

Regional Issue Brief



For the Eastern Europe and Central Asia Regional
Dialogue of the Global Commission on HIV and the Law

19 May 2011
Chişinău, Moldova



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Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
CIS	Commonwealth of Independent States
ECDC	European Centre for Disease Control
EHRN	European Harm Reduction Network
EML	Essential Medicine List
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV	Human Immunodeficiency Virus
HIV laws	National laws on HIV/AIDS, Prevention of HIV/AIDS
HCV	Hepatitis C virus
HBV	Hepatitis B virus
MSM	Men who have sex with men
OSI	Open Society Institute
OST	Opioid Substitution Therapy
PMDT	Programmatic Management of Drug Resistant Tuberculosis
NGO	Non-Governmental Organisation
STI	Sexually Transmitted Infections
SWAN	Sex Workers' Rights Advocacy Network
TB	Tuberculosis
TG	Transgender people
TRIPS	Agreement on Trade Related Aspects of Intellectual Property Rights
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organisation
WTO	World Trade Organisation



1. Introduction

Eastern Europe and Central Asia is the only part of the world where the Human Immunodeficiency Virus (HIV) epidemic remains on the rise.¹ Despite notable achievements in addressing aspects of the epidemic in the region (e.g. close to universal access to prevention of vertical transmission services; modest expansion of evidence-based HIV prevention services) much more remains to be done, and there is an urgent need to act. In recent years, many countries of the region have reviewed their legislation and policies and subsequently adopted a more responsive and evidence-informed approach. However, there remain laws, policies and practices that constitute significant barriers to an effective and human rights-based HIV response. The epidemic in most of the region is concentrated among key populations at higher risk such as people who inject drugs, sex workers, men who have sex with men (MSM) and people in prisons. In many instances, punitive and coercive laws against these groups reinforce and perpetuate stigma and discrimination, lead to human rights violations and contribute to the further spread of HIV. A number of countries lack protective laws that are specifically directed at people living with HIV and key populations at higher risk. General human rights and anti-discrimination laws are rarely applied in relation to vulnerable and stigmatised groups and reports of implementing practices that push people away from services are frequent.

Globally, countries increasingly acknowledge the negative effects of punitive legislation, policies, and regulations on access to, and uptake of, HIV prevention, treatment, care, and support, and on the rights and dignity of people living with or vulnerable to HIV.² Despite reporting of an increase in laws that protect people living with HIV and populations at higher risk, there is little evidence that these laws are effectively enforced, and countries inconsistently support implementation in planning and budgeting.³ UN entities, including UNAIDS and other international organisations have repeatedly urged states to consider taking steps towards removing punitive laws, policies, practices, stigma and discrimination that block effective responses to HIV.⁴ They urged the elimination of criminal and other laws that

¹ UNAIDS (2010), *Report on the Global AIDS Epidemic 2010*.

² According to UNAIDS, in 2010, 67% countries reported the existence of laws that present such obstacles. UNAIDS (2010), *Report on the Global AIDS Epidemic 2010*.

³ In 2010, 123 countries in the world reported having laws and regulations that protect people living with HIV against discrimination. 106 countries (62%) reported having laws or regulations that specify protections for key populations at higher risk such as women, young people, men who have sex with men, people who inject drugs, sex workers, prisoners and migrants. Fewer than 50% of countries however costed or budgeted such programmes. It is not clear whether efforts are implemented at sufficient scale and of a quality to make real and sustained improvements to the lives of people living with HIV and other members of key populations at higher risk of exposure. UNAIDS (2010), *Report on the Global AIDS Epidemic 2010*.

⁴ UNAIDS (2010), *Getting to Zero: 2011-2015 Strategy Joint United Nations Programme on HIV/AIDS*.

undermine HIV prevention, treatment, care and support efforts, and violate the human rights of people living with HIV and members of key populations affected by the epidemic. The importance of human rights protection in the effective response to the epidemic is increasingly acknowledged and is difficult to overemphasise.⁵

This analysis is prepared for the Global Commission on HIV and the Law. In May 2011, members of the Global Commission examined the relationships between legal environments, HIV and the law in a Regional Dialogue with stakeholders from Eastern Europe and Central Asia.

This analysis covers 20 countries of Eastern Europe and Central Asia, including 12 former Soviet Union countries (Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Kyrgyzstan, Moldova, Russia, Tajikistan, Turkmenistan, Ukraine, and Uzbekistan), seven countries that used to belong to the socialist bloc (Albania, Bosnia and Herzegovina, Croatia, Kosovo, Montenegro, Serbia and the former Yugoslav Republic of Macedonia) and Turkey. This analysis prioritises countries with a higher HIV burden (Russia, Ukraine, Belarus, Moldova, Kazakhstan, Kyrgyzstan, Tajikistan and Uzbekistan). Since an exhaustive analysis of legislation and policies in every country was beyond the scope of this paper, examples are given selectively, in order to illustrate common challenges, provide specific examples of empowering or disempowering legal environments, and illustrate possible solutions and good practices. The former Soviet Union countries are often grouped together due to the similarity of legal and policy frameworks, implementing practices and programmatic approaches to the HIV response in general.

All countries included in this analysis have civil law systems and, except for Turkey, used to belong to the socialist bloc. Since the start of transition some 20 years ago, all countries have reformed their legislation and begun to pay more attention to human rights and freedoms.⁶ However, analysis of legislation, especially in the former Soviet Union countries, shows that approaches are at times paternalistic and coercive, and often rely on involuntary HIV and drug testing, punitive drug laws, registration of people who use drugs, negative law enforcement attitudes towards groups of people at higher risk of HIV infection, and lack of respect for human rights and freedoms. Countries of the former Soviet Union still possess a high number of punitive laws, many of which are vestiges of Soviet legislation, and which may impede effective HIV responses. Countries of Southeast Europe have a slightly higher number of protective laws, including those that may be used to protect people at higher risk of infection.

Even in cases in which countries adopt sound laws and policies in compliance with international standards, they are frequently not implemented, or are only partially implemented,

⁵ See more in *Special Rapporteur on the Right of the Highest Attainable Standard of Health*, (2009). <http://www.ohchr.org/EN/Issues/Health/Pages/SRRightHealthIndex.aspx>.

⁶ Countries of the region ratified major international human rights treaties, such as the International Covenant on Civil and Political Rights, International Covenant on Economic, Social and Cultural Rights, CEDAW, Convention on the Rights of the Child, Convention against Torture. Countries of Eastern Europe (apart from Belarus) and South Eastern Europe are members of the Council of Europe and have ratified the European Convention of Human Rights.

contributing to the repressive legal environment and undermining effective HIV responses. In practice, marginalised groups endure harassment from law enforcement bodies, stigmatisation and discrimination of persons living with HIV by health care providers remains common and HIV-related rights violations remain frequent.

The Regional Dialogue served as an important forum for analysing criminal laws, policies and law enforcement practices. This paper provides useful context for the Regional Dialogue.



2. Background Information

Eastern Europe and Central Asia stands out as the one region that does not fit the larger global trend of declining or stabilising new HIV infections and decreased mortality from Acquired Immunodeficiency Syndrome (AIDS).⁷ The number of people living with HIV in the region has almost tripled since 2000 to reach an estimated total of 1.4 million in 2009, compared with 760,000 in 2010.⁸ Increases of up to 700% in HIV incidence have been found in some parts of the Russian Federation since 2006.⁹ An estimated 130,000 people, half of them living in Russia, became infected in 2009 alone.¹⁰ Newly reported HIV cases have increased in several Central Asian countries, including Uzbekistan, which has the largest epidemic in Central Asia.¹¹ Between 2000 and 2009, HIV incidence increased by more than 25% in five countries in the region: Armenia, Georgia, Kazakhstan, Kyrgyzstan and Tajikistan.¹²

Adult HIV prevalence is 0.8% across the region¹³ and 1% or higher in Russia and Ukraine, the two most populous countries in the region, which together account for almost 90% of newly reported HIV diagnoses. AIDS-related deaths continue to rise. There were an estimated 76,000 AIDS-related deaths in 2009 compared to 18,000 in 2001, a four-fold increase during this period.¹⁴

In Russia and Ukraine there are an estimated two million and 400,000 people who inject drugs, respectively, which puts the two countries among the world's highest in terms of prevalence of drug use.¹⁵ The rise in new HIV infections in Eastern Europe and Central Asia is happening mainly due to continuing high levels of HIV transmission, which most frequently occurs in networks of people who inject drugs and their sexual partners and, to a lesser extent, sex workers, their sexual partners, and MSM.

⁷ UNAIDS (2010), *Report on the Global AIDS Epidemic 2010*.

⁸ Ibid.

⁹ UNICEF (2010), *Blame and Banishment: The Underground HIV Epidemic Affecting Children in Eastern Europe and Central Asia*.

¹⁰ European Harm Reduction Network (EHRN) (2010), *Achieving Universal Access in Eastern, South East Europe and Central Asia: An HIV Community Perspective*.

¹¹ UNAIDS (2010), *Report on the Global AIDS Epidemic 2010*.

¹² UNAIDS (2010), *Global Report Fact Sheet, Eastern Europe and Central Asia*.

¹³ EHRN (2010), *Achieving Universal Access in Eastern, South East Europe and Central Asia: An HIV Community Perspective*.

¹⁴ Ibid, at pp. 38-39.

¹⁵ Hoover, J. (2009), *Shining Light on a Hidden Epidemic: Why and How Civil Society Advocates can support the Expansion of Hepatitis C treatment in Eastern Europe and Central Asia*, Open Society Institute.

The epidemic in the Balkans (Southeast Europe) and Turkey has distinct characteristics and is characterised by low HIV prevalence with prevailing sexual transmission.¹⁶ MSM make up around 10% of new and cumulative cases in Southeast Europe, with as high as 50% of all infections in Croatia.¹⁷ Georgia is categorised as having a low-prevalence HIV epidemic with the estimated HIV prevalence below 0.01% with the highest HIV prevalence observed among MSM (3.7%) followed by people who inject drugs and sex workers.¹⁸ Turkey (the only non-former Soviet country in the region) is considered to be at a low level epidemic, where the main route of transmission is through heterosexual sex (57%) followed by male-to-male sex at 9% and injecting drug use at 4% of cases where the transmission route is known. Sex work can be considered a major driver of the epidemic in Turkey and sex workers form a significant portion of those vulnerable to HIV.¹⁹ In Albania, 54% of all cases are associated with migration or travel. Roma across the Balkan countries are more vulnerable due to lower access to health care, social exclusion and higher rates of injecting drug use and sex work.²⁰

An estimated one-quarter of the 3.7 million people who inject drugs in the region (most of whom are men) are living with HIV. In the Russian Federation, more than one third (37%) of the country's estimated two million people who inject drugs are believed to be living with HIV, compared with between 39% and 50% in Ukraine. In contrast, Albania identified the first case of HIV among people who inject drugs only in 2009. The epidemic is spreading from people who inject drugs (predominantly male) to their sexual partners (predominantly female); as such, the proportion of women living with HIV is growing. By 2009, an estimated 45% of the people living with HIV in Ukraine were women, compared with 41% in 2004 and 37% in 1999.²¹

The interplay between sex work and injecting drug use is accelerating the spread of HIV in the region. At least 30% of sex workers in Russia, for example, have injected drugs, and the high HIV infection levels found among sex workers in Ukraine (14% to 31% in various studies) are largely attributable to the overlap of paid sex with injecting drug use. High HIV rates are recorded among sex workers in Belarus (6.4%).²² Georgia and Kazakhstan report prevalence between 1-1.3% among sex workers. In contrast, no reported HIV cases were associated with sex work in the former Yugoslav Republic of Macedonia.²³

¹⁶ EHRN (2010), *Achieving Universal Access in Eastern, South East Europe and Central Asia: An HIV Community Perspective*.

¹⁷ Ibid. at p. 12.

¹⁸ Around 2940 (2350-3666) in 2008 and 3390 (2369-43330) by the end of 2009 year. *Georgia: UNGASS Country Progress Report (2010)*.

¹⁹ The number of reported cumulative cases reached 3.898 (771 AIDS and 3.127 HIV) as of December 2009. *Turkey: UNGASS Country Progress Report (2010)*.

²⁰ EHRN (2010), *Achieving Universal Access in Eastern, South East Europe and Central Asia: An HIV Community Perspective*.

²¹ UNAIDS (2010), *Report on the Global AIDS Epidemic 2010*, Chapter 2, at p. 38.

²² EHRN (2010), *Achieving Universal Access in Eastern, South East Europe and Central Asia: An HIV Community Perspective*.

²³ Ibid.

High HIV prevalence has been found in prison populations, especially among incarcerated people who inject drugs. Low or non-existent HIV prevalence among prisoners was found in the former Yugoslav Republic of Macedonia while Kazakhstan has up to 7.6% and Ukraine 15% (at least 10,000 prisoners).²⁴ In Belarus, 21% of all HIV cases were diagnosed among prisoners.²⁵

Unprotected sex between men is responsible for a small share of officially reported new HIV infections in the region—less than 1% of people newly diagnosed with HIV infection for whom the route of transmission was identified. However, official data may underestimate the actual extent of infection in this highly stigmatised population. In small surveys, the HIV prevalence among MSM has ranged from zero in Belarus and parts of Central Asia to 5% in Georgia, 6% in the Russian Federation and between 4% (in Kyiv) and 23% (in Odessa) in Ukraine.²⁶ Other countries, with the exceptions of Albania and Kazakhstan, estimate HIV prevalence among MSM above 1%.²⁷

Throughout the region, people living with HIV are disproportionately affected by TB and Hepatitis C virus (HCV). Tuberculosis (TB) remains a leading cause of death among those with HIV²⁸, and the rates of multi-drug resistant TB are high (11 countries in the region are considered by the World Health Organisation (WHO) to have high MDR-TB prevalence.²⁹ Since people who inject drugs constitute a large proportion of people living with HIV, they disproportionately suffer from HCV. Ten million people are currently living with HCV in the region. Studies among people who inject drugs and are living with HIV in the region have found HCV/HIV co-infection prevalence to be greater than 80% among persons living with HIV.³⁰

²⁴ Ibid.

²⁵ Ibid.

²⁶ Ibid.

²⁷ Ibid.

²⁸ Report of the Secretary General (28 March 2011), *Uniting for Universal Access: Towards zero new infections, zero discrimination, zero AIDS related deaths*, at p. 15.

²⁹ WHO Progress Report 2011, *Towards universal access to diagnosis and treatment of multi-drug resistant and extensively drug resistant tuberculosis by 2015*. at p. 2

³⁰ International Harm Reduction Association, (2010), *Global State of Harm Reduction*, at p. 74.



3. The Right to Health

3.1. Access to General Health Care

The Law

Each country has a specific article in its constitution that guarantees its citizens access to health care. In addition, public health legislation governs relationships in the sphere of health care, including the right to free health care services. A large number of decrees, orders and instructions supplement the laws and provide guidelines to the general principles entrenched in them. For the most part, constitutional and legislative provisions comply with international standards, but implementing legislation that receives less scrutiny may depart from these standards. In the countries of the former Soviet Union, primary health care is provided based on territorial divisions, in which a healthcare facility is responsible for the provision of basic services to people residing in a certain administrative territory. Specialised secondary care is provided by facilities and departments specialising in a particular disease, such as narcological dispensaries (drug dependence clinics), AIDS, TB and Sexually Transmitted Infection (STI) centres, oncological and other hospitals. This leads to departmentalised health care lacking links between departments and difficulties in accessing care if a patient has more than one condition.

In the majority of the countries under study, the government establishes a guaranteed scope of free health care assistance at state healthcare facilities for citizens, which usually includes primary health care, accident and emergency medical care and secondary health care upon referral by a primary health care practitioner. This includes treatment for drug dependence, HIV infection and opportunistic infections (Russia, Ukraine, Kazakhstan, Tajikistan and Uzbekistan). Usually these services are provided to citizens.³¹ In Kyrgyzstan, on the other hand, healthcare services and medications are provided free of charge only in the case of emergency care; in other cases, health care is provided on the basis of medical insurance; co-payment by the patient is required in many instances (such as drug dependence treatment). The government of Kyrgyzstan annually adopts a “Programme of State Guarantees” that determines specific population categories entitled to certain free primary healthcare services.³²

³¹ Turkmenistan according to its law provides free use of public health facilities to its citizens, foreign nationals, stateless persons and refugees.

³² See more on health care legislation and access in Azerbaijan and Central Asian countries in UNODC, Canadian HIV/AIDS Legal Network, (2010), *Accessibility of HIV Prevention, Treatment and Care Services for People who Use Drugs and Incarcerated People in Azerbaijan, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan: Legislative and Policy Analysis and Recommendations for Reform*.

In at least Russia, Ukraine, Azerbaijan, Kazakhstan, Turkmenistan, Uzbekistan and Belarus, legislation and government regulations or orders classify some health conditions as socially significant or socially dangerous diseases. The lists of such diseases frequently include HIV infection and AIDS, viral hepatitis B and C, tuberculosis, sexually transmitted diseases, and mental and behavioural disorders (including drug dependence). Inclusion in these lists may mean both benefits for those with the disease (e.g., free treatment) and restrictions on rights (e.g. being subjected to coercive testing, treatment and disqualification from working in certain professions).³³

Healthcare legislation in the study countries list patients' rights and responsibilities. For example, in Tajikistan, the Law "On Public Health Care" lists patients' rights which include the following: the right to a respectful and humane attitude on the part of health-care staff; the choice of a doctor, including a family and attending physician; access to a lawyer or other legal representative to protect the patient's rights.³⁴ Less frequently, these laws formalise such patients' rights as the right to decline treatment, the right to participate in decision-making about treatment, and a right to full information. Articles 32-33 of the Russian Federation's Framework law on citizens' health protection stipulate patients' rights and the rights of certain categories of people (pregnant women, conscripts and military personnel, people in prisons, minors) and stipulate the right to consent to treatment and the right to decline it. According to Article 34, healthcare interventions without a person's consent (or the consent of one's guardian and representative) are provided if persons are criminal offenders or suffering from diseases deemed dangerous to others, psychiatric diseases or are criminal offenders. The decision on treatment is taken by a health care professional and the decision regarding in-patient compulsory treatment is taken by the court.³⁵ Lack of specific mention of the patients' right to decline treatment (i.e. in some countries of Central Asia), and the right to participate in the decision making about treatment limits people's enjoyment of their rights. Also, this research has found no evidence that such patients' rights are guaranteed in practice by enforcement mechanisms.

Generally, legal entrenchment of HIV-related strategies and interventions happens by adopting national strategies on HIV/AIDS which define general directions and priorities for the HIV response³⁶ and omnibus HIV/AIDS laws. National laws on HIV/AIDS or the prevention of

³³ Ibid.

³⁴ Tajikistan's Law *On public health care*, No. 419 (15 May 1997) Article 31, cited from UNODC and Canadian HIV/AIDS Legal Network, (2010), at p. 62.

³⁵ Russian Federation, *Framework law on health protection of citizens* [Основы законодательства об охране здоровья граждан], (22 July 1993), N 5487-1.

³⁶ For example, National Strategic HIV/AIDS Programme for 2007 –2011 of Turkey contains national targets and strategies on HIV protection and prevention, diagnosis and treatment, increasing accessibility to HIV Voluntary Counselling Services, monitoring and evaluation, social support and intersectoral collaboration targeting the general population and vulnerable populations. Turkey: UNGASS Country Project Report, (2010). See also, Armenia National AIDS Plan, 2007-2011, Kosovo Strategic Plan on HIV/AIDS, 2009-2013, National Program for Prevention and Control of HIV/AIDS/STIs 2006–2010.

HIV/AIDS (HIV laws) identify rights and responsibilities of people living with HIV, and specify the responsibilities of government bodies and healthcare facilities. Some countries address HIV-related matters in general public health laws or laws on infectious diseases. Legislation usually provides for free testing and treatment of persons requiring Antiretroviral Therapy (ART) and treatment of opportunistic infections and co-infections. All studied countries, except for Turkmenistan, receive or have received in the past some support for their national HIV response from the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) which helps governments provide HIV-related care and support services free-of-charge. During the last five years, many study countries have reviewed and updated their legislation with regard to HIV and revised laws moving towards a more protective environment for persons living with HIV.³⁷ Albania's 2008 law on HIV addresses protection of persons living with HIV from discrimination in the employment sphere and promotes the establishment of safe places where affected people have access to life-saving treatment and establishes a complaints mechanism. The Kosovo Government is currently drafting secondary legislation on the prevention and treatment of HIV/AIDS.

Russia's law on HIV provides for certain rights for families whose children are HIV positive; minors under 18 years of age are provided with pensions, benefits and other social protection measures for children with disabilities. Their caretakers are guaranteed social support (Article 18).

The 2010 Ukraine law on HIV introduced several positive changes:

- a) It removed mandatory disclosure of HIV-positive status prior to any activity that may risk exposure and introduced stricter protection of confidentiality. People living with HIV now have the right to seek compensation for unlawful disclosure of their HIV status.
- b) It removed restrictions on entry, stay and residency based solely on HIV positive status.
- c) It introduced clear and detailed procedures for HIV testing.
- d) It provided a legal basis for opioid substitution therapy (OST) for HIV positive people who inject drugs and other people who need it.
- e) It established the legal framework for government funding of Non-Governmental Organisations (NGOs) that provide HIV services.
- f) It guaranteed the right of HIV positive people to reproductive health services.
- g) It guarantees harm reduction services, including needle exchange and substitution treatment for people who inject drugs; post-exposure prophylaxis for healthcare providers and victims of sexual violence; and independent access to HIV services for adolescents.

³⁷ EHRN (2010), *Achieving Universal Access in Eastern, South East Europe and Central Asia: An HIV Community Perspective*.

An exception to these positive trends is Belarus, where there is no specific HIV law, but the current legislation on “socially dangerous diseases” envisages mandatory treatment for HIV.³⁸

Implementing Practices and Areas of Concern

- 1) According to reports, the reality of access to health care in the study countries varies greatly because of limited funding and the poor quality of free health services. Despite the fact that healthcare services are free, the patient may have to provide his or her own meals, medications and bed linens.³⁹ The amount of patient co-payment may reach high levels, which jeopardises access to health care for people with low incomes.⁴⁰ The number of health care facilities is higher in urban areas, while rural areas lack many specific services.
- 2) According to some information, in the countries of Southeast Europe, people living with HIV sometimes are not able to access healthcare services due to lack of equipment for implementing universal precautions, or fear and lack of understanding by health workers about the modes of HIV transmission.
- 3) The accessibility of services is impeded by the legal requirement that services be provided on the basis of residency and only to people who are able to show identity documents. People who belong to populations at higher risk of HIV infection frequently do not possess them. This limits their access to health services, as well as for people without permanent residence and internal migrants. In the Russian Federation, internal migrants face difficulties in accessing health care, which is provided on the basis of residence. Registration is needed to receive healthcare services, but obtaining it is often cumbersome and expensive, and lack of registration status may have serious official or unofficial consequences for internal migrants. A migrant without registration is often denied both short-term (for purposes of Prevention of Mother to Child Transmission) and long-term ART and will typically be directed to his or her city of origin to receive the treatment.⁴¹ The characterisation of a person with HIV infection, drug dependence and other conditions as socially dangerous or posing a danger to others may reinforce stigma and discrimination that limits access to health care for those who need it most and puts people in danger of coercive testing and treatment.⁴²

³⁸ The law of the Republic of Belarus (4 June 2008), *On amendments of the Public Health Law*, and EHRN (2010), *Achieving Universal Access in Eastern, South East Europe and Central Asia: An HIV Community Perspective*, at p. 27.

³⁹ UNODC, Canadian HIV/AIDS Legal Network, (2010), *Accessibility of HIV Prevention, Treatment and Care Services for People who Use Drugs and Incarcerated People in Azerbaijan, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan: Legislative and Policy Analysis and Recommendations for Reform*,

⁴⁰ WHO Europe (2009), *The European Health Report, 2009: Health and Health Systems*.

⁴¹ Human Right Watch (2009), *Discrimination, Denial, and Deportation: Human Rights Abuses Affecting Migrants Living with HIV*.

