been left room to interpret in good faith the concept of ‘invention’ within their legal systems, subject only to the application of the rules for interpretation set out by the Vienna Convention on the Law of the Treaties\textsuperscript{5}. Similarly, the TRIPS Agreement allows WTO Member countries to adopt their own definitions of the patentability standards (novelty, inventive step/non-obviousness, industrial applicability/utility). Article 27.1 prescribes, in effect, that patents "shall be available for any inventions … provided that they are new, involve an inventive step and are capable of industrial application", but does not contain any specification about the precise way in which these criteria are to be applied.

The definition of the patentability criteria constitutes a key aspect of patent policy, with implications in other areas, such as industrial and public health policies. If patents are granted on the basis of lax standards of patentability, undue limitations on competition may arise out without any significant trade-off in terms of more innovation to address society’s needs. Limitations resulting from patents granted without a rigorous application of the patentability criteria are noticeable in the case of several ARVs. For instance, a number of patents following the base compound patent for ritonavir relate to incremental developments, including polymorphs and new


\textsuperscript{5} See Articles 31 and 32 of the Convention. The method of interpretation codified by this Convention has been extensively used in GATT/WTO jurisprudence, including with regard to the TRIPS Agreement.
formulations, such as a soft-gel capsule and solid dispersion form (also known as the heat-stable form), the patentability of which would be questionable in the light of well-defined patentability criteria. Similarly, lopinavir polymorphic forms and formulations do not seem to present an inventive step sufficient for the grant of a patent. The combination of lopinavir with ritonavir, for which patents have been applied for in many jurisdictions, does not present either a synergistic effect of an inventive nature so as to justify the grant of protection. This means that appropriate patent policies to assess whether a claimed invention makes a genuine technical contribution to the state of the art may be crucial to ensure generic competition and thereby significantly increase the number of patients under treatment. Although compulsory licenses may be used to mitigate the impact of a granted patent (see next section), the application of rigorous standards of patentability at the time of the examination of the patent application, would avoid the need to resort to such licenses and, hence, the political strains sometimes associated to their grant. In addition, no royalties would be charged on products that should be in the public domain.

III.2. Use of Compulsory Licensing and Pricing of Medicines

Patents grant exclusive rights that allow its owner to exclude potential competitors during the whole patent term. Hence, he may charge the prices that the market bears, as monopolists do. This situation has been tangible in the case of many ARVs, particularly in respect of second line treatment. In order to improve access to patented medicines through a reduction of prices, governments may resort to compulsory licenses or government use (for non-commercial purposes) which authorize a private party or a government entity to use a patented invention against payment of a remuneration to the patent owner. The grant of compulsory licenses or government use is explicitly permitted by article 31 of the TRIPS Agreement, which determines the conditions but not the grounds that may be invoked therefor. In some cases, before a compulsory license is granted, it is necessary to enter into negotiations with the patent owner to obtain a voluntary license. Failure to reach an agreement opens the way for government action.

While until recently compulsory licenses/government use had been mainly utilized in developed countries (notably in the USA), in the past decade several developing countries have issued compulsory licences/government use in order to increase access to medicines (see Table I).

<table>
<thead>
<tr>
<th>Date</th>
<th>Country</th>
<th>Product</th>
<th>Duration</th>
<th>Royalties</th>
<th>Cost reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2003</td>
<td>Zimbabwe</td>
<td>all HIV/AIDS-related medicines</td>
<td>not indicated</td>
<td>not indicated</td>
<td>Prices determined by the government</td>
</tr>
<tr>
<td>Oct. 2003</td>
<td>Malaysia</td>
<td>didanosine, didanosine + zidovudine, FDC didanosine + zidovudine</td>
<td>2 years</td>
<td>not indicated</td>
<td>Ceiling prices determined by the government</td>
</tr>
<tr>
<td>Sept. 2004</td>
<td>Zambia</td>
<td>FDC lamivudine+ stavudine+ nevirapine</td>
<td>until notification of expiry of the compulsory licence</td>
<td>2.5%</td>
<td></td>
</tr>
<tr>
<td>Oct. 2004</td>
<td>Indonesia</td>
<td>lamivudine, nevirapine</td>
<td>7-8 years (end patent term)</td>
<td>0.5%</td>
<td></td>
</tr>
<tr>
<td>Oct. 2004</td>
<td>Ghana</td>
<td>CL to</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Country</td>
<td>Product</td>
<td>Date (duration)</td>
<td>Royalty</td>
<td>Source</td>
</tr>
<tr>
<td>----------------</td>
<td>-------------</td>
<td>--------------------</td>
<td>--------------------------------------</td>
<td>---------</td>
<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td>2005</td>
<td></td>
<td>import ARVs from India</td>
<td>reduction almost 50%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nov. 2006</td>
<td>Thailand</td>
<td>efavirenz</td>
<td>until December 2011</td>
<td>0.5%</td>
<td>Price of the generic version around 50% of the original</td>
</tr>
<tr>
<td>Jan. 2007</td>
<td>Thailand</td>
<td>lopinavir/ritonavir</td>
<td>until 31 January 2012</td>
<td>0.5%</td>
<td>Generic version expected to cost 20% less than original</td>
</tr>
<tr>
<td>Jan. 2007</td>
<td>Thailand</td>
<td>clopidogrel</td>
<td>patent expiry or no longer needed</td>
<td>0.5%</td>
<td>Cost expected to drop from 120 baht per pill to 6-2 baht</td>
</tr>
<tr>
<td>March 2007</td>
<td>Indonesia</td>
<td>efavirenz</td>
<td>until 07 August 2013</td>
<td>0.5%</td>
<td></td>
</tr>
<tr>
<td>May 2007</td>
<td>Brazil</td>
<td>efavirenz</td>
<td>5 years</td>
<td>1.5%</td>
<td>Generic version priced at 28% of the original</td>
</tr>
<tr>
<td>Jan. 2008</td>
<td>Thailand</td>
<td>Several cancer drugs</td>
<td>Patent expiry or no longer needed</td>
<td>3-5%</td>
<td></td>
</tr>
<tr>
<td>April 2010</td>
<td>Ecuador</td>
<td>- ritonavir</td>
<td>until 30 November 2014</td>
<td></td>
<td>Initial price reduction between 20% and 27%</td>
</tr>
</tbody>
</table>


Compulsory licenses/government use have been grounded in many cases on a declaration of ‘emergency’ situations. It is up to each government to decide when such situations exist. The high cost of the patented products and the ensuing limitation in their supply to patients in need may be sufficient to consider that an emergency exists. In these cases, there is no need to negotiate with the patent owner a voluntary license as a pre-
condition to proceed. Compulsory licenses/government use have also been decided on other grounds, including general considerations of public interest. In most cases, the authorized use has been for the importation of the required medicines. The royalty rates applied on the price of the licensed product varied from 0.5% to 4%. Significantly, the grant of compulsory licenses/government use permitted the respective governments to obtain substantial savings in the purchase of the covered medicines.

The experience with the grant of compulsory licenses/government use shows that these are mechanisms that may be effective in increasing access to ARVs and other drugs. Some governments that used them (notably Thailand) were subject to pressures from the US government and the European Commission, as well as to retaliation by some pharmaceutical companies. However, this has not always been the case and it should not discourage governments from using these legitimate tools when needed. National laws should provide for simple and expeditious procedures for the grant of compulsory licenses and decisions of government use. If appealed by the patent owner, the execution of a compulsory licenses/government use should not be suspended. As indicated in the previous table, the rate of royalties should not exceed those generally applicable to commercial transactions; they can also be adjusted having the per capita GDP of a particular country into account.

III.3. Limitations of Paragraph 6 System

While, as mentioned the TRIPS Agreement allows countries some flexibilities in relation to patents that can be useful for ensuring access to medicines necessary for the treatment of diseases, including HIV/AIDS, the essential requirement for utilizing these flexibilities is the availability of a domestic industry capable of producing the required drugs. However, a critical impediment for many developing countries and LDCs is the lack of domestic pharmaceutical manufacturing capacity. The TRIPS Agreement allows compulsory licensing to supply predominantly the domestic market, which disentitles countries without a sufficient domestic manufacturing capacity to use of a compulsory license.

In this context, paragraph 6 of the 2001 WTO Doha Declaration on TRIPS and Public Health recognized that countries with insufficient or no manufacturing capacities in the pharmaceutical sector could face difficulties in making effective use of compulsory licensing under the TRIPS Agreement and instructed the TRIPS Council to find an expeditious solution to this problem and report to the General Council by the end of 2002.

Accordingly, the WTO General Council adopted a Decision on 30 August 2003 which established a system\(^6\) under which a country can issue a compulsory license for the purpose of exporting generic medicines to countries with insufficient or no manufacturing capacity, if such a country issues a notification specifying the name and quantity of the medicines needed, confirms its lack of manufacturing capacity, and the grant or intention to grant a compulsory license where the medicine is patented in its territory.

While the paragraph 6 system sought to facilitate the use of compulsory licenses for the purpose of exporting medicines to countries with insufficient pharmaceutical manufacturing capacity, the terms under which the system can be used has actually put in place obligations on importing countries that are more onerous than they are for countries that can use a compulsory license for the domestic market.

Therefore, while the paragraph 6 system has been celebrated as an important flexibility for developing countries and LDCs, in actual practice there has been a lack of willingness to use the system. This is largely due to the fact that the system is unnecessarily burdensome and complicated. Even in the Canada-Rwanda case, it took a long time to complete the requirements under the paragraph 6 system. Thus, the system has been less effective than it should have been. Therefore, it is important to examine the reasons behind the limited use of the system and also address systemic deficiencies.

Current Experience of Implementation of the Para 6 System

The experience suggests that there are hurdles within the Decision which make it difficult for countries with little or no manufacturing capacity to import a generic drug under a compulsory licence, and unattractive or well as difficult for generic manufacturers to export a drug under compulsory licence.

Limited number of countries adopted implementing legislation: To date, only a limited number of countries (Canada, Norway, China, India, Switzerland, Philippine, Singapore and the European Union, have adopted

\(^6\) The text of this Decision has been incorporated as article 31bis of the TRIPS Agreement, subject however to its approval in accordance with WTO rules. So far (August 2011) only 34members (including the European Union) have notified their approval of the amendment.
legislation to implement the August 30th Decision as an exporting country.

**Limited use:** Only one importing country (Rwanda) used the mechanism to import cheaper life-saving medicines (it means that 21,000 HIV/AIDS patients received the 3-FDC (AZT, 3TC, NVP) from the Canadian generic company Apotex.⁷

**Notification:** Under the terms of the Decision, a potential importing country must send a notification in writing to the WTO TRIPS Council, declaring its intention to import pharmaceutical products according to the provisions set out in the Decision. The notification must include the specific names and expected quantities of the product needed. Unless the importing country is classified as a least-developed country (LDC), it must also specify whether the product is under patent, and provide information that establishes that it lacks sufficient manufacturing capacity in the pharmaceutical sector to develop the drug being ordered.

No country has so far notified its intention to use the mechanism provided by the Decision.

**Anti-diversion measures:** The Decision imposes conditions for commercialization of the products made under the compulsory license. They must be clearly identified as being produced under the Decision through specific labelling; they should be specially packaged to be distinguishable from the branded product and its shape or colour, and the generic manufacturer must post specific information about the quantity of the product, its destination and distinguishing features. These measures are to ensure that the product will only be exported to the destination stated in the compulsory license.

**Some key problems/hurdles of the mechanism**

(1) **Prior negotiation needed before a compulsory licence is granted**

Before a generic company can apply to a government to issue a compulsory licence allowing the firm to begin exporting a drug under the August 30th Decision, the generic company has to engage in negotiations with the patent holder for a voluntary licence.⁸ Negotiations for a voluntary license may be protracted and complex, and a source of considerable delays. Prior negotiations act as a disincentive to generic manufacturers to participate in the process.

(2) **The Decision comprises a succession of complex procedural steps**

Let us assume a potential purchaser, under the terms of the Decision, has forecasted needs and identified a generic producer willing to participate in the process and fill the drug order, and the manufacturer has completed negotiations with the patent holder, and the terms for a voluntary licence have been rejected.

A first problem to overcome is that an offer for sale a patented product may be deemed an infringement of the patentee’s exclusive rights (article 28 of the TRIPS Agreement). This may limit the participation in bidding procedures.

The generic firm must apply for a compulsory licence in its home country, from which the drugs will be exported and, unless the importing country has decided to make government use for non commercial purposes, the firm would also need to seek and obtain a compulsory license in the country where the pharmaceutical products are destined if they are under patent there. This requires considerable human and financial resources on the part of the generic firm, particularly when seeking to file a compulsory licence in the country of destination, where the generic may have no prior contacts or experience.

Each of these steps is time-consuming and holds no guarantee of success. The authorisation to export life-saving drugs can be delayed (if negotiations for a voluntary licence are prolonged), or even denied.

A compulsory licence for export can only be granted once the heavy procedural steps described have been completed successfully. It did not have to be this way; in fact the WTO chose to stay away from designing an

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⁷ This product was already available from Indian generic companies.

⁸ For example, article 6.3 (b) and article 9 of the EC Regulation No. 816/2006 implementing the decision states that an applicant for a compulsory license has to produce evidence of efforts to have prior negotiations with the right-holder. See Regulation (EC) No 816/2006 of the European Parliament and of the Council of 17 May 2006 on compulsory licensing of patents relating to the manufacture of pharmaceutical products for export to countries with public health problems, available at http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2006:157:0001:0007:EN:PDF.

⁹ In order to avoid delays, the Canadian law provides, for instance, for a thirty days period of negotiations for a voluntary license with the patent holder, before filing an application for compulsory license. See Section 21.04 (3) (c) (i) of the Patent Act of Canada, available at http://laws-lois.justice.gc.ca/eng/acts/P-4/page-10.html.
automatic procedure which would have been possible under WTO law (based on article 30 of the TRIPS Agreement).

(3) Limited authorization
The August 30th mechanism is based on a drug-by-drug, country-by-country and case-by-case decision-making process. Indeed, the compulsory licence application must stipulate the destination and the quantity of drugs that are to be purchased and exported under the licence. Drug needs must therefore be determined with precision beforehand. If medical needs increase, and more patients are included into a programme than forecasted in the compulsory licence application, the only way to purchase more drugs is to begin the process again, starting with the voluntary licence negotiations between brand and generic manufacturers detailed above. A stock-out due to the procedural hurdles may lead to the treatment being interrupted and as a consequence patients may develop increased drug resistance (as in case of HIV/AIDS), creating the need for more expensive treatment.

If, on the contrary, needs have been overestimated, and a quantity of drugs is unused, but are desperately needed in a third country, the entire process must also start again from scratch and the unused drugs may just remain stockpiled until they expire. Re-exportation of medicines imported under the system to another developing or least developed country in a similar situation is not permitted, unless there is a regional trade agreement between the two.

From a manufacturer’s perspective, this means that the whole process must be undertaken each time it fills an order for a pharmaceutical product destined for export. This does not allow generic manufacturers to exploit economies of scale and creates a disincentive to produce and export medicines to meet the public health needs of third countries.

4) The patent holder can control the process
Even after the process for production and subsequent export of the medicines under the system has initiated, and the respective notifications are made, the patent holder can intervene to detain or stall the use of the system. For example, the patent holder may decide to offer the medicines at lower cost or for free, thus making it unnecessary to use the system in that particular case. This also creates a huge uncertainty and creates additional risk and disincentives for the manufacturer in the country of export.

Impact of Free Trade Agreements
Access to medicines, particularly HIV treatment programmes, are likely to be severely affected due to the onerous obligations imposed on developing countries under bilateral and regional trade agreements, including free trade agreements (FTA), economic partnership agreements (EPA) and bilateral investment treaties (BITs). The report of the UN Special Rapporteur on the Right to Health finds that TRIPS and FTAs have a negative impact on access to affordable medicines and recommends that developing countries do not adopt TRIPS-plus standards of IP protection.

The EPAs and FTAs tend to include provisions on IP protection and enforcement that expand the standards under the TRIPS Agreement or introduce additional obligations that go beyond the TRIPS Agreement. Hence, the standards in the EPAs and FTAs can reduce significantly the ability of developing countries to make full use of the flexibilities contained in the TRIPS Agreement, which is a necessary safeguard for most developing countries to address public health challenges of ensuring availability of affordable medicines and medical devices.

The TRIPS-plus requirements under such agreements include the following:

10 “Developed countries and LDCs should not introduce TRIPS-plus standards in their national laws. Developed countries should not encourage developing countries and LDCs to enter into TRIPS-plus FTAs and should be mindful of actions which may infringe upon the right to health.” See Promotion and Protection of all Human Rights, Civil, Political, Economic, Social and Cultural Rights including the Right to Development: Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Anand Grover, 11th session of the Human Rights Council of the United Nations General Assembly, A/HRC/11/12, 31 March 2009, paragraph 108, p.29, available at http://www2.ohchr.org/english/bodies/hrcouncil/docs/11session/A.HRC.11.12_en.pdf.
1) **Increasing the scope of patent protection** to new uses or to new forms of old medicines, which can vest an additional 20 year monopoly on existing medicines based on new therapeutic indications for known drugs or minor changes in drug formulation or process.

2) **Extending the term of the patent beyond 20 years** to compensate for delays in the examination of the patent application or in securing necessary marketing regulatory approval.

3) **Patent linkage** requirements that will prevent marketing approval of generic versions of a patented medicine.

4) **Data exclusivity** requirements that will prevent governments from relying on clinical trial data to register generic medicines even where there is no patent infringement.

5) **Enhanced scope of IP enforcement through, for instance, border measures** which will enable customs to seize generic medicines in situations of import, export or transit on suspicion of infringement of a patent.

6) **Requiring IP enforcement action** to be directed against manufacturers, suppliers, distributors of generic medicines as well as treatment providers.

In addition, investment chapters in such agreements or bilateral investment protection treaties (BITs) can define IPRs as a form of investment, and regulatory action on right holders may thus be challenged, under certain circumstances, as an act of expropriation of investment.

The potential negative impact of FTAs on developing countries was also recognized by some members of the US Congress. A 2007 report of the Government Accountability Office (GAO) states that FTAs with developing countries threaten their ability to take necessary public health measures and could significantly delay the availability of lower cost generic medicines.

### III.4. Making Full Use of the TRIPS Flexibilities to Foster a Domestic Pharmaceutical Industry

An important challenge for developing countries and LDCs in order to realize the objective of ensuring access to affordable medicines and treatment for diseases like HIV/AIDS is to develop a strong domestic pharmaceutical industry that can produce generic versions of medicines to meet the public health requirements of the country. Some of those countries have adopted policies to that end. For example, the East African Community (EAC) adopted a Regional Pharmaceutical Manufacturing Plan of Action (RPMPOA) 2011-16, which serves as a roadmap to guide the EAC towards evolving an efficient and effective pharmaceutical manufacturing industry to supply essential medicines to national, regional and international markets.

The EAC also adopted a Regional Intellectual Property Policy and a Protocol on the Utilisation of Public Health Related WTO-TRIPS Flexibilities and the Approximation of National Intellectual Property Legislation. The Protocol seeks to provide guidance to the EAC Partner States on how their IP legislation should be adjusted to enable them to fully use the public health related TRIPS flexibilities, to restrict patentability of pharmaceutical products and medical devices in order to keep them in the public domain in order to promote a local pharmaceutical industry and ensure access to affordable medicines.

### IV. Ensuring Sustainability of Pharmaceutical Industry in Developing Countries

In addition to promoting the growth a strong and effective domestic pharmaceutical industry, there is a critical need to ensure that the existing pharmaceutical capacity in the developing countries is sustained and

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11 The ‘patent linkage’ is typically imposed in FTAs with the USA.


strengthened. A crucial challenge in this context is the trend of takeover of generic pharmaceutical companies in developing countries, noticeably India, by multinational pharmaceutical companies. This is of particular concern in the context of HIV/AIDS, because the existence of a strong and sustainable generic industry in developing countries will be necessary to ensure availability of affordable generic forms of second-line HIV/AIDS treatment as increasing resistance grows to existing first-line treatment. It should be noted that the generic industry played a major role in supplying generic medicines for first line treatment which significantly brought down the prices for such medicines in developing countries. As domestic companies get taken over by MNCs, an important public health concern will be how to ensure similar availability of affordable second-line treatment. Governments in developing countries are concerned about this and there is a need to explore the role that governments can play to address such public policy concerns.

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TO: Global Commission on HIV and the Law

I thank the Global Commission on HIV and the Law for this opportunity to share my perspective on one of the Commission’s focus issues: HIV criminalization. As a practicing attorney involved in representing individuals with HIV and as an independent scholar of HIV law and policy issues for more than 25 years, I hope that my perspective on these issues will benefit the Commission’s important and timely mission.

My purpose in writing is not to provide an overview of HIV criminalization legal issues, which has been presented in many other publications, including my own. Instead, I want to point to several issues that I believe have been under-appreciated or overlooked by many advocates and organizations addressing this issue, but that are nevertheless important for effective advocacy.

My comments are intentionally brief and succinct, but if any point is unclear or if the Commission believes that a lengthier or more detailed discussion is appropriate, I would be pleased to respond as needed. Similarly, in the belief that Commission members are already very familiar with this subject and the literature addressing it, I have omitted extensive use of citations. But if the Commission deems it appropriate, I’d be happy to provide specific references to the statutes, cases, and secondary sources that are relevant to my discussion.

HIV criminalization efforts have been widely condemned by the HIV and human rights advocacy communities, and thus I take it as a given that the application of criminal laws to people with HIV does little if anything to deter knowing transmission of HIV via sexual contact, while at the same time enhancing the stigma of HIV and potentially frustrating prevention efforts that are based on confidentiality of health care information and confidence in health care and public health organizations. Moreover, specific prosecutions of individuals with HIV have resulted in unfair convictions - based on “expert” witness testimony that does not accurately reflect the state of our knowledge about HIV and how it is transmitted – or in disproportionately severe sentences compared with offenses involving similar risks of harm.

My focus here is on HIV criminalization in the United States, although many of the points will apply as well for laws and policies in other high income countries. Developments within the United States are also potentially influential on legal and policy trends and reforms where needed in other areas of the world.

The Nature and Extent of the HIV Criminalization Problem

Although many individuals with HIV have been prosecuted, convicted, and sentenced in the United States for crimes involving transmission or risk of transmission of HIV, we actually know very little about the nature and
extent of HIV criminalization in practice. Although it is rarely commented on, one of the most remarkable aspects of the law enforcement approach to HIV is that it appears to be sparingly used, even though all states and the U.S. federal government have laws that can be used to prosecute individuals for knowing risk of HIV transmission.

According to the *Global Criminalisation Scan Report* (2010), for example, the U.S. has an estimated 0.25 convictions per 1,000 persons with HIV, significantly lower than most high income countries surveyed. In contrast, Sweden is identified as having the highest rate of convictions with an estimated 6.12 persons per thousand. Comparison of these rates thus suggests that HIV criminal law enforcement is not a priority in the U.S., even though the U.S. leads the world in terms of absolute number of prosecutions and convictions.

In 1993, at a time of heightened interest in HIV criminal prosecutions, the U.S. Sentencing Commission studied the issue and concluded that there was no need to adopt an HIV-specific sentencing standard for cases in the federal (U.S.) criminal courts. In its review of 235 criminal cases sentenced during 1993, the Commission found that transmission of HIV was an issue in only 1 case.

As Lazzarini et al. (2003) show in a comprehensive published survey of print news media coverage and court case reports of HIV exposure criminal prosecutions in the U.S. from 1986 to 2001, the number of reports of prosecutions has remained extremely low in comparison to the estimated number of individuals with HIV and the estimated number of new HIV infections each year. The highest level of reported prosecutions occurred in 1998 (more than 50) and 1993 (30). More recently (2010), the Center for HIV Law and Policy (New York, NY) has also surveyed news media and court case reports nationally, but has identified surprisingly low numbers of recent cases. For example, Texas is among the top five states in terms of AIDS case reporting in the U.S., yet during approximately the past two years, only about 5 criminal prosecutions involving HIV transmission have been identified. Although it is safe to assume that these surveys present under-counts of the actual cases, the numbers of cases prosecuted each year appear to be relatively low.

Although HIV prosecutions would not appear to be a law enforcement priority, we rarely, if ever, know why the (relatively few) cases that are prosecuted were identified and approved for prosecution. Because adequately detailed, uniform, and comprehensive case data are not generally available for HIV cases prosecuted in the state courts (unlike the federal (U.S.) court system or in other countries), it is indeed very difficult to identify trends or patterns in law enforcement. However, the apparently low priority given to HIV prosecutions may indicate that many prosecutors at municipal and county levels have already determined that these cases are generally not appropriate for criminal prosecution.

We should be very cautious in relying on specific case reports in making generalizations about the nature of criminalization. There may be many more cases that we do not know about because they are resolved without the issuance of a reported judicial ruling or without news media attention. (A dismissal or acquittal, for example, would not result in a published judicial ruling, although it may be likely to be reported in the news media.) Although many cases may seem to present an unjust outcome for the defendant with HIV, it may be difficult in many cases to determine whether that outcome is the result of institutional or structural issues (particularly the applicable “black letter” law) or the result of inadequate defense counsel, deficient “scientific” testimony from “expert” witnesses, lack of defense access to effective expert witnesses, jury bias and fears about HIV in general, or discretionary rulings from the court on evidentiary or other issues that have influenced the result – or some combination of two or more of these factors.

We can, however, glean from case reports information about sentences imposed upon conviction. This information, combined with an assessment of the applicable statutory sentencing provisions, can provide some insight, particularly when compared with other offenses and sentences as authorized by law and then as imposed by the courts. However, we should still be cautious in this assessment. Case reports may not disclose all the factors concerning the defendant’s history that were taken into account by the sentencing judge. Depending on the circumstances, the judge may not be required to state reasons why a sentence of a specific length was
deemed appropriate. Nevertheless, such an assessment of the case reports raises, at the least, a reasonable question about the fairness of the convictions and sentences imposed on many individuals in jail in the U.S. at this time.

**Effectively Engaging the Criminal Justice System**

In order to reform the criminal law in this context, it is crucial to frame the issues in a way that effectively engages judges and law enforcement officials. As attractive as arguments for “ending criminalization of HIV” are, we should consider whether such wholesale arguments will be widely successful, and if at all successful, whether likely in the near term.

The AIDS epidemic already provides another example of significant conflict between law enforcement and public health interests – largely but not entirely resolved at this point: access to sterile syringes through syringe exchange programs and other programs that required reform of drug possession and paraphernalia laws. The history of syringe access efforts in the United States, where they have been highly controversial, is instructive. Several indicia of successful efforts:

- often initiated at local levels
- had the support of or lacked overt opposition from local public health agencies or other government agencies (in some areas government agencies actually initiated such programs)
- were promoted as an effective means to reduce HIV transmission, but without increasing injection drug use
- were promoted as a more effective means to address injection drug use, with emphasis on access to health care and rehabilitative services, than criminal prosecution, conviction, and incarceration
- did not appear to endorse or socially approve of the underlying drug injecting activity
- sought legal change that was incremental or partial, and did not seek widespread repeal or complete “decriminalization” of injection drug-related conduct
- had the support of at least some specialist professional associations

Efforts to address criminalization present a very different situation. Syringe access was promoted as a means to reduce HIV transmission, although, it should be noted, even after scientific studies established that such programs were effective in reducing HIV transmission and did not also promote injection drug use, effective political opposition to such programs continued. Although there are some studies supporting the view that criminal laws do not deter sexual behaviors posing a risk of transmission, and that thus a change in those laws will not result in an increase in HIV transmission, there is less compelling evidence to support the view that criminal law enforcement actually results in an increase HIV transmission. Critics of criminalization often emphasize (correctly) that criminalization places prevention responsibility solely on the infected partner in a sexual relationship, as well as having other negative considerations such as the impact on public health or social policy (such as impact of criminal investigations on patient privacy, or criminal prosecutions as reinforcing HIV stigma). Although such human rights critiques may be generally valid, this criticism may be more effectively articulated in more traditional criminal law values, such as achieving proportionality and consistency, and avoiding unwarranted disparities with other similar offenses. To date, however, studies involving the comparative analysis of HIV offenses and other crimes, including crimes against the person, are lacking. Ideally, such studies should include a review of police investigation and prosecutorial standards.

Note also that HIV-specific statutes were adopted by state legislatures years ago when HIV transmission issues were poorly understood, fear of HIV was at a high level, and the harm of HIV infection was more immediately substantial and serious than it generally is today. Similarly, many reported cases from earlier years may continue to be relied on as judicial precedent, even though the underlying scientific and medical understanding of the disease has changed. To date, however, the history of the adoption of HIV-specific statutes in the states that adopted them, and the social and political context for the enactment of such laws, remains largely unwritten.
The Continuum of HIV Criminal Law Scenarios

I recommend that we organize our thinking about this issue according to a continuum of blameworthiness or culpability (or lack thereof) in regard to HIV transmission. At both ends of the continuum are cases that should not be controversial in how they should be treated:

- **High culpability cases** – intentionally infecting another for the purpose of causing HIV disease (e.g., physician intentionally injects patient with HIV to cause HIV disease)

- **Low culpability cases** – engaging in assaultive behavior that poses only an imaginary risk of HIV transmission (e.g., HIV positive prisoner spits, or throws body waste, at law enforcement or corrections personnel)

The criminal justice system’s handling of the rare cases in the “high culpability” end of the continuum is largely noncontroversial. The far more numerous “low culpability” cases continue to be problematic and deserving of criticism and refutation in terms of statutory definitions of risk of HIV transmission, as well as the reliability and scientific acceptability of evidence presented to support such convictions.

Far more cases, however, fall between these two ends of the continuum, and typically they involve the knowing risk of HIV transmission by sexual contact without disclosure of HIV status. Among these cases, whether brought under traditional criminal laws (e.g., assault or reckless endangerment) or under HIV-specific laws, distinctions can be made as to whether the HIV positive partner did not disclose his or her status, or whether HIV positive partner affirmatively deceived his or her partner, and as a result of the deception, the risk of transmission is increased, for example as a result of the failure to use condoms. Although a review of the law on this point is beyond the scope of this submission, suffice it to say that the concept of legal duty to disclose or warn in advance of risking or causing harm is well-entrenched and widely accepted in both the criminal and civil law systems.

The Concept of Criminal Negligence and Inchoate Crimes

Some opponents of HIV criminalization have argued that in cases in which transmission has not occurred, and where the potential defendant did not intend to transmit HIV, there should be no criminal sanction. This view reasons that if there is no harm, or no intent to cause harm, then there is no crime and thus no punishment is warranted. (On the other hand, under this reasoning, criminal liability is based not on the conduct of the defendant, but instead on the chance result of the defendant’s conduct. Some lucky potential defendants go free, while others, whose bad luck it is that their conduct resulted in harm, face prosecution.) In advancing this particular argument against criminalization, however, we should be aware of the ways in which it runs directly counter to existing criminal laws on other subjects, and thus may fail to persuade many law enforcement professionals and judges accustomed to thinking in terms of these other laws. To demonstrate this point, I will next discuss two examples of such laws.

In 1988, California adopted a law that addresses a problem that is remarkably analogous to that of knowing HIV exposure, without actual transmission, through sexual contact. This law (Cal. Penal Code § 246.3) prohibits the “negligent discharge” of a firearm, which is defined as willfully firing in a grossly negligent manner that could result in death or injury to a person. There is no requirement of any intent to cause harm (indeed, the law was adopted to deter celebratory shooting of guns into the air, not at people). Nor is there any requirement that the shooting actually result in death or injury. Under the law, a person acts with “gross negligence” when the way he or she acts is so different from the way an ordinarily careful person would act in the same situation that his or her act amounts to disregard for human life or indifference to the consequences of that act. In their interpretation of this law, the California courts have noted that for conviction, it is only necessary that there be a “possibility” of hitting someone. Despite that fact that no one intends harm, and no one is injured, California takes this offense
seriously; it can be charged as either a felony or misdemeanor, depending on the circumstances and the defendant’s criminal history. If a death is the accidental result of the shooting, it can be prosecuted as second-degree murder under the California felony-murder rule.

My second example is much more common, and drawn from my own jurisdiction, although similar laws can be found in many, if not all, states. Under the Pennsylvania Motor Vehicle Code (§ 3714) mere “careless” driving is a summary offense, resulting in the issuance of a nominal fine. Even if serious bodily injury results from such carelessness, upon conviction a fine of only $250 is imposed. But if the driver is not merely careless, but instead is “reckless” and causes serious bodily injury, the offense is treated far more seriously as a third degree felony (§ 3732.1). In general, recklessness is defined as a “conscious disregard” of substantial and unjustifiable risk. In contrast, criminal negligence is generally defined as involving the same substantial and unjustifiable risk, but instead of consciously disregarding the risk, the defendant’s risk-taking is merely inadvertent, the result of inattention. In none of these situations, however, is there any requirement that the defendant intend to cause harm.

These examples illustrate the way in which the criminal law penalizes conduct with and without harmful results, and grades these differing categories differently for punishment purposes. The California negligent firing of a firearm offense is a “conduct offense,” in which the occurrence of the underlying harm is irrelevant, although that underlying harm is one that the law is intended to prevent. Similarly, the Pennsylvania careless driving statute is also a conduct offense punished whether or not any harm results, but if the carelessness does result in harm (serious bodily injury), then the penalty is increased. Next, if the driver is not merely careless, but instead consciously disregards the risk of harm, and the harm results (a “conduct and harm” offense), the offense is now classified much higher, as a felony. Under neither the California nor the Pennsylvania statute is it likely that the actual risk of the offense conduct is quantifiable.

The analogy to sexual contact posing a knowing risk of HIV transmission should be clear: the law often penalizes this behavior as a conduct offense, like negligently firing a firearm in California or driving recklessly in Pennsylvania, without regard to the result that occurs. One task of an effective campaign against criminalization of HIV is to acknowledge this approach of the criminal law generally, and then to distinguish HIV criminal laws from it.

Making Sense of Risk of Transmission

In addressing the risk of HIV transmission, the law has a difficult problem: addressing conduct posing a risk that is difficult to measure precisely, but that is estimated to be very small, and if the event risked by that conduct occurs, the harm is substantial or significant. Several points need to be kept in mind in discussing risk of HIV transmission in the context of the criminal law. First, risk of HIV infection should be considered separately from the harm of infection. Many judicial decisions that address risk of transmission discuss it in tandem with the harm of being infected with HIV, and what are actually two separate concepts become conflated. This is particularly true in cases, perhaps more frequent in the earlier years of the epidemic than they are now, when the harm of HIV infection was viewed as infection with an essentially untreatable disease that rapidly progressed to severely disabling conditions and then death. Because of the seriousness of the harm, courts (as well as legislatures in adopting HIV specific criminal statutes), often minimized consideration of the fact, depending on the circumstances, that the risk of transmission is highly remote, theoretical, or so low as to be unmeasurable.

Currently, the harm of HIV infection continues to be widely viewed as a serious or substantial harm, and given the health impact of HIV disease, even in light of significantly improved therapies, efforts to rebut such a view are not likely to be persuasive. Nevertheless, the “serious harm” of HIV infection today is not generally the “serious harm” of HIV infection of years ago.

Just as the harmful impact of HIV transmission has changed over time, we now have more, and presumably more reliable, estimates of per-act risk of transmission. Risk discussion can rely on quantitative terms, thus allowing
comparison with risks of other harms. Although detailed, comparative studies have apparently not been undertaken to show that some significant risks of harm are deemed inappropriate for criminal law sanctions, while other risks of harm are penalized, albeit far less severely than comparable risks of HIV transmission. There are, however, many examples, particularly for offenses involving motor vehicle safety, that demonstrate this disparity. Admittedly, it is true that these distinctions, and the concepts of “acceptable” or “tolerable” risk,” or adequate “safety,” are socially and culturally determined, and not governed by objective standards. Nevertheless, the wide disparity in treatment of HIV risk, compared to other comparable risks, makes it difficult to infer that anything other than scapegoating is at work.

Although transmission of HIV from a single act of sexual intercourse is unlikely, several factors reduce the risk even further: the use of condoms, antiretroviral (ART) treatments that reduce viral load, and pre-exposure ART. No clear consensus has developed for the view that one or more of these factors reduces the risk of transmission to such a low level that there should be no criminal liability for sexual contact that would otherwise pose a risk of transmission. Some courts have recently been receptive to arguments regarding the low risk of transmission, and a valuable analogy is provided in the American Law Institute Model Penal Code (§ 5.05(2)) which recognizes that when a defendant’s conduct is so “inherently unlikely” to result in the underlying crime, then the conduct does not present a danger justifying conviction and punishment at the ordinary level or dismissal of the criminal charge is appropriate. There have been reported cases of courts’ favorable reception of defense arguments based on low viral load, and in the future many prosecutors may decline to prosecute such cases.

Conclusion

In considering the most effective approach to addressing HIV criminalization, the Commission’s findings should reflect what is known and not known about the extent and nature of law enforcement efforts to address HIV offenses. There are gaps in our knowledge, particularly in regard to the comparative analysis of HIV criminal offenses and other non-HIV offenses. This may be an area where the Commission should undertake or recommend additional research to support its findings.

The Commission’s findings and recommendations should also effectively engage the criminal justice system (in particular prosecutors and judges who effectively manage that system), and thus should directly address traditional criminal law doctrines upon which much of HIV criminalization rests.

Finally, the Commission should make specific findings about the circumstances under which the risk of transmission is reduced to such an extent that prosecution as a serious criminal offense is not warranted. Although such findings may not compel a call for complete abandonment of criminal law enforcement relating to HIV transmission, they may nevertheless persuade many prosecutors to decline prosecution (either as official policy or as informal practice) of HIV offenses in the vast majority of cases that previously would have been prosecuted. This outcome may result either from law enforcement officials’ recognition that prosecution is unwarranted, given the remote nature of the risk, or by their recognition that it will be difficult to prove the level of risk necessary to convict in a specific case.

To Whom It May Concern:

Re: The need for evidence-based illicit drug policies to reduce the spread of HIV/AIDS

I am writing to make the Global Commission on HIV and the Law aware of the Vienna Declaration. The Vienna Declaration is a statement seeking to improve community health and safety by calling for evidence-based drug
policies grounded in a human rights framework. The Declaration is designed to inform regional dialogues on drug policy reform, such as those being undertaken by the Commission.

As you will know, outside of sub-Saharan Africa, injecting drug use accounts for approximately one in three new cases of HIV. In some areas of rapid HIV spread, such as Eastern Europe and Central Asia, injecting drug use is the primary cause of new HIV infections. To that end, the effectiveness of opioid substitution therapy (OST) and needles and syringe programmes is well-documented. According to various scientific reviews conducted by the World Health Organization (WHO), these programmes reduce HIV rates by helping to reduce the number of people sharing needles and syringes contaminated with HIV. Increasing the availability of these programmes substantially reduces the spread of HIV and produces significant savings in future health care costs, along with saving lives. The programmes are cost-effective, and they help drug users access critically needed health care and drug treatment. However, legal barriers to these and other essential services mean hundreds of thousands of people become infected with HIV and Hepatitis C (HCV) every year. Further, the criminalization of people who inject drugs across global regions has resulted in prisons overcrowded with people awaiting trial, often for minor drug offences. For instance, it is now estimated that one in nine African American males between the ages of 20 and 34 are incarcerated on any given day in the US, largely as a result of drug-related criminal convictions. This emphasis on criminalization simply produces a cycle of disease transmission, along with broken homes and livelihoods destroyed. HIV outbreaks have also been reported in prisons. Yet these costs, along with the more direct costs of the ‘war on drugs’, produce no measurable benefits, and do not affect drug supply levels nor rates of drug use. As such, a paradigm shift in the development of drug policies is urgently needed.

The Vienna Declaration therefore calls on governments and international organizations, including the United Nations, to immediately take a number of steps towards evidence-based drug policy reform, including:

- Review the effectiveness of current drug policies;
- Implement and evaluate a science-based public health approach to address the harms stemming from illicit drug use;
- Decriminalize drug users;
- Scale up evidence-based drug dependence treatment options; and
- Abolish ineffective compulsory drug treatment centres that violate the Universal Declaration of Human Rights.

The Declaration also calls for the meaningful involvement of people who use drugs in developing, monitoring and implementing services and policies that affect their lives.

Simply, those that support the Vienna Declaration seek to improve the health and safety of communities affected by drug use. However, to address HIV and addiction issues among vulnerable persons, what is needed is an approach that prioritizes public health over incarceration, and that addresses the underlying causes of substance use in a culturally appropriate way. The Vienna Declaration calls for a full policy reorientation towards health- and evidence-based approaches. The Declaration was adopted as the Official Conference Declaration of the XVIII International AIDS Conference (AIDS 2010) held in Vienna, Austria on July 18th to 23rd, 2010, was drafted by a team of international experts and initiated by several of the world’s leading HIV and drug policy scientific bodies: the International AIDS Society, the BC Centre for Excellence in HIV/AIDS, and the International Centre for Science in Drug Policy (ICSDP). Currently, over 20,000 individuals and 400 organizations have endorsed the Declaration, including Human Rights Watch, the Canadian Public Health Association, the International Association of Physicians in AIDS Care, and the International Federation of Health and Human Rights Organizations. The Declaration has also been endorsed by Nobel Laureates and religious, political, law enforcement, and scientific leaders from across the globe. Finally, the Declaration has been adopted by a number of municipalities as a guiding document for the development of evidence-based drug policies.

Growing international support for the Vienna Declaration demonstrates that leading researchers, health professionals, civil society organizations and the general public are uniting in the call for evidence-based drug
policies grounded in a human rights framework that recognize the unique policy challenges of reducing health inequities among illicit drug users. As we collectively work towards evidence-based drug policies, the leadership of members of the Global Commission on HIV and the Law will be crucial to ensuring that we develop effective drug policies based on scientific evidence. Enclosed is a summary report of the Vienna Declaration. We welcome the Global Commission on HIV and the Law to use the Vienna Declaration as a submission for its ongoing work.

17 United States  Center for Reproductive Rights

THE NEED FOR A PROTECTIVE LEGAL AND POLICY ENVIRONMENT TO PREVENT HUMAN RIGHTS VIOLATIONS AT THE INTERSECTION OF HIV AND REPRODUCTIVE RIGHTS

The Center for Reproductive Rights (the “Center”) is a nonprofit legal advocacy organization dedicated to promoting and defending women’s reproductive rights worldwide. The Center uses the law to advance reproductive freedom as a fundamental human right that all governments are legally obligated to respect, protect, and fulfill for all women, irrespective of their HIV status.

Women living with HIV often face pervasive stigma and discrimination that limit their full and equal participation in society, either in spite of government laws or policies or directly resulting from official policies and practices. Such stigma and discrimination often translate into significant barriers to quality, acceptable healthcare, including reproductive healthcare, for instance in the form of delays or denial of care, violence in the healthcare setting, and involuntary HIV testing or disclosure. They can also contribute to disturbing legislative and policy trends.

Drawing from representative case studies from India, Kenya, Nigeria, and Chile, this submission identifies some of the primary barriers to sexual and reproductive health and rights that women living with HIV encounter worldwide. The submission then analyzes how these policies and practices undermine international, regional, and national commitments to respect, protect, and fulfill basic human rights for women living with HIV. The issues highlighted in this submission underline the importance of a legal and policy environment that promotes full respect for human rights for women living with HIV, rather than one that fuels stigma and discrimination. The submission further demonstrates that the development of protective laws and policies is insufficient absent effective oversight and accountability mechanisms to ensure their implementation.

Case Study: India

The high incidence of preventable maternal mortality in India reveals an already precarious situation for pregnant women in the country, which is only aggravated by the often-discriminatory attitudes of health service providers towards pregnant women living with HIV. Despite having developed favorable policies and procedural guidelines, including programs to prevent vertical transmission and provision of free antiretroviral treatment, the Indian government has failed to adequately implement these policies. As a result, pregnant women living with HIV in India frequently encounter barriers when seeking reproductive healthcare, including basic maternal care, safe abortion services, and family planning services, as the following examples demonstrate.

Gita Bai, a 30-year-old low-income woman, was denied pregnancy-related care because she was HIV-positive. In March 2007, Gita Bai went to a local hospital in Madhya Pradesh for prenatal care, as she was nearing her delivery time. After a preliminary examination, she was taken to the ward for admission. However, the hospital staff discharged her without providing any medical assistance when they discovered her HIV-positive status. Shortly thereafter, when Gita Bai returned to the hospital with contractions, doctors forcibly prevented her from re-entering the premises due to her HIV status. She was forced to deliver her child on the street outside the hospital. When she tried to re-enter the hospital immediately after giving birth, the hospital staff again physically barred her entrance. Although Gita Bai was admitted to the hospital when she returned two days later seeking treatment for pregnancy-related complications, she was routinely neglected by hospital staff. She was never advised about using nevirapine to
minimize the risk of transmission to her newborn, nor did they provide her the drug. Gita Bai died a few days later from excess bleeding, sepsis, and post-delivery complications that could have been prevented with timely and appropriate maternal healthcare both prior to childbirth and postpartum. The denial of respectful care did not end with her death, however, as it was reported that the hospital neglected to perform a post mortem and attempted to dispose of her body quickly. The police refused to register a formal complaint against the hospital for her death. A petition seeking an immediate investigation into Gita Bai’s death and compensation for her family was submitted in October 2007 to the Madhya Pradesh State Human Rights Commission,1 but no action has been taken to date.


Mrs. X was also forced to deliver a child under inhumane and undignified conditions due to her HIV-positive status. Upon going into labor, she and her husband, Mr. X, went to a private nursing home in Kolkata where she was asked to undergo a blood test. Sometime later, Mr. X was also requested to take a blood test. He initially refused, but was compelled to take it when the home’s staff refused to treat his wife without him doing so. After these tests, the staff informed Mr. and Mrs. X of their HIV-positive status, but did not provide counseling or discuss treatment options. Instead, the staff attempted to remove Mrs. X from the home. When Mrs. X started to deliver the baby in the hallway, she was pulled into a side room, but the medical staff was still reluctant to treat her and refused to provide the minimum obstetric and postpartum care required. Although cesarean sections were recommended at that time to minimize the risk of vertical transmission, Mrs. X was not offered this option. Nor were Mrs. X’s labor wounds stitched after delivery, and she developed a severe infection as a result. The staff failed to provide her newborn with nevirapine and ignored government guidelines stipulating against HIV testing within a child’s first 18 months, instead testing the newborn only 15 minutes after birth, yielding an HIV-positive diagnosis. In further disregard of Mrs. and Mr. X’s rights, the staff disclosed their HIV status to family members without permission, and advised family members to stay away to avoid infection. Due to this breach in confidentiality, their lives have become unbearable; relatives and local community members began to neglect and avoid the entire family, which has resulted in immense mental suffering on the part of Mrs. X.

Mrs. X has continues to encounter ill treatment and neglect when seeking medical care. After her birthing experience, she went to the local government hospital. The private nursing home transmitted Mrs. X’s medical records with the family’s HIV status highlighted, in violation of medical ethics and patient confidentiality. As a result, the government hospital reportedly failed to properly examine Mrs. X, and she developed an infection that was never treated. In fact, Mrs. X was only admitted into the hospital in order to accompany her child and not for treatment of her own medical problems. Further, it was only at this public hospital that the child finally received nevirapine and other required medication. Mrs. X’s humiliating and inhumane treatment at the private nursing home and the neglect experienced in the government hospital have deterred her 3 from seeking medical assistance and treatment to the detriment of her health. Her case is currently pending before the High Court of Kolkata.2

2 Mr. X v. v. Union of India and Others, W.P. of 2010, High Court at Calcutta (WEST MIDNAPORE)
5 Id., at 40.
6 Id., at 21.

Case Study: Kenya

In Kenya, the HIV/AIDS epidemic disproportionately impacts women, among whom the prevalence rate of HIV is nearly twice that of men.3 Personal testimony from the Center’s report, At Risk: Rights Violations of HIV-positive Women in Kenyan Health Facilities, demonstrates a series of infringements on the rights of women living with HIV.

Anonymous: “I gave birth at 3 p.m. and was stitched at 4 p.m. I was just waiting. The baby was crying. I later learned that the stitching equipment was not there and [that] is what they were looking for. I was not told. ... I was left there. Later they came and I had bled. [I] was in pain. The baby was cold. ... There was no water. I had to
get water from home. ... There was no proper hygiene. I left after three days. My experience was not good. ... The baby was just covered with a lesso [wrapper]. . . . The baby had not been cleaned. I am the one who cleaned the baby with cold water. You had to buy cotton and if you don’t have [any] they quarrel [with] you. Pads also you must have.”

Anonymous: “[The nurse] knew [my daughter] was HIV positive. [My daughter] was so mistreated that after delivering she was told to lie on the bed for one hour, without being stitched and not knowing where her child was. I saw her in the evening. I observed that if the child was not cleaned [of] the blood, the child would become HIV-positive just like the mother and yet they were supposed to save the baby. This was not good . . . in the labour ward there is a lot of circus and if this is not rectified, the children born to HIV-positive mothers will not turn out to be negative.”

According to Prudence, a casual worker (non-medical staff) in a delivery ward in a district hospital, “if you go to [the antenatal] clinic, you are asked to have a test, but [if] the woman refuses the test secretly. . . . When you go to the clinic the first time [the woman] goes for testing and [is] told [the testing] is for malaria or blood group, etc. You will think they are testing for malaria. But if you cooperate [it] is okay. They will do PMCT [prevention of mother-to-child transmission]. . . . But if you refuse they deal with you accordingly . . . since you cannot force patients to be tested, it is done secretly.”

Christine: “No one informed [me] of the intention [to] screen the blood for HIV. I kept quiet; [the doctors] came and surrounded me while I lay on the bed as they discussed my status in medical language without explaining to me about my status. They did not tell me of my status but they kept asking me how I was feeling and which part of my body was ailing. . . . When I was discharged, one doctor took me to a room and I knew he wanted to inform me of the results of the test but I told him that I would come for them later as they had taken blood samples without permission. I felt this was wrong treatment from the hospital.”

7 Id., at 26.


10 WHO, World Health Statistics 2010, supra note 9, at 35.


Case study: Nigeria

In Nigeria, knowledge of HIV risk factors and prevention measures is low, and comprehension of transmission routes is especially dismal. Efforts aimed at preventing the spread of HIV in Nigeria have centered on “sexual abstinence, mutually faithful monogamy between HIV-negative partners, and condom use for people not practicing abstinence.” Consequently, there is wide-spread discrimination against people living with HIV, as exemplified by Mrs. X’s experiences.

Mrs. X, employed as a banker at a reputable company, applied to another similar organization and was offered a position there. On her first day at the new company, she was required to undergo mandatory medical tests. Shortly after undergoing the tests, she was asked to take a six-month, unremunerated leave of absence. On inquiring about the reason, she was informally told that her medical tests showed that she was both pregnant and living with HIV, and that it was the company’s policy not to hire either pregnant women or people living with HIV. Her numerous appeals to management, asking them to reconsider their decision were rejected. Instead, she was
given the option of resigning, as opposed to being terminated, which would reflect badly on her employment records. Ultimately, even this option was taken away—when she eventually realized that the company would not reconsider and went to submit her resignation, she was handed a termination letter instead. While the letter did not give any reasons for her termination, Mrs. X is convinced she was fired due to her pregnancy and HIV statuses. The widespread discrimination against people living with HIV in Nigeria and anti-maternity practices in the private sector further support her claim. Mrs. X took her case to the National Human Rights Commission and, at their behest, a criminal case was initiated by the attorney general of the state in which the corporation is situated. The company has denied any wrongdoing. The case is still pending.

Case Study: Chile

Chile has a relatively low HIV prevalence at 0.3%9 and the government has made great strides in responding to HIV—it has adopted a national plan on the prevention, testing, and treatment of HIV/AIDS, 82% of Chileans with advanced HIV infection are currently receiving antiretroviral treatment,10 and Chile’s law on HIV mandates that neither private nor public health institutions can deny access to healthcare services on the basis of serological status.11 However, the Chilean government has failed to transform these laws or the State’s domestic and international human rights commitments into tangible protections for women living with HIV. The experiences of Julia and Francisca12 illustrate the abuses that Chilean women living with HIV encounter.

Julia decided to have a child in consultation with her partner and their physician after carefully considering the facts: Julia’s viral load was undetectable and she had access to the interventions necessary to minimize the risk of vertical transmission, so there was a good chance that her child would be born HIV negative. However, healthcare professionals repeatedly chided Julia after she became pregnant, telling her, “What were you thinking? Don’t you see that you are going to have a sick child?” During the first trimester of her pregnancy, Julia began experiencing an orange-colored vaginal discharge. Concerned, she went to the hospital, but instead of treating her, hospital workers turned her away and told her to return for her regularly scheduled check-up. She was admitted to the hospital three days later, hemorrhaging and with severe abdominal pain, but she still sat untreated while the hospital staff attended all the HIV-negative patients first, including those who arrived after Julia. Her pregnancy ended in a miscarriage shortly thereafter, and a paramedic told her, “It is because God knows, because you were going to have a sick child.” To this day, she wonders what would have happened if she had received prompt medical attention. The mistreatment she suffered has also kept her away from seeking healthcare services: “I tolerate as much pain as I can, until I cannot tolerate it anymore.”13

Francisca was 20 years old when she was forcibly sterilized during a cesarean delivery. Francisca had learned that she was HIV positive during a routine prenatal exam, and she took all the necessary steps to reduce the risk of vertical transmission. In November 2002, Francisca checked into the hospital for her scheduled cesarean, but the night before the operation was scheduled to take place, she went into labor. Francisca was brought into the operating room shortly after midnight. Without ever discussing family planning options or Francisca’s desires around childbirth—and contrary to Chilean law14—the surgeon decided to surgically sterilize her while he performed the delivery. “I learned that they had sterilized me at the time of the cesarean when I awoke from anesthesia a few hours later. I was in the recovery room at the [hospital] when [the nurse] told me that I was sterilized and that I would not be able to have any more children,” Francisca explained. “They treated me like I
was less than a person. It was not my decision to end my fertility; they took it away from me.” Francisca’s son was born HIV negative, and Francisca and her husband both mourn their inability to provide their son with siblings. Francisca lamented, “Being sterilized, I feel like less than a woman because, for me, fertility is a vital part of being a woman.” Francisca challenged the surgeon’s actions in the local courts, but her case was dismissed.15

By ratifying international and regional human rights treaties, governments around the world have signified their commitment to respect, protect, and fulfill basic human rights—including the rights to life, health, equality, reproductive autonomy, and freedom from torture or cruel, inhuman or degrading treatment—for all individuals, irrespective of their sex or HIV status. Yet, as these case studies demonstrate, women living with HIV routinely face discrimination and violence in healthcare settings, involuntary HIV testing without counseling or guarantees of confidentiality, and are increasingly subjects of discriminatory legislation, violating their fundamental human rights.

**Discrimination and Violence in Healthcare Settings**

Women living with HIV face pervasive discrimination and violence in healthcare settings, including delays in and denial of basic reproductive healthcare services, despite the fact that women living with HIV are entitled to the same standard of care as HIV-negative women. This is particularly problematic because pregnant women may need additional medical interventions to ensure prevention of vertical transmission. Moreover, in countries with high HIV prevalence, HIV has become a leading cause of death during pregnancy and the postpartum period.16 These discriminatory delays or denials of care can be fatal, as in Gita Bai’s case. A woman in Congo Brazzaville described how, after giving birth alone in a maternity ward because no staff would treat her due to her HIV-positive status, her newborn died from falling off the bed.17 Such practices can also contribute to serious health complications and, as in the situations of Mrs. X of India and Julia, deter women living with HIV from seeking necessary healthcare in the future.


18 Email from a nongovernmental organization working with HIV-positive women in Kerala, India (Jan. 25, 2011) (on file with author).

19 DIGNITY DENIED, *supra* note 13, at 23.


Women living with HIV also encounter discriminatory attitudes from healthcare providers regarding their childbearing decisions. This occurs despite women’s right to make sexual and reproductive choices, irrespective of their HIV status, and the fact that with the appropriate interventions, the risk of vertical transmission can be reduced to less than 2%. Anecdotes indicate that these attitudes can manifest in a range of discriminatory conduct, including denying women access to safe abortions18 or conditioning receipt of antiretrovirals on contraceptive use. HIV-positive patients may also be segregated from HIV-negative patients or receive biased, degrading, or unscientific information from healthcare providers.19 Involuntary sterilization, as in the case of Franciscia, is a particularly pernicious manifestation of such discriminatory treatment. Given the permanent nature of surgical sterilization, international guidelines note that “special care must be taken to ensure that every woman makes a voluntary informed choice of method....Health care workers should ensure that women [living with HIV] are not pressured or coerced to undergo the procedure and that the decision is not made in a moment of crisis.”20 Despite this, there is growing evidence that involuntary sterilization of women living with HIV is a global problem, 7

with reports of the practice emerging also from the Dominican Republic,21 Mexico,22 Namibia,23 South Africa,24 and Venezuela.25

21 HUMAN RIGHTS WATCH (HRW), *A TEST OF INEQUALITY: DISCRIMINATION AGAINST WOMEN LIVING WITH HIV

22 Tamil Kendall, Reproductive Rights Violations Reported by Mexican Women with HIV, 11 HEALTH AND HUM. RTS. IN PRACTICE 79, 84 (2009).


24 Anna-Maria Lombard, South Africa: HIV-positive women sterilised against their will, CITY PRESS, June 7, 2010.


28 AT RISK, supra note 4, at 21.

29 DIGNITY DENIED, supra note 13, at 20.

30 Id., at 20.

Discrimination and violence in healthcare settings can violate women’s rights to, inter alia, life, health, autonomy, freedom from torture or cruel, inhuman or degrading treatment, freedom from gender-based violence, and equality and non-discrimination.26

Non-Consensual HIV Testing and Disclosure

The World Health Organization and UNAIDS have emphasized that, in order to be effective, HIV testing must be “confidential, be accompanied by counselling, [and] only be conducted with informed consent.”27 However, laws that call for mandatory testing and disclosure or States’ failure to adequately implement protective laws and policies contribute to healthcare providers testing women and disclosing their HIV status to partners, family members and sometimes even employers without their consent.

Failures to obtain informed consent for HIV testing are disturbingly common throughout the world. Only half of Kenya’s public health facilities and only 15% of its maternity wards comply with the country’s informed consent regulations,28 and a majority of the women interviewed in the Center’s report Dignity Denied reported not having received any counseling prior to testing for HIV,29 indicating that informed consent was not obtained prior to testing.30 As the experience of Mrs. X in Nigeria demonstrates, involuntary testing for and disclosure of HIV status is not limited to healthcare settings, and such practices can carry significant consequences in employment and other spheres. 8

With respect to confidentiality, many of the women the Center interviewed in Chile reported breaches in the healthcare setting. For example, women frequently noted that their medical charts indicated “HIV-positive” in giant letters at the top of the chart, often in red ink or highlighted, or that nametags or signage advertised the nature of that hospital unit. Several women also reported problems with hospital staff disclosing their HIV status to other patients or family members.31 As shown by the case of Mrs. X in India, non-consensual disclosure of HIV status places women at risk of abandonment, neglect, separation from their children and even ostracism by their husbands, partners and/or community, as well as risk of physical, sexual and psychological abuse. In Uganda, for example, HIV-positive women are often subjected to violence due to their HIV status.32 As a result, many women fear learning or disclosing their HIV status, as they risk being accused of bringing HIV into the home, being subjected to domestic violence, or being evicted.33 In 2008 alone, five cases were reported of women being murdered by their husbands once they learned that their wives were living with HIV.34 31 Id., at 21-22.
Non-consensual HIV testing, especially in the context of prenatal care, and involuntary disclosure of HIV status violates women’s rights to autonomy, dignity, health, privacy, equality and non-discrimination, and equal protection of the law. Research has also shown that violations of consent and confidentiality discourage pregnant women—regardless of their HIV status—from obtaining healthcare services, including HIV testing, drug treatment, pre- and post-natal care and means to prevent vertical transmission.35

**Disturbing Legislative Trends**

Fueling or exacerbating human rights violations faced by women in healthcare settings are disturbing legislative trends. Laws that have been passed or are being considered call for mandatory HIV testing in many circumstances, including pregnancy, non-consensual partner disclosure, and criminalization of HIV transmission, including vertical transmission either implicitly or explicitly.36 For example, the Ugandan Parliament was considering a bill37 that included provisions criminalizing transmission of HIV, permitting non-consensual disclosure of one’s status, and providing for routine testing for victims of sexual offences, pregnant women, and partners of pregnant women without requiring informed consent.38 While the bill is currently shelved due to intensive advocacy against it, the fact that such legislation progressed as far as it did is highly problematic.9

While the stated goals of such legislation usually include protecting the rights of and eliminating discrimination against individuals living with HIV, such legislation instead compounds the already dire situation of healthcare systems that lack respect for patients’ rights and contributes to widespread stigma and discrimination against people living with HIV and violence against women. Laws criminalizing HIV transmission, often overly broad and poorly drafted, could penalize individuals who practice safer sex and/or disclose their HIV status to their sexual partners or women who transmit HIV to their children, either in utero or during labor and delivery. Criminalization of vertical transmission could also further exacerbate the already negative attitudes of some healthcare workers towards the childbearing decisions of women living with HIV. Compulsory testing of pregnant women may likewise discourage women from seeking healthcare, which, in turn, would undermine HIV prevention efforts. The International Guidelines on HIV/AIDS and Human Rights recognize that the compulsory testing of pregnant women is a coercive measure that ineffectively combats the spread of HIV and restricts the human rights of the individual.39

39 UNAIDS, INTERNATIONAL GUIDELINES ON HIV/AIDS, supra note 27, para. 105.

In light of such grave threats to women’s human rights, we hope that the Commission will support the development of a legal and policy environment that contains strong protections for women’s rights. Specifically:

To ensure that legal and policy responses to HIV and AIDS emphasize the protection of women’s rights, especially the rights to sexual and reproductive autonomy and equality and non-discrimination, rather than exacerbating existing stigma and discrimination experienced by women living with HIV.

To ensure that HIV legislation and policies focus on protecting the human rights of those living with HIV and the development of comprehensive and evidence-based prevention methods, rather than introducing provisions such as criminalization of transmission that can increase women’s risks and vulnerabilities, and to call on states to review and repeal harmful and/or discriminatory legislation.
To ensure the enactment of laws and policies that fully protect women’s reproductive rights and their application in the context of women living with HIV, including development of a legal framework which effectively prohibits and punishes sterilization without consent.

To support the development and implementation of laws and policies which reduce discrimination against HIV-positive women in healthcare settings, with a particular emphasis on reducing the multiple forms of stigma that contribute to abusive and/or neglectful reproductive health services for women living with HIV.

To encourage the passage of legislation and policies that require medical providers to obtain informed consent prior to HIV testing and disclosure of HIV status and impose strict confidentiality standards in the context of HIV, and to create effective enforcement mechanisms to guarantee these protections.

To strengthen, or encourage the development of, accessible and effective accountability mechanisms with the requisite sensitivity and expertise to address violations occurring at the intersection of HIV and reproductive rights.

Patent Pool: A Developing Country Perspective
K M Gopakumar, Third World Network

While the use of TRIPS flexibilities remains the effective strategy to ensure access to affordable ARV medicines, there is a move to advocate other alternatives like patent pool or voluntary license to address access to medicine question in developing countries. According to the outcome document of the High Level Meeting on HIV/AIDS “encouraging the voluntary use, where appropriate, of new mechanisms such as partnerships, tiered pricing, open-source sharing of patents and patent pools benefitting all developing countries, including through entities such as the Medicines Patent Pool, to help reduce treatment costs and encourage development of new HIV treatment formulations, including HIV medicines and point-of-care diagnostics, in particular for children”. Thus pool and voluntary license are recognized as new alternatives along with non-working mechanisms like tired pricing. Political support for the pool also came from the G-8 Declaration 2011. It states that “We welcome the Patent Pool Initiative launched by UNITAID in order to facilitate the production of affordable generic medicines well-adapted for use in resource-poor settings, and we encourage the voluntary participation of patent owners, private and public, in the project”. It is important to examine the feasibility of pool and voluntary license as a credible alternative to use of TRIPS flexibilities.

The pool is expected to address five common problems existing in the availability and supply of ARV medicines viz. single source of supply, smaller global generic market size, barriers to follow on innovation and legal uncertainty. The pool is to address these problems through five actions. Viz. diversify the supply of sources to reduce prices, expand the size of generic market, facilitate the development of improved formulations, reduce the transaction cost for fixed dose combinations and increasing the legal certainty to reduce prices. However, the most important function of the pool is the reduction of transaction cost by providing the “one stop shop” to issue voluntary license for generic companies without going through tedious process of license negotiations or legal

1 http://www.g20-g8.com/g8-g20/g8/english/news/news/renewed-commitment-for-freedom-and-democracy_1314.html
2 Patent pool implementation plan, November 2009, p. 13
3 Ibid
procedure for the obtainment compulsory license or government use license mechanisms provide under Article 31 of TRIPS. There are certain concerns regarding the ability of patent pool especially the Medicines Patent Pool in pharmaceuticals to fulfil that vision. The following paragraphs summarises some of the major concerns on the potential of pool to act as a one-stop shop for voluntary license from patent owner often pharmaceutical MNCs and generic companies.

The moot question is that whether pool would able to provide voluntary licenses to generic companies without any conditions affecting their freedom of operation. In other words the license from pool would be able to supply the medicine to all developing countries without any conditions affecting competition. That depends on the bargaining power of the Medicine Patents Pool (MPP) to convince patent holders to provide their patent license through the pool. Currently MPP is a Swiss Foundation, a Non-Governmental Organisation (NGO), independent of UNITAID, which is providing the funds to MPP. This independent status (independent of inter governmental organisation UNITAID) creates an asymmetry in the bargaining power between patent holders and patent holders often pharmaceutical MNCs and this would work in favour of patent holders. Further, except adverse publicity there is compulsion especially legal compulsion on the patent holder to join the pool. This asymmetric relation between MPP and patent holding pharmaceutical MNCs may result in incorporation of restrictive conditions that favouring the patent holder in the patent pool voluntary license. Hence, one cannot expect voluntary license form pool as an alternative to use of TRIPS flexibility including compulsory license or government use.

The advocacy and political push such as G8 declaration for patent pool also bear the threat of undermining advocacy and strategies towards mainstreaming of TRIPS flexibilities. A voluntary license with restrictive conditions can be used by pharmaceutical MNCs “to delay and even prevent developing countries from using public health safeguards like Cl”.

Further, concerns are whether patent pool license creates segmentation of developing country market. Peoples Health Movement (PHM) expressed this concern in a letter which states that “we understand that there is a proposal to segment the markets of developing countries (that are classified as low and middle income countries) through the patent pool implementation plan, whereby pharmaceutical companies would able to choose countries in which the patent pool would be made operational and/or negotiate the terms an conditions for the inclusion of all these countries in the pool”. Such fragmentation also results in different royalty rate. However, the most important issue is that whether the voluntary license holder would be bale to supply to the excluded countries under a compulsory license.

Another important concern with regard to patent pool voluntary license is that such license is that “patients and governments in these countries will effectively be paying increased royalty even though they are not required to enforce patent rights on pharmaceuticals”. This would happen if the license agreement covers the LDCs too. In the past Gilied sciences issued a voluntary license covering LDC.

Gilied voluntary license contains very restrictive provision. It restrict the license holder’s freedom to supply APIs. Further it imposes condition on the right holder to defend the patent rights. It also imposed geographical restrictions on the licensee and also contains exclusive grant back provisions.

Thus voluntary license through patent pool or independent voluntary license with restrictive conditions is not the real alternative to use of TRIPS flexibilities. Thus it is important for developing countries governments to

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5 ibid
6 Letter from PHM to UNITAID Board Chair dated 10th December 2009 available at http://www.phmovement.org/en/node/2720
7 ibid
8 supra note 4
9 For details see : http://www.i-mak.org/storage/Oxfam%20Voluntary%20Licensing%20Research%20IMAK%20Website.pdf
incorporate the TRIPS flexibilities to the optimal level in their domestic patent law. The following paragraphs deals with some specific shortcomings of MPP/Gilead licensing agreements for Indian generic manufactures. (Annex 1 spells out a report co-authored by the author on the MPP license).

One of the important concerns with regard to the voluntary license signed between Gilead Sciences and Medicines Patent Pool (hereafter license) includes Tenfovir disoproxil fumarate (TDF) among other three molecules. However, there is no product patent protection for TDF in India. The product patent application was rejected in 2009. Cipla, one of the major Indian generic manufacturer is producing the generic medicine without any voluntary license form Gilead Sciences. Other Indian manufactures are producing TDF through a voluntary license obtained from Gilead sciences. Further, the license agreement Appendix 2 cites only two valid patents viz. an Indian patent and an Indonesian patent. However, the Indian patent is a process patent and does not really block the generic production. The appendix also mentions 8 pending patent applications. Out of this 8 pending applications two applications are related to nucleotide analogues viz. 2076/DEL/1997 and its divisional application 602/DEL/2007. The original application i.e 2076/DEL/1997 was rejected in 2009 through a pregnant opposition proceedings and appeal against the rejection is pending at the intellectual property appellate tribunal. Other six applications on Nucleotide Analog composition and synthesis are divisional applications of patent application 2174/DEL/1998, which obtained a process patent. Patent office rejected two patent applications viz. 896/DEL/2002 and 963/DEL2002 out of these six pending patent applications through pre grant opposition. Further more patent opposition is pending before the Indian patent office on other three patent applications viz. 1135/DEL/2007, 2256/DEL/2009 and 2100/DEL/2007. Hence the license is not a patent license but a license on patent application for which the licensee is obliged today a 3% royalty, which may go up to 5% in the event of a grant of patent. Thus Gilead is seeking rent from Indian licensees on the basis of pending patent applications with questionable claims.

Apart the Indonesian patent the Agreement does not cite any foreign patent application. This raises the question that there is no valid patent or pending patent applications in the other 109 countries out of the 111 countries listed in Appendix 1. If that is the case Gilead is seeking royalty from Indian generic companies for supplying countries with there is no patent for TDF and also imposes stringent conditions on Indian generic manufactures.

Another important issue is that this license bundled two molecules viz. elvitegravir(EVG) and Cobicistat(Cobi) and a fixed dose combination viz..QUAD. However, all the two molecules are yet to obtain the marketing approval for HIV/AIDS treatment. Generally speaking, it will take 3-5 years after the marketing approval to assess the safety and efficacy of a new medicine. This license might be an attempt to push a particular product without enough evidence.

One of the important progresses under this license is allowing licensee to supply products to a country, which is not included in the appendixes as territories included for different products. However, a perusal of the concerned provisions shows that such an option would remain only in theory not in practices. The conditions put in paragraph 10.3.d follows paragraph 6 model and makes the Indian licensee to seek compulsory license for supplying to the country which issued CL. One of the important condition is that licensee and Gilead are in agreement (with such agreement not to be unreasonably withheld)regarding the existence, scope and content of such compulsory license”. Thus Gilead’s consent is required to supply to a country through a compulsory license. This goes beyond the compulsory license envisaged under patent statues.

The license excluded many countries especially the whole of Latin America form the scope of the license. In many countries patent for TDF is not existing. hence, the licensees i.e the Indian companies cannot supply. In the absence of patents there is no possibility of supply of medicines under compulsory license. Further, the license is limited to Indian generic manufactures and manufactures form other countries have been excluded. Since India is one of the major source of supply of Generic Medicines for HIV/AIDS treatment such a license would have the effect of dividing the market between appendix countries and non appendix countries and preventing the supply of generic medicines to non appendix developing countries by preventing Indian generic companies, who obtain the license.

Another important claim about the license is that it allows production of paediatric formulation, fixed dose combinations, new use like hepatitis B. However, the Indian Patents Act prohibits patenting of new use,
formulations and fixed dose combinations. Thus enabling provisions in the license for fixed dose combination, new use and paediatric formulations are in a way is reinforcing evergreening practices and undermining Section 3 (d) of Indian Patent’s Act.

Annex 1

**Gilead grants license to medicines pool, devil is in details**

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London/New Delhi, 20 Jul (Sangeeta Shashikant and K. M. Gopakumar) -- There are mixed reactions to the first licensing agreement between Gilead Sciences, one of the world’s largest pharmaceutical companies, and the Medicines Patent Pool (MPP), a Swiss foundation, for the production of some HIV/AIDS medicines.

The Medicines Patent Pool and UNITAID (an international drug purchasing facility to provide medicines to the poor for HIV/AIDS, malaria and tuberculosis) announced on 12 July, a voluntary license agreement between MPP and Gilead Sciences for the production of tenofovir, emtricitabine, cobicistat and elvitegravir, as well as a combination of these products called "Quad" for the treatment of HIV/AIDS. Tenofovir is also licensed for use to treat Hepatitis B, common among the poor in many developing countries.

Ellen t’Hoen, Executive Director of the Medicines Patent Pool, marked the agreement as a "milestone in managing patents for public health", while Stephen O’Brien, Minister of International Development for the United Kingdom, welcomed the agreement and noted that the UK would continue to support the Pool as an important contribution to ensuring that the largest number of people living with HIV get access to the treatments they need. However, concerns were also voiced by others involved in seeking better access to affordable medicines, as they pointed to the shortcomings of the agreement reached. Medecins sans Frontieres (MSF) noted in its press release that "the agreement falls significantly short of what is needed to fully meet the public health needs for HIV/AIDS".

The MPP is an independent Swiss foundation based in Geneva and funded by UNITAID under a five-year Memorandum of Understanding. It focuses on negotiating with patent holders to interest them in licensing their intellectual property to other producers to facilitate the production of generic medicines initially for the treatment of HIV/AIDS.

[In 2006, Brazil, Chile, France, Norway and the United Kingdom decided to create UNITAID, an international drug purchasing facility financed with resources that would be both sustainable and predictable. A tax on airline tickets was chosen as the most appropriate means of providing sustainable funding. There are 29 countries supporting UNITAID today and the three diseases covered are HIV/AIDS, malaria and tuberculosis.]

In July 2008, the UNITAID board decided to explore the possibility of establishing a voluntary patent pool for medicines, and in December 2009, agreed to create the MPP as a separate entity, which would focus on increasing access to HIV medicines in developing countries.

Unsurprisingly, many developed countries have trumpeted their support for the MPP, as it advocates the use of voluntary measures to facilitate access to medicines.

[Developed countries such as the US and the EU have a long history of criticizing and threatening retaliatory measures against developing countries that use compulsory licenses to make treatments available to their local populations.]

The approach taken by the MPP has given rise to concerns that while "Big Pharma" gains publicity by participating in the pool, such a "voluntary" mechanism is likely to further undermine the use of flexibilities (e.g. compulsory licence) under the WTO agreement on intellectual property rights to facilitate access to medicines. There are also concerns that the MPP may undermine support and resources for patent oppositions in India, legitimize "evergreening" practices, as well as segment developing-country markets.

["Evergreening" is a strategy often used by patent holders to lengthen the period of monopoly that they have over a particular product. For example, new patents for another 20 years are obtained for changes to a product...
whose patent term is expiring, and such changes are subject to a low standard of "inventiveness" to justify a new patent, thus extending the product's monopoly in the market. Many of the legal and technical steps taken to do this have been widely criticized by public health advocates over the past two decades. For example, patents are granted over fixed dose combinations as well as over new uses or formulation of known products.]

Several of these concerns appear to be justified in view of the terms and conditions contained in the licenses agreed to by MPP and Gilead, leading certain non-governmental groups to question whether "voluntary measures" work to promote access to medicines.

Health Gap, in its press statement, noted that the patent pool licenses are "demonstrating the inherent limitations of voluntary measures to address the needs of affordable medicines".

The licenses agreed to between MPP and Gilead Sciences are in three documents. The first is the primary licensing agreement signed by the Pool and Gilead, the second is an "amended and restated" sub-license agreement for existing Gilead sub-licensees, while the third document is a sub-license agreement for new sub-licensees. This third license agreement is a tripartite agreement among Gilead Sciences, MPP and the potential licensee (in this case, Indian generic companies).

The licenses cover tenofovir (TDF), cobicistat (COBI), elvitegravir (EVG) and the Quad (a fixed-dose combination of TDF-COBI-EVG-emtricitabine).

[TDF is a medicine used in combination with other antiretroviral (ARV) medicines in first and second line regimens for treating HIV, as well as for Hepatitis B. TDF is recommended by the WHO to replace stavudine, a widely used HIV treatment in the developing world that is less preferred due to the adverse side effects. Emtricitabine is an ARV medicine used in first and second line treatment for adults. COBI and EVG are medical products that are in development and yet to be approved for use in HIV treatment.]

In its press release, the MPP highlighted the key features of the licenses. These include: licensing of products still in clinical development that ensure speedier availability of such medicines in developing countries; key flexibilities in intellectual property have been preserved; payment of royalties between 3-5% of generic sales with royalties waived for any new pediatric formulations; an increase in the geographical scope of the licenses.

The licenses allow for the supply of TDF and emtricitabine in 111 countries, for cobicistat in 102 countries and for EVG and the Quad in 99 countries; contain agreement to make publicly available the text of the licenses; and termination clauses that allow the licensees to terminate the license for one medicine, while retaining the license to produce the others.

Despite these claims in the press release, the actual terms and conditions of the licenses raise a variety of issues and concerns.

A major critique of the licenses is that products produced under the licenses are only for supply to a specific list of countries (listed in Appendices to the licenses) and as such exclude from the scope of the licenses many developing countries, including countries with significant populations of people living with HIV. Hence, the licensee (i.e. Indian generic companies) cannot supply many developing countries that are excluded from the scope of the license. For example, except for Bolivia, Cuba, Ecuador and El Salvador, no other South and Central American countries are included in the licenses.

Act-Up Paris, another organization, in its press release, noted: "In total 5 million people living with HIV will be excluded from the Patent Pool. Moreover, the agreement will exclude countries with important generic manufacturing capacity, and limit the production of medicines to Indian generic firms, thus restricting competition that lower the price of drugs. Gilead has placed limits in excess of WTO rules to prohibit local production in poor countries".

The exclusion of all these countries in the first deal between a drug company and the Patent Pool constitutes a dangerous precedent that risks limiting the scope of the programme," it stressed.

As a result, the MPP/Gilead licenses segment developing-country markets between those that can be supplied under the licenses and those that are not covered by the licenses.
The list of countries excluded from the Patent Pool/Gilead deal for Gilead's drugs already on the market -- in Asia: Malaysia, North Korea, China, and the Philippines; in Latin America: Argentina, Brazil, Chile, Colombia, Paraguay, Peru, Uruguay, and Venezuela; in Central America: Costa Rica, Mexico, and Panama; in Middle East: Iran, Iraq, Lebanon, and Jordan; in Eastern Europe and the Baltics: Albania, Azerbaijan, Belarus, Bulgaria, Croatia, Czech Rep, Estonia, Hungary, Latvia, Lithuania, Montenegro, Poland, Republic of Kosovo, Republic of Macedonia, Romania, Russia, Serbia, Slovak Rep, Turkey, and Ukraine; in Africa: Algeria, Egypt, Morocco, Tunisia, and Libya; in Island Nations: Marshall Islands, and Micronesia. -- Source: Act-Up Paris news release dated 18 July 2011.

The list of countries excluded from the Patent Pool for Gilead drugs still in trials -- in Asia: Malaysia, North Korea, China, the Philippines, Kazakhstan, Sri Lanka, Thailand, Turkmenistan, and Indonesia; in Latin America: Argentina, Brazil, Chile, Colombia, Paraguay, Peru, Uruguay, Venezuela, Ecuador, and El Salvador; in Central America: Costa Rica, Mexico, and Panama; in Middle East: Iran, Iraq, Lebanon, and Jordan; in Eastern Europe and Baltics: Albania, Azerbaijan, Belarus, Bulgaria, Croatia, Czech Rep, Estonia, Hungary, Latvia, Lithuania, Montenegro, Poland, Republic of Kosovo, Republic of Macedonia, Romania, Russia, Serbia, Slovak Rep, Turkey, and Ukraine; in Africa: Algeria, Egypt, Morocco, Tunisia, Libya, Botswana, and Namibia; in Island Nations: Marshall Islands, and Micronesia. -- Source: Act-Up Paris news release dated 18 July 2011.

It could be argued that Section 10.3(d) of the licenses could reduce the adverse effect of not being included in the scope of the license, as it allows export to countries (outside the scope of the license) that have issued compulsory license (CL) over the products concerned. However, that flexibility is subject to several restrictions, in particular that the licensee and Gilead Science must be in agreement with regard to the existence, scope and content of such CL issued in the importing country (with Gilead not unreasonably withholding its agreement) and/or the government of India has issued a CL for the export of the product to a country (outside the scope of the license), but the importing country must have also issued a CL if a valid patent exists in its territory.

Section 10.3(d) seems to suggest that even if there is no valid patent in a country (outside the scope of the license), such a country cannot be supplied under the voluntary licence granted unless India issues a compulsory license to supply that country. This would then require operationalising Section 92A of the Indian Patents Act which pertains to mandatory compulsory license “to any country having insufficient or no manufacturing capacity in the pharmaceutical sector for the concerned product to address public health problems”.

Section 92A was incorporated to implement the 30 August 2003 WTO General Council decision (that has been criticized for containing cumbersome procedures) to facilitate exportation of patented medicines produced under a compulsory license. The requirement of compulsory license would act as a disincentive for generic companies to supply individual countries excluded from the license.

Further, the licenses are limited to Indian generic manufacturers. Other generic manufacturers from developing countries that have capacity to produce, such as in Thailand and in Brazil, have been excluded from the scope of the license.

The MPP/Gilead licenses also require that the active pharmaceutical ingredients (API) for the products licensed are to be supplied only by those licensed by Gilead to produce those API or are produced by the licensee under the license.

In addition, one of the licence features highlighted is that the termination clauses allow the licensees to terminate the license for one medicine, while retaining the license to produce the others. However it should be noted that termination clauses are linked to restrictions.

Even though the license provides the option to terminate any of the license for API such termination would also result in the termination of the license to produce the product using the terminated API. For instance, the license states that “any termination by Licensee of its license to TDF pursuant to this Section 10.5 shall in turn terminate the license and rights granted to licensee hereunder with respect TDF product and TDF Combination product, and any other product containing TDF”.

This suggests that the API license is bundled with the product and as such a generic manufacturer would be unable to produce a TDF product under the license using API produced by entities not licensed by Gilead.
Further, the licenses impose restrictive conditions on the supply of APIs and products to a country outside the scope of the licenses. Section 10.3 (c) suggests that even when patents containing a valid claim have been held invalid beyond the possibility of any further appeal in India and in the country outside the scope of the licenses, the licensee is only able to supply such API or products after the licensee reaches agreement with Gilead that no valid patents exist and that the licensee has been able to obtain applicable regulatory approval in such country.

This suggests that supply to countries outside the scope of the license by the licensee even after the patents are held to be invalid would need to be agreeable to Gilead Sciences.

[According to the definition section, reference to "Patents" includes not only patents listed in the Appendix of the licenses but also to any other patents and patent applications (and resulting patents therefrom) owned by Gilead or exclusively licensed by Gilead from Japan Tobacco Agreement covering APIs of products mentioned in the license. This broad definition of "Patents" thus covers any patent or patent application (existing and future applications) containing the APIs of TDF, FTC, EVF, and COBI within the scope of license].

As such, the final disposal of patents in the license means the disposal of not only the patents listed but also any other patents or patent applications pertaining to the licensed molecules. This provision can easily be used to evergreen the license agreement.

Another important issue is with regard to TDF’s inclusion in the scope of the license. Presently, there is no product patent protection for TDF in India. The patent application filed by Gilead Sciences was successfully opposed in 2009 by generic companies such as Cipla and civil society organisations working on access to HIV/AIDS medicines using the pre-grant opposition system in India. Gilead has filed an appeal against that decision but the appeal has yet to be heard.

Appendix 2 to the licenses lists eight patent applications in India related to TDF products and processes. Of these applications, at least three applications, which include a product patent application, have been rejected at the pre-grant opposition stage, while three more such applications are facing patent opposition before the Indian patent office.

As such, it appears that the license granted is not for patents that have been granted but on patent applications with questionable patent claims, which are likely to be rejected during the opposition proceedings.

Moreover, apart from India and Indonesia, Appendix 2 of the license agreement does not cite any other foreign patent application with regard to TDF. This suggests that there is no valid patent or pending patent applications in the other countries listed in Appendix 2 and as such, Gilead is seeking royalty from Indian generic companies for supplying to countries that have no patent for TDF.

On the issue of royalty, according to the terms of the licenses (Section 4.9), royalties will have to be paid until the expiration or the date of expiration of the last to expire “Patent containing a valid claim covering the manufacture, use, import, offer for sale or sale of API or the Product in India”.

In addition the section adds that royalties do not have to be paid if “all Patents containing a valid claim” are "held invalid or unenforceable beyond the possibility of any further appeal" in India and in the importing country.

According to the definition section, reference to "Patents" includes not only patents listed in the Appendix of the licenses but also to any other patents and patent applications (and resulting patents therefrom) owned by Gilead or exclusively licensed by Gilead from Japan Tobacco Agreement covering APIs of products mentioned in the license. This broad definition of "Patents" thus covers any patent or patent application (existing and future applications) containing the APIs of TDF, FTC, EVF, and COBI within the scope of license.

As such, the final disposal of patents in the license means the disposal of not only the patents listed but also any other patents or patent applications (that have been filed or have yet to be filed) pertaining to the licensed molecules.

This means that royalties will have to be paid until expiration or determination of validity on all patents and patent applications containing a valid claim covering the manufacture, use, import, offer for sale of the API or the Product. This could take many years and during these years Gilead will be allowed to claim royalties over
questionable patent claims.

It also suggests that royalties would be paid while a patent application is pending examination as well as in the interim period (i.e. after the decision of the pre-grant opposition) before the final appeal is heard, which could also take many years. Usually, during these periods, generic manufacturers are free to produce generic versions without payment of any royalties.

[Cipla's opposition to the TDF patent application in India succeeded in 2009 and although pending appeal, Cipla continues to produce generic versions without any payment of royalties. Other major generic manufacturers produce TDF under a voluntary license from Gilead Sciences.]

Another concern with regard to the licenses is that it extends to fixed-dose combinations, pediatric formulations, as well as new uses such as the use of TDF for treatment of hepatitis B, thus implicitly legitimizing the practice of "evergreening". The licenses also encourage such practice with its provision for mandatory grant back by the licensee (i.e. the generic manufacturer) to Gilead Sciences of improvements made on the licensed products.

India enacted a specific provision in its patent law, commonly referred to as "Section 3(d)", to combat such a practice. Section 3(d), in combination with provisions on pre-grant opposition in the Indian patent law has been used on numerous occasions by generic companies as well as civil society organisations to challenge and nullify patent applications that claim such bad patents. As a result, many key medicines such as imatinib mesylate, tenofovir, and nevirapine hemihydrate are currently not covered by patents in India, giving Indian manufacturers the freedom to manufacture the generic versions of such products.

In some cases, a pre-grant opposition challenge has resulted either in withdrawals of applications such as the one for Lamivudine/zidovudine combination or changes in patent claims.

Following the success in India, groups in Thailand and Brazil have also pursued a similar strategy to safeguard their access to generic medicines.

However, the patent pool licenses could undermine the use of patent oppositions, as it is likely to lead to much fewer such legal challenges to bad patenting practices, particularly as Indian generic manufacturers may simply opt for a voluntary license instead of engaging in an opposition against multinational pharmaceutical companies such as Gilead Sciences. This is likely to result not only in bad patents continuing to remain valid, but also even more aggressive use of "evergreening" practices by pharmaceutical manufacturers.

Several conditions in the licenses would restrict use of critical TRIPS flexibilities, such as parallel importation.

[Parallel import is the import and resale in a country without the consent of the patent holder of a patented product when that product has been legitimately put in the market of the exporting country under a parallel patent.]

The licenses explicitly require the licensee to guarantee that there will be no diversion of API or other chemical entities generated during the process of manufacturing of API or the products outside of India except as expressly permitted by Gilead Sciences.

Further, third party resellers would also need to enter into agreement with the licensee to ensure that the terms of the licenses (signed between the licensee and Gilead) are also abided by such resellers. The agreement between the licensee and the resellers would have to be notified to Gilead in writing, with copies provided to Gilead for its review. Gilead has the right to terminate the right of the licensee to sell to such reseller.

Effectively, the terms of the licenses are quite stringent, presumably to ensure that flexibilities such as parallel importation are not used by countries to import products that are produced under the license.

The terms of the licenses also require that the licensee produces API and products consistently with applicable Indian manufacturing standards, standards of the importing country and additional standards either set by the WHO pre-qualification or European Medicines Agency or the US Food and Drug Administration. This requirement effectively is likely to limit the use of the licenses to more advanced Indian generic companies, while excluding the small and medium sized industry that produce quality generic medicines.
THREATS TO ACCESS TO MEDICINES CONTINUE

In June 2011, at a UN meeting in New York, the international community committed that at latest 15 million people will be on antiretroviral therapies by 2015.

However, it is difficult to hope that this target would be achieved, as the war against generics continues and actions of multinational pharmaceutical companies continue to deny treatment to large segments of populations living with HIV.

Act-Up Paris noted in its press release of 18 July that: "... the European Commission ... have been pushing trade policies (including free trade and so-called anti-counterfeiting agreements) that aim to block the fabrication and the export of generic drugs. Without low-cost medicine, global commitments to achieve Universal Access to treatment will not be reachable". It further noted that Gilead's announcement cannot hide the war against generic medicines, pointing out that the MPP/Gilead agreement excludes many countries.

MSF, in a press release on its report on HIV drug pricing (on 18 July), noted: "Several pharmaceutical companies have abandoned HIV drug discount programmes in middle-income countries".

It further said that "Tibotec/Johnson & Johnson exclude all countries classified as ‘middle-income' from their price reductions; Abbott excludes low-income and lower middle-income countries from discounts for one of its drugs; and ViiV (Pfizer and GlaxoSmithKline) no longer offers reduced prices to middle-income countries, even when programmes are fully funded by the Global Fund to Fight AIDS, TB and Malaria or the US government's PEPFAR programme."

MSF also noted Merck's announcement that it will no longer issue price discounts for 49 middle-income countries for its new drug raltegravir. Today, Brazil is paying $5,870 per patient per year (ppy) for just this one HIV drug; in least-developed countries, Merck charges $675 ppy for the drug, which is already four times the price of the recommended triple first-line combination (TDF/3TC/EFV).

"This development comes on the heels of a number of developing countries being excluded from (the July) agreement between drug company Gilead and MPP," MSF added. +

19 Switzerland International Organization for Migration

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

In response to the Specialist Call for Submissions, the International Organization for Migration (IOM) Migration Health Division submits the following responses and recommendations surrounding laws and practices as they relate to HIV and migrant health issues. IOM would like to highlight two specific areas in which the law can be used to scale up effective HIV responses. The first is related to elimination of HIV related entry, stay and residence restrictions and the second relates to migrants’ access to HIV prevention, testing and treatment services regardless of legal migration status.

Background:
Migration and human mobility are growing phenomena in the 21st Century. Globalization, demographic trends, environmental changes, and rapid travel and communication have had a deep impact on the size and patterns of modern migration, from traditionally unidirectional movement to major receiving countries, to increasingly diverse and complex movements which are multi-directional, seasonal and circular. Estimates suggest there are currently 214 million international migrants and 740 million internal migrants.1 These trends are expected to continue and underpin the importance of the ways in which governments address the developmental and societal aspects of migration, including policies and legislation specific to HIV which impact migrants and mobile populations.
Entry, Stay and Residence Restrictions

Since the beginning of the HIV epidemic, countries have imposed travel restrictions on people living with HIV. These restrictions include laws prohibiting HIV-positive individuals from entering countries for purposes of tourism, business, employment, or education. They also restrict the entry or stay of individuals who wish to apply for asylum or migrate for long-term residence. Governments have given two reasons for imposing such restrictions: as an attempt to protect national public health and to avoid the economic burden of providing HIV-related health care to these individuals. Despite these claims, experts have concluded that HIV-specific travel restrictions do not protect the health of the public and are in fact poor public health practice. The International Task Team on HIV-related Travel Restrictions produced a report in December 2008 in which they stated that, “The Task Team found no evidence that HIV-related restrictions on entry, stay and residence protect the public health and was concerned that they may in fact impede efforts to protect the public health.” The second reason given for entry, stay and residence restrictions for people living with HIV cites the economic implications for host countries. However, this same economic rationale is not often applied equally to other chronic health conditions. Travel restrictions, if only applied to HIV and not to similar chronic health conditions, are clearly discriminatory against persons living with HIV.

In principle, exclusion on the basis of HIV is "prima facie" arbitrary, because it is not related to a public health objective or to a public pursue objective. Furthermore, despite the discretion states have in determining whom to admit to their territory, discriminating on the basis of health status is contrary to international law when the aim is illegitimate, the means used are disproportionate, or when a protected right or interest is affected. One such example would be the right to be protected against refoulement. The principle of equality of treatment may be violated if a distinction is based on prohibited grounds, including health status, or if it has no objective and reasonable justification. The same can be said if an asylum seeker is denied entry into the country and access to asylum procedures on the basis of her/his health status or if the applicant falls under the international provisions on children or the family, in particular the best interests of the child and the right of the family to reunification.

In 2010, a review of HIV-related entry and residence regulations found that 31 countries had legislation surrounding deportation of HIV-positive non-nationals, and 22 countries that refuse entry to HIV-positive non-nationals. Most countries with entry restrictions also mandate obligatory HIV tests. In many cases the HIV testing is conducted without appropriate pre- or post-test counseling or assurance of confidentiality, and referrals are not provided for HIV prevention, treatment, or support services. Some countries also require that non-nationals residing in their country take HIV tests periodically to renew their documentation status. If they are found to be HIV-positive, they may be sent to a detention facility and deported.

Access to HIV-related services regardless of documentation status

Migrants face many obstacles in accessing essential health care services due to a number of factors; these include irregular migration status, language barriers, a lack of migrant inclusive health policies in the country where they reside, lack of awareness of available services, and discrimination. Such access disparities have negative consequences on the well-being of migrants and their communities, and undermine the realization of global health goals such as HIV prevention.
Migrants’ access to health services varies widely between countries. However, most countries base access to non-emergency health care services on a migrant’s migration status. This means that in many countries undocumented migrants do not have access to preventive or primary care services, which includes HIV prevention, counseling and testing, and treatment services. Even in countries where legislation mandates that all individuals, regardless of documentation status, have access to HIV treatment, undocumented migrants report difficulties accessing the system. Additionally, undocumented migrants often report difficulty accessing services in host countries because of language barriers and fear that utilization of public services will lead to deportation. These concerns are not unwarranted, as there are countries which have legislation requiring health care providers to report undocumented migrants to migration officials.

**Specific Recommendations:**

**Entry, stay and residence restrictions**
- IOM recommends that countries remove all HIV-related entry, stay or residence restrictions for the following reasons: entry, stay and residence restrictions have not been shown to protect the health of the public, and may in fact impede public health efforts; the increased efficacy and decreased cost of HIV medications allow persons living with HIV to continue to work and live long, productive lives, therefore providing economic benefit to the State.
- HIV testing related to entry, stay or residence should be done voluntarily, on the basis of informed consent, and with assurance of strict confidentiality. Pre- and post-test counseling should be provided in a culturally appropriate manner and in a language that the migrant understands.
- Return, as with entry, stay and residence conditions, must not breach international migration law. For example, persons with life-threatening medical conditions who cannot continue treatment in their country of origin may not, at the risk of hastening death in distressing circumstances and thus causing inhuman treatment, be returned.
- States should meet the following conditions for sustainable return and reintegration for people living with HIV: the necessary medical treatment is available and accessible; the returnee can acquire an income that is sufficient to cover regular expense for her/him and the family and to cover all costs related to medical treatment in the country of return; the returnee finds a place with a supportive social network and has the ability to cope with possible stigma from society as a whole. Such conditions can be assessed only by taking into consideration the individual’s specific situation and the context in which she or he would return.
- Any policies regarding HIV-related entry, stay or residence restrictions should be clearly stated and publicly available. Policies should be implemented in a consistent and fair manner.

**Access to HIV-related services regardless of documentation status**
- All people, regardless of documentation status, should have access to evidence-based HIV programmes including HIV prevention education, counseling and testing, and treatment and support services.
- States should explicitly recognize the right to health by law, clearly defining entitlements by law, publicizing them to migrants and health care providers, ensuring appropriate implementation measures, reducing unnecessary and burdensome bureaucratic procedures, ensuring health care regardless of a person’s immigration status, and providing protection and assistance to victims of trafficking regardless of whether they cooperate with law enforcement services.
- HIV services should be provided in a culturally-appropriate manner, and when possible, in migrant’s native language.

**Conclusion:**
Migration legislation and other HIV-related legislation impact migrants and their communities. HIV-related entry, stay and residence restrictions are not only discriminatory against persons living with HIV, but they also impede public health HIV prevention efforts. Denying or limiting access to preventive and primary care services on the basis of legal status goes against the fundamental human right to health. Elimination of entry, stay and residence restrictions, in addition to ensuring access to HIV education, voluntary counseling and testing, and treatment services regardless of legal status would greatly enhance the global HIV response and move toward fulfillment of
the right to health.

IOM recognizes that countries may face challenges in implementing the recommendations above. Lack of adequate funding and limited capacities often inhibit countries’ abilities to implement legislation surrounding increasing access to HIV-related services. IOM welcomes the opportunity to collaborate with UNDP, UNAIDS, other intergovernmental and international organizations, and national governments to address these challenges. We look forward to working closely with the Secretariat of the Global Commission on HIV and the Law to provide technical assistance and guidance on the creation of new laws and policies which eliminate HIV-related entry, stay and residence restrictions and ensure universal access to HIV services for migrants, regardless of legal migration status.

5 UNHCR. Note on HIV/AIDS and the Protection of Refugees, IDPs and Other Persons of Concern. UNHCR, 2006: pp. 50-69.
To the Global Commission on HIV and the Law:

Human Rights Watch has monitored human rights abuses linked to HIV/AIDS since 2001, producing more than 40 reports and hundreds of recommendations on countries as diverse as the United States, Jamaica, Vietnam, Ukraine, Uganda, and India, among others. These reports reflect the first-hand testimonies of adults and children living with and affected by HIV, as well as those whose marginalized status increases their vulnerability. The testimonies reveal the terrifying range of human rights abuses that fuel the epidemic, and aim at compelling governments and donors to address these abuses as part of an effective AIDS response.

These widespread and systematic abuses, problematic in themselves, also frustrate effective responses to HIV/AIDS by denying marginalized people access to proven HIV prevention, care, and treatment services, and by to impeding access to pain treatment to some one million people living with HIV/AIDS.

The issues discussed here raise considerable legal and strategic questions for states seeking to meet their international human rights obligations. This submission sets forth specific recommendations on how the law can effectively shape the HIV response and operate as a “game changer” by focusing on the following key areas:

- Access to controlled essential medicines for pain treatment and drug dependence
- Drugs, criminal law, and policing practices
- Compulsory drug detention centers
- Prisoners
- Migrants

HRW also monitors HIV/AIDS-related abuses of LGBT persons, persons with disabilities, and sex workers, a full discussion of which exceeds the scope of this submission. We are available as a resource to the Commission should it seek further information on these issues.¹
I. Drug Policy

Access to Controlled Medicines for Drug and Pain Treatment

Opioids, like methadone and morphine, are essential medicines that play a key role in preventing and treating HIV/AIDS. Opioid substitution treatment is the most effective form of treatment of people with opioid dependence (such as heroin addiction). ii It lowers HIV infection rates among drug users and enables many opioid-dependent people with HIV to enter treatment.iii Morphine is essential for the treatment of pain and other symptoms faced by many people living with HIV.iv

Due to their potential misuse, methadone, morphine and other opioid medications are controlled medications. Under the 1961 Single Convention on Narcotic Drugs, countries must regulate their manufacture, distribution and prescription to prevent misuse while simultaneously ensuring their adequate availability for legitimate purposes." Since all transactions with these medications are regulated, the law plays a pivotal role in ensuring their accessibility for patients.vi

While laws and regulations for controlled medications should carefully balance the need for good patient access with the need to prevent misuse, our research shows that in many countries the law impedes medication accessibility. In their zeal to prevent misuse of controlled substances, many countries impose requirements on distribution, prescription and dispensing that exceed those of the Single Convention and severely limit patient access and proper medical practice. Often, physicians also fear the legal scrutiny that accompanies prescribing these medications and the potential for severe penalties for sometimes even unintentional errors in handling controlled substances.vii

In 2009 and 2010, Human Rights Watch conducted a survey to map barriers to opioid analgesic availability in 40 countries. We found that 30 countries imposed regulations exceeding Single Convention requirements. In countries including Russia and Ukraine, multiple physicians must sign off on every prescription for an opioid medicationviii; in two-thirds of India’s states, a hospital or pharmacy requires multiple licenses that are difficult to obtain and must all be valid at the same time in order to buy opioid analgesicsix; in countries including Egypt, Ukraine and Georgia, only physicians of certain medical specialties, like oncology, are allowed to prescribe opioid analgesics.ix In 34 of the 40 countries, key informants reported that doctors are reluctant to prescribe opioids because of fear of legal sanction for mishandling them.x In some countries, the law is used to altogether ban the availability of controlled medications. For example, Russia’s drug laws ban the use of methadone in the treatment of opioid drug dependence.xi

Overly restrictive regulations majorly contribute to the inadequate availability of controlled medications worldwide. The World Health Organization estimates that every year tens of millions of people across the globe who suffer from moderate to severe pain cannot access adequate pain treatment. This includes one million end-stage AIDS patients.xii Our survey
found that the consumption of opioid pain medications in 35 countries between 2006 and 2008 would not have been enough to treat even one percent of their terminal cancer and HIV/AIDS patients.\textsuperscript{xiv} Similarly, hundreds of thousands of opioid-dependent persons do not have access to opioid substitution therapy.\textsuperscript{xv}

Some countries have started amending overly restrictive drug laws and regulations to neutralize their negative impact on opioid medication availability. For example, the Indian government has proposed amendments (which to date have been implemented in only about a third of India’s states) to state laws to simplify regulations addressing morphine access,\textsuperscript{xvi} and Colombia\textsuperscript{xvii}, Georgia\textsuperscript{xviii} and Vietnam\textsuperscript{xix} have relaxed prescription regulations.

Additional country examples show how law can proactively improve the availability of these medications. For example, some:

- **Explicitly recognize the indispensible nature of controlled medications and state responsibility to ensure their availability.** The Single Convention recognizes that controlled substances are “indispensable for the relief of pain and suffering” and that government must make adequate provision to ensure their accessibility and availability for that purpose. Several countries have included similar language in their drug laws. The United States\textsuperscript{xx} and Australia\textsuperscript{xxi} both recognize that many controlled substances have a legitimate medical purpose and are necessary for the health and welfare of people. Drug laws in Australia,\textsuperscript{xxi} Georgia\textsuperscript{xxii} and Uganda\textsuperscript{xxiv} explicitly recognize the government’s responsibility to ensure the adequate availability of these controlled medications.

- **Regulate availability in pharmacies.** Our survey found that in 35 of 40 countries only some pharmacies (at most) are licensed to stock opioid medications due to additional bureaucracy and official scrutiny.\textsuperscript{xxv} This means that patients, or their relatives, often must travel long distances to fill prescriptions. Countries like Poland and Vietnam have sought to address this issue through innovative legislation. In Poland, all pharmacies must be licensed for controlled medications.\textsuperscript{xxvi} Those that do not wish to obtain such licenses must request a waiver.\textsuperscript{xxvii}

- **Broaden prescribing rights.** In countries with a physician deficit, not enough prescribers exist to ensure that patients can access opioid medications if only doctors can write prescriptions. To address this issue, Uganda adopted new drug regulations in 2003 that allow nurses who have been trained in palliative care to prescribe morphine. This regulatory change was a game changer in the availability of pain treatment outside Uganda’s main urban centers, since nurses in dozens of districts can now prescribe pain medications to patients with HIV and cancer who need them.\textsuperscript{xxviii} In Vietnam, new drug regulations adopted in 2008 state that the provincial health service is responsible for ensuring the availability of opioid medications for outpatients. It stipulates that in difficult-to-reach areas where the sales of opioid medications cannot be otherwise arranged the pharmaceutical department of the local hospital is responsible for providing patients with the medications.\textsuperscript{xxix}
Recommendations:

The Commission should call on States to:
- Review their drug laws and regulations and amend any provisions that unnecessarily impede the availability of controlled medications for legitimate medical purpose. They should use the WHO Policy Guidelines Ensuring Balance in National Policies on Controlled Substances, Guidance for Availability and Accessibility for Controlled Medicines for this purpose.
- Explicitly recognize in drug laws and regulations that controlled substances are indispensible for the public health and welfare and the state’s responsibility to ensure their adequate availability.
- Use the law to ensure both the adequate availability of controlled medications in pharmacies and healthcare institutions, and an adequate number of prescribers to meet patient need.

Drugs, Criminal Law, and Policing Practices

UN health and drug control agencies—including the Joint United Nations Programme on HIV/AIDS (UNAIDS), the World Health Organization (WHO), the UN Office on Drugs and Crime (UNODC) and the International Narcotics Control Board (INCB)—have endorsed a wide range of interventions for the prevention, treatment, and care of HIV among people who use drugs. These include opioid substitution therapy and access to needle and syringe exchange programs as essential components of HIV/AIDS programs for people who use drugs. Yet punitive laws, policies and practices keep many drug users from receiving these lifesaving services, even in countries where they are legal.

Almost every country criminalizes drug possession for personal consumption. In many, drug use itself is a crime. The implications for those with a dependency—a chronic, relapsing medical condition—are particularly serious. Individuals have a right to obtain lifesaving health services without fear of punishment or discrimination. But in some countries, many people who inject drugs do not carry sterile syringes or other injecting equipment, even if they legally can, because possession of such equipment can mark an individual as a drug user and expose him to punishment on other grounds. Many do not seek treatment or attend harm reduction services, again, for fear of arrest.

In many other countries, carrying drug paraphernalia is illegal. This can deter safer drug use as users fear attracting police attention. It also can deter the initiation of harm reduction services as service providers worry about the legal implications of providing clean equipment.

Moreover, police target drug users and harm reduction services for arrest, extortion, and ill-treatment. There are a number of systematic reasons why this abuse continues unabated. In some countries, police must fulfill arrest quotas, and drug users make easy targets for police needing to do so. For example, in Ukraine, drug users can be arrested and convicted for possession of small amounts of drugs, often less than one dose.
Many countries have taken measures to protect drug users’ rights by instituting structural changes in policing practices to protect drug users’ access to HIV-related and other health services. In the United States, some jurisdictions protect drug users’ access to harm reduction services through court orders barring police from arresting or punishing needle exchange participants for drug possession based on residue in used syringes, or through directing police to avoid syringe exchange site areas. Further concerns about criminalization’s harmful effects on the health and human rights of people who use drugs have prompted governments to decriminalize possession of small quantities of drugs for personal use either in law or in practice.

The UN drug conventions grant some flexibility with respect to penalization of possession and use of controlled substances. The International Narcotics Control Board, the treaty body charged with monitoring drug control treaties and interpreting their provisions concluded that Portugal’s 2001 drug law reform decriminalizing the possession of small amounts of controlled drugs for personal use and drug use itself was consistent with the international drug control treaties. The UNODC also raised concern about drug criminalization’s harmful effects on the health and human rights of people who use drugs, and encouraged the use of alternative approaches to drug enforcement, including stopping the incarceration of petty offenders and reforming performance indicators that promote high numbers of arrests (as compared to targeting violent criminals or high-volume dealers).

**Recommendations:**

**The Commission should call on States to:**

- Review the impact on health and other human rights of laws criminalizing possession of small amounts of drugs for personal use and consider reforming laws that have a negative effect.

- Reform police performance indicators that promote high numbers of arrests.

- Reform drug paraphernalia laws to remove barriers to sterile syringe access and to ensure that drug users and harm reduction providers do not fear arrest for engaging in HIV prevention-related activity.

**Compulsory Drug Detention Centers**

In many countries throughout Asia, people identified as drug users are detained in closed centers for months or years in the name of drug “treatment” and “rehabilitation.” Sent by police on mere suspicion of drug use, diverted into “treatment” as an alternative to incarceration, involuntarily committed pursuant to administrative law, or referred by relatives, the detention of people who use drugs usually takes place without due process (such as a trial or judicial order for detention) or a clinical assessment of whether the person is, in fact, drug dependent. These centers are often run or staffed by military or public security forces. Inside the centers, detainees are often denied evidence-based drug treatment and HIV and other basic health services, and instead forced to perform arduous
physical exercises, military drills and/or forced labor. They are punished by staff, often in brutal ways, for infringing internal center rules.

Human Rights Watch believes that, to protect the health (including effective HIV treatment and prevention) and other human rights of detainees, detainees should be released and the centers should be closed. Human Rights Watch believes that donor support should focus on releasing detainees from these centers so they can access appropriate treatment in the community.

In Cambodia, people who use drugs—dependent or not—are routinely rounded up by police and sent to government-run drug detention centers, where detention and arduous physical exercises are the mainstays of their “treatment.” There are over 2,000 people held in 11 centers across the country. In these centers, they face torture and extreme physical cruelty—including sexual violence, and being shocked with electric batons and beaten with twisted electrical wire. People are held in such centers regardless of entry assessments that they are not dependent on drugs. There is no access to legal counsel while in police custody or during subsequent detention in the centers, no judicial authorization of detention, nor any opportunity for its review. In 2008, nearly one-quarter of detainees in Cambodia’s compulsory drug detention centers were aged 18 or below. They were detained alongside adults, forced to work, and physically abused.