⁴² Cabinet of Ministers of the Republic of Uzbekistan, *On approving the list of social diseases and establishing privileges for people suffering from them*, Resolution No. 153 (20 March 1997). The list was adopted by the Cabinet of Ministers of the Republic of Uzbekistan, Order No. 96 (20 February 1997). Tajikistan’s Law *On public health care*, No. 419 (15 May 1997) Article 31. See more in UNODC, Canadian HIV/AIDS Legal Network, (2010), *Accessibility of*

- 4) Violations of confidentiality are rampant with many health workers having an inadequate understanding of patients' rights, and a lack of responsibility when breaches of confidentiality happen. Despite legal protections, discrimination by healthcare workers against people living with HIV, sex workers, MSM and transgender people is frequently reported. According to official information, in Kosovo knowledge about HIV is low even among health care workers, which leads to high levels of stigma and discrimination against persons living with HIV.⁴³ Patients themselves have little understanding of their rights and the means of protecting them.
- 5) Instead of one comprehensive system of integrated treatment, patients have to deal with several narrowly focused healthcare organisations: that is, drug dependence, tuberculosis and HIV are all treated in different facilities, a situation which creates barriers to access, and consequently endangers health.

3.2. HIV Prevention

HIV prevention is usually listed among the main priorities of National AIDS Programmes, strategies and HIV laws in the region. However, as noted by UNAIDS, the greatest challenge to strengthening the impact of prevention is the reluctance of planners and implementers to focus programmatic efforts where they produce maximum results. In Eastern Europe and Central Asia, a region experiencing primarily concentrated epidemics, 89% of HIV-prevention investments are not focused on people at higher risk, such as people who inject drugs, sex workers and their clients, and MSM. Instead, efforts are concentrated elsewhere, usually on more politically palatable areas.⁴⁴

HIV prevention for the general population is the focus of most activities, consisting mainly of production and distribution of educational materials, education in schools and universities, and public awareness campaigns.⁴⁵ According to the European Centre for Disease Control (ECDC), 80% of countries in Europe believe that a range of prevention services are available to the majority of people in need. These include access to safe blood; universal precautions in healthcare settings; prevention of vertical transmission; information and educational materials on risk reduction; condom promotion; and access to HIV testing and counseling. The figures are

HIV Prevention, Treatment and Care Services for People who Use Drugs and Incarcerated People in Azerbaijan, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan: Legislative and Policy Analysis and Recommendations for Reform at p. 62.

⁴³ Results from a study in 2005 by the National Institute of Public Health (NIPH) on HIV-related attitudes among health-care staff reveal that only 52% had correct knowledge on the routes of HIV transmission; while 43% would isolate a person living with HIV; and 67% favours mandatory HIV testing for all hospitalised patients. HIV/AIDS in Legislation of the Kosovo Government, (2010), *Overview and analyses of legislation in the Kosovo Government with a quick and useful reference to address protection of human rights for people living with HIV/AIDS*, UN Theme Group on HIV/AIDS.

⁴⁴ UNAIDS (2010), *Report on the Global AIDS Epidemic 2010* at pp. 64-65.

⁴⁵ UNDP (2008), *Living with HIV in Eastern Europe and Central Asia*, Report on Georgia, at p. 15.

lower for harm/risk reduction services for key populations, such as people who inject drugs, MSM and sex workers.⁴⁶ According to the Andrey Rylkov Foundation, in Russia out of 19.5 billion rubles (USD\$650 million) planned for HIV every year from 2011 to 2013, only 3% is earmarked for HIV prevention for the year 2011 and 2012, and even less (1%) for the year 2013. Taking into account Russia's vocal opposition to harm reduction (see below), none of these resources are expected to be directed to key populations.⁴⁷

HIV prevention for key populations at higher risk, such as harm reduction measures, are sometimes mentioned in HIV Strategies and Plans but rarely in HIV laws. Even more often such measures are entrenched in implementing acts or do not receive legislative foundation at all. These interventions are rarely funded by the governments, which instead rely on funding from the Global Fund. Kyrgyzstan and Moldova were the first Commonwealth of Independent States (CIS) countries to implement harm reduction interventions and to some extent entrench these measures in their national legislation.

One of the most important reasons for the worsening of the epidemiological situation in Russia is the lack of HIV prevention for key populations at risk of infection. Interventions to address this lack funding suffer from ineffective organisation, utilise non-effective and not evidence-informed methods, and are far from international standards. The participation of civil society groups in prevention activities is decreasing.

- Submission from a Russian participant to the Global Commission on HIV & the Law

In Moldova, harm reduction is considered a major component of the government's most recent HIV strategy. Prevention is among four main strategic priorities of the 2006-2010 National Strategic Plan of Georgia. Additionally, in 2005, Georgia adopted a special state programme on "Support to healthy lifestyle, prevention of social diseases", which included a separate component on HIV prevention. The target groups of the programme include people who inject drugs, sex workers, MSM, individuals with hepatitis B and C or Tuberculosis, infants of HIV-positive women, sailors, soldiers, prisoners, and medical staff.⁴⁸ In Azerbaijan, Kyrgyzstan, Kazakhstan, Uzbekistan and Tajikistan the national programmes on HIV mention HIV prevention among people who inject drugs as an area of concern and in some of these programmes there are explicit references to certain harm reduction programmes as part of the countries' HIV strategies.⁴⁹

⁴⁶ European Centre for Disease Prevention and Control (2010), *Implementing the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia: 2010 Progress Report*. at p. 43

⁴⁷ Andrey Rylkov Foundation for Health and Social Justice, Canadian HIV/AIDS Legal Network (2011), *Additional information to the Report to the International Committee on Economic, Social and Cultural Rights on implementation by the Russian Federation of article 12 of the International Covenant on Economic, Social and Cultural Rights as it relates to access of people who inject drugs to drug treatment and HIV prevention, care and treatment programmes*.

⁴⁸ UNDP (2008), *Living with HIV in Eastern Europe and Central Asia, Report on Georgia* at p.14.

⁴⁹ UNODC, Canadian HIV/AIDS Legal Network (2010), *Accessibility of HIV Prevention, Treatment and Care Services for People who Use Drugs and Incarcerated People in Azerbaijan, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan: Legislative and Policy Analysis and Recommendations for Reform*, at p. 73 - 76.

Even less frequently, HIV strategies and laws mention HIV prevention among people in prisons and closed settings. The Moldovan National Programme for Prevention and Control of HIV/AIDS/STIs for 2006–stipulates that needle exchange and methadone are important elements of a comprehensive response and explicitly mentions that the Ministry of Justice has to “ensure the development of activities and measures to prevent and control HIV/AIDS and STIs in penitentiary institutions through extending harm reduction programmes and substitution treatment.” The 2007 “Law on HIV/AIDS Infection Prevention” also contains an article on prevention activities in penitentiary institutions.⁵⁰ A notable exception is the Russian Federation. Its 2010 Anti-drug strategy specifically includes countermeasures against advocacy of such HIV prevention measures as OST and opposition to other harm reduction measures. Turkmenistan’s legislation does not contain harm reduction interventions.

Legal provisions for the prevention of hospital HIV transmission and adoption of universal precautions, prevention of vertical transmission and HIV education for the general population are included in legislation, as well as treatment and prevention protocols.

Implementing practices

Significant advances have been made in the region in relation to primary prevention of HIV infection among children and youth, and prevention of vertical transmission of HIV. For example, in Ukraine 94.9% of pregnant women living with HIV received ART. Numerous HIV awareness campaigns have been conducted in Moldova, mostly targeting young people. The “Guidelines on PMTCT Issues” discuss key messages and priorities with regard to prevention of vertical transmission.⁵¹ Following its National Programme for HIV prevention, Belarus implements wide actions aimed at HIV prevention in schools.⁵² However, according to some testimonies, barriers to prevention, including to prevention of vertical transmission of HIV exist in prisons and detention centres. Limited access to condoms and unavailability of caesarian sections in prisons (provided only on a paid basis) are reported.⁵³

Several instances of hospital HIV transmission happened in 2007-2008 in Central Asia, in which cases responsible people were charged and sentenced.⁵⁴ Although in Russia, according to the Rules on Sanitary Standards on HIV prevention, post-exposure prophylaxis should be made

⁵⁰ OSI, International Harm Reduction Development Program (2009), *Harm Reduction in Prison: the Moldova Model* at p. 20.

⁵¹ International Treatment Preparedness Coalition (2009), *Missing the Target 7. Failing Women, Failing Children: HIV, Vertical Transmission and Women’s Health*, at p. 36.

⁵² Republic of Belarus (2010). *UNGASS National Progress Report*.

⁵³ EHRN and Association of OST participants of Ukraine (2010), *Access of key populations at higher risk to HIV prevention, treatment, care and support in Ukraine* (in Russian).

⁵⁴ See for example, Utyasheva, L, (2008), *Nine health care workers guilty of negligence causing HIV transmission*, HIV/AIDS Policy and Law Review, Vol. 13, No. 2/3, Canadian HIV/AIDS Legal Network; Utyasheva, L, (2007), *Several HIV outbreaks linked to transfusions of tainted blood and poor sanitary conditions in hospitals*, HIV/AIDS Policy and Law Review, Vol. 12, No. 2/3, Canadian HIV/AIDS Legal Network.

available to all people who encountered risk of exposure,⁵⁵ according to anecdotal evidence, post-exposure prophylaxis is not readily available from public health care services nor available for sale in pharmacies. Some reports show that health care facilities provide medicines only to health care workers exposed during work and children.

In the study countries needles and condoms are generally available in pharmacies at low cost, although sometimes concerns are expressed about the quality of condoms. There are reports from several regions of Russia that pharmacies refuse to sell sterile syringes to drug users.⁵⁶ Needle and syringe programmes (NSPs) exist in all study countries, except for Turkey. More often, these programmes are mandated by regulations and other implementing legislation, but sometimes they function without legal basis. NSPs coverage is often low. Law enforcement patrolling areas close to pharmacies often create obstacles to access to needles and syringes. These issues are discussed at length in Section 6 below.

Areas of concern

- 1) Lack of targeted HIV prevention interventions directed at key populations at higher risk (including harm reduction) that are entrenched in legislation and implemented in practice.
- 2) Little or no funding to existing interventions from governments' budgets.
- 3) Lack of access to HIV prevention services for MSM and sex workers, due to stigma and discrimination.
- 4) Lack of post-exposure prophylaxis and prevention measures in prisons.
- 5) Lack of free post-exposure prophylaxis for victims of sexual violence.

3.3. HIV testing and counselling

Studies conducted in the region suggest that the main problems related to HIV testing are connected with low testing uptake, mostly caused by the fact that confidentiality is not consistently protected, as well as high levels of stigma and discrimination associated with HIV. Estimates show that some countries have large numbers of people who do not know their HIV positive status. For example, Ukraine estimates that only 28% of persons living with HIV know their status. In Georgia, late presenters who are diagnosed with advanced HIV comprise an average of 45% of all new cases since 2004. AIDS rates continued to increase there in 2009 and

⁵⁵ Ministry of Health and Social Development of the Russian Federation, *On Sanitary Standards for HIV Prevention*, №1 11.01.2011, 25 March 2011. СП 3.1.5. 2826-10.

⁵⁶ Andrey Rylkov Foundation for Health and Social Justice (2010), *Report to the International Committee on Economic, Social and Cultural Rights on implementation by the Russian Federation of article 12 of the International Covenant on Economic, Social and Cultural Rights as it relates to access of people who inject drugs to drug treatment and HIV prevention, care and treatment programmes.*

reached 6.5 cases per 100,000 population, the second highest rate in all of European and Central Asia.⁵⁷

Usually, HIV laws contain provisions on voluntary HIV testing and counseling and provide for compulsory HIV testing for blood and tissue donors and in some other “limited circumstances”. Often implementing subsidiary regulations contain wider provisions for compulsory and mandatory testing for various categories of people (Azerbaijan, Belarus, Georgia, Kazakhstan, Russia and Uzbekistan).

Informed consent is required for testing as a rule, but practices of obtaining informed consent vary widely and sometimes the law does not stipulate how the consent is to be obtained. Kyrgyzstan is one of the exceptions, where “informed written consent” from the person or his/her legal guardian is explicitly required by the law.⁵⁸ In Russia, during pre-test counseling, a special consent form is to be filled in two copies, one for the patient, and one for the health care facility.⁵⁹ An order of Kazakhstan’s Ministry of Health states that testing is to be done only with the informed consent of the patient and accompanied by counseling. In Turkmenistan, the law guarantees access of everyone to “voluntary, confidential, anonymous HIV testing,” but does not explicitly require informed consent to HIV testing.⁶⁰ In 2008, Tajikistan’s Ministry of Health adopted detailed guidelines on HIV testing, which provide for free anonymous or confidential HIV testing, with informed consent, which can be written or oral.⁶¹ Pre-and post-test counseling to accompany HIV testing is required by law or policy in all study countries.

Anonymous HIV testing exists in at least some countries, but sometimes only for a fee (Azerbaijan, Russia). Anonymous free HIV testing is available in Kyrgyzstan and Kazakhstan, where anonymous testing providers do not request identification documents or the patient’s name and address; testing is done using a code, according to which the result is given to the patient. Coded results about each newly identified case of HIV infection are immediately sent to the local epidemiological control facilities.⁶² In Moldova, the law mandates that information about patients’ HIV status be sent to his or her specific health care service provider, who has ultimate responsibility for treatment. The law permits health care providers to: a) inform

⁵⁷ EHRN (2010), *Achieving Universal Access in Eastern, South East Europe and Central Asia: An HIV Community Perspective*, p. 12.

⁵⁸ The Law of the Republic of Kyrgyzstan “On HIV”, Article 7.

⁵⁹ Ministry of Health and Social Development of the Russian Federation, (2011), *Sanitary standards on HIV prevention*, at para 5.8.

⁶⁰ Ministry of Health of Kazakhstan, Order No. 227 (9 March 2004). Law of Turkmenistan on prevention of HIV, Article 5. The wording of this article and similar provisions in some other project countries state simultaneously that testing is “anonymous” and “confidential”; whether there is access to any testing that is entirely anonymous remains unclear. UNODC and Canadian HIV/AIDS Legal Network, (2010), at p. 77.

⁶¹ Government of Tajikistan, (2008), *On Procedure of testing in order to identify persons infected with HIV, their registration, medical assistance to and preventive care of people living with HIV, and the list of people obliged to undergo mandatory confidential HIV testing on epidemiological indications*, Resolution No. 171. UNODC and Canadian HIV/AIDS Legal Network, (2010), at p. 77.

⁶² *Ibid* p. 77.

parents of minors without the young person's consent; and b) disclose HIV status information to the spouse or partner of an HIV-positive person if a "risk" of HIV transmission is perceived by the provider. The law does, however, forbid medical personnel from discussing individuals' HIV status outside such specific instances. Several HIV-positive respondents said that this provision is commonly violated at different points in the system.⁶³ In Kosovo, if an anonymous HIV test comes back positive, the person is obliged to provide personal information to the person presenting the test results. HIV is included in the list of the obligatory infections to be reported. The reported data are kept confidentially at the National Institute of Public Health.⁶⁴

Confidentiality is guaranteed by law, but in all study countries reports note that information on HIV status may be and is shared, without patients' consent and often without a justification, with law enforcement representatives and in health facilities beyond AIDS centres. This is discussed further in the section on confidentiality below.

Involuntary HIV testing: National HIV laws in the study countries explicitly mention mandatory or compulsory testing for HIV only for blood donors, and in some other "limited circumstances"

Stigma: In Serbia many people do not know about their rights, including the right to health. Especially this refers to those who are out of the health care system such as people who inject drugs and sex workers. These groups of people do not seek government services as they may be forced to reveal their HIV status. Concerning the fact that stigma is still very high and strongly influences the life of somebody who is HIV positive, the access to HIV treatment is not always easy. Patient privacy is frequently violated. There is practice by doctors to write in red bold, letters on patient's medical records their HIV status. Also, there is an inability of HIV positive people to enter into various social institutions because HIV is seen as infection diseases. One of the major problems is that people are not even willing to use the rights that they do possess, as they feel under pressure to reveal their HIV status.

- *Submission from International AID Network, Serbia*

such as of foreigners seeking entry and prisoners. In many countries they also fail to prohibit the broader application of involuntary testing, including for non-health purposes such as immigration or employment. In many former Soviet Union countries ministerial or departmental guidelines, orders or instructions expand the categories of people who may be tested involuntarily.

- Mandatory HIV testing for foreign nationals and stateless persons (among others) occurs in Kazakhstan, Kyrgyzstan, Russia, Tajikistan, Turkmenistan and Uzbekistan.
- Testing as a condition of employment for people working in certain jobs and periodic check-ups is required in Azerbaijan, Kazakhstan, Kyrgyzstan, Russia, Tajikistan and Uzbekistan. These professions include health care workers and people working in the food

⁶³ ITPC (2009), *Missing the Target 7. Failing Women, Failing Children: HIV, Vertical Transmission and Women's Health* at p. 40.

⁶⁴ HIV/AIDS in Legislation of the Kosovo Government (2010), *Overview and analyses of legislation in the Kosovo Government with a quick and useful reference to address protection of human rights for people living with HIV/AIDS*, UN Theme Group on HIV/AIDS.

sector.⁶⁵ If these workers refuse to undergo HIV testing, they may be dismissed from work.

- Military conscripts and personnel must undergo HIV testing upon entering military service and six months later in Kazakhstan, Russia, Tajikistan and Uzbekistan. If found HIV-positive, people are dismissed from military schools and the armed forces.
- The law of Uzbekistan mandates testing for HIV (and other STIs, tuberculosis and drug dependence) before marriage. If testing determines that one or both parties planning to marry have one or more of the above conditions, registration of marriage is done after confirming awareness of both parties about the results of these tests.⁶⁶

In Belarus, Kazakhstan and Russia, according to the law people may be subject to “mandatory confidential medical examination for detecting HIV infection” if there are “substantial grounds” to think that they may be infected with HIV, pursuant to an order by a health care facility, prosecution and investigation agencies or a court. Furthermore, people who avoid medical examination or treatment in the case of a person with a disease that can be a “serious hazard” to others can be fined by court.⁶⁷ In Kyrgyzstan, compulsory HIV testing may be ordered by the court based on an application by the police or public prosecutor; nobody but the police officer who requested the compulsory testing or the public prosecutor has the right to receive the results of the test. In Uzbekistan, it is an administrative offence for a person to avoid testing for HIV or STIs if there is “sufficient information” to believe he or she could be infected, as well as for a person to refuse to disclose the source of infection with HIV or an STI.⁶⁸

In several study countries, the national HIV law or subsidiary regulations specify mandatory HIV (and STI) testing for key populations at higher risk. In Azerbaijan orders of the Ministry of Health have identified the following people as targets for HIV testing to be pursued by health

⁶⁵ In Azerbaijan, Kyrgyzstan and Turkmenistan orders of the Ministry of Health have made HIV testing mandatory at least for people working in the food sector. HIV screening is carried out prior to employment in certain positions, and employees on this list are also obliged to undergo periodic health check-ups. In Tajikistan mandatory HIV testing is conducted for certain categories of employees on the basis of “epidemiological indications,” as a pre-condition of employment and at regular check-ups: medical doctors and nurses who work at AIDS centres and other healthcare facilities who work with people living with HIV; health care staff of medical labs that do HIV testing; health care staff who deal with blood; and tattoo providers. In Turkmenistan, certain workers of public health bodies (those whose jobs involve working with blood) are subject to mandatory HIV testing as a condition of their employment. See UNODC, Canadian HIV/AIDS Legal Network (2010), *Accessibility of HIV Prevention, Treatment and Care Services for People who Use Drugs and Incarcerated People in Azerbaijan, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan: Legislative and Policy Analysis and Recommendations for Reform*, In Russia, according to the Federal Law on HIV/AIDS, pre-employment HIV testing and annual checkups are mandated for various types of health care personnel, such as AIDS centre workers and surgeons (Federal law *On prevention of spread of the disease caused by HIV*, February 24, 1995 (last amended 27.07.2010, No. 203-FZ.).

⁶⁶ For more information on compulsory and mandatory HIV testing in Azerbaijan and five Central Asian countries see UNODC, Canadian HIV/AIDS Legal Network, (2010), *Accessibility of HIV Prevention, Treatment and Care Services for People who Use Drugs and Incarcerated People in Azerbaijan, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan: Legislative and Policy Analysis and Recommendations for Reform*,

⁶⁷ See for example Law of the Republic of Belarus on Public Health, Article 28, (11 January 2002), with amendments of 4 June 2008. (Закон о здравоохранении).

⁶⁸ Ibid.

care providers: pregnant women, people who use drugs, people in prison, sex workers, men who have sex with men, and patients with tuberculosis or STIs.⁶⁹ In Belarus, people on narcological registries are tested for HIV during first referral to drug dependence treatment, and consecutively, at least once a year. Pregnant women and people in prisons are tested for HIV on compulsory basis in Belarus. People in prisons are tested for HIV on a compulsory basis in Russia.

In practice, even where legal regulations do not specify HIV testing for vulnerable groups there are reports that it does happen in practice, leading to further stigmatisation and marginalisation, breaches of confidentiality and further human rights abuses. According to the People Living with HIV Stigma Index, carried out in Russia in 2010, involuntary HIV testing is widely practiced in Russia; 40% of all respondents (all together 660 people were interviewed in 11 regions of the country) did not consent to testing voluntarily and autonomously. Only 19% received pre- and post-test counseling; approximately half of the respondents did not receive any counselling at all.⁷⁰

It appears that at least Ukraine, Kyrgyzstan and Kosovo have reformed their laws and eliminated legal provisions that would either permit or require compulsory and mandatory HIV testing.

Involuntary disclosure of sexual partners: In the majority of the reviewed countries, when a person is diagnosed with HIV, contact tracing is performed. For example, in Russia, the patient is suggested to notify his/her partners of the risk of exposure and refer them to an AIDS centre, or provide healthcare workers with contact information. The regulation specifies that partners are notified about their risk of exposure preserving anonymity of the patient, and that healthcare personnel are under responsibility to preserve confidentiality.⁷¹

In Russia, disclosure of HIV information without one's (or a representative's) consent is conducted in the following circumstances:

- a) if a person is not in a position to indicate his/her will;
- b) if there is threat of spread of infectious diseases;
- c) following a request from investigative bodies, prosecutor and courts, or in case of criminal investigation or court hearing;
- d) following requests of military bodies (relating to military personnel and conscripts);
- e) for notifying parents and guardians of a minor under 18 years old; and

⁶⁹ UNODC, Canadian HIV/AIDS Legal Network, (2010), *Accessibility of HIV Prevention, Treatment and Care Services for People who Use Drugs and Incarcerated People in Azerbaijan, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan: Legislative and Policy Analysis and Recommendations for Reform* at p. 71.

⁷⁰ Стигматизация и дискриминация людей, живущих с ВИЧ в России, 2011 Отчет «Стигматизация и дискриминация людей, живущих с ВИЧ в России» подготовлен МРОО «Сообщество ЛЖВ» на основе результатов социологического исследования «Индекс Стигмы людей, живущих с ВИЧ в России», проведенного в 2010 г.

⁷¹ Ministry of Health and Social Development of the Russian Federation (2011), *Sanitary Standards on HIV Prevention*, at para 6.4.2.

- f) if there are reasons to think that persons health was compromised as a result of violation of the law.⁷²

Obviously, this list of reasons for involuntary disclosure is considerably wider than the circumstances recommended by the International Guidelines on HIV/AIDS and Human Rights.⁷³

Refusal of the person with HIV (or other STI) to identify sexual partners can result in criminal or administrative charges in Turkmenistan and Azerbaijan. In several countries, people can also be charged with an administrative offense if they refuse treatment for a sexually transmitted infection.⁷⁴

Areas of concern

- 1) Lack of prohibition of broad application of involuntary HIV testing to key populations at higher risk, and in employment and education infringes on human rights and contributes to creating an unfavourable legal environment.
- 2) Frequent violations of confidentiality related to HIV testing lead to low uptake of testing and push people away from health care services, and negatively affect mortality and morbidity as people are diagnosed late.
- 3) Requirements for the process of obtaining informed consent to HIV testing are vague.
- 4) Rules for involuntary disclosure of HIV diagnosis are broad, and there is a lack of processes creating safe environments for voluntary disclosure.
- 5) Restrictions on HIV testing for minors exist, creating barriers to access of children and youth to HIV-related services without consent of a parent or guardian. This is discussed further in the section on children and youth below.

3.4. HIV treatment and care

Treatment for HIV

As of 2010, ART and treatment of opportunistic infections was available in all countries in the region (with the exception of Turkmenistan)⁷⁵ and coverage within countries has grown significantly. Yet the Eastern Europe and Central Asia region has almost the lowest level of access to ART among low and middle income countries with an estimated rate of only 19%

⁷² Ibid.at para 7.

⁷³ UNAIDS and OHCHR (2006), *International Guidelines on HIV/AIDS and Human Rights* at para 20(g).

⁷⁴ UNODC, Canadian HIV/AIDS Legal Network, (2010), *Accessibility of HIV Prevention, Treatment and Care Services for People who Use Drugs and Incarcerated People in Azerbaijan, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan: Legislative and Policy Analysis and Recommendations for Reform*, at pp.71-78.

⁷⁵ It appears that ART is currently unavailable in Turkmenistan. In 2008 the government reported only two officially registered HIV infection cases, one of these persons has since died. Currently UNAIDS does not have any information on Turkmenistan.

coverage, whereas the global average is 36%. Inadequate access for populations at higher risk, for example lack of support for treatment uptake and adherence, as well as stigmatisation of people who use drugs (who in most countries in the region comprise the majority of persons living with HIV) is the key reason for lower access in the region.⁷⁶ In Ukraine the percentage of people who use drugs among people receiving ART is only 7,7%. The percentage of people who use drugs is low even among people on the waiting list of ART - 12.6%.⁷⁷ With the low HIV prevalence, South East Europe has higher levels of access, in many cases with rates that can be considered 'universal'. In many countries however, estimates of coverage may be of limited reliability due to the fact that significant numbers of people do not know their status.⁷⁸

National laws guarantee access to HIV treatment and care, but in reality countries of the region encounter many challenges in organising uninterrupted access to medicines for all. Treatment Guidelines and protocols for HIV/AIDS are adopted in most countries, and are usually based on the general treatment guidelines from the WHO European region. Several changes could be made to adopt these guidelines to the specific situation of the country. However, some countries of the region have yet to follow the new 2010 WHO guidelines regarding the beginning of treatment. In many countries, health authorities still use the old WHO recommendations starting the therapy at CD4 200.⁷⁹ [For more on the regulation of ART in national legislation see Section on Essential Medicines]

Several countries in the region are reported to have weak procurement and supply systems and poor organisational capacity which are to blame for frequent stock outs of ART medicines. In Russia, where 70,000 people receiving ART medicines and approximately 50 000 are in need of it, stock outs and delays in provision of ART medicines are common place.⁸⁰ In 2010 major stock outs happened; according to NGO project Simona+, 10 out of 20 researched regions experienced major stock outs. Stock-outs have led to treatment interruptions. Some patients had to change treatment regimens even when it was not medically necessary; others had to continue on treatment with half of required medicines or were taken off of medication altogether. The Ministry of Health and Social Protection needs support to strengthen the procurement and distribution systems. The stock outs in Russia have led to activists submitting complaints to the UN Rapporteur on the right to the highest attainable standard of health and challenging the situation in national courts.⁸¹ Interruptions in provision of treatment have also

⁷⁶ EHRN (2010), *Achieving Universal Access in Eastern, South East Europe and Central Asia: An HIV Community Perspective* at p. 5.

⁷⁷ EHRN and Association of OST participants of Ukraine (2010), *Access of key populations at higher risk to HIV prevention, treatment, care and support in Ukraine (in Russian)*.

⁷⁸ EHRN (2010), *Achieving Universal Access in Eastern, South East Europe and Central Asia: An HIV Community Perspective* at p. 30.

⁷⁹ Ibid.

⁸⁰ Parfitt, T, (2011), *Russia's drug supply system leaves HIV-patients wanting*, *The Lancet*, Vol. 377 at pp. 369-370,

⁸¹ Ibid.

been recorded throughout the region, specifically in Albania, Belarus, Georgia, Macedonia and Ukraine.⁸²

Treatment of co-infections: Hepatitis

For the estimated 10 million people currently living with HCV in the region, the impact is particularly devastating. The International Harm Reduction Association estimates that HCV prevalence among people who inject drugs is high in the region, with 65,7% in Kazakhstan, and from 61-79% in Ukraine. Studies among people who inject drugs and are living with HIV in the region have found HCV/HIV co-infection prevalence to be greater than 80%.⁸³ In Ukraine, 160-180 thousand are likely to have chronic HCV. In Georgia and Moldova, HCV is believed to have spread to 6% of the entire adult population (200,000 persons in each country).⁸⁴

According to reports there are no national programmes for prevention and monitoring of HCV epidemics, national diagnostic and treatment standards are lacking, and there is no reliable epidemiological and statistical data. Hepatitis B virus (HBV) vaccination recommended for persons living with HIV is rarely available.⁸⁵ The treatment is expensive, and the access to diagnostics and treatment is problematic across the region. Free of charge HCV treatment in Russia is guaranteed by law, but anecdotal evidence suggests that receiving testing and treatment is problematic. In practice, testing is conducted on a paid basis and is extremely expensive.⁸⁶ In Kyrgyzstan, for a limited number of patients medication for Hepatitis C is currently available through governmental programmes thanks to humanitarian aid from donors.

Treatment for Tuberculosis

TB remains a leading cause of death among people living with HIV.⁸⁷ Incidence in TB is declining globally, including in the region, but this progress is undermined by the expansion of the MDR-TB. Out of 27 countries considered by WHO to have high multi-drug-resistant-TB burden, 11 are in the region: Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Kyrgyzstan, Moldova, Russia, Tajikistan, Ukraine and Uzbekistan.⁸⁸

⁸² EHRN (2010), *Achieving Universal Access in Eastern, South East Europe and Central Asia: An HIV Community Perspective* at p. 31.

⁸³ International Harm Reduction Association, (2010), *Global State of Harm Reduction*, at p. 74.

⁸⁴ Open Society Institute, Resolution of the workshop participants, *Access to Essential Medicines In Eastern European and Central Asian Countries*, Vilnius, September 2010.

⁸⁵ EHRN (2010), *Achieving Universal Access in Eastern, South East Europe and Central Asia: An HIV Community Perspective* at p. 31.

⁸⁶ See Andrey Rylkov Foundation, at <http://rylkov-fond.ru/> (in Russian).

⁸⁷ Report of the Secretary General, (28 March 2011), *Uniting for Universal Access: Towards zero new infections, zero discrimination, zero AIDS related deaths*, at, p. 15.

⁸⁸ WHO Progress Report 2011, *Towards universal access to diagnosis and treatment of multi-drug resistant and extensively drug resistant tuberculosis by 2015*.at p. 2

In general, anti-TB medication is available for free, including MDR-TB drugs. According to WHO 2011, the high burden MDR-TB countries of the region do not usually have the National TB Infection control plan, but all have the WHO recommended Programmatic Management of Drug Resistant Tuberculosis (PMDT) Expansion Plan, and the majority have PMDT Guidelines.⁸⁹ All countries with high burdens of MDR-TB provide social support to promote adherence to treatment. Social support may include food packages, transportation vouchers, counseling and psychosocial support, among others. While nearly all countries report having a nationally endorsed PMDT expansion plan, the actual number of MDR-TB patients diagnosed and enrolled in treatment remains very low.⁹⁰

The detection of TB in persons living with HIV however remains challenging mainly due to the lack of experienced medical staff. One of the considerable gaps in treatment of HIV-TB co-infections is that the TB registry is not linked to the HIV/AIDS register. A more integrated approach is needed in service delivery, including better access to HIV testing for people with TB and TB testing for persons living with HIV.⁹¹

In 2011, Russia has introduced compulsory testing and treatment of TB. Anybody displaying any signs of having TB is tested. After TB is diagnosed patients are to be monitored in a TB dispensary. Duration of observation is determined by the diagnosis, co-infections and other circumstances.⁹²

STI treatment

STI testing and treatment is supposedly free in all reviewed countries (as socially significant diseases along with HIV), but is usually carried out nominally (recording the name and address of the patient). Anonymous STI testing and treatment are rare. Due to frequent breaches of confidentiality patients may be reluctant to undergo testing and treatment, especially if they belong to key populations at higher risk. According to a survey by the Open Society Institute done in Azerbaijan, 26% of women drug users surveyed reported that the doctors at STI clinics asked for “a lot of money.” In Kyrgyzstan, 21% of the respondents indicated that they had not attended medical services in the past year, and 82% of those said they did not see the doctor due to lack of money. In Ukraine, only pregnant women can access STI treatment services free of charge; most local clinics refer women who are not pregnant to specialised laboratories for STI tests, where high fees place these services beyond the reach of most women drug users.⁹³

⁸⁹ Ibid. at p. 21.

⁹⁰ Ibid. at p. 21.

⁹¹ EHRN (2010), *Achieving Universal Access in Eastern, South East Europe and Central Asia: An HIV Community Perspective* and WHO Progress Report (2011), *Towards universal access to diagnosis and treatment of multi-drug resistant and extensively drug resistant tuberculosis by 2015*.

⁹² Порядок оказания медицинской помощи больным туберкулезом в Российской Федерации, 28.12.2010.

⁹³ OSI (2009), *Women, Harm Reduction and HIV: Key Findings from Azerbaijan, Georgia, Kyrgyzstan, Russia and Ukraine* at p. 50.

Palliative care

Palliative care and access to opioid analgesics for pain relief are regulated in legislation of all reviewed countries. But while regulations guarantee (often limited) access to palliative care, access to opioid analgesics is restricted by the regulator and is very low in the countries of the region.

A 2006 review of hospice care found that all countries of the reviewed region belong to the group of countries with some level of localised hospice-palliative care, but with low coverage.⁹⁴

Several reviewed countries do have palliative care strategies/guidelines, but actual services are often lacking. In Serbia, the government approved a national palliative care strategy in 2009 that recognises opioids as essential for pain relief and palliative care and provides patients with immediate release oral morphine.⁹⁵ There are normative provisions on palliative care for persons living with HIV in Russia - the standards provide for establishment and operation of palliative care wards and hospital wings, as well as provision of home palliative care⁹⁶ (it is not clear to what extent these policies are implemented). In Russia, access to analgesics is especially limited - research shows only 15% coverage of morphine needs of patients suffering severe pain.⁹⁷

The Open Society Institute (OSI) Public Health Program has worked in several regional countries to establish a framework for palliative care. With its assistance, Moldova recently developed a new palliative care policy framework with the national concept for palliative care adopted by the Parliament, and regulations on the organisation of palliative care services approved by the Ministry of Health. The National Cancer Programme includes palliative care and is in line with the WHO recommendations. The essential medicines list is to be revised to include oral morphine. The ministerial order controlling the prescription and delivery of analgesics has been reviewed by the Oncology Institute, the Drug and Medicines Agency, the National Standing Committee on Drug Control, and the Association of Pharmacists and is now finally awaiting approval.⁹⁸

In Georgia, the first inpatient palliative care consultation service and inpatient unit in a cancer hospital in the region were established. The Global Fund is supporting palliative home care services for AIDS patients in three areas of the country. These initiatives focus on the development and delivery of palliative care mainly for adult patients but there is an

⁹⁴ Wright, M, Wood, J, Lynch, T, Clark, D. (2006), *Mapping levels of palliative care development: A global view*, International Observatory on End of Life Care, Lancaster University, UK at p. 18-20.

⁹⁵ OSI (2010), *Easing the Pain: Successes and Challenges in International Palliative Care* at p. 25.

⁹⁶ Ministry of Health and Social Development of the Russian Federation, Decree *On palliative care to patients with HIV infection*, 17 September 2007, No. 610.

⁹⁷ Lohman, D, Schleifer, R, Amon, J. (2010), *Access to pain treatment as a human right*, BMC Medicine.

⁹⁸ OSI (2010), *Easing the Pain: Successes and challenges in international palliative care*.

acknowledged need for pediatric and geriatric palliative care. OSI established an initiative that links legal services with palliative care programmes.

In Ukraine, the government created the Institute of Palliative Medicine and charged it with palliative care development throughout the country. The work was done on ensuring essential medicine availability and revising the legal framework for the implementation of palliative care.⁹⁹

Areas of concern

Civil society organisations have identified the following problems in the treatment area (some of which have been mentioned before, but are also important to emphasise in this regard):

- 1) Access to services is hampered by the policy of providing them on the basis of one's place of residence. People belonging to key populations at higher risk may not be able to receive services, including ART, because of this.
- 2) Treatment is free, but testing, CD count and some other services are provided on a paid basis. Sometimes additional fees are imposed arbitrarily/based on implementing guidelines, which contradicts legislation mandating free services.
- 3) Prisons and detention facilities provide lower access to ART and CD4 count and viral load testing.¹⁰⁰
- 4) De facto low coverage by ART of key populations at higher risk shows systematic discrimination, marginalisation and pushing people away from services, which creates significant drawbacks in response to the epidemic
- 5) As indicated earlier, one of the problems is the absence of integrated care. In cases of co-infection and combination with drug

In Moldova, despite the law protecting privacy, victims of illegal and unjustified disclosure of HIV are reluctant to defend their rights due to several reasons: a) police officers lack knowledge and techniques to examine cases of disclosure of confidential medical information related to HIV status; b) police officers lack training on HIV, human rights and discrimination issues, right to private life, including right to protection of the personal data and often stigmatize persons with HIV/AIDS; c) victims of disclosure are reluctant to submit complaints to the police because usually the disclosure is committed by the doctors of the medical institution at the place of patients' residencies. The Administrative Code does not provide effective remedies in case police refusal to open an administrative case on disclosure. Persons living with HIV live in the same area as police officers and other persons from the administrative commissions and are not willing to disclose their problems related to disclosure because of fear of stigmatization. Almost all persons living with HIV that suffered disclosure in our work refused to undertake a civil claim on compensation of the non pecuniary damages caused by the doctors' disclosure of the confidential information related to HIV status, stating that they are afraid of negative attitude of doctors in further access to medical assistance.

The case of T.P. 0132: the doctor disclosed T.P. 0132's HIV status to other patients and to the staff of the hospital's section. T.P. 0132 was in the hospital, while he was under medical treatment due to a car accident, and was placed in a separate room due to his HIV status.

⁹⁹ Ibid. at p. 68-70.

¹⁰⁰ EHRN and Association of OST participants of Ukraine (2010), *Access of key populations at higher risk to HIV prevention, treatment, care and support in Ukraine* (in Russian).

dependence people have to go to at least three different health centers for daily care and treatment.¹⁰¹ Separate planning approaches are often undertaken for prevention and treatment, and little integration occurs at the level of service delivery. Referral systems for people who test HIV-positive are frequently fragmented and unmonitored. There is insufficient integration of TB control with the healthcare system and specifically poor linkage with HIV services. It is necessary to build synergy between TB and HIV programmes.

- 6) There is a lack of access to anonymous free testing and treatment for hepatitis and STIs.
- 7) Low level of access and legislative hurdles restrict access to opioid analgesics for pain relief and access to palliative care.

Other cases referring to the disclosure of confidential medical information related to HIV status occurred in different regions of Moldova and were suspected of being committed by the family doctors to the third parties: In the cases C.S. 0078 and C.A. 0190 the family doctors divulged this information in the village and the villagers started to ignore these persons, the latter being asked direct questions related to their HIV status. In the case C.A. 0190, even the pupils were informed at school that in the family of C.S. 0190 a person lives with HIV. C.A. 0190 was asked by her mother to use personal cutlery and to cook personal food.

Submission from Moldovan Institute for Human Rights, Moldova

3.5. Confidentiality of medical information

Legislation of all reviewed countries contains some provisions for confidentiality of patient's health information, usually in HIV laws and public health laws. For example, Article 60 of Public Health Law of Belarus provides for the duty of health care workers to protect confidentiality. However, according to research by the United Nations Office on Drugs and Crime (UNODC) and the Canadian HIV/AIDS Legal Network, despite frequent breaches of confidentiality (particularly for stigmatised conditions such as HIV infection and drug dependence), health care workers are rarely held liable for disclosure of confidential information.¹⁰² There have been very few cases of launching legal proceedings for breaches of such provisions (such as health care workers disclosing a patient's confidential HIV diagnosis). In Russia, according to People living with HIV Stigma Index, 41% contended knowing that information about their HIV status was disclosed without their consent to third parties. Only 14% of respondents were confident that health care workers did not disclose HIV status and other information to third parties, whereas 27% were confident that they did.¹⁰³

¹⁰¹ See more in OSI (September 2008), *PSM in the Kyrgyz Republic, A rapid assessment of procurement and supply activities financed by the Global Fund* available at http://www.soros.org/initiatives/health/focus/access/articles_publications/publications/psmkirgystan_20090226/kyrgyz_20090414.pdf.

¹⁰² UNODC, Canadian HIV/AIDS Legal Network (2010), *Accessibility of HIV Prevention, Treatment and Care Services for People who Use Drugs and Incarcerated People in Azerbaijan, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan: Legislative and Policy Analysis and Recommendations for Reform*, at p. 155.

¹⁰³ Стигматизация и дискриминация людей, живущих с ВИЧ в России, 2011 Отчет «Стигматизация и дискриминация людей, живущих с ВИЧ в России» подготовлен МРОО «Сообщество ЛЖВ» на основе

Generally, according to many laws in the region, medical information may be disclosed without a patient's consent if law enforcement agencies, a prosecutor, the court or health care facilities present an official request. In some countries of the region, there is an obligation of health care staff to inform law enforcement agencies about overdoses and referrals for narcological assistance. Privacy laws in Croatia are ambiguous, as they leave open the possibility for any authorised person – and the number of such persons can be high – to obtain insight into the medical documentation of a patient without his or her consent. This may mean that every health worker has the right to access, authorised or unauthorised, a patient's entire medical documentation or specific parts of it, and the right to provide the collected data to other health workers.¹⁰⁴

Frequent breaches of confidentiality which inevitably push people who need services away from health care institutions, make provisions of anonymous services especially important and valuable. However, reports from some countries expose the lack of free access to anonymous voluntary testing and treatment (for sexually transmitted infections, drug dependence treatment, HIV testing, etc.). Additionally, in many countries, the design of systems is such that confidentiality is inherently difficult to maintain. For example, in order to receive social benefits, families may have to prove every year that a disability is still present, namely that their child is still HIV-positive. Facing annual review unnecessarily expands the number of people who know about a person's HIV status.

Mandatory registration for many health and social programmes sets a high threshold that dissuades many from seeking preventive or treatment services, particularly vulnerable populations.¹⁰⁵

Areas of concern

- 1) Lack of free anonymous testing and treatment services.
- 2) Limited legislative protection of confidentiality, including lack of working enforcement provisions. Frequent violations of confidentiality.
- 3) Wide legal provisions for sharing medical information. No knowledge on part of health care providers regarding patients' rights.

результатов социологического исследования «Индекс Стигмы людей, живущих с ВИЧ в России», проведенного в 2010 г.

¹⁰⁴ Article 2 of the *Regulation on the Use and Protection of Data Contained in the Medical Documentation of Patients in CEZIH*, Cited from *UN Theme Group on HIV/AIDS, Report on the work of the of the National Consultant for HIV/AIDS and human rights in 2010*, Croatia, (2011), at p. 11-12.

¹⁰⁵ UNICEF (2010), *Blame and Banishment: The Underground HIV Epidemic Affecting Children in Eastern Europe and Central Asia* at p. 41.

3.6. Access to essential medicines

The legal and regulatory environment plays a critical role in ensuring access to safe and efficacious essential medicines of good quality, and increasing the affordability of medicines for governments through available flexibilities. The availability of essential medicines in the study countries is compromised by several factors: poor medicine supply and distribution systems, insufficient healthcare facilities and staff, low investment in the healthcare systems (compared to other sectors), and the high cost of medicines. The high cost of medicines is predicated, among others, by levels of intellectual property protection that exceed the requirements of the World Trade Organisation (WTO) *Agreement on Trade-related Aspects of Intellectual Property* (TRIPS) and prevents countries from integrating the public health flexibilities of this Agreement in their national laws, or from using them in practice. Most WTO members in the region have either not incorporated the TRIPS public health flexibilities, or have introduced protection provisions that exceed the minimum requirements of TRIPS (TRIPS-plus provisions). The access of more affordable generics to the market may be further hampered by intellectual property protection requirements in connection with negotiations of free trade agreements with the European Free Trade Association (EFTA) and the European Union.¹⁰⁶ The majority of the study countries have National Essential Medicines Lists (EML), which are used as the basis for procurement and supply of medicines in the public and private sectors and schemes that reimburse medicine costs. They also guide local medicine production. ART, HCV, TB, overdose and OST medication, and pain relief should be on those lists in order to be provided for free or subsidised by the state.

In many countries drug registration, procurement, and supply management systems are inadequate, drug stock-outs are common, and most people are not treated with ART regimens that are consistent with recent WHO recommendations for improved first-line and standardised second-line treatment combinations. The systems of supply management and procurement are not transparent, and in many cases even government bodies responsible for procurement and supply do not possess pertinent information. Key ART, particularly newer and second-line therapies, including those in the WHO EML and in the WHO European Region general treatment guidelines are not yet registered/ included in the National EML.¹⁰⁷

In order to be marketed in a given country, medicines need to be registered. Sometimes the procedure for registration in a country is cumbersome and expensive, so not all pharmaceutical companies are willing or able to register their medicines. As the purchasing entity fully depends on the registered products, a country may end up paying a high price for a particular product

¹⁰⁶ Background paper prepared by Konstantinov, B. (2010) for the seminar *Intellectual Property Rights and Access to Essential Medicines in Ukraine: Challenges and Opportunities in Free Trade Agreement Negotiations, Multilateral Instruments and National Laws*, Kiev, Ukraine.

¹⁰⁷ OSI (2008), *PSM in the Kyrgyz Republic*; ITPC (2007), *Missing the Target 5, Improving AIDS Drug Access and Advancing Health Care for All; Intellectual Property Rights and Access to Essential Medicines in Ukraine: Challenges and Opportunities in Free Trade Agreement Negotiations, Multilateral Instruments and National Laws*, (21-22 June), Kiev, Ukraine.

since there may be only one manufacturer who registered it. Various reports show that if countries' registration law is applied strictly, the complete range of necessary ART according to the treatment guidelines cannot be procured.¹⁰⁸

In Russia, numerous cases of long-term hold-ups in the registration process have been reported.¹⁰⁹ For some drugs, the process takes only a couple of months, while for others it takes years. Clear reasons for the delays are not given and corruption is suspected. Drug purchases are arranged through a centralised tender. Although a computerised system for tracking drug requirements at the country's AIDS Centers has been developed, through which AIDS Centers enter the quantities of drugs they require, the Federal standard on the quantities of drugs that should be ordered is often not followed. This has resulted in overstocking some drugs and stock-out of others. The tender process in Russia has also been problematic. According to reports, some products purchased are of questionable quality, or not recommended by WHO, which leads to distrust of generics in the country.¹¹⁰

Since the creation of the WTO in 1994, almost all study countries have either become WTO member states or are negotiating their accession.¹¹¹ Currently, Albania, Armenia, Croatia, Georgia, Kyrgyzstan, Moldova, Turkey and Ukraine are members of the WTO. Russia and Montenegro have completed negotiations and are in the process of joining the organisation. Azerbaijan, Belarus, Bosnia and Herzegovina, Kazakhstan, Kosovo, Macedonia, Serbia, and Uzbekistan are negotiating accession. Turkmenistan is not a candidate.

All member states of the WTO (except for least-developed countries) must provide patent protection to pharmaceuticals in their national laws, as required by the TRIPS Agreement. Countries can include the public flexibilities of the TRIPS Agreement, which were also reaffirmed by the Doha Declaration on TRIPS and Public Health (2001). The flexibilities allow countries to apply stricter regulations regarding what medicines are patentable, object to patent applications, issue compulsory licenses and government use orders, use parallel importation, apply general exceptions including regulatory or experimental use exceptions, and make use of transitional periods.¹¹² According to reports, even though some study countries

¹⁰⁸ Ibid.

¹⁰⁹ Parfitt, T (2011), *Russia's drug supply system leaves HIV-patients wanting*, The Lancet, Vol. 377 at p. 369-370; ITPC (2007), *Missing the Target 5, Improving AIDS Drug Access and Advancing Health Care for All*.

¹¹⁰ ITPC (2007), *Missing the Target 5, Improving AIDS Drug Access and Advancing Health Care for All*.

¹¹¹ For members of the WTO, see http://www.wto.org/english/thewto_e/whatis_e/tif_e/org6_e.htm.