Abusive conditions are prevalent in many of China’s compulsory drug detention centers, notwithstanding its 2008 Anti-Drug Law that referred to drug users as “patients” and promised legal protections for them. In fact, China’s 2008 Anti-Drug Law gives government officials and security forces widespread discretion to incarcerate individuals suspected of drug use for up to six years without trial or judicial oversight. Individuals detained in Chinese drug detention centers are routinely beaten, denied medical treatment, and forced to work up to 18 hours a day without pay. Although sentenced to “rehabilitation,” they are denied access to effective drug dependency treatment and provided no opportunity to learn skills to reintegrate into the community. According to UNAIDS, as many as half a million people are confined in drug detention centers at any given time.

In Vietnam, people who use drugs are held in government detention centers without due process and forced to perform menial labor for up to four years in the name of “labor therapy.” There are some 40,000 people held in 123 centers across the country. Detainees have no access to lawyers, no trial and no means of challenging their detention. They are denied evidence-based treatment for drug dependence. An estimated 15 to 60 percent of detainees are infected with HIV, but few centers provide appropriate medical care for HIV, TB, or other opportunistic diseases. Those who infringe center rules, including the obligation to work, are beaten, shocked with electrical batons, denied food or water, or confined in disciplinary rooms. Children are also held in these centers, and forced to work, beaten, and abused.

Some international donor support to drug detention centers has reinforced the centers’ ability to arbitrarily detain drug users. The [US] State Department’s Bureau of International Narcotics and Law Enforcement Affairs (INL) has provided training for center staff in drug detention centers in Vietnam and Cambodia, while UNODC has funded the training of center
staff in Vietnam. Other donors such as the [US] President’s Emergency Plan for AIDS Relief (PEPFAR), the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the World Bank have supported centers with HIV-focused interventions, funding HIV testing, treatment, and trainings for staff.

Efforts by international donors to support HIV treatment in detention centers can have the perverse impact of enabling governments to continue detaining HIV-positive drug users. Under Vietnamese law, for example, HIV-positive individuals in detention have a right to be released if drug detention centers cannot provide appropriate medical care. In practice, international donor support for HIV treatment inside these centers has facilitated continued detention of individuals who would otherwise be eligible for release from detention and transferred to a government hospital or returned home for treatment and care. In some cases, as in Vietnam, where forced labor is part of the system, governments can maximize profits while denying detainees effective drug dependency treatment.

Recommendations:

The Commission should:

• Publicly call for immediate release of current detainees and permanent closure of all compulsory drug detention centers.
• Publicly call for an investigation into allegations of human rights violations inside such centers, holding those responsible for violations to account, and reasonable compensation for detainees and former detainees for harm to physical and mental health during detention.
• Actively encourage expansion of community-based drug dependency treatment that is medically appropriate and comports with international standards.
• Publicly call for bilateral and multilateral donors and NGOs to 1) review all funding, programming, and activities directed to assisting drug detention centers to ensure no funding is supporting policies or programs that violate international human rights law, including prohibitions on arbitrary detention, forced labor, torture and ill-treatment; 2) immediately cease all funding for capacity-building projects for drug dependency treatment in the centers; 3) call for immediate release of all people living with HIV and ensure they have access to HIV and other necessary health services.

II. Prisoners

Incarceration is a critical risk factor for HIV for those incarcerated and their social networks. Specifically, incarceration may:

• Disrupt social networks that limit HIV and hepatitis transmission;
• Disproportionately affect marginalized people;
• Deny harm reduction services to prisoners despite evidence that in prison, prisoners continue to inject drugs and have sex, placing them at risk for HIV and hepatitis transmission;
• Expose prisoners to overcrowding and other conditions that greatly increase the risk of acquiring TB and other communicable diseases;
• Upon release, subject prisoners to a high risk of drug overdose, reduced capacity to adhere to antiretroviral therapy, and increased homelessness, unemployment and other social determinants of health associated with higher rates of HIV.
Each of the above factors makes finding alternatives to incarceration a necessary response to the HIV epidemic worldwide, both for prisoners and members of their social networks.

International organizations—including the WHO, UNODC, and UNAIDS—recommend that comprehensive, evidence-based HIV-prevention services, including needle and syringe exchange, drug-dependence treatment (including opioid substitution therapy) and condoms, be provided to prisoners. Yet in many countries, prisoners and others detained in state custody have little or no access to such services even when they are available in the general community. This situation persists despite strong evidence that these are effective and inexpensive measures to prevent HIV and the lack of evidence that they pose security risks to warders or detainees. For those who are infected, adequate care may be unavailable.

**Lack of Condoms**

Sexual activity takes place in many countries’ prisons, including consensual sex between adults; relationships where sex is traded by the most vulnerable in exchange for food, soap, and other basic necessities not provided by the prison; and cases of rape. While prison officials in Zambia and Uganda recognize that sexual activity takes place among prisoners, HIV prevention efforts are severely hampered by a ban on condoms. Condoms are prohibited in prisons because of the broader criminalization of same-sex sexual conduct in both countries. Further, despite clear evidence that sexual activity occurs in U.S. prisons and examples of successful condom distribution in prisons throughout the world, U.S. corrections officials continue to resist making condoms available to inmates, citing the prohibition on sex between inmates and alleged security concerns. In the U.S., currently, only a handful of state prisons and some large urban jails (including Washington DC, San Francisco, and New York City) make condoms available to inmates.

**Lack of Harm Reduction Services**

Though injection drug use is common in many prisons, access to HIV prevention and effective drug treatment services are often limited. Within the U.S., substitution therapy is almost non-existent in prisons, and access to drug dependence treatment is limited. Human Rights Watch found that New York State prisons lack substitution therapy despite housing a high percentage of inmates with histories of opioid use and dependence. Further, punishment for drug use in these prisons is extremely harsh and frequently results in long periods of disciplinary confinement without access to treatment.

Withholding access to sterile syringes and to methadone or buprenorphine maintenance therapy increases the risk of sharing injection equipment, and in turn, vulnerability to HIV and hepatitis. Forced, abrupt opioid withdrawal (both from legally prescribed therapy like methadone as well as from illicit opioids) can cause profound mental and physical pain and cause detainees to risk HIV and other blood-borne diseases by sharing injection equipment to lessen withdrawal symptoms. Unassisted opioid detoxification also increases the risk of fatal overdose if individuals relapse into drug use, which is common.

**Lack of Care**

While international human rights law requires that states provide health care in prisons that is adequate and at least equivalent to the care available to the general population, Human Rights Watch has found significant gaps in the availability of HIV-related care.
services in prisons.

For example, HIV prevalence in Zambian prisons was last measured at 27 percent, and in Ugandan prisons at 11 percent, both approximately twice national prevalence estimates. Though prisons expanded HIV testing in recent years, proper treatment is impossible in both countries' prisons in the absence of prison-based health services. In 2010, the Zambia Prisons Service employed only 14 health staff—including one physician—to serve its 16,666 prisoners, and had no prison-based anti-retroviral therapy (ART) facilities. Of Uganda’s 223 prisons, prison-based ART only existed in 2011 at one prison hospital in Kampala.

In both countries, access to care is frequently controlled by medically unqualified and untrained prison officers. Lack of adequate prison staff, transportation, and fuel for the transfer of sick prisoners, as well as security fears, keep inmates from accessing medical care outside of the prisons, in some cases for weeks after they fall ill. Additionally, in Uganda, prisoners requiring transfer to facilities with HIV treatment may be denied or delayed care, and instead forced to engage in a brutal hard-labor system. Prisoners receiving ART may be transferred away from the one prison-based facility where they can receive care in order to ease congestion or boost hard labor on farms.

**Arbitrary and Extended Pre-trial Detention**

In many of sub-Saharan Africa’s prisons, detainees face severe overcrowding, which leads directly to tuberculosis transmission and can contribute to sexual violence, fuelling the spread of HIV. Both Zambian and Ugandan prisons exemplify how arbitrary or extended pre-trial detention can promote prison overcrowding and the transmission of HIV and TB.

Zambian prisons were crowded to over 300 percent of capacity in 2010, and Ugandan prisons were at 225 percent of capacity in 2011. Overcrowding is so severe that inmates are forced to sleep on one side, or seated or in shifts in cells with little ventilation. Prolonged pre-trial detention in violation of Zambia and Uganda’s international human rights obligations majorly contributes to such overcrowding. Pre-trial detainees constitute over one-third of the total prison population in Zambia, and over half of the prison population in Uganda. Remand prisoners wait for years for their cases to be resolved. One prisoner in Zambia, now convicted, reported being held 10 years in pre-trial detention; another in Uganda was incarcerated for nine.

In Zambia, the police and Drug Enforcement Commission enjoy broad powers under Zambian law, and reportedly arrest and hold numerous alleged family members, friends, and innocent bystanders as “co-conspirators” when their primary targets cannot be found. Unavailability of bail and low levels of legal representation contribute to unnecessary and unjust extended pre-trial detention. Lack of funding for community service alternatives, restrictions on the use of parole to prisoners with longer sentences, and delays in appeals further contribute to overcrowding. In Uganda, while efforts have been made in recent years to address case backlogs, an insufficient number of judges, judges' failure to grant bail in accordance with Ugandan law, and inadequate legal representation still conspire to create significant remand times, particularly for prisoners awaiting trial before the High Court. Corruption is reportedly rampant in the criminal justice system, from arrest through trial, so in some cases those imprisoned are simply those unable to pay a necessary bribe.
Where bail is an option, as in New York City, thousands of people accused of minor crimes also are held in pre-trial detention in each year solely because they cannot afford to pay small bail amounts.\textsuperscript{lx}

**Recommendations to states to scale up the HIV response for prisoners:**

- **Decriminalize same-sex relationships** between consenting adults.
- **Provide condoms to all prisoners and prison officers, alongside education on harm reduction to increase condom acceptance,** even if same-sex relationships continue to be criminalized. The prisons of Lesotho have adopted such a strategy as a public health measure, and could serve as a potential example.
- **Prioritize criminal justice reform to address unjust incarcerations, decongest prisons, and decrease the transmission of HIV and TB** by:
  - Limiting police powers to carry out mass arrests;
  - **Increasing the availability of non-custodial alternatives** including bail, community service, supervised release, and parole; and
  - Providing detainees with access to legal representation from the time of arrest.
- **Establish clear guidelines on the provision of prison-based health services, and scale up those services** to: conduct health screening of all prisoners upon entry and at regular intervals; offer voluntary HIV counseling and testing to all inmates entering prison and all existing inmates and prompt initiation on antiretroviral treatment; and ensure access to antenatal services, including Prevention of Mother-to-Child Transmission (PMTCT), early infant testing, and ART for infants.
- **Ensure access to harm reduction services** including sterile syringes and evidence-based drug dependence treatment including opioid-substitution therapy.

**III. Migrants**

**Restrictions on Entry, Stay, and Residence**

The World Health Organization has declared that HIV-related restrictions on entry, stay, and residence are not beneficial from a public health standpoint;\textsuperscript{lx} nevertheless, 66 of 192 countries for which data was available placed restrictions on entry, stay, and residence for people living with HIV in 2010. Thirty-one countries would deport people living with HIV or ask them to leave the country if diagnosed with HIV.\textsuperscript{lxii} These restrictions violate the International Covenant on Civil and Political Rights' guarantee that all people have the right to equal protection under the law without regard to status, including HIV status.\textsuperscript{lxiii} They can also result in violations of human rights obligations, like the principle of non-refoulement of refugees; the obligation to protect the family and the child's best interests; and unjustifiably interfere with rights such as the right to privacy; the right to freedom of association; the right to information; the right to seek asylum; as well as the rights to education, the highest attainable standard of health, dignity, and life.

For those migrants—including labor migrants and short-term travellers—moving to countries with such restrictions, a failure to disclose HIV status can result in job loss, deportation (including return to countries grossly lacking HIV treatment provisions), and the inability to re-enter the country at a later time. Yet HIV-related restrictions on entry, stay, and residence frequently do not coincide with complementary public health measures to ensure HIV treatment for migrants.\textsuperscript{lxiv}
Freedom from Refoulement

HIV-positive individuals may undergo deportation for a host of immigration-related violations, or, in some countries, as a consequence of their HIV-positive status itself. For example, in 2008 the Korea Center for Disease Control and Prevention reported that 521 of the 647 foreigners diagnosed with HIV to date were “forced to leave the country.” In Saudi Arabia, HIV testing is required for applications for long-term work permits and renewal, and individuals testing positive are deported as a result of their HIV status itself. Similarly, the United Arab Emirates Ministry of Health confirmed that under national law, “expatriates with HIV are deported.”

The principle of non-refoulement applies in international human rights and refugee law. In human rights law it establishes an absolute prohibition on the deportation of a person to another state where substantial grounds exist for believing that the person would be in danger of being subjected to torture or other cruel, inhuman, or degrading treatment or punishment. Both the European Court of Human Rights and the Inter-American Commission on Human Rights have held under certain defined circumstances, that deportation of a person living with HIV to a country with substandard health care and support for persons with HIV violates the principle of non-refoulement.

Discrimination

Despite commitments made toward universal access to care for people living with HIV/AIDS, migrant populations often face discrimination in treatment program entitlement or by care providers. For example, under the South African Constitution, individuals with irregular legal status are accorded a wide range of human rights, including the right of access to emergency and basic health care, and antiretroviral treatment. Yet Human Rights Watch and other non-profit groups have found gaps between South African law and actual access to HIV care for refugees, asylum seekers, and undocumented migrants. Many are denied ART and other healthcare services outright; and sub-standard treatment, user fees, and verbal abuse further limit their access to HIV services.

Within the U.S., Human Rights Watch found that the U.S. government agency responsible for ensuring that immigrant detainees receive necessary medical care does not know how many detainees have HIV or AIDS, need treatment, or are receiving necessary care. Agency policies fail to meet national and international guidelines for HIV care in correctional settings. The consequence of this wilful indifference is poor care, untreated infection, increased risk of resistance to HIV medications, and even death.

Internal migrants also face difficulties in obtaining HIV/AIDS services. Access barriers to HIV/AIDS-related services faced by internal migrants when they move from their place of origin include internal migration restrictions, as well as logistical, linguistic and cultural barriers to HIV/AIDS prevention and treatment. For example, in India, internal migrants moving from one state to another may have difficulty accessing health care programs because of an inability to use government issued “ration cards” outside their home authority and logistical challenges in obtaining new cards. In Russia, internal migrants who move to regions that require registration as a precondition for care may be less able to gain HIV/AIDS treatment than their non-migrant counterparts. In China, individuals without hukou (a form of registration with local authorities that is often time-consuming, expensive, or difficult for internal migrants to obtain) are unable to access basic public services like health care and are forced to pay all costs, limiting HIV-positive migrants’ access to...
Dear Commission

This submission responds specifically to your focus on “laws and practices that facilitate or impede HIV related treatment access”. The AHPN believes that in the UK, immigration law and related practices create significant barriers to access to HIV treatment for African and other people engaged in the immigration process. These barriers emerge at different stages of the immigration process, from arrival in the UK, through applications for regularised status to detention prior to removal, and return to country of origin. The removal of these barriers would substantially improve access to HIV treatment in the UK, with corresponding impacts on HIV-related health burdens, onward transmission and the overall trajectory of the HIV epidemic. As such, altering immigration law to safeguard access to HIV treatment and related healthcare at every stage of the immigration process would allow effective HIV responses to be scaled up – by facilitating effective response in a most at risk population – and indeed be a ‘game-changer’ with respect to the UK’s HIV epidemic.

**Recommendations to states to scale up the HIV response for migrants:**

- Immediately eliminate HIV-related restrictions on entry, stay, and residence.
- Re-examine deportation of HIV-positive individuals to countries where treatment and social support structures are inadequate, in accordance with international and regional law non-refoulement prohibitions and additional complementary bases of protection.
- Offer free or low-cost ART to non-citizens on the same terms as citizens. This includes providing free or low-cost ART for PMTCT to non-citizen HIV-positive pregnant women and removing all barriers to their enrolment in such programs. States should begin or continue to provide comprehensive medical services for HIV, including ART drugs, to individuals in detention awaiting deportation on at least the same basis as that offered to the general population.
- Work with neighbor states to standardize health passports or health information cards used by individuals on both sides of the border, and standardize recommended drug treatment regimens to ensure that patients can seamlessly switch treatment from one side of the border to another.
- Immediately eliminate restrictions based on origin—where formal or informal eligibility restrictions on access to health care exist—to enable internal migrants to access HIV services.
- Remove restrictions on movement that prevent or delay internal migrants from establishing residence in urban areas. The harsh consequences and rights violations of restrictions on internal migration in some countries can include detention or deportation. Fear of such consequences may lead internal migrants to avoid HIV-related services even when they are available.
The African Health Policy Network (AHPN) is the UK’s leading African health policy organisation, working to influence policy on health and wellbeing issues affecting Africans in the UK. AHPN is a network of membership organisations and individuals with a common goal to improve the health and wellbeing of the UK’s African population. We work across a number of health issues, including HIV, mental health, TB, stroke, diabetes, and cancer, that disproportionately affect the African community in the UK. Our priority focus of work is HIV. Our work is also focussed on the wider determinants of health, including economic, social and cultural determinants. In this context, immigration and its impacts has always formed a core component of our policy work. Over a number of years, we have developed a broad and detailed understanding of the interaction between immigration law and HIV, and through a range of researches have repeatedly uncovered flaws in the system that have serious, negative and even devastating effects on access to HIV treatment.

The UK’s HIV epidemic is characterised by two most at risk populations: black African people (particularly people from sub-Saharan Africa) and men who have sex with men (MSM). The Health Protection Agency (HPA) estimated that there were 23,288 Black Africans living with diagnosed HIV infection in the UK in 2009, which accounted for 36 per cent of all HIV infected people accessing care. In the past decade the number of Black Africans accessing HIV treatment has increased almost five-fold from 4,922 in 2000 to 23,288 in 2009. This makes Black Africans the second most affected population group by HIV after MSM.

As a population group, the African community is therefore disproportionately affected by HIV. Many members of this community are also caught up in the immigration system. The relationship between the UK immigration system and HIV is complex, and in many cases deeply problematic. This interrelationship was initially identified some time ago by our community stakeholders, who identified two key issues: the deportation of people living with HIV and access to treatment for immigration applicants in the UK.

As a community based and led organisation, the AHPN’s policy and research agenda is shaped by the issues identified by our members and stakeholders. This influence led to our launching the Destination Unknown campaign. Destination Unknown used research to identify the challenges posed by the immigration system to an effective HIV response, and advocacy to lobby the UK government to solve these problems. The campaign is shaped by the recognition that having an HIV diagnosis coupled with an undetermined immigration status means negotiating two major life uncertainties: the uncertainty of living with HIV and the uncertainty of migration. Living with HIV can be dominated by uncertainties: about health, treatment access and the future. Additionally, people who migrate experience significant levels of uncertainty: including their legal status, fear of deportation, financial uncertainty and barriers to the use of healthcare services. Their experience of HIV is informed by their experiences in their country of birth (where HIV can be heavily stigmatised, access to treatment is inadequate and HIV may lead to death). An uncertain immigration status and the possibility of deportation each reduce peoples’ life chances. These uncertainties compound each other.

Destination Unknown is a major ongoing campaign, comprising both policy and advocacy. The policy side of Destination Unknown takes the form of three major reports. These reports show a change in our thinking, from calling for no deportation of people living with HIV to a more pragmatic understanding of the inevitability of the immigration process – calling instead for a process of deportation that is safe and humane. The recommendations contained in each of these reports suggest actions which, if taken by the UK government, would significantly impact on the UK’s HIV epidemic and serve to safeguard access to HIV treatment for individuals that need it.

The first report, Completing the Picture, examined the country reports produced by the UK Home Office about the availability of HIV treatment in African countries of return for migrants including Zambia and Zimbabwe. It combined this analysis with a mapping of treatment availability in these countries. The key findings of this report are:

- The standard and quality of reporting on the availability and accessibility of HIV treatment in African countries of return contained in these reports is inadequate. This inadequacy is having a negative impact
on the outcome of asylum and human rights applications, by suggesting treatment is accessible where this is not the case.

- There is an inconsistency between asylum and immigration policy and the UK Government’s commitment to international development goals and Human Rights.
- There is a lack of co-operation between different government departments and liaison with experts on HIV and AIDS as well as pharmaceutical sources on the accessibility of drugs.
- There are limited cost indicators, both national as well as individual costs, available for HIV treatment and care.

The report called for the country reports to be more informed and take into account accessibility as well as availability of treatment. The flaws which this study uncovered in the country reporting system are yet to be fully rectified. In the mean time, individuals continue to be returned to countries based on insufficient information, especially as a result of the conflation of the availability and accessibility of treatment.

The second report, *From a Destination Unknown to a Safe Place*, looks at the impact of deporting people living with HIV from the UK, in response to the impact of jurisprudence emerging from the European Court of Human Rights originating in *D v UK*, which had the effect of overturning the UK government’s previous informal policy of permitting refused asylum seekers who were living with HIV to remain in the UK. Consequently, HIV positive people can be deported from the UK, even where treatment is unavailable or prohibitively expensive in the country of return. This led the AHPN to launch this report, which called on the government to delay removals of people living with HIV until antiretroviral treatment is more readily accessible and affordable in the countries of return. It further concludes that the UK government should stop using legal force to compel removals, and instead move towards a policy scheme of agreed, safe and sustainable resettlement (ASSURE) in country of origin for HIV positive migrants without regular status who opt for it, based on informed consent, doctors’ judgement and dialogue between NHS clinicians and counterparts in the country to which the migrant returns. Such a scheme would ensure continuity of care and treatment access for individuals undergoing deportation, safeguarding their health and wellbeing. Implementing ASSURE in UK law would have the effect of significantly improving law with respect to HIV and treatment access.

The final report, *Returned to Risk*, jointly published by Human Rights Watch, Deutsche AIDS-Hilfe, the European AIDS Treatment Group, and the AHPN, reviews the deportation of people living with HIV internationally. This report recommends that all States should: publish comprehensive information about HIV-positive individuals deported, including the numbers of individuals removed, grounds for removal, and countries to which they are deported; review national standards on deportation of people living with HIV to ensure compliance with international human rights law; where feasible, contact health authorities and anticipated providers in each deportee’s country of origin to devise a plan for continuing to assure care without interruption; and possibly provide a temporary medication supply if necessary. At the international level, this too provides an opportunity to ensure access to treatment, care and support is preserved through deportation processes, positively impacting on HIV responses in both the countries of departure and of return.

The Destination Unknown campaign also involved an activist component, mobilising the UK’s African community to take action against the deportation of African people living with HIV. Launched with the support of South Africa’s Treatment Action Campaign, Destination Unknown targeted the Home office and elected Members of Parliament (MPs). The campaign tools resembled an airline ticket, 10000 of which were distributed to community-based organisations throughout the UK. Campaigners could also lobby their MPs through an online campaign site. The campaign garnered the support of a trade union and Black and ethnic media. Over 50 MPs endorsed the campaign, including the All-Party Parliamentary Group on AIDS. The campaign significantly mobilised migrant networks and people living with HIV who normally would not get involved in political advocacy because of fear of being exposed as HIV positive and/or as an undocumented migrant. The scale of the mobilisation achieved by this activist campaign is indicative of the level of concern in the African community regarding the impact of immigration laws and practices on the HIV response.
A further cause for concern is the impact immigration laws have on access to treatment within the UK. According to UK law, individuals who require healthcare may be charged to access some parts of the National Health Service. This stipulation covers anyone who: entered the UK without formal documentation; is in the UK on a visitor’s visa; has overstayed a visa of any kind; holds a British passport, but is not ordinarily resident in the UK; or has failed in an asylum claim and in all possible appeals, and their treatment commenced after the asylum claim was finally refused. Some services are nevertheless available free of any charge to everyone, including treatment for some infectious diseases, as this is deemed to have wider public health benefits. However, treatment for HIV is specifically excluded from these exemptions, with only initial HIV testing and counselling provided without charge. Anti-retroviral treatment for HIV is therefore available only upon payment of a fee to those individuals in these categories. Such individuals are also not legally allowed to work in the UK.

AHPN opposes the application of charges to HIV treatment, as it creates significant barriers preventing access to treatment. While it is unclear how many people are directly affected by charging for HIV treatment (as enforcement is at the discretion of the treating physician, and we don’t have accurate statistics for irregular immigrants), the rule also has further, unintended consequences. People who believe they may be charged for treatment are less likely to access HIV testing. It also impacts on rates of onward transmission, with implications for public health.

Opposition to charging for HIV treatment has been widely and vocally expressed in the UK, by AHPN and other NGOs, and by public bodies:

- The International development committee stated: “We see a clear contradiction between a policy of routinely charging those failed asylum seekers who want to start a course of treatment after their application has been rejected and Government advocacy of the universal access goal”
- and the Joint Committee on Human Rights stated: “We accept that there is no universal worldwide access to free medical treatment, but recommend that on the basis of common humanity, and in support of its wider international goal of halting the spread of HIV/AIDS, the Government should provide free HIV/AIDS treatment for refused asylum seekers for as long as they remain in the UK. Absence of treatment for serious infectious diseases raises wider public health risks.”

Nevertheless, the rule continues to apply.

More recently, a new issue regarding immigration processes and the HIV response has emerged, adding to the existing problems around deportation of people living with HIV and charging for HIV treatment in the UK. This issue concerns access to HIV treatment in Immigration Removal Centres (IRCs). Since the introduction of the Immigration Act 1971, the UK government has had powers to detain individuals at certain stages of the immigration process. There has since been widespread detention of foreign nationals awaiting decisions on their asylum claims, or awaiting deportation following a failed application. Enshrined in this act is the power to impose restrictions on the movement of immigrants whilst their claims are being processed. There is no time limit, which means that a person can be detained in prison-like facilities for a number of years without being released. Today there are 10 Immigration Removal Centres (IRCs) in England and Wales, and 1 in Scotland. As a snapshot: on the 25th January 2011, there were 2,893 persons detained under the Immigration Act powers. Amongst those detained in these facilities are a number of Africans, including African people living with HIV. Various reports and researches have shown that some of these people are denied regular access to essential HIV medication while detained, endangering their health and even their lives.

This issue first came to the attention of the AHPN at an earlier stage of the Destination Unknown campaign, in a project called Proof Positive. This project was initiated following recognition that a wider evidence base was needed to support Destination Unknown. Consequently, a new format of evidence was developed to provide this foundation. AHPN staff and volunteers were trained to interview African asylum applicants living with HIV, edit their stories for anonymity and then swear them in as true statements before a legal representative. This process
created legal affidavits that carried more weight than more normal interview reportage. From this campaign, evidence emerged that individuals detained in Immigration Removal Centres were experiencing interruptions to their treatment. One case study, known as ‘Exhibit A’, illustrates the issue: A was held for two days in police custody without medication, before being transferred to a detention centre. While held there, A missed a number of doses of her treatment, because her medication had to be refrigerated and she was not always able to access it. She was also supposed to eat with her medication, but on many occasions was not permitted to do so. When she was finally released, her medication was not given to her, and she had to wait for an appointment for a new prescription:

“The medication I had at the detention centre was not given to me once I was free to go. I was told to go to a GP to get them but we don’t get the ARVs from a GP. I need to get them from my consultant, especially because of the special combination I am on. I came back without medication. I should have complained but I was scared to be taken back to detention.”

Missing just one day of ARV treatment can affect resistance. Continued disruptions and interruptions to treatment such as those experienced by A can have very serious negative effects on health.

Evidence from the Proof Positive project was supported by anecdotal evidence from our members and communities, that individuals detained in removal centres were experiencing problems with regular access to treatment. This led AHPN to launch a new, currently ongoing research study. The study is designed to establish the extent to which access to treatment is limited for African people living with HIV, how many people are affected by it and the impact it has, with specific reference to those people detained in IRCs. The study is being conducted within a human rights based framework. The study is conducted using action research with currently or previously detained African individuals, to establish their experiences and generate empirical data. This has been complemented by bibliographic research, specifically relating to the private companies contracted by the UK government to operate IRCs on their behalf. This research has found that the contracts themselves are not open to public scrutiny – they are kept secret as the contents are said to be commercially sensitive. We are therefore unable to determine what requirements the UK government places on these private operating companies regarding the treatment of detainees, healthcare and human rights. We do have access, however, to the operating standards and codes of practice published by these companies. Study of these has shown that they all contain assurances that those detained will be treated with dignity and respect, and receive a standard of healthcare equivalent to that the majority population receive under the NHS. These assurances have formed the basis for comparison of the findings of our action research.

This research is now completed and currently being written up. Initial findings indicate that the assurances given by the operating companies in their standards and codes are not lived up to in practice. People living with HIV detained in IRCs are experiencing interruptions and delays to their treatment, breaches of privacy and confidentiality and deportation without adequate supplies of treatment. Systemic failures are therefore endangering the health and lives of individuals affected by increasing the risk of resistance. Within IRCs, delays and interruptions to treatment, and lack of adequate, timely and regular access to treatment are exposing individuals to the risk of resistance, opportunistic infections and further health complications.

One of the individuals interviewed provides an illuminating case study. J, a 41 year old gay Ugandan man, has been in the UK since 1995. During that time he has made a number of unsuccessful applications and appeals regarding his immigration status. He has also experienced a number of periods of detention, both in police and immigration detention. In each of these detention facilities, he has had access to his HIV treatment interrupted or denied. In J’s words:

“I was kept in the police station for two days without my medication.”

“This time [in an immigration removal centre] I was kept for four days without my medication.”

These preliminary research findings suggest that the UK government is not safeguarding sufficiently the genuine access to HIV treatment of people detained under Immigration Act powers. This issue combines with those previously discussed to lead AHPN to conclude that immigration law and practice in the UK is impeding the HIV
response and undermining the UK government’s stated commitment to universal access to HIV treatment. Genuine, meaningful universal access requires treatment to be available, accessible to all who need it (without barriers of punitive or prohibitive financial costs) and safeguarded from interference. Where this interference occurs as a result of a government implemented process, including detention and deportation, the government is responsible for denying regular access to treatment. We therefore suggest that the following response to the questions put by the Commission:

**How can the law be used to scale up effective HIV responses?**

An effective HIV response necessarily includes the principle of universal access to HIV treatment. For a government to satisfy the requirements of this principle, it must ensure treatment is accessible to all who need it regardless of financial position, and that no action taken by that government or under their authority has the effect of negating or disrupting access to treatment. We therefore call on the UK government to:

- make the necessary legal changes and amendments to ensure that HIV treatment is guaranteed free to all who need it, at point of care and afterwards
- adopt the ASSURE programme for deportation of people living with HIV
- ensure that HIV treatment is made available and accessible without disruption to everyone in immigration detention that needs it

**How can the law be a ‘game-changer’ - i.e.: substantially change the trajectory of the HIV epidemic?**

Immigration law, given its wide impacts on one of the UK’s most affected population groups by HIV, can be a ‘game-changer’, if it is utilised to implement the goal of universal access to HIV treatment domestically. Ensuring treatment is available to all who need it would have the effect of reducing onward transmission of HIV, lessening the public health and individual health burdens of HIV, reducing the numbers of untested and late diagnosed people from the African community and contribute to halting the spread of HIV. The steps needed to achieve this are not prohibitively difficult or expensive. All that is lacking is political will.

AHPN is continuing to campaign for the UK government to make these changes to immigration law, and would like to thank the Commission for the opportunity to share the results of our work. The House of Lords (one of the two Houses of Parliament of the UK), recently published a report based on the findings of its Select Committee on HIV and AIDS. Included in the recommendations of this report is a call on the government to end charges for HIV treatment, which they determine is wrong for public health, practical and ethical reasons. This is a positive step, and the AHPN joins many others in lobbying the government to implement this recommendation. We are also continuing our research and will be publishing the full findings shortly.

In all our work, we continue to be guided and led by our members, and it is in their words that the most powerful arguments for improving immigration law and processes can be found, and so it with these that we will conclude. One of our membership networks is Ffena, a UK-wide activist network of African people living with HIV. At a recent meeting of the Scottish arm of this network, held in Edinburgh, Scotland on the 25th of June 2011, Ffena members agreed that immigration is the most pressing difficulty they face. In their words:

- ‘Even when they know your HIV status, still think you can be sent back [to country of origin] and access treatment there’
- ‘Treatment is not really available back home’
- ‘Leads people to want to stop taking medication, so they will be admitted to hospital and can’t be deported’
- One participant reported a judge at her immigration hearing telling her she ‘had to be at the stage of dying before she could get indefinite leave to remain’ – she is now not taking her medication
- Another member felt it would be better to die in the UK where at least her children would be cared for
- 3 of the 12 participants are not currently taking their medication, all for reasons related to their
immigration status

- ‘Back home treatment might be officially free but to get it you have to make payments by the back door. Where there is no life or work back home, how can you pay this?’
- ‘Cope by not thinking about it’
- ‘If you allow yourself to be stressed you could kill yourself’
- ‘Easy to judge people for not taking their medication, but get to the breaking point, tried everything, don’t know what else to do’

EXECUTIVE SUMMARY

For a long time Uganda’s experience in dealing with the HIV/AIDS pandemic has been heralded worldwide as a successful and model response. Nonetheless this is beginning to change with high prevalence rates being registered currently. While it is true that prevalence rates have registered a downward trend since the early 1990’s, the current resurgence in new infections is worrying. Moreover, in recent times, HIV/AIDS has been observed to affect certain population groups disproportionately hence the concept of Most at Risk Populations (MARPS). In spite of the vulnerability these groups face, they do not have effective access to most HIV/AIDS prevention, care and treatment programs, which leaves them with very few options to protect themselves against the pandemic and greatly inhibits prevention of further spread of the virus.

Mainstreaming MARPS in AIDS prevention, care and treatment programs is therefore very significant in curtailing further spread of the pandemic. This is not without challenges and one of the major impediments is the rather unfavorable policy and legal framework. Just to mention, Uganda maintains criminalization of homosexuality and commercial sex work and more recently the country introduced a bill criminalizing the intentional transmission of HIV. All these glaring loopholes in the legal and policy framework have the undesirable effect of alienating CSW and MSM further from HIV/AIDS related policies, programs and services.

This submission points out the pitfalls of such an approach and makes certain recommendations regarding how the situation can better be handled.

1.0 INTRODUCTION

This submission examines Uganda’s legal framework with regard to the situation of the Most At Risk Populations (MARPS) and with specific focus on Men who have Sex with Men (MSM) and Commercial Sexual Workers (CSW).

The submission makes a critical analysis of the domestic legal framework and how it relates to the situation of CSW and MSM; examines the impacts that this legal and policy framework has had on HIV in these communities, and finally draws conclusions and makes appropriate recommendations.

2.0 UGANDAN LAWS RELATING TO MARPS

Uganda has a range of laws and policies applicable to CSW and MSM in Uganda, whether positively or negatively, as considered below.

2.1 Constitution of the Republic of Uganda, 1995
The promulgation of 1995 Constitution of the Republic of Uganda marked a new era in the history of the country. Recognizing Uganda's past dark history, the Constitution seeks to restore people's power, democracy, human rights and rule of law. In this respect, the 1995 Constitution contains a comprehensive bill of rights in Chapter 4. The breadth of rights provided for range from civil political rights to economic social and cultural rights as well as group rights such as rights of women and children. All these rights are critical for access by MSM and CSWs to health services especially in the context of HIV/AIDS.

Article 21 of the Constitution is one of the most significant for the protection of the rights of MSM and to some extent CSWs. It provides for freedom from non-discrimination in the following terms:-

Art 21
(1) All persons are equal before and under the law in all spheres of political, economic, social and cultural life and in every other respect and shall enjoy equal protection of the law.
(2) Without prejudice to clause (1) of this article, a person shall not be discriminated against on the ground of sex, race, colour, ethnic origin, tribe, birth, creed or religion, social or economic standing, political opinion or disability.
(3) For the purposes of this article, “discriminate” means to give different treatment to different persons attributable only or mainly to their respective descriptions by sex, race, colour, ethnic origin, tribe, birth, creed or religion, social or economic standing, political opinion or disability.

Like the ICCPR, ICESCR and ACHPR, the Constitution of Uganda prohibits discrimination on grounds of sex. International human rights jurisprudence has defined ‘sex’ has been defined to include sexual orientation and there is no reason why ‘sex’ as used in the Ugandan Constitution cannot be afforded the same interpretation.

Conscious of the fact that the Constitution outright prohibits same sex marriages, it is argued here that given the fact that the constitution does not expressly prohibit same sex relationships that are not marriages. This is subject to determination of the courts but it is submitted that the Constitution as it is now does not necessarily bar same sex relationships.

Discrimination of MSM in health service delivery and HIV/AIDS programmes and interventions is therefore counter to the spirit of the Constitution in Article 21.

The same argument applies with equal force to the situation of CSWs given the express terms of the Constitution that guarantee the right not to be discriminated against to all persons. Additionally, progressive decisions from across the globe illustrate that sex workers should be afforded equal protection before the law like all other citizens. In Bangladesh Society for the Enforcement of Human Rights and Ors v. Government of Bangladesh and Ors for example, it was stated that the eviction of prostitutes from their brothels was illegal, threatened their livelihood and in effect their right to life. In light of this discussion it can be concluded that CSW like MSM are afforded the same protection like other citizens under Article 21.

The right to privacy enshrined in Article 27 of the Constitution is yet another concrete provision central to protection of rights of MSM and CSW. This provision affords all citizens the right not to be subjected to an unlawful search of their person, home or other property. Further, the Article provides for protection from interference with the privacy of any persons home, correspondence, communication or other property. Most of the activities of MSM and CSW are private and therefore guarded by the Constitution. This has been confirmed by the courts in the recent decision involving suspected gay women in Victor Juliet Mukasa v. Attorney General. In this case the petitioner and her guest- a female were arrested, detained, rebuked for being gay and their house searched without a warrant. In finding for the petitioners the court stated that they were entitled to a right to privacy under Article 21 the Constitution and found the acts of the police illegal. The court while

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1 Preamble, Constitution of Uganda 1995
2 Toonen v. Australia
3 Article 31
quoting the UDHR stated; ‘Human rights must be respected. It has been found that the actions of the officials that molested Victor Mukasa and Oyoo were unconstitutional, inhuman, and should be condemned.’ Justice Arach called upon the international conventions and emphasized that the Universal Declaration of Human Rights enjoins us to respect human rights and protect them in a spirit of brotherhood, which includes sisterhood.

This decision is very significant for rights of MSM and provides the most recent jurisprudence on this context. It is clear that the rights under the Constitution are available to all including MSM without any form of discrimination. For this reason it is concluded that the Constitution to a greater extent recognizes the rights of MSM and this should be replicated in HIV/AIDS programmes.

The foregoing discussion notwithstanding, the Constitution still has express limitations on the full exercise of rights and freedoms by MSM. Article 31 for example expressly restricts marriage to a man and woman and expressly prohibits same sex marriages. As indicated above, what seems to be prohibited in this provision are same sex marriages and same sex activities may not be prohibited per se. Nonetheless prohibition of same sex marriages has an overwhelming impact on the rights of MSM although they may not intend to formalize their relationships through marriage. Most service providers for example understand all same sex relationships to be illegal under the law and are not willing to extend services to MSM.

There is urgent need therefore to put the recent court ruling guaranteeing rights under the Constitution to all citizens. This entails a review of relevant legal and policy frame works to have them conform to the provisions of the constitution.

### 2.2 Penal Code Act, Cap 120

The Penal Code provides the major criminal regime and establishes various acts that constitute offences in Uganda while at the same time providing for sanctions. The Act came into force in June 1950 and like most laws was inherited from Victorian England. Despite numerous social and political transformations that have occurred in the country, the Act retains most of its text in similar terms as it was in 1950. It is for this reason that the Penal Code Act still criminalizes consensual sex activity of persons of the same sex as well commercial sex work; both of which have since been decriminalized in England where it has its origins.

Section 145 of the Act provides for unnatural offences and under that section it is an offence for any person to have carnal knowledge of any person against the order of nature. It is also an offence for any person to permit a male person to have carnal knowledge of him or her against the order of nature. This offence is punishable by life imprisonment. Clearly this provision targets the position of MSM as they are perceived to have sex against the order of nature. In light of the discussion above, it is submitted that this section greatly unfairly restricts citizen’s rights to privacy. This is contrary to provisions of the Constitution in Article 27 and is subject to constitutional challenge.

The penal provisions on sex work are contained from Section 136 to Section 139 of the Penal Code. These provisions define ‘prostitution’, make it an offence and punish that offence and related ones such as providing rent or assisting persons engaged in sex work with a maximum sentence of seven years’ imprisonment. In addition, perhaps due to difficulties in proving the offence of ‘prostitution’ sex workers are arrested and charged for the offence of being ‘idle and disorderly’ under Section 167 of the Penal Code. The criminalization of a profession that is recognized as the oldest in the world is not only unpractical and hypocritical, but it also dehumanizes and stigmatizes those who engage it in as well as their clients and managers. Moreover, although

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4 The Penal Code Ordinance was introduced in the Uganda Protectorate in 1950 under the authority of S.15 (2) of the 1902 of the Uganda Order-in-Council. This latter provision enabled the application to the Uganda protectorate of laws in the United Kingdom and its other colonies as they existed on or before 11th August 1902. It was on this basis that the Indian Penal Code Act was extended and applied in Uganda in 1950. It is this law that today exists as the Uganda Penal Code Act, Cap 120.
the law is expressed to be neutral in terms of gender, the practical effect of the law is that it creates another layer of discrimination and marginalization against women who are usually targeted in police ‘sting’ operations while their male clients get off scot-free.

Moreover, in the context of HIV/AIDS, the combined effect of the penal provisions on same sex activity and commercial sex work is to send MSM and CSW underground for fear of prosecution. This not only limits their fundamental rights under the Constitution but also makes them more prone to HIV/AIDS as they are discouraged from seeking HIV/AIDS related services from service providers.

A tangential, though equally important, effect is that it has a chilling effect on public health initiatives as doctors and other medical professionals may be ill-equipped or prepared to respond to the unique medical needs of these communities.

Repeal of these laws is therefore necessary to actualize the rights of MSM and CSW guaranteed under the Constitution in line with Article 275 of the Constitution that provides for modification of existing law to bring it into conformity with the Constitution.

2.3 Anti-Homosexuality Bill

The Anti-Homosexuality Bill, also popularly known as the ‘Bahati’ Bill is one of the most controversial legislations for which Uganda has come to be known for. The Bill emerged as a private members Bill in 2009 and has since been at the center of debate attracting reactions from both national and international levels.

The overall object of the Bill is to protect the ‘traditional’ family through prohibition of same sex relationships. It is also stated that the Bill seeks to strengthen the capacity to deal with internal and external threats to the traditional heterosexual family among others. The Bill also makes heterosexual marriage the only recognized form of marriage in Uganda, prohibits licensing of all organizations that promote homosexuality as well as ratification of treaties and protocols counter to its provisions.

In substantive terms, the Bill criminalizes any form of same sex sexual activity and any person who purports to contract a marriage with a person of the same sex commits an offence under the Bill. Both of these offences are punishable by life imprisonment. The effect of these provisions like the those of the Penal Code Act is to drive persons involved in any form of same sex sexual activities underground for fear of prosecution and rightly so for fear of public reprisal as the spirit of the Bill entitles the public to ‘kill’ what are seen as moral deviates.

Secondly and central to MSM in relation to health and specifically with regard to HIV/AIDS services is criminalization of acts of ‘promotion of homosexuality and failure to disclose the offence of homosexuality under Clauses 13 and 14 respectively. Under these provisions it is an offence to; a) participate in production, procurement, marketing, broadcasting, dissemination, publication of pornographic materials for purposes of promoting homosexuality; (b) fund or sponsor homosexuality or other related activities; (c) offer premises and other related fixed or movable assets for purposes of homosexuality or promoting homosexuality; (d) use electronic devices which include internet, films, mobile phones for purposes of homosexuality or promoting homosexuality. Accomplices are also equally liable.

Upon conviction the offender is liable to pay a fine or suffer imprisonment for a minimum of five years and a
maximum of seven years or both. Where the offender is a corporate body or a business or non-governmental association, upon conviction the certificate of registration shall be cancelled. Clearly while the above provision is worded in terms of promotion of homosexuality, it affects me, you, your neighbor, the landlord, reverend and inevitably the health worker attending to MSM. Any form of advocacy for the rights of MSM can be construed as an act of promotion of homosexuality by way of disseminating and publishing pornographic materials and may also be seen as funding or sponsoring homosexuality.

Beyond this there is real danger of MSM rights activists being branded accomplices for the purpose of the provision especially where they are involved in advising, counseling and other activities that involve establishing contact with MSM. Health service providers inevitably suffer the same risk.

Related to the above provision is the offence of failure to disclose the offence of homosexuality under Clause 14 of the Bill. Any person who omits to report an offence under the Act is also deemed to have committed an offence. This provision overrides well recognized obligations of confidentiality implied in a fiduciary relationship for example between a doctor and patient which is relevant in this case.

Although the Anti-Homosexuality Bill is yet to be made law, it remains a real threat to MSM. So far it has served to reignite public stigma against MSM further threatening possibilities of them having equal access to health services and in particular HIV/AIDS related services.

2.4 HIV/AIDS Prevention and Control Bill, 2010

The Prevention of HIV/AIDS Bill is yet another controversial legislation that has been proposed in recent times. The Bill provides for mandatory testing, mandatory or unauthorized disclosure of HIV status criminalizes intentional transmission of HIV/AIDS and imposes capital punishment on those found guilty of intentional transmission.

CSW are very likely to be subjected to mandatory testing under the Bill and this has the effect of drawing further from HIV/AIDS service providers for fear of being subjected to an HIV/AIDS test against their will. Since under the law homosexuality is a criminal offence, even MSM may be subjected to HIV/AIDS testing against their will which also drives them from health service providers. The totality of the provisions of the Bill therefore threaten rights of MSM and CSW and will have the effect of alienating them further from HIV/AIDS prevention, care and prevention programmes.

3.0 IMPACT OF UGANDA’S LAWS AND POLICIES ON MARPS IN UGANDA

In this section we seek to make a preliminary examination of the impact of these laws and policies on MARPS in Uganda, with a focus on MSM and CSW.

In Uganda, apart from the progressive policy on HIV/AIDS that existed for a long time regarding the general population, the laws and policies regarding MSM and CSWs have been, as shown above, historically retrogressive.

Thus, according to 2007 statistics from the Uganda AIDS Commission, while HIV/AIDS has claimed one million lives over a span of two decades since the first case was discovered in Rakai in 1982, and while currently, about

12 Id
13 Clauses 13, 14, 15 and 17
14 Clause 39 and 41
15 Presently an estimated 1.2 million Ugandans are believed to be living with the virus and prevalence rates are estimated to be between 6% and 7%. See Uganda AIDS Commission (UAC) and UNAIDS (2009), Final Report of the Uganda HIV Modes of Transmission and Prevention Response Analysis, Kampala, March.
one million people (6.4% of adults and 0.7% of children) are infected with the virus, HIV prevalence rate among CSWs Uganda stands at 47.2%! This represents about half of the population of sex workers.

On the other hand, according to the Crane Survey joint conducted between 2008 and 2009 by the School on Public Health of Makerere University and the AIDS Control Programme of the Ministry of Public Health, with funding from the US Government’s PEPFAR programme, HIV prevalence rate among MSMs in Uganda stands at 13.2%! This suggests that MSMs are twice as likely to be infected with HIV as the general population.

The criminalization of sex work and homosexual activity has made CSWs and MSM target populations, unable to effectively access medical services that are relevant to their needs and unable to obtain the protection of the police when our number are raped, assaulted and exploited. These twin factors, based squarely on repressive, colonial and outdated laws, appear to be driving the epidemic amongst these communities.

Although the Ministry of Health (MoH) and the Uganda AIDS Commission (UAC) have acknowledged this reality and have established the Most at Risk Populations Initiative (MARPs) which aims at meeting the HIV Prevention, Treatment and Care needs of vulnerable groups, including Sex workers, this and other such initiatives cannot be fully effective in a hypocritical legal environment that alternately denies the existence of these communities; criminalizes their activities and creates a hostile working environment that is inimical to HIV/AIDS prevention.

In spite of the vulnerability these groups face, they do not have effective access to most HIV/AIDS prevention, care and treatment programs, which leaves them with very few options to protect themselves against the pandemic and greatly inhibits prevention of further spread of the virus.

4.0 CONCLUSIONS AND RECOMMENDATIONS

AIDS is no longer [just] a disease. It is a human rights issue — Nelson Mandela

HIV has a remarkable capacity to exploit the pre-existing fault lines of society - Jonathan Mann

This submission has highlighted the fact that Uganda’s laws are inadequate to address the situation of MARPS within the national HIV response, and especially that of MSM and CSWs. Indeed, in many instances, most especially the provisions of the Penal Code Act, the laws are such that they act as an obstacle to the necessary public health interventions necessary to adequately deal with HIV.

It should be noted that Uganda’s early success in the fight against HIV/AIDS was achieved by an open, honest and pragmatic approach that promoted truth over denial. As such Uganda was able to drastically reduce HIV prevalence at a time that in the majority of the world was seeing an increase. Law and policy therefore has a direct impact on the spread of HIV. Good laws can reduce the spread of HIV, and bad laws can serve as a significant driver of the virus. While it may be true that a majority of Ugandans may not like the activities of MSM and CSWs, societal disapproval cannot and should not preclude strong evidence-based public health interventions to curb the spread of HIV among these communities. After all, human rights (including the rights to health and to life) cannot be subjected to referenda or opinion polls. Uganda has already had the sad experience of seeing many of its people die from AIDS when drugs could have been made available to save their lives. Parliament should not stand by and allow the other genocide by denial that is currently taking place – where a legal framework is systematically killing off a section of Ugandans by unnecessarily making them vulnerable to contracting HIV.

The only way forward is by a complete overhaul of the current legal framework. We propose a decriminalize of consensual sexual activity between consenting adults of the same sex, as well as a decriminalization of sex work,
even if this is accompanied by regulation as is the case in Senegal. In the meantime, the government would be well served to adopt a harm reduction policy that recognizes the public health needs of these communities, and would involve for instance, provision of water-based lubricants for use by MSM as well as providing free condoms for use by sex workers.

Specialist Submission to The Global Commission on HIV and the Law: Men who have Sex with Men (MSM)

Dear Commissioners,

Men who have sex with men (MSM)1 bear a disproportionately heavy burden of the global HIV epidemic. This public health crisis is indicative of broader, structural factors that exacerbate vulnerability among MSM – including laws, policies and practices that sustain and entrench inequality.

As an expanding global network of AIDS organizations, MSM networks, and advocates committed to ensuring robust coverage of and equitable access to effective HIV prevention, care, treatment, and support services tailored to the needs of gay men and other MSM, The Global Forum on MSM & HIV (MSMGF) has advocated for recognition of the influence of laws and policy environments on the HIV epidemic among MSM since our inception.

We urge you to take careful consideration of the issues, challenges and recommendations in this letter, and make bold recommendations pertaining to HIV among MSM in your final report.

How can the law be used to scale up effective HIV responses among MSM?

As a benchmark for what constitutes “an effective HIV response”, we will employ UNAIDS’ universal access targets. These signal unfettered access to HIV prevention, care, treatment and support, and also include ‘basic principles’: services which are equitable, accessible, affordable, comprehensive and sustainable over the long-term1.

Epidemiology: HIV among MSM

MSM bear a disproportionate burden of the epidemic as compared to the general population in virtually every world region (Figure 1).
Encouragingly, we know there a number of HIV interventions that ARE effective for MSM:

An exciting proliferation of publications in recent months establish authoritative standards for effective HIV responses among MSM, including reports from the World Bank2 and the World Health Organization3 detailing the evidence base for each recommended intervention. In addition, promising advances are currently being made in biomedical prevention with numerous clinical trials on Pre-Exposure Prophylaxis.

In short, a range of effective HIV prevention interventions for MSM do exist.

However, MSM have not been able to access HIV services:

Research shows that access to MSM-targeted HIV interventions in real-world settings has been extremely problematic:

• A survey of over 5,000 MSM from around the globe found that less than half could easily access HIV prevention services; that only 36% were able to easily access treatment; and less than a third had easy access to behavioural interventions and HIV education materials. Regression analyses for multiple factors found that experiences of homophobia were the most powerful predictor of compromised access to HIV services.4
• Qualitative interviews with MSM from a diverse array of world regions (Africa, Asia, the Caribbean, Eastern Europe, Central Asia, Latin America, North America and Western Europe) revealed a common set of factors that undermined access to HIV services: 1) homophobia, 2) HIV stigma, 3) criminalization and repressive policies, 4) lack of awareness among providers, and 5) safety5.

The key role of structural barriers in hindering the HIV response among MSM is echoed by a variety of research and reports6 7 8, as well as regional submissions to the Global Commission on HIV and the Law2

The law plays an important role in access to HIV services

For the purposes of this Commission, we will focus on laws and policies have had direct and indirect impacts on the public health of MSM in the context of HIV, in particular (a) the ability to provide quality HIV services for MSM; and (b) the ability of MSM to freely access these services, where they exist.

Impact on PROVISION and QUALITY of HIV programs for MSM:

Breaking the cycle of HIV transmission requires many elements, including the availability of high-quality HIV
programs for MSM. Around the world, a common set of laws and policies have been identified that render this work difficult or impossible to carry out:

- **Rejection of applications for legal registration of NGOs focused on LGBT issues**

  o **Issue:** Grassroots organizations are often uniquely placed to understand the needs of local MSM, and many have developed networks and resources over time to provide high-quality services. However, organizations that focus on MSM and other sexual and gender minorities can be prevented from attaining legal registration as an organization because of their target populations.

  o **Effect:** This leaves NGOs vulnerable to arbitrary closure by government officials, and handicaps the ability of NGOs to secure funding support, office space, and representation at policy and program planning arenas.

  o **Examples:** Botswana9, China10, Kyrgyzstan11, Mongolia12, Mozambique13, Turkey14, Ukraine15

- **Condoms and HIV education materials become evidence for prosecution**

  o **Issue:** Condoms remain one of the best evidence-based forms of HIV prevention available 16 17 18 19. Educational materials that contain explicit information on how HIV is transmitted between men, including effective steps for HIV prevention among MSM, are essential for equipping MSM with the knowledge and power to negotiate for their own safety. However, condoms and HIV prevention materials have been seized by law enforcement officials as evidence of sex work and the promotion of homosexuality.

  o **Effect:** When possession of condoms and educational materials becomes unsafe, service providers and individuals may abandon these prevention tools, reasoning that the immediate threat of arrest takes precedence over the potential threat of HIV. This exacerbates HIV risk and undermines contact between HIV service providers and MSM.

  o **Examples:** Philippines20, Cameroon21, Lithuania22

- **Criminal laws against sex between men undermine effective HIV program delivery**

  o **Issue:** According to a recent report by ILGA, 76 countries in the world had criminal laws prohibiting same-sex acts between consenting adults at the time of the document’s release in May 201123. A variety of laws around the world are used to enforce penalties against sex between men, including offences for sodomy, buggery, gross indecency, “unnatural sex”, and “carnal intercourse against the order of nature”. The severity of these punishments varies, in some cases going as far as life imprisonment (8 countries) and death (5 countries). In addition to laws prohibiting sex between men, a variety of other laws are regularly used and enforced against MSM in a discriminatory manner, including laws on public order, prostitution, trafficking, obscenity, loitering, vagrancy, and cross-dressing24, 25. These laws provide grounds for a range of actions that deter the provision of quality HIV services for MSM.

  o **Effects:** Raids, harassment and arrests by law enforcement at LGBT and HIV program sites. Discourages staff from working in such programs, deters client participation in such programs, causes loss of valuable materials. Health service providers face repercussions for providing HIV services to MSM.

  o **Examples:** China26, Georgia27, Ghana28, Malaysia29, Peru30, Senegal31, Syria32, Turkey33, Uganda34, Zimbabwe35.