¹¹² WTO Agreement on Trade-related Aspects of Intellectual Property Rights http://www.wto.org/english/tratop_e/trips_e/t_agm0_e.htm. Cited from background paper prepared by Konstantinov, B. (2010), for the seminar *Intellectual Property Rights and Access to Essential Medicines in Ukraine: Challenges and Opportunities in Free Trade Agreement Negotiations, Multilateral Instruments and National Laws*, Kiev, Ukraine. at p. 4.

have incorporated TRIPS flexibilities into their national legislation they do not use these flexibilities.¹¹³

Ukraine has adopted numerous “TRIPS-plus” provisions in excess of the Agreement’s requirements - for instance in patentability, patent extension, data exclusivity and enforcement.¹¹⁴ Before joining the WTO in 2008, Ukraine had revised some national laws, such as the *Law on Protection of the Rights on Inventions and Utility Models*, the *Law on Medicines*, the *Ukrainian Criminal Code* and *Customs Code* and other laws and by-laws. Of particular concern are the six years of test data exclusivity regime and the patent-registration linkage, included in Article 9 of the *Law on Medicines*.¹¹⁵ Test data exclusivity is not required by the TRIPS Agreement, which protects undisclosed information against “unfair commercial use”. Under test data exclusivity regimes drug regulatory authorities are prohibited from accepting for registration generic applications that refer to the existence of already submitted originator’s test data (without ever using, or even accessing them), and claim bioequivalence. Through test data exclusivity generic competitors are forced to either unnecessarily repeat pre-clinical and clinical trials to collect their own data, or to wait until the expiration of the exclusivity period. Data exclusivity effectively secures market monopoly of the originator companies even when there is no patent protection of the medicine. It restricts competition and keep medicines’ prices high. Similarly, a patent-registration linkage prevents a medicine from being registered in case there are claims that it infringes, or even concerns that it might infringe, a patent right. This linkage is provided despite the fact that patent rights are private and drug registration is a public administrative procedure aimed at securing quality, safety and efficacy, and not related to intellectual property rights compliance. Even in cases where no patent is actually infringed, patent-registration linkage can be used - and has been used - as an efficient tool to block generic competition.

According to data of the Ukrainian HIV/AIDS Committee, the National Pharmacological Committee, and The All-Ukrainian Network of People living with HIV, because of data exclusivity two generic versions of lopinavir/ritonavir (Lopimun and Ritocom) were de-registered and banned from the market, and the registration of a third antiretroviral, the triple combination emtricitabine/tenofovir/efavirenz (generic version of Atripla®), was prevented.¹¹⁶

¹¹³ A comprehensive overview of the patents laws of the CIS countries and analysis of flexibilities that they allow is contained in Musungu, S.F. (2009), *The Potential Impact of WTO Accession, FTAs and Partnership Agreements on Access to Medicines in the Commonwealth of Independent States*.

¹¹⁴ See more in a background paper prepared by Konstantinov, B. (2010) for the seminar *Intellectual Property Rights and Access to Essential Medicines in Ukraine: Challenges and Opportunities in Free Trade Agreement Negotiations, Multilateral Instruments and National Laws*, Kiev, Ukraine.

¹¹⁵ The initial period of five years of data exclusivity in Ukraine was extended with one additional year pursuant the conditions agreed upon in the Free Trade Agreement with the European Free Trade Association (EFTA) in June 2010.

¹¹⁶ See more in a background paper prepared by Konstantinov, B. (2010) for the seminar *Intellectual Property Rights and Access to Essential Medicines in Ukraine: Challenges and Opportunities in Free Trade Agreement Negotiations, Multilateral Instruments and National Laws*, Kiev, Ukraine.

Interestingly, Ukrainian legislation has retained some important flexibilities, most notably a compulsory licensing and government use regime. Unlike most other laws of the study countries, the Ukrainian compulsory licensing regime does not require court decisions but a decision of the government. The secondary legislation for issuing a compulsory license is also developed. However, so far Ukraine has not used this flexibility, or any other flexibility that it has retained.¹¹⁷ In the process of its accession to the WTO, most likely under pressure from developed negotiating partners, Russia also agreed on TRIPS-plus provisions. The most significant problem is the decision to introduce test data exclusivity, as envisioned in Article 18, Paragraph 6 of the Russian *Law on Circulation of Medicines*. The Article will enter into force immediately after Russia's WTO accession, without any transitional period. According to Article 18, Paragraph 6, Russia will provide six years of test data exclusivity.

Russia's data exclusivity regime envisions the date of registration in the country as the starting point of the exclusivity. This is a much stricter measure compared to data exclusivity regimes in high income markets such as the European Union, where the starting period of the exclusivity is the date of first registration anywhere in the community. In practice this means that even "old" medicines could receive full six-year period of exclusive protection in Russia, thereby eliminating generic competition. More importantly, Article 18, Paragraph 6 does not refer to "undisclosed information" but just to "information". Therefore, even information that is otherwise publicly available can be considered exclusive to prevent registration of generics. The law also refers to "medicines", instead of "new chemical entities", or "new active ingredients", which further expands the opportunities to misuse the data exclusivity regime to block generic competition and maintain high prices. The provision is very similar to Article 9, Part 17 of the Ukrainian Law on Medicines, where data exclusivity is arranged, and the detrimental effect of which was discussed above.

On 1 January 2010, the documents for the creation of a Customs Union between Belarus, Kazakhstan and Russia entered into force. On 1 January 2012, the Customs Union Agreement on Common Regulatory Principles in the Field of Protection of Intellectual Property Rights will enter into force. This Agreement allegedly aims to "harmonize the regulatory principles for IP protection" between the signatory countries, but in effect requires compliance with the TRIPS Agreement from Belarus and Kazakhstan. These countries are not yet WTO Member States and do not benefit from any concessions under WTO regime.

The Agreement foresees the introduction of border measures and criminal sanctions for all sorts of intellectual property rights infringements, which is not required by the TRIPS Agreement. Article 51 of the TRIPS Agreement requires border measures for "counterfeit trademark or pirated copyright goods" and not for patents. Article 61 TRIPS requires criminal sanctions only in "cases of willful trademark counterfeiting or copyright piracy on a commercial scale", again excluding patents. Border measures (seizures, confiscation, and possibly destruction) for alleged patent infringement are significant disincentives for generic producers

¹¹⁷ Ibid.

to enter national markets, since they can and have been misused against generics.¹¹⁸ The same is valid for criminal sanctions.

In its section on patent protection, the Agreement on Common Regulatory Principles between the Customs Union countries envisions that “[p]arties may provide for restriction of the rights granted with titles of protection, provided that such exceptions do not cause undue harm to the normal exploitation of inventions, utility models or industrial designs and do not unreasonably prejudice the legitimate interests of the patent owner, taking into account the legitimate interests of third parties.” This TRIPS-plus provision curtails the right of Customs Union countries to use the TRIPS Agreement flexibilities. Certain other aspects of the Agreement, such as the limitation of parallel importation opportunities only to countries of the Union, are also a reason for concern.

The Benchmarking report produced by OSI¹¹⁹ showed that variations in prices paid for ART across former Soviet Union countries are extremely significant, with Russia paying the highest (times higher than the global median price) and Ukraine paying among the lowest for the same medicines (although other sources indicate that lower prices in Ukraine are no longer the case). The report stresses that countries should strive to have a high percent of their procurements at prices below the 50th percentile, or better below the 25th price percentile, meaning that most of their ART should be purchased at or below global median price. Kazakhstan and the Ukraine have 34% and 38%, respectively, of all their ART purchases in the lowest quartile of reported prices. Several countries have purchased solid dosage form ART at prices less than the global median price, including Belarus (44% of all such purchases), Kazakhstan and Ukraine (51% each), Moldova and Tajikistan (42% each), and Uzbekistan (33%). The Russian Federation paid the highest prices at 83% and 95%, respectively, of all solid ART purchases in the highest quartile of global procurement prices. Other countries paying high prices are Armenia and Kyrgyzstan with 69% and 86% of procurements, respectively, being in the 75th percentile or greater.¹²⁰

According to the same OSI report, not all countries use the opportunity to purchase cheaper generic versions of ART medicines. When both generic and brand name ART were available, Tajikistan chose the generic version 92% of the time and Kyrgyzstan 100%, however these percentages are based on small numbers of reported procurements. At the time of the OSI research, the Russian Federation consistently bought brand name ART, regardless of whether

¹¹⁸ For instance, in 2009 customs officials at the Amsterdam Airport in the Netherlands seized a shipment of abacavir sulphate tablets, manufactured by Aurobindo, claiming that the medicines were “counterfeit” and violated patent rights. The medicines were in fact good quality, did not infringe patents and were to be distributed by the Clinton Foundation. The shipment was funded by UNITAID. After months of delay the medicines were ultimately released. See UNDP (2010), *Good Practice Guide: Improving Access to Treatment by Utilizing Public Health Flexibilities in the WTO TRIPS Agreement*, at p. 46.

¹¹⁹ OSI (2008), *Benchmarking the Antiretroviral prices in the countries of the former Soviet Union*.

¹²⁰ Another report indicates that prices in Russia are estimated to be ten times higher than in neighboring Ukraine, which has a comparable prevalence rate, see ITPC (2007), *Missing the Target 5, Improving AIDS Drug Access and Advancing Health Care for All*.

the generic was available. When faced with this same choice, Armenia purchased generics no more than 33% of the time. A total of \$31.9 million dollars was spent in the region in excess of global median prices over the period July 2002-March 2008, which is more than half of the total amount spent on ART (the total amount of money spent on ART was reported to be \$59.69 million). Of this excess expenditure, \$19.9 million dollars was 'excess' money spent by the Russian Federation. Ukraine spent an 'excess' amount of \$7.9 million dollars. The total number of additional people that could have been provided first line ART for one year if ART had been purchased at global median prices ranged from 80,985 to 335,873, depending upon the ART regimen (these estimates included Estonia and?? which are not part of the region studied in this paper). This is approximately 3-14 times the total number of people presently on ART in these former Soviet Union countries. In the Russian Federation alone, approximately 50,446 to 209,219 additional patients could have been provided with first line ART for one year if ART had been purchased at global median prices.¹²¹

Areas of concern

- 1) Reluctance to use the TRIPS public health flexibilities, even if this possibility exists in national law. Adoption of provisions which exceed the requirements of the TRIPS Agreement (TRIPS-plus) and hinder the opportunity to use the flexibilities – during accession to the WTO, or through bilateral trade agreements. Proliferation of TRIPS-plus measures through the Customs Union Belarus-Kazakhstan-Russia.
- 2) Poor procurement, supply and management systems, resulting in corruption and stock outs.
- 3) Political negotiation of TRIPS-plus provisions compromising public health care interests.

¹²¹ OSI (2008), *Benchmarking the Antiretroviral prices in the countries of the former Soviet Union*.



4. Equality, Non-Discrimination and Human Rights for Persons Living with HIV and Key Populations at Higher Risk

Equality and protection from discrimination

Constitutions and Criminal Codes: Legislation of all countries in the region contains constitutional equality and anti-discrimination provisions. These provisions usually contain general principles of equality before the law, equal rights for men and women, prohibition of discrimination on various grounds and respect and protection of human rights for all. These provisions usually do not specifically mention prohibition of discrimination on the ground of health (or HIV status), which could be included in laws, such as HIV law, law on health care or anti-discrimination law. For example, the constitutions of Azerbaijan, Kazakhstan, Kyrgyzstan, Moldova and Russia guarantee equality of citizens or freedom from discrimination.^{122,123} Health

¹²² Azerbaijan's Constitution provides for a right to have one's health protected (Article 41), while Article 25 provides as follows: "The state guarantees equality of rights and liberties of everyone, irrespective of race, nationality, religion, language, sex, origin, financial position, occupation, political convictions, membership in political parties, trade unions and other public organisations. Rights and liberties of a person cannot be restricted due to race, nationality, religion, language, sex, origin, conviction, political and social belonging.", Article 14(2) of the Constitution of Kazakhstan reads as follows: "No one shall be subject to any discrimination for reasons of origin, social status, property status, occupation, sex, race, nationality, language, attitude towards religion, convictions, place of residence or any other status." In Kyrgyzstan, the Constitution guarantees freedom from discrimination "on the grounds of descent, sex, race, nationality, language, political and religious beliefs, or any other grounds of personal or social characteristics. Article 16 of the Constitution of Moldova states that 'All citizens are equal before the law and the public authorities, without any discrimination as to race, nationality, ethnic origin, language, religion, sex, political choice, personal property or social origin'. Article 20 adds that 'Every citizen has the right to obtain effective protection from competent courts of jurisdiction against actions infringing on his/her legitimate rights, freedoms and interests' and 'No law may restrict the access to justice'. Cited from UNODC, Canadian HIV/AIDS Legal Network, (2010), *Accessibility of HIV Prevention, Treatment and Care Services for People who Use Drugs and Incarcerated People in Azerbaijan, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan: Legislative and Policy Analysis and Recommendations for Reform*.

¹²³ According to the Constitution of the Republic of Armenia, everyone is equal before the law. Any discrimination based on grounds of sex, race, color, ethnic or social origin, genetic features, language, religion or belief, political

is not mentioned as a prohibited ground for discrimination. In some countries, violation of such non-discrimination clauses is penalised by that country's Criminal Code (Azerbaijan, Russia, Kazakhstan, Uzbekistan, Tajikistan, Turkmenistan, Uzbekistan and Ukraine).¹²⁴ There is no evidence that these criminal law provisions are being enforced. Health legislation establishes the obligation of health care and pharmacy workers to provide assistance to anyone needing it. Criminal codes may create criminal responsibility for healthcare professionals who fail to assist patients without a legitimate reason. Article 190 of the Criminal Code of Belarus, "Violation of the equality of citizens," stipulates punishment "for the intended direct or indirect violation or limitation of rights and freedoms, or for the establishment of direct or indirect preferences for citizens depending on their sex, race, nationality, language, origin, property status or official capacity, place of residence, religious belief, membership in civil society organisations, which inflicted significant harm to rights, freedoms and legal interests of citizens."

Anti-discrimination laws

Several Balkan countries adopted specific anti-discrimination laws, a feature that does not exist in the most of the former Soviet Union countries. Croatia was the first country in the region to enact its Anti-Discrimination Law in 2008 (which came in force on January 1, 2009). Serbia (February 29, 2009), Bosnia and Herzegovina (July 23, 2009), and Montenegro (July 27, 2010) soon followed. In these laws prohibition of discrimination either explicitly includes health status, or is formulated in an open way. The anti-discrimination law of Kosovo aims to prevent and combat discrimination, promote equality and implement the principle of equal treatment of the citizens of Kosovo under the rule of law. The law states that there shall be no direct or indirect discrimination against any person or persons based on sex, gender, age, marital status, language, mental or physical disability, sexual orientation, political affiliation or conviction, ethnic origin, nationality, religion or belief, race, social origin, property, birth or any other status.¹²⁵ The Ombudsperson of Kosovo, which reviews cases according to its mandate, is authorised to receive and investigate complaints concerning violations of rights based on discrimination is.¹²⁶

or any other opinion, membership of a national minority, property, birth, disability, age or other personal or social circumstances is prohibited. This article does not specifically prohibit discrimination on the grounds of health, but it can be interpreted as such.

¹²⁴ Criminal Codes of Azerbaijan, Article 154; Turkmenistan, Article 145; Uzbekistan, Article 141. The Criminal Code of Kazakhstan establishes criminal liability for "direct or indirect restriction of rights and freedoms of a person" based on a number of specific listed grounds, as well as discrimination based on "any other circumstances." (Article 141). According to the Criminal Code of Tajikistan, direct or indirect violation of the right to equality is to be punished by a fine. (Article 143). UNODC, Canadian HIV/AIDS Legal Network, (2010), *Accessibility of HIV Prevention, Treatment and Care Services for People who Use Drugs and Incarcerated People in Azerbaijan, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan: Legislative and Policy Analysis and Recommendations for Reform*,

¹²⁵ Kosovo Anti-discrimination Law, Article 2.

¹²⁶ HIV/AIDS in Legislation of the Kosovo Government (2010), *Overview and analyses of legislation in the Kosovo Government with a quick and useful reference to address protection of human rights for people living with HIV/AIDS. Kosovo*. UN Theme Group on HIV/AIDS.

Other legislation

National laws on the protection of people with disabilities may contain a specific article prohibiting discrimination against people with disabilities. In the majority of countries HIV, AIDS or AIDS-related diseases are considered to lead to disability and thus require protection and the right to certain social support. (In comparison, some other world jurisdictions consider HIV or AIDS as “disabilities” as such, and not as conditions “leading to disabilities” (i.e. Canada, the United States). Theoretically, in countries which prohibit discrimination on the ground of health and which define drug dependence as an illness (all study countries), disability protection could be afforded to people with drug dependence, but there is no evidence that this could be achieved in practice.

Healthcare laws may prohibit discrimination on the ground of health and/or impose the obligation on health care professionals to render medical care to everyone. According to Article 17 of the Framework law on protection of citizens’ health of Russia, the state guarantees its citizens protection from all forms of discrimination on the ground of their health.¹²⁷

Employment laws and Labour Codes may also contain antidiscrimination clauses: the Georgian Labour Code states that it is “forbidden to discriminate on the basis of race, skin colour, language, ethnical or social belonging, nationality, origin, economic status, placement, age, gender, sexual orientation, disability, religious or other belonging, family status, political or other opinion”. It also obliges employers to sustain an environment that secures the life and health of its employees. It does not mention HIV specifically.¹²⁸

HIV laws (or laws on infectious diseases) also formally prohibit discrimination on the basis of HIV status in the spheres of employment, education and health care and also guarantee other rights.¹²⁹ For example,

Most people in our society and in many countries in Europe and the CIS consider people vulnerable to HIV to be potential criminals, even when their behaviour is not a crime under the law. During the period of drug use I was more than once subjected to pressure and harassment by law enforcement agencies, including police officers. Representatives of our community are often discriminated against although the legislation provides sufficient protection to prevent such discrimination and ensure assistance to victims. We have to face and survive unjust treatment due to lack of knowledge of individuals but also AIDS-phobia. As a consequence, due to fear of being disadvantaged, people avoid visiting clinics and social services and referrals to legal services. Most often, when citizens witness discrimination, they prefer not to intervene.

- *Submission from Youth for Right to Life, Moldova*

Discrimination of persons living with HIV, people at increased risk of infection, particularly injecting drug use and sex workers, remains very high according to various studies of both Ukrainian and international human rights institutions. This is observed primarily by law enforcement personnel, health institutions and educational institutions. The stigma of persons living with HIV and their marginalization has been increasing.

- *Submission from The Right to Hope, Ukraine*

¹²⁷ Russian Federation, *Framework law on health protection of citizens* [Основы законодательства об охране здоровья граждан], 22 July 1993, N 5487-1.

¹²⁸ UNDP (2008), *Living with HIV in Eastern Europe and Central Asia, Report on Georgia*, at p. 17.

¹²⁹ For example, Law of Tajikistan *On counteracting HIV* Article 13.

in Armenia, Article 14 of the Law on HIV makes provisions for the rights and obligations of HIV-infected individuals and their family members. Under this law, HIV-positive individuals have the right to:

- a) receive the results of laboratory testing in written form;
- b) non-discriminatory attitudes;
- c) demand confidentiality (except in cases stipulated by current legislation);
- d) continue working (except in cases stipulated by the government); and
- e) be provided with counseling, including information about HIV prevention methods.

In Belarus, Article 29 of the Law on Public Health specifies rights and responsibilities of people living with HIV (state benefits, pensions, free public health care, prohibition of discrimination in employment, right to prevention at work). The framework law on health care of Ukraine is meant to protect people living with HIV and members of vulnerable groups from human rights abuses. However this legislation is not always implemented.¹³⁰

Several positive developments in protection of human rights of persons living with HIV and populations at higher risk have happened in Croatia. The proposals for a new Criminal Code include the introduction of a new criminal offence of vilification, which would incriminate a person who expresses or spreads a factual claim regarding another person that can be damaging to that person's honor or reputation. An aggravated form of this offence takes place if perpetrated through the media. In 2006, Croatia broadened the application of its "hate crime" legislation to offences committed against person on the grounds "of his/her ... sexual orientation ... or other characteristic"¹³¹ Now there is a proposal to widen this definition further to include people living with HIV.¹³²

Prohibition of discrimination even where it does not mention the right to health is broad enough to theoretically afford protection to persons living with HIV and key populations at higher risk if such laws were enforced and procedures for implementation of anti-discrimination provisions were developed. In many countries such developments are yet to happen.

More significantly, there is no protective legislation specifically aimed at protection of rights and interests of groups of people at high risk of HIV/AIDS infection such as MSM, people who use drugs, sex workers and prisoners from discrimination and other human rights abuses. In the very few countries where limited elements of this protection exist, there is little evidence of them being implemented.

¹³⁰ Law of the Republic of Belarus *on Public health* (Закон о здравоохранении) amendments of 4 June, 2008, Article 29, cited from *National Progress Report of Belarus*, UNGASS, at p. 59. Основы законодательства Украины о здравоохранении, 19 November 1992.

¹³¹ UNDP (2010), *Report exploring the link between MSM with homophobia and HIV/AIDS in countries: Bosnia and Herzegovina, Croatia, Montenegro and Serbia*.

¹³² UN Theme Group on HIV/AIDS (2011), *Report on the work of the National Consultant for HIV/AIDS and human rights in 2010*, Croatia at p. 23.

Implementing practices

Despite the fact that legislation proclaims equality and non-discrimination, the same legislation (or more often implementing acts or by-laws) provides for infringement of human rights and violation of the proclaimed equality, which is not justified by public health or other public interests. Several countries of the CIS and Eastern Europe restrict rights of people living with HIV and key populations at higher risk to employment, education (such professions as health care worker, hospitality industry, military, food, childcare) and family relations.

Despite the fact that all study countries have laws that define drug dependence as a disease,¹³³ which could be interpreted as including prohibition of discrimination, there are frequent legislative restrictions on rights of people who use drugs or those who are drug dependent, particularly in the former Soviet Union countries.

Employment

As discussed above, some countries compose lists of professions in which people with infectious diseases (including HIV) cannot be employed. In Azerbaijan, persons living with HIV cannot work in child care and food sectors.¹³⁴ In Kyrgyzstan, health care personnel must submit a certificate that verifies their HIV-negative status in order to be employed and also periodically after appointment. In Tajikistan, some government departments and organisations mandate HIV testing of military personnel and cadets, health care professionals and workers in the food industry. In Turkmenistan, if a person is HIV-positive he or she cannot hold positions which may

¹³³ For example, Kazakhstan's Law *On narcotic drugs, psychotropic substances and precursors, and the measures to counteract illicit drug trafficking and abuse* Law No. 2002/15, Article 1(15); Tajikistan's Law *On narcotic drugs, psychotropic substances and precursors* (10 December 1999), Article 2. In Azerbaijan drug dependence is defined as a chronic disease under the Law *On narcological service and control* and those who are dependent on drugs might be considered as legally disabled (and able to access corresponding social security benefits), since the national Law *On the prevention of physical disability, rehabilitation and social protection of the disabled* could extend to cover those who are dependent on drugs. Among other provisions, this law protects people with a disability from discrimination. However, there are no mechanisms for social support and protection from discrimination. Law of Azerbaijan *On narcological service and control*, Article 16.5.; Law *On the prevention of physical disability, rehabilitation and social protection of the disabled* (25 August 1998). Cited from: UNODC, Canadian HIV/AIDS Legal Network (2010), *Accessibility of HIV Prevention, Treatment and Care Services for People who Use Drugs and Incarcerated People in Azerbaijan, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan: Legislative and Policy Analysis and Recommendations for Reform*.

¹³⁴ Law of Azerbaijan *On prevention of HIV and AIDS*, Articles 6-9 and Regulation of the Ministry of Health of Azerbaijan, No. 157 (23 October 1997); Ministry of Health and Ministry of Defense of the Republic of Kazakhstan, Joint Order No.562 (4 November 2005) and No. 342 (19 September 2005). Government of Kyrgyzstan, *Professions, trades and posts which are subject to obligatory physical examination*, Resolution No. 296 (25 April 2006); Law *On HIV/AIDS in the Kyrgyz Republic* (13 August 2005), Article 8. Ministry of Health of the Republic of Uzbekistan, Interdepartmental Instruction *On organising HIV prevention measures* (2000). 476 Ministry of Health, Ministry of Labour and Federation of Trade Unions of the Republic of Uzbekistan, Joint Resolution No 03/1 (6 December 1999). Cited from UNODC, Canadian HIV/AIDS Legal Network (2010), *Accessibility of HIV Prevention, Treatment and Care Services for People who Use Drugs and Incarcerated People in Azerbaijan, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan: Legislative and Policy Analysis and Recommendations for Reform*.

involve work with blood, such as working as a surgeon, gynaecologist or laboratory assistant. In Uzbekistan, people living with HIV are prohibited from being employed in health care positions as well as child-care positions, positions providing massage services or cosmetic services (e.g., hair styling). In Kazakhstan and Uzbekistan, soldiers and conscripts must undergo HIV testing on recruitment and six months afterward. In Russia, people with HIV cannot work at AIDS centres or in laboratories. In Croatia people living with HIV cannot work in police forces.

Some countries prohibit people registered as dependent on drugs from working in certain professions and performing certain activities. This prohibition usually lasts as long as the person is registered as a drug user or drug dependent (some countries have two separate registries: short term registry for people who use drugs (up to a year) and longer term registry for those who are dependent on drugs (usually three to five years)) regardless of whether the person is able to perform the functions of the job. In Kyrgyzstan, high school students enrolling in specialist high schools, such as military schools, must undergo a drug test. Also some law enforcement bodies, drug control agencies and the Office of the Public Prosecutor oblige those applying for a job to undergo drug tests. In Turkmenistan, persons registered for drug dependence treatment are prohibited from performing certain kinds of so-called “high risk” professions and activities (pilots, drivers, railway personnel and steeplejacks). In Uzbekistan, also there is a long list of occupations that are prohibited for people with drug dependence.¹³⁵

On the positive side, some of these provisions are beginning to be challenged in courts. In February 2011, Russia’s Supreme Court rendered a judgment in favor of an HIV-positive passenger jet pilot who was dismissed from his position after his HIV-positive status was disclosed.¹³⁶ In Croatia, an HIV-free certificate is no longer required in order to be a security

¹³⁵ In Azerbaijan the Law *On narcological service and control*, Article 24.4; Cabinet of Ministers of Azerbaijan, Resolution *On the list of professions and positions, that are restricted for people with drug dependence and terms of restriction* (last amended 13 February 2008); and Cabinet of Ministers of Azerbaijan, Resolution *On medical examination of people in specific areas of work and profession, connected with high risk, in state narcological facilities*, Resolution No. 145 (12 September 2002) and No. 018 (February 2003). Government of Kazakhstan, Resolution *On the list of medical and psychological counter- recommendations for certain professions and jobs connected with high risk*, Resolution No. 668 (18 June 2002); Ministry of Health, *Instruction on mandatory preventive and periodical medical check-ups of workers, that are influenced by harmful, dangerous and unfavourable employment risks and determination of professional capacity*, Instruction No. 243 (12 March 2004), paragraphs 12.4 and 13. Tajikistan, Law *On narcological assistance*, Law No. 67 (8 December 2003), Article 8. 492 Law *On narcotic drugs, psychotropic substances, precursors and measures of counteraction of their trafficking*, Article 53. Ministry of Health/ Ministry of Labor and Social Protection/Trade Union Federation Council of Uzbekistan, Resolution *On Establishing a List of Professional Activities Restricted for People with Drug Dependence*, Joint Resolution No. 8/46/14-10 (7 April 2003). Cited from UNODC, Canadian HIV/AIDS Legal Network (2010), *Accessibility of HIV Prevention, Treatment and Care Services for People who Use Drugs and Incarcerated People in Azerbaijan, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan: Legislative and Policy Analysis and Recommendations for Reform*.

¹³⁶ ВИЧ полетам не помеха. Верховный Суд разрешил управлять самолетами ВИЧ-инфицированным. 17 February 2011, Gazeta.ru

guard in the private sector, to be employed as a maritime worker, airline company staff or to work in the military.¹³⁷

Ukraine's Law No. 1972-12, amended on 23 December 2010, contains a general prohibition against discrimination on the basis of real or perceived HIV status. It is prohibited, among other things, to dismiss an individual from employment, deny access to employment, refuse enrolment in educational institutions, or deny access to health care, social care and social services on the basis of real or perceived HIV status. Section 4 provides for the right of different organisations, including trade unions, to participate in awareness-raising activities for HIV prevention, treatment, care & support. Section 5 provides that measures to prevent HIV infection shall be developed, adopted & implemented by central & local executive authorities, local self-government bodies, as well as in enterprises, institutions, organisations. While the national legislation now provides explicit protections against discrimination on the basis of real or perceived HIV status in employment & other settings, effective implementation of this protective legislation is weak, & the efficacy of legal & regulatory acts to prevent discrimination of vulnerable groups is assessed as low. In addition, an extremely low number of successful legal suits related to discrimination is noted (1 case in the past two years). It is not sufficient to address HIV-related stigma & discrimination through the adoption of specific protections against discrimination on grounds of real or perceived HIV status. Provision must also be made to ensure adequate enforcement along with increased awareness of their rights among the population concerned.

- Submission from Trade Union Confederation, FPU, Ukraine

Limitation of other rights: right to education, right to found a family

In some project countries, people seeking enrollment to vocational training and higher education institutions are required to present a medical certificate, which includes affirmation that one is not on the narcological registry as a person who uses drugs or is dependent on drugs or alcohol, and that one does not have HIV.¹³⁸

In Russia, Belarus, Tajikistan, Kazakhstan, Kyrgyzstan, Moldova, Uzbekistan and Turkmenistan legislation provides for lists of the diseases (including HIV and drug dependence) that automatically prevent someone from adopting children.¹³⁹

In many former Soviet Union countries persons who use drugs may be deprived of custody of children or parental rights, even if there is no evidence of child neglect or abuse.¹⁴⁰ The

¹³⁷ *Regulation on Changes and Amendments of the Regulation on the Method of Determining the General and Special Health Capacity of Guards and Security Staff in the Private Security Sector*, Official Gazette no. 16/11., Cited from UN Theme Group on HIV/AIDS, *Report on the work of the of the National Consultant for HIV/AIDS and human rights in 2010*, Croatia, (2011), at p. 25.

¹³⁸ UNODC, Canadian HIV/AIDS Legal Network (2010), *Accessibility of HIV Prevention, Treatment and Care Services for People who Use Drugs and Incarcerated People in Azerbaijan, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan: Legislative and Policy Analysis and Recommendations for Reform*.at p. 124..

¹³⁹ Government of Kazakhstan, *List of Diseases Preventing Child Adoption, Guardianship and, Foster Care*, Resolution No.842 (24 June 1999). Government of Tajikistan, Resolution No. 406 (1 October 2004). Cited from UNODC and Canadian HIV/AIDS Legal Network, (2010), at p. 143.

¹⁴⁰ Azerbaijan's Family Code, Law No. 781-2 (28 December 1999), Article 64. Government of Kazakhstan, *List of Diseases Preventing Child Adoption, Guardianship and, Foster Care*, Resolution No.842 (24 June 1999). Government of Tajikistan, Resolution No. 406 (1 October 2004). In Kazakhstan, parents are deprived of parental

assessment in Georgia reported that registration as a “drug addict” is legal grounds for loss of custody; according to this assessment, 13% of respondents had lost custody of a child due to drug use. In Azerbaijan, 22% of women who used drugs reported facing threats of losing custody of a child due to drug use (and 41% of assessment participants declined to answer this question). Among those in Azerbaijan threatened with removal of their children, 23% reported that they “solved the problem” by paying money, and 12% faced actual legal action (62% did not report on the outcome of custody threats).¹⁴¹ In Russia, a certificate stating that a person is a chronic drug user is accepted as sufficient evidence that a child should be removed from that parent’s custody, even if the drug use occurred years ago. Article 69 of the Family Code states that drug dependence in itself can be a reason for denial of custody. In Kyrgyzstan, Article 147 of the Family Code makes chronic drug dependence the basis for loss of custody. In Ukraine, women drug users who leave their children with family members or with government services, while hospitalised or in drug treatment are sometimes unable to get them back when they return. Moreover, few women drug users can afford to hire a lawyer to defend their parental rights.¹⁴²

In many study countries, a person has to undergo a physical examination (including a drug test) or provide a “drug free” certificate in order to be issued a driver’s license.¹⁴³ In Turkmenistan, if a court considers that a person using drugs “puts his family in a grave financial situation”, then the court can revoke that person’s legal capacity. One of the consequences of this finding is that the person loses the right to vote. Similar provisions exist in all the project countries.¹⁴⁴

rights if they “are recognized in due order as a person abusing alcohol, drugs or substances”. Law *On Marriage and Family*, Law No.321-I (17 December 1998), Article 67. Tajikistan’s Family Code, Article 69. Turkmenistan’s Code on Marriage and Family, Articles 70 and 115. Family Code of Uzbekistan, Article 79.

¹⁴¹ Open Society Institute (2009), *Women, Harm Reduction and HIV: Key Findings from Azerbaijan, Georgia, Kyrgyzstan, Russia and Ukraine* at p. 39.

¹⁴² EHRN (2010), *Women and Drug Policy in Eurasia* at p. 4.

¹⁴³ In Kazakhstan, people registered in drug treatment facilities are restricted from holding a driver’s licence. (Ministry of Health, Order No.243 (12 February 2004). In Kyrgyzstan, applicants for a drivers licence must pass a physical examination which includes a drug test. In Kyrgyzstan *Regulation for examinations, issuance to citizens of driver’s licenses and the admission of drivers to driving vehicles*, No. 420 (4 August 1999).) In Tajikistan, a Decision of the Cabinet of Ministers prohibits those with drug dependence from holding a driver’s licence. In Turkmenistan, those who are registered as using drugs or dependent on them are not permitted to hold a driver’s licence. (Ministry of the Interior, Order No. 138 (26 July 2000), paragraph 2.2. 506 Ministry of Health, *On improvement of the procedure of undergoing pre-employment preventive and current medical exam* (6 June 2000). In Uzbekistan, a person who wants to get a driver’s licence requires a ‘drug-free’ certificate from a narcological centre. Cited from UNODC, Canadian HIV/AIDS Legal Network (2010), *Accessibility of HIV Prevention, Treatment and Care Services for People who Use Drugs and Incarcerated People in Azerbaijan, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan: Legislative and Policy Analysis and Recommendations for Reform*.

¹⁴⁴ See Law *On narcotics, psychotropic substances, precursors and counteraction measures to their illegal circulation*, Article 53, and Turkmenistan’s Civil Code, Articles 26(1) and 27(1). Uzbekistan’s Civil Code, Article 31. Cited from UNODC, Canadian HIV/AIDS Legal Network (2010), *Accessibility of HIV Prevention, Treatment and Care Services for People who Use Drugs and Incarcerated People in Azerbaijan, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan: Legislative and Policy Analysis and Recommendations for Reform*.

Areas of concern

- 1) Despite the fact that equal rights are guaranteed to everyone, there is an obvious lack of protective laws aimed at protection of human rights of people most vulnerable to HIV, such as people who use drugs, sex workers, people in prisons and MSM. There is also evidence, that general protective laws are rarely enforced in relation to persons living with HIV and even the general population.
- 2) Restrictions of rights of people who use drugs and persons living with HIV further marginalise them and are unjustifiable.



5. Criminalisation of HIV Transmission and Exposure

International policy documents on this issue recommend the application of general criminal laws and only in cases of intentional HIV transmission (as opposed to creating specific HIV-related provisions that criminalise both exposure and unintentional transmission). Contrary to this recommendation, the majority of the reviewed countries of the region have chosen to criminalise both exposure and transmission, and most do it through specific HIV-related criminal law provisions.¹⁴⁵ Six countries (Albania, Bosnia and Herzegovina, Croatia, Kosovo, Macedonia and Turkey) provide for the application of general non-HIV specific laws only to cases of actual transmission (whether intentional or unintentional). The few cases described below show that these provisions are rarely applied, and, seemingly, only to cases of actual transmission. The current low level of enforcement could be explained by the population's low level of trust of law enforcement and the judiciary, and frequent violations of confidentiality, including by the media. This, however, does not create safeguards against overly broad application of the law. Ideally the below provisions should be amended in order to criminalise (by general criminal legislation) only actual intentional HIV transmission as recommended by international standards.

According to the "Global Criminalization Scan" by GNP+, which mapped the existence of laws, practices and policies that impact the HIV response, all study countries chose to criminalise exposure to and transmission of HIV. The criminal codes of most of the study countries provide for liability for both exposure and transmission. In some countries the same or different article also criminalises transmission of other STIs. The law imposes harsher sentences if a person transmits the virus on purpose to two or more people, to juveniles or to pregnant women.

Specific articles criminalising both exposure to HIV and HIV transmission exist in the Criminal Codes of most of the reviewed countries: Armenia¹⁴⁶, Azerbaijan¹⁴⁷, Belarus¹⁴⁸, Georgia¹⁴⁹,

¹⁴⁵ UNAIDS and OHCHR (2006), *International Guidelines on HIV/AIDS and Human Rights*.

¹⁴⁶ Article 123 of the Criminal code, mentioning exposure to "evident risk" of HIV and willful transmission (by anyone who is HIV-positive), with penalty up to eight years. Criminalisation of transmission of other STIs is contained in Article 124 of the Criminal Code. Cited from GNP+, *Global Criminalization Scan*, available at <http://www.gnpplus.net/criminalisation>, [Accessed on: April 14, 2011]

¹⁴⁷ Article 140 of the Criminal Code of the Azerbaijan Republic criminalised both exposure and transmission with a sentence to corrective work up to 2 years through to 8 years imprisonment. Cited from GNP+, *Global Criminalization Scan*, available at <http://www.gnpplus.net/criminalisation>, [Accessed on: April 14, 2011].

Kazakhstan¹⁵⁰, Kyrgyzstan¹⁵¹, Moldova¹⁵², Montenegro¹⁵³, Serbia¹⁵⁴, Russia, Tajikistan, Turkmenistan¹⁵⁵, Ukraine, and Uzbekistan.

In other countries, although no HIV specific laws criminalising HIV exposure and transmission are adopted, existing public health or criminal legislation is used to criminalise transmission of HIV. For example, in Bosnia and Herzegovina, Article 211 of the Entity law (criminal acts against the health of people) “Transmission of communicable diseases” penalises transmission, with sentences ranging from a fine to 10 years imprisonment.¹⁵⁶ In Croatia, Article 99 (aggravated bodily injury) and Article 239 (transmission of venereal disease) of the Criminal Code are said to be applicable to situations of HIV transmission. Both countries prosecute only instances of actual HIV transmission. The same is true in Macedonia¹⁵⁷ and Turkey.¹⁵⁸

Albania and Kosovo have no laws that specifically mention criminalisation of HIV exposure and transmission, but Kosovo’s Criminal Code has a specific article on transmission of venereal diseases. According to Chapter XXI of the Criminal Code of Kosovo, anyone who fails “to comply with the provisions or orders of the competent public entity in the field of health-establishing controls, disinfections or quarantines of sick persons or other measures aimed at preventing or fighting contagious diseases among people and thereby causes the transmission

¹⁴⁸ Article 158 of the Criminal Code of the Republic of Belarus, Sentence is up to 15 years in prison. Cited from GNP+, *Global Criminalization Scan*, available at <http://www.gnpplus.net/criminalisation>, [Accessed on: April 14, 2011].

¹⁴⁹ Art. 131 of the Criminal Code criminalises both exposure and transmission, with penalty - imprisonment from three to ten years. Other articles prosecute exposure and transmission of highly dangerous infections. Cited from GNP+, *Global Criminalization Scan*, available at <http://www.gnpplus.net/criminalisation>, [Accessed April 14, 2011].

¹⁵⁰ Republic of Kazakhstan, Article 116 of the Criminal Code. Cited from GNP+, *Global Criminalisation Scan*, available at <http://www.gnpplus.net/criminalisation>, [Accessed on: April 14, 2011].

¹⁵¹ Kyrgyzstan Republic: Both the HIV law and Criminal Code contain provisions criminalising exposure and transmission. Cited from GNP+, *Global Criminalisation Scan*, available at <http://www.gnpplus.net/criminalisation>, [Accessed on: April 14, 2011].

¹⁵² Republic of Moldova Code of Criminal Procedures (2002), Articles 211 and 212, and Article 29 of the Law on AIDS (2007). Both exposure and transmission are subject to prosecution. Sentences range from 'up to three years' imprisonment through to a maximum of eight years imprisonment. Cited from GNP+, *Global Criminalization Scan*, available at <http://www.gnpplus.net/criminalisation>, [Accessed on: April 14, 2011].

¹⁵³ Penal Code of the Republic of Montenegro, Article 289. Cited from GNP+, *Global Criminalization Scan*, available at <http://www.gnpplus.net/criminalisation>, [Accessed on: April 14, 2011]

¹⁵⁴ Republic of Serbia, Criminal Code, Article 250. Cited from GNP+, *Global Criminalization Scan*, available at <http://www.gnpplus.net/criminalisation>, [Accessed on: April 14, 2011].

¹⁵⁵ Law of Turkmenistan *On Prevention of Disease Caused by Human Immunodeficiency Virus (HIV infection)* adopted on July 7, 2001.

¹⁵⁶ Cited from GNP+ *Global Criminalization scan*, [Accessed on: April 12, 2011]

¹⁵⁷ Section 21 of the Penal code of the Former Yugoslav Republic of Macedonia (which deals with Crimes Against Human Health) does contain Article 205 (Transmission of Infectious Diseases) that may be used, at least in theory, to launch a criminal prosecution. Both exposure and transmission are subject to prosecution. Punishable sentences range from a fine through to 10 years imprisonment. Cited from GNP+, *Global Criminalization Scan*, available at <http://www.gnpplus.net/criminalisation>, [Accessed on: April 14, 2011]

¹⁵⁸ Turkish Criminal Law № 86 (Intentional injury). Cited from GNP+, *Global Criminalization Scan*, available at <http://www.gnpplus.net/criminalisation>, [Accessed on: April 14, 2011]

of a contagious disease shall be punished by a fine or by imprisonment of up to one year.”¹⁵⁹ In general, transmission of contagious diseases is considered a criminal offence punishable by imprisonment from six months to twelve years for “serious bodily injury or serious impairment to health”. Article 217 is specific about the transmission of venereal diseases, stating: “(1) Whoever knows that he or she is infected with the HIV virus or any venereal disease and knowingly hides this fact and infects another person shall be punished by imprisonment of up to one year. (2) When the offence provided for in paragraph 1 of the present article results in serious and permanent impairment to health or the death of a person, the perpetrator shall be punished by imprisonment of one to ten years. (3) Criminal proceedings for the offence provided for in paragraph 1 of the present article shall be initiated by a motion.”¹⁶⁰

Very few prosecutions have taken place in the region. According to information collected by GNP+, in Azerbaijan, several instances of HIV transmission have been prosecuted under the Criminal Code since 2001 (at least five cases were noted as of April 2011). At least one conviction has occurred in Belarus, while two people were prosecuted in Georgia. In Serbia, to date only one prosecution is known to have been brought to court (in 2006). In Turkey, one man was prosecuted and found guilty of “injury”, although the case was initially handled as an “act of murder”. In all reported cases it is believed the prosecuted individuals are male, charged with transmitting to female sexual partners.

In Kyrgyzstan, although there have been no prosecutions for sexual transmission, there have been several prosecutions (at least 15, according to GNP+) for HIV transmission due to medical negligence in hospitals. All of these prosecutions occurred in 2008, and at least three convictions have been made.¹⁶¹

¹⁵⁹ HIV/AIDS in Legislation of the Kosovo Government (2010), *Overview and analyses of legislation in the Kosovo Government with a quick and useful reference to address protection of human rights for people living with HIV/AIDS*, UN Theme Group on HIV/AIDS.

¹⁶⁰ Ibid.

¹⁶¹ Cited from GNP+ *Global Criminalization scan*, , available at <http://www.gnpplus.net/criminalisation>, [Accessed on: April 12, 2011]



6. Women and HIV

The Law

Women remain at high risk of acquiring HIV and disproportionately suffer the negative consequences of HIV and AIDS. Despite the fact that gender equality is declared on paper, it has not been achieved in reality. Discrimination persists in political, economic and other areas of life. Women also suffer high levels of domestic violence. Gender inequality is starker in rural areas, where women and girls have lower levels of education, little to no knowledge about HIV limited access to health care services and higher levels of stigmatisation and discrimination. In many countries of the region, the HIV epidemic started among men (mainly men who inject drugs), but in recent years has shown a considerable increase among women. Women now account for some 40% of new cases compared to just 24% under a decade ago. The total number of HIV-positive pregnancies has doubled during the past five years.¹⁶²

One of the notable achievements of the region as mentioned above is the almost universal coverage of prevention of vertical transmission in many countries. An estimated 94% of pregnant women have access to antiretroviral prophylaxis. HIV testing rates in pregnant women are above 80% (this testing in many cases is mandatory).¹⁶³

HIV Prevention and Treatment Standards in the study cover primary and secondary HIV prevention for women. Gender neutral provisions on access to treatment of HIV and other diseases and social support services do exist. In reality however, there are reports of numerous violations that make women more vulnerable to HIV and the harsher effects of it.

Implementing practices: According to reports, there are high pregnancy termination rates among HIV-positive women: in the Russian Federation in 2007 and 2008, 40 and 38% respectively of all pregnant women testing positive for HIV terminated their pregnancies. In Kazakhstan, where all pregnant women were tested for HIV, 34% of pregnancies in HIV-positive women ended in termination in 2008 and 38% in 2009. There are also numerous anecdotal reports of HIV-infected women being recommended to have an abortion by healthcare providers. Such practices reflect both lack of knowledge and training of health care professionals, with respect to the risks of vertical transmission of HIV and the benefits of prevention, as well as the discriminatory attitude towards HIV-positive women held by some

¹⁶² UNICEF (2010), *Blame and Banishment: The Underground HIV Epidemic Affecting Children in Eastern Europe and Central Asia*, at p. 2.

¹⁶³ *Ibid.* at p. 44.

providers.¹⁶⁴ In this case women's right to have a family and the right to non-discrimination are violated.

In 2011, hundreds of reports emerged from Uzbekistan concerning forced sterilisation of women, primarily targeting those with low income, youth and those over 35 years and women with HIV, tuberculosis, drug dependence or other conditions. Instruments used for the procedure are often not sterile, which puts women at increased risk. There are reports that some employers require certificates of sterilisation before hiring a woman.¹⁶⁵ According to anecdotal evidence, doctors receive oral orders to persuade women to undergo hysterectomies, with some news agencies reporting quotas of two surgeries a day as well as reprimands for non-compliance.¹⁶⁶ Some women report being sterilised without their knowledge, and others were led to believe that medical intervention was necessary to treat dangerous conditions.

The reported challenges in prevention of vertical transmission in the region include improvement of primary prevention of HIV infection among young women of childbearing age, and the prevention of unintended pregnancies among HIV-positive women. There are also reports that prevention of vertical transmission is frequently unavailable in prisons and detention centers and that women stop receiving ART after giving birth. In some countries, some women, including young and rural women, possess poor knowledge of family planning issues and availability of contraception. HIV-positive women may experience difficulties accessing child care services as well.

As a drug user living with HIV I have experienced isolation, fear, despair, as well as stigma and discrimination. I encountered stigma and discrimination in society in general, and in health care facilities when during labor I was denied hospitalisation by medical workers because of my status and lost my child because of the neglect of the doctors. I have encountered disclosure of my status among medical workers and outside

Submission from Kazakhstan to the Global Commission on HIV and the Law

Across the region women face high levels of domestic violence, and women living with HIV and other vulnerable women may disproportionately suffer from it. Women who experience domestic violence may be more vulnerable to HIV and drug use. This research could not find government programmes and interventions aimed at prevention of domestic violence that would take into account specific vulnerability of women living with HIV and women who use drugs.

Women who use drugs: HIV-positive women are subject to stigma and discrimination. The situation is more difficult for those who are subject to several layers of stigma and

¹⁶⁴ Ibid. at p. 43.

¹⁶⁵ DiBranco, A. (2010), *Hundreds of Uzbek women report forced sterilization*, Change.org, at <http://news.change.org/stories/hundreds-of-uzbek-women-report-forced-sterilization>.