- **Criminal laws against sex between men hinder the development of effective health policies for MSM**
o **Issue:** Criminal status of MSM also contributes to underrepresentation of MSM in the development and implementation of policies and programs

o **Effects:** Criminal status of MSM results in the development of inappropriate policies and programs, lack of resources for research and programs, lack of attention to MSM in national surveillance programs, failure to include MSM in educational curricula (including medical training and healthcare provider curricula).

o **Examples:** Lack of representation of MSM on Global Fund Country Coordinating Mechanisms36, 37; lack of global funding dedicated to HIV programs targeting MSM38; lack of knowledge and training on MSM-specific health issues in clinical curricula39,40, 41, 42, 43.

- **Criminal laws against sex between men result in the exclusion of MSM from decision-making arenas**

o **Issue:** Criminal prosecution legitimizes high-level, policy-related homophobia.

o **The effect:** Decision-makers invoke MSM-criminalization laws to justify a lack of surveillance, reporting and HIV service coverage for MSM

o **Examples:** Reporting on MSM-related UNGASS indicators has been found to be statistically lower in countries that criminalize sex between men44. For example, Saudi Arabia (whose penal code includes the death penalty for MSM) explains their lack of data concerning MSM in this way: “Indicator is irrelevant and inappropriate at KSA. Homosexuality is deemed as a criminal social evil that is highly stigmatized. MSM are prosecuted and penalized. The society discourages homosexuality. The few cases of MSM are usually hidden and are extremely difficult to map out.”45

**Impact on ACCESS to and UTILIZATION of HIV programs for MSM**

Even the highest quality HIV-related services in the world cannot achieve maximum impact unless MSM can safely and openly access them. Laws and policies that create hostile environments act as powerful deterrents and barriers to universal access.

- **Criminal prosecution legitimizes high levels of stigma against MSM in communities and healthcare settings**

o **Issue:** Even in contexts where criminal laws against MSM are not enforced, the mere existence of such laws in the penal code serves as justification for abuse, discrimination, stigma, and homophobia against MSM.

o **Effect:** MSM avoid accessing health services owing to potential or experienced abuse by clinic staff and community backlash if their sexual behaviour is revealed

o **Examples:** Botswana46, Malawi47, Namibia48

- **Violence and other human rights violations against MSM are committed with impunity**

o **Issue:** Laws that are used to target, harass, and arrest MSM leave little recourse for MSM who seek justice when their rights are violated.

o **Effect:** It becomes dangerous for MSM to divulge information or access a service that may reveal their sexual behaviour

o **Examples:** Armenia49, China50, Iraq51 52, Uganda53
Hostile environments contribute to disproportionately high rates of depression, anxiety and substance abuse among MSM.

- **Issue**: Consistently hostile environments leave little room for building healthy communities, connectedness and self-worth among MSM.

- **Effect**: These conditions undermine the capacity of MSM to access services and to protect themselves and their partners.

- **Examples**: Numerous studies have examined “syndemics” among MSM, including mental health and HIV risk; depression among MSM; changes in alcohol consumption; co-occurring psychosocial health problems among MSM; cyclical re-incarceration; as well as examining resilience as an untapped resource for MSM programming.

**How can the law be a ‘game-changer’ that substantially changes the trajectory of the HIV epidemic?**

Evidence shows that Universal Access for MSM can be a ‘game-changer’ – by reducing the trajectory of the overall global epidemic.

An analysis across four different HIV epidemic scenarios, representing the major epidemic trends in low- and middle-income countries around the world, found that achieving high rates of coverage of HIV prevention and treatment services among MSM not only has positive impacts for this concentrated epidemic, but it can also be the deciding factor in reducing the HIV burden of an entire country (see figure 1, below). This data has profound implications: achieving universal access to HIV prevention, care, treatment and support services for MSM worldwide would truly constitute a ‘game changer’ in the HIV response, not just among MSM, but for everyone infected and affected by HIV.

**Figure 2.** Projection of the Number of New HIV Infections with Implementation of Three Intervention Scenarios for MSM, Peru, 2008-20015


**Addressing structural determinants is an essential game-changer for the HIV response**

Basic HIV program activities can achieve greater impact when enhanced by structural interventions, including legal reform and community-centred design and delivery. A new study published in the *Lancet* calls for a transition beyond commodity-based, piecemeal efforts, to addressing “critical enablers” that affect the overall context in which HIV services are delivered (see figure 3 below).

**Figure 3** – Proposed framework for the new investment approach
This echoes previous work by Gupta et al.,62 and Blankenship et al,63 which likewise place structural determinants at the core of an effective HIV response, with special attention to community mobilization, integration of HIV services, contingent funding, and economic and educational interventions. Researchers assert this new investment framework will enable universal access by 2015, at a cost of US$22 billion, an overall cost-effective approach64. Leveraging maximum impact from dwindling HIV funding is indeed a game-changer for the HIV response.

**Potential “game-changing” impacts of the Law**

The World Bank65, UNAIDS66, the Global Fund67, the President’s Emergency Plan for AIDS Relief (PEPFAR)68, and the World Health Organization69 all agree that addressing the impact of laws and policies is essential to the success of HIV work among MSM. Opportunities for intervention include:

1. **Review and repeal laws that undermine the HIV response among MSM**

Country-specific analysis of laws and policies that impact on HIV services for MSM (as discussed above) as well as recommendations for action are urgently needed. The application of international human rights law with regard to sexual orientation and gender identity has been articulated by the Yogyakarta Principles70 71. The UN Special Rapporteur on the human right to health has also reported specifically on the issue of same-sex
criminalization. The mere existence of criminal laws can sometimes legitimize or exacerbate homophobia and abuse. A tabloid newspaper in Uganda ran a front-page story outing members of the LGBT community under the headline “hang them!”, including the name and photograph of LGBT activist David Kato who was murdered soon thereafter. The editor defended his decision to publish the story in part by claiming that homosexuals are “self-confessed criminals”.

While decriminalization of homosexuality is ultimately necessary to achieve universal access for MSM, we cannot and should not wait until full decriminalization is achieved to roll out HIV programs for MSM. It is possible to enhance access to HIV services for MSM even in criminalized contexts, and the long process to repeal criminal laws is no excuse to delay the provision of life-saving services.

2. Address the inappropriate enforcement of laws that hinder access to HIV services for MSM, through coordination, education and training with the judiciary and law enforcement officials

When law enforcement officials and other elements of the legal system abuse laws that can be wielded against MSM, or crack down on enforcement of normally ‘dormant’ laws in the face of political upheaval, the ability of organizations to offer HIV services to MSM is severely restricted, and also negatively impacts client utilization of those services.

MSM were included in Senegal’s national 2007-2011 National AIDS strategy, but after the 2008 International Conference on AIDS in Africa (ICASA) brought a global spotlight to this work, nine men were arrested on accusations of homosexuality, and MSM-specific HIV prevention materials were seized as evidence. The effects of this raid were shown to have a dramatically detrimental impact on use of services by MSM in Senegal.

3. Establish laws that protect the health and rights of MSM, and bring perpetrators of violence and other human rights abuses against MSM to justice

Stigma, discrimination and violence have a powerful effect on provision of and access to HIV programs for MSM. The establishment and enforcement of laws designed to decrease stigma, discrimination and violence against MSM can also create an enabling environment for the provision of and access to HIV programs for MSM. Holding perpetrators accountable for their actions is likewise important in this regard.

4. Implement know-your-rights campaigns, and create enabling environments in which individuals can lay claim to their rights

Even where protective laws exist, it takes a serious amount of effort for any individual to come forward and lay claim to their rights. People living with HIV, MSM, and other marginalized communities – including sex workers, people who use drugs, and transgender people – must have opportunities to learn about their rights, and have support to seek justice.

Focus group interviews with MSM in Canada uncovered instances of individuals who avoided accessing certain employer-based health benefits for fear of social repercussions of disclosing sexual orientation or HIV status in the workplace. Instead, they sought the anonymity provided by public coverage. This revealed very clearly that even where protective laws exist, supportive environments are critical to upholding and claiming rights.

5. Integrate the law as a core pillar in all National AIDS Responses, and adopt a rights-based approach to the HIV response

The law plays a vital role in the creation of enabling environments that facilitate universal access to HIV services for MSM. A comparison of HIV prevalence rates in various Caribbean countries both with and without laws criminalizing homosexuality revealed consistently higher HIV prevalence rates among MSM in countries that outlaw same-sex behaviour (see Figure 4 below). An analysis of UNAIDS annual country reports found countries...
whose laws did not criminalize homosexuality had a significantly higher proportion of reporting on the five UNGASS indicators relevant to MSM3 (p value of .003).

Figure 4: HIV among MSM in Caribbean Countries: Comparison by Criminalization of Homosexuality


Rights-based approaches that prioritize community systems strengthening and the creation of enabling environments should be prioritized in the response.

Conclusion

The disproportionate prevalence of HIV among MSM, coupled with outrageous violations of rights that continue to occur against gay men, illustrate a clear role for the law in creating enabling structural environments in which MSM will be able to fulfil their right to health, including universal access to HIV prevention care, and treatment services. We request bold, action-oriented recommendations from the Commissioners toward this end.

24  Canada  Individual(s)

The problem of "significant risk": Exploring the public health impact of criminalizing HIV non-disclosure

A B S T R A C T

Using criminal law powers to respond to people living with HIV (PHAs) who expose sexual partners to HIV or transmit the virus to them is a prominent global HIV public policy issue. While there are widespread concerns about the public health impact of HIV-related criminalization, the social science literature on the topic is limited. This article responds to that gap in knowledge by reporting on the results of qualitative research conducted with service providers and PHAs in Canada. The article draws on a studies in the social organization of knowledge perspective and insights from critical criminology and work on the "medico-legal borderland." It investigates the role played by the legal concept of "significant risk" in coordinating criminal law governance and its interface with public health and HIV prevention. In doing so, the article emphasizes that exploring the public health impact of criminalization must move past the criminal law-PHA dyad to address broader social and institutional
processes relevant to HIV prevention.

Drawing on individual and focus group interviews, this article explores how criminal law governance shapes the activities of providers engaged in HIV prevention counseling, conceptualized as a complex of activities linking clinicians, public health officials, front-line counselors, PHAs, and others. It emphasizes three key findings: (1) the concept of significant risk poses serious problems to risk communication in HIV counseling and contributes to contradictory advice about disclosure obligations; (2) criminalization discourages PHAs' openness about HIV non-disclosure in counseling relationships; and (3) the recontextualization of public health interpretations of significant risk in criminal proceedings can intensify criminalization.

Introduction

Using criminal law powers to govern the risk of HIV transmission is a prominent global HIV public policy issue. Concerns about criminalization have been propelled by an acceleration in the prosecution of HIV-related sexual offenses, particularly in Europe and North America, and by a move in a number of West African states to establish HIV-specific criminal laws (Pearshouse, 2007). The World Health Organization, UNAIDS, civil society organizations, legal scholars and others have responded to these developments by arguing that criminalizing HIV transmission and/or exposure seriously hinders established public health approaches to preventing HIV transmission (Bernard, 2010; Cameron & Rule, 2009; Elliott, 2002; Galletly & Pinkerton, 2006; GNPþ, 2010; Open Society Institute, 2008; UNAIDS, 2008; WHO, 2006; Wolf & Vezina, 2004).

Critics frame the criminal law as a blunt instrument that is ineffective at regulating the complex sexual activities that figure in HIV transmission. They emphasize that the vast majority of people with HIV (PHAs) take precautions to prevent HIV transmission and suggest curtailing the use of the criminal law, often citing conduct that intentionally and successfully transmits HIV as the relevant threshold (Burris & Cameron, 2008). A number of critics claim that criminalization disrupts access to HIV testing, education and support services (Wainberg, 2009) and erodes public health norms that support mutual responsibility for HIV prevention (Cameron, Burris, & Clayton, 2008). Others emphasize that criminalization heightens HIV-related stigma (GNPþ, 2010), while undermining action on the underlying social factors responsible for HIV transmission (Open Society Institute, 2008).

The critique of criminalizing HIV transmission/exposure is limited by the slim base of theoretically-informed social science research that addresses its central claims. Drawing on a studies in the social organization of knowledge perspective (Smith, 2005), this article responds to that knowledge gap by reporting on E-mail address: ericm@yorku.ca. research on the public health impact of criminalizing HIV non-disclosure in Canada. The article differs from the established literature in two central ways. First, its primary empirical focus is not the activities of PHAs or those at risk of HIV infection, but the work of providers engaged in HIV prevention counseling. Second, it draws on insights from critical criminology and work on the “medico-legal borderland” to offer a more relational understanding of how the criminal law affects HIV prevention.

My approach is to explore criminal law/public health relations as the social organization of knowledge. In particular, I emphasize how the legal concept of significant risk, and providers’ and PHAs’ responses to it, figure prominently in problems that arise at the site of HIV prevention counseling. The article continues with a brief review of the literature, the Canadian legal context, and the study's methods. It then discusses key research findings, emphasizing how: (1) the vagueness of the significant risk concept hinders risk communication in HIV counseling and contributes to contradictory advice about PHAs’ disclosure obligations; (2) criminalization discourages open communication about non-disclosure in counseling relationships; and (3) the recontextualization of public health interpretations of significant risk can intensify criminal law liability.

The research literature
Most empirical research on the public health impact of criminalizing HIV transmission/exposure has been conducted by academic lawyers and applied social scientists in the United States and the U.K. The studies use a range of qualitative and quantitative methods and focus on PHAs as well as “at-risk” populations, including gay men, injection drug users, women, and African-Americans, among others (see, for example, Dodds & Keogh, 2006; Galletly & Dickson-Gomez, 2009). The central topics explored are PHAs' experiences and understandings of criminal laws related to HIV exposure/transmission and the relationship between such laws and sexual risk behaviors (see, for example, Burris, Beletsky, Burleson, Case, & Lazzarini, 2007; Dodds et al., 2008).

The literature points to a mix of responses toward criminalization on the part of PHAs. While many support criminalization, they do so in a context of widespread misunderstanding of their criminal law obligations (Galletly, DiFrancesisco, & Pinkerton, 2009), concerns about the effects of criminalization such as secondary disclosure and heightened HIV-related stigmatization (Dodds & Keogh, 2006; Galletly & Dickson-Gomez, 2009), and a preference for a qualified use of the criminal law (Klitzman et al., 2004). Criminal laws have also been shown to have varied and contradictory effects on the sexual activities of PHAs. Comparative survey research has found very few differences between the self-reported sexual activities of research participants who reside in jurisdictions with HIV-specific legislation and those who do not (Burris et al., 2007; Horvath, Weinmeyer, & Roser, 2010). Qualitative research has found that while some PHAs respond to criminalization with increased disclosure of their HIV-positive status before sex, others disclose less often, while almost half report no impact (Dodds, Bourne & Weait, 2009). On balance, the existing literature concludes that criminal laws do not enhance activities that deter HIV transmission and cautions against their use.

This article contributes to the literature by exploring for the first time, to my knowledge, the impact of criminalizing HIV nondisclosure not only on PHAs or “at-risk” persons, but those who work in HIV prevention, treatment and support. It is fitting to privilege PHAs in research on criminalization, given the dramatic and punitive consequences it poses for them. However, any effects of the criminal law on HIV prevention occur through a complex set of institutional and social processes that extend beyond the criminal law-PHA behavior dyad. Those processes link expert and popular representations of sexual risks and of the criminal law, criminal justice and law enforcement activities, the interpretive and sexual practices of PHAs and HIV-negative individuals and the work activities of clinicians, public health providers and front-line AIDS service providers, among others.

Drawing on an understanding of the criminal law as a “socially embedded phenomenon” (Pue, 2010) and on insights from work on the “medico-legal borderland” (Timmermans & Gabe, 2003), this article seeks to put in place a more relational understanding of how criminalization shapes HIV prevention. That means recognizing that HIV prevention is accomplished through a complex of activities involving a range of actors. It means understanding that the public health impact of criminalization is about more than PHAs’ behavior; it is about how the work of providers is affected, how their counseling relationships with PHAs are influenced, and how flows of information about HIV risk are shaped and with what consequences. This article explores these questions from the primary empirical site of HIV prevention counseling. It emphasizes how counseling and problems arising in it are discursively shaped by a form of criminal lawgovernance coordinated by the concept of “significant risk.”

**The Canadian context**

In Canada, PHAs have a criminal law obligation to disclose their HIV-positive status to others before engaging with them in activities that pose a “significant risk of serious bodily harm” (i.e. HIV transmission). This legal obligation was established in 1998 by the Supreme Court of Canada’s decision in R v Cuverrier (1998). The Supreme Court established that in circumstances of sexual activity where a “significant risk” of HIV transmission is posed, not disclosing one’s HIV-positive status can be deemed a fraud that vitiates a person’s consent to sexual activity. The decision established that an HIV-positive man who engages in unprotected vaginal intercourse poses a significant risk of serious bodily harm (Elliott, 1999). The Supreme Court did not further
define what constitutes a significant risk, nor establish clear parameters for determining when a significant risk has occurred. Prosecutions for non-disclosure in the context of sexual activities that pose a minimal risk of HIV transmission such as oral sex or protected intercourse have followed. Lower court decisions have not clarified the “significant risk test” and have inconsistently drawn on scientific research, particularly with respect to the impact of HIV viral load on HIV transmission (Mykhalovskiy, Betteridge, & McLay, 2010). The overall lack of clarity and overreach of significant risk have been central to the concerns raised by legal advocates post-Cuerrier (Elliott, 1999; Symington, 2009).

In Canada, using the criminal law to respond to circumstances of alleged HIV non-disclosure has intensified in recent years, leading some to describe the country as a world leader in HIV-related criminal prosecutions (Cameron, 2009). From 1989 to 2009 inclusive, there were at least 104 cases in which 98 individuals were charged with criminal offenses related to HIV non-disclosure in sexual circumstances. However, approximately 65% of these cases occurred in the last six years. The majority of individuals (65%) who faced charges are men who allegedly failed to disclose their HIV-positive status to female sexual partners. In Ontario, Canada’s largest province, from 2004 to 2009, 50% of these men were from Black Caribbean or African communities, a finding explained by various factors including concerns within Black communities about secondary disclosure of HIV-positive status, the media’s overwhelming focus on cases involving Black male defendants, and the history of discrimination faced by Black men in the Ontario criminal justice system (ACCHO, 2010). Canada does not have an HIV-specific criminal law but uses established criminal offenses to prosecute PHAs for non-disclosure. Since the Cuerrier decision, PHAs have been routinely charged with aggravated sexual assault, which carries a maximum penalty of life imprisonment. As of 2009, 63% of known criminal cases in Canada resulted in convictions and 83% of convictions resulted in prison sentences. In 38% of convictions, HIV transmission did not occur (Mykhalovskiy et al., 2010).

Methods

This study is part of a criminal law reform project that was conducted in Ontario. The project explored four forms of evidence (the interview data reported here, pattern data on criminal charges, scientific research on HIV transmission risks, and court records) with a view to encouraging a more evidence-informed application of the criminal law. The project’s key policy recommendation is to establish prosecutorial guidelines to restrict the application of the criminal law, a response to criminalization that has proven effective in other jurisdictions (Azad, 2008; Mykhalovskiy et al., 2010).

Individual and focus group interviews were conducted from January to September, 2010. A total of 56 individuals participated. Twenty-eight service providers were interviewed individually. Four focus groups were conducted with a total of 26 PHAs; 2 PHAs unable to attend were interviewed individually. The choice of focus groups may seem counterintuitive given the controversial nature of the issue, but criminalization is a popular topic in HIV-positive communities and most of the PHA participants were known to one another as ASO (AIDS service organization) clients. Focus groups were designed to explore PHAs’ understandings of significant risk and broader experiences of criminalization, not their sexual practices.

All interviews were conducted in one of three cities in Ontario-Toronto, Ottawa and Hamilton. Individual interviews lasted from 38 to 81 min, while focus groups lasted from 87 to 93 min. All interviews were tape-recorded and transcribed. Ethics approval for the study was received from York University. Service providers were treated as key informants (Spradley, 1979) and were chosen on the basis of having specialized knowledge of and first-hand experiences related to criminalization. Providers came from a range of sites where work related to HIV prevention occurs: ASOs (8); an HIV clinic (3); public health (7); law (4); and physician care (6). PHAs were chosen from a variety of social and economic locations. One focus group was mixed with respect to gender, race and sexual orientation, one was conducted with gay men, one with economically marginalized PHAs and one with youth. Focus group participants were recruited through provider referral or response to an electronic study announcement circulated by ASOs. They received an honorarium of $30.
This study was influenced by studies in the social organization of knowledge, an approach to sociological inquiry developed by Canadian sociologist Dorothy Smith. This body of work locates inquiry in the “everyday world” and seeks to explore how people’s activities enter into and are coordinated across time and place by professional and managerial discourses and practices. Studies in the social organization of knowledge treat knowledge as an active constituent of the social and try to explicate the large-scale social and institutional relations, including those of the law, through which contemporary societies are governed (Smith, 2005). Interviews were designed to elicit experiential narratives in which participants reflected on the topic of criminalizing HIV nondisclosure in ways grounded in their actual, day-to-day experiences. Service providers were asked to describe their hands-on experiences related to the criminalization of HIV non-disclosure including how they counseled PHAs about their criminal law obligations. Focus groups addressed participants’ understandings of significant risk and their experiences of criminalization, relationships with providers, and HIV-related stigma.

Analysis of interview data was focused on bringing into view how an abstract criminal law obligation is made meaningful and expresses itself in people’s lives through multiple social and institutional channels. Individual transcripts were explored internally and across one another, a process aided by topically tagging the data with data management software. People’s accounts were read for their translocal social organization (Devault & McCoy, 2002), that is, for the traces of extended forms of coordination, principally those of discourse, that shaped them and the experiences to which they refer. This approach to analysis encouraged an understanding not only of what people felt about criminalization, but how their activities were shaped by and entered into the relations criminalization organizes.

Results

PHAs, significant risk and uncertainty

In Canada, criminal law governance of HIV non-disclosure is conceptually coordinated by the concept of significant risk. As a component of formal legal discourse, the term aims to preserve the credibility of criminal justice by ensuring that criminal liability applies to non-disclosure only in the context of activities that pose a serious risk of HIV transmission. As already noted, the ambiguity of significant risk has prevented it from appropriately restricting prosecutions. This study suggests that the effects of the concept’s vagueness are compounded when significant risk circulates beyond the formal limits of criminal law discourse and enters into the registers of PHAs’ everyday lives.

HIV-positive participants were widely concerned about the significant risk test. Most experienced the concept in remote terms; it was part of the unfamiliar language of criminal law they had heard about through HIV-positive friends, the media, ASOs, or public health. The concept’s remoteness was compounded by their experience of it as something that was, in of itself, vague and uncertain. The question “What is significant risk?” was a common reference point in interviews with PHAs who repeatedly emphasized its indeterminate character. One PHA I individually interviewed noted:

What’s significant risk? That’s what I never understand. Like it’s significant risk, but what necessarily is significant risk? The whole haziness of the law around HIV, I find it kind of makes you a little bit angry, especially being an HIV-positive person.

(Interview 25)

PHAs emphasized how, in the context of their daily lives, the concept failed to provide meaningful guidance about what forms of sexual activity must be preceded by disclosure. The concept’s vagueness coupled with its remove from the registers of daily
sexual practice made it particularly troubling for them:

The significant risk test is too ambiguous and it doesn’t set up any proper guidelines for people to follow.
(Focus Group 2)
It’s pretty scary because you don’t know what you can do and what you can’t do.
(Focus Group 3)

Unable to determine their disclosure obligations with any certainty, HIV-positive participants were left angry, confused, and frightened. Some responded by withdrawing from sexual activity altogether. Others claimed to disclose in all sexual circumstances, while others suggested becoming less open about their HIV-positive status. In their efforts to determine “what you can do and can’t do” many became caught in a tension between different forms of risk knowledge. Their encounters with significant risk ran up against a more familiar and established terrain of risk discourse—public health concepts that connect epidemiological risk with particular sexual activities, such as oral sex, distributed along a gradient of no, negligible, low and high levels of transmission risk. While the latter form of risk discourse more easily guided their daily sexual conduct, it did not answer the question of what constitutes a significant risk and left unresolved their confusion about the relationship between and authority of different forms of risk knowledge:

I don’t know what is it I have to disclose for if I’m using condoms.
(Focus Group 1)

Providers, criminalization and HIV prevention counseling

Providers involved in HIV counseling expressed two central concerns about the impact of criminalization on their work. First, they emphasized how the uncertainty of significant risk challenged their efforts to mediate between different forms of risk knowledge in their counseling relationships. Second, they emphasized how criminalization hampered their ability to establish counseling relationships in which PHAs could be open about their sexual activities and difficulties with disclosure.

Significant risk, knowledge mediation and HIV counseling

From a public understanding of science perspective (Irwin & Wynne, 1996), HIV prevention counseling can be understood as a form of risk communication that mediates between different forms of knowledge. It involves efforts to bridge the so-called gap between lay risk knowledges and public health ways of knowing about the risks of HIV transmission. Front-line HIV prevention workers are accustomed to negotiating the terms of public health discourse. They are familiar with statistical uncertainty and the challenges of applying population-level risk estimates to individual circumstances. They have devised a range of communicative strategies for translating public health risk concepts into the registers of their clients’ daily lives. The same cannot be said of their relationship to legal risk concepts.

The particular ambiguity of significant risk, the absence of parameters that might clarify its reach, and the difficulty of making it “make sense” in experiential terms posed particular challenges for providers. One participant expressed a common sense of frustration with significant risk, noting how its vagueness complicated communication with her HIV-positive clients:

Working on the front-line there is a lack of clarity [about significant risk] and you can write three-million [agency] policies but they’re still not going to be clear because the law’s not
clear. So it makes my work, sometimes, and the things I can say or can’t say unclear. (HIV Counselor Interview 21)

Given their responsibilities for mediating between formal expertise and lay knowledge, and the high stakes involved in communicating about significant risk, providers responded to its ambiguity in various ways. Many sought to extend the reach of their own knowledge by consulting resources on criminalization produced by the Canadian HIV/AIDS Legal Network. Others found comfort in organizational divisions of responsibility for communicating about the law and referred clients who had questions about significant risk to legal agencies. A common strategy was to repeat the terms of the Cuerrier decision to clients or to review the decisions of recent criminal cases with them. Such efforts may have familiarized PHAs with the discursive character of criminal law reason. However, in some instances, they compounded the presence of uncertainty about formal disclosure obligations in HIV counseling and left unanswered the question of what is a significant risk:

They’re looking for some kind of certainty. ‘Is that significant risk or is it not?’ And I don’t feel that I have certainty on that. There is, in some ways, an ongoing murkiness like all you can say is ‘This is what is considered significant risk based on what has happened in cases so far.’

EM: How do clients react to that? Well, it’s a murky answer. It’s not a certain answer. All I can say is ‘it’s not the most precise term’ and I will explore with them what does that bring up for them. It actually gives direction in some ways, but also can raise a spectrum of uncertainty in the unknown. ‘Am I doing enough or am I not?’ Some people are able to navigate uncertainty but there’s a whole group of people [for whom] its very destabilizing. (Social Worker, HIV Clinic Interview 3)

This study suggests that despite providers’ better efforts to respond to the ambiguity of significant risk, its inherent vagueness has resulted in inconsistent information about the legal obligation to disclose being provided to PHAs. This was evidenced in the range of interpretations of the significant risk test provided by key informants in interviews. Some felt that protected anal or vaginal intercourse did not pose a significant risk of HIV transmission and, therefore, did not require disclosure. Others emphasized that unprotected oral intercourse was not a significant risk. Still others refused to define parameters of any kind. It comes as no surprise that varied interpretations of an unclear legal risk concept have resulted in contradictory advice to PHAs about when they are obliged by the criminal law to disclose. Public health nurses cited concerns about the mixed messages that resulted:

We are so close to Toronto, we have clients coming in and out of the region and crossing jurisdictions all the time and, so, if you have one person interpreting it this way and we’re interpreting it this way, it really sends mixed messages and it creates a lot of confusion. People [PHAs] aren’t really sure what they need to do and what their responsibility is. (Public Health Nurse-Interview 20)

There’s a lot of anxiety with clients that I deal with, and there’s a lot of gray areas that haven’t been covered around these [court] decisions. I think it’s very important for people to know exactly. They want to know ‘Ok when do I need to tell a partner?’
So public health says one thing, your doctor says another and there’s so many variables. There’s just different messages getting out from different people.

(Public Health Nurse-Interview 13)

Criminalization and the discouragement of openness in HIV prevention counseling

The Cuerrier decision presumes that criminalizing HIV nondisclosure promotes “frankness” and “honesty” in sexual communication between PHAs and their sexual partners (Cuerrier, 1998, 72). For many PHAs, HIV counseling can be an important source of support in making decisions about sexual communication. In this study, providers had many concerns about how criminalizing HIV non-disclosure hindered their efforts to work with PHAs in open ways about their sexual activities and disclosure practices. The extent of their concerns calls into question legal presumptions about the relationship between the threat of criminal sanction and HIV disclosure.

Counseling with an eye to the law

Key informants from public health expressed their concerns about criminalization by emphasizing the consequences of counseling “with an eye to the law.” They used this phrase to refer to how criminal law governance interfered with public health reasoning and practice in ways that were potentially corrosive of voluntary counseling and client-centered approaches. Public health counselors viewed criminalization as running contrary to a public health perspective. They oriented to HIV prevention as a “health issue,” not a criminal law concern and understood public health responses to non-disclosure to be a matter of balancing public safety with PHAs’ needs. They also privileged client-centered approaches based on voluntary counseling over more coercive public health measures which were viewed as a last resort, to be used only in cases of unusually recalcitrant PHAs.

Some public health nurses were concerned that the increased use of the criminal law discouraged PHAs from approaching or maintaining relationships with public health. The source of their concern was sensationalist media stories of high profile criminal cases in which police press releases urged sexual contacts of the accused to contact public health authorities or health care providers for HIV testing. Respondents felt such media coverage discouraged PHAs from approaching public health because of an impression of close ties between public health and the police.

So every time this happens where an individual is charged the sensationalism in the newspapers and in the media is exactly the same every time. I think that with respect to public health there’s a lot of misinformation out there about what we actually do. So we’re not the law. There is public health law but we don’t, you know, we don’t go to the police and we don’t report individuals that are having unsafe sex to the police.

(Public Health Nurse-Interview 20)

While public health respondents repeatedly emphasized distinctions between public health and criminal law functions, they were also genuinely concerned about the potential erosion of public health practice and reasoning as their activities increasingly entered into relationship with the criminal law governance of health risks. The notion of carrying out HIV prevention “with an eye to the law” aptly describes the nuanced shifts in public health counseling with which participants were concerned. The phrase suggests how criminal law regulation creeps into the practice and consciousness of public health nurses who engage in public health
counseling from a stance of growing preoccupation with legal concerns and consequences. For some, working with an eye to the law referred to the challenges of maintaining a public health focus in counseling in the context of their own and their clients’ concerns about criminal law disclosure obligations. For others, it involved an uneasiness about whether or how to counsel newly-infected individuals about their option to pursue criminal charges against HIV-positive partners whom they felt may have not disclosed to them. Counseling with an eye to the law also referred to how public health staff had a heightened awareness of and concern for public health’s liabilities, something which had been amplified by recent civil law suits brought against public health for failing in their duty to warn the public and prevent harm in cases involving HIV non-disclosure (Betteridge, 2009).

Overall, participants described counseling with an eye to the law as constraining their work and contributing to counseling circumstances that discouraged openness and honesty on the part of PHAs. They worried that in response to criminalization public health might prematurely turn to coercive approaches to risk management at the expense of relationship building and more open, client-centered counseling efforts:

I wouldn’t say I’m satisfied with the way things are now. Certainly the [criminal] cases have been really highly publicized and broken down and scrutinized and judged and I don’t particularly like to see this issue where it is now and it just seems that it’s happening more and more. I think our front-line staff is really fearful that this is going to be, it used to be sort of few and far between that things would sort of escalate to that point. But I think it’s happening more and more and more and people are really fearful about how that will impact our relationships with our clients and our ability to work with them. Staff’s really fearful that this is going to become something that they’re more and more drawn into. That this is becoming, that we’re managing this with such a legal focus.

(Public Health Nurse-Interview 17)

**Chills in counseling**

Front-line staff from ASOs and family physicians did not generally refer to counseling with an “eye to the law” in their accounts of how criminalization affected their HIV prevention work. Rather, they spoke about how the criminal law created “a chill” in their counseling relationships with HIV-positive clients and patients. The notion of a chill referred to restrictions or limitations on open dialogue in counseling, particularly a disinclination on the part of PHAs to discuss challenges they may be facing disclosing their HIV-positive status to sexual partners. Counseling limits of this sort are an important example of how the criminal law’s impact on HIV prevention is relational and mediated. They arise as part of counselors responses to criminalization, in particular their concerns about the vulnerable legal status of counseling records, expressed to their clients through cautions about the limits of client confidentiality.

Providers’ concerns about confidentiality arose in the context of their awareness of criminal trials in which information shared in HIV prevention counseling sessions had been subpoenaed and entered into court proceedings. Some providers spoke about the struggles they faced trying to balance the duty to inform HIV-positive clients about the limits of client confidentiality with their efforts to create a trusting counseling
relationship with them:

Hopefully [I’m] going to balance the message of what my clinical responsibilities may be with regards to the law, with where my positioning is, which is: ‘I operate within the boundaries of the law but, for our conversation here, this is going to be about you and how I can help you make better decisions.’ So, absolutely, it’s key in my head around how is this going to impact our future conversations.

(ASO Worker Interview 16)

Despite their better efforts to build trust, providers remained concerned about how the criminal law can operate contrary to its formal objectives by dissuading open dialogue about precisely the behavior it seeks to regulate. One case manager reflected on her understanding of how criminalization placed limits on what clients felt able to communicate to her:

They feel like they’re being centered out, that their whole sexuality is being policed. And we have to, like I’m going to admit here that I think the counseling relationship and the total disclosure, you know, is impeded by the criminalization. I think there are things that might be hidden from me that otherwise wouldn’t be. I think it does impede how open clients are and I have a feeling that they really want to talk about more but they take a step back because of criminalization.

(ASO Case Manager Interview 21)

A physician interviewed for the study echoed these remarks. He described situations in which patients had requested that conversations about non-disclosure not be charted and suggested that some of his patients had not been forthcoming about their sexual practices because of legal worries. Placing himself in their shoes he noted, “If I was in the same situation would that have implications on what I would say to my doctor and not say to my doctor? Yes, absolutely it would.”

Accounts of this sort highlight the complex relationship between criminal law governance and the circumstances through which non-disclosure is brought into language and discussed. On one hand, criminalization has produced much discussion about HIV non-disclosure in community and mainstream media. It is also a focus of conversation and dialogue among PHAs and among providers for whom questions about how and to whom PHAs disclose have developed a new salience. But at the level of one of the primary communicative forms through which HIV prevention is enacted—individual counseling—criminal law governance contributes to regulating and limiting discussion of HIV nondisclosure in highly problematic ways.

Responding to false allegations of HIV non-disclosure

While providers emphasized the limitations to HIV prevention posed by criminal law governance, they also spoke about their efforts to respond in positive ways to the problems it posed for PHAs. Drawing attention to those efforts helps prevent an overly deterministic critique of criminalization. While it is clear that their overall experience of criminalization was of its negative consequences, providers’ creative responses to those consequences suggested important sites of innovation in HIV prevention. One prominent example focused on the problem of false accusations about PHAs’ non-disclosure. A number of focus group participants, particularly Black African women newly arrived to Canada, were concerned about false claims that their partners might make about them not having disclosed their HIV-positive status. A service provider described her understanding of the problem:
People who are at risk of prosecution are terrified. I mean really scared. They get scared when there’s been a messy break up. I’ve had a lot of people just afraid that they’re going to be manipulated. That this break up isn’t going well and so what’s the best tool someone can use to make their life miserable is to pick up the phone and lay a charge against them. And even if nothing comes of that charge, well, they’re going to be raked through the courts. It can really get ugly. It can be somebody sponsored by a same-sex partner or an opposite sex partner and their sponsorship depends on this person, things aren’t going well and then we see these individuals threatening, you know, various things.

(ASO Case Manager Interview 15)

Concerns about false allegations of non-disclosure help to situate the act of disclosure in the real world of interpersonal relationships as against the idealized representation of formal legal responsibilities expressed by criminal law discourse. They suggest how, in the context of unequal relationships, the legal requirement to disclose can be subject to manipulation in the sense that partners can use false claims of non-disclosure to control and threaten PHAs. They further suggest a certain erosion of confidence in the law as both providers and PHAs come to understand that disclosure provides no guarantee against potentially damaging legal entanglements for PHAs, especially those who are socially or economically marginalized.

Providers described an interesting effort to respond to these circumstances by transforming what their clients experienced as a private, intimate act into a witnessed event. Mindful of the difficulty of proving that one has disclosed, particularly when court proceedings take the form of adjudicating “he said/she said” claims, some providers reported taking steps to producing a formal organizational presence for their clients’ disclosure. According to one provider, PHAs and their partners are invited to the agency for HIV prevention counseling. At that time, documents are signed by both individuals or counseling records are made that indicate that disclosure took place and HIV counseling was provided. In this way a textual record attesting to disclosure having occurred is created that can be used to counter subsequent claims that it did not.

**Recontextualizing public health knowledge**

This study emphasizes how the criminal law affects HIV prevention counseling. But it also suggests how providers’ responses to criminalization feed back into the criminal justice system in problematic ways. This circularity of public health/criminal law relations becomes visible when one considers the emergence of counseling advice that ostensibly detaches risk from the disclosure obligation. In interviews, it became clear that some providers have responded to the vagueness of the significant risk test by counseling their clients to disclose their HIV-positive status to sexual partners prior to all sexual activities, regardless of the transmission risks they pose. The quotes that follow suggest the range of this practice:

If the [public] health officers call you what they tell you is, ‘make sure that you disclose your status to whomever.’ They don’t tell you if it’s significant risk or whatever. They’re just like ‘you have to disclose it.’

(Focus Group 4)

We counsel people to always inform prior to any penetrative sex.

EM: What do you mean by penetrative sex?

Any oral sex, any anal sex, any vaginal sex with or without
a condom.
(Public Health Nurse-Interview 13)
We don’t know what significant risk is, right? Because it means different things to different people or different judges, right? So I cannot interpret what it means for somebody else. So what we usually say, what I usually say, is that in Canada if you have sex, protected or otherwise, without disclosing, I used to say unprotected but now I say protected, once you have sex without disclosing your HIV status to somebody, you could go to jail. You could be charged.
(ASO Worker-Interview 22)

Providers explained this broad approach to counseling about disclosure obligations as a response to the uncertainty of the significant risk test, as a way to protect clients from criminal prosecution and as a response to concerns about their own legal liability. While it is an understandable move, it suggests a troubling consequence of the use of the criminal law to govern HIV transmission risks—the emergence of counseling strategies that encourage a practice of disclosure that exceeds the criminal law obligation, as defined by the significant risk threshold. This has the arguable effect of detaching disclosure from risk governance in favor of a blanket moral obligation to disclose in all sexual situations. At least one provider suggested how the complexities of counseling around significant risk can give way to a type of moral entrepreneurship in which counselors emphasize an obligation on the part of PHAs to ensure that all sexual partners, in all circumstances, “always know.”

A further troubling consequence of this approach to counseling about disclosure obligations is its potential to influence judicial decision making. An important feature of the intersection of public health and criminal law regulation is the movement of public health knowledge into court proceedings where it is recontextualized and comes to coordinate relations of criminal law decision making and punishment. When entered into evidence in court proceedings, public health or physician advice to the accused to disclose in all circumstances can influence judicial interpretation of the significant risk test in ways that, contrary to the aims of well-meaning providers, do not protect PHAs from prosecution but, in fact, increase their criminal law liability:

There’s a tendency to sort of transmogrify, almost, public health formulations of what people should be doing into criminal law obligations. And so you’ll see prosecutors and you’ll see judges for example citing to the fact that this person was counseled by public health nurse X on these three occasions to disclose and use a condom and then that becomes used to sort of bootstrap the criminal law obligation into you have an obligation to disclose and to use condoms, which in fact is not what the Supreme Court said in Guerrier.
(Lawyer-Interview 5)

Discussion

Critical criminologists and socio-legal scholars have encouraged ways of thinking about criminal law governance as a thoroughly social process with complex and multiple effects (Garland, 2001; Rose & Valverde, 1998). In contrast to formalist analyses that explore the impact of criminal law immanently, such as through studies of whether it truly deters a given prohibited set of behaviors, they recommend analyses of how the criminal law shapes a broad range of “extralegal” social relations. The many insightful studies that show how, through multiple social and institutional sites, criminalization processes extend their reach beyond the formal governance of the criminal law subject provide but one example (Mosher & Brockman, 2010). The study of the public health impact of criminalizing HIV transmission/exposure can gain much from such a perspective on the
nature of criminal law governance. At times, the critique of criminalization has suffered from a too simple explanatory calculus. Too often, criminal law is approached in abstract form and linked with PHAs or HIV-negative individuals in vacuo in bold claims that, for example, criminalization will deter people from seeking HIV testing. Normative critique of criminalization need not be reduced to such equations.

The alternative explored here takes a more relational approach that disrupts criminal law’s presumption of an individuated, rationally-bound legal subject by orienting to criminal law governance and HIV prevention as socially embedded phenomena (Adam, Elliot, Husbands, Murray, & Maxwell, 2008; Weait 2003). The intent has been to explore features of the social organization of a form of criminal law governance that regulates HIV nondisclosure through the concept of significant risk. A particular concern has been to examine how it shapes HIV prevention, conceptualized as a complex of activities and forms of reasoning linking clinicians, public health officials, front-line HIV counselors, PHAs and others. This approach locates inquiry in an analytical and empirical space that Timmermans and Gabe refer to as “the medico-legal borderland” (2003:6). They use the term to decry the absence of dialogue between criminology and medical sociology and to encourage critical analyses of sites in which health care and criminal-legal practices intersect. The medico-legal borderland suggests multiple possibilities for analysis including investigation of new forms of social control, the intersection of criminal law and health care governance and the emergence of hybrid health/crime subjects.

This article contributes to the study of the medico-legal borderland by exploring the intersection of public health and the growing use of criminal law powers to regulate HIV transmission risks. The analysis privileges a dynamic of criminal law impact on HIV prevention counseling, while avoiding the pitfalls of determinism by acknowledging that HIV prevention also shapes the domain of criminal law. Indeed, in a manner similar to findings about knowledge flows from other research (Solin, 2004), at this study site, public health knowledge, in the form of counseling records, enters into and is recontextualized within criminal law proceedings with contradictory effects. At the same time, the circularity of public health/criminal law relations is demonstrated by how public health counseling and record keeping are carried out with an “eye to the law,” that is, in anticipation of their potential documentary entry into criminal justice processes.

The findings reported here suggest a host of tensions and problems that arise when the relatively distinct rationalities and forms of risk governance represented by public health and criminal law intersect. In the Canadian context, criminal law governance targets practices of disclosure, relies on an unspecified legal concept of significant risk and aims to punish and contain. Public health governance is nominally averse to punishment, focuses on safer sex practices and relies, in the first instance, on strategies of collaboration and professional client interaction to reduce risk. The growing reach of the criminal law in the context of a history of public health intervention creates tensions at the level of competing forms of risk knowledge and ways of framing responsibility for HIV transmission and the place of the bodies and conduct of PHAs therein.

This study shows how the lack of clarity of the significant risk test and the growing reach of criminal prosecutions, particularly in circumstances when, from a public health perspective, a negligible or low risk of HIV transmission has been posed, has led to anxiety, confusion and contradictory HIV counseling advice. PHAs are unable to determine what their criminal law obligations are and remain confused about the relationship between established public health risk knowledge and safer sex messaging and the parameters of the significant risk test. Their burdens are shared by clinicians, public health nurses and HIV counselors who report serious problems in their HIV prevention work. In a perverse fashion, rather than promoting openness, criminalization has made it more difficult to provide meaningful HIV prevention counseling and support about HIV non-disclosure. While the use of the criminal law may be warranted in some circumstances, the expansive use of a vague legal concept of significant risk does little good either for preventing HIV transmission or for the credibility of the criminal justice system.
Dear Sir/Madame:

Based on my background as an activist, a community leader, a person living with HIV, my personal, academic, professional experiences, my expertise in HIV and community development work, I will like to respond to the following questions “How can the law be used to scale up effective HIV responses?” and How can the law be a “game-changer” – i.e.: substantially change the trajectory of HIV epidemic through a guideline proposals of an A-Z action plan to execute my approach that would be relevant to the commission’s work on HIV and the LAW.

I will first of all start with the letter A which stands for Activism. The reasons why I chose activism as an effective tools is because ever since the discovery of the AIDS epidemic, HIV/AIDS activists from all around the globe today had made is possible to give the disease a human face. As the result of people living with HIV and AIDS and their involvement and other supports such as community activists the Denver principal was adopted in 1983, showing an effective method of dealing with the disease by those affected and infected and today we see the impact at every level of the world. From a recent experienced in my home country Liberia I would recommend the commission to read this article just posted by the Foundation for AIDS Research amfAR the only donor who supports my work in Liberia.


B = becoming aware of the laws in place, How to used the law

C = Communities commitments, with community involvement the commission will be able to recognized the different communities affected by the disease and leaned best practices at the community level, such as community of women living with HIV and AIDS, Men who have sex with other men (MSM), LBGTI community recognition per countries, and regions, PLWHIV, Sex workers, IDU’s, and indigenous people, Civil society organization and the inclusion of all others community based groups. Country assessments should be carry out to map national assessments will aim to establish the current status of programmes to put in place a system of watch dogs mechanism, that will be commonly known as countries or national commission on HIV and the LAW, that will reduce stigma, discrimination and homophobic amongst people and create good laws that will protect the right of all. They will also identify the gaps and the needs for accelerated action. National plans and guidelines put in place will be revised in order to ensure the successful implementation of this Global commission on HIV and the Laws Plan of action at the community, national, country, regional, and international level.

D = Documentations of laws that affect the lives of people living with HIV and AIDS. Reviews the existing laws at countries level the good and bad laws that were put in place by our leaders or founding fathers. Documenting case studies, violence’s as the result of the laws. The development of different delegation to spear head work of the commission at differ level with in an existing community or country.

E = Education, education is key to every community of society. When people are educated about the laws and know how the different laws affect their lives and as of the result of this method they will start to know how to use the laws. As a common saying goes education is the best teacher.

F = Findings opportunities at the community level for projects such as the AIDS law project at counties and communities level. Without founding opportunities the commission will find it hard to carry out its work and this could lead to a set back. The establishment of global funds on HIV and the Laws should be put in place to support HIV and the Laws projects. The grants and other funding opportunities in the country and the area in most need, it should be natural to make sure that these funds will be reprogrammed to the areas that deliver the most.

G = Governments, our national governments should be held accountable for laws that they creates to dehumanize people lives and be sue for human right violations. Government should set aside special commission to look into matter affecting HIV and the IAWs at countries level.

H = Human Rights, Human rights for all regardless of sexual orientation, sexes, women, Child right, elderly people, PLWHIV etc all rights are human rights and human being are to be respected no matter what their behavior is or the cultural or traditions are.

I = Individuals rights and implementation of the commission work at countries level is important. Which people
are respected based on their individual rights as a person. The laws put in place would affect the lives of every
individual on a personal note and people will start to respect each other rights and give their views from their
standpoint on how the laws affect them. For an example a survey could be development on the basis of how
individuals see a given law with in a county and how does it affect their lives. The creations of a global steering
group or committees (GSG or C) to provide oversight on the implementation of the Global Plan and ongoing
accountability for progress towards the agreed goals of the commission should be form. Those that will be
selected of appointed as representatives of civil society organizations to serve as members of the GSG or C.
They conscious of commission’s mandates and they do represent the full range and perspectives of civil society,
particularly people living with HIV around the Globe, and encourage the UN system in countries to facilitate
wider engagement and input in this process.
K= Knowing the laws and Keeping the laws in place. When people tend to know the laws and what it is all about
they are bond to abide by the laws. As it is said the people in the bible kept the laws of God and abide by it. A
form of a book where everybody is able to carry like a bible to read every day and know their laws within their
different countries is a way forward. Knowing the disease and the epidemiology is very important.
J- Judiciary system is an important part. Encourage people from the community to participate in sections at
country level and serve as jurors as well.
L= Legal system as a way to explain the laws in a lad man tongues of views. The translation and interpretation of
the legal system in different language’s, tribe’s, dialects and vanicolours
M= Monitoring and evaluation of countries projects and reports, Motivations of groups to continues this work
and be Awarded with some form of recognition for outstanding work in the community etc.
N= Networking and Information’s sharing of best practices.
O= Organizations support and listing of all those working in HIV, Human rights and the laws to form a list server
and forum to report country responses to the commission
P= Policies, Plans, Protection, Publication produce, put in place good polices, Get a country action plans and
strategy to protect people rights and keep the laws that are made to correct good and bad.
Q= Question those laws that are questionable and those that put people at danger and those that fuel violence’s
and homophobic and crimes against minorities. Are the people affected by the current laws in countries if yes
how can we address this form of violence against a group of people? Are there updated National HIV Strategy
- or a National Disease strategy in which HIV and the Laws is included? If not (or if you have one and it is ending in
2012) it will be good to start working towards a new one. Or, if the strategy does not cover the period 2013 to
2017 then consider updating it. Are there already groups on ground working on HIV and the laws in countries to
work with or build partnership with? Are there HIV funding and grants in your country - are there any previous
HIV grants in the country, are the funds used on interventions that deliver results and can be expanded, or the
funds are used for interventions that are less efficient and therefore the funds can be reprogrammed to
something more efficient, i.e. higher impact interventions?
R= Representations of all communities on the board or steering committees from to spear head the work of the
commission at countries level (Women, Men, Boy, Girl, Youths and young Adults, Religious leaders, LGBTI,
MSM, WSW, CSW, PLWHIV, Lawyer, Etc.).
S= Speak out about the commission’s work and stop criminations of PLWHIV and Same Sex lovers or genders
around world, Drug users and sex workers. Sustainability of the commission work at country level is important.
Sustaining the gains made on HIV and the laws in countries - a special attention should be on how to sustain
the achievements made in countries and how to ensure that the national budget will contribute to programmes
HIV and the Laws and to taking over interventions that are not funded any donors.
T- Task Force creation and technical assistances given to groups working with the commission for project
implantation
U= Universal access to HIV treatment, care support, legal assistance to people needing help and the Law to
fight for their right, and discrimination cases, Access to fighting legal cases against people and providers who
breach the health information’s.
V= Visibility of the law, let people be able to see and feels the impact of the laws protecting them,
W= Women rights when the rights of women are put in place all other rights are respected because women are
peace maker and home makers. They are the first to be violated by their male’s counterpart and society at
The highest levels of victim’s domestic violence are women and sexual minorities groups in every country in the world.

X= stands for Xing out the bad laws. Discourage criminations laws and put in place better laws to protect the right of the individuals. The elimination of every form of laws that are in place against the protection of people is important in the response to HIV and AIDS i.e. Sex laws, Crimination laws, etc.

Z= Zoning of region in groups. Different countries and part of the world should be zone according to languages, geographical location, and legal systems. For example for common wealth countries, Francophone’s and Anglophones speaking should form a zoning system and working groups. Within these zones focus groups dissection should be center around the connections between HIV, the law and universal access. Selected delegation and their allies should conduct interviews at the community level and countries level throughout the entire globe with people living with HIV and affected by HIV in order to understand their knowledge of and experiences with the LAWS and to gather suggestion for solution .Data and information gather should be analyzed and summarized and submitted to the commission.

Selling sex in unsafe spaces: Sex work risk environments in Phnom Penh, Cambodia

Abstract

Background: The risk environment framework provides a valuable but under-utilised heuristic for understanding environmental vulnerability to HIV and other sexually transmitted infections among female sex workers. Brothels have been shown to be safer than street-based sex work, with higher rates of consistent condom use and lower HIV prevalence. While entertainment venues are also assumed to be safer than street-based sex work, few studies have examined environmental influences on vulnerability to HIV in this context.

Methods: As part of the Young Women’s Health Study, a prospective observational study of young women (15-29 years) engaged in sex work in Phnom Penh, we conducted in-depth interviews (n=33) to explore vulnerability to HIV/STI and related harms. Interviews were conducted in Khmer by trained interviewers, transcribed and translated into English and analysed for thematic content.

Results: The intensification of anti-prostitution and anti-trafficking efforts in Cambodia has increased the number of women working in entertainment venues and on the street. Our results confirm that street-based sex work places women at risk of HIV/STI infection and identify significant environmental risks related to entertainment-based sex work, including limited access to condoms and alcohol-related intoxification. Our data also indicate that exposure to violence and interactions with the police are mediated by the settings in which sex is sold. In particular, transacting sex in environments such as guest houses where there is little or no oversight in the form of peer or managerial support or protection, may increase vulnerability to HIV/STI.

Conclusions: Entertainment venues may also provide a high risk environment for sex work. Our results indicate that strategies designed to address HIV prevention among brothel-based FSWs in Cambodia have not translated well to street and entertainment based sex work venues in which increasing numbers of women are working. There is an urgent need for targeted interventions, supported by legal and policy reforms, designed to reduce the environmental risks of sex work in these settings. Future research should seek to investigate sex work venues as risk environments, explore the role of different business models in mediating these environments, and identify and quantify exposure to risk in different occupational settings.