¹⁶⁶ Tynan, D. (2010), *Uzbekistan: Tashkent pursuing forced sterilization policy*, Eurasia.org, at <http://www.eurasianet.org/departments/civilsociety/articles/eav032310.shtml>. and Najibullah, F. (2010), *Forced Sterilization Scare Feeds on Uzbek Distrust*, Radio Liberty, at http://www.rferl.org/content/Forced_Sterilization_Scare_Feeds_On_Uzbek_Distrust/1989708.html.

discrimination, such as women who use drugs or provide sex services - factors that further increase their vulnerability to HIV. Women who inject drugs are at higher risk of acquiring HIV for more reasons than physiological ones. They reported frequently being “second on the needle” and sharing injection equipment. Many do not perform injections themselves, but rely on a male partner to perform injections. The assessments document a significant overlap between drug use and sex work, as well as low levels of condom use and limited access to sexual health services. Nearly 43% of women who use drugs interviewed in the Russian regions exchanged sex for drugs or money; 62% of women interviewed in Kyrgyzstan identified themselves as sex workers, and 84% of women interviewed in Azerbaijan engaged in transactional sex for drugs or money. Women reported challenges negotiating condom use with clients during sex work.¹⁶⁷ UNAIDS estimates that 35% of women living with HIV in Eastern Europe and Central Asia acquired the virus through injecting drug use, and a further 50% were infected through unsafe sex with partners who inject drugs.¹⁶⁸

Women who use drugs are highly stigmatised and marginalised. According to reports, coverage of voluntary testing and counseling among this group of people is low. Despite the high percentage of women drug users whose sexual partners were themselves using drugs, more than four in five women had not been tested for HIV (in Georgia, Kyrgyzstan and Azerbaijan).¹⁶⁹ Alternatively, health care providers test them for HIV without counseling, consent, or knowledge that they are being tested, particularly during pregnancy or labor.

They are frequently denied health care, and many report judgmental attitudes by treatment providers. Pregnant women with a history of drug use are significantly less likely to receive prenatal care, including timely HIV tests and, when necessary, antiretrovirals for prevention of vertical transmission of HIV. Those who access prenatal care often do so only late in pregnancy or when in labor. Pregnant drug users may be pressured to have abortions or to give up their newborns, and mothers with a history of drug use often have problems maintaining custody of their children. Access to obstetricians and gynecologists familiar with the issues of drug use during pregnancy was practically nonexistent, and many women reported judgmental or stigmatising attitudes by providers, as well as prohibitive fees.¹⁷⁰

Research in many countries of the region indicates that women have limited access to harm reduction and drug dependence treatment services, which are rarely tailored for the needs of women who use drugs.¹⁷¹ Some inpatient drug treatment facilities lack private rooms or beds for women patients or expertise in women-specific needs. The assessment in St. Petersburg noted a number of other gender-specific obstacles to treatment, such as restrictions on

¹⁶⁷ OSI (2009), *Women, Harm Reduction and HIV: Key Findings from Azerbaijan, Georgia, Kyrgyzstan, Russia and Ukraine*.

¹⁶⁸ OSI, IHRD (2010), *Making Harm Reduction Work for Women: The Ukrainian Experience*, at p. 5.

¹⁶⁹ OSI (2009), *Women, Harm Reduction and HIV: Key Findings from Azerbaijan, Georgia, Kyrgyzstan, Russia, and Ukraine*, at pp. 7-8.

¹⁷⁰ *Ibid.*

¹⁷¹ *Ibid.*

admitting homeless women and women with family members still using drugs. Drug treatment facilities generally had poor referral to sexual and reproductive health services.¹⁷² Lack of methadone or buprenorphine in maternity wards also forces women out of the hospital immediately after giving birth in search of drugs to relieve withdrawal symptoms. Some maternity wards release babies for adoption without the mother's consent.¹⁷³

Access to sterile injection equipment or methadone treatment is extremely limited for male and female prisoners in all countries surveyed. While Kyrgyzstan offers needle exchange in prisons, and Georgia and Kyrgyzstan both offer some methadone treatment in penal institutions, these are not available to women prisoners. Post-release services are inadequate to satisfy women's needs, especially women with small children, since shelter is only provided for a duration which is often too short for the women to find more permanent housing or other benefits.¹⁷⁴ In-patient drug dependence treatment is male-oriented and there are virtually no specially trained staff and facilities to accommodate women drug users. Facilities do not accept children or couples, forcing women to choose between treatment and their families. Women are more likely than men to be the primary caregivers for children and sometimes have no place to leave them during in-patient medical treatment.¹⁷⁵

Women who use drugs experience high levels of poverty, incarceration and domestic violence. Some medical facilities report cases of domestic violence to the police; but women who use drugs distrust the police and many have also experienced physical and sexual violence at the hands of police officers. Legal and social services intended to support women in the event of domestic or police violence were found to be unsupportive, ineffective or inaccessible due to financial constraints. Many women drug users do not have passports, often because they have been incarcerated, and many lack the residency registration needed to receive free medical and social services and secure housing.

As mentioned above, according to the law in many countries (Russia, Ukraine, Kazakhstan, Kyrgyzstan, Uzbekistan, Azerbaijan, Tajikistan and Turkmenistan) women may lose custody of their children as a result of being registered as drug users. This is discussed further in the section on human rights, below. Some report difficulties accessing medical care and providing education for their children if schools and medical services become aware of the mother's history of drug use. In St. Petersburg, Russia, the medical staff of primary health centers note women's drug use status on their child's medical record regardless of whether it is relevant to the child's health. A note on a child's medical record stating maternal drug use can lead directly to refusal of school admission for the child..¹⁷⁶

¹⁷² Ibid.

¹⁷³ Ibid.

¹⁷⁴ Ibid.

¹⁷⁵ EHRN (2010), *Women and Drug Policy in Eurasia*, at p. 4

¹⁷⁶ Ibid.

In recent years Ukraine has instituted several harm reduction programmes specifically tailored to women. These projects integrated sexual and reproductive health and rights into harm reduction strategies; offered low-threshold, mobile HIV and STI testing services, gender-specific information, counseling and support; and provided case management to improve follow-up and treatment adherence. Several projects focused on motherhood and family preservation, offering medical and social support to improve maternal and child health, increasing access to medical and social services, improving parenting skills, helping women maintain or regain custody of their children, and enabling women to make free, informed choices about childbearing. One project focused on legal aid and social support, providing women drug users with free legal representation and advice. It assisted homeless clients with housing and advocated for the establishment of government funded social housing for women who use drugs.¹⁷⁷

Areas of concern

- 1) Gender discrimination exists in various spheres of life, including access to health care. Health care providers specifically exhibit high levels of stigma and discrimination with regards to HIV-positive women and women who use drugs.
- 2) Pregnant women in some countries are involuntarily tested for HIV and STIs.
- 3) Education and training for social and health care workers who work with women drug users is not sufficient.
- 4) Specific harm reduction services for women who use drugs are lacking. It is necessary to establish gender sensitive HIV prevention programmes, provide drug dependence treatment options for women and women with children, as well as OST services for women in maternity hospitals.
- 5) Women living with HIV and belonging to key populations are at higher risk when faced with gender-based violence. Very few programmes are in place to engage men and boys in efforts to eliminate gender-based violence and inculcate healthier gender norms.

¹⁷⁷ OSI, IHRD (2010), *Making Harm Reduction Work for Women: The Ukrainian Experience*, at p. 16.



7. Children/Youth and HIV

Globally, access to ART is lower for children who need it (28%) than for adults (37%).¹⁷⁸ In the region however, treatment coverage for HIV-positive children is high, with some countries reporting it to be as high as 85%.¹⁷⁹ But new infections among children and young people remain high: one-third of all new HIV infections in the region occurred among those 15–24 years of age and more than 80% of people living with HIV in the region are under 30 years old.¹⁸⁰

Children and youth on the margins of society, such as street children, young drug injectors, sex workers and combinations of these are the most vulnerable to HIV in Eastern Europe and Central Asia. The average age of injecting drug users in the region is very low, with the age of initiating injecting still decreasing: in Moscow, in 2005 the average age of injection initiation was 16 years old. In Macedonia, a growing number of 12- and 13-year-olds are already using drugs.¹⁸¹ A recent study of 15- to 19-year-old street children in St. Petersburg, involving 313 participants, found that almost 40% of them were HIV-positive. Injecting drug use was found to be the strongest risk factor, with a greater than 20-fold increased risk of HIV.¹⁸² Some 80% of sex workers in Central and Eastern Europe are young people, with female drug users often selling sex to support their drug use and that of their male partners.¹⁸³ In Ukraine, in 2006, HIV prevalence among girls aged 15-19 selling sex exceeded 19% compared to 1.4% in the general adult population.¹⁸⁴

A study in Montenegro of 288 Roma youths aged 15-24 indicated extremely low school enrollment rates, especially among girls. In fact 44% of the young Roma women, and 22.3% of the young men had never been to school. Knowledge of HIV transmission was poor, with less than one in four under-18-year-olds correctly informed, although males were significantly better informed than females.¹⁸⁵

¹⁷⁸ Report of the Secretary General (28 March 2011), *Uniting for Universal Access: Towards zero new infections, zero discrimination, zero AIDS related deaths*, at p. 13.

¹⁷⁹ UNICEF (2010), *Blame and Banishment: The Underground HIV Epidemic Affecting Children in Eastern Europe and Central Asia*, at p. 44.

¹⁸⁰ *Ibid.* at p. 2.

¹⁸¹ *Ibid.*

¹⁸² *Ibid.*, at p. 31.

¹⁸³ *Ibid.* at p. 2.

¹⁸⁴ *Ibid.*

¹⁸⁵ *Ibid.* at pp.19-20.

Children with HIV are often refused acceptance to kindergartens in Ukraine. The number of complaints related to violations of HIV-status confidentiality and the resulting infringement of the rights of their children has increased in our region. As a result of disclosure by a district physician of her status, a resident of one of the villages of the Poltava region, Marina P, not only lost her job, but also was discriminated against by people in the village. Her 5 year-old daughter was refused admission to kindergarten as her mother's medical status was disclosed.

Submission from The Light of Hope, Ukraine

The right to access quality treatment for children is violated - there are no ART formulations for children, and healthcare facilities as a rule use adult drugs that need to be broken up. There are not enough tests for TB diagnostics among children with HIV. There is low or lack of government social and psychological support for families with children with HIV. The way disability status is officially recognised and recorded involves the indication of a child's diagnosis in order to be enrolled in school. This leads to disclosure of diagnosis. This fear of disclosure stops up to 25 % of families from obtaining social support/disability pensions for their children. Furthermore several Ministry of Education decrees mandate teachers to collect information about children's health, with indication of diagnosis, which leads to discrimination in schools. Children with HIV are refused acceptance to the government resorts of the Crimea. Nor are children with HIV offered for adoption in the Crimea.

Submission from Our Hope Foundation, Ukraine

Younger drug users tend to have poorer access to harm reduction services, and in some cases practice higher-risk behaviors. In Moldova, where close to a third of the injecting drug users surveyed were younger than 18, adolescents were more reluctant to obtain clean injecting equipment from exchange programmes, drop-in centres, or outreach workers compared to adults (11.4% vs. 28.6%).¹⁸⁶ In Serbia, outreach workers or exchange programmes were used by adults more often than by young drug injectors (24.7% vs. 4.8%). It was found that younger users were more likely to obtain needles from acquaintances. Adolescents were also less likely to have ever had an HIV test; for instance, in Albania, although just over a third (37.3%) of surveyed injecting drug users had never had an HIV test, none of those under 18 had done so.¹⁸⁷

The law and implementing practices

Theoretically, post-Soviet laws on child protection concentrate on social protection and the interests of the child. But with the system of social support in decay, this protection is largely non-existent. Although national HIV laws provide for special rights and benefits to families of HIV-positive children, in reality this protection is rarely available. Evidence from the region shows children living with or affected by HIV being refused entry to school and child care/kindergartens.¹⁸⁸ Sometimes in order to be enrolled in child care or school, children are required to submit health certificates, which may include an HIV test. In other cases, children may be refused enrollment on account of their HIV-positive status or if the parents' drug use becomes known. This contradicts the prohibition of discrimination of persons living with HIV

¹⁸⁶ Ibid.

¹⁸⁷ Ibid. at p. 21

¹⁸⁸ Ibid. at p. 42.

and the prohibition of discrimination based on health or social status. Reports also indicate that some families of children living with HIV choose to forgo the little social protection available to them due to concerns about confidentiality and discrimination.¹⁸⁹

Across the entire region, children born to HIV-positive mothers are at higher risk of being abandoned. In the Russian Federation and Ukraine, about 6 to 10% of children born to HIV-positive mothers are abandoned in maternity wards, paediatric hospitals and residential institutions, with little opportunity for foster care or adoption.¹⁹⁰ Analysis shows that in many cases, lack of support and knowledge about HIV and available treatment is to blame for the high rates of abandonment. Other key factors increasing the likelihood of abandonment are: unwanted pregnancy, poverty, lack of family support, drug and alcohol use, fear of the infant having birth defects or disabilities, and an inability to support the high cost of care. Some women also reported being advised or pressured to abandon their babies by their families or by health-care professionals. Children who are abandoned usually end up in institutional care, where they are frequently exposed to a various abuses.¹⁹¹

Children and youth have limited access to HIV testing and treatment services. In countries where adults can be anonymously tested for HIV, children and youths generally cannot. As a child cannot independently consent to testing, the consent of a parent or guardian is necessary, which creates an obstacle to accessing services. The Manual on HIV Counseling and Testing of Croatia stipulates that minors (children) cannot undergo HIV testing without the informed consent of a parent or a guardian, although a counselor may advise minors on prevention measures regarding HIV and other sexually transmitted diseases.¹⁹² The age of consent for health care services is often not specified, which may mean the age could range from 16 to 18 years old. According to anecdotal evidence, the age threshold for accessing HIV testing without parental consent is higher than the

Some cases from our practice: In the case of ID 0157 (12 November 2011), the boy was refused to be placed in a boarding school because of HIV-positive status. The director of the school stated that it refuses to accept the child in the institution without receipt of a letter of acceptance issued by the Ministry of Education regarding his placement in the boarding school. The case of MV 0045 registered on 26 April 2010: the HIV status of five-year-old girl was divulged by the social worker to the kindergarten. The attitude of the teacher and the kindergarten's director and staff changed in a negative way towards the baby and the parents decided to withdraw the child from the institution. The residents of the nearby villages also found out about the HIV status of the girl. Her parents left the village with her and moved to the Russian Federation.

- *Submission from Moldovan Institute for Human Rights*

¹⁸⁹ Ibid.

¹⁹⁰ Ibid., at p. 7.

¹⁹¹ According to the UNICEF report, institutionalization of children is often portrayed as being in the best interests of the child, with pregnant young women who use drugs being convinced that they cannot be good mothers. Relinquishment is in part due to a residual trust placed in these institutions by populations themselves, frontline service providers and policy makers. But it is also due to the lack of support for families under stress and to unfinished reforms in social welfare and protection services. See UNICEF (2010), *Blame and Banishment: The Underground HIV epidemic Affecting Children in Eastern Europe and Central Asia*, at p. 7).

¹⁹² UN Theme Group on HIV/AIDS (2011), *Report on the work of the National Consultant for HIV/AIDS and human rights in 2010, Croatia*, at pp. 27-28.

age of consent for sexual services (i.e. Croatia, Serbia, Bosnia and Herzegovina and Montenegro). This provision does not make sense as minors are less protected than adults because of their lack of legal capacity.

Children and young people belonging to hard-to-reach populations such as street children are more seriously affected by the negative effects of HIV. Existing health and social welfare services are not tailored to adolescents at greatest risk, who are instead prosecuted and exposed to moral judgment. HIV programming for youth in the region has largely focused on prevention education aimed at the general population of young people utilising information campaigns, school and life skills-based curricula, and to some extent peer outreach and youth-friendly services. These peer-led programmes tend to focus on young people in formal settings (schools and youth clubs). Many fail to adequately address the specific risk behaviors and environments of especially vulnerable young people and tend to be insensitive to the many factors that influence their risk taking.¹⁹³ Generally, throughout the region, education on sexual and reproductive health and rights is absent, or of low quality.

A large majority of interventions for vulnerable or high-risk groups in the region are oriented towards adult populations. For example, very few interventions in the region specifically target recent initiates to injecting drug use or those who inject only occasionally. Needle and syringe exchange has little to offer young people who use drugs but do not inject. In several countries, pharmacies reported refusing to sell syringes and needles to youth and adolescents (under 18 years of age). Harm reduction programmes sometimes also impose age constraints and refuse services to people under 18. A frequent approach taken by police in dealing with youth engaged in illicit behavior has been the conducting of 'raids' in which minors are caught, registered, monitored, and in certain cases, sent to detention centres. High levels of police harassment are reported in the region: 73.9% of street children in Ukraine and 60.9% and 48% of young drug injectors in Serbia and Moldova respectively reported police harassment. Most countries have no juvenile justice systems and apply adult criminal justice procedures to young drug use offenders.¹⁹⁴

Areas of concern

- 1) Discrimination of HIV-positive children exists with regard to education, enrollment in school and childcare.
- 2) The high age at which adolescents are allowed to consent to their own testing without the permission of a parent or guardian creates an obstacle to testing.
- 3) Child protection agencies rarely deal with vulnerability and health, including HIV and drug use, and rarely provide social protection to marginalised youths most in need of it. Health care and civil authorities need to establish non-judgmental services that address the special needs of children and youth at higher risk of HIV infection, such as children who use drugs.

¹⁹³ UNICEF (2010), *Blame and Banishment: The Underground HIV Epidemic Affecting Children in Eastern Europe and Central Asia*, at p. 23.

¹⁹⁴ *Ibid.* at p. 24.

- 4) Juvenile justice systems do not exist in many countries of the region.
- 5) Education on sexual and reproductive rights issues is absent or limited, and there are no national strategies on reproductive health.



8. People Who Use Drugs and Drug Laws and Policies

The region is home to 3.7 million people who inject drugs, representing almost one quarter of the world total.¹⁹⁵ Some 1.8 million of these people live in the Russian Federation, 300,000 in Azerbaijan and 291,000 in Ukraine. The highest prevalence of injecting drug use in the adult population worldwide is now found in Azerbaijan (5.21%), Georgia (4.19%), Russian Federation (1.78%) and Ukraine (1.16%).¹⁹⁶

People who inject drugs account for more than 60% of all HIV infections in Belarus, Georgia, Kazakhstan, Kyrgyzstan, Moldova, Russia, Ukraine, Tajikistan, and Uzbekistan. Despite high HIV prevalence in this population, ART and harm reduction service coverage remains low. According to the Global Prevention Working Group, ART levels for people who inject drugs are the lowest for any population at risk for HIV infection.¹⁹⁷ The highest estimates of people who inject drugs receiving ART were in Ukraine (1,860) and Russia (1,331), but these estimates represent very low percentages of the total number of injecting drug users living with HIV, ranging from less than 2% in Ukraine to only 0.2% in Russia.¹⁹⁸

In Kosovo, despite the current low level of HIV prevalence, studies reveal the potential for expansion. High-risk behaviours among people who inject drugs, including sharing of used needles and low condom use, have already translated into high HBV and HCV rates (13 and 20% respectively). According to official survey data, 13% of injection drug users utilised a used syringe or needle on their last drug use, while 29% of surveyed people who inject drugs had shared a syringe or needle with someone else in the last month. In addition, results show that 63% of sexually active people who inject drugs in the study (89% of respondents) had had sex with non-regular sex partners, of which 37% was with multiple non-regular sex partners. Only half used a condom with non-regular sex partners, indicating they did not think it was necessary (64%) or did not think of it (26%).¹⁹⁹ Their HIV risk is further exacerbated by only very recent introduction of limited needle and syringe exchanges and the absence of any harm-reduction services in Kosovo. More than half (54%) of the respondents indicated difficulties in accessing

¹⁹⁵ Mathers B, et al. (2010), *HIV prevention, treatment and care for people who inject drugs: a systematic review of global, regional and national coverage*. The Lancet, 375(9719):1014–28.

¹⁹⁶ International Harm Reduction Association (2010), *The Global State of Harm Reduction*.

¹⁹⁷ Beyrer, B, Malinowska-Sempruch, K, Kamarulzaman, A, Kazatchkine, M, Sidibe, M, Strathdee, S.A, (2010), *Time to Act: A call for Comprehensive response to HIV in people who use drugs*, Lancet.

¹⁹⁸ International Harm Reduction Association (2010), *Global State of Harm Reduction*. at p. 24.

¹⁹⁹ Kosovo Strategic Plan on HIV/AIDS 2009 – 2013.

clean syringes and needles. While most people who inject drugs would get their syringes from pharmacies, negative attitudes among pharmacists often prevented them from acquiring clean syringes and needles. There was a significant relationship between difficulties in accessing clean injecting equipment and sharing syringes and needles: 49% gave their used syringes or needles to others, while 37% took them from others.²⁰⁰

Only in Moldova, Armenia and countries of Central Asia, reports indicate medium to high levels of syringe distribution coverage, with the rest of the region having very low coverage. In Central Asia, coverage of NSPs is higher than in Eastern Europe: NSP sites in Kazakhstan, Kyrgyzstan, Tajikistan and Uzbekistan are reported to reach approximately 1/3 of people who inject drugs and to distribute an average of 92 needles and syringes per person per year. In Eastern Europe between 7% and 15% of people who inject drugs are accessing NSPs at least once a year and only nine needles and syringes are distributed annually per person injecting drugs.²⁰¹ Across eighteen countries in the region an average of only one NSP site is available per 1,000 people who inject drugs. The proportion of people who inject drugs accessing NSP in a year ranged from 59% in Armenia and 39% in Ukraine to 7% in Belarus and Russia and 1% in Georgia. NSP sites operate in Turkmenistan's capital, Ashgabat. There are no harm reduction interventions, including NSPs, in Turkey.²⁰²

Across the region, all but five countries have some form of OST provision. In Russia, Kosovo, Turkey, Turkmenistan, and Uzbekistan (where a pilot OST site was shut down in June 2009) OST is not available. Programmes have recently started in Tajikistan. Even where programmes exist, OST is accessible to less than 5% of opioid users, with the exception of Croatia. Ukraine began implementing OST in 2004 first using buprenorphine and later added methadone. During the next five years, it set up the biggest and most rapidly growing substitution treatment programme of any country of the former Soviet Union (except the European Union member Baltic States), with more than 5,500 people in treatment in 2010. Expansion to 20,000 patients is planned by the end of 2013. Still less than 2% of people who inject drugs receive OST in Ukraine and less than 1% receive it in Belarus, Georgia and Kazakhstan. In almost all countries where they exist, OST programmes have remained at the pilot stage, are not scaled up and rarely are entrenched in the legislation.²⁰³

Despite the recent drawbacks in the form of government harassment of harm reduction services, Ukraine is considered a success story, where four years of comprehensive, sustained funding for and implementation of evidence-based harm reduction programming have helped reduce the HIV incidence among people who inject drugs. All data indicates that HIV transmission among people who inject drugs in Ukraine appears to be significantly decreasing. HIV infections among people who started injecting drugs in only the past two years decreased

²⁰⁰ Ibid.

²⁰¹ International Harm Reduction Association (2010), *Global State of Harm Reduction*, at p. 23.

²⁰² B. Mathers et al, (2010), *HIV prevention, treatment, and care services for people who inject drugs: a systematic review of global, regional, and national coverage*, The Lancet.

²⁰³ Ibid. and see also International Harm Reduction Association (2010), *Global State of Harm Reduction*, at p. 24.

from a peak of 30% in 2004 to 11% in 2008. Research in Ukraine shows that people who inject drugs are increasingly adopting key HIV risk-reduction measures. The percentage of people who inject drugs who report using sterile injecting equipment at last injection rose from 80% in 2006 to 86% in 2008. In 2009, about 4600 people who inject drugs were accessing OST at any time.²⁰⁴

Needles and syringes are usually widely available in pharmacies and are inexpensive. According to anecdotal reports, some pharmacies adopt rules limiting selling needles and syringes at night hours or more than a certain number to one person. Some pharmacies/harm reduction programmes may have an age threshold, such as 18 years old, turning away people younger than this age. Possession of drug paraphernalia (syringes, disinfectants, utensils etc.) is not itself an offence in any of the study countries.

The Law

Drug policies in the region consist of Anti-Drug Strategies, laws on narcotic drugs and psychotropic substances, and drug related offences in Administrative and Criminal Codes. Perhaps it is emblematic that drug dependence treatment issues are usually included in drug laws, and not in specific laws on drug dependence treatment or rehabilitation. This point serves to emphasise the law enforcement approach towards drug use still in force in the majority of the former Soviet Union countries. In the former Soviet Union countries drug laws were adopted in the 1990s, in structure and substance largely following Russia's 1997 "Law on narcotic drugs and psychotropic substances".²⁰⁵

In most countries in the region (particularly Georgia, Russia and Ukraine), national drug policy documents and budgets continue to prioritise drug supply reduction as the key pillar of drug policy, resulting in an over-reliance on law enforcement and neglecting investment in drug demand or harm reduction. In the majority of the reviewed countries, drug laws and policies could be characterized as punitive, with harsh sentences for possession of miniscule amounts of drugs and high incarceration rates for people who use drugs. This significantly contributes to the spread of the HIV epidemic. In Georgia, where drug use is criminalised, significantly more funds are attributed to drug testing than to treatment, and fines for users who test positive may reach up to 200% of the average monthly salary. On the other hand, Armenia decriminalised drug consumption in 2009.²⁰⁶ Drug policy was identified as a barrier to treatment by 63% of countries in Europe and Central Asia that reported on progress related to the Dublin Declaration.²⁰⁷

²⁰⁴ UNAIDS (2010), *Report on the Global AIDS Epidemic 2010*, at p. 71.

²⁰⁵ See the analysis of influence of Russia's drug policy and Narcotics law on Central Asian countries in Utyasheva, L, Elliott, R. (2009), *Effects of UN and Russian Influence on Drug Policy in Central Asia*, in *At What Cost?: HIV and Human Rights Consequences of the Global 'War on Drugs*, Open Society Institute.

²⁰⁶ International Harm Reduction Association (2010), *Global State of Harm Reduction*, at p. 25.

²⁰⁷ UNAIDS (2010), *Report on the Global AIDS Epidemic 2010*.

Simple drug use is criminalised at least in Russia, Georgia, Kazakhstan, Kyrgyzstan, Tajikistan and Uzbekistan. The 1997 Russian “Law on narcotic drugs and psychotropic substances”, prohibits drug use per se; it is punishable by fines according to the Code on Administrative Offences of the Russian Federation.²⁰⁸ Recently, following a recommendation from the President, there have been discussions to introduce criminal responsibility for drug use. In Kazakhstan, Kyrgyzstan, Tajikistan and Uzbekistan, drug laws are modeled after the Russian example²⁰⁹, with prohibition (and criminalisation) of drug use, compulsory drug testing on suspicion of drug use, registration of drug users and widely formulated prohibition of propaganda of drug use and drugs (incitement).

In Serbia, drug use is not allowed in any location. In Bosnia and Herzegovina, abuse of narcotic drugs is prohibited and includes use of narcotic drugs outside therapeutic indications, in excessive dose levels, or over an unjustified period of time.²¹⁰ In Ukraine, according to the Criminal Code public illegal drug use is punishable. Imprisonment for this offence can be up to five years.²¹¹ Simple drug use is an administrative offence in Moldova, according to Article 85 of the Administrative Offences Code passed in 2008. But despite this strict punitive approach, the new Administrative Offences Code introduced community service as a sanction for a drug-related administrative offence, and excluded arrest for minor drug offences, such as personal drug use and illegal purchase or possession of narcotic drugs or psychotropic substances in small amounts without the purpose of sale. These are punished with a fine or community service of up to 40 hours. According to the amendments made to the Moldovan Penal Code in 2008, the punishments for drug-related crimes were reduced, with, depending on the case, the application of alternatives to imprisonment, such as community service, being promoted and increased.²¹²

I had a lot of problems with violations of human rights when I was using drugs. I was constantly pressured by the police and ill-treated only for the fact that I am a drug user and I was repeatedly tortured during interrogation. I was denied access to medical care when I was suffering from a high temperature and abscesses. In addition to health problems, drug users face such problems as criminal prosecution by law enforcement, manifestation of negative attitudes from society, denial of medical care and so on. We can see vivid social discrimination against IDUs and persons living with HIV when representatives of these groups cannot obtain the required medical services and social assistance in spite of our achievements in advocacy and successful information campaigns. There are certain problems in relations with the police even when we are able to involve members of this group in treatment and prevention of HIV.

- *Submission from The Light of Hope, Ukraine*

²⁰⁸ Code of the Russian Federation on Administrative Offences, Article 6.9, 30 December, 2001, 195-FZ, last amendments of 21 April 2011.

²⁰⁹ Utyasheva, L, Elliott, R (2009), *Effects of UN and Russian Influence on Drug Policy in Central Asia*, in *At What Cost?: HIV and Human Rights Consequences of the Global ‘War on Drugs*, at p. 96, Open Society Institute.

²¹⁰ Law on Prevention and Combat of the Abuse of Narcotics, European Monitoring Centre for Drugs and Drug Addiction, country page on Bosnia and Herzegovina, <http://www.emcdda.europa.eu/publications/country-overviews/ba> [Accessed on: April 12, 2011].

²¹¹ European Monitoring Centre for Drugs and Drug Addiction, country page on Ukraine, <http://www.emcdda.europa.eu/publications/country-overviews/ua#nlaws>.

²¹² Ibid.

Drug possession even of miniscule amounts for personal use is a criminal offence in most reviewed countries. Recently Ukraine revised its progressive regulative changes of two years ago that increased the amounts of drugs that one may legally possess from trace amounts of drugs to the size of small doses that users would actually use.²¹³ This criminalises and marginalises people who use drugs, creates obstacles to implementation of harm reduction measures (i.e. when possession of residual amount of drugs in a used syringe constitutes a criminal offence), and contributes to the further spread of the injection driven epidemic in the region.

Usually administrative and criminal penalties for possession vary with the type of drug, alleged purpose of possession and the amount possessed. Legislation distinguishes between illegal drug possession without intention to sell and with intention to sell (i.e. the Criminal Code of Uzbekistan).²¹⁴ In Uzbekistan, illegal production, acquisition, possession, transportation or mailing of narcotic or psychotropic substances in “small” quantities without intention to sell is considered to be an administrative misdemeanor in accordance with the Code on Administrative Liability. Offences involving “exceeding small” and “large” quantities of controlled substances are considered to be criminal offences, but the severity of punishment varies depending if the offence was committed with or without intention to sell.

The criminal law of Azerbaijan distinguishes possession of narcotics for personal use and possession for purposes of sale.²¹⁵ The Code on Administrative Offences provides liability for manufacturing, cultivating, acquiring, possessing, and sending of narcotic drugs, psychotropic substances and precursors for personal use (as opposed to for sale). Possession of even very

²¹³ EHRN (2010), *Achieving Universal Access in Eastern, South East Europe and Central Asia: An HIV Community Perspective*.

²¹⁴ For example, the Criminal Code of Uzbekistan provides for the following criminal offences (among others): a) illicit production, acquisition, possession and other activities related to narcotic drugs and psychotropic substances without intent to sell are punishable by a fine or correctional labour for up to three years, arrest for up to six months or imprisonment for up to three years; b) illicit production, acquisition, possession and other actions with narcotic drugs or psychotropic substances with intention to sell, as well as actual sale, are punishable by imprisonment from three to five years; illicit sale of narcotic drugs or psychotropic substances in large quantities is punishable by imprisonment from 19 to 20 years. c) “involvement” [вовлечение] in the use of narcotic or psychotropic substances is punishable by corrective labour for up to three years or imprisonment for up to three years. Cited from UNODC, Canadian HIV/AIDS Legal Network (2010), *Accessibility of HIV Prevention, Treatment and Care Services for People who Use Drugs and Incarcerated People in Azerbaijan, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan: Legislative and Policy Analysis and Recommendations for Reform*.

²¹⁵ In Azerbaijan, according to the Criminal Code, illegal acquisition or possession of narcotics or psychotropic substances, without the intention to sell, in a quantity which exceeds a defined quantity “for personal use” is a criminal offence punishable by up to three years’ imprisonment (i.e. possessing between 0.15g, the ceiling of the “personal use” range, and 0.2g of heroin attracts criminal liability, even if there is no intent to sell). Illegal acquisition or possession, with intention to sell, of a quantity of narcotics or psychotropic substances exceeding the quantity defined “for personal use” is punishable by three to seven years’ imprisonment, with or without the confiscation of property. Cited from UNODC, Canadian HIV/AIDS Legal Network (2010), *Accessibility of HIV Prevention, Treatment and Care Services for People who Use Drugs and Incarcerated People in Azerbaijan, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan: Legislative and Policy Analysis and Recommendations for Reform*.

small quantities of drugs leads to administrative liability, punishable by a fine or administrative detention for 15 days. Amounts of drugs considered to be “for personal use” are determined by the Cabinet of Ministers (e.g., under 0.15g in the case of heroin).

Some countries apply a more reasoned approach. For example, in Albania, possession of a ‘day dosage’ of drugs for personal use is not punishable. Although there are no official drug tables that define drug types and amounts and punishment of them, in practice the quantity of the drug seized can influence the judge in deciding between the minimum and maximum punishment for the offence. In Serbia, possession of illegal drugs is a criminal act, with no differentiation based on quantities or types of drugs, but a person who is in possession of drugs for personal use might not be sentenced.²¹⁶

Some Eastern and South Eastern European countries also possess strict drug laws. According to Articles 283, 284, 285 and 286 of the Albanian Penal Code, severe penal sanctions are imposed for circulation (selling), manufacture, preparation, distribution and transportation of drugs and psychotropic substances (without distinction) — five–ten years’ imprisonment for production, selling, distribution and possession, and seven–15 years for trafficking. These sanctions are stricter if the offence is committed by an organised group.²¹⁷ In Bosnia and Herzegovina, law enforcement does not distinguish between possession for personal use or possession in small quantities. This causes problems when harm reduction measures such as the provision of needles and syringes are implemented, as possession of dirty syringes might be considered as an administrative offence or a crime.²¹⁸

In Belarus, most drug offences are characterised as “serious” or “very serious” (even if the offence in question is possession of miniscule amounts of narcotic drugs), leading to stricter penalties than offences of “little danger”. Punishment may vary from six-month to 15-years in prison, with or without confiscation of property. Committing a crime while intoxicated (under influence of drugs) is considered to be an aggravating circumstance with more severe punishment. If a crime was committed by a drug dependent person, the courts may sentence him/her to imprisonment with compulsory drug dependence treatment in prison.²¹⁹

Legislative provisions for harm reduction

The majority of study countries have national HIV or drug laws and policies explicitly supporting harm reduction. (Azerbaijan, Russia and Turkmenistan remain the exceptions.)²²⁰ Among the

²¹⁶ European Monitoring Centre for Drugs and Drug Addiction, country page on Serbia, available at <http://www.emcdda.europa.eu/publications/country-overviews/rs>.

²¹⁷ Ibid.

²¹⁸ European Monitoring Centre for Drugs and Drug Addiction, country page on Bosnia and Herzegovina, available at <http://www.emcdda.europa.eu/publications/country-overviews/ba>, [Accessed on: April 12, 2011].

²¹⁹ European Monitoring Centre for Drugs and Drug Addiction, country page on Belarus, available at <http://www.emcdda.europa.eu/publications/country-overviews/by>.

²²⁰ IHRA, (2010), *Global State of Harm Reduction*, at p. 24.

main objectives of the Kosovo Strategic Plan on HIV/AIDS 2009 – 2013 are: a) increased coverage and utilisation of HIV prevention services by key populations at higher HIV risk (people who inject drugs, sex workers, MSM, people in prisons and detention centres), including VCT, STI prevention and/or harm-reduction programmes; and b) increased knowledge and HIV-safe behaviours (consistent condom use and use of sterile injecting equipment) by key populations at higher HIV risk.

In the majority of the review countries major legal obstacles to harm reduction have been removed. Russia is a notable exception, with no mention of harm reduction in its HIV law and HIV Strategy, and with explicit opposition to it in its new Anti-Drugs strategy. OST is explicitly prohibited in Article 31 of Russia's 1997 law on narcotic drugs, which bans treatment of drug dependence using methadone and buprenorphine: "the use of narcotic drugs and psychotropic substances included in List II for the treatment of drug dependence shall be prohibited."²²¹ Use of any substances of the list I are prohibited for medical purposes (which includes methadone). The "State Anti-Drug Policy Strategy of the Russian Federation until 2020", adopted in 2010, reiterates the legal ban of OST with use of methadone and buprenorphine. It also provides that one of its activities and goals is "not admitting on the territory of the Russian Federation the use of substitution therapy of drug dependence treatment with use of drug means and psychotropic substances from the List I and II" (para 32 (d)). Paragraph 48 lists "attempts to legalise substitution therapy with use of narcotic drugs and promotion of drug use under pretext of syringe replacement" as "partially manageable risks for implementation of the Strategy".²²² Furthermore, in its other strategic documents and Resolutions, Russia declares as one of its goals counteracting the spread of harm reduction measures.²²³

The 2010 Plan for the Implementation of the State Anti-Drug Policy Strategy provides more specificities: It stipulates a responsibility of the Federal Drug Control Service and the Federal executive agencies to develop by the end of 2012 "proposals on legal restrictions on the territory of the Russian Federation of organisations whose activities are aimed at drawing [public] attention to alternative methods of drug treatment (substitution therapy, harm reduction and other)".²²⁴

²²¹ Federal Law of the Russian Federation, *On narcotic drugs and psychotropic substances*, (adopted on 8 January 1998), Article 31(6).

²²² Russian Federation, Strategy of the State Anti-Drug Policy of the Russian Federation until 2020, adopted by the Presidential Decree, 9 June 2010, No 690, available at <http://graph.document.kremlin.ru/page.aspx?1;1285491>.

²²³ Utyasheva, L, Elliott, R (2009), *Effects of UN and Russian Influence on Drug Policy in Central Asia*, in *At What Cost?: HIV and Human Rights Consequences of the Global 'War on Drugs'*, Open Society Institute

²²⁴ Plan for the Implementation of the State Anti-Drug Policy Strategy of the Russian Federation until 2020, State Anti-Drug Committee, <http://www.stratgap.ru/pages/strategy/3662/3887/4548/4580/index.shtml>, (2010). Cited from Andrey Rylkov Foundation for Health and Social Justice, Canadian HIV/AIDS Legal Network, *Additional information to the Report to the International Committee on Economic, Social and Cultural Rights on implementation by the Russian Federation of article 12 of the International Covenant on Economic, Social and Cultural Rights as it relates to access of people who inject drugs to drug treatment and HIV prevention, care and treatment programmes*.

Legal provision for NSPs

In Kazakhstan and Uzbekistan, the government-funded NSPs exist at so-called “trust points” established by the national HIV programmes. In Kazakhstan, the government is funding NSPs as of 2008; before then, these programmes were largely funded by the Global Fund.. Trust points are established at AIDS centres and other health care facilities, and are coordinated by them. Kyrgyzstan has a decade-long history of NSPs, largely operated by NGOs, but at national level a legal and regulatory framework that defines the procedures of dispensing, exchanging, collecting and disposing of needles and syringes has not yet been adopted; NGOs have adopted their own internal instructions and regulations in this regard. In Tajikistan, establishment of NSPs is provided by the national HIV programme. NSPs are carried out in AIDS centres and in NGOs. There is no legislation or implementing acts on NSPs, as there is no funding from the government.²²⁵

Apart from the aforementioned strict drug law provisions where possession of residual amount in a used syringe may constitute an administrative or criminal offence, and thus endanger NSPs, there are other laws that could be used as barriers to successful functioning of harm reduction interventions.

Prohibition of propaganda: The legislation of many countries contains broad prohibitions of propaganda (or inducement to drug use), which could theoretically be interpreted to intimidate and harass harm reduction interventions, peer- to - peer services and create obstacles if countries decided to implement safer injection drug facilities. According to the law of the Russian Federation, propaganda of narcotic drugs and psychotropic substances is prohibited, including individuals’ and organisations’ activities disseminating information about methods of development, manufacture and use, places to find drugs, printing and dissemination of books and other media information, dissemination of information on TV and other means of communication, and other activities related to drugs. This broad article was amended in 2010, to specifically provide for the prohibition of propaganda regarding the advantages of narcotic drugs for medical purposes, which affects a person’s will or having a negative impact on one’s psychological or physical health.²²⁶ In Azerbaijan, the Criminal Code provides criminal liability for “incitement to use” narcotic drugs or psychotropic substances, as well as “organizing or running drug consumption sites”, each of which is punishable by imposing “limitations of freedoms” for up to three years or imprisonment for two to five years. The Criminal Code does not define “incitement”, but the law on circulation of narcotics, psychotropic substances and precursors defines it as “direct or indirect incitement to illegal use of narcotics and psychotropic

²²⁵ UNODC, Canadian HIV/AIDS Legal Network (2010), *Accessibility of HIV Prevention, Treatment and Care Services for People who Use Drugs and Incarcerated People in Azerbaijan, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan: Legislative and Policy Analysis and Recommendations for Reform*.at p. 71.

²²⁶ Federal law of the Russian Federation on Narcotic drugs and psychotropic substances, last amended 27 July 2010., ФЕДЕРАЛЬНЫЙ ЗАКОН О НАРКОТИЧЕСКИХ СРЕДСТВАХ И ПСИХОТРОПНЫХ ВЕЩЕСТВАХ от 27.07.2010 N 223-ФЗ, от 28.12.2010 N 417-ФЗ) 8 января 1998 года N 3-ФЗ.

substances by means of artistic, audio, video and other materials, including computerised information and other means.”²²⁷

In Macedonia, Article 216 of the Criminal Code prohibits inducement of drug use. A person who induces another to take narcotics, psychotropic substances and precursors, or who gives narcotics, psychotropic substances and precursors to another for this person or someone else, or who makes available premises for the taking of narcotics, psychotropic substances and precursors, or in some other way enables another to take narcotics, psychotropic substances and precursors, shall be punished with imprisonment of three months to five years. If the crime is committed toward a juvenile, or toward several persons, or if it causes especially severe consequences, the offender shall be punished with imprisonment of one to 10 years.²²⁸

It appears that provision of the Kosovo’s Criminal Code provision (relating to illegal possession, distribution and facilitation of drug use), does not exempt health workers engaged in harm reduction measures (i.e. NSP) from criminal responsibility. This may conflict with harm reduction interventions carried out in the country, namely NSPs.²²⁹

Drug treatment

Drug treatment is usually free (except for Kyrgyzstan, where it is provided on the basis of co-payment by the patient). In many countries, drug dependence treatment options are limited, with very low success rates and no government provided rehabilitation. In most of the countries of the former Soviet Union there are no government funded rehabilitation programmes for drug dependent people, nor are there systems for social re-integration. According to reports, Georgia has not been able to provide its population with free-of-charge treatment for drug dependence. There were no domestic funds allocated for treatment-rehabilitation programmes in 2005-2007; in 2008, the government initiated a detoxification programme, though on a very limited scale: it has only benefited 78 people.²³⁰ While the drug laws of several countries in Central Asia contain provisions on compulsory drug dependence treatment²³¹ inside and outside prisons, there is little evidence that compulsory drug treatment is carried out for the general population. More often compulsory treatment of drug dependence occurs in prisons, where drug dependent offenders undergo treatment together with their prison sentence following a court order.

²²⁷ UNODC and Canadian HIV/AIDS Legal Network, 2010.

²²⁸ European Monitoring Centre for Drugs and Drug Addiction, country page on Macedonia, <http://www.emcdda.europa.eu/publications/country-overviews/mk>, [Accessed on: April 12, 2011].

²²⁹ HIV/AIDS in Legislation of the Kosovo Government. *Overview and analyses of legislation in the Kosovo Government with a quick and useful reference to address protection of human rights for people living with HIV/AIDS*. (2010), UN Theme Group on HIV/AIDS.

²³⁰ Georgia: UNGASS Country Progress report, 2010.

²³¹ Utyasheva, L, Elliott, R. (2009), *Effects of UN and Russian Influence on Drug Policy in Central Asia*, in *At What Cost?: HIV and Human Rights Consequences of the Global ‘War on Drugs’* Open Society Institute

The number of state drug treatment facilities in the Russian Federation is under resourced and the quality of state drug treatment services is very poor. According to official information, during the last five years the narcological service has undergone an increase in the number of doctors having more than one job at a time and decreases in the number of drug clinics, drug treatment specialists, drug clinics capacities and durations of treatment. There has been no increase in the number of rehabilitation centers and a very slow increase in the number of psychologists and social workers, who are the basis for the rehabilitation process, suggesting that the focus of the clinics is on detoxification rather than rehabilitation.. According to Russian specialists, not more than 8.6% remain drug free within a year after participation in a drug treatment programme. On average, a drug dependent person has between five and six hospitalisations in their lifetime.²³²

Drug treatment facilities (mainly for detoxification) are accessible free of charge only for patients who agree to undergo registration, which often leads to deprivation of certain rights, for example, ineligibility for a driving licence or certain jobs. Anonymous drug treatment is only available privately and usually is unaffordable for many people who use drugs. The drug treatment system operates contrary to international drug treatment standards. Overreliance on use of antipsychotics makes their prescription a common practice regardless of whether clients suffer any psychotic disorders beside drug dependence.²³³

Opioid substitution therapy

Among Central Asian countries, Kyrgyzstan, where OST programmes have been running since 2002, has the highest coverage of patients, but even there only 948 people receive OST (while there are approximately 25,000 people who inject drugs in the country). In Kazakhstan, a pilot programme began in 2008, with only 50 people receiving it. In Tajikistan, a pilot OST programme was introduced in the second quarter of 2010, with plans proposed to cover up to 700 people by 2014.²³⁴ OST is not offered by primary care

OST: Patients who are detained do not have access to OST. Police does not consider that it is their obligation to provide OST patients with their medication. Police uses withdrawal syndrome of OST patients to receive necessary information. There are records of “provocation” of OST patients by health care workers. In one case a health care worker gave a patient OST medication without official stamp, allegedly so that police officers who were on “duty” next to the OST would find it and arrest her, which did not happen only by chance.

- *Submission from Ukraine to the Global Commission on HIV and the Law*

physicians in any of the Central Asian countries even though it has proven successful in many other countries, nor is it offered by government or NGO HIV prevention and treatment centers.

²³² Andrey Rylkov Foundation for Health and Social Justice (2010), *Report to the International Committee on Economic, Social and Cultural Rights on implementation by the Russian Federation of article 12 of the International Covenant on Economic, Social and Cultural Rights as it relates to access of people who inject drugs to drug treatment and HIV prevention, care and treatment programs.*

²³³ Ibid.

²³⁴ Latypov, A, Otiashvili, D, Aizberg, O and Boltaev, A, (2010), *OST in Central Asia: Towards Diverse and Effective treatment options for drug dependence*, EHRN at p. 5.

The only country where OST programmes are offered at family (primary) medical centers and within the penitentiary system is Kyrgyzstan. In Kazakhstan and Tajikistan (according to Ministry of Health guidelines), OST is provided only in specialised state drug treatment institutions, which limits access to treatment and the potential for different models to suit different patient needs, as well as hampering innovation in the field.²³⁵

None of the countries in this study have provisions in law that define the key principles of substitution therapy programmes and guarantee that the state will provide them. In Kazakhstan, the main documents related to the pilot programme are two decrees from the Ministry of Health, which explain the technical organisation of the treatment and give recommendations for support, rather than offering any kind of normative backup. As of late 2009, with the exception of Kyrgyzstan, none of the countries have included methadone and buprenorphine in their lists of essential medicines.²³⁶ The system of registering people with opioid dependence is often named as one of the main factors preventing many potential clients from taking part in substitution therapy programmes. The legal frameworks of Kazakhstan, Kyrgyzstan, Tajikistan and Uzbekistan protect the privacy of medical information, but there are frequent violations.²³⁷ There are also regulatory or quasi-legal means by which medical information is shared within the health system and outside of it, especially with the police.

The other reason for low coverage is strict rules for patient eligibility. One of the criteria for patients' eligibility for substitution therapy in Kazakhstan, Kyrgyzstan and Tajikistan is a history of unsuccessful attempts at treatment through state abstinence-based treatment programmes. In Ukraine, according to a OST patients report, the programme threshold is very high. People need to provide evidence of three to six previously failed attempts at drug dependence treatment and to undergo testing. Because the state drug treatment centres often do not use evidence-based approaches, a significant proportion of injection drug users seek help at various NGOs, religious rehabilitation programmes, traditional medicine practitioners, and other service providers or support groups. Treatment attempts at these facilities often do not qualify as previous treatment attempts according to regulatory documents and therefore many people who have sought treatment outside of state services are ineligible for treatment. In addition, the law does not allow for take-away doses and people need to pick up their medication in person from the clinic daily. There are no OST

In Armenia, a punitive approach to drug use is prevailing. Drug dependent people are rarely seen as patients with their rights deserving protection. Data on registered and previously registered drug dependent people are collected by the Narcological Dispensary and later transferred to the Ministry of Health care. For prevention of criminal activity, police periodically collects [this] data which serves as basis for criminal prosecution of people who use drugs. Our work in monitoring rights to a free trial of persons charged with illicit traffic of narcotic drugs (2008-2010) show that in almost all cases when the law-enforcing bodies gathered operative information regarding the preparation and usage of drugs, they have collected artificial proofs to impose accusation or bring people to criminal liability for illicit drug traffic.