Keywords: sex work, risk, environment, vulnerability, HIV, STI, young women, entertainment, Cambodia

Introduction

The literature suggests that brothel-based sex work may be safer than street-based sex work with lower HIV prevalence and higher consistent condom use documented among this group (Church et al. 2001; Remple et al. 2007). Concomittantly, several studies have shown that street-based female sex workers (FSW) may be more vulnerable to HIV and other sexually transmitted infections (STI) as they earn less from each customer, have sex with higher numbers of partners, and are more likely to use drugs (McKeganey and Barnard 1996; Pyett and...
Indeed, our previous research which documented high HIV prevalence (23%) and incidence (3.6/100 person years) among young women engaged in sex work in Phnom Penh found that freelance (street-based) FSWs were at greater risk of HIV infection compared to entertainment-based FSWs (AOR 5.85; 95% CI 1.59 –21.58) and women who reported having a boss or manager were at lower risk of infection than those who did not (Couture et al. 2011). Freelance FSWs and women who reported working in multiple venues were also older and had a longer history of employment as sex workers compared to women working in brothels and entertainment venues. Variables independently and significantly associated with prevalent HIV included street compared to entertainment-based sex work, younger age at first sex, and ever having been tested for HIV.

However, while entertainment-based sex work is assumed to be safer than street-based sex work (Remple et al. 2007), few studies have examined environmental influences on vulnerability to HIV/STI in this context (Sherman et al. 2010). The risk environment framework provides a valuable but under-utilised heuristic for understanding environmental vulnerability to HIV/STI, or the ways in which physical and social spaces determine risk and harm beyond individual behaviour (Rhodes 2009). The current study aimed to explore the relationships between sex work environments and exposure to HIV/STI and related harms.

Methods
The Young Women’s Health Study (YWHS) is a prospective observational study of young women engaged in sex work in a variety of settings in Phnom Penh. Epidemiological aims are to: 1) estimate prevalence and incidence of HIV and STIs including human papilloma virus (HPV); 2) examine the socio-cultural factors and associated risk posed by ATS use and; 3) assess rates of completion and adherence to a multi-dose vaccine regimen for the prevention of HPV among eligible participants. The study methodology has been described in detail elsewhere (Couture et al. 2011). As part of the YWHS, we conducted 33 in-depth interviews with young women engaged in sex work in brothels, entertainment venues and in streets and parks. Women were recruited through neighbourhood-based outreach by study staff employed by the Cambodia Women’s Development Association (CWDA), a community partner of the YWHS. Eligibility criteria were that women were aged 15 to 29 years, reported transactional sex (sex in exchange for money, goods, services, or drugs) within the last three months and understood spoken Khmer. Following a careful process of verbal and written consent, women were interviewed at the CWDA offices and the Cambodian Prostitutes Union Women’s Room, a community location used by various sex worker organisations in Phnom Penh. Interviews were conducted in Khmer by trained interviewers under the supervision of two medical anthropologists, including a Cambodian national, and took between 40 minutes and two hours to complete. Participants were reimbursed $USD 5 for their participation. Ethical approval for the study was provided by the Cambodian National Ethics Committee, the University of California San Francisco Institutional Review Board and the University of New South Wales Human Research Ethics Committee.

Interviews were digitally-recorded and transcribed verbatim in Khmer. Transcripts were checked for accuracy against the recordings, and translated into English. Following the general tenets and principles of grounded theory (Strauss and Corbin 1990), data were analyzed in both Khmer and English using an inductive approach. Two researchers reviewed the data, one in Khmer and one in English. Interview narratives were read and re-read and emerging themes discussed and refined to develop an initial coding scheme. Data were then formally coded in parallel by two researchers using both open and axial coding to clarify and consolidate initial themes (Ezzy 2002).

Identification of final themes and interpretation of results was performed by consensus and four key themes - limited access to prevention, intoxication with alcohol and other drugs, exposure to violence and negative interactions with the police – used to construct a typology of sex work risk environments. The relative importance of each theme within each of the three settings (brothels, entertainment venues, streets and parks) was quantified by assigning a score from 1 “Low” to 3 “High” and the scores for each theme were summed to
provide a measure of overall risk environment.

**Sex work environments**

Sex work in Phnom Penh is negotiated and transacted in a range of settings. Women reported working in brothels, massage parlours, guest houses, restaurants, karaoke establishments, bars, beer gardens, parks and on the street. All participants were classified as currently working in one of three settings – brothels, streets and parks or entertainment venues.

**Brothels**

While many women had previous experience working in brothels, only four currently worked in brothels. Brothel-based participants identified as sex workers, had no other employment and had a manager/owner. Factors identified by participants who worked in brothels as mediating occupational risk included the fact that brothels typically set the prices for services and the provision for on-site transactions and their oversight by owners/managers.

*Brothel owners set the price so I charged customers based on the price that the brothel owner set (Chantha, 29 year-old brothel-based worker).*

Yes, there is a manager. They decide money. [Does the manager take money?] Yes. [Does he also take care of the money?] Yes, we only need to have sex. [How much do you get per time?] US$ 20 (Srey Oun, 20 year-old brothel-based worker).

Most women with experience working in brothels felt that having a manager brought benefits in terms of personal safety through protection from violence and the police.

*I it is safer with a boss such as when there is a problem, they deal with it. When policeman catch us, they pay for us ... They protect us. When people fight us, they also protect us (Srey Oun, 20 year-old brothel-based worker).*

In return however, brothel-based sex workers were required to surrender a portion of their earnings. Historically, brothels in Cambodia also provided FSWs in Cambodia with a place to live, food, water, electricity and, in some cases, drugs, typically methamphetamines or yama. Women often ran “tabs” with brothel owners and some women reported “banking” their earnings with owners, withdrawing small amounts for makeup, clothes and medicine, as well as sending remittances to their families.

*I want to open my own embellishment shop (beauty salon).[How much have you saved?] I saved US$ 3,000 now. [Oh that is a lot. Where do you put your money?] I save with other people. [Who do you save with?] The boss. If I save with myself, I will spend. If I save with my boss, he will put in the bank.[Do you trust him?] I do because the identity card is with me. [Why do you trust him?] Because I also know his house. I know his character. He said if I can save money and correct myself, he is happy for me (Srey Oun, 20 year-old brothel-based worker).*

This type of informal banking system where brothel owners keep the accounts often led to sex workers accumulating significant debts. As noted by Marten (2005), women are vulnerable to being cheated by owners who manage their finances and women who are illiterate are at an increased disadvantage because they are unable to dispute the accounts.

**Streets and Parks**

Street-based workers (n=13) generally worked for themselves, typically meeting clients on the street or in parks and utilising local guest houses for transactions. Some of these women also had other means of income generation such as selling food at street stalls and few had managers. All had previous experience conducting sex work in other settings, including brothels and entertainment venues. Previous research suggests that street-based FSWs are more likely than other sex workers to report having unprotected sex in return for increased payment (Shannon et al. 2008; Johnston et al. 2010). Women working on the street may have fewer economic
options and be subject to greater pressures resulting in unsafe sex (Shannon et al. 2008). While street-based sex reported lower prices per transaction, most identified the fact that they worked independently and were able to retain all of their earnings as a benefit of street-based work.

The price for women working along the park is a bit cheaper than the price in the bars, such as French ones. Although we earn more from the bars, we also share the money with other people. For the money we earn from working near the park, we keep all the money (Srey Sor, 25 year-old street-based worker).

I don’t like having a boss. I don’t want to be under their control. They benefit from my sweat. If by myself, I can decide to do or not to do ... if we are independent, we can do anything we want. No-one controls us (Nath, 23 year-old street-based worker).

Entertainment Venues

Sex is well integrated into the entertainment industry in Cambodia, and is often just one of many services on offer. Entertainment-based workers (n=16) consisted of women who, in addition to exchanging sex for cash/goods, were employed, typically in entertainment and drinking establishments. Eight women reported currently working in karaoke establishments, seven worked in beer gardens, and one worked in a bar. These women also typically had a manager and utilised guest houses and hotels for transacting sex. Working in an entertainment venues means that a range of occupational identities, apart from that of sex worker, are potentially available to young women. These included being a waitress (Rot Tok) or hostess (O Tes).

[How many workers are there at your work place?] Well ... about 30 or 40 people. There are many departmental services. There are people who are waiter/waitress, Rot Tes (service girls), beer girl... [What kind of service do you offer?] Well, I am Rot Tes (service girl) and also ice service worker. [Are you a waitress?] Yes, I am a waitress (Rot Tok). [When you go out with customers, do you sleep with them? What kinds of service do you provide then?] Vaginal sex (Channy, 19 year-old entertainment venue-based worker).

Despite the opportunities they present for women to engage in commercial sex transactions, these venues were differentiated from brothels in that they were primarily designated as environments for drinking, eating and listening to music.

It is a normal drinking place and if the customer wants woman, they can date and go for walk, and we can go for a walk (Kannitha, 20 year-old entertainment venue-based worker).

[Normally, what service do you provide to customers?] I sit with customers, accompany them. I let them kiss and hug, and if they need sex, I can also have sex with them (Mealea, 23 year-old entertainment venue-based worker).

However, occupational identity and, in particular, identification as a sex worker, has been shown in other contexts to influence vulnerability through awareness of and adherence to occupation norms, with women who do not perceive themselves as sex workers at increased risk (Maher and Curtis 1992). For example, unlike brothels, sex negotiated in entertainment venues was transacted off-premises in guest houses and hotels.

[Usually, what services did you provide?] Take care them, eat with them and if they need sex, we can also provide them. I can go out with them but if they need sex service at that place, I can also do it because there is a hotel upstairs (Sophea, 24 year-old entertainment venue-based worker).

[When you and other women go out with the customer, how much do you get?] Fifty to sixty dollars [Does the customer have sex with you at your work place, or he takes you out?] He takes me out (Phary, 19 year-old entertainment venue-based worker).
Some women reported that owners/managers of entertainment establishments required them to pay a fee for going “home” with customers. This was in addition to the income owners made from requiring clients to purchase alcoholic drinks for women. Examining the data by occupational setting, we identified four themes influencing women’s vulnerability to HIV/STI — Access to prevention, Intoxication with alcohol and other drugs, Exposure to violence and Policing practices. Each of these is described below.

1. Access to Prevention
In 2001-2002 the Cambodian government introduced a policy of 100% condom use which required brothel owners to register sex workers and send them for monthly STI examinations. Unlike Thailand, where testing of sex workers is not mandatory and violations are verified through contact tracing of male clients who test positive for STIs, in Cambodia violations were implied by a positive STI test at a mandatory clinic visit and undercover operatives obtaining consent for sex without a condom (Marten 2005). While it was not universally enforced, the policy provided that brothels be fined and potentially closed following multiple violations. It has been reported that many brothel owners historically failed to register women and that women sometimes avoided monthly STI checks by sending other women in their place or by paying bribes (Marten 2005).

In 2009 the Ministry of Health revised its standard operating procedures for the continuum of prevention to care and treatment approach for women working in the entertainment industry. According to this document, “Cambodia’s changing epidemic … has seen a tremendous increase in the number of women working in non-brothel based entertainment establishments and changes in the nature of transactional sex over the past five years … changes in Cambodia’s policy environment, particularly the promulgation of the 2008 Law on the Suppression of Human Trafficking, which has made it more difficult to implement the existing 100% condom use programme” (Ministry of Health 2009:1). Both street and entertainment-based FSWs in our study reported being reluctant to source and carry condoms, particularly following the introduction of the new anti-trafficking law in 2008 (Plummer 2009; UNIAP 2009).

It’s hard. Hard to find place to get (condoms) (Rumduol, 27 year-old street-based worker).

[Can policeman’s activities affect women in searching for condom?] Yes, it affects. It can make women delay or miss buying condom, and we can’t sleep with customers. And we lose income (Phary, 19 year-old entertainment venue-based worker).

Entertainment-based sex workers reported having to source their own condoms because venues were reluctant to offer them in case they provided evidence of sex work on premises.

When I hold condom, they (police) will catch me because they said I am a sex worker (Ny, 27 year-old entertainment venue-based worker).

I never keep the condom with me. If I need, I will buy it and my customer also has it (Sophea, 28 year-old entertainment venue-based worker).

However, street-based FSWs were more likely to report that policing impacted their ability to access HIV prevention services, including condoms and HIV testing.

Last time the policemen ordered the sex worker at the garden to have sex with them and also make the woman eat the condom. They use their position as a policeman to order us to have sex, to eat condom and if we deny, they take out their gun and warn us (Srey Sor, 25 year-old street-based worker).

2. Intoxication with Alcohol and Other Drugs
Women also identified intoxication as a key barrier to successful negotiation of condom use (Maher et al. 2011). However, this may be a function of occupational environment, with women working in entertainment venues identifying intoxication as a near-universal characteristic of clients. Risks of entertainment-based sex work
identified by women included promotion of alcohol, heavy alcohol and amphetamine type stimulant (ATS) consumption by FSWs and clients, limited access to condoms, and demands by intoxicated clients for unprotected sex. 

*Sometimes when he is drunk he does not use condom but I told him to use it. If customer does not agree I can’t force him ... because he is too much drunk and it is useless to talk. So I have to follow him (Davy, 20 year-old entertainment-based worker).*

Alcohol use, in particular, is related to occupational settings, with women working in entertainment venues more likely to drink more than brothel or street-based FSWs (Li et al. 2010). In contrast, some research suggests that street-based sex workers may refrain from drinking as a protective strategy and a way of maintaining some control (Agha and Nchima 2004).

*When the alcohol gets in, he always requests me not to use condom (Srey Mao, 27 year-old entertainment-based worker).*

The literature suggests that ATS use has a disinhibiting effect on sexual decisionmaking (Halkitis and Jerome 2008) and is associated with unprotected sex (Molitor et al. 1998; Couture et al. in press). Women in the current study who worked in entertainment venues reported that drug use reduced inhibitions.

*At my workplace, some customers drink the shaking pill (ecstasy). I worked and I used to drink in a situation that a customer put the drug in my drink and I did not know. I drank it, and kept shaking (Sophea, 24 year-old entertainment-based worker) [T]he shaking drug is used at the working place because it can make us lose memory and can do naked dance so the customers also finds us pretty and they want us (Mealea, 23 year-old entertainment-based worker).*

However, they also reported that ATS use, while functional in facilitating sex work and lowering inhibitions (Maher et al. 2011), impaired condom negotiation skills. Clients may also be more likely to seek out those who use drugs in order to manipulate their vulnerability to negotiate sex without condoms (Strathdee et al. 2008; Johnston et al. 2010).

*Using drug makes us unconscious, hang over and forget a lot. So, we may not know if the customer does not use the condom because we don’t negotiate with them (Sophea, 24 year-old entertainment-based worker). [I]t made us happy, not afraid and have many partners without condom (Rany, 20 year-old entertainment-based worker). When using the drug, it makes us brave to face with HIV/AIDS and STDs ... forget to use condom. Yes, so happy and forget to use condom (Roth, 19 year-old entertainment-based worker).*

In a study of exotic dancers in Baltimore, Sherman et al. (2010) found that crack cocaine smokers were more likely than women who did not smoke crack cocaine to engage in transactional sex. Similarly our results suggest that ATS use may provide both a coping mechanism for women and a way to reduce their inhibitions in conducting sex work.

### 3. Exposure to Violence

Almost all women reported exposure to violence, including acts perpetrated by clients, gangsters, owners/managers, partners and police.

*I used to be threatened by the gangsters several times. [I see. Do they threaten you? Do you agree with them?] Yes. They curse and look down on us. [I see.] They brought me to their house and they threatened me. They use a club to threaten me (Tin, 27 year-old street-based worker).*

Consistent with the literature (McKeganey and Barnard 1996; Church et al. 2001; Shannon et al. 2008, 2009a;
Johnston et al. 2010; Zhang et al. in press), street-based sex workers reported particularly high levels of violence, including sexual violence.

It is so difficult for a sex worker like me who works at garden, along the street Tuol Kork, Street 271. Sometimes, customers wear civilian clothes but they are soldiers ... He took me to his camp and there were 20-30 soldiers. I could not go anywhere ... I begged them not to have sex with me too much for I did not have power. I did not say I got [HIV] disease, because they hate it and I am afraid they would kill me (Ny, 27 year-old street-based worker).

Street and entertainment-based FSWs who transacted sex off-site were also more likely to report being forced to have sex with multiple clients. 

They took me by car to a guesthouse and they force me to have sex with 4 other men ...
Not used condom because it was a force (Srey Mao, 27 year-old entertainment based worker). 

Sometimes, there is only one man who brings us out with him. But when we arrive his place, there are 4 or 5, 6 or 7 men at his place. [Where do they bring you?] Sometimes to a guest house, sometimes not the guest house, but at other place which is quiet (Phary, 19 year-old entertainment-based worker).

Reports of physical violence were particularly high among street and entertainment-based FSWs who used guest houses to transact sex.

The guest house owner did not help women no matter how women were beaten, they never stop the customers. The workers of the guest house also scolded me (Srey Sor, 25 year-old street-based worker).

High levels of violence among women working in street and entertainment venues suggest that typologies of sex work which focus on the type of sex worker may obscure the role of the environments in which sex is transacted, in mediating risk. In contrast, brothel-based sex workers reported being protected from violence by clients and from the police, by owners/managers (Me-Kars).

I have boss to protect me then customers dare not to look down on me. For women who have no boss, they may be mistreated (Srey Mom, 20 year-old brothel-based worker).

20 If someone hurts us, they protect us. No one can look down on us. If we have any problem, they come (Srey Oun, 20 year-old brothel-based worker).

Exposure to violence is clearly mediated by sex work setting, with women reporting that in contrast to street and entertainment-based sex work, brothels historically provided potential oversight of transactions and some measure of protection for women. For entertainment and street-based FSWs, transacting sex in guest houses and hotels was identified as increasing vulnerability to sexual and physical violence.

4. Policing Practices

Interactions with police were also determined by sex work settings. Women reported that brothel and entertainment venue owners often paid the police.

Policemen come to get money but they get it from the restaurant owner not the women. So they get money from the restaurant owner (Davy, 20 year-old entertainment venue-based worker).

[Does policeman make any trouble to you at your workplace?] No. We already pay the policemen. They do not come and make any trouble to us. [In case policemen come and make any trouble to you, what is your strategy to solve the problem with them?] I will call the boss to solve it (Cheata, 18 year-old entertainment venue-based worker).
Entertainment-based sex workers reported infrequent interactions and few problems with the police. [Have you ever had problem with policeman?] No. [Is there policeman going to the restaurant?] Yes, there is. They go there for eating and drinking. They don’t care about this matter (Phary, 19 year-old entertainment venue-based worker).

We (venue) already pay the policemen. They do not come and make any trouble to us (Cheata, 18 year-old entertainment venue-based worker). If women has manager, their manager will solve the case with policemen to release women (Pally, 29 year-old street-based worker).

As has been documented in other settings, street-based sex workers were more likely to report being targeted by police and subjected to a range of abuses including extortion, forced sex and other violence (USAID 2006; Human Rights Watch 2010).

I don’t have any manager. I work independently by myself. I work near the park every day and the policeman chases me, kicks and uses violence on me, so I cannot earn much. I am starving and have no money to pay for house rental fee, water and electricity. The house owner kicks me out of their house. I stay out homeless under the rain while the policeman also chases me so I need to work very hard to earn money (Srey Sor, 25 year-old street-based worker).

I work by myself independently. Now I cannot earn much because the policeman chases me a lot (Srey Sor, 25 year-old street-based worker).

Last time he (police boss) was so cruel. He hit a woman with the tree till she was unconscious (Phalla, 19 year-old street-based worker).

Policeman came to catch us, chase us not to do sex working ... They fight, they kick and slap (Leak, 23 year-old street-based worker).

Street-based FSWs were also more likely than either brothel or entertainment-based sex workers to report being sent by the police to mandatory detention or correction centres (Human Rights Watch 2010). They [police] told us to go to the center and hit us seriously. [What did you do at the center?] We learnt to sew ... They educate us...we learnt how to sew pillow. We learnt to sew pillow and they said if we know how to do it, we will be released. We did not learn. We wanted to come back home; we have husbands, we cannot be there. [What did they say?] They did not allow and asked us to stay 3-5 months. If we know how to do, we can go back. We did not agree; we wanted to go back. They locked the door. I secretly escaped by crashing the door. My leg got a scar. The wall was full of broken glasses (Nath, 23 year-old street-based worker).

According to the National AIDS Authority, “The 2008 Law on the Suppression of Human Trafficking and Sexual Exploitation has led to fundamental changes in the entertainment establishment environment with brothel closures and sex workers enduring more harassment and arrests than in the past. The legislation has had negative effects on HIV prevention efforts as it has made it more difficult to reach out to women and girls who sell sex” (2011: 30-31). This was confirmed by women in the current study, with former brothel-based FSWs reporting being displaced to entertainment venue and street-based sex work following the introduction of the new law.

Before we have our own house but now we need to go to guest house and need to take time to bargain about the price (Vy, 27 year-old street-based worker).

Yes, I was told that they will catch. Before (the new law) they did not catch because we paid money, but now no matter how much we pay, they need to close (Srey Oun, 20 year-old brothel-based worker).

However, our data suggest that brothel owners in Phnom Penh appear to have modified the way they conduct business rather than exit the market. One risk management strategy on the part of brothel owners identified by
women was that brothels no longer accommodated FSWs on-site. Women reported that, following the crackdown, they rented private accommodation which was sometimes paid for by brothel owners. 

There is only one boss...but now he is caught and live in different place ...They rent for me. [They rent for you but you have to live outside?] Right, live outside. [They only need to pay for you?] They paid. We live in a different room to room because we are afraid of policeman. [In the past, they rent for you and lived together?] Right, we have 3-4 people if we are together. [And the rented place is far?] A bit far. [Do you need to ride motorbike or you can walk there?] I take motor taxi (Laughs) [So, you pay for motor taxi driver?] They paid. [How do they prepare motor taxi?] Yes, they rent in a month. When it is time we need, the motor taxi driver comes ... The working place is the same. We are together at workplace. [So, customers will go to that place?] Yes, to that place they know. We work together at work place and we sleep in different places (Srey Oun, 20 year-old brothel-based worker).

[Are you under control of a brothel owner?] I lived with a brothel owner. [How about now?] Now, policemen arrest all brothel owners (laughs) so, I rent a house to live. [How many women are there at your work place?] About ten women (Bopha, 24 year-old brothel-based worker).

She [boss] rent a separate house for me to stay. She did not allow me to stay with her ... [So does the boss go with you when you go with customers or what?] She is afraid that I take away the money so she waits to get money first before I go to sleep with customer at a guesthouse (Srey Mom, 29 year-old brothel-based worker).

This adaptation, as well as the shift from transacting sex on-site to guest houses and hotels described above, represents a form of risk displacement from owners/managers to women.

Table 1: Vulnerability to HIV/STI by Risk Environment

<table>
<thead>
<tr>
<th></th>
<th>Brothels</th>
<th>Entertainment venues</th>
<th>Streets &amp; parks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limited access to prevention</td>
<td>1</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Intoxication with alcohol and other drugs</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Exposure to violence</td>
<td>2</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Aggressive policing practices</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Risk environment *</td>
<td>6 (Medium)</td>
<td>10 (High)</td>
<td>11 (High)</td>
</tr>
</tbody>
</table>

Key: Low = 1, Medium = 2, High = 3

Table 1 presents a typology of sex work environments identified in our study by the four key dimensions of environmental vulnerability - limited access to prevention, intoxication with alcohol and other drugs, exposure to violence and negative interactions with the police - which emerged from the qualitative data.
Summarising the scores across all four dimensions allows us to visualize the occupational field. While brothels rank as medium risk, entertainment venues represent a high risk environment and street-based sex work provides the highest risk environment according to our classification.

**Conclusions**

The sex work landscape in Cambodia has undergone significant changes in recent years. Between 2002 and 2009 there was a 300% increase in the estimated number of FSWs. During the same period, the nature of sex work has undergone a fundamental shift, with a steady decline in the proportion of brothel-based FSWs and an exponential increase in entertainment-based FSWs. Estimates suggest that in 2009 there were a total of 36,713 FSWs in Cambodia. Of these only 4% identified as brothel-based with the remaining 96% or 35,535 women non brothel-based (http://www.nchads.org/BCC/EW/2009%20q4%20EW.pdf).

This shift was clearly accelerated by the implementation of the new anti-trafficking law by the Cambodian government in early 2008. While ostensibly designed to suppress human trafficking and sexual exploitation “in order to protect the rights and dignity of human beings, to improve the health and welfare of citizens, to preserve and enhance good national customs, and to implement the UN Protocol to Prevent, Suppress and Punish Trafficking, community groups, human rights advocates and the National AIDS Authority have reported that the new law has displaced sex workers, increased their exploitation and reduced their access to condoms and health care (National AIDS Authority 2010). Indeed, Family Health International report a 26% reduction in women seeking STI services, a 16% decrease in HIV testing uptake and a 46% increase in the number of women working on the street following the introduction of the law (Francis 2008).

Our study is the first to identify environmental influences on vulnerability to HIV/STI among FSWs in this context and has implications for policy and programs designed to prevent or reduce HIV/STI in sex workers more generally. In particular, results suggest that removing restrictive legal sanctions that inhibit condom use, reducing violence against sex workers and avoiding aggressive policing approaches, are necessary to reduce the occupational risks of sex work.

Findings presented here are consistent with previous research which suggests that street-based sex work places women at increased risk for HIV/STI infection (Couture et al. 2011) and that this risk is mediated by violence and aggressive policing (Shannon et al. 2009b; Rhodes et al. 2008). Sex workers who experience violence are more likely to report events that put them at higher risk of STI, such as higher rates of anal sex and condom failure (Shannon and Csete 2010; Decker et al. 2010; Shannon et al. 2009a).

While evidence suggests that FSWs in Cambodia experience high levels of violence (USAID 2006), how this impacts on sexual risk and condom use is not well understood. Our results suggest that the association between violence and condom use is mediated by the environments in which sex is sold. The data presented here also indicate that interactions between sex workers and the police are mediated by the settings in which sex is both negotiated and transacted. In particular, following the 2008 police crackdown, while sex continues to be negotiated in a range of settings, including in brothels and on the street, more women are now transacting sex in risky environments such as guest houses where there is little or no oversight, support or protection.

Police crackdowns are a familiar public policy response to sex work and drug use, globally (Human Rights Watch 2003, 2010; Open Society Institute 2009; Blankenship and Koester 2002). However, a growing body of research identifies negative outcomes for drug users, including disruption of peer networks, displacement, and increased vulnerability to violence and blood-borne pathogens (Maher and Dixon 1999; Wood et al. 2004; Cooper et al. 2004; Davis et al. 2005; Pollini et al. 2007; Werb et al. 2009). Our findings suggest that enforcement based approaches to sex work also risk significant adverse public health consequences and support global calls for the removal of criminal sanctions targeting this group (Shannon et al. 2009a).
Our results suggest that, in some settings, entertainment venues may also provide a high risk environment, especially where alcohol and other drug use is a feature of the environment and where sex is transacted off-site. Using the risk environment framework developed by Rhodes (2009) we identified a number of risks specific to this setting, including the promotion of alcohol and heavy alcohol consumption by FSWs and clients, limited access to condoms and demands by intoxicated clients for unprotected sex. A recent review identified strong cultural norms around drinking and visiting sex workers with “pro-alcohol environment, norms and practices ... embedded in the ‘routine’ activities of commercial sex work” (Li et al. 2010: 196) and women working in entertainment venues more likely to drink more than brothel or street-based FSWs (Li et al. 2010).

While ATS use was prevalent among women working in all three settings (Maher et al. 2011), women working in entertainment venues, many of whom may not identify as sex workers, were more likely to be exposed to alcohol and to report alcohol-related intoxication. Our data suggest that several features associated with these settings produce risk beyond that of individual behaviour and that typologies of sex workers may serve to obscure the crucial role of sex work settings in mediating risk. Our results suggest a need for targeted interventions, supported by legal and policy reforms, including support for sex worker advocacy organizations, that attempt to reduce the occupational risks of sex work in specific settings. While most interventions targeting FSWs to date have focussed on individual behaviour change, environmental interventions which seek to reduce or ameliorate the hazards associated with the venues in which sex is sold have the potential for greater effectiveness in facilitating behaviour change (Sherman et al. 2010). Finally, the data presented here indicate a need for further research that seeks to investigate sex work venues as HIV risk environments, explore the role of different business models in mediating these environments, and identify and quantify exposure to risk in different occupational settings.

To the Members of the Global Commission on HIV and the Law,

The International Labour Organization (ILO) acknowledges the important contribution to the HIV response of the work undertaken by the Global Commission on HIV and the Law in gathering information on national legal and policy frameworks relevant to HIV and AIDS and their application in practice. ILO trusts that the Commission will address the essential issue of HIV-related stigma and discrimination in employment and occupation in its evaluation of national legal and policy responses, and that its recommendations will urge countries to take measures to prevent and prohibit all forms of stigma and discrimination in the world of work on the basis of real and perceived HIV status.

Governments and international bodies have long recognized the human rights dimension of the HIV pandemic, and the need to provide protections for persons living with or affected by HIV from all forms of discrimination, including in employment. The 1996 International Guidelines on HIV/AIDS and Human Rights called on governments to “enact or strengthen anti-discrimination and other protective laws that protect vulnerable groups, people living with HIV/AIDS and people with disabilities from discrimination in both the public and private sectors, ensure privacy and confidentiality...and effective administrative and civil remedies.” 1 In referring to the principle of non-discrimination, the Guidelines noted the particular relevance of ILO conventions and recommendations, “such as ILO instruments concerning discrimination in employment and occupation, termination of employment, protection of workers’ privacy, and health and safety at work”.

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The Declaration of Commitment on HIV/AIDS adopted by the United Nations General Assembly Special Session on AIDS (UNGASS) in June 2001 called for governments to strengthen or enforce legislation, regulations and other measures to eliminate discrimination and protect the human rights of people living with HIV and vulnerable groups in all aspects of their daily lives, including in employment (at paragraph 58). The 2001 Declaration recognized the importance of developing and implementing legislation to protect the human rights at work of persons living with HIV and AIDS as well as key vulnerable groups. Paragraph 69 of the Declaration called on governments ‘…. to develop national legal and policy frameworks that protect, in the workplace, the rights and dignity of persons living with and affected by HIV and AIDS, and those at greater risk of HIV and AIDS, in consultation with representatives of employers and workers, taking account of established international guidelines on HIV and AIDS and the workplace.’

Many countries have now adopted legislation dealing specifically with workplace issues related to HIV and AIDS that addresses stigma and discrimination in employment and occupation. 2 The nature and extent of measures taken varies between countries and regions. Some countries have provided for protections against HIV-related discrimination through general AIDS laws, 3 equal opportunity legislation, general labour laws, including codes of conduct on HIV and AIDS and employment 4 or disability legislation. Others have interpreted general constitutional provisions on equality to cover HIV and AIDS. 5

A national legal framework protecting rights at work not only protects workers living with or affected by HIV or AIDS—including job applicants and job seekers—from discrimination, but also supports effective HIV prevention efforts and helps to reduce the impact of HIV and AIDS on workers, their families and dependents. The ILO provides technical advisory support to its tripartite constituents (governments, and employers’ and workers’ organizations) and other relevant stakeholders in developing laws and policies to protect workplace rights, and to labour administrations and national judicial authorities to promote implementation of protective legislation. Despite progress made in the development and implementation of laws and policies aimed at protecting the human rights of persons living with and affected by HIV, including key vulnerable groups, HIV-related stigma and discrimination remains widespread. 6 Many employers consider HIV to be a condition that renders people unfit for work. Where a worker’s HIV-positive status is known to an employer, the worker may either be denied employment or summarily dismissed. HIV-related stigma is also common, and is due both to beliefs linking HIV to “immoral” behaviours as well as to misconceptions around the means of transmission. As a result of these misconceptions, many employers and co-workers may believe (wrongly) that an HIV-positive co-worker poses a safety risk in the workplace. Stigma leads to fear in the workplace, causing workers to be ostracized and in many cases to be forced out of employment, and in some cases courts have even supported such actions. 7

As noted in the Report of the Secretary-General of 28 March 2011, three out of ten countries have not adopted effective measures to protect persons living with HIV from discrimination. The Secretary-General observed that “in many countries, people living with HIV are at high risk of losing their homes, employment, property and inheritance due to inadequate protection.” 8 The Report cites the results of an international survey of persons

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4 For example, the South African Code of Good Practice on Key Aspects of HIV/AIDS and Employment (2000) was promulgated under the Employment Equity Act, Act No. 55 of 1998.
5 In Hoffman v. South African Airways, CCT 17/00, 28 September 2000, the Constitutional Court of South Africa interpreted the South African Constitution as providing protections against discrimination on the basis of HIV status. On this basis, the Court concluded that refusal to hire an otherwise qualified HIV-positive job applicant was discriminatory.
7 As an example, in a ruling issued on 17 February 2009 (Case No. 676/2009), the Greek Supreme Court upheld the dismissal of an HIV-positive worker as reasonable, citing the pressure put on the employer by co-workers who refused to work with their HIV-positive colleague once his status became known.
living with HIV in 2010, which found that “more than one-third had experienced loss of employment, denial of health care, social or vocational exclusion and/or involuntary disclosure.”

Recognizing the need to address HIV-related stigma and discrimination in workplace settings, the 2011 Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS calls on governments to “commit to mitigate the impact of the epidemic on workers, their families, their dependants, workplaces and economies, including by taking into account all relevant conventions of the International Labour Organization, as well as the guidance provided by the relevant International Labour Organization recommendations, including Recommendation No. 200, and call on employers, trade and labour unions, employees and volunteers to eliminate stigma and discrimination, protect human rights and facilitate access to HIV prevention, treatment, care and support.”

ILO Action on HIV and AIDS

As the United Nations specialized agency mandated to develop and supervise international labour standards, the International Labour Organization has developed standards to guide national HIV responses aimed at preventing and prohibiting HIV-related stigma and discrimination in the world of work. The HIV and AIDS Recommendation, 2010 (No, 200), the first international labour standard focusing on HIV and AIDS in employment, calls for the adoption of comprehensive protections against stigma and discrimination on the basis of real or perceived HIV status. The Recommendation builds on the ILO Code of practice on HIV/AIDS and the world of work (2001), which provided for key principles to guide workplace responses at national, sectoral and enterprise levels, including the principles of non-discrimination and gender equality.

Recommendation No. 200 supports explicitly the development of anti-discrimination legislation, calling for governments to adopt existing measures or put new ones in place where national legislation providing for protections against discrimination is inadequate (Paragraph 12). Recommendation No. 200 also calls for development of a policy framework for the workplace, calling on governments to adopt national policies and programmes on HIV and AIDS and the world of work and on occupational safety and health, where they do not already exist; and to integrate these policies and programmes into development plans and poverty reduction strategies, including decent work, sustainable enterprises and income-generating strategies. These policies and programmes should be developed through an inclusive participatory process, in consultation with employers’ and workers’ organizations as well as taking into account the views of organizations of PLHIV and other relevant sectors.

Recognizing that discrimination hinders efforts to prevent HIV and reduce its impacts, including at the workplace, many companies have adopted policies declaring a policy of zero tolerance for discrimination in the workplace and have taken steps to ensure that HIV status is not a factor for consideration in any aspect of the employment relationship, including recruitment and selection, remuneration and other conditions of work, training opportunities, promotion, access to benefits or termination. Through workplace prevention programmes, enterprises, working in collaboration with workers’ representatives, have applied these policies, raising awareness of HIV and reducing risk behaviours while also reducing HIV-related fear and stigmatisation. In addition to providing reasonable accommodation where appropriate, workplaces can put into place good practices such as job sharing and pooling of sick leave to assist workers living with HIV or HIV-related illnesses as well as those who may have care giving responsibilities for HIV-positive family members or dependents in addition to their work responsibilities.

The Recommendation applies to all workers, regardless of whether they are seeking work or are already in employment, and regardless of the type of work or sector—formal or informal—in which they are engaged. Its provisions extend to family members and dependents as well as to persons belonging to key vulnerable or at risk groups, and to the armed forces and uniformed services. It provides that there should be no discrimination against or stigmatization of workers (particularly job seekers and job applicants) on the grounds of real or perceived HIV status, or the fact that they belong to regions of the world or segments of the population

9 Id., at paragraph 32.
10 United Nations General Assembly, A/65/L.77, 8 June 2011, at paragraph 85.
perceived to be at greater risk of or more vulnerable to HIV infection (paragraphs 3(c)). It also provides that there should be no mandatory HIV testing for employment purposes, and that workers, their families and dependents should enjoy protection of their privacy, including confidentiality related to HIV and AIDS. Workers should not be required to disclose their own HIV status or that of others (paragraphs 3(h) and (i), 24-29).

Recommendation No. 200 provides for protections against discrimination in all aspects of employment, including recruitment, terms and conditions of employment and protection from unjustified dismissal. Paragraph 10 of the Recommendation provides that “real or perceived HIV status should not be a ground of discrimination preventing the recruitment or continued employment or the pursuit of equal opportunities consistent with the provisions of the Discrimination (Employment and Occupation) Convention, 1958 (No. 111).” Paragraph 9 invites governments, in consultation with the most representative groups of employers and workers, to consider extending protection equal to that available under Convention No. 111 to prevent HIV-related discrimination. ILO Convention No. 111 is the key international instrument establishing the right of equality of opportunity and treatment in employment and occupation. It prohibits any distinction, exclusion or preference which has the effect of nullifying or impairing equality of opportunity and treatment in access to jobs, training, promotion, security of tenure, terms and conditions of work (including remuneration, leave, social security and other employment-related benefits). Convention No. 111 covers both direct and indirect discrimination and also provides for positive measures designed to meet the particular needs of persons requiring special attention, for example, persons with disabilities. This aspect of Convention No. 111 could be helpful in providing for special protections in national legislative frameworks for persons belonging to vulnerable groups.

In seeking to prevent HIV-related discrimination in the world of work, it should be recalled that not only do stigma and discrimination prevent persons living with or affected by HIV or AIDS from having access to work and to equal conditions of work, in many countries it prevents them from entering into or engaging in specific occupations. Convention No. 111 also specifically addresses the concept of employment and occupation in its Article 1(3), which defines employment and occupation as including “access to vocational training, access to employment and to particular occupations, and conditions of employment.”

The Recommendation provides that real or perceived HIV status should not be a cause of termination and that persons with HIV-related illness should not be denied the possibility of continuing to carry out their work, with reasonable accommodation if needed (paragraphs 11 and 13). In addition, the Recommendation provides for equal access for workers and their dependants in access to social security systems and occupational insurance schemes, as well as in access to benefits under those schemes, such as for health care and death and disability benefits (paragraph 20). It supports explicitly the development of anti-discrimination legislation, calling for governments to adapt existing measures or put new ones in place where protections against discrimination are inadequate (paragraph 12).

The Impact of Recommendation No. 200

Recommendation No. 200 has already influenced the development of national legislation on non-discrimination. Since its adoption, the Recommendation’s key principles on non-discrimination and protections against employment-related screening and unjustified dismissal have also been cited in national jurisprudence to uphold individual workplace rights.

On 16 February 2011, in the case of *Gary Shane Allpass v. Mooikloof Estates (Pty) Ltd*, (Case No. JS178/09), the Johannesburg Labour Court found that the complainant had been discriminated against and unfairly dismissed due to his HIV status and awarded him compensatory damages and costs. The Court considered that the dismissal violated the equality rights enshrined in [subsections (a) and (b) of section 9 of] the Constitution of the Republic of South Africa Act, No. 108 of 1996. The Court also considered that the dismissal violated [sections

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13 See, for example, the Law on HIV and AIDS, Law No. 135-11, adopted by the Dominican Republic on 7 June 2011.
In 2011, the Brazilian Federal Superior Labour Tribunal issued two rulings finding in favour of an HIV-positive
worker: Adriana Ricardo da Rosa contra Sociedade de Ônibus Porto Alegrense Ltda. – SOPAL (Case No. TST-RR-
104900-64.2002.5.04.0022, issued 3 August 2011) and Edson Osório Leites contra SOGAL – Sociedade de Ônibus
Gaúcha Ltda (Case No. TST-RR-61600-92.2005.5.04.0201, issued 22 June 2011). The Tribunal held in both
cases that the workers had been discriminated against and unfairly dismissed on the basis of their HIV status,
ordering that they be reinstated and compensated for lost wages and benefits.

The complainants in the Brazilian labour court cases argued that their dismissals were due to their HIV-positive
status, that the employers’ actions were discriminatory and violated their fundamental rights under the
Brazilian Constitution. In the decisions, the Tribunal referred to the same two ILO international labour
standards: Convention No. 111 and Recommendation No. 200. The Tribunal observed in both cases that
Recommendation No. 200 prohibits discrimination against HIV-positive workers and provides that member
States should ensure that workers not be discriminated against or stigmatized because of their real or perceived
HIV-status.

The Tribunal referred in both cases to paragraphs 10 and 11 of Recommendation No. 200, which provide that
real or perceived HIV status should not be a ground of discrimination preventing recruitment or continued
employment and that it should not be a cause for termination of employment. The Tribunal decision also
emphasized that Recommendation No. 200 calls for ILO member States to promote the retention in work and
recruitment of persons living with HIV.

Challenges in Establishing and Implementing Enabling Legal Frameworks

While the national legislative frameworks adopted by most countries contain at least some provisions
protecting the rights of persons living with and affected by HIV or AIDS, these take different forms depending
upon the circumstances of each country and coverage provided may be partial. There may be no provision for
protection against discrimination in employment and occupation or coverage may be limited. For example,
legislation providing explicit protection against discrimination on the basis of HIV status may provide
protections for workers but not job applicants. Providing protections for workers but omitting jobseekers fails to
protect against discrimination in recruitment and selection processes.

In addition, it is crucial to extend workplace protections to workers in all sectors. Those working in the armed
forces and uniformed services are often excluded from coverage under labour laws, as are domestic workers,
but both are explicitly covered by the Recommendation. An example of good practice in this regard is article 3
of Mozambique’s Law No. 5/2002 which “applies to all workers and job applicants in the public and private
sectors, including domestic workers”.

Protections against mandatory HIV testing for employment purposes should be strengthened. Where countries
do provide protection from mandatory testing there may be exceptions that enable employers to require
testing despite legislative protections to the contrary. In certain cases job applicants or workers are tested for

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14 The full text of the rulings (in Portuguese only) are available on the ILO website at http://www.ilo.org/aids/lang--
en/index.htm
HIV during entrance or periodic medical examinations without their knowledge or consent. The first they may know of their HIV-status may be through a rejection or termination letter. In addition, consideration should be given to ensuring that consent given to HIV testing in the employment context be genuinely voluntary and that informed consent was given. This is particularly crucial given the unequal bargaining power that exists between employer and employee or job applicant. Informed and genuinely voluntary consent to HIV testing for employment should be required, as contemplated in paragraph 24 of Recommendation No. 200. The national legislation should also provide protection against retaliation by an employer where a job applicant or worker refuses to undergo an HIV test for employment.

The employer must also be placed under an obligation to maintain the confidentiality of the worker’s HIV status. Disclosure of an individual’s HIV status by an employer can have devastating results for the worker affected where a discriminatory working environment exists.

Where comprehensive positive legal frameworks exist, they may not be sufficiently broad to protect those who encounter stigma and discrimination not because they are living with HIV in fact, but because of their perceived status. Provision should be made to ensure that those who may be discriminated against because they belong, or may be thought to belong, to a group perceived to be at higher risk of HIV infection (for example, migrant workers from high HIV-burden countries or men who have sex with men) are protected from discrimination at work.

In addition, it is important to ensure comprehensive protections as concerns all aspects of the employment relationship, including robust provisions against unjust dismissal and ensuring equality of access to employment-related benefits, such as health, disability and life insurance.

Where comprehensive protections exist, provision should be made for effective enforcement mechanisms and procedures. Recommendation No. 200 calls for the establishment of easily accessible dispute resolution procedures which provide redress for violations of rights. To be accessible, the national mechanisms must be either free or affordable, particularly for workers who may have suffered loss of their job or livelihood due to discrimination and therefore lack the financial means to initiate costly litigation. Lengthy delays in judicial proceedings may also deter workers from claiming their rights. Fast-track procedures in HIV and AIDS employment-related cases would not only better meet the needs of a worker who has lost his or her employment but would also address the concerns of workers with AIDS-related illness for whom delays in justice mean justice denied. In addition, to be accessible, national mechanisms and procedures should provide for access to legal services or other assistance for workers who may require help to understand and invoke the procedures available.

Provisions should be made to protect the privacy and confidentiality of workers seeking redress through national mechanisms. Even where workers assert their right to be free from HIV-related stigma and discrimination in the workplace, the media attention drawn to their cases may have profound negative consequences on the worker’s professional and personal lives. Unwanted media scrutiny may deter many workers from filing otherwise meritorious claims. Such protection should extend not only to the complainant, but also to witnesses whose testimony may be vital to the success of the claim. The burden of proving discrimination in a workplace setting can also pose significant obstacles to a worker. Often, documents and records necessary for the establishment of a prima facie claim of discrimination are in the hands of the employer or another third party, and the job applicant or worker may not have access to needed evidence. In such cases, placing the burden of proof on the worker may once again lead to denial of justice in meritorious claims. For this reason, many jurisdictions have provided for a shifting burden of proof. Examining the issue of burden of proof in two cases involving allegations of unjust dismissal, the Brazilian 15 See, for example, Kingaipe v. Attorney General, Zambia High Court, Judgement No. 2009/HL/86, 27 May 2010, in which the complainants were subjected to HIV testing without their knowledge while employed by the Zambian Air Force.
Federal Superior Labour Tribunal concluded that the respondent employer --not the complainant—had the duty of proving that the dismissal was not due to the complainant’s HIV status. 16

Recommendations and Conclusions

There are significant gaps in protection from HIV-related stigma and discrimination in employment and occupation in many countries, with coverage being either fragmented or merely inadequate. It is recommended that reviews undertaken of national legal frameworks examine all aspects of the national legislation relevant to HIV and AIDS to ensure overall coherence. Such a review should include civil, criminal and labour legislation as well as regulations pertaining to occupational safety and health and other relevant regulations. For example, a provision in the labour law might prohibit discrimination in employment on the basis of real or perceived HIV status, while mandatory HIV testing is nevertheless required for certain occupations under national health regulations, with an HIV-positive diagnosis excluding the individual from engaging in the particular profession. Such discrepancies should be identified and addressed to ensure comprehensive protections against HIV-related discrimination.

In addition to law reform efforts, enforcement and access to justice issues should be addressed. Effective, independent and easily accessible national mechanisms need to be developed and supported. Moreover, complainants whose rights have been violated on the basis of HIV status, whether real or perceived, should have free or affordable access to legal services and be able to avail themselves of fast-track procedures to protect their rights while also safeguarding their privacy interests.

Finally, to ensure that protective laws are invoked and applied, it is necessary to disseminate information in accessible format and as widely as possible so that members of the public know what their rights are under the national legislative framework and can take steps to invoke the protections available. This is particularly important given that many of those who may experience HIV-related discrimination, both in the working environment and outside of it, also belong to groups that may be particularly vulnerable or marginalized for other reasons, including migrant workers, sex workers, men who have sex with men and injecting drug users. For the law to be an effective tool for HIV prevention and to prevent stigma and discrimination, it must be disseminated to the public and made accessible to all.

16 Supra at footnote 14.
The Network of Low HIV Prevalence Countries in Central and South East Europe (NeLP) is a developing network of HIV activists from 16 countries of the region. It was established during the first meeting of the NeLP partners held in Budapest from 24 to 27 June 2011 upon the initiative of the HIV/AIDS programme of the Hungarian Civil Liberties Union. Initial activities are funded by the East East: Partnership Beyond Borders of the Open Society Foundations, and additionally supported by the European AIDS Treatment Group (EATG) and International HIV Partnerships.

The aim of this submission is to approach the Global Commission on HIV and the Law to take into consideration the specific issues which PLHIV, as well as populations most at risk of HIV, are facing in this LP region, before finalizing their recommendations. We strongly believe that the efforts of the Commission can have an important impact for the benefit of people confronting HIV in Central and South East Europe.

The Budapest Declaration

During their initial meeting, NeLP partners of all 16 represented countries launched the Budapest Declaration with the aim of drawing attention to the need of substantial strengthening of the response to HIV in this LP region. The Declaration is founded on the consideration of issues specific to the low HIV prevalence countries, quite often neglected and undermined, especially when compared to the more easily perceived serious conditions in high HIV prevalence environments in the broader region of Eastern Europe and Central Asia. Furthermore, it points out that what is now high prevalence in many countries in the World, started as once low prevalence.

Basic considerations of the Declaration

The low number of people living with HIV, as well as medical staff and supporters, leads to a rather limited capacity to respond to the epidemic. While HIV is not perceived as a major problem by the respective national governments, people living with or affected by HIV face the same problems as people in high prevalence countries, including violations of human rights, limited access to treatment and quite often very low standard of care.

Despite the support many of our countries have received by the Global Fund to Fight AIDS, Tuberculosis and Malaria, very few of them have managed to implement coordinated and effective national HIV strategies. In such circumstances, the Global Fund withdraws without having secured sustainable national responses to the epidemic.

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1 Albania, Bosnia & Herzegovina, Bulgaria, Croatia, Cyprus, Czech Republic, Greece, Hungary, Kosovo, Macedonia, Montenegro, Romania, Serbia, Slovakia, Slovenia and Turkey
2 The whole text of the Budapest Declaration can be seen at [http://www.nelp-hiv.org/budapest-declaration](http://www.nelp-hiv.org/budapest-declaration)
... and its major concerns

Much work needs to be done not only to provide life-saving treatments, but also to refine entire national programs dealing with all aspects of HIV. In most of our countries, services for people living with HIV and those most vulnerable to HIV infection are underdeveloped and below the standards of most European countries.

Our civil societies, stunted by authoritarian regimes, need empowerment, strengthening and, most important, funding. Poor HIV conditions here are manifestations of deep systemic problems in most of our health care systems.

The Declaration calls in particular on the governments and other stakeholders to renew and refocus their attentions on HIV in Central and South East Europe.

Treatment and care

People with HIV often start treatment without proper monitoring. Many countries lack second-line combination therapy for treatment-experienced patients. Drug licensure, compounded by the large number of countries relative to the small number of people living with HIV per country, is cumbersome and costly. Consequently, many countries of our region too often encounter serious shortages of treatment and diagnostic tests.

Demands:

- Focussed national, regional and international action to stop stock-outs.
- Regardless of the existing national procurement legislation, governments to ensure the sustainable, continuous supply of treatment and diagnostics including paediatric formulations, treatment for opportunistic infections and non-HIV related infections and basic diagnostic tests (CD4, viral load and resistance tests).
- National treatment guidelines to be adopted and applied universally including PMTCT and paediatric guidelines.
- Treatment to be available for all those in need with special attention to those in prison or institutions.
- All HIV health care providers to be provided, in a supportive environment, quality training and continuous medical education, including ethics and communication.
- People living with HIV to have access to treatment literacy programmes and counselling on side effects, nutrition, etc.
- Support services for people living with HIV including support groups, psychosocial support, social and legal help, home care, palliative and hospice services to be available and sustainable.

Policy and legislation

Legal institutions in most of our countries need modernisation; basic legal structures leave HIV stigma and discrimination unchallenged. Criminalization of HIV transmission remains a fact. Under these conditions those most vulnerable to HIV are less likely to seek HIV testing and learn about their HIV status, and PLHIV are less likely to seek medical care.

Demands:

- All national responses to HIV to be multi-sectoral and coordinated effectively by the central governments, with the active and meaningful participation of civil society, the community and PLHIV at all levels of decision- and policy-making.
- Implementation of effective anti-discrimination legislation, which outlaws discrimination based on HIV status.
- All groups most vulnerable to HIV to be free from threats of penalization and criminalization.
Legal protection for all necessary prevention programmes.
Protection for the human rights of people living with HIV in all areas of prevention, treatment and care.

Prevention and testing

HIV testing rates in Central and South East Europe are among the lowest in Europe. Some of our governments discourage HIV testing and underfund HIV testing programmes to make HIV rates appear to be low. Consequently, HIV-positive people are diagnosed very late with their immune systems unnecessarily compromised.

Minimal government resources are expended for prevention campaigns and messages are often ineffective to reach those most vulnerable to HIV.

Demands:
- People living with HIV to play active roles in developing all prevention programmes.
- Access to information for all, including non-judgemental sex and health education with effective, targeted HIV media campaigns.
- Focus on risk education, prevention and testing for those most susceptible to HIV infection.
- Support to the civil society organisations in implementing their prevention programmes.
- Ensuring anonymous, voluntary and confidential counselling and testing at no cost to the individual.
- Treatment for STIs to be readily available.
- Ready access to preventive tools, including condoms, female condoms, lubricants, and microbicides for those most vulnerable to HIV including prisoners.

Key populations

Gay men and other MSM

In most of our countries, gay men and other men who have sex with men comprise the highest infected population; pilot testing projects have shown concentrated epidemics. On the other hand, discrimination and intolerance towards LGBT people are very high in our regions.

We want our governments to finance and support the implementation of community-based testing and counseling for men who have sex with men and to identify the real HIV prevalence in this key population.

Women

We want our governments
- to address the intersections between HIV vulnerability, gender inequality and violence against women and girls.
- to prescribe by law the right to sexual and reproductive health.
- to allow self-determination for pregnant women to make an informed choice whether to be tested for HIV and to decide, if HIV positive, if they want to keep their child.
- to allow abortion as a choice.
- to support effective programmes for the prevention of mother-to-child transmission.
- to fight violence against women and sexual trafficking.
Injecting drug users

Although prevalence among injecting drug users in our regions is far lower than in North East Europe, drug use is criminalized in most of our countries and IDUs are highly marginalized both by society and health care service providers.

We want our governments
- to decriminalize drug use.
- to integrate gender-sensitive services for female injecting drug users in harm-reduction programmes.
- to promote access to effective harm-reduction programmes including opioid substitution treatment and needle / syringe exchange, and expand their coverage, especially for those in prisons or institutions.
- to diminish discrimination in access to HIV and HCV treatment for injecting drug users.

Migrants and ethnic minorities

Migrants and ethnic minorities, including Roma, have long suffered from discrimination in our regions. Some of our countries still have HIV-specific visa/residence regulations and deportations.

We want our governments
- to provide information and services to migrants and ethnic minorities and protect against their discrimination by public education and implement and enforce anti-discrimination legislation.
- to change discriminatory legislation regarding testing policies and visa and residence applications, which exclude people living with HIV.
- to provide testing, treatment and monitoring services for noncitizens.

Sex workers

We want our governments to de-penalize and de-criminalize sex work and provide access to information, services and prevention for sex workers and their clients.

II. 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 (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, 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 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.

II. 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 the 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 4\(^{th}\) worldwide in volume of production and 13\(^{th}\) in production.\(^3\) More importantly during this period India’s ability to produce generic medicines generated competition to originator products, 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 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 30\(^{th}\) 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. 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 shows 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.
- 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.
- Brazil’s compulsory licence on Efaverinz medicine used to treat HIV/AIDS was estimated to save it US$240 million until 2012.
- Ecuador’s compulsory license for lopinavir/ritonavir, allowed it to access generic versions at half the price of the patented Kaletra.

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 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 deny 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, and thus in enabling member states to achieve the treatment targets set out in the 2010 UNGA declaration.

**II. Revise the 30th August 2003 decision**

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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.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.
6 http://ictsd.org/i/ip/38960/
7 http://msfindia.in/content.php?con_id=85
8 http://www.citizen.org/pressroom/pressroomredirect.cfm?ID=3116
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 30 August 2003 was translated into a permanent amendment of the TRIPS Agreement on 6 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. 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.

The whole process of exporting from Canada to Rwanda was a fragile process, marked with significant delays. Apotex agreed to produce a 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".

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.

III. TRIPS plus policies: Hampering access to affordable medicines

TRIPS plus in Bilateral, Trade and Investment Agreements

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, bilateral investment treaties (BITs) and WTO accession packages for countries to adopt a variety of TRIPS plus measures. TRIPS plus measures pushed for adoption 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 ports.

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 affordable 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.”

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 as well as with individual ASEAN

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16 See http://www.msf.org.uk/fta_press_20100423.news
17 “No Data Exclusivity Clauses in Trade Pacts, Assures India”, published in SUNS #7186 dated 8 July 2011
countries, 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.\textsuperscript{18}

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 the 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.\textsuperscript{19} If this amount was not spent, Colombians would have to reduce their medicine consumption by 44% by 2030.\textsuperscript{20} 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.\textsuperscript{21}

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.\textsuperscript{22} 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 threat to access to medicines also arises from provisions on investment in bilateral investment treaties as well as investment chapters in trade agreements. These provisions define ‘investment’ broadly, to include IP e.g. patents and clinical-trial data and also contain “expropriation” clauses that includes investor state dispute settlement. As a result countries (that agree to such provisions) that do anything to reduce the value of the investment (for example issue a compulsory license to import generic versions) have to compensate the affected company (usually at market value) or be subjected to expensive arbitration proceedings by the company against the country.

It is clear that provisions on investment will have huge implications for access to medicines should any country press on to take measures overcoming the IP barrier to medicines. For example tobacco giants are well known for invoking investor-state dispute mechanisms in bilateral investment agreements to challenge moves of governments, which are aimed at controlling the widespread use of tobacco products.\textsuperscript{23}

\textsuperscript{18} http://www.bilaterals.org/spip.php?article14281
\textsuperscript{23} In February, 2010, three Philip Morris International (PMI) companies, based in Lausanne, filed a request for arbitration against Uruguay at the World Bank’s International Centre for Settlement of Investment Disputes ("ICSID"). They contended that certain Uruguayan regulations, on the packaging and labeling of tobacco products, have hurt their business substantially and thus violated Uruguay’s trade agreements with Switzerland, where Philip Morris International
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\(^\text{24}\), the United Nations Committee on Economic, Social and Cultural Rights\(^\text{25}\) and the United Nations Committee on the Rights of the Child\(^\text{26}\).

It is quite apparent from the above explanation that 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 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.

**TRIPS plus in Anti-Counterfeiting Agreements**

In recent years there has also been a proliferation of “anti-counterfeiting” initiatives. These initiatives launched by proponents of an IP “maximalist agenda” are aimed at increasing IP enforcement far beyond the standards set in the WTO, in ways that are “TRIPS-Plus-Plus” and do have an adverse impact on access to generic medicines.

However the proponents, mainly global business firms and governments in OECD countries, are making use of trade agreements, plurilateral government initiatives and programmes in international agencies to push their agenda to set or enforce higher IP standards, using concepts such as “counterfeiting”.

“Counterfeit” is defined by the WTO-TRIPS Agreement as referring to a special category of trademark violation. Footnote to Article 51 of TRIPS defines the term "counterfeit trademark goods" as “any goods, including packaging, bearing without authorization a trademark which is identical to the trademark validly registered in respect of such goods, or which cannot be distinguished in its essential aspects from such a trademark, and which thereby infringes the rights of the owner of the trademark in question under the law of the country of importation”. For violations of counterfeit trademark goods (i.e. literal copying of registered trademarks), heightened measures are prescribed by the TRIPS Agreement such as border measures by customs for importation of such goods and criminal penalties in cases of “wilful” trademark counterfeiting on a “commercial scale”.\(^\text{27}\)

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\(^{27}\) See Article 51 and 61 of the TRIPS Agreement. Note: Cases of counterfeit trademark violation must be distinguished from normal civil trademark violations for which civil remedies (and not criminal sanctions are suitable)\(^\text{27}\). Such cases would include situations where an infringing mark is confusingly similar (but not identical to) to a registered mark or a well-known mark. For example, the Delhi High Court in a civil case in India held that a generic manufacturer’s use of the trade name “Meromer” did not infringe the originator’s trade name “Meronem”, as both names were derived from the INN of the medicine, “Meropenem”\(^\text{27}\). Such situations are a common occurrence in the pharmaceutical field since both the originator and generic companies derive their names from INN and should not be treated as cases deserving criminal sanctions.
However the same term “Counterfeit” is also being used to refer to medicines of compromised quality and safety. The dual use/meaning of the term “Counterfeit” in international circles has enabled proponents of an IP maximalist agenda to propagate confusion and to advance an IP enforcement framework as a solution to dealing with compromised medicines. Various international agencies such as the Interpol, the World Customs Organisation (WCO), the World Intellectual Property Organisation (WIPO) have been enlisted to advance the IP enforcement agenda.28

The aggressive anti-counterfeit push has led to the adoption of legal frameworks focused on IP enforcement with provisions that hamper access to generic medicines as well as that are likely to have a chilling effect on the production of generic medicines in developing countries.

For instance, in Kenya, Tanzania and Uganda, as well as at the East African Community (EAC) regional level itself several anti-counterfeiting legislations have been, or are in the process of being enacted. Although the given rationale for such legislations is to protect the public from unsafe products, these legislations are only about protecting the rights of the IP holder and contain provisions that are damaging for access to generic medicines.

For instance such legislations through their erroneously broad definition of counterfeit makes every generic pharmaceutical a counterfeit.

In Kenya, enactment of the Anti-Counterfeit Act 2008 has been challenged by persons living with HIV/AIDS (PLWHA) on grounds that the Act will deny them access to affordable drugs and thus their Right to Life. More recently, PLWHA won a victory as the High court decided that pending final decision on the case, the anti-counterfeit agency of Kenya cannot take action against the import and export of generic medicines.

In 2010, EU and its 27 member countries, US, Japan, Australia, Canada, Korea, Mexico, Morocco, New Zealand, Singapore, and Switzerland concluded negotiations of ACTA – Anti-Counterfeiting Trade Agreement. This plurilateral initiative was to achieve a common standard for IP enforcement in the context of counterfeiting and piracy with the final aim of ensuring the universalisation of these standards by forcing developing countries to accept it.

ACTA generated significant controversy as it was negotiated through a secretive process, although its broad ranging norms are expected to adversely impact fundamental human rights including the right to health. Although public health consideration is one of the rationale presented for ACTA, in actual fact the agreement is simply aimed at protecting and enforcing the rights of the IP holder. In fact it is anticipated that ACTA will through its many TRIPS plus plus provisions have detrimental effects on access to affordable medicines.29

For example the border measure provisions found in ACTA are way beyond the minimum requirements of the TRIPS Agreement. Unlike the TRIPS Agreement whereby border measures are obligated only for importation of counterfeit trademark goods and copyright piracy, ACTA’s provisions extends the scope of the agreement to all IP infringements (except for patent and data protection) and requires ex-officio suspension procedures for exports as well as for goods in transit.

Such provisions are problematic as they contain elements that are likely to lead to more seizures of generic

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28 For a more detailed discussion see “Unpacking Counterfeit Medicines” (2010), K.M. Gopakumar, Sangeeta Shashikant, Third World Network.
medicines. The scope of the border measures is extended to include “similar” products. As it is often the case that generic and brand name have similar names as they are both drawn from the international non-proprietary names, the extended scope with the additional expansion of border measures to goods-in transit as well as goods to be exported is likely to lead to more seizures of generic medicines.

It is well known that the seizures of quality medicines that took place at European ports in 2008/2009 were the result of such broad and expansive IP enforcement provisions.  

IV. 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 and policy 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.  

(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 revise the 30th August 2003 decision.

(iv) That developing countries resist adoption of TRIPS plus measures (including investment provisions that includes intellectual property) and that developed countries stop pressuring developing countries to adopt such measures.

(v) That issues of intellectual property infringement and enforcement are distinct from those issues pertaining to proliferation of medical products of compromised quality, safety and efficacy. Anti-counterfeiting IP enforcement legislation are not suitable for protecting public health from poor quality medicines. Measures to contain the proliferation of compromised medical products should be public health oriented and focused on issues such as enhancing access to affordable medicines, strengthening the capacity of drug regulatory authorities, rational use of drugs. etc.

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30 For example in Feb. 2009, the AIDS medicine Abacavir bound for Nigeria was seized in Amsterdam and was released after a complaint by the UN, which was the recipient. In May 2009, the generic drug Amoxicillin (used in treating many bacterial infections) was seized in Frankfurt airport en route from India to Vanuatu. It was released after GSK the company holding the brand name “Amoxil”, informed the Customs that there was no trademark infringement. Delay of 4 weeks.

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

We are the African and Black Diaspora Global Network (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
- Australian Federation of AIDS Organizations-Australia

Diaspora engagement is increasingly becoming a valued and necessary component to addressing the multidimensional and intersecting contexts that impact mobile and migrant populations. Diasporas have commonly been defined as migrant and/or mobile populations and their descendants who have maintained strong links with their countries of origin. Civil society, governments, researchers and donors in both origin and destination countries are building greater awareness and urgency regarding the impacts of Diaspora contexts on health, the law, and human rights.

In the context of Diasporas, global population mobility is a complex, heterogeneous and growing phenomenon. In 2005, 3% of the global population were migrants. In the same year, 8.4 million refugees and 23.7 million internally displaced people in 50 countries were seeking shelter and safety. Due to various gender-related factors, the proportion of migrants who are women is increasing, with women now accounting for approximately half of the global migrant population.

Migrant and mobile populations bear a heightened risk of HIV infection, in part due to the complex institutional structures, processes and policies that mediate the migration process and movement of people. Marginalised groups, including undocumented migrants, sex workers, trafficked persons, ethnic minorities, injecting drug users (IDUs), men who have sex with men (MSM), incarcerated persons, and people living with HIV/AIDS (PLWHA) can experience exploitation, violence and exclusion. Factors leading to this can include their high level of mobility and circular migration patterns, legal status, language and cultural differences, lack of information, education and work, poor access to prevention, harm reduction and health care services, social exclusion, and gender related factors.

We believe that the impact of the law on African/Black populations living in the Diaspora with HIV reflects some of the most systemic and damaging impacts of racism, oppression, and inequality on health and fulfillment of human rights. When migrant/immigrant/refugee ABD populations are also considered, a myriad of unjust laws and policies relating to immigration and criminalization further create enabling environments for increased vulnerabilities to acquiring and/or transmitting HIV. ABD populations are over-represented in the criminal justice system, as well as in the HIV/AIDS epidemic, and when these realities are combined and considered within a global context, these shared and interconnected disparities must be acknowledged and addressed at local, national, regional and international levels.

When looking at rates of new infections in many high income countries, migrant and mobile ABD populations often are disproportionately affected, resulting in increased HIV vulnerability and threats to multiple factors across the determinants of health. Further, the impacts of racism, homophobia, colonialism, xenophobia, gender inequality, and stigma/discrimination reflect the additional structural and social factors that further
impede scale up and efficacy of targeted HIV responses for ABD populations. Ultimately, the better we understand the nuances and barriers experienced by emerging key vulnerable populations of ABD communities, the better our interventions and responses will be across the Diaspora. Creating and enforcing supportive and enabling legal environments is one approach to begin dismantling these inequalities and ensuring ABD populations are able to access and retain their basic health and human rights.

**How can the law be used to scale up effective HIV responses?**

Addressing the systemic knowledge gaps regarding how HIV status impacts particular criminal and immigration laws, as well as how HIV is acquired and prevented are critical to ensure and sustain scale up of effective human rights-based HIV responses for ABD populations. The following is a summary of some interconnected and overlapping issues resulting from this double knowledge gap with regards to the law and HIV:

- Lack of knowledge regarding specifics of what criminal laws are applied to HIV transmission and how they are enforced
- How HIV status impacts immigration policies for entry into country of destination
- How laws should inform personal choices, decision-making, and sexual behaviours regarding disclosure of HIV status
- Liability, privacy legislation and confidentiality expectations of service providers whose clients reveal sexual behaviour and activity that could be considered ‘criminal activity’
- Lack of HIV transmission and prevention knowledge amongst lawmakers, law enforcement, lawyers, judges, government stakeholders, immigration and detention officers leading to uniformed decisions and application of the law and related policies
- Lack of HIV transmission and prevention knowledge amongst media stakeholders leading to racist and discriminatory reports and portrayals
- Lack of clarity regarding interpretation of the law leading to further lack of clarity in translation of legal rights to clients in a service provider context

**Lack of Awareness and Knowledge of the Law and how it is applies to HIV transmission**

- Across populations and stakeholders, consistent experiences of lack of awareness, knowledge and rights with regards to immigration and criminal laws impacting HIV/AIDS (in particular non-disclosure law, refugee determination process), as well as impacts of HIV status on disability assistance, health insurance, employment status and other social support programs;
  - AIDS Service Organization front-line workers and service providers
  - Related staff within community services and programs linked to determinants of health
  - Ethno-specific community organizations
  - Public health stakeholders including physicians, public health nurses
  - Community leaders and individuals
  - Government stakeholders (e.g. department of immigration, department of justice)
- Insufficient translated materials and resources significant contributor to lack of knowledge and unhealthy behaviors across sub-populations (e.g. social isolation, fear of sexual and physical intimacy, fear of gender-based violence, lack of agency for condom negotiation)

**Lack of Awareness of HIV/AIDS transmission, disease progression and prevention**

- Need for open dialogues and spaces for ABD women living with HIV to talk about having unprotected sex; these discussions more accessible amongst gay/MSM but women living with HIV are having unprotected sex under diverse circumstances;
- Amongst lawyers, judges, policy analysts, journalists and media-based editors this lack of knowledge leads to:
  - Defendants pleading guilty to crimes they did not commit depending on interpretation of the law
  - Wrongful convictions
  - Unjust deportation decisions (in some cases including individuals who have already obtained refugee status)
Inaccurate and racist reporting in the media impacting public opinion leading to increased stigma, discrimination of ABD communities, reinforced stereotypes, fear, and support of harsher criminal laws and immigration policies.

The law could be used to scale up effective HIV responses by decriminalising activities proven to be effective in HIV prevention, removing legal barriers to diagnostic and screening tests for everyone, regardless of who or where they are, and removing legal barriers to accessing affordable effective treatment and appropriate monitoring and support services for everyone living with HIV, regardless of who or where they are. 4

How can the law substantially change the trajectory of the HIV epidemic?

The only way for the law to have a significant impact on the HIV epidemic for ABD populations is for the acknowledgment and removal of historic, systemic and institutionalized racism and discrimination practices that underlie established legal and justice frameworks, creating health and social inequities. When utilizing a determinants of health perspective, the impact of these harmful legal barriers and restrictions have devastating implications in human rights, health rights, gender-based violence, violence against sexual diversities, sexual and reproductive rights, employment equity, access to education, social support services, immigration status and other areas that will continue to fuel the growth of this epidemic in key vulnerable populations.

Appendix 1 is an illustration of the impacts of HIV/AIDS on migrant and mobile populations, using African and Black populations in the Diaspora as a reference point. With these alarming HIV rates among ABD migrant populations across countries with diverse socio-political histories, health care systems, social support mechanisms, and ethno-cultural diversities, the common thread amongst these experiences is that the vulnerable populations are mobile and African/Black.

The challenge then becomes addressing these two factors (mobility and ethnicity) within the context of supportive and enabling legal environments not only within countries, but around the world. Migrants with HIV are denied equitable access to effective treatment, support and reproductive rights based on their migrant status, with disproportionate impacts on ABD migrant populations in both developed and developing countries. Vulnerability is further impacted when we consider the ‘triad of discrimination’ these conditions results in:

- Discrimination based on HIV status (including criminalization of HIV exposure and/or transmission)
- Discrimination based on ethnicity (institutional and structural racism)
- Discrimination based on migrant status (including immigration laws, detention and deportation policies, refugee and asylum conditions, rights for undocumented migrants)

This triad creates multiple opportunities for human rights abuses, decreases access to health care services and treatments, and marginalizes individuals and communities. With inadequate, unjust, non-enforced or non-existent legal conditions to address the threats this triad creates, we will continue to see these disparities amongst ABD populations around the globe.

Additional risk factors linked to migration and this “triad of discrimination” include loss of livelihood and material means, the breakdown of social institutions and norms, and disruption to health services including access to and provision of sexual and reproductive health services, voluntary counselling and testing facilities, post-exposure prophylaxis, other prevention technologies, and anti-retroviral treatments (UNAIDS, 2010).

Migrants as ‘non-citizens’ have diminished voice, efficacy and influence in both regional and global efforts to address inequalities and health disparities; thus political and social attitudes towards migrants ultimately affect access to HIV prevention and care.

The Human Development Report released in 2009 by the United Nations Development Programme applied the Migrant Accessibility Index and various other measures to 61 developed and developing nations to demonstrate which countries had greater policy, social, and legal environments for migrants. 5

While high income countries like Canada had some of the highest scores, many of the other countries did show significantly diminished capacities for migrants to obtain health, labor and social rights.

Looking at a snapshot of three countries that showed higher scores on the index compared to most, there are still the creation and application of laws that lead to significant human rights abuses and increased HIV vulnerabilities that disproportionately impact ABD populations:

**United Kingdom**
• In 1993, the country had an immigration detention capacity of some 250. By 2003, it was operating seven immigration removal centres with a capacity of approximately 1,600. By 2011, the estate had grown to 15 dedicated facilities with a total estimated capacity of 3,500 (source- Global Detention Project)
• 2010 report Detained and Denied by Medical Justice based on the first ever comprehensive analysis of treatment of HIV+ immigration detainees in the UK draws on medical evidence from 8 independent clinicians who assessed the 35 individuals interviewed for the report; findings included:
  ○ Majority of detainees were from SSA
  ○ Of the 35 interviewed, 28 were women and 3 were children
  ○ 80% discovered their HIV status after their arrival in the UK
  ○ 60% had disruptions in their medication
  ○ 77% were deported with little or no medication
  ○ 66% were subjected to harmful practices, so dangerous that they may have led to permanent harm, including;
  • Denial of access to hospital for appointments with HIV specialists
  • A failure to carry out or pass on the results of tests to determine resistance to particular medications
  • Putting detainees at risk of contracting opportunistic infections

Israel
• Israel has experienced a wave of immigration comprised largely of asylum seekers from Eritrea and Sudan
• The rightwing Likud-led government has responded with a number of increasingly restrictive measures, including: the creation of a specialized immigration force called the Oz Unit, which is tasked with deporting all of the country’s more than 200,000 irregular residents; plans to build a wall along Israel’s border with Egypt (source-Global Detention Project)
• A proposal to build a massive new detention facility to confine up to 10,000 so-called infiltrators (unauthorized non-citizens); and the introduction in the Knesset of a new “infiltration” law whose draconian measures regarding detention and deportation of asylum seekers led a coalition of Israeli human rights groups to describe it as “one of the most dangerous bills ever presented.” (source-Global Detention Project)

Spain
• Increasingly larger waves of sub-Saharan Africans attempting to reach the country
• Introduced in 2009 several amendments to its Organic Law—which provides, inter alia, the grounds for the detention of migrants—that aligned the country with key European Directives relating to immigration and increased the amount of time a non-citizen can be held in administrative detention
• The country has also come under increasing criticism for conditions at some of its facilities, which gained international attention in November 2010 when several detainees at a Barcelona facility went on hunger strike to denounce “degrading treatment” there (source-Global Detention Project)

• In reviewing legal policies, statues and laws linked to migration, health, criminalization and HIV, member states can look at countries like Canada for insights on the types of legal reforms that could be implemented that could result in decreased vulnerabilities and fewer detrimental impacts of HIV on ABD populations (i.e. constitutional mandates for legal aid services for immigrant and refugee populations; humanitarian and compassionate grounds for refugee applications based on inadequate access to health services and treatment in country of origin). Utilizing the Migrant Accessibility Index as a measure for monitoring existing conditions and documenting progress on creating more enabling environments for migrant populations is one way member states could begin to take accountability and action on ensuring the law has a significant impact on reversing the epidemic.
• We ask the commission to consider the following selected recommendations as first steps in addressing the negative impacts of the law and HIV that can be initiated at the local level and scaled up at national, regional and international levels:
• GIMMPA Principle: Greater Involvement of Migrant and Mobile Populations Living with HIV/AIDS- Initiation of a global call for action to create a set of GIMMPA Principles that are developed,
implemented and disseminated in partnership with relevant and diverse stakeholders

- Increased and protected resources from government for AIDS Service Organizations to do targeted outreach, knowledge translation and awareness building initiatives, including resources for translation to ensure increased literacy of the law, HIV, and its myriad of implications across a variety of legal systems and frameworks, contexts and scenarios

- Better integration of HIV with other chronic disease health issues within a rights-based framework to encompass broader public health objectives rather than specific HIV, immigration, or criminalization that are often stigmatized and silenced within marginalized ethno-specific communities

- Better use of ethno-specific community leaders (heads of cultural associations, faith leaders) to address internalized community patterns of homophobia, HIV related stigma and discrimination

- Increased partnerships and collaborations amongst relevant stakeholders in countries of origin and destination to improve continuity of care and minimize human rights and health abuses due to inadequate treatment access during immigration/deportation processes

- Development of guidelines for service providers with regards to HIV non-disclosure law or other HIV criminalization and immigration laws and how they impact existing privacy laws, confidentiality, liability and enforcement guidelines

- Development of guidelines for police with regards to handling HIV criminalization cases to ensure health and human rights are protected from the influence of systemic and institutional disadvantages for ABD populations

- Development of prosecutorial guidelines for HIV criminalization and immigration cases

- Greater advocacy role of national ASO's to ensure their respective governments are maintaining their international human rights obligations

- Developing mechanisms to ensure media is held accountable for discriminatory practices (whether through internal process or an external monitoring/regulatory body)

- Maintaining government funding levels for legal aid clinics and legal support services and an eventual scale up of those resources

- Constitutional mandates to have legal aid for refugee and immigration services; should be adopted by UN member states

- Increased partnership and resource exchanges between legal services, public health, ASO, community stakeholders to increase knowledge of criminalization and immigration laws linked to HIV (e.g. cross-training, workshops, skillsbuilding, educational modules)

- Better understanding of legal determination of ‘significant risk’ and how it is informed by public health conceptions of significant risk

- Development of national HIV frameworks that address issues of immigration, criminalization and how it impacts access to treatment, care and support

In 2008, 67% of people living with HIV were in the sub-Saharan African region. Yet over 80% of the 2.7 million people living with HIV globally in 2008 were living in regions with significant populations of new and/or historic African Diaspora (UNAIDS, 2010). ABD populations are at the forefront of the epidemic outside of Africa, and the historical impacts of systemic and institutionalized racism and discrimination within legal systems and frameworks around the world compound existing vulnerabilities and disparities amongst ABD populations. With unprecedented advances in bio-medical research showing the potential of treatment as prevention, we have the scientific knowledge to be able to halt the spread of HIV and begin healing the damage HIV/AIDS has made across the determinants of health, particularly those from vulnerable and marginalized communities. However, if systemic changes to oppressive legal environments around the globe are not prioritized, continued disproportionate impacts of HIV and the law will be experienced by our communities, resulting in continued abuse of human rights and unnecessary or premature loss of life. We hope that our collective moral and ethical obligation to ensure the rights of all global citizens are protected will guide our future efforts to create sustainable legal environments that guarantee, rather than hinder, the eventual end of the HIV/AIDS epidemic.
Appendix 1

<table>
<thead>
<tr>
<th>Country/Region</th>
<th>Year(s)</th>
<th>Proportion of HIV among ABD Populations</th>
<th>Source</th>
</tr>
</thead>
<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 who 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>
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<td></td>
<td>2006</td>
<td>Out those with known geographical origin, 60% (5046/8354) of HIV infections were from SSA. In HIV cases with known geographical origin due to MTCT, 41% (69/169) were from SSA</td>
<td>ECDC 2009c, 22</td>
</tr>
<tr>
<td>France</td>
<td>2003-2008</td>
<td>Amongst all women newly diagnosed, 65% or 2/3 were African migrants</td>
<td>EPI-VIH Study Group, 2002</td>
</tr>
<tr>
<td>Germany</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>Greece</td>
<td>2006</td>
<td>Nearly 4% of new HIV infections in 2006 were among migrant populations, the majority from SSA</td>
<td>ECDC, 2010</td>
</tr>
<tr>
<td>Netherlands</td>
<td>2006</td>
<td>40% of new HIV infections in 2006 amongst migrants, with the majority coming from SSA</td>
<td>ECDC, 2010</td>
</tr>
<tr>
<td>New Zealand</td>
<td>2009</td>
<td>African migrants represented 14% of new HIV diagnoses</td>
<td>NAF, 2010</td>
</tr>
<tr>
<td>Portugal</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>Spain</td>
<td>2006</td>
<td>38% of new HIV infections were amongst migrant populations, the majority from SSA</td>
<td>ECDC 2010</td>
</tr>
<tr>
<td>UK</td>
<td>2004-2006</td>
<td>70% HIV prevalence accounted for by migrant/immigrant/refugee populations</td>
<td>HPA, 2006</td>
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<tr>
<td></td>
<td></td>
<td>90% migrants from SSA</td>
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<tr>
<td></td>
<td></td>
<td>85% of those migrants were infected before leaving country of origin</td>
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<td></td>
<td>Up to 2009</td>
<td>20-25% of HIV-positive African residents and ~50% of HIV-positive African MSM may have acquired their HIV infection in the UK</td>
<td>ECDC 2009c, 34</td>
</tr>
<tr>
<td>United States</td>
<td>2002-2007</td>
<td>Of foreign-born individuals diagnosed with HIV 38% were women from Africa and the Caribbean, and 30% were men from the same regions</td>
<td>CDC, 2009</td>
</tr>
</tbody>
</table>
1 EXECUTIVE SUMMARY
The Second International Consultation on HIV-Related Legal Services and Rights brought together lawyers and activists from Southern Africa, the Middle East and North Africa (MENA), Latin America and the USA. The objectives of the Consultation were: to review progress in strengthening and expanding HIV-related legal services and rights; share regional perspectives on criminalization, the rights of women and girls, and access to medicines; and identify actions for the next year.

1.1 Regional Updates
Regional updates described a diverse range of activities led by lawyers and activists. Presentations confirmed that significant progress in addressing HIV-related legal services and rights is occurring, although the context is highly challenging. Capacity building efforts are increasing the overall number of lawyers and activists with knowledge and skills on HIV-related legal issues.

In all regions resource mobilization is increasingly difficult as funding levels decline due to global economic conditions and the increased focus of donors on other health priorities. Many HIV funders prefer to focus on less controversial treatment and awareness programs, rather than human rights advocacy. In every region, lawyers and activists confront personal safety threats by speaking out on controversial issues.

Strategic litigation is delivering results in Southern Africa, the USA and Latin America. Strategic litigation has been successful as a result of community mobilization strategies involving organized collaborations between communities and lawyers.

A case against the Zambia Air Force established that a policy of non-consensual testing was unlawful. Women are mounting legal challenges against coerced sterilization in Namibia. Cases in Malawi and Botswana have addressed homophobic laws. Cases in relation to women’s property and inheritance rights have been conducted in Botswana, Malawi and Lesotho. In Malawi, mandatory testing of sex workers is being challenged. The rights of HIV positive prisoners are being considered in cases in Zimbabwe and Botswana.

In the USA, there has been progress in challenging punitive sodomy laws enforced against sex workers in Louisiana. In another case, the US Court of Appeals struck down the requirement that recipients of federal funds oppose the decriminalization of sex work. In Latin America, litigation has been successful, particularly in relation to access to treatment. Lawyers in Brazil have played an important role in challenging patents. In the context of the revolutions being experienced in the MENA region, there is hope for improved human rights protections for people living with HIV (PLHIV), women and girls, and key populations such as sex workers, people who use drugs and men who have sex with men (MSM).

“It is not enough to focus on good law and a good judiciary, an enabling environment is essential. A culture of litigation needs first a culture of acceptance, particularly from religious leaders and media messaging.”
Dr Khadija T. Moalla, UNDP Programme Coordinator for HIV in Arab States

However, it was noted that in all regions, the coverage of legal services that have HIV experience or expertise remains extremely low. Litigation is time consuming and costly. Creating demand from communities for litigation involves tackling stigma. There is a very limited culture of providing pro bono legal services, outside of the USA.

1.2 Rights of Women and Girls
Advocacy needs to engage with culture as well as law reform to achieve progress in addressing gender inequalities that contribute to HIV vulnerability. Customary laws are often more important than statutory laws in determining gender relations. Practices such as female genital mutilation and polygamy, and concepts of honor divorce, can be harmful. Property and inheritance issues are primarily resolved under customary law provisions in Africa. In Central America, women have very limited inheritance rights under the customary laws of indigenous communities.

Engaging religious leaders and training of police, judiciary and NGOs are important. With the assistance of evidence and science, women can act as leaders to change the way religion is interpreted, and to challenge violence against women.
The separation of religion and state was a key theme. In Southern Africa, culture and religion are associated with polygamy. In Latin America and Southern Africa, advocacy needs to address the influence of the Christian churches on policies related to sexual and reproductive health rights. Some leaders have been persuaded to change their perspectives. Church leaders are now preaching against homophobia in some communities. In Louisiana, USA, advocacy groups were able to persuade the churches to support law reform by emphasizing the impact of sex work prosecutions on women’s lives.

Despite the existence of protective domestic violence laws, violence against women persists. Many countries in Latin America, the Middle East and North Africa do not criminalize marital rape. Laws that establish sexual and reproductive health rights for women are slowly developing. Women living with HIV lack access to reproductive health services and receive little or no information about their sexual and reproductive health rights. Women living with HIV are subjected to sterilization and forced abortion. Policies should support assisted childbirth and adoption as options for women living with HIV.

In Southern Africa, property and inheritance rights are a major equality issue. There are numerous laws that overtly discriminate against women and girls. HIV testing of pregnant women without their consent occurs in all regions. Lawyers have not yet pushed far enough on constitutional rights to test issues such as women’s right to abortion. There is very little priority placed on women’s rights and reproductive health issues because there is very little funding for programs addressing these issues. In Southern Africa, ensuring women living with HIV obtain access to prevention and treatment services for cervical cancer is an urgent priority.

Advocates in Egypt persuaded parliamentarians that the unequal age of eligibility to marry contributes to HIV vulnerability. This resulted in a change in the law to equalize the age. Key gender equality issues that can be addressed through networks include assisted reproduction, forced sterilization and violence against women.

1.3 Criminalization

Participants discussed criminalization of sex work, drug use, homosexual acts, and HIV transmission. A key principle for advocacy is that governments should not interfere in sexual matters between consenting adults. Participants agreed that governments should be secular rather than impose religious moral values. Decriminalization requires changing the mindsets of lawyers and policymakers regarding sexual minorities and sex workers, and community mobilization. In El Salvador, sex workers organized themselves to resist abuses. In Argentina, sex workers formed a labor union and there is now a network promoting the rights of sex workers in Latin America and the Caribbean.

Same sex practices are illegal in many countries and reports of police abuses are common. Sex between men has been decriminalized in India as a result of litigation based on constitutional rights. A similar constitutional challenge may not work in the African context. Instead, a range of interventions may be required including ‘know your rights’ campaigns, documentation of and redress for specific rights violations, legal aid, and work with national human rights institutions and mainstream human rights and HIV organizations. Africa is experiencing a growing movement of activism, with increasing visibility of sexual minority rights issues.

There is a proliferation of HIV exposure laws in the USA, where the criminal law is used to prosecute PLHIV for spitting, although there is no basis in science for HIV transmission risk in such contexts. Laws and law enforcement have a disproportionate impact on African Americas living with HIV. Although sodomy laws in other states are considered unconstitutional, the state of Louisiana has continued to enforce the Crimes Against Nature Statute (CANS) against sex workers. A strategy was implemented to challenge the CANS law using litigation, advocacy and media. This approach has partially succeeded and a new law has removed many of the problems.

There are similar intersections of issues relating to HIV vulnerability, stigma, criminalization, housing, employment and race in Southern Africa and Southern USA. Sex workers in Southern Africa are often charged with loitering and pay bribes or provide sex to police to avoid prosecution. Sex workers are exposed to police harassment and sexual violence. Sex workers are difficult to reach: stigma is a barrier to rights protection.

It is helpful to use public health arguments e.g. in Uganda, these arguments helped to defeat the Anti-Homosexuality Bill. Collating case data to provide evidence of trends to present to legislators and policy makers is important. Advocates need to highlight inconsistencies such as lack of alignment between policies of the justice sector, which punishes MSM and drives communities underground, and the health sector, which is
urging MSM to come forward and access health services. Advocates in different regions could benefit from comparative research on the concept of the criminalization of unnatural acts, and research on how the legal system addresses sex workers, people who use drugs and MSM – looking at issues relating to evidence, police conduct, duration of detention and penalties.

1.4 Access to Treatment
Obstacles to treatment access include discriminatory laws and practices, interruptions to supply, high prices, and patent laws. Access to treatment can be supported by reducing stigma and discrimination and addressing barriers created by criminalization that prevent outreach services reaching hidden populations. When first-line treatments fail, patients need to be able to access second-line treatment regimens, which are far more expensive. The effect of patents on drug prices is a critical issue for all regions.

In 2009, the MENA region had an ARV coverage level of around 12%, the lowest in comparison to other regions of the globe. Yet, in theory, ARVs are affordable – almost all MENA countries provide ARVs for free. However, obstacles to treatment access include discriminatory laws and practices, centralization and control of distribution and interruptions to supply due to procurement issues, policies on prices, and patent laws.

Litigation has been a successful strategy in Latin America. In Venezuela, a court ordered the government to supply patients with antiretroviral drugs. In Peru, a case confirmed the rights of PLHIV to permanent supply of drugs and monitoring tests. The Inter-American Commission on Human Rights has made a series of important findings to secure the right to health of PLHIV in OAS Member States. In Brazil, advocacy has focused on the impact of the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS). Lawyers have mounted in six patent challenges. Experience has demonstrated that use of pre-grant opposition processes to prevent patents being issued can produce fast and positive results. Two important treatment access court cases are pending in Brazil.

In South Africa, the Treatment Action Campaign (TAC) focused on community mobilization and advocacy to force the government to draft a national treatment plan. TAC uses litigation, public protests and the media to pressure government departments. The AIDS Rights Alliance for Southern Africa (ARASA) has learnt the importance of combining bottom up and top down approaches. ARASA promotes treatment and rights literacy at the community level so that there is demand for the right to health, and also targets governments through advocacy at national, regional and global levels.

Governments need to strengthen resolve to exercise TRIPS flexibilities. The Medicines Patent Pool provides access to some ARVs but many middle-income countries are excluded. Some wealthy countries have cheaper ARVs than poor countries because of pricing regulations. For countries with less demand it may be possible to work with regional organizations to find joint solutions so low HIV prevalence countries are not penalized. There is a correlation between countries that lack democracy and low levels of treatment access because people are not equipped to demand their rights. The starting point is awareness raising that access to treatment is a human right.

1.5 Future Actions
It was suggested that future collaborations (whether within regions or between regions) should focus on a limited number of agreed priorities. Joint actions should avoid duplicating of activities that can already be done via existing networks. Regional networks can supply leadership to progress national issues. Discussions relating to inter-regional networking identified rights of women and girls and decriminalization issues as priorities, particularly in relation to sex work. Another opportunity is cross-regional collaboration on access to treatment.

2 BACKGROUND
The Second International Consultation on HIV-Related Legal Services and Rights was convened as part of the project Strengthening and Expanding HIV-related Legal Services and Rights, implemented through a partnership between the Ford Foundation and the International Development Law Organization (IDLO). The Consultation was convened as a follow-up to the First International Consultation on HIV-Related Legal Services and Rights held in Vienna in July 2010.

The objectives of the International Consultation were to:
1. review progress in strengthening and expanding HIV-related legal services and rights in the period July 2010 – June 2011;  
2. share regional perspectives on criminalization, the rights of women and girls, and access to medicines; and  
3. identify concrete actions to strengthen and expand HIV-related legal services and rights in the next 12 months.

The International Consultation brought together lawyers and activists from Southern Africa, the Middle East and North Africa, Latin America and the United States of America (USA). Representatives of the following countries participated in the convening:  
1. Southern Africa: Namibia, Zimbabwe and South Africa;  
2. Middle East and North Africa: Egypt and Lebanon;  
3. Latin America: Brazil, Colombia, Costa Rica, Chile, El Salvador, Mexico, Nicaragua, Panama, Peru, Dominican Republic and Venezuela;  
4. USA.

Participants were primarily people working in non-government organizations (NGOs) that provide HIV-related legal services or engage in HIV-related human rights advocacy.

3 REGIONAL UPDATES

3.1 Latin America

There has been significant progress since 2010. A project to strengthen HIV-related legal services was commenced in Mexico, El Salvador, Guatemala, Colombia and Peru (February 2011-March 2012), with financial support from the Ford Foundation and technical assistance from IDLO. Components of the project included:  
1. Monitoring and evaluation (M&E) model for delivery of legal services;  
2. a videoconference with five partner organizations;  
3. workshops with partner organizations to share best practices in the provision of legal services related to HIV; and  
4. an on-line course on HIV law and policy.

A Community of Practice on HIV and the Law in Latin America has been established using a virtual platform to provide access to relevant regional and national jurisprudence, discussion forums on common issues, and support from experts. The Community of Practice provides opportunities to share regional and national laws on HIV and human rights and to access a group of legal experts and attorneys.  
The IDLO Toolkit: Scaling Up HIV-Related Legal Services was translated and adapted for Latin American audiences. The Latin American (Spanish) version will be published by the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Development Programme (UNDP), the Pan-American Health Organization (PAHO) and IDLO in 2011. A focus group of experts was convened to review and adapt the translation and to identify examples of legal services in the region for inclusion in the Toolkit. A Plan for dissemination of the Toolkit was proposed by this group.

Legal service providers and community representatives participated in the Latin America Regional Dialogue of the Global Commission on HIV and the Law (Sao Paolo, 26-27 June 2011). The project partner from Guatemala (the Iturbide Foundation) participated in the Regional Dialogue and an IDLO representative (legal officer, health law (Latin America)) attended as an observer. It was significant that the Regional Dialogue provided an opportunity for people living with HIV and most-at-risk populations to raise their concerns directly with government and United Nations representatives. It is anticipated that the Global Commission’s report in December 2011 will inform regional and national priorities for strengthening laws and legal services in 2012.

The Organization of American States (OAS) resolution 2600 on ‘Human Rights, Sexual Orientation and Gender Identity’ (2010) required the OAS to discuss the status of the human rights of lesbian, gay, bisexual, and transgender people at the OAS General Assembly. In June 2011, a new resolution was adopted by the OAS General Assembly condemning discrimination against people based on sexual orientation or gender identity.
This OAS meeting provided the first opportunity for a transgender person to address member states. The new OAS resolution includes reference to transgender people for the first time. This signifies that representatives of most-at-risk populations can participate actively in policy discussions – rather than provide only token representation. In the past, such populations as transgender people, men who have sex with men (MSM) and sex workers had not even been mentioned by some governments. The framework of legal protections against discrimination continues to be constrained by stigma, which means that the most marginalized populations seldom have access to the justice system. Human rights defenders also face physical risks in their work.

1 Mr. Ruben Ernesto, Director of REDLA+ (Latin American Network of People Living with HIV/AIDS).

3.2 Middle East and North Africa (MENA)
In the context of the revolutions being experienced in several Arab countries, there is increased hope for improved recognition of rights for all populations, including people living with HIV. However, there is also a need to monitor changes to ensure that populations are not excluded from the benefits of progress in recognition of civil rights and liberties. Many lawyers and judges still fear HIV transmission through interaction on a professional level with people living with HIV.

Activities that have been implemented since 2010 in the region include:
1. legal awareness;
2. legal consultations and direct support;
3. legal cases concerned with most-at-risk populations; and
4. an increase in legal support for people living with HIV and most-at-risk populations provided by human rights associations.

Common legal problems include discrimination, employment disputes, harassment by security personnel, problems associated with Personal Status Codes, arbitrary arrests and prosecutions of most-at-risk populations, and violation of rights to treatment and care. Legal developments relating to injecting drug use have included:
(i) the introduction of substitution drugs, such as methadone, in Morocco; and
(ii) the introduction of diversionary programs in Lebanon, which allow charges to be dropped if injecting drug users are willing to receive treatment and rehabilitation.

However, there has been resistance to implementing these programs from some members of the judiciary who still consider imprisonment as the only option. The HIV/AIDS Regional Program in the Arab States (HARPAS) has developed a proposal for an Arab Convention on HIV and the Protection of the Rights of People Living with HIV. HARPAS has supported the development of laws for protecting the rights of people living with HIV in countries such as Yemen, Qatar and Bahrain. The law enacted in 2009 in Yemen provides an important example of a progressive law on HIV for the region. People living with HIV are playing an increasingly active role as trainers and advocates for spreading awareness of rights in their communities and addressing stigma and discrimination (e.g. the Positive Prevention Program in Tunisia, the Positive Visions Association and the Friends of PLHIV Association (Jordan), and other programs in Egypt). NGO alliances and networks have been formed that work on legal and rights issues (e.g. the Anti-Stigma and Discrimination Forum; the network of faith-based organizations fighting Dr. Mervat Nessiem, Center for Development Services.

AIDS in Arab countries; and a taskforce of agencies working in the field of HIV-related health and rights). Other organizations working in the field of human rights in the countries of the MENA region are addressing HIV-related issues in their work.

The media is influential and could play a more prominent role in efforts to reduce stigma and discrimination. In Jordan, the media has played a positive role in pressuring physicians and hospitals to treat people living with HIV. Workshops have been held for media personnel in Kuwait and Saudi Arabia. In Jordan, Egypt and Tunisia people living with HIV have been encouraged to talk openly and share their stories with others through different media. Films that present the rights of people living with HIV and most-at-risk populations from a legal, religious
and scientific point of view are an important intervention. A radio program was produced in Morocco that received questions on HIV-related problems. IDLO, the Ford Foundation and OFID have funded a small grants program for HIV-related legal activities, in cooperation with the Centre for Development Services. Eligible countries are Jordan, Algeria, Morocco, Tunisia and Lebanon. The Second Consultation on HIV-related Legal Services and Rights in the MENA Region was held with the participation of Egypt, Jordan, Lebanon, Morocco and Tunisia. The Fourth MENA regional consultation will be held in Cairo, from 27-29 July 2011. It is anticipated that 150 experts in the field of legal rights and services will attend, including doctors, anthropologists, religious leaders, NGOs and lawyers from all Arab countries.

The “Common Grounds” Project encourages exchange of experiences amongst legal and health organizations that provide direct services in the field of HIV. The aim is to create a holistic approach to work in this field.

Recent activities in the MENA region have included:
1. Three technical meetings were held to discuss the best methods for reaching most-at-risk populations and raising their awareness regarding legal rights and services.
2. A workshop was held on access to HIV-related services by MSM, sponsored by UNAIDS, Helem Association-Lebanon, the International HIV/AIDS Alliance, and the Regional Arab Network Against AIDS.
3. A workshop was held on the “Rights of people living with HIV” in Tunisia in 2010.
4. Work has commenced on an Arabic language component of the AIDSlex database (www.aidslex.org) on HIV and the law.
5. The IDLO/UNAIDS/UNDP Toolkit: HIV-related Legal Services was translated into Arabic.
6. A guidebook on women’s rights has been developed by HARPAS.
7. The El Shehab Association and the Center for Development Services (CDS) are developing an operational manual on HIV and legal rights.
8. The Anti-Stigma and Discrimination Forum published a booklet of stories of HIV-related stigma and discrimination: “Messages from Egypt”.
9. Training workshops were conducted by the Freedom and Justice Program, with technical and financial support from Ford Foundation and IDLO, for Egyptian lawyers regarding legal rights and services.
10. In Jordan, the Amal Association formed a group of lawyers and judges trained on HIV-related issues.
11. Training was conducted for judges in Lebanon.
12. In Morocco, a meeting was held on the rights of people living with HIV. The Al Nahar Association organized a national women’s campaign to fight HIV-related stigma and discrimination. This began on 8 March 2011 (International Women's Day) and will continue until 8 March 2012.
13. A study was conducted on the legal needs of people living with HIV and most-at-risk populations by the Egyptian Initiative for Personal Rights (EIPR). In Egypt, groups of lawyers are providing some specialized legal services and are developing written materials on HIV.
14. A project on the legal empowerment of MSM and injecting drug users is being implemented by the Program on Freedom from Addiction and AIDS, in partnership with CDS, funded by the Ford Foundation.
15. Al-Shehab Association is raising the awareness of sex workers regarding health and legal rights, and providing them with legal support.

An increased emphasis on leadership is an important development. UNDP has conducted workshops on leadership and women living with HIV in Egypt, and leadership and risky practices amongst youth in Saudi Arabia and the Palestinian Territories (HARPAS). It was noted that women living with HIV in Arab states face complex discrimination due to the low status of women in society generally, as well as the stigma associated with HIV. The African Organization for Fighting AIDS (OPALS) in Morocco has established a service that answers questions regarding sexuality and reproductive health using text messages. This service provides complete confidentiality to its users.

A priority for future work is improved documentation of experiences in the field of HIV-related legal rights and services to inform policy development. This requires exchange of experiences amongst lawyers and human rights activists in the Middle East. Incorporating HIV-related legal, rights and health aspects into medical, law
and police school curricula is another priority.

### 3.3 Southern Africa

There have been significant developments in HIV-related litigation. A case against the Zambia Air Force addressed the issue of non-consensual HIV testing. Two air force personnel were tested without consent, and were provided with anti-retroviral drugs (ARVs). They were not told that they had been tested for HIV, that the test results were positive or that the drugs they had been provided with were for treating HIV. The Southern Africa Litigation Centre worked with the Zambia AIDS Law Research and Advocacy Network and others to mount the court case. The case established that the Zambia Air Force policy of non-consensual testing was unlawful.

Three HIV positive women in Namibia are suing health and social service authorities for coerced sterilization. Community consultations had revealed that sterilization of HIV positive women without their consent was a common practice. The case is supported by the Southern Africa Litigation Centre. Judgment is expected soon and the lawyers for the women are optimistic that the claims will be successful. Cases in Malawi and Botswana have addressed homophobia. In Botswana, a case has been filed challenging the sodomy law as unconstitutional. The judgment has yet to be handed down. In Malawi two persons were charged with sodomy offences and held in custody for several months. They were found guilty and sentenced to 14 years imprisonment. An advocacy campaign succeeded in securing their release. The President pardoned them, although without acknowledging that the sodomy law is unjust. The Malawi case was an advocacy success but not a legal victory – it does not set a precedent and the sodomy law remains on the statute books. Cases in relation to women’s property and inheritance rights have been conducted in Botswana, Malawi and Lesotho.

3 Ms. Michaela Clayton (AIDS and Rights Alliance for Southern Africa (ARASA)).

There have been two recent prosecutions of people living with HIV for exposure or transmission of HIV in Zimbabwe. In one case, a woman was charged with exposing another person to HIV. There was no evidence that HIV had been transmitted. Zimbabwe Lawyers for Human Rights applied to the Supreme Court to set aside the HIV exposure offence in the Penal Code as too wide and in breach of constitutional rights to non-discrimination. The Supreme Court was unable to hear the appeal because the notes and judgment from the hearing of the case had been removed from the file of the court that originally heard the case. Although there was eventually a good outcome for the client, the discriminatory law remains in place. In another case that is pending judgment, the constitutionality of the Penal Code offence is to be tested. This involves a charge of HIV transmission against a member of parliament.

In Malawi, a case has been filed which seeks to set aside the policy that requires mandatory testing of sex workers when they are arrested. The grounds for the challenge include breach of rights to privacy and non-discrimination. The results of this case are pending. The rights of HIV positive prisoners are being considered in cases in Zimbabwe and Botswana. A claim has been lodged against the Attorney General and Commissioner for Prisons in Zimbabwe complaining against the refusal of prison authorities to allow a prisoner to access antiretroviral drugs (ARVs) while on remand. The prisoner also alleges that he has been discriminated against by being placed in solitary confinement because he complained about lack of access to treatments. The prisoner is represented by Zimbabwe Lawyers for Human Rights. Rights of HIV positive prisoners to access good nutrition are also being considered. The case in Botswana is seeking to establish the rights of prisoners who are not citizens to access ARVs.

Training on HIV and the law has been provided in Zimbabwe (by Zimbabwe Lawyers for Human Rights) and in Botswana.

Training for magistrates and lawyers from Indian Ocean states (Madagascar, Mauritius, the Comoros and the Seychelles) was held in Madagascar. Some participants noted that this training was the first time that they had thought about HIV as a human rights issue.

The AIDS and Rights Alliance for Southern Africa (ARASA) and Human Rights Watch have conducted research on HIV and tuberculosis in prisons in Zambia. Advocacy on prisoners’ rights is challenging because all prisoners suffer from poor conditions, not just those living with HIV – so it is important that successes have system-wide benefits. In Zimbabwe and Zambia there are reports of people being detained in remand prisons for up to ten
years. In Zambia and other SADC countries overcrowding in prisons is horrendous, which has a direct impact on transmission of tuberculosis and prisoners’ health. Many countries have not developed sentencing alternatives to incarceration. Future challenges include the need to improve regional coordination and ensuring that judges are trained on HIV and related legal issues.

3.4 United States of America (USA)

Common HIV-related legal issues include access to affordable housing, tenancy disputes, immigration, employment, family law, and access to benefits. In 2010-2011 there have been new collaborations between legal services and community organizations, particularly in Southern USA. The need for community-wide advocacy strategies is indicated by the decreasing receptiveness of federal courts to civil rights claims, narrowing of available remedies, and serious underfunding of legal services. Efforts to address underserved areas include a new network of attorneys with expertise in critical areas, and programs addressing rights funded by Southern REACH (Regional Expansion of Access and Capacity to Address HIV/AIDS), an initiative providing grant resources and technical support.

In *Alliance for Open Society Int’l v. USAID* (2011) the US Court of Appeals struck down the part of the *U.S. Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003* that requires organizations to explicitly oppose sex work if they receive federal funds to engage in global HIV/AIDS activities. The decision only affects U.S. organizations. The Positive Justice Project was launched in 2010 to address criminalization of HIV exposure, non-disclosure and transmission. Effective legal help for people living with HIV charged with these criminal offences is important but challenging, due to the inherent biases of the justice system which disadvantage low-income clients, and the lack of resources available to defendants and Public Defenders. Clients rely on Public Defenders who often need technical support on scientific evidence relating to transmission risk. The creation of centralized resources for defenders has been very helpful. In Louisiana there has been progress in challenging punitive sodomy laws that are enforced against sex workers.

National developments include:
1. Federal disability discrimination laws have been significantly improved.
2. Legal advocates have taken the lead on expansion and enforcement of the *Americans with Disabilities Act*, informed consent and other patients rights issues, and anti-criminalization efforts.
3. Health care reform will result in improvements. From 2014, people on low incomes will be eligible for publicly funded health care. People living with HIV will no longer have to be disabled before being eligible for publicly funded health care.
4. Some discriminatory health insurance practices are to be prohibited (e.g. a person cannot be charged higher premiums based solely on their health status or gender).

*Ongoing priorities*

Access to legal services in general is difficult. There are fewer than 60 HIV-specific legal service programs nationwide. Many of these programs are very small.

For housing cases, there is a shortage of lawyers to ensure federally funded programs comply with guidelines and are flexible when dealing with clients who breach program rules. Advocates are also needed to educate state and city governments, and work towards getting funding for housing for people living with HIV in their budgets.

Criminalization is a major concern with 36 US states and territories having HIV-specific criminal laws. There have been at least 100 new prosecutions over the last 2½ years and new HIV-specific criminal laws continue to be adopted.

Women living with HIV face significant obstacles in exercising their reproductive health rights. A recent survey found only 14% of survey participants believed HIV positive women should have children. One third said they “would not support at all” an HIV-positive woman’s decision to have a child. This view has been reflected in patient forms used by testing and health department staff. In Mississippi, until late 2010 a state post-test
counseling form required client acknowledgement of the need to avoid pregnancy. Women’s autonomy is challenged in treatment decisions. Opt-out testing is the preferred approach when HIV testing is provided to women and prisoners, and HIV testing is mandatory for pregnant women. Challenges to women’s custody of children are based on treatment choices and perceptions around treatment. There have been some positive developments relating to women’s rights. Common law and the U.S. Constitution recognize the right to refuse treatment and choose pregnancy. State courts have recognized the right of a mother to refuse ARVs during pregnancy, despite the increased risk of HIV transmission to her child. The Americans with Disabilities Act and the Rehabilitation Act operate to ensure women living with HIV are not discriminated against in provision of treatment, care and support services.

It has been beneficial to reference international treaties and customary international law that underscore women’s right to consent to or refuse treatment. Courts are more receptive to challenges when it is pointed out that practices, such as coercive medical treatment, are out of line with the approach taken by other countries. In summary, most major gains have been the product of organized collaborations between communities and lawyers. Centralized resource sharing and networks can be a highly efficient and effective approach. These strategies alleviate but do not solve the crisis of inadequate funding for lawyers to provide legal services to clients and advocacy for legislative and policy change.

**Discussion arising from regional updates**

Penalties for HIV exposure offences are disproportionate. In the USA, sentences for killing a person with a car can be a less than those for exposure to HIV (without HIV transmission). It is inappropriate to rely on the criminal law when the problem is really one with personal relationships. For other sexually transmitted infections (STIs), betrayal in the context of relationships is generally resolved through civil processes in the USA. For HIV, the criminal law is preferred. This may be because poor people cannot afford to take civil action or because HIV is seen as worse than other transmissible conditions and more deserving of criminal penalties. Litigation is time consuming and costly. Funding is a critical issue in all regions. There is a very limited culture of pro bono legal services in Southern Africa (unlike in the USA). In Latin America, judges are often not receptive to being trained. In Africa, lawyers are often reluctant to be associated with HIV-related laws or sodomy laws. They need training not just on the science of HIV but also HIV-related laws and case developments. In Southern Africa there are some female judges who are prepared to talk to their colleagues and raise awareness about HIV and human rights – we need to use this strategy because judges are resistant to being trained by non-judges. Regional human rights institutions can be engaged, e.g. the African Commission on Human and People’s Rights. Lawyers should make better use of these international organizations, and regional tribunals, such as the Inter-American Human Rights System, to set an example with high impact cases. In the USA there has been reliance on domestic civil rights law but there is a need to expand our understanding of available remedies to include regional mechanisms and to reconsider the utility of broader human rights social movements. In Egypt, 20 lawyers have been trained in HIV and the law, including issues related to sodomy laws, and this pool of lawyers is very helpful in assisting to defend the rights of most-at-risk populations.

In the MENA region, a high priority should be given to training police and prosecutors, as well as judges and lawyers. In Latin America as well there needs to be increased focus on the whole law and justice sector – the police are the first to violate rights and there is a chain of legal authorities, including judges, public attorneys and district attorneys who would benefit from HIV and human rights training and awareness raising. Peer education needs to occur among other legal sector players, such as police and corrections officers, some of whom are living with HIV themselves. In the MENA region, education on the rights of people living with HIV has been incorporated into courses for clinicians and nurses. Strengthened links between legal and health associations is required. Lawyers need doctors at their side when they talk about HIV and science.

Misuse of language contributes to ignorance. It is fraught to talk in terms of ‘high-risk communities’ in the context of criminalization, given that the risk of transmission is very low for each incident of sex.

**4 RIGHTS OF WOMEN AND GIRLS**

**Vulnerabilities and opportunities after the Arab spring revolutions**

It is important to have a theoretical framework to inform our vision of priorities during a time of upheaval.
Changing unjust laws is insufficient. Change needs to occur at a deeper, more fundamental level. Gender is socially constructed so we need to engage with religion and culture to achieve enduring progress. Laws operate in the exterior, objective world but to achieve change we also need to affect the subjective domains of collective cultural norms and individual values. Norms, values and traditions perpetuate gender power differentials.

For example, homosexuality per se is not criminalized in Egypt but homosexual men are targeted by police because of the religious and cultural beliefs of police. So we need to engage at the subjective level to address the views of police and magistrates if we are going to change law enforcement practices. Customary laws are often more important than statutory laws in determining gender relations. Gender is a power relationship and the way the relationship is defined is created by society. Advocates need not only challenge laws, but also the underlying traditions that perpetuate power relationships if we are going to achieve a paradigm shift to protective and empowering laws. Manifestations of patriarchal systems include female genital mutilation (FGM), polygamy and concepts of honor divorce. Women who experience FGM are 300 times more at risk of HIV transmission.

According to social change theorist Otto Scharmer, social problems can be understood by identifying three layers of complexity: dynamic, social and generative. Dynamic complexity involves policies. Social complexity involves values, beliefs and norms. Generative complexity involves understanding disruptive patterns of change, such as we now see in the MENA region. To respond to these levels of complexity we need to approach social change with an open mind (noticing difference), an open heart (empathic listening), and an open will to connect to an emerging new future.

5 Dr Khadija Moalla, Regional HIV/AIDS Practice Leader, Programme Coordinator for Arab States, UNDP.

“A significant challenge in the public health framework is that beyond the standardized pre-test and post-test HIV counseling, there is no conversation surrounding the next decisions in a woman’s life – Can I have children? How can I go about having children? Where can I go for support? On these issues women do not know where to turn for support to enable them to lead the life they want to live.”


In the context of women’s rights, equality means much more than 50% of decision makers being women. 50% representation is not helpful if representatives do not have a shared understanding of gender and power. Scattered interventions are not enough. We need fundamental changes to complex social norms and structural factors that contribute to gender violence and inequality. This requires change agents who can provide transformational leadership and challenge rigid dogmatic beliefs. With the assistance of evidence and science, women can act as leaders to change the way religion is interpreted. We have seen examples of this in working with women from Sudan. At first, some women advocated FGM as their tradition, but after deeper examination of the issue they changed their opinion. Instead of learning from the past, the focus was on learning from emerging new futures. This allows a process of ‘presencing’ to occur, which is a process of self realization. Revolutions are times of instability and opportunity. It is possible that gender inequalities will be reduced and a new humanity will manifest, but it is also possible that patriarchy may become stronger and fundamentalism may gain more power.

We need a ‘full spectrum response’ addressing immediate and underlying causes, laws, systems, and leadership. Advocacy needs to target religious leaders as the guardians of religious values, and to influence the media. Political change requires challenging reactionary political, religious and media discourse.

Discussion
There are limits to that which can be achieved by raising awareness among religious leaders, which is sometimes not very productive. Religion is informed and defined by religious intellectuals, not just religious leaders.

We need a better evidence base on actions of the judiciary and the police. We cannot realistically achieve legal aid for all people living with HIV and most-at-risk populations. Research into police and judicial practices can provide a sound basis for our work to achieve systemic change.
The separation of religion and state and the importance of a secular state to enjoyment of human rights are key themes. Tunisia has been a secular country since 1956. Tunisia legalized abortion in 1956, 20 years before France. Sex work is also legal in Tunisia. In Southern Africa, culture and religion are associated with polygamy and violent opposition to homosexuality. Leaders have been persuaded through training to change their perspectives. Church leaders are now preaching against homophobia in some communities in South Africa. When advocates work with leaders, it is important to not just provide information, but to change their worldview. In the MENA region, HARPAS has worked with leaders to transform their views by bringing the best of them together. Magistrates and police take power from what they think is the true meaning of religion, so we need to encourage a paradigm shift. The current emphasis on ‘test and treat’ as the priority approach to both HIV prevention and treatment is troubling. During the UN General Assembly Special Session on HIV/AIDS in June 2011, the Vatican argued that it was unnecessary to talk about sexual and reproductive health because we just need to provide treatment. A narrow focus on testing and treatment ignores the need to address gender inequality and gender-based violence as underlying causes of HIV vulnerability. Gender does not refer only to men and women, but also to transgender people.

Rights of women and girls: Latin America
Advocacy on sexual and reproductive health rights in Latin America is difficult because of religious taboos and stigma. Women represent 34% of the total population of people with HIV in Latin America. Heterosexual sex is the main route of infection among women. Young women (15 to 24 years) are most affected. There are increasing cases of HIV among indigenous women. HIV policies omit the needs of some marginalized populations (e.g. lesbian and bisexual women, and mobile populations). There are no specialized sexual or reproductive health care services for female prisoners. In addition to biological factors that increase women’s risk of acquiring HIV, gender inequality defines a context of poverty, discrimination, lack of power and violence that makes women more vulnerable. Premature sexual activity is often involuntary, uninformed and unprotected. Sexual violence exposes women and girls to risk, including coerced sex, sexual harassment or rape. Women postpone their own health care due to being assigned the role of caregivers.

Women living with HIV are often victims of sexual assault and domestic violence. Fear of violence limits the ability of women to negotiate safer sexual behavior. Forced sex directly increases the risk of HIV in women. Childhood abuse increases the sexual risks during adolescence and adulthood. Women living with HIV who disclose their diagnosis to their partners are at greater risk of violence. Despite the existence of protective laws, violence against women persists; the application of the law is inconsistent. Many countries do not criminalize marital rape. Laws that establish sexual and reproductive health rights for women are controversial and slow developing. Policy makers do not recognize the link between reproductive health rights and HIV. Women living with HIV lack access to reproductive health services, suffer discrimination and violation of confidentiality, and receive little or no information about their sexual and reproductive health rights. Women living with HIV are often subjected to sterilization and forced abortion. Legislation and public policies are failing to address the growing feminization of the epidemic and violence against women. There is a lack of protocols for rape cases involving post-exposure prophylaxis for HIV and other STIs and emergency hormonal contraception. There is a lack of public investment in female condoms.

Stigma, discrimination and denial of the sexual life of women who are living with HIV contributes to the violation of the right to decide the number and spacing of children and undermines the health of women. There is a failure to provide counseling on family planning as part of HIV care. Assisted child-birth and adoption as options for women living with HIV are absent in national HIV policies and programs.

6 Ms. Yolanda Guirola, the Norma Virginia Guirola de Herrera Institute of Women’s Studies, El Salvador.
Advocacy on women’s rights is poorly coordinated and there is a lack of consensus on common agendas in the context of HIV. We see a division in the women’s movement in relation to advocacy for policies to promote the sexual and reproductive health rights of women. Advocacy needs to address the increased involvement of the church in the definition of public policies related to sexual and reproductive rights of women and comprehensive sex education.

There is a lack of funding for advocacy work on issues of women’s rights. Women and HIV need to be more
prominent on the agenda of the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund).

Actions to reduce women’s vulnerability include:
1. Develop specific prevention campaigns for women to recognize gender inequalities and make visible the vulnerability of women to HIV;
2. Identify gender-based violence as a routine part of prenatal care and post-test counseling for women living with HIV;
3. Provide STI and HIV prevention services to victims of sexual violence;
4. Ensure the integration of HIV services with sexual and reproductive health services;
5. Provide more information about HIV, especially among women whose partners have risky sexual behaviors;
6. Expand HIV testing and counseling services for women of childbearing age;
7. Support programs that prevent sexual and gender-based violence;
8. Provide comprehensive sex education in educational institutions;
9. Ensure adolescents can access guidance and information on sexual and reproductive health services;
10. Ensure empowerment of women and girls is included in HIV policy frameworks.

Rights of women and girls: Southern Africa
7 Ms Priti Patel, Southern Africa Litigation Centre.

The issues in Southern Africa are similar to those described in Latin America. There is very little work being done on sexual and reproductive health rights.

Property and inheritance rights are a major gender equality issue. There are numerous laws that overtly discriminate against women and girls. For example, in Lesotho only the firstborn legitimate son has the right to inherit. Although there are constitutional rights to gender equality, discriminatory laws remain on the statute books. Governments have no political drive to rectify these laws and case-by-case legal challenges are very piecemeal. Forced sterilization and HIV testing of pregnant women without their consent in public and private hospitals represent widespread violations of women’s rights.

In Botswana, an NGO working in the HIV field stipulated a condition of employment that employees not become pregnant. This indicates the extent to which sex discrimination is entrenched. As in Latin America, in some countries marital rape is not criminalized. No country in the region is focusing on the relationship between HIV and cervical cancer, which is preventable and treatable. There is a higher mortality rate for cervical cancer among women living with HIV.

There are no government policies to assist women living with HIV and women in general to access HIV services. Public health models focus on individuals and their sexual partners. Post-test counseling focuses on ‘how to protect yourself and your partner’ – there is no conversation about how to have children and where you can go for support about reproductive health issues. There is a failure to recognize the social pressure placed on women to have children in African communities. There is little attention given to the right of women to reproductive choices. Women do not know where to turn for support.

When the International Community of Women Living with HIV/AIDS (ICW) held a meeting with young women living with HIV in Namibia to discuss their rights, some women said that they had been sterilized but they did not understand that to be a violation of their rights. They had not known that they had been sterilized when it occurred, it was disclosed later when they went back to hospital for a check-up. When told, the women were not surprised they had been sterilized, as they did not understand they had a right to fulfill their reproductive choices even if they were HIV positive. When during the course of the meeting with ICW the women became aware that their rights had been violated by forced sterilization, other rights violations were disclosed. Lawyers have not yet pushed far enough on constitutional rights to test issues such as women’s right to abortion. Women’s rights groups are poorly coordinated, so duplication of advocacy efforts is an issue. There is very little priority placed on women’s rights and reproductive health issues because there is very little funding for programs addressing these issues.

Sex work is criminalized within the Southern African region. Sex workers are arrested for offences such as loitering and vagrancy. Police can hold sex workers for up to 48 hours and extort money from them. Strategically, the Southern Africa Litigation Centre wants to work with other groups that are targeted by
loitering laws. This will allow advocacy to focus on the broader unifying issue of the rights of citizens to protection from police abuses. Litigation strategy needs to recognize how most-at-risk populations are perceived. A case challenging the compulsory testing of female sex workers has been carefully framed to focus on testing without consent, rather than the fact that the women who were tested are sex workers.

A priority is to better understand the prevalent violations of women’s rights, which requires research and local dialogue to uncover abuses and inform an advocacy strategy. We need to be vigilant to ensure sexual and reproductive health rights are not lost while so much emphasis is given to ARVs. Ensuring women living with HIV obtain access to prevention and treatment services for cervical cancer is an urgent priority.

**Discussion: rights of women and girls**

Stigma is the underlying cause of discriminatory laws and practices. We should target media and religious leaders to tackle the beliefs that generate stigma and justify discriminatory customary laws e.g. in relation to early marriage and FGM.

For women to call for their rights they must know what their rights are, which requires creating spaces where women can present their own agendas relating to employment rights, family rights, inheritance and housing. In El Salvador, human rights organizations have proposed multidisciplinary laws addressing women’s rights in education, labor, prisons, migration and mobile populations. In El Salvador a clinic offers a holistic package of services including psychological, medical and legal assistance to women living with and affected by HIV.

In the MENA region knowledge production is recognized as important, which means supporting progressive thinkers, including women scholars, who are pioneering religious thinkers. For example, an intellectual moderate was able to challenge FGM. Religious factors affect policy in all regions. The anti-prostitution pledge introduced by the USA Leadership Law on HIV/AIDS had religious origins. Religious groups also oppose harm reduction laws.

In Central America, customary laws of indigenous communities sometimes go against the interests of women, e.g. women have very limited inheritance rights in traditional communities in Mexico.

Property and inheritance issues are primarily resolved under customary law provisions in Africa. Although we can mount constitutional arguments, we also need to do a lot of work on the ground to change community beliefs and tap into deeper conversations. In Lebanon, law reform is not realistic in the short term, so we have to focus on the judiciary. It may lead to positive results if research focuses on creating change based on a body of evidence that supports a reinterpretation of the law. We need a multi-disciplinary approach. Insisting on the importance of religious leaders is risky and could lead to negative results if ideology is the point of reference rather than evidence.

In the MENA region, sex workers are difficult to reach because they are highly stigmatized and they have little sense of community. In Egypt, it is more difficult to reach female drug users than male drug users.

HIV can be a useful entry point in arguing for women’s rights e.g. in the MENA region we were able to persuade parliamentarians that unequal age of eligibility to marry contributes to HIV vulnerability. This resulted in a change in the law to equalize the age of eligibility to marry. It is a common experience of Egyptian women to marry at a young age such as 13. They may hence acquire HIV from their spouse while still very young.

How can we use human rights norms to address customary law and the obstacles of tradition? In Zimbabwe, although the Constitution states that divorce settlements are governed by customary law, the courts have been prepared to intervene based on the concept of overarching rule of tacit universal partnership.

Litigation provides us with tools by which we can bring about social change. Litigation and law reform for sex workers’ rights in Louisiana is based on a social movement. Advocacy groups were able to persuade the churches to support law reform by emphasizing the impact of prosecutions on women’s lives.

Women lack ownership in the concepts of human rights defined by international treaties and national constitutions. If ownership in these concepts is promoted at the community level then women will fight for their rights. The dual system that operates in many countries of customary law and statutory human rights law is unhelpful. Courts are not going to change laws unless there are popular education campaigns on HIV, gender equality and human rights, efforts to train advocates and support for more women to participate in the legal profession. In Zimbabwe, a quota system was established so that more women were admitted into law school. Women’s legal organizations in East and Southern Africa have led to an increased profile of women in the
profession including judicial appointments. In Latin America there has been a movement to introduce sexual and reproductive health law and to consider issues such as same-sex marriage and abortion in universities. The mainstream women’s movement has been reluctant to engage in the rights of women living with HIV. ICW has documented violations of positive women’s rights and examined legal frameworks and services across a number of countries. The strategy has been to bring women together to build regional momentum to address these issues.

In the USA there has been a campaign for resource allocation arguing if 30% of the epidemic burden is borne by women then 30% of resources should go to women. Key issues that can be highlighted and addressed through networks include assisted reproduction, forced sterilization and violence against women. In Brazil, we need to form alliances with the mainstream women’s movement, e.g., in support of the historic Maria da Pena Law on violence against women. Sterilization is the only sexual and reproductive health service being provided to HIV-positive women in Peru. Women are sometimes provided financial incentives to participate in clinical trials that are ethically questionable.

In South Africa, many women were blamed for bringing HIV into the home. The Treatment Action Campaign (TAC) worked with the AIDS Law Project to successfully advocate for a new broader definition of rape in the Sexual Offences Act. However, pursuing a rape prosecution is traumatic for women and only one in nine reported rapes results in a conviction.

**Small group feedback: rights of women and girls**

**MENA**

Women lack access to legal aid and legal information. Very few organizations offer women legal services. Laws are interpreted according to religion and culture. Engaging religious leaders and training of police, judiciary and NGOs is important. Some NGOs refuse to deal with cases that concern HIV. A new jurisprudence needs to evolve that supports vulnerable groups. Privacy can be protected by new means such as electronic litigation.

Society needs to understand the reasons why people sell sex. Economic factors often determine individual women’s involvement in the sex trade so it should not be criminalized. Social and economic empowerment is required. People who engage in sex work should do so without coercion. In cases of coercion and trafficking, the law should target the traffickers and the victims should not be criminalized.

Increasingly, civil society organizations are defending the rights of women and MSM, and more progressive laws are being introduced e.g., the rights of women to request divorce. In the MENA region, networking needs to occur at the regional level, using electronic portals for sharing information and encouraging greater participation.

**Southern Africa**

The group focused on the need to develop a common movement to overcome differences in ideology and competition for money. Some women’s organizations do not identify with a human rights agenda and are uncomfortable addressing or associating with sex workers’ rights. It is easier to reach common ground on issues such as inheritance. Cooperation at the regional level may assist to define a common vision and to address structural issues that lead to organizations becoming territorial.

**Latin America**

In Brazil, very few feminists are interested in HIV. We need to develop approaches to encourage interest and engagement in HIV issues from the women’s movement. We could make use of events of Inter-American Commission on Human Rights. The rights of female prisoners are a priority. In many countries, religious discourse has been an obstacle to the use of condoms. An alternative discourse based on sexual and reproductive health rights should be articulated to resolve this problem. Emphasizing the importance of a secular state is strategically important.

**USA**

To achieve progress on the issue of sexual health education, advocacy should first mount the case for legally mandated sexual health education for children in care facilities, such as juvenile correctional facilities. Education should address the needs of lesbian, gay, bisexual, transgender and intersex people and address sexual violence for males and females. States have legal obligations to provide services to children in care, so arguing that this duty includes the obligation to provide sexual health education is a viable legal argument. Such an approach requires working with public health officials, health care workers, legislatures, children who have been through
facilities, and the broader public to justify the policy as important. The rationale for the policy change includes cost effectiveness factors. Evidence of the incidence of HIV and STIs among children in facilities would be important. Success in achieving this policy change would provide the foundation to then focus on advocating for sex education in schools.

5 CRIMINALIZATION
Criminalization of lesbian, gay, bisexual, transgender and intersex people (LGBTI) and MSM in Africa

Same sex practices are illegal in thirty-eight African countries. There are an increasing number of countries trying to either introduce such laws or increase the penalty when the law exists already. Penal code provisions are increasingly being used to arrest, detain, blackmail and silence MSM across Africa. Laws are being applied because LGBTI communities are more visible; access to justice, legal aid and legal assistance are limited. When arrested, it is often difficult to secure legal representation for LGBTI people and MSM. Lawyers are often ignorant about LGBTI rights. Access to justice is compromised by homophobia and ignorance, exemplified by the views of some prominent political leaders (Presidents Nujoma of Namibia, Mugabe of Zimbabwe and Zuma of South Africa).

Some laws are overtly discriminatory, such as laws criminalizing same-sex practices between adults (e.g. Botswana, Malawi). In some countries, laws relating to public decency, vagrancy, public order or idleness are enforced against MSM (e.g. Mozambique, Nigeria). An example of the impact of these laws is the arrest and detention of the couple in Malawi in 2010. We are seeing frequent harassment of LGBTI people and their defenders (e.g. targeting of organizations by police in Senegal and Malawi). There is very limited solidarity and support from other movements. In Ghana, a prominent women’s rights organization argued for criminalization of same-sex practices in a constitutional review. In Malawi, the Law Society thanked the police for the sodomy arrests. HIV-related services targeting MSM and transgender people are unavailable in mainstream healthcare facilities in Africa.

Discrimination is often rooted in ignorance. People perceive homosexuality as un-African, un-Christian and a ‘white’ disease. Many Africans are unaware that sex between men occurs in the community. There is a perception that neo-colonial agendas are informing the claims of those advocating for homosexual rights and this represents a threat to national sovereignty. Communities are concerned that homosexual rights agendas are mostly about redefining marriage and adoption and represent a threat to orthodox understandings of the family. It is also perceived that advocates for homosexual rights (including donors who threaten cuts to aid funding if homosexual rights are violated) are pushing for special rights for a small minority when mainstream issues, such as the rights of women and girls and economic development, are yet to be addressed.

8 Mr Joel Nana, African Men for Sexual Health and Rights (AMSHeR).

“Decriminalization is a component of the protective framework in which we work. We cannot wait for sodomy to be decriminalized in order to ensure that men who have sex with men can access services; the ability of men who have sex with men to access services has to be protected, regardless of the status of criminal laws.”
Joel Gustave Nana Ngongang, African Men for Sexual Health and Rights, AMSHeR.

Sex between men has been decriminalized in India as a result of litigation based on constitutional rights. LGBTI issues are complex – it is never just about the law, so this litigation-based approach may not work in the African context. In India, the approach was successful because of unique circumstances: a culture of litigation; a body of jurisprudence to build a case on; an understanding of the issues among the judiciary; an organized community to be the public face of the litigation, to initiate the legal process and make the claims; and voices of tolerance from those who supported decriminalization in the broader community.

In the African context, a range of interventions are required to create a more enabling environment including ‘know your rights’ campaigns, documentation of and redress for specific rights violations, legal aid, and work with a broad range of partners (e.g. national human rights institutions, sexual and reproductive health organizations, mainstream human rights and HIV organizations). In Senegal, the national human rights institution initially denied that men arrested for sodomy offences had experienced human rights violations on the grounds that these men are criminals. Strategic partnerships and participation are important at the national
level through national HIV commissions and Country Coordinating Mechanisms of the Global Fund to Fight AIDS, Tuberculosis and Malaria. Africa is experiencing a growing movement of strong activism for LGBTI rights, and involved organizations have adopted a regional strategy with a focus on building capacity and increasing visibility at country and regional level. Examples of progress in 2010-2011 include:
2. The establishment of a committee on the rights of people living with HIV and vulnerable communities (including MSM) by the African Commission on Human and People’s Rights;
3. Advocacy successes in Uganda (retraction of the Anti-homosexuality Bill) and Malawi (Presidential pardon of sodomy offences);
4. In Senegal, nine year sentences for homosexual acts were overturned; and
5. African Men for Sexual Health and Rights (AMSHeR) is arguing with some success for inclusion of MSM issues in national strategic plans and proposals to the Global Fund.

There is still a preference of funders to focus on less controversial programmatic areas (such as condom programs) rather than human rights advocacy. When funders are prepared to provide support for rights-related initiatives, it is often only for strategic litigation. This can be unhelpful or even damaging if inappropriate cases are packaged as strategic litigation to please funders.
Priority actions include: building bridges with other movements (e.g. sex workers) to work on broader issues of discrimination and abusive policing practices; supporting and participating in work at the regional level; and increasing support to community-led interventions. Work at the regional level is crucial because in many cases there are no country-level organizations to provide advocacy at the national level. Regional organizations provide a space for advocates to share lessons and learn from each other. Funding from the Ford Foundation has been essential to sustain the regional work of the advocacy group AMSHeR since it was established two years ago.

It is difficult to track the number of incidents of arrests of LGBTI people and MSM, but they are frequent, and people are often sentenced to terms of imprisonment. When AMSHeR is made aware of specific cases, the strategy is to exert pressure from different angles including international political pressure. In Senegal, AMSHeR used religious leaders. AMSHeR also argue that by arresting MSM the justice sector is undermining the work of the health sector, which uses donor funds to target MSM in HIV prevention. Ultimately when AMSHeR intervenes, most cases result in early release. Sometimes this is the result of an acquittal, sometimes the defendant is released on bail and the trial is discontinued. But the laws remain on the statute books.

**Criminalization: USA**

9 Mr. Alexis Agathocleous, Center for Constitutional Rights, and Ms. Davida Finger, Loyola University.
There is a proliferation of HIV exposure laws in the USA and an HIV crisis in prisons. Laws and law enforcement have a disproportionate impact on African Americans living with HIV. Most civil rights law draws on the concept of the right to privacy that was developed in the 1960s through case law on contraception, in the 1970s through abortion case law, and as a result of the 2003 case that struck down sodomy laws as unconstitutional (*Lawrence v. Texas*).

Populations that have not benefited from the concept of the right to privacy include LGBTI communities, sex workers, low-income women of color who engage in survival sex work, and people living with HIV.
Although privacy jurisprudence has established a right to contraception, police nonetheless use the fact that a person has condoms on their person as evidence of intent to engage in sex work.
In Louisiana, people accused of sex work have been charged under the *Prostitution Statute* or the *Crimes Against Nature Statute* (CANS). Police and prosecutors have had discretion to determine which statute to use when charging persons accused of sex work, with significantly different consequences for the person charged. Under CANS, the offence of “unnatural carnal copulation” (defined as oral and anal sex), is a felony with heavy penalties. People who are convicted under this provision are placed on the public sex offender register. Conversely, an offence under the *Prostitution Statute* (which encompasses all sexual penetration), is not a felony and does not result in registration of the offender on the public sex offender registry. Notably, 40% of the
people listed on the Orleans sex offender registry are people convicted under this sodomy statute. 76% of people convicted under CANS are women, 80% of whom are African American. The CANS provision has been interpreted as outlawing all unnatural carnal copulation for money and has been applied to sex workers including low-income African American women, transgender women and MSM. Although sodomy laws in other states are considered unconstitutional, the state of Louisiana has continued to enforce the CANS law against sex workers. The sex offender register, which includes the convicted person’s name and photo, represents a disproportionate and ongoing penalty for sex workers convicted under the CANS law. Offenders are required to advise local schools and businesses of their registration on the register and carry a card that identifies them as a sex offender. Registration creates barriers to access treatment, housing and employment.

In particular, registration on the sex offender register restricts access to accommodation. Housing services are reluctant to provide housing to people on the sex offender register. In the context of the post Hurricane Katrina housing shortage and associated increases in rental prices, it can be extremely difficult for persons convicted under the CANS provision to secure housing. Successful advocacy has required long term and meaningful collaboration and partnerships with non-profit organizations and lawmakers. The sex offender register was adopted in the early 1990s. Local police and sheriffs share data with state police, who send data to federal authorities. Information on the national register is available internationally.

A strategy was implemented to challenge the CANS law using litigation, advocacy and media. A federal civil rights lawsuit was lodged against the Governor of Louisiana, the police department, and other state actors. The claim demanded penalties to be reduced, an end to registering offenders, and removal of offenders from the registry. Advocacy involved work with community groups and lawmakers to promote understanding of the injustice of the situation and the need for a coherent policy framework. Work with media resulted in a newspaper editorial calling for repeal of the law.

A new law signed in 2011 addresses many of the problems created by the CANS law. The new law was enacted as a result of litigation in the case of Doe v. Jindal and eliminates the requirement that sex work offenders be registered on the sex offender register. However, the new law applies only to convictions after August 2011. The litigation was a successful collaboration between community organizations and legal advocates. Lawyers are awaiting a decision on whether sex workers convicted under the CANS law prior to August 2011 can be removed from the sex offender register.

Louisiana has very high HIV rates. 75% of newly diagnosed HIV cases are African Americans. Causes include lack of access to condoms, a widespread lack of sex education and health education generally, and the role of some evangelical churches in Southern states which perpetuate some of the stigma. Socio-historic determinants include the history of poverty, racism and gender issues that are amplified in Southern regions of USA. Louisiana criminalizes HIV exposure regardless of intent and has legislation prohibiting sex education in schools and clinics. Sterilization and drug testing of welfare recipients has been proposed. Criminalization of exposure to HIV results in sex workers and people living with HIV being placed on the sex offender register, which compounds social and economic disadvantage.

**Southern Africa: criminalization of sex work**

It was noted that there is a similar intersection of issues relating to housing, employment and race that affect HIV vulnerability in Southern Africa, as in Southern USA. The video “From behind the shadows” was shown, which depicts the human impact of the criminalization of sex work in Harare, Zimbabwe. Sex workers are mostly charged with loitering under the Criminal Procedure Act. Sex workers either pay a bribe or provide sex to police to avoid prosecution. They are prone to being abused, raped and assaulted. The stigma associated with sex work means police assume they are guilty and should be detained and abused. Sex workers are difficult to reach: stigma is a barrier to HIV prevention and rights protection.

**Discussion**

Governments should not interfere in private sexual matters between consenting adults. Governments should be secular rather than impose religious moral values. Decriminalization requires changing the mindsets of lawyers and policymakers regarding LGBTI communities and sex workers. In Africa, decriminalization is very important, but is not our first battle. Protection is the utmost goal in LGBTI advocacy. Access to services that offer
protection is fundamental and can happen in advance of decriminalization.

It is helpful to characterize the need for sex education and to eliminate homophobia as public health issues. In some African countries, clinicians are often willing to provide services to MSM. In Uganda, clinicians went to parliament to argue the public health reasons to oppose the Anti-Homosexuality Bill.

In Zimbabwe, sex workers prefer anonymity rather than legal representation. Many do not want to jeopardize their relationship with police. Sex workers find it more expedient to negotiate directly with the police, which may mean tacit acceptance of rights violations (extortion and sexual assault). In Louisiana it was possible to file the lawsuit anonymously. Creating demand from communities for litigation involves tackling stigma. Collating case data to provide evidence of trends to present to legislators and policy makers is important. Advocates need to highlight inconsistencies such as lack of alignment between policies of the justice sector, which punishes MSM and drives communities underground, and the health sector, which is urging MSM to come forward and access health services (e.g. MSM in Senegal).

The USA is resistant to international human rights laws and mechanisms. There is increasing interest from civil rights communities to mobilize new tools, although US jurisprudence is seen as unassailable. There is often an arrogant reluctance within the USA to look to the international community for new approaches and mechanisms for promoting human rights. Louisiana is an anomaly; no other state criminalizes solicitation of sodomy. Thirty-four states have statutes criminalizing HIV exposure, which triggers sex offender registration requirements. The criminal law is used in pernicious ways to prosecute people spitting at police or a prison officer, although there is no basis in science for such prosecutions. In Louisiana, conversations with church leaders were important to explain the life situation and lack of life choices of sex workers and to generate empathy. Stories told by women affected by the law helped to bring the community together around the issue. It is important as ‘movement lawyers’ to ask communities what their demands and priorities are before litigating.

In many states of the USA, convicted felons lose the right to vote while in prison and for a period post-release. In reality, due to the disproportionate number of African Americans and Latinos in prison, this takes voting power away from African-Americans and Latinos. Community organizing and litigation are addressing and changing these laws state by state. Advocates in different regions could benefit from comparative research on the concept of the criminalization of unnatural acts, and research on how the legal system addresses sex workers, injecting drug users and MSM – looking at issues relating to evidence, police conduct, duration of detention and penalties. The police and judiciary may respond if they know that advocates and researchers are monitoring their conduct. Using evidence-based research, a judgment in Lebanon held that sex between men in private is not an ‘unnatural’ act for the purposes of Lebanese law.

Some religious leaders in the MENA region acknowledge in private that MSM have full rights to health and privacy, notwithstanding that the conduct of sex between men remains sinful according to religious doctrine. Whereas in Arab communities, privacy is respected by culture, in sub-Saharan Africa culture is not individualist and privacy is less well protected or understood.

In the Arab states, 40 years ago sex work was not criminalized. In Egypt there was no tradition to criminalize sex work until fear of the spread of STIs led to application of criminal laws.

In MENA countries where there is no specific sodomy offence, police rely on sex work offences to arrest MSM. Police also rely on invasive anal examinations as ‘proof of homosexuality.’ The medical profession needs to be held accountable for producing medical reports that purport to provide evidence of male homosexual acts, but which have no scientific basis. Such conduct is a clear violation of medical ethics. Police and judiciary consider prostitution to include homosexual acts; possession of condoms is used as evidence of a misdemeanor. Men are detained and monitored after release. Under strict Sharia law, male homosexual acts can be punished with a death sentence. The rise of religious fundamentalism means that we may see explicit criminalization of homosexual acts and harsher penalties.

In El Salvador, sex workers organized themselves to resist abuses. In Argentina, sex workers formed a labor union and there is now a network promoting the rights of sex workers in Latin America and the Caribbean that has submitted a proposal to the Global Fund. There is also a regional LGBTI association. Regional networks can supply leadership to progress national issues.

Criminalization of HIV transmission in Brazil has involved three courts cases that found people living with HIV
guilty of attempted murder with cruel intention.

6 ACCESS TO TREATMENT
Access to Treatment in the MENA region

HIV prevalence in the MENA region remains low, except in Djibouti and southern Sudan (South Sudan). There are concentrated epidemics in Egypt and Sudan among MSM; in Bahrain, Libya and Oman among injecting drug users, and in Algeria, Morocco and possibly Yemen among sex workers. The trend is one of rising HIV prevalence, rising rates of new HIV infections and rising AIDS-related deaths.

Access to treatment is an essential component of the right to health. Coverage of health sector interventions is influenced by availability of services and demand. In 2009, the MENA region had an ARV coverage level of around 12%, the lowest in comparison to other regions of the globe. Coverage of ARV drugs is particularly low in Sudan (South Sudan), Somalia and Egypt. There is diversity within the region, with some countries such as Tunisia enjoying ARV coverage levels of greater than 50% and Oman of more than 90%.

In theory, ARVs are affordable – almost all MENA countries provide ARVs for free. However, obstacles to treatment access include discriminatory laws and practices, centralization and control of distribution and interruptions to supply due to procurement issues, policies on prices, and patent laws.

Demand for ARVs is influenced by uptake of HIV testing and timely introduction of ARVs, monitoring and follow-up. HIV testing and counseling services are expanding and improving, and there is more civil society engagement in testing programs allowing outreach to most-at-risk populations. Factors that need to be addressed to ensure optimal levels of demand for ARVs include:

1. Reducing stigma and discrimination by changing attitudes and raising awareness;
2. Addressing barriers created by criminalization that prevent outreach services reaching hidden populations;
3. Ensuring laws and ethical standards prevent breaches of confidentiality; and
4. Ensuring that prevention programs are targeted and well designed.

The number of HIV testing and counseling facilities is inadequate given the population size. There are gaps between HIV testing efforts and the identification of cases. For example, a disproportionate number of tests are done on migrants. A recent study showed that although migrants represent only 15% of positive results, 60% of tests are done on migrants.

10 Dr. Ragia Elgerzawy, Egyptian Initiative for Personal Rights.

"If one person needs treatment, she has a right to be treated, even if she is the only person in the country."

Renata Camile Reis, Brazilian Interdisciplinary AIDS Association, ABIA.

Mandatory testing is the most prevalent approach. This violates rights to privacy and bodily integrity. Poor monitoring of new diagnoses can result in delay between clinical eligibility for ARVs and the initiation of treatment. Lack of information and fragmentation of health care services can lead to late initiation of treatment.

For example, in Egypt HIV services are not well integrated into the broader health care system. Fever hospitals are the only public hospitals that attend to people living with HIV. There is no systematic follow-up of patients for drug adherence or resistance. There is a lack of clinicians with experience in HIV medicine. Laboratory services are limited. CD4 tests are only available in two places, and viral load tests are only available for children. Adherence to ARV regimens and patient retention levels provide a good indication of efficiency and effectiveness of treatment. Twelve month ARV retention rates vary across the region: Egypt 75%; Djibouti 74%; Yemen 93%; Algeria 97%; Lebanon 20%. Improvements in treatment access have beneficial affects on quality of life, prevention of HIV transmission and reduction of illness, deaths and the associated cost burdens on the health system.

Treatment failure is an emerging problem caused by a combination of factors: insufficient knowledge among patients and health care workers, sub-optimal adherence to drug regimens, drug stock-outs, and inadequate patient monitoring mechanisms. When first-line treatments fail, patients need to be able to access second-line treatment regimens, which are at least six times more expensive.

Recommendations:

1. Adoption of high quality medical standards consistent with the World Health Organization's
recommendations relating to full and continuous access to care, patient follow-up and adherence monitoring, proper selection and prescription of drugs, community-based health care approaches and continuity of ARV drug supplies.

2. Raising awareness about human rights and legal rights.
   a. Improvements in access to justice for people living with HIV and most-at-risk populations;
   b. Challenging police misconduct and improper law enforcement practices;
   c. Strategic litigation in cases of discrimination;
   d. Redress and compensation for victims of discrimination; and
   e. The effect of intellectual property rights on drug prices.

Access to treatment: Latin America

11 Ms. Renata Reis, Brazilian Interdisciplinary AIDS Association (ABIA).

Latin America has ARV coverage levels of over 50%, which is higher than most low and middle-income countries globally. In the Venezuelan case of Cruz Bermúdez et al. v. Ministerio de Sanidad y Asistencia Social (1999) an action was filed against the Health and Assistance Ministry due to its refusal to provide HIV treatments. The claim alleged violation of rights to life, health, personal freedom and security, and denial of the benefits of science and technology. The Constitutional Court ordered the Ministry to supply the applicants with ARVs, as well as any drugs needed to treat opportunistic illnesses. The Constitutional Court also ordered that the President of Venezuela adjust the budgetary allocation for HIV to pay for treatments. In the Peruvian case of Azanca Alhelí Meza García (2004) a person living with HIV lodged a claim against the Ministry of Health requesting full medical care, including permanent supply of drugs, CD4 tests and viral load tests. This case is a key precedent for the enforceability of social rights in Peru. The Court ordered that action be taken to ensure the realization of the right to health regardless of the limited financial resources initially assigned to the sector.

A petition was filed against El Salvador in the Inter-American Commission on Human Rights alleging violation of the rights to life, health and full development of personality of a group of people living with HIV, in 2001. The case was grounded on the state’s failure to provide ARVs. The Commission declared the case admissible and made recommendations. The parties are still trying to reach an agreement on how to comply with the Commission’s recommendations.

Between 2000 and 2002, the Inter-American Commission on Human Rights granted precautionary measures on behalf of over 400 people living with HIV in OAS Member States (Bolivia, Chile, Colombia, Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras and Peru). In most cases the Commission requested the State to provide the beneficiaries with the ‘treatment indispensable for their survival’.

In Brazil, advocacy has focused on the impact of the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS). TRIPS established minimum standards for protection of intellectual property rights that World Trade Organization member states were required to comply with from 2005. TRIPS allows states to legislate for flexibilities such as compulsory licensing to enable drugs to be made available to address public health priorities, but flexibilities have proved difficult to implement in practice. For example, Paraguay includes all flexibilities in its patent law but has not applied these flexibilities in practice. Governments are often reluctant to implement flexibilities because of pressure from the USA and the large drug companies not to use TRIPS flexibilities.

The Working Group on Intellectual Property (GTPI) of the Brazilian Network for the Integration of Peoples has been formed to focus on legal suits, advocacy, opinions on bills, capacity building, media appearances and publications. GTPI has been involved in six patent challenges, working preemptively to address weak patent applications (e.g. patent applications for drugs that are produced by very minor or superficial changes to an existing drug). Three pre-grant oppositions have been successful (in relation to Kaletra and Tenofovir). A pre-grant opposition in relation to Truvada is awaiting examination. Experience has demonstrated that use of pre-grant opposition processes to prevent patents being issued can produce fast and positive results.

Two court cases are pending in Brazil. One relates to a civil action for a license to issue Kaletra, which is awaiting an appeal judgment. The initial trial in relation to Kaletra appears to have been unsuccessful in 2010 due to fear of retaliation from the USA, rather than legal grounds. The other case awaiting judgment relates to a petition to the Prosecutor General claiming that laws relating to ‘pipeline’ patents are unconstitutional. Over 1,100 pipeline
patents were requested in Brazil under provisions that enabled firms to apply for patents simply on the basis that a patent already existed that had been granted by another country. The international Medicines Patent Pool has signed a licensing agreement with the drug company Gilead in relation to four ARVs. Many middle-income countries are excluded from the Patent Pool deal for Gilead’s ARV drugs, including Argentina, Brazil, Chile, Colombia, Paraguay, Peru, Uruguay, Venezuela, Costa Rica, Mexico and Panama. Challenges that we face include: financing of litigation; courts are often unprepared to judge patent issues due to corruption or political pressure; and the need for training of lawyers on intellectual property and other monopoly practices (including competition law).

**Discussion: Access to treatment**

There is a correlation between countries that lack democracy and low levels of treatment access because people are not equipped to demand their rights. The democratic deficit has health consequences. Citizens need to understand that treatment access is a right, rather than an act of charity. The starting point is awareness raising that access to treatment is a human right, understood in terms of the rights to health, to life and to non-discrimination. In many countries, (e.g. Colombia) there is no political will to break patents. In Mexico, despite the provision of health insurance by the state, bureaucratic obstacles have led to interruptions in the supply of ARVs. Class actions may be necessary against drug companies or governments to ensure treatment access.

It is difficult for treatment activists in Brazil to access medical expertise. The Brazilian Interdisciplinary AIDS Association (ABIA) has the technical support of one pharmacist who works for Médecins Sans Frontières. Universities and research centers are wary of supporting activist lawyers because they rely on private sector financial contributions. There has been success in South-South cooperation between Brazil and India on some patent oppositions.

In South Africa, the Treatment Action Campaign (TAC) focused on treatment literacy at the community level at a time when the nation’s President denied that HIV causes AIDS. Community mobilization and advocacy forced the government to draft a national HIV treatment plan. Although this was successful, some populations were omitted from the plan. TAC had to work with public interest lawyers (Section 27) to mount litigation to confirm the right of prisoners to access treatments. TAC uses all available means, including demonstrations and the media, working through lawyers, NGOs and activists, to pressure government departments in health, finance, trade and industry to work together to improve treatment and care. HIV has enabled us to identify flaws within South Africa’s overall health system. The government has been pressured to produce a plan for the health system as a whole, including building health centers closer to communities and addressing shortages of health care workers. South Africa is moving towards a national health insurance model. Similarly, ARASA has learnt the importance of combining bottom up and top down approaches. ARASA promotes treatment and rights literacy at the community level so that there is demand for the right to health, and also targets governments through advocacy at national, regional and global levels. ARASA is increasingly focusing on a broad health agenda, such as advocating for a global framework convention on the right to health. This broader advocacy agenda requires alliances to be forged with health activists, trade unions and civil movements beyond HIV.

In Zimbabwe, 600,000 people lack treatment access but arguments based on the right to health have limitations because courts will not instruct the executive arm of government where to allocate resources.

A current issue threatening treatment access is the introduction of new European anticounterfeiting laws, allowing generic drugs to be confiscated and destroyed in Europe prior to delivery to Africa or Latin America. Drug companies and governments are both responsible for these laws. Access to generic drugs may be reduced as a result of the anticounterfeiting provisions of trade agreements.

The MENA countries lack drug manufacturing capacity so rely on ARV imports, but the level of demand for ARVs is small and there is little negotiating power to reduce prices. Local production capacity is important but not essential, as compulsory licenses can in theory be used to import drugs if governments have the political will. For the MENA region, it may be more important to negotiate lower prices if it is politically unrealistic to break patents. There may be a need for a different approach compared to high HIV prevalence countries. In the Middle East, migrant workers who are compulsorily tested for HIV have no rights to treatment and are deported. The issues of travel restrictions and treatment rights overlap. Governments need to strengthen resolve to exercise TRIPS flexibilities. It is not only the drug companies who are responsible. Pricing policies vary...
in each country. Some wealthy countries such as Spain have cheaper ARVs than Egypt because of pricing regulations. Price reductions can be achieved by working through a common purchase market. Negotiations with drug companies for voluntary licenses have been successful for second and third-line ARVs. For countries with less demand it may be possible to work with regional organizations to find joint solutions so low HIV prevalence countries are not penalized.

In the Southern USA states such as Mississippi, there is a lack of infectious disease specialists, especially in rural areas. The system in place in Mississippi requires Disease Intervention Specialists to identify and notify sexual partners of individuals who test positive for HIV. Mississippi limits Medicaid beneficiaries to five prescription drugs a month, which may not cover all of a persons HIV prescription drug needs. Federal drug assistance relies on state contributions. Conservative states do not invest in drugs so there are long waiting lists.

IDLO and UNDP training on patents and access to medicines in Nepal in April 2011 resulted in recommendations to inform amendments to proposed intellectual property legislation. In Egypt, Justice and Freedom has held several meetings with the PLHIV to help them write and finalize a document on their rights to have proper access to medicines. The document notes issues related to improper medications and healthcare in general for PLHIV. Violations of patient rights perpetrated by government hospitals have also been documented, and these reports have been presented to the government. The next step will be to refer cases to the judiciary and prosecutors regarding allegations of corruption and misallocation of funds.

7 PLANNING FOR THE FUTURE
In advance of the Consultation, participants were asked to identify upcoming events and priorities for advocacy and networking. Events that were identified included: the Regional Dialogue meetings of the Global Commission on HIV and the Law; national, regional and global HIV Conferences; meetings of funders including Global Fund processes; events and processes relating to violence against women, sexual and reproductive health rights and trafficking; and international thematic days (e.g. International Women’s Day, International Labor Day). In the MENA region there are specific opportunities such as meetings of the League of Arab States focusing on human rights and health, meetings of the Arab Parliament and processes for the drafting of new national constitutions.

Priorities for networking among lawyers included:
1. electronic networking: email lists: exchange lessons, best practices, web-based seminars, developing databases of legal services and centralized collections of resources such as precedent cases, court documents, scientific resources relevant to litigation and model laws;
2. face-to-face networking: exchange programs for legal activists and interns; and identification of lead people in countries and regions as liaison points. Respondents identified the following key stakeholders that lawyers’ networks need to engage with:
   1. national, regional and global networks of people living with HIV and most-at-risk populations;
   2. mainstream human rights movements including national human rights commissions, regional human rights institutions, human rights NGOs, women’s organizations and migrant workers organizations; and
   3. faith-based organizations including religious leaders and religious intellectuals.

Responses suggested that joint actions (whether within regions or between regions) should be limited in number, feasible given constraints of time and money, timely and focused on agreed priorities that the most important in terms of strengthening legal services and rights. Further, joint actions should avoid duplicating of activities that can already be done via existing networks and should represent a worthwhile investment for overworked advocates.

“Bodies have to be free and governments have to be secular in order to [effectively] respond to HIV.”
German Humberto Rincon Perfetti, Colombian lawyer.

Discussion
There are strong parallels between regions in relation to criminalization issues such as sex work. There has already been sharing and learning between regions on useful approaches. There is a common principle of the interference of the state in private consensual sexual relations. Another opportunity is cross-regional collaboration on access to treatment. We can exploit existing tools, for example we can publish stories of

More young lawyers should be encouraged to gain experience in HIV-related matters. This could be achieved by including HIV issues in university legal clinics. In Latin America, participants reported using law students through internships during the summer. This gives students public interest litigation experience and, ideally, inspires them to build a career in the legal aid sector. In the USA, an overhaul of law school curricula is required to integrate practice issues into courses and give students greater opportunities for clinical experience. In Egypt, young graduates can apply for placements with NGOs. Under this program 500,000 young people have been matched with NGOs. This approach can be applied to match young lawyers with human rights NGOs that address HIV-related issues. It is important that donors receive proposals for strengthening legal services. Seed grants may be available to help NGOs develop proposals.

Closing comment by Chair, Dr Khadija Moalla

This is now a global movement on HIV-related law, legal services and human rights. IDLO and the Ford Foundation are offering a platform for collaboration. A key theme has been solidarity: the space that unites us is the space of oneness. Human rights and values of justice, freedom, respect and dignity are universal, regardless of religion, nationality, gender or sexual orientation. United Nations agencies and governments need to be at the service of communities: we need a paradigm shift towards greater accountability to communities. South-South cooperation is valuable, and let us not forget there is a South in the nations of the North.

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32 United States Individual

The public health term “men who have sex with men” (MSM) was first adopted to better describe same-sex sexual behavior regardless of orientation, but the label has, in practice, rarely if ever disaggregated male sex workers who serve men (MSW) or their clients from the MSM label more generally. This is in spite of the fact that MSW face categorically different risks of HIV exposure and treatment access. The erasure translates to unambiguously negative public health outcomes for MSW that are demonstrably rooted in criminal legal responses to sex work as they overlap with anti-sodomy, restrictive migration, and “anti-trafficking” regimes resulting in the profiling of MSW as traffickers.

In the midst of a policy and research vacuum on the subject, this brief sets out actionable policy recommendations for legal reform. The brief’s recommendations include: (1) the full decriminalization of sex work, including “proxy charges” such as loitering, false personation, and disorderly conduct and other charges under which MSW are arrested; (2) the rejection of “demand side” criminalization regimes such as the so-called Swedish Model, which threaten to drastically increase the already-epidemic practice of profiling of male sex workers as “pimps” and “traffickers”; and, finally, (3) the decriminalization and preservation of safer sex venues, where MSW often work, such as public parks and bathrooms, bathhouses, peepshows, brothels, streets, strip clubs, and other cruising zones as public health resources in the fight against HIV and AIDS.

Snapshot—Indonesia

Feraldo Saragi, male sex worker and co-founder of the 1,500 sex worker-strong Indonesia Social Changes Organization (OPSI) has decried the use of laws to demolish commercial sex venues, arguing that “as a result, sex workers go to narrow alleys or boarding houses to look for clients” fueling an increase in HIV transmission.

BACKGROUND

In 1948, Alfred Kinsey found that 10 percent of adult men (ages 15 to 55) engaged in same-sex sexual encounters for at least three years of their life. In 2005, Carlos Cáceres found that between three and 20 percent of all men are estimated to have sex with other men at least once in their lives in parts of Asia, Europe and Latin America. Despite Cáceres’ update, many still assume from Kinsey’s starting point that the population of MSW (let alone transgender sex workers) is by far a minority among sex workers globally. But in some communities, male or transgender sex workers may be far more numerous than female sex workers. While there are few comprehensive population studies, in one U.S. government-funded population estimate of minors who trade sex in New York City, researchers found that 54 percent of youth who trade sex are boys.

In addition to obscuring local majorities of MSW, the “10 percent rule” also vastly overestimates the importance of sexual orientation among people who trade sex more generally, whatever their gender identity. In fact, studies show a very large portion of sex workers may exchange sex with someone they are not “sexually oriented” towards. For instance, in a population study of male sex workers in South Africa, only 37 percent of male sex workers identified as homosexual, compared to 64 percent of MSM who were not involved in the sex trades. Similarly, in a study of the U.S. gay male porn industry, 25 to 40 percent of men were found to be straight identified. These studies support the proposition that MSW experiences have been made largely invisible by MSM public health interventions, despite the purportedly “umbrella” nature of the term.

To remedy this failure, it is important to identify the difference between MSW and other MSM in relation to specific HIV vulnerabilities and barriers to treatment access. While insufficient room exists in this brief, a preliminary outline must include: (1) policing and incarceration of MSW for prostitution-related crimes, (2) profiling of MSW “pimps” or “traffickers,” (3) less discretion for MSW in the choice of sexual partners, (4) higher demand among MSW for cost-prohibitive safer sex resources (e.g. condoms, lubrication) for a variety of differently-equipped clients, (5) potential monetary incentive to MSW to engage in unprotected sex, (6) high rate of self-identification among MSW as “straight” in the midst of “gay” or “bisexual”-targeted or exclusive sexual health resources, and (7) increased risk of punitive consequences to disclosure of MSW status to public health agents, government entitlement officers, and law enforcement when reporting crimes perpetrated against them.

While male sex workers’ HIV vulnerabilities and barriers to treatment access are markedly different than other MSM, few if any of U.N. human rights mechanisms or MSM civil society organizations have raised—let alone championed—the specific health needs of male sex workers. While the repeal of anti-sodomy laws,

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establishment of same-sex partnerships, and the elimination of employment discrimination that are embraced by these organizations arguably overlap with MSW needs, additional priorities must include an end to the police harassment and rape, mass arrest, incarceration, and deportation, all of which exacerbate HIV transmission and limit access to HIV prevention and treatment services. Moreover, male sex workers must be affirmatively involved and supported in collective organization efforts for better working conditions.

RECOMMENDATIONS

Fully decriminalize sex work, including “proxy charges” such as loitering, false personation, and disorderly conduct in addition to other charges under which MSW are arrested. It is often stated as a truism that anti-prostitution policing affects primarily female sex workers. However, the reality is far different in that while MSW are less likely than female sex workers to be arrested under laws with “prostitution” in the title, statistics show MSW may be more likely to be arrested, only under different laws. For instance, in New York City, boys involved in the sex trade are 160 percent more likely to have an arrest history than girls.8

Reject “demand side” criminalization regimes such as the so-called Swedish Model, which threaten to drastically increase the already-epidemic practice of profiling of male sex workers as “pimps” and “traffickers.” In Sweden, where the “demand side” criminalization of clients of sex workers has been in effect for many years, many MSW are still subject to abuses. The Swedish Federation for LGBT Rights has argued that MSW in Sweden are often denied services as a result of not fitting the Swedish profile of female victimization.9

Decriminalize and preserve safer sex venues, where MSW often work, such as public parks and bathrooms, bathhouses, peepshows, brothels, streets, strip clubs, and other cruising zones etc. The preservation of safer sex venues as public health intervention points has been an invaluable tool in combating HIV and AIDS. Where safer sex venues are subjected to closure, sexual activities move to private and increasingly isolated locations. Moreover, policing of such venues may result in arrest, harassment, and deportation for the many people—disproportionately low-income and migrant communities in high-income countries—who may not otherwise have online networking access to facilitate such encounters.

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8 Curtis et.al., supra note 5.
Review of laws and practices that in our view impede HIV prevention, treatment, care and support access in the world of work

The workplace remains one of the main settings where human rights violations against people living with or perceived as living with HIV occur. Membership of any at-risk group subject to discrimination increases the risk of HIV transmission, and at the same time reduces access to employment as well as HIV prevention, care and treatment. This is particularly the case when such discrimination results in more difficult access to the formal economy, where HIV/AIDS measures are more readily available. At the same time, the workplace with its consultative and deliberative structures (social dialogue) offers unique opportunities to reach those who are at risk or are infected, as most of the persons vulnerable to or living with HIV (PLHIV) are of working age (between the ages 15-49). Also, other institutional settings such as healthcare facilities, schools, prisons, emergency services and social welfare settings are at the same time workplaces as well.

1. Non-discrimination framework

HIV-related discrimination in the workplace often arises in relation to access to employment and to particular occupations, assignment/relocation, appointment, promotion, terms and conditions of employment, access to vocational training, as well as termination. In legislative terms it can be covered:

- Explicitly - by extending the list of prohibited grounds for discrimination in employment to include HIV status (real or perceived) in constitutional law (e.g., Transitional Constitution of the South Sudan, 2011)², specific AIDS laws, including on labour and employment (e.g. Peru Ley Nº 26626 of 1996³ and Decreto Supremo Nº 019-2006-TR of 2006)⁴;⁵ Dominican Republic Ley de VIH/SIDA No. 135-11 of 2011,⁶ Mozambique Act No. 5 of 2002)⁶, general anti-discrimination laws, or general labour codes or laws (e.g. Philippines Employment Act of 2001⁷; Spain Ley del Estatuto de los Trabajadores 11/1994 of 1994;⁸ Zimbabwe Labour Relations Act of 2005 (last amendment)⁹ Namibia Labour Act No. 11 of 2007)¹⁰;

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⁵ Ley de VIH/SIDA de la Republica Dominicana No. 135-11 of 7.06.2011 available at: http://copresida.gob.do/sitioweb/PDF/Ley%20%20de%20VIH%20y%20SIDA%20de%20la%20Republica%20Dominicana%20No.135-11.pdf


Implicitly - HIV status, if not explicitly covered, can be protected under other grounds (e.g., health status, disability, sexual orientation) as for example in the United Kingdom (Disability Discrimination Act of 7 April 2005) the United States (Americans with Disabilities Act of 1990) as amended up to 2008 by Public Law No. 110-325, New Zealand (New Zealand Human Rights Act 1993 No 82) Canada (Quebec Charter of Human Rights and Freedom, 1975 and the Decision of the Supreme Court of Canada 2000 SCC 27 [2000] SCJ No 24 (QL) or Romania (Emergency Ordinance No 137/2000).

There is a clear and urgent need to fill in the gap in protections against discrimination on the basis of real or perceived HIV status by non-discrimination law that applies to workplace. Coverage of HIV status under general anti-discrimination legislation may be limited. Some laws that could apply to discrimination on grounds on HIV status may still create specific exemptions concerning, e.g., infectious diseases or migration (Australia Disability Discrimination Act 1992 (amended) – Sections 48 and 52). Even in case of countries that enjoy a comprehensive policy framework on HIV/AIDS or even on HIV/AIDS and the world of work specifically, there might be no legislation protecting the rights of PLHIV. Accordingly, gaps in non-discrimination legal framework, related infringements of human rights and the need for action in this were pointed out in several 2010 UNGASS reports, for instance by Jordan, Trinidad and Tobago and Kenya.

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16 “There are no anti-discrimination laws pertaining to education or the workplace; on the contrary, laws sanctioning the dismissal of “persons with communicable and infectious” diseases, can be, and are, used to deny PLHIV employment and educational opportunities. Testing is mandatory for non-Jordanians applying for work permits in Jordan and Jordanian nationals seeking employment within government agencies.” 2010 UNGASS Report Jordan (p.13), available at: http://www.unaids.org/en/dataanalysis/monitoringcountryprogress/2010progressreportssubmittedbycountries/jordan_2010_country_progress_report_en.pdf

17 “The assessment found that PLHIV encounter discrimination based on their HIV status in the workplace, in health care settings and in the provision of goods and services such as credit and insurance services. There is no protection in the law however against discrimination on the ground of ‘HIV status or suspected HIV status’. General anti-discrimination legislation (the Equal Opportunity Act 2000) exists, but ‘HIV status or suspected HIV status’ is not included as a prohibited ground of discrimination.” 2010 UNGASS Report Trinidad and
Recommendations

The national regulation should afford protection equal to that available under the ILO’s Discrimination (Employment and Occupation) Convention, 1958 (No 111), for instance by including real or perceived HIV status among prohibited grounds of discrimination provided for under national anti-discrimination laws. Applicability should be clearly stated and gaps in protection should be identified (e.g. whether or not protection of HIV-related discrimination can be covered by disability in case of HIV-positive persons with no health problems).

Discrimination on grounds of perceived HIV status should also be covered under legislation as persons may be discriminated against simply because of their association with HIV-positive persons. For example, the non-discrimination principle of the 1998 Costa Rica General Act on HIV/AIDS (Article 4)\(^\text{19}\) covers also relatives and persons closely related to people living with HIV.

Failure to extend protections against discrimination to the informal sector may be equal to systemic discrimination. Coverage of the informal sector should be considered. For example, Mozambique’s Act No 5/2002 applies to all workers, including domestic workers, who are often excluded from labour regulations (Article 3).\(^\text{20}\)

One of the possible measures to protect people being subjected to HIV-related discrimination in recruitment or employment could be to adopt procedural rules reversing the burden of proof by placing a primary obligation on employers to prove that they did not discriminate, once a difference in treatment is established by the worker (as in the EU non-discrimination regulation).\(^\text{21}\)

2. Mandatory Testing and Disclosure

The ILO Recommendation provides that there should be no mandatory HIV testing and disclosure in the workplace (paragraphs 3(i), 24-29), regardless of sector or type of work. This prohibition applies to workers, job seekers, job applicants, and it also explicitly covers migrant workers (paragraphs 27-28). However, this standard


is in reality widely violated.

- Mandatory HIV testing is most commonly found in the contest of certain occupations such as: health personnel - e.g. Indonesia (Decision No. 20/DJPPK/VI/2005);\(^{22}\)
- Aviation personnel, particularly pilots – e.g., USA (Code of Federal Regulations);\(^{23}\) International Civil Aviation Organization (ICAO Manual of civil aviation medicine 2006, Ch. 12)\(^{24}\) as well as Joint Aviation Authority (JAA) of Europe (JAA Manual of civil aviation medicine 2006).\(^{25}\) New Civil Aviation Authority Regulations for Swaziland for 2011 prohibit the granting of pilots’ licences to individuals who are HIV-positive or have tuberculosis.\(^{26}\) Good practice is also found (e.g., case Hoffman v. South Africa Airways, 2000).\(^{27}\)
- Armed forces and uniformed services (e.g. Indonesia,\(^{28}\) Rwanda,\(^{29}\) Uganda,\(^{30}\) Zambia,\(^{31}\) Viet Nam\(^{32}\)) as well as civil service (e.g. China,\(^{33}\) Jordan),\(^{34}\)

\(^{22}\) Mandatory testing applies to those who may be working in an environment where they will be exposed to the virus; see Decision No. 20/DJPPK/VI/2005 providing technical guidance on the prevention and control of HIV/AIDS in the workplace, 2005 (Part C, s. 2(c)), available at: http://www.ilo.org/wcmsp5/groups/public/---asia/---ro-bangkok/---ilo-jakarta/documents/publication/wcms_123957.pdf


\(^{27}\) In 2000 the Constitutional Court of South Africa found that the SAA regulation excluding people with HIV from recruitment violated equality rights. Instead, even in an occupation at risk medical examination should define the person’s ability to work. Constitutional Court of South Africa, Jacques Charl Hoffman v. South African Airways, 28 September 2000, Case No. CCT 17/00 available at: http://www.saflii.org/za/cases/ZACC/2000/17.pdf


Even where mandatory HIV testing in the workplace is prohibited by law, challenges may arise where regulations are issued aiming at scaling-up HIV testing such as the opt-out (provider-initiated) HIV testing rule. In such cases guidance may be unclear and may allow for contradictory interpretations. For instance, in Botswana (the first African country that introduced routine HIV testing in all healthcare settings in 2004) the existing policies - including the National Policy on HIV/AIDS36 - recommend measures to protect against mandatory HIV testing in the workplace. However, these policies are not legally binding, leaving their implementation to the discretion of each employer. While no official statistics have been collected on this issue, acts of discrimination are common and lack of legislation leaves the courts unable to find the employment related HIV testing illegal. Two court cases already underscored an urgent need for specific legislation. Both cases involved employees whose employment was terminated as a result of a positive HIV test37 or as a result of the refusal to undergo a HIV test.38 In the first case the Botswana Industrial Court ruled that the termination was both substantively and procedurally unfair but, in the absence of relevant law, not illegal. In both cases the Court was unable to outlaw HIV testing and it exhorted to the legislature to address this issue.39 For years, this lack of binding legal protection of HIV-related rights at the workplace has been a concern for the national trade union centre, Botswana Federation of Trade Unions (BFTU), which is affiliated to the ITUC. The draft act has been under negotiations since 2006, but still with no conclusion.

In the Czech Republic HIV+ patients are required to disclose their HIV status to a medical practitioner before any

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35 The issue of HIV related travel restrictions is well researched and the database available at: http://hivtravel.org/ provides with information on countries that do not support freedom of movement for PLHIV.

36 Botswana Ministry of Labour and Home Affairs Policy in HIV/AIDS in the Workplace, 2003, Article 8.1.1. Available at: http://www.ilo.org/aids/legislation/lang--en/docName--WCMS_125675/index.htm .Draft national policy on HIV/AIDS and employment, 2007. Section 7.5.6 regulates that if for any reason an employer or public authority determines that HIV testing is necessary and is a bona fide occupational requirement, such as the protection of public health and safety, the authorisation of the courts of law must be sought. see: ILO 2007 White Report “HIV/AIDS and the world of work” par 266.


procedure, with the sanction of possible criminal charges where they fail to do so (Article 53(1) of the Czech Public Health Protection Act No. 258/2000).\textsuperscript{40} Medical boards may explicitly encourage their members to initiate such prosecution if they find any of their patients failed to inform about their HIV positive status.\textsuperscript{41} Laws obliging patients to disclose their HIV status to medical practitioners outside of the employment setting can negatively impact on occupational medicine where workers (including job applicants) are required to recurrently undergo medical examination which may violate mandatory HIV testing prohibition. Accordingly, several national 2010 UNGASS reports expressed concerns about gaps in national legislation that do not allow for unambiguous interpretation of protection concerning mandatory HIV testing in the workplace.\textsuperscript{42}

**Recommendations:**

Countries need to develop laws and policies that balance the need for disclosure of HIV information with the protection of the privacy and autonomy of individuals with respect to their HIV status. The law should provide for explicit or implied but unambiguous prohibition of mandatory HIV testing or disclosure for employment purposes, regardless of occupation or type of work.\textsuperscript{43} The coverage of this prohibition should reflect the scope of application of the ILO HIV and AIDS Recommendation (Article 2).\textsuperscript{44}

It should be considered that because workers are dependent on their employers, meaningful consent to workplace testing may not be possible. Accordingly, the law should provide that the prohibition of HIV testing in the workplace should not be waived solely by the person giving his/her consent (see: opinions of the EU Data Protection Working Party 1999-2002 or ILO 2003).\textsuperscript{45}

If testing is offered by the employer, additional safeguards should be put in place. Examples include

\textsuperscript{40} Czech Public Health Protection Act No. 258/2000, available at: \url{http://apps.who.int/idhr-rls/idhr/531CR02007.pdf}

\textsuperscript{41} This is currently the case of the Czech Dental Society. The text of the Society's recommendation can be found here: \url{http://dent.cz/detail-novinky.pho?id_polozka=103&id_strana=4}.

\textsuperscript{42} See e.g. 2010 UNGASS Report Kenya “The approach to testing and counseling is officially voluntary; however, there are cases of mandatory testing during recruitment”, (p. 32), available at: \url{http://www.unaids.org/en/dataanalysis/monitoringcountryprogress/2010progressreportssubmittedbycountries/kenya_2010_country_progress_report_en.pdf}.

\textsuperscript{43} The World Medical Association (WMA) in its “Statement on HIV/AIDS and the Medical Profession policy” released in 2006 states that even for public health purposes, mandatory HIV testing of an individual against his or her will is a violation of medical ethics and human rights and therefore exceptions to this rule may be made only in the most extreme cases and should be subject to review by an ethics panel or to judicial review (point 13) \url{http://www.wma.net/en/30publications/10policies/a25/index.html}.

\textsuperscript{44} ILO HIV and AIDS Recommendation, Article 2: “This Recommendation covers: (a) all workers working under all forms or arrangements, and at all workplaces, including:(i) persons in any employment or occupation; (ii) those in training, including interns and apprentices;(iii) volunteers;(iv) jobseekers and job applicants; and (v) laid-off and suspended workers;(b) all sectors of economic activity, including the private and public sectors and the formal and informal economies; and(c) armed forces and uniformed services”.

requirements of data protection regulations concerning the purpose of data collection (EU Data Protection Directive 95/46/EC or OECD Guidelines 1980)\textsuperscript{46} such as legitimacy, specificity and explicit formulation of the purpose of workplace HIV testing as well as consultations with workers’ representatives.\textsuperscript{47} Another example of additional requirements comes from South Africa, where HIV testing for employment purposes is prohibited unless determined to be justifiable by the Labour Court, voluntary and anonymous.\textsuperscript{48}

Where worker’s consent is relied on, consent must always be freely given, written, specific and informed.

Denying testing should result in no negative consequences for the worker.

3. Confidentiality and data protection

Lack of confidence in protection of personal medical information is a threat to public health globally and a core factor in the continued spread of HIV/AIDS, as perceptions of confidentiality determine people’s uptake of HIV/AIDS services, also if provided in the workplace.\textsuperscript{49} Realisation of the right to data confidentiality is affected both by the growing demand for data as a part of scaling-up HIV services and improved service monitoring as well as by the dependence of this right on the existence of comprehensive data protection laws and regulations. These laws do not exist in a significant part of the world, including almost all Africa.\textsuperscript{50}

In many countries such as Botswana or Zambia, the lack of specific legislation on privacy, confidentiality and data protection relevant to HIV and AIDS in the workplace makes it impossible to safeguard employees from infringement on their privacy and confidentiality rights. In the cited case Jimson v BBS from Botswana, an HIV-positive man was forced to undergo an HIV test by his employer 19 days after he finished his pre-employment medical exam. The doctor who performed the test sent the results directly to the employer. The complainant received his test results through the mail, enclosed with a letter of termination. Because of the lack of specific legislation in that country outlawing mandatory HIV testing in the workplace as well as the lack of data


\textsuperscript{47} See the following provisions of the Directive 95/46/EC and 1980 OECD Guidelines on fair and lawful data processing: Directive 95/46/EC Article 6(1a) (fair processing); Article 8(1) (consent for processing); Articles 10 and 11 (notification principle) and OECD 80 Paragraph 7 (collection limitation). See the following provisions of the Directive 95/46/EC and 1980 OECD Guidelines on purposes of data processing: Directive 95/46/EC Article 6(1b) (collection purpose principle) and OECD 80 Paragraph 9 (purpose specification).

\textsuperscript{48} See: Employment Equity Act, 55 of 1998 (Section 7) as well as Joy Mining Machinery, A Division of Harnischfeger (SA) (Pty) Ltd v NUMSA & others (2002) 23 ILJ 391 (LC) where the Labour Court dealt with the first ever case under Section 7 of the EEA. A similar requirement is considered in the Botswana draft national policy on HIV/AIDS and employment, 2007 which regulates that if for any reason an employer or public authority determines that HIV testing is necessary and is a bona fide occupational requirement, such as the protection of public health and safety, the authorization of the courts of law must be sought.

\textsuperscript{49} See e.g. Mundy, J. & Dickinson, D. (2004) “Factors affecting the uptake of voluntary HIV/AIDS VCT services in the workplace” In: HIV/AIDS in the Workplace Symposium Proceedings, June 2004, Johannesburg, South Africa. See also e.g. 2010 UNGASS Report Montenegro “However, the absence of, or poor, confidentiality in HIV testing and STI services is still considered a major barrier to uptake of this service” (p. 12), available at: http://www.unaids.org/en/dataanalysis/monitoringcountryprogress/2010progressreportssubmittedbycountries/montenegro_2010_country_progress_report_en.pdf

protection regulation, it was not possible to address the issue of the unauthorised disclosure. The fact that the doctor sent the results to the employer constituted not only infringement of the right to HIV post-counselling (adequately established in the Botswana national policy on HIV/AIDS in the workplace) but especially it was in breach of privacy and confidentiality rights (also adequately established in the Botswana national policy on HIV/AIDS in the workplace), rules of medical secrecy as well as data protection standards.

Accordingly, in the Czech Republic the law requires medical practitioners to disclose the patient’s epidemiologic status if referred to another practitioner (Directive of the Czech Ministry of Health No 385/2006 Article 1(1)(j)). This regulation might have serious consequences if combined with occupational health medicine and the requirements of health check-ups for the employees and result in unauthorised disclosure of person’s HIV status to the employer.

In South Africa, the country that recognises the right to privacy of personal data as a constitutional right, legislation that deals specifically with data protection (The Protection of Personal Information Bill, 2009) has only been passed by the parliament in 2009, after 12 years of negotiations and drafting.

Recommendations

Workplace HIV data processing practices should observe internationally recognised standards (such as data minimisation, period of data maintenance minimisation, data use limitation, data accuracy, data subject’s right to access and redress data, security risk arrangements, auditability and sanctions, staff training, separate storage arrangements, etc). For instance, it is necessary that if HIV-related data is processed in the workplace (e.g., for the needs of management of HIV/AIDS prevention, testing, treatment, care and support program offered to employees), all data processing is required by law to be handled by persons subject to the professional obligation of secrecy equivalent to that applying to health professionals. Access to medical records in the workplace should be restricted, secondary uses should be regulated, application of purpose and

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56 Definition of data processing is contained in Article 2(b) of the EC Directive 95/46/EC of 24.10.1995 available at: [http://aspe.hhs.gov/DATACNCL/eudirect.htm#ART7](http://aspe.hhs.gov/DATACNCL/eudirect.htm#ART7)

proportionality tests should be considered. Otherwise, wrongful disclosures of HIV status, including workplace context, can result in breakdown of family cohesion, social exclusion or even death. Legal regulation cannot limit its application to the formal sector. Lack of coverage of the informal sector with rights framework and measures may equal systemic discrimination.

CONCLUSIONS

There is a clear gap in policy- and law-making and its implementation when it comes to the HIV and AIDS in the world of work. The gap directly affects people vulnerable to or living with HIV and should be addressed. Apart from the issues outlined in this document, other key workplace-related issues include discrimination in award of benefits, sick leave, disability, reasonable accommodation, workplace testing and occupational HIV transmission. These issues need more research and attention as well.

Accordingly, there is a need to install a sense of ownership of workplace-related legislative HIV responses, which should be seen as cross-cutting and multi-sectoral. The ILO HIV and AIDS Recommendation No 200 should be used as widely as possible as a source of inspiration in order to develop judicial principles, interpretation and public policy.

Countries need to develop laws and policies that balance the need for disclosure of HIV information with the protection of the privacy and autonomy of individuals with respect to their HIV status. Correlation of HIV-related privacy and confidentiality rights with the (non-) existence of data protection laws and regulations (and their implementation in practice) at the national level is under-researched. Further attention is needed taking into account a vast gap in regulation worldwide.

Multisectoral consultations in developing national strategies and financing plans for combating HIV and AIDS should be strengthened, ensuring among others, involvement of ministries of labour, labour administrations services and judicial authorities competent in labour issues. Effective labour inspection is vital for promoting national legislation and good practice at the enterprise level, making decent work a reality.

National HIV/AIDS programs rarely include the workplace, and employers and trade unions are rarely included in the national response in spite of the immense potential contribution they can make - so far only about 30 countries worldwide have reported that they have adopted rules regulating HIV/AIDS in the world of work (2009 ILO Report).58 Representatives of workers and employers and people living with HIV should be included in National AIDS Councils as it has recently taken place in, e.g., Zimbabwe or the Dominican Republic. All institutions and enterprises should be required to collaborate with the National AIDS Authority to develop HIV workplace education programs and prevention plans for the world of work.

Government ratification and implementation of ILO Conventions 87 (Freedom of Association) and 98 (Collective Bargaining), and full respect for the provisions of these Conventions by employers, are the most effective ways of ensuring that all the employment rights and interests of workers living with HIV and AIDS are protected. All necessary steps need to be taken to ensure that all workers are protected by the realisation of these rights.


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The Importance of Sterile Needles

The availability of sterile needles to intravenous drug users is essential to the prevention of new HIV infections.1 It is well established that such programs correlate with significant declines in HIV transmission among intravenous drug users, while not increasing drug use.2 In New York State, nearly 40% of all cumulative AIDS cases report use of, or contact with, injection drugs.3

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1 See Access to Sterile Syringes Fact Sheet, U.S. Centers for Disease Control and Prevention (December 2005) (indicating that if intravenous drug users “use a new sterile syringe for every drug injection, it can substantially reduce their risks of acquiring and transmitted blood-borne viral infections” and describing the availability of sterile needles as “necessary” to the prevention of HIV infections) available at http://www.cdc.gov/idu/facts/acl_idu_acc.htm.


Accordingly, as an obvious exposure category, the Committee has strongly supported changes in the law which facilitate easy access to clean syringes.

Given the demonstrated value of needle exchanges, and the negative impact of criminal drug and paraphernalia possession laws on syringe access, the New York City Bar Association’s Special Committee on AIDS has long advocated for legal reform in this area. Effective legal reform, though, must include not only the implementation of a needle access program, but also the removal of those laws that dilute the effectiveness of such a program.

Prior to 2001, syringes could only be purchased legally in New York with a medical prescription. Unlawful possession of syringes was illegal, as was possession of syringes with drug residue. Such restrictions increased infection rates and were a public health disaster. In 2001, New York State changed its Public Health Law to authorize a demonstration program to expand access to sterile hypodermic needles and syringes. This program, known as ESAP (Expanded Syringe Access Demonstration Program), allowed for the purchase of syringes without a medical prescription. It also provided for the inclusion of a safety insert with the purchase of syringes to demonstrate their proper use and to explain the risk of blood borne disease.
In 2009, ESAP was made a permanent program, and syringe access is now the law in New York. The change in law was a vital component of the fight against new infections in New York. Because of the success of the syringe access program, the state has taken further steps to ensure ready access to clean needles. Most importantly, New York State Penal Law was amended so that possession of a residual amount of a controlled substance in or on a syringe obtained pursuant to the syringe access program is no longer considered criminal conduct in New York. In addition to these changes, governments should place no restrictions on (1) the age a person must to access clean needles, (2) the number of syringes allowed to be sold at one time, or (3) advertising for the sale of syringes.

Criminalizing the use of sterile needles or of residue discovered in needles severely undermines the public health by discouraging the participation in syringe exchange programs. Even though syringe programs like those in New York have been scientifically proven to help fight HIV transmission, movements to restrict or undermine access to sterile needles remain pervasive. The UN and its member countries should continue to advocate for such programs, and to dispel any misinformation associated with their effectiveness.

The Detrimental Effects of Criminalizing HIV Transmission

Fortunately, the transmission of HIV is not a crime in New York. However, concerns about the persistent spread of HIV have inspired the adoption of laws that criminalize HIV transmission or exposure across the globe. In the US, 34 states have enacted such statutes. Criminalization statutes aim to punish malicious transmission, to prevent transmission by discouraging risk behaviors, and to protect vulnerable populations, such as women who are infected by partners that fail to disclose their status. Though these goals are important, in practice, criminalization laws do not prevent transmission and in fact work against preventative efforts by officially promoting fear, ignorance and prejudices.

Very few individuals maliciously expose others to HIV, and those who do should be prosecuted under existing penal laws. Not only are existing laws sufficient for that purpose, the basic realities of transmission make laws that specifically criminalize HIV exposure unjust. Misunderstandings regarding the science of transmission, fear, and the complicated nature of the virus mean that many laws punish behavior that poses no risk of transmission or is otherwise not morally blameworthy. In the US, for example, many statutes broadly criminalize exposing others to "bodily fluids," and numerous prosecutions have been brought against an HIV-positive individual alleged to have bitten someone, despite the fact that transmission does not occur via saliva. Criminalizing actions that do not pose a risk of transmitting the virus promotes dangerous misinformation about HIV transmission.

Moreover, criminalization statutes assume a level of moral blameworthiness that make it virtually impossible for an individual living with HIV to remain "innocent". The laws do not account for the ethical gradations represented by a person, for example, who took steps to prevent transmission, who believed his or her HIV status was known, who had an undetectable viral load, who believed that his or her behavior did not pose a risk of transmission, or who had agreed to mutually acceptable risks with a partner. Because these statutes do not require an intent to expose another to the virus, the subjective spectrum of risk and moral blameworthiness posed by these common scenarios leads to selective prosecution and misapplication of law.
In exposure or transmission cases, the difficulty of proving key facts, including date of infection, pre-exposure disclosure of status, or attempts at risk mediation efforts such as condom use makes convictions based on incomplete information inevitable. Because of the window period after infection in which HIV test results are inaccurate, and because individuals are unlikely to be tested with great frequency, it is often difficult to pinpoint the exact time of transmission. Disclosure is often the only affirmative defense to prosecution, yet proving that a status disclosure occurred can be particularly problematic as most cases arise between former sex partners, creating an emotional “he said she said” dispute. In an illustrative example, one woman in the state of Georgia received a sentence of eight years despite the testimony of two witnesses who maintained that her sexual partner was aware of her HIV status and the fact that her status had been reported on the front page of her local newspaper.

Furthermore, criminalization statutes often provide for grossly severe punishments relative to any intended or actual harm. A man in Iowa was sentenced to 25 years in jail for one sexual encounter even though he had an undetectable viral load, used a condom, and did not actually transmit HIV. His case was not atypical. In many jurisdictions, even when HIV is not transmitted and a condom is used, having consensual sex while HIV-positive results in a longer jail term than vehicular manslaughter. Upon release, individuals convicted of exposure or transmission are often forced to register as sex offenders and to suffer the social, economic, and personal burdens that accompany that label.

By treating HIV-positive individuals as dangerous and potentially criminal vectors of disease, statutes that criminalize exposure or transmission officially support and encourage HIV stigma. In fact, HIV counselors are often obliged to warn that agreeing to a routine screening could result in criminal liability. Unsurprisingly, HIV-positive individuals report experiencing increased stigma as a result of criminalization and media attention surrounding trials for exposure. Fear of facing ostracism at the hands of friends and family, stigmatized reactions to HIV in the workplace, or rejection by the community at large are some of the main reasons people forgo testing, fail to maintain treatment regimens, and/or avoid disclosing their status.
Dear Global Commission on HIV and the Law,

Ten years have passed since the Doha Declaration established that the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) “can and should be interpreted and implemented in a manner supportive of [World Trade Organization’s] members’ right to protect public health and, in particular, to promote access to medicines for all.”

In that time, generic competition has fueled a revolution in global HIV/AIDS treatment, reducing costs of first-line HIV/AIDS medicines by 99 percent, from over $10,000 per person per year to under $100 per person per year today. This has helped six million people in low- and middle-income countries access lifesaving antiretroviral therapy. As costs have fallen, governments and global donors have exponentially increased their treatment programming.

But newer therapies, including second- and third-line medicines, are widely patented, aggressively monopolized and still very expensive. The high costs of patented HIV medicines compromise the finances of HIV/AIDS programs, including not only treatment but also prevention services.

Laws that criminalize HIV are sometimes promoted as a means to protect vulnerable populations, most often women who contract the virus from a male partner who fails to disclose his status, is unfaithful, or forces her to engage in unprotected sex. Here too, applying criminal law to HIV exposure actually exacerbates existing problems. Because women engage more frequently with the health care system, they are likely to discover their status before their partner does. To avoid criminal liability, immediately upon discovering her status, a woman must inform her partner or, potentially, refuse intercourse. For many women, however, either of these options would lead to disastrous results – including abuse, ostracism, blame for introducing HIV into the household, loss of children, or eviction.

The spread of HIV is not powered by criminals, but by ordinary people acting in ordinary ways. Most transmission occurs during a consensual sexual act between individuals who are unaware of their status. Twenty-five years of experience has shown that the existence of criminalization statutes do not deter HIV-positive individuals from engaging in risk behaviors. Rather than propagating legislation demonizing HIV-positive individuals, lawmakers should turn their attention to the obstacles that keep people from protecting their health and their partners. Eradicating stigma, combating misinformation, ensuring access to confidential testing and treatment, and providing social services all encourage and allow HIV positive individuals to discover their status and prevent transmission. By promulgating fear, discrimination, and ignorance, HIV-specific criminal statutes do just the opposite.

10 Ralf Jürgens et. al., Ten Reasons to Oppose the Criminalization of HIV Exposure or Transmission, 17 Reproductive Health Matters 163 (2009).
12 Ralf Jürgens et. al., Ten Reasons to Oppose the Criminalization of HIV Exposure or Transmission, 17 Reproductive Health Matters 163 (2009).
13 Id.
15 Id.
Looking ten years further ahead, we can envision two radically different scenarios based on recent events.

In the first scenario, patent holder interests prevail in major trade agreements, at international organizations and in public debate. The US successfully isolates India through the Trans-Pacific Free Trade Agreement and inaugurates low patentability standards throughout the Asia-Pacific, limiting not only treatment access but generic production. As mergers in India and elsewhere eliminate viable global sources of generic supply, the economies of scale necessary to advance global generic competition prove unattainable. Treatment costs for newer medicines remain exceptionally high, making it more difficult to scale up treatment to meet global objectives including the Millennium Development Goals. Many people die needlessly, for lack of access to existing medicines.

In the second scenario, the access to medicines movement wins major concessions in trade agreements and at international organizations. Governments begin to use compulsory licensing and other competition measures with greater frequency, reducing costs and improving countries’ bargaining positions. This in turn increases the power and attraction of the voluntary Medicines Patent Pool – to which the United States could begin making significant contributions through government licensing rights to federally-sponsored research. Game-changing strategies like innovation inducement prizes and a global framework on research and development gain adherents. Taken together, a new “innovation plus access” framework emerges. Perhaps most importantly, more efficient research and development and lower treatment costs help inaugurate the era of global treatment as prevention.

A recent study has suggested antiretroviral therapy can, under the right conditions, reduce HIV transmission rates by 96%. This provides an unprecedented opportunity to cut transmission as we expand access to treatment – and possibly even effectively end AIDS in our time. The policies the international community establishes for innovation plus access can make the difference.

**So, how can we guarantee sustainable & universal access to HIV/AIDS treatment in the future?**

Two approaches must be pursued concurrently in our strategy to guarantee access to HIV/AIDS treatment in the future. One approach is to encourage and assist countries’ use of TRIPS-flexibilities and to engage in other strategies within the current system to provide access. The second approach must focus on exploring and utilizing alternatives which deal with rising costs of treatment and scaling up of IP across the world.

Alternative models of innovation have been at the forefront of discussions on biomedical research and development. Most prominently, discussions are taking place at the WHO. In 2006, the WHO Commission on Intellectual Property, Innovation and Public Health asserted that “for diseases affecting millions of poor people in developing countries, patents are not a relevant factor or effective in stimulating R&D and bringing new products to the market.” Following this report, all countries, including EU Member States, agreed to a comprehensive ‘Global Strategy and Plan of Action (GSPA) on Public Health, Innovation and Intellectual Property’ at the World Health Assembly in May 2008. The strategy includes the promotion of measures to increase access to medicines and encourages member states to develop new models of biomedical innovation in order to ensure both access and innovation. The GSPA calls on stakeholders to “explore and promote a range of incentive schemes for research and development including addressing the de-linking of the cost of R&D and the price of health products.” This way it would not be the price of medicines that is used to retrieve the cost of the innovation, and broad access would be possible immediately after the product came on the market. A Consultative Working Group on Research and Development: Financing and Coordination (CEWG) has been established to analyze various proposals for innovative mechanisms.  

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EU member states in the “EU Communication and Council Conclusions on Global Health,” in May 2010, called for further exploration of innovation models that de-link the cost of R&D from the price of medicines. Another important policy development regarding access and innovation is the “Innovation Union Communication,” which is a flagship policy for the 2020 strategy, which states that EU innovation should be needs-driven, more efficient, cooperative, and inter alia calls for the creation of platforms for open innovation and citizen engagement, including through the awarding of prizes for research. These EU-sponsored initiatives show that there is potential within developed countries to advance and support the exploration of new models on innovation.

Alternatives
Parallel to the intergovernmental policy discussions and international debates, various proposals and projects have been developed by governments, civil society, academics and industry. A number of these initiatives aim to ensure affordability of newly developed products, delinking the price of the product from the cost of the R&D and dismissing the exclusivity model. Other proposals seek to attract funding for research into neglected diseases, without including the aforementioned principles. Some are relevant for patients in developed countries, while others focus entirely on developing countries and/or neglected diseases. While a number of these initiatives have already been implemented, others still remain policy proposals. This section briefly describes some of the proposed mechanisms, some of which are currently being implemented.

Humanitarian or Equitable Licensing:
One of the proposals being considered is humanitarian or equitable licensing of IP rights, especially for R&D that has received public funding. The rationale behind equitable licensing is to generate the highest possible social benefit out of publicly-funded research. In a case where R&D results are licensed to a private company, the contract would include a set of conditions with the aim of achieving a low product price, high accessibility and, if possible, an access concept. For example, this access concept could be a differential pricing condition, ensuring affordable prices in developing countries.

The equitable or humanitarian licensing concept encourages open or non-exclusive licensing of patented technology. Non-exclusive licensing grants the right to use something, such as IP, on a non-exclusive basis. The same right can be granted to several licensees allowing more than one actor to make use of results stemming from (publicly-funded) R&D. The license can also be open, meaning anybody can use it. In the field of biomedical technology, non-exclusive licensing would generally allow for broader access to the technologies and health products, as it allows for more than one company to exploit the innovation, enabling generic competition, and in consequence, lower prices.

The first time the term equitable licensing was used was when Yale University renegotiated its license with Bristol-Myers Squibb (BMS) with regard to the HIV-medicine Stavudine (Zerit®) in 2001. Now, there are several institutionalised equitable licensing programs like the “Socially Responsible IP Management Program” at UC Berkeley.

Equitable Licensing is now in use in the United States by several universities and by the National Institutes of Health, and is promoted by GSK and the Gates Foundation in the area of certain neglected diseases. UC

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4 Particularly relevant elements of the Council Conclusions with regards to access and innovation are the 18 “c. exploring models that dissociate the cost of research and development and the prices of medicines in relation to the GSPOA, including the opportunities for EU technology transfer to developing countries,” and “d. ensuring that EU public investments in health research secure access to the knowledge and tools generated as a global public good and help generate socially essential medical products at affordable prices, to be used through rational use.”


6 http://ipira.berkeley.edu/socially-responsible-ip-management

7 Wagner, Equitable Licensing, Submission to the CEWG, 2011


Berkeley’s Socially Responsible IP Management Program has collaborated with both companies on licensing agreements to ensure affordable pricing in low-income countries for products stemming from university research. Projects with agreements under this program include TB vaccine research, malaria ACT research and research on a possible HIV treatment, among others.\textsuperscript{10}

**Voluntary licenses to the Medicines Patent Pool**

Obtaining a licence for existing patents can be done on a case by case basis through voluntary or non-voluntary licensing. But, it is also possible to manage IP collectively through patent pooling. The Medicines Patent Pool (MPP) was established for the development and production of second-generation antiretroviral drugs (ARVs) and fixed-dose combinations (FDCs) used to treat adults and children with HIV/AIDS. The MPP is designed to reduce the price of existing medicines and speed up their availability. Here, any producer may pay royalties to patent owners in order to manufacture patented medicines and sell them in countries well before the expiration of the patent term.

**Prizes For Innovation**

Prizes are an incentive system to induce R&D for new essential medicines, and can be implemented in a manner that ensures competition, affordability and widespread access. In the open licensing approaches, cash prizes would be a substitute for exclusive rights to sell products and monopoly prices. Innovators would be awarded large monetary “prizes” based in part or in whole on the improvements to health outcomes over existing products. This would dramatically reduce incentives for the marketing and promotion of medicines that are used irrationally, or that are not better than the benchmarked alternatives. Prizes can also be designed to provide incentives to share materials, data, technology and access to knowledge.\textsuperscript{11} While drawing up the prizes may seem difficult, in reality, this represents less of a challenge than determining the appropriate reimbursements for biomedical products.

There already exists a variety of prize schemes relevant to medicines development. In order to further advance discussions on prize fund models, government- and donor-backed research must be carried out to investigate the costs, benefits and feasibility of various implementation schemes.

The most ambitious prize fund approaches combine several different prize mechanisms. These include (1) end-product prizes that are awarded to the developers of products that are registered for sale and used by patients, (2) open source dividend prizes, which reward upstream open sharing of knowledge, data, materials and technology, and (3) prizes for earlier or interim development, such as achieving specific product development benchmarks or identifying biomarkers.

All of the issues in the design of prizes involve some controversy, including in particular the management of intellectual property rights, or the use of open source dividends. Some have argued that prize funds should not require open licenses on patents, and/or that prizes should only be used for achieving interim product development, and never be a substitute for the monopoly for the final product.\textsuperscript{12} Within the pharmaceutical industry, some companies, like Gilead, J&J and Novartis have expressed support for exploring final product prizes for products like AIDS or TB medicines in developing countries, but oppose the use of prizes for products like cancer medicines, or AIDS and TB medicines in high-income countries.

An open source dividend for the prizes rewards researchers and organizations for sharing knowledge and information relating to product development. For example, in several of the WHO proposals being considered by the CEWG, 10% of the total final product prize would be reserved for entities making useful information contributions to the end product. To qualify for the open source payment, entrants must make their work freely available.\textsuperscript{13}
The Donor Fund Prize

One specific proposal is the Donor Prize Proposal for HIV/AIDS treatment, which addresses the problem of the rising costs for antiretroviral drugs (ARVs) and the large number of people who still lack access to these treatments. Donor-funded treatment initiatives such as the Global Fund, UNITAID and the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR) depend upon generic competition, with more than 90% of donor-funded AIDS medications to developing countries supplied by Indian generic manufacturers. As generic competition is restrained and costs of treatment rise because patients are switching to more expensive second-and third-line treatment, donors such as the Global Fund may not be able to continue to finance treatment of 5.2 million PLHIV, not to mention the 9.7 million PLHIV in need who still lack access to treatment. Donors therefore urgently need to find a way to pay less for ARVs. The donor prize proposal presents a possible solution for reconciling innovation and access for certain markets where donors play an important role on the demand side. The donor prize fund would address the need for donors to have access to second- and third-generation HIV/AIDS medicines at competitive generic prices, while providing rewards to innovators. The prize proposal asks donors to place a fraction of their budget used for purchasing drug treatment (for example, 10%) into a funding pool that would be used to reward companies who license their patent to the MPP. Subsequently, generics suppliers would be able to easily obtain licences for these patents, in turn enabling donors to purchase generic medicines at marginal costs. Tying the prize fund reward to the need to licence patents to the MPP would create strong economic incentives for industry to adopt such a licensing practice, and to accept the scope of these licences would extend to developing and middle-income countries.

There is some controversy concerning the proposal to set aside a fraction of the budget currently used to purchase medicines for the prize fund rewards. Some fear this would interfere with current treatment programs. The rationale, however, is that the prize fund would effectively increase the donor’s purchasing power. While it would be slightly more expensive to buy the cheap generic products, this would be offset by dramatic decreases in prices for the patented medicines now only available from originators. Furthermore, creating a market for generic products through open licensing would allow developing countries that do not benefit directly as grant recipients from the donor programs to benefit from the greater economies of scale and more efficient supply of low cost versions of medicines.

The Prize Fund for HIV/AIDS

U.S. Senator Bernie Sanders introduced The Prize Fund for HIV/AIDS (S. 1138, 112th Congress) as an alternative innovation incentive system to exclusive marketing rights. “The proposed legislation would eliminate patent and other intellectual property barriers to the introduction of generic medicines for AIDS.” Rather than monopoly marketing rights (and the monopoly prices which come with them), innovation would be rewarded with a prize fund of more than $3 billion per year (.02% of U.S. GDP). The fund would be financed by the U.S. federal government and private health insurance programs. Though the $3 billion price tag is considerable, savings due to the increased competition between pharmaceutical manufacturers are expected to total more than $7 billion per year in the U.S. domestic market alone.

Three different programs would allocate the prize money:

Ibid.
End Product Prizes would distribute prizes to “the first person who registers a, ‘Qualifying Treatment for HIV/AIDS,’ or a new manufacturing process for such a product.” The size of these prizes would be based on the value of innovation measured in terms of the number of patients who benefit, the needs of special populations (e.g. paediatric HIV patients), the incremental therapeutic benefit of the drug or process and the improved efficiency of the manufacturing process.\textsuperscript{18}

Open Source Dividend. At least 5% of the prize fund would be devoted to rewarding “the open, non-discriminatory and royalty-free sharing of knowledge, data, materials and technology that has contributed to the development of the new medicines or manufacturing efficiencies that qualified for the end product prizes.”\textsuperscript{19}

The Donor Innovation Prize Fund would be established by the Secretary of the Department of Health and Human Services. This fund would receive an amount equal to 10 percent of the cost of AIDS drugs in programs supported by PEPFAR and other federally funded HIV/AIDS treatment programs. Prizes from this fund would only be distributed as rewards for products which permit open competition in developing countries by\textsuperscript{20},

- not patenting products,
- providing non-discriminatory royalty-free open licenses and other IP claims on at least a field of use for the treatment of HIV/AIDS in developing countries, or
- licensing to the Medicines Patent Pool.

Coordination and Funding: Essential Global Health and Biomedical R&D Treaty

A binding intergovernmental instrument regarding the coordination and financing of biomedical R&D is being considered at the WHO. This instrument would contain financial obligations for countries to contribute to R&D financing with incentives that deliver innovation and access. Since 2000, discussions on such an instrument have been taking place, and the need to coordinate and prioritize R&D has become increasingly obvious and pressing. Discussions at the WHO are becoming more concrete, most specifically in the establishment of the Consultative Expert Working Group on R&D Financing and Coordination, which is recommending for negotiations to start. Negotiations on such a binding intergovernmental instrument would take place under the auspices of the WHO. The proposal to develop an Essential Global Health and Biomedical R&D Treaty would have a huge impact on public health as it would aim to create a new global framework for supporting priority medical research and development that is based upon the equitable sharing of the costs of research and development and incentives to invest in needs driven R&D. The treaty would provide the framework for ensuring that sufficient, regular, predictable and sustainable financing for R&D for type I, II and III diseases is secured and that mechanisms to facilitate health needs assessment, priority setting and the assessment of funding needs are developed and put into practice.

The Objectives of such a treaty would be to promote a sustainable system of medical innovation that would:

1. Ensure adequate and predictable sources of finance for needs-driven medical R&D particularly relevant to diseases and conditions which disproportionately affect developing countries;
2. fairly allocate the costs of supporting needs-driven medical R&D, in particular, to meet the health needs of developing countries;
3. identify priority areas of needs-driven R&D;
4. explore and promote a range of incentive schemes for health-needs-driven R&D addressing the de-linkage of the costs of R&D and the price of health products;
5. encourage the broad dissemination of information, sharing of knowledge, and access to useful medical inventions, including the facilitation of access to publicly-funded research;
6. promote transparent and ethical principles for clinical trials involving human beings as a requirement of registration of medicines and health-related technologies;
7. enable medical researchers to build upon the work of others;

\textsuperscript{18} Ibid.
\textsuperscript{19} Ibid.
\textsuperscript{20} Ibid.
8. support diversity and competition;
9. utilize cost-effective incentives to invest in promising and successful research projects that address health care needs;
10. enhance the transfer and building of technological knowledge and R&D capacity to further social and economic welfare and development in developing countries and;
11. promote equitable access to new medical technologies, so that all share in the benefits of scientific advancement.

Recommendations:

Explore and support these proposals by, among other things:

- Engage in a feasibility study of the Donor Prize Fund.
- Encourage companies to license to the Medicines Patent Pool.
- Encourage the EU and the US to constructively engage in discussions around an Essential Health and Medical R&D treaty.
- Support the mandating of equitable licensing of publicly funded biomedical research.

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**ICAAP PROTEST – CHRONOLOGY OF EVENTS**

**Day 1: 26 August 2011, Friday, Opening day of 10th ICAAP.**

- South Korean activists protest on Free Trade Agreements, the discrimination of LGBT, sex workers, migrants, other community in Korea, and the ICAAP participants’ visa and entry issues at opening ceremony by holding up pickets.

- During the Opening ceremony protest, when a Korean activist shouted against Chin, Soo-Hee, the Korean Minister of Health & Welfare, denouncing the Korean government’s failure to help participants enter into the country to attend ICAAP, the security guards grabbed him, blocked his mouth with hands, and dragged him outside of the room. Korean activists tried to stop the guards. When the guards released him, the activists peacefully left the opening ceremony room.

- South Korean activists are shocked and concerned about the guards’ irregular behavior on the activists’ peaceful protest but not aware that those security guards were actually the police. They think that the guards behavior was due to their overzealous motivation to protect Fiji President and does not think that this would affect their FTA protest on the following day as long as it does not happen near Fiji President.

- Koreans and Regional activist meet at 7pm inside BEXCO to discuss about the FTA protest to be taken out within the BEXCO complex next day, 27th August 2011.

- During the activist meeting some concern is raised about another possible irregular action by the guards of the Fiji President or BEXCO, but activists remind the ICAAP tradition and organizing committee’s assurance that peaceful protests would be protected. Activists plan on routes for marches inside conference building. It was discussed and agreed that the issue will be raised to Michel Sidibé
Day 2: Saturday, 27 August 2011

- UNAIDS guarantees support and action on ensuring the safety of South Korean Activists.

- 2:00 pm. FTA protest begins – inside BEXCO. Marchers proceed over the 3 levels of the conference centre.

- BEXCO security attempts to stop the protest on level three but the protest continues without any threat of violence.

- Staff of PCO/LOC follow participants

- Around 3:00 PM, a number of ICAAP delegates report seeing “security/police vans” parked outside the Exhibition Hall and question what is going on. This happened as sessions were about to be convened in the C105 area opposite the Exhibition Hall.

- A Korean activist (Jae-activist as well as LOC Community Organizer) sees man taking photos of participants with his cell phone at the second level. The activist asks him to verify his identification and why he’s taking photos, and the man responds that it is because the protest looks good. Jae notices the man again when the protest is almost coming to an end at the AP village and hears that the man is talking to someone that “I’m the police, and I need to take photos of this.” He confronts him whether he is the police and why he takes photos. He denies that he was taking photos. The man refuses to reveal his identification and begins to move away. He looks for the human rights lawyer, Chang.

- M and J (both Korean activists) request the man to hand his cell phone over to them. The man (identified as Policeman afterwards) gives the cell phone to J, saying “checking it by yourself.” She hands it over to Jae again, and Jae passes it on to E (Korean activist).

- Lawyer Chang comes and demands the policeman to verify his identification with her (as is a right under Korean law), showing her lawyer identification card. The man gives his business card to her (he was identified ‘Lee Hyungchul’ as a policeman of Intelligence Dept at Haeundae Police station). Lawyer Chang remonstrates with him about illegal evidence-taking and surveillance by taking photos of the participants without permission and not verifying his identification. The policeman keeps denying his taking photos.

- E gives the cellphone to Jae, and Jae hands it over to J. J says it has an external hard drive and hands it over to E again for checking. After checking the cellphone, E gives it to J, and J gives it back to Jae. Jae returns the cellphone to the policeman, Lee Hyung-Chul.

- Upon the incident, other participants cancel their last speech of the FTA protest at the Exhibition hall and come to the gathering. Around 10 policemen in plain clothes (black suit) surround the participants.

- Someone among the police begins to order arrests of several Korean participants including Y (Korean activist, Chair of Solidarity for LGBT Human Rights of Korea), Jae and Lawyer Chang, alleging “object extortion (Ki-mul-tal-chi),” the term of which does not exist under the Korean criminal law. Activists present attempts to block the police’s illegal arrest follow.

- Three or four policemen try to arrest Y forcibly. Some of activists who participated the march suspend them not to drag him away. Yol got hurt on his body and got bruises on his arms and legs during the police’s illegal attempt to arrest.

- Jae and another LOC staff member strongly remonstrate with the policeman about their violence against peaceful demonstrators. Jae says to the police, “You were the ones who broke the law. Don’t make any more trouble.” When he turns his back, a policeman in pink stripe shirts (presumably the head of the team) grabs his belt and orders others to drag him away. About 10 officers grab Jae’s arms, waist and neck forcefully, which nearly choked him. They throw him down to the ground and start to...
drag him across the floor. He is then carried out by arms and feet, and smashed into a perspex ticket barrier by police and the barrier shatters Hans Billimoria and Korean activists jumped on Jae not to be dragged away and protect him. Then the policemen holding Jae were dismissed.

- Jae is visibly shaken and sobbing uncontrollably, his glasses are gone, his clothes ripped and belt broken. It takes three or four people to calm him down. Jae suffers minor bruises in his shoulders, scratches on his arms and back pain.

- In the meantime, four uniformed policemen forcibly arrest Lawyer Chang. She asks for the allegation against her but no one responds. Policemen forcibly put her into the police car in front of Bexco. She gets bruises on her arms and body aches in the process. In the car, she keeps asking the reason for arrest and remonstrates with them. Still no one responds. She remonstrates with the policemen about their illegal arrest, and the policemen say to her to claim at the court.

- Police/security continue to try and take Jae into custody – one participant asks those in proximity to ‘split’ into two groups. One to go outside and assist lawyer, the other to remain in Asia Pacific village to protect Jae.

- Activists surround police car to stop the removal of lawyer Chang. More protesters and other ICAAP participants join and crowd around the police car.

- Stand-off between policy/security lasted about 45 minutes (from 2:55pm to 3:41pm) to stop the police and release Lawyer Chang from illegal arrest and detention.

- JK, a Korean activist and interpreter, asks questions to one of the people in black suit who were surrounding the police car in the front side. The man, who was on the driver’s side, admits that they are there to guard the President of Fiji. When JK confronts that they were doing with the participants has nothing to do with protection of Fiji President and that this is beyond their authority, the man answers that they have the authority because they are the police. When JK asks the police man who is in charge, a person in pink stripe shirt comes and says that we can consider him as the person in charge. When JK asks the reason of arresting Chang, the policemen in pink stripe shirt says that Lawyer Chang was arrested for ‘object extortion,’ for the act of forcibly taking cellphone from the policeman.

- J comes to the policeman in pink stripe shirt and says that the cellphone was voluntarily handed to the activists and returned to the owner and that Chang has nothing to do with taking the cellphone. The pink-shirt policeman refuses to hear and insists that Chang committed ‘object extortion.’

- Several protesters injured by the police— One female Australian got hurt on her legs by one riot police’s feet and was treated at First Aid. One Indonesian man got hurt on his right hand maybe broken bones so was treated with cast at the hospital. Some of Nepalese got abrasion. TG female is ripped off her by police who pull her by her hair and her hair extensions are pulled out. Odi is kneed in his left eye, breaking his glasses into his face and leaving him with a cut and bruise just next to his eye that took more than two weeks to heal.

- The policemen recourse to violence on the participants; pushing them against the wall and down on the floor, trample on them, lifting and throwing them away, and pulling their arms. From the violence, more than 40 participants got injured, many with large bruises on their arms from the police.

- Participants notify to the policemen that some of people are PLHIV and women and keep reminding them of this. The police ignore these notifications. The police simply say to them to go to hospital if they are patients.

- Riot police arrive and begin to forcibly remove activists surrounding police car.

- The police car with Lawyer Chang inside begins to move when the car is still surrounded by people. In the process, several activists were almost hit by the car—when the car began to move, an international participant fell to the ground and lightly hits his head to the front bumper of the car, and a Korean participant was almost pinned under the car.

- Police car manages to free itself and takes Lawyer Chang to police station. Crowd disperses.

- Emergency Community meeting immediately called in AP village
• 50 to 60 community representatives gather in AP Village to discuss the situation – meeting lead by South Korean activists who are extremely concerned for their safety and that of the Human Rights lawyer.

• UNAIDS asked to make a public and immediate statement on the situation, and to act urgently to ensure the safety and security of South Korean activists.

• UNAIDS confirms statement is being developed and GFATM confirms they are also to put out a public statement. It is announced that these statements will be released by the close of business in Geneva.

• Around 4:30pm, Y and Jae taken to the emergency room of a near hospital after first treatment at First Aid within BEXCO.

• Community representatives stay at the AP village until human rights lawyer is freed. In the meantime, activists go to all sessions happening at the first and second floor of convention hall and explain the situation to the participants. Some of the sessions were seen to have been cancelled already in room C 101 and C 102, while some were cancelled as either speakers in sessions or delegates in sessions walked off from the session and room after listening to our plea and denouncing the police act.

• Three policemen come to Jae in the hospital. One of them makes threat that they would press criminal charge against Jae for “interference of official acts (Kongmujiphang-bangheo).”

• Lawyer Chang released after over two and half hours after being taken under custody locked inside the police car and then in the police station (from 2:55 to 5:30). At the police station, the police does not know or find any possible allegation against her that could justify the arrest. She only answered questions as a reference. Lee Hyung-Chul, the policeman from Intelligence Department, denies that he took photos but later admits that he posed to take photos.

• Meeting at AP village ends.

• Around 7pm, Jae, who was in the hospital, asked by PCO and policemen to go voluntarily to the police station. At the time, Jae was not informed that he is to be interrogated as a suspect. When he arrives the police station, Lee Hyung-Chul, the plainclothes officer already wrote a statement alleging that Jae took his mobile phone and committed an unlawful interference with a police officer. Jae makes a statement that defends himself against Lee Hyung-Chul’s allegation. Interrogation continues for two hours.

• Press conference held from 6:00pm. Korean activists prepare and read a statement that condemns the police’s illegal actions and human rights violations, including unlawful evidence-taking, surveillance, and arrest, which infringed the rights to free expression and assembly. In the statement, Korean ICAAP participants demand apologies from those who are responsible for the incident, including the police, the LOC, and the Minister of Health and Welfare, and asks UN, including UNAIDS, to respond to the situation. The statement is supported by 84 local and regional organizations and individuals in Asia and the Pacific.

Day 3: Sunday, 28 August 2011

• Meeting is held at BEXCO at 8:00 AM with representatives from LOC, ASAP, Korean activists and regional people to develop and agree on statement. The statement contains apologies from LOC and ASAP that they failed to ensure safety of the participants and condemnation of the police violence on the peaceful demonstrations.

• Korean activists raise the issue of the police’s presence at the conference without wearing uniform or name badges, which make participants vulnerable to the police’s illegal actions and harassment. Later that day, Secretary General of ICAAP10 LOC tells the activists that LOC assigned a room for the police and had them stay there when they are not on duty to protect the President of Fiji.
• Meeting of Korean and International participants scheduled for 7pm in the evening.

• Meeting goes past 1:30 AM. Activists prepare a new statement with five demands and articles for the next day’s ICAAP newspaper (ICAAP Herald). The five demands included: assurance on confidentiality of personal information; protection from the threats of civil and criminal action against the activists; protection from harassment and discrimination by the police, BEXCO, and others; independent investigation on the police violence and human rights violations; and assurance of safety and security of all participants.