- *Submission from Helsinki Citizens Assembly, Armenia*

²³⁵ Ibid.

²³⁶ Ibid.

²³⁷ Ibid.

clinics in small towns, although their establishment is mandated by the law.²³⁸ There is extensive evidence of negative attitudes of healthcare workers toward OST patients.

In 2010 and 2011, in Ukraine a number of law enforcement attacks on substitution treatment programmes and harassment of patients have been reported.²³⁹ Police have raided drug treatment clinics, interrogated, fingerprinted and photographed patients, confiscated medical records and medications, and detained medical personnel. The raids have resulted in interruptions in treatment, and two doctors have been charged with drug trafficking. Despite police claims that these raids and arrests are part of legitimate efforts to enforce Ukraine's drug regulations and prevent misuse of opioid medications, many of the raids appear to have been conducted without probable cause and in violation of internal police rules. Furthermore, in 2011, the Ministry of Interior's department of drug enforcement issued an order to collect personal data of patients enrolled in opiate substitution programmes across Ukraine. Since then, police have been pursuing patients at clinics and at home. Police have denied access to services, including provision of necessary medication, if patients do not provide confidential information, including their HIV status and criminal record.²⁴⁰

Drug user registry

At least a few Eastern European and Central Asian countries, including Russia, Kazakhstan, Kyrgyzstan, and Ukraine continue to maintain drug user registries, created in accordance with national drug laws. Georgia, in contrast, has recently removed its registry.²⁴¹ Most Central Asian countries maintain two registries: one of people who use drugs, with information on people who are known to use drugs recreationally, and the other of people who are dependent on drugs - obtained from drug dependence treatment facilities, who are obliged to submit information on people who seek treatment. Being put on the registry frequently results in violations of economic and social rights; for example, people on the registry can be prohibited from receiving driving licences or acquiring certain jobs. Having one's name removed from the database is difficult and requires proving that one has not used drugs for some period of time. The negative consequences of being on a registry are numerous: risk of harassment and extortion by the police, risk of losing custody of children, loss of confidentiality, and repercussions at work, educational institutions, etc.²⁴²

²³⁸ EHRN and Association of OST participants of Ukraine (2010), *Access of key populations at higher risk to HIV prevention, treatment, care and support in Ukraine* (in Russian).

²³⁹ Lohman, D. (2010), *Why is Ukraine revising HIV policy*, Human Rights Watch, The Guardian.

²⁴⁰ Ibid.

²⁴¹ EHRN (2010), *Achieving Universal Access in Eastern, South East Europe and Central Asia: An HIV Community Perspective* at p. 27.

²⁴² Shields, A. (2009), *The Effects of Drug User Registration Laws on People's Rights and Health: Key Findings from Russia, Georgia, and Ukraine*, OSI.

Drug testing

Drug testing according to laws of many former Soviet Union countries is done to determine drug use, or to detect if a person is under the influence of drugs. Pursuant to a decision by the Cabinet of Ministers of Azerbaijan, if there is a ‘substantiated suspicion’ that a person is intoxicated by a narcotic, is driving under the influence of drugs, or carries narcotics and psychotropic substances in or on his or her body, he or she may be subjected to medical examination at the request of police. The medical examination is conducted in state narcotic medical institutions. If the person refuses to be tested, an administrative fine may be imposed.²⁴³ In Azerbaijan, avoiding drug testing also leads to an administrative fine, which could be ordered by the police or another administrative official. Article 44 of the Russian law on Narcotic drugs, stipulates that people may be subject to drug testing if there are reasons to believe that a person has consumed drugs, is under the influence of drugs or is drug dependent. In 2010-2022, Russian policymakers began the push towards introducing legislation to implement drug testing in all Russian high schools.

The Criminal Code of Uzbekistan provides several bases on which a person may be subjected to drug testing without his or her consent. Police, investigative authorities and courts may order a person to be tested if there are “sufficient reasons to believe” that he or she suffers from drug dependence, is in a state of intoxication, has used a narcotic or psychotropic substance without medical prescription, or is carrying a narcotic or psychotropic substance inside his or her body.²⁴⁴ The 2007 Georgian law also provides for wide drug testing and searches.

In Georgia there is no distinction between dealers, casual and dependent users. Drug use is punishable first by administrative law and criminal code by up to one year imprisonment. The 2007 Law against drug offences triggered marginalisation of people who use drugs depriving them of a number of fundamental civil rights, and in some cases of private property. Mainly because of lack of accessibility, bad social-economic situation, lack of patient confidentiality and information delivery the credibility of OST is challenged in spite of success stories and effectiveness of the programs. Patients complain about long lines and corruption at medical institutions. There is a lack of trained human resources in the field; expensive detoxification programs administered at four government-funded clinics have the capacity to treat 25 patients per month and the price of detoxification programme is \$1000-\$1500; the primary rehabilitation programme costs \$570 and methadone substitution therapy centers do not include an extensive psycho-social rehabilitation program.

In Russia in 2010, prosecutors were reported to be engaged in massive legal actions to withdraw registered drug users’ driver’s licences, allegedly following the instructions of the Federal General Prosecutor’s Office. Prosecutors in the Republic of Tatarstan demanded private information about all the registered drug users in the Republic from drug treatment clinics. Upon receipt of such information prosecutors successfully initiated a legal action and withdrew the driver’s licences of all registered drug users. The court did not address the massive violation of the right to privacy, procedural violations and

²⁴³ UNODC, Canadian HIV/AIDS Legal Network (2010), *Accessibility of HIV Prevention, Treatment and Care Services for People who Use Drugs and Incarcerated People in Azerbaijan, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan: Legislative and Policy Analysis and Recommendations for Reform*.

²⁴⁴ Ibid.

In a recent case, an HIV-positive person taking ART drug Efavirenz was fined for illicit drug use. City administrative court and then city appellate court of Georgia held that the person perpetrated administrative misdemeanor of drug use as he tested positive for drugs. HIV-positive claimed that because of his HIV infection he takes specific ART drugs under the supervision of a doctor and that he did not use marijuana. It is known that drug Efavirenz sometimes have a false positive result for marijuana. He also attached a letter from the HIV/AIDS centre to his application. The letter signed by a doctor used as evidence confirmed the applicant's arguments.

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obvious discrimination. The information about the registered people was openly sent to the traffic police for action.²⁴⁵

Overdose

Drug overdose is common in countries of the region, including Kyrgyzstan, Russia, and Tajikistan. Overdose is the second leading known cause of death among drug users in Russia, and is a leading cause of death among drug users in most other Eastern European and Central Asian states for which any data are available.²⁴⁶ Russia officially reported 9,354 overdose deaths in 2006, by far the highest rate in the region.²⁴⁷

Emergency and hospital-based overdose care is broadly available in most countries, although availability may be limited by distance, poor roads, inadequate number of ambulances, and limited access to naloxone for medical providers. In some states, emergency departments and medical examiner's offices frequently do not record overdose as the cause of admission or death due to a combination of lack of reimbursement for services, legal implications for patients and families and the social stigma of drug use.

Overdose is briefly noted in selected policy documents but few detailed objectives or explicit means to address the problem are noted. Recent national policy and executive documents in Tajikistan consider overdose as a more prominent component of health and HIV agendas. Laws in some states appear contradictory in that overdose witnesses or medical providers may be legally obligated to report overdose to police while drug users are simultaneously promised access to medical services. No laws exist in any of the countries surveyed to establish overdose

²⁴⁵ Andrey Rylkov Foundation for Health and Social Justice, Canadian HIV/AIDS Legal Network (2010), *Additional information to the Report to the International Committee on Economic, Social and Cultural Rights on implementation by the Russian Federation of article 12 of the International Covenant on Economic, Social and Cultural Rights as it relates to access of people who inject drugs to drug treatment and HIV prevention, care and treatment programs.*

²⁴⁶ IHRA, *The Global State of Harm Reduction*, at p. 114.

²⁴⁷ EHRN, (2008) *Overdose: A Major Cause of Preventable Death in Central and Eastern Europe in Central Asia.*

prevention programmes, protect witnesses who call emergency services, or encourage naloxone distribution.

The overdose medication naloxone is registered in most study countries and is used by medical institutions and staff in case of overdose. It is not a registered medical drug in Tajikistan and frequently unavailable in Russia and Kyrgyzstan. Naloxone is theoretically available by prescription in pharmacies although this is not accepted practice, and only a handful of low-threshold programmes in Russia, Kyrgyzstan, and Tajikistan provide naloxone for lay administration. The availability of naloxene on ambulances is often restricted to specialised ambulances in major city centers or sometimes not available at all. Non-medical staff are prohibited from handling it, meaning that peer interventions (i.e., one drug user assisting another in the event of overdose) are not possible. The existence of a drug user registry may deter users from calling emergency medical services, as ambulances are required to report overdose cases to the police and there are reports that people who overdose may be arrested for drug use.

Other forms of police abuse and violations of the rights of drug users are frequently reported: extortion, police filling their arrest quotas with drug users, procuring false confessions from drug users in withdrawal and unnecessarily patrolling pharmacies and harm reduction facilities.

Areas of concern

- 1) Repressive drug laws and policies that criminalise drug use and possession of miniscule amounts of drugs marginalise and criminalise a significant portion of population, and create significant barriers to effective HIV responses.
- 2) Other drug policies, such as registration of people who use drugs, criminalisation of possession of trace amounts of drugs in syringes and broad application of prohibition of propaganda, create barriers to the functioning of harm reduction measures. Lack of

Repressive drug policy: Drug use in the country is heavily criminalised which results in incarceration of a significant number of people who use drugs. The majority of our clients were first time sentenced for small offences, such as possession of small amounts (i.e. less than 1 day dosage of drugs). It is known that police officers have an “arrest quota”, which means that in a certain period of time they are obliged to arrest a certain amount of people for offences related to drugs - and this is deemed to be an indicator of effectiveness of their work. This leads to frequent “planting of drugs”, blackmailing of people who use drugs (police requires them give contacts of other people who use drugs), sentencing to disproportionately harsh sentence and others. Also if a person has one criminal conviction, it is likely that he/she would be sentenced for the second time if arrested. Thus people who use drugs become “hostages of the system” - if a person is “caught” once, he/she could be threatened with a new sentence even for little missteps. We are confident that incarceration for use and possession of drugs without purpose of sale should be repealed, as this practice only worsens the situation. There is no drug dependence treatment in prison, social connections are broken, health deteriorates, psychological problems are formed. People are released from prison much more disintegrated and the majority of them continue using drugs. Former prisoners are often discriminated against, it is difficult for them to find a job, and many are refused to be registered in employment centres. They frequently are faced with a problem of obtaining identification documents. People released from prisons have no social and legal support.

- *Submission from Russia to the Global Commission on HIV and the Law*

legislative entrenchment of NSP, OST and other harm reduction measures puts these programmes at risk of political caprice and makes their future uncertain.

- 3) OST eligibility threshold is very high, which makes it difficult to access for many people in need.
- 4) Access to HIV treatment and other services is lower for people who use drugs than for the general population. This reflects the discrimination they face in the healthcare sector; reports also indicate discrimination in other spheres of life.
- 5) Laws and policies create barriers to the use of naloxone for overdose management, specifically by people other than medical professionals.



9. Sex Work

Although sex workers are seen as being particularly at risk of HIV infection globally, HIV prevalence rates among sex workers are relatively low in the majority of countries of the region. Condom use during transactional sex is reported by sex workers to be relatively high and probably more relevant to their risk than generic measures of knowledge about HIV. However, this is not true of all sex workers; those who also inject drugs, male and transgender sex workers, those from countries with generalized epidemics, and those who work on the street have higher rates of HIV infection.²⁴⁸

Most countries of the region have direct prohibitions of sex work included in their Administrative and Criminal Codes. In two countries, Albania and Ukraine, prostitution constitutes a criminal offence. In Armenia, Belarus, Bosnia and Herzegovina, Croatia, Macedonia, Moldova, Russia, Serbia, Montenegro, Turkmenistan, and Uzbekistan, sex work is directly prohibited, with administrative liability in place. In Belarus, Macedonia, Russia and Azerbaijan, prostitution is an administrative offence, punishable by a fine (Administrative Code of the Republic of Belarus, Article 17.5; Law on Misdemeanors against Public Peace and Order of the Republic of Macedonia, Article 27; Administrative Code of the Russian Federation, Article 6.11;) Fines can be as high as 50 times the monthly minimum wage. According to Article 308 of the Code of Administrative Offences. According to the Administrative Codes of Tajikistan and Uzbekistan, prostitution is an administrative offence punishable by a fine or warning. Repeated offence committed within the same year leads to a higher fine.

Pimping is prohibited in all countries of the region (it is an administrative offense in Russia and a criminal offence in all other countries), with punishments varying from a fine to imprisonment.²⁴⁹

Under the Criminal Codes of all reviewed countries (Article 131 of Uzbek Code), “organizing brothels and pimping with the purpose of receiving profit or other immoral reasons” is punishable with a fine or correctional labour for up to three years. Article 238 of the Criminal Code of Tajikistan criminalises “involvement” in prostitution using force, coercion or threats. Article 239 provides for criminal liability for organising and maintaining brothels or pimping, which is punishable by fine, or imprisonment for up to five years. In Turkmenistan, the same

²⁴⁸ European Centre for Disease Prevention and Control (2010). *Implementing the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia: 2010 progress report*, at p. 2, Stockholm: ECDC.

²⁴⁹ Central European and Eurasian Harm Reduction Network (2005), „*Sex Work, HIV/AIDS and Human Rights In Central and Eastern Europe and Central Asia*.

provisions are entrenched in Articles 176(1) and 176(2) of the Administrative Offences Code, and Article 138 of the Criminal Code.

Sex work *per se* is not prohibited in Kazakhstan, Kyrgyzstan and Turkey. The Criminal Codes of Kazakhstan and Kyrgyzstan prohibit involvement in sex work using violence, threats and coercion and organising and maintaining brothels for prostitution. If the prohibition of involvement into sex work using violence is justifiable and protects human rights of people involved, then the prohibition on organizing and maintaining brothels could pose a problem for sex workers' ability to control their own working conditions and better protect their own safety, including with respect to HIV and STI prevention. Consequences of the criminalisation of brothel-keeping may include higher levels of mobility among sex workers. This often translates into staff at sex worker and harm reduction projects losing contact with clients for extended periods of time, which directly reduces effective delivery of vital health, legal, and social services. Direct prohibition of brothel-keeping also means that sex workers are often forced to work on the streets or in their clients' cars, which can further endanger their health and safety and make them easy targets for corrupt and abusive police officers.

In Croatia, during the deliberations on the new Criminal Code, there was a proposition to widen the criminal offence of "prostitution", which would criminalise not only sex workers but also persons using sexual services in exchange for payment. The law would criminalise the "use of sexual services of a person, accompanied by the provision or promise of monetary or other forms of compensation, regardless of whether such compensation has been provided or promised to the person who is prostituting oneself, or to another person."²⁵⁰

Respondents note that this legislation may not always be enforced and even with protective laws in place, sex workers are still regularly abused, harassed, and detained. There is a gap between legal regulations and actual police practices. For example, in Russia the police rarely enforce the relevant provisions criminalising prostitution, because they find it difficult to prove that sexual services have been sold. As a result, sex workers are often detained or arrested on the basis of other legal provisions covering breach of public order, hooliganism, or absence of residency permits.

Penalisation of sex work, with particular reference to its categorisation as a criminal act, "social and pathologic phenomenon" or "social evil", only contributes to the increase of stigma and discrimination against sex workers and of their vulnerability to HIV/AIDS. Criminal prosecution of sex workers, pursuant to the criminal provision for causing "transmission of infectious diseases" by means of a "sex act or otherwise", has endangered the success of existing programmes for HIV/AIDS prevention in sex workers.

- Submission from BIM-FV Skopje, Macedonia

Even where sex work and associated activities are not criminalised, implementing acts (directives and guidelines from the Ministry of Internal Affairs) and actual law-enforcement practices often contradict legislation and contribute to abuse of sex worker rights. Police

²⁵⁰ UN Theme Group on HIV/AIDS (2011), *Report on the work of the National Consultant for HIV/AIDS and human rights in 2010, Croatia*, at, p. 22.

regularly arrest sex workers on the street or simply threaten to arrest them in order to extort bribes. They are often detained on the basis of alleged breach of passport regime or breach of public order. The threat of such harassment continues to restrict sex workers' ability and inclination to access vital health services, including medical care and harm reduction.²⁵¹

Research conducted by the Sex Workers' Rights Advocacy Network (SWAN) revealed that the police were the people most frequently reported by sex workers to be a threat to their safety in several countries of the region (Kyrgyzstan, Ukraine, Russia, and Macedonia). In all countries of the region where research was conducted, sex workers reported high levels of physical or sexual violence by police officers: 41.7% (86/206) of respondents reported that they had been physically abused by police, while 36.5% (77/211) reported that police had sexually assaulted them. Police retaliation, intimidation, and violence against sex workers who complain of abuse create obstacles to sex workers' access to justice. In some cases police appear to be committing violence against sex workers, arresting and detaining them as part of a government policy to intimidate them and "cleanse" certain areas. Members of easily identifiable ethnic minority groups, as well as male and transgender sex workers, were found to be particularly vulnerable to police violence and discrimination both as sex workers and for their ethnic identity or gender expression. Even in cases where there are legal grounds for the detention of sex workers, police commit serious violations of due process and routinely abuse sex workers in custody.²⁵²

Recently, at a training for law enforcement in Serbia, a police officer summarised the views and attitudes of the police by saying that sex workers do not deserve to be protected, that time on their protection should not be wasted, as they were willingly engaging in risk on top of engaging in illegal activities which, according to him do not grant them the same rights as other citizens. ... Forced and mandatory testing... confiscating condoms as 'evidence' are among frequent occurrences. As one sex worker in Macedonia put it: "the police stop me and look in my bag, and when they find many condoms they say 'come with me to the police station, you are doing prostitution', and for this reason I cannot take many condoms with me."

- *Submission from Sex Worker's Rights Advocacy Network (SWAN) for Central & Eastern Europe & Central Asia*

After being detained by the police, sex workers report being forced to undergo testing for HIV or sexually transmitted infections (STIs). In Kyrgyzstan, 35% of sex workers reported being tested for HIV or other STIs against their will after being picked up by police. In Ukraine, 25% of sex workers reported that authorities subjected them to testing for HIV or other STIs against their will. In November 2008, police in Macedonia arrested more than 30 people and held them in custody on charges of suspicion of "involvement in prostitution". On the following day, the detainees accused of being sex workers were subjected to forcible testing for HIV and hepatitis B and C. Seven women who tested positive for hepatitis C face

²⁵¹ Central and Eastern European Harm Reduction Network (2005), *Sex Work, HIV/AIDS, and Human Rights in Central and Eastern Europe and Central Asia*, http://www.soros.org/initiatives/health/focus/sharp/articles_publications/publications/sexwork_20051018/sex%20work%20in%20ceeca_report_2005.pdf at p. 36.

²⁵² SWAN (October 2009), *Arrest the violence: Human Rights Abuses against sex workers in central and Eastern Europe and Central Asia*. at p. 30-31.

criminal charges by Macedonia's Ministry of Interior for allegedly "transmitting an infectious disease."²⁵³

The threat of arrest, harassment, extortion and violence by police pushes many sex workers into isolated areas, such as rural highways and places far from city centers. This increases their vulnerability to violence by both police and civilian assailants, and cuts them off from vital support services. Fear of the police forces sex workers to undertake rushed negotiations with clients and forego processes for screening out aggressive, drunk or potentially violent clients. Lack of access to police protection creates a climate of impunity for crimes against sex workers and has made them easy and frequent targets of violence from the general population. This is, in part, reflected in the very high levels of physical and sexual violence sex workers in all countries reported by people such as clients, bosses, partners, hooligans, thugs, neo-fascists, etc. Sex workers identified stigmatisation of sex work as further fueling sexual and physical violence against them and creating conditions of impunity for the perpetrators. Sexual violence committed by police and clients against sex workers puts sex workers at increased risk of HIV infection. Police also confiscate condoms to use as "evidence" of sex work, forcing sex workers to rush or skip negotiations about condom use with their clients, and financially burdening sex workers with police fines and demands for bribes. This can create situations in which sex workers sacrifice condom use for the increased income of unprotected sex. State failure to halt police crackdowns and violence puts sex workers at higher risk of sexual violence, including rape, and violent coercion to forego the use of condoms.²⁵⁴

Areas of concern

- 1) Criminalisation of sex work and associated practices, as well as rampant human rights abuses against people involved in sex work raise concerns. Police abuse and harassment is frequent and is associated with impunity for violations of sex worker rights.
- 2) Lack of access to health care facilities and discrimination on the part of medical workers impedes successful HIV responses.

²⁵³ Ibid. at p. 37.

²⁵⁴ SWAN (2009), *Arrest the violence: Human Rights Abuses against sex workers in central and Eastern Europe and Central Asia* at p.40.



10. Men Who Have Sex with Men and Transgender People

Estimated HIV prevalence rates among MSM in the region are:

- Ukraine, 8.6% (2009)
- Moldova, 4.8% (2008)
- Georgia, 3.7% (2008)
- Russian Federation, 3.5% (2007)
- Belarus, 3.1% (2008) and 2.1% (2009)
- Armenia, 2% (2007)
- Azerbaijan 1.1% (2008)
- Albania, less than 1% (2007)

Levels of STI prevalence, which are indicators of risky sexual behavior, are higher than of HIV prevalence, ranging from 4% to 41% in Moldova, Russian Federation, Georgia and Belarus. The highest data for syphilis prevalence was found in Belarus (41%) and Georgia (31.4%). Collected data show high risk of STI infections, including HBV and HCV among MSM in Eastern Europe and Central Asia.²⁵⁵ As the epidemic in Eastern Europe is driven in large part by injecting drug use, it is interesting that comparatively low levels of injecting drug use among MSM is seen in Ukraine (1.3% of MSM reported injecting drugs during last six month), in Belarus (2%) and in Russian Federation (4%). Much higher levels of injecting drug behavior are shown among MSM in Caucasus countries: Georgia (9.3%) and Azerbaijan (12%).²⁵⁶ There is a high level of safe sexual behavior – compared to heterosexual people – in some countries of the region. High levels of consistent condom use have been reported in Albania (61%), Georgia (61.7%), Armenia (74.3%), Russian Federation (78.7%) and Ukraine (82.1%).

According to routine epidemiological and sentinel surveillance data of Eastern European countries, MSM populations take third or fourth place after injecting drug users, sex workers and prison populations as the main driving force of the epidemic. However, with no consistent or accurate reporting, and high levels of homophobia and transphobia, it is very likely that official case reporting figures underestimate the numbers of MSM living with and acquiring HIV in the Caucasus countries, Moldova, Ukraine, the Russian Federation and elsewhere in Eastern European. MSM are considered one of the key populations at higher risk of HIV in the

²⁵⁵ International HIV/AIDS Alliance (2010), *Men having sex with men in Eastern Europe: Implications of a Hidden HIV Epidemic*, Regional Analysis Report.

²⁵⁶ EHRN (2010), *Achieving Universal Access in Eastern, South East Europe and Central Asia* at pp. 26-38.

prevention strategies of national programmes in most of the assessed countries. They are also included in the national goals for scaling up towards universal access to HIV prevention, treatment, care and support for groups at high risk of HIV. But the level of prioritization for this group is low in all countries of the studied region. There is a general lack of research and data regarding this population and their needs. Commitments to MSM programming in national strategic plans have generally not resulted in any government funding.²⁵⁷

Albania, Armenia, Belarus, Georgia, Moldova, Russia and Ukraine mentioned programmes targeting MSM in their National Strategic Plans or National AIDS Plans.²⁵⁸ In Azerbaijan, governmental resources are not allocated for HIV/AIDS prevention among MSM. In Belarus, prevention work among MSM was included in the National HIV Prevention Programme for 2006–2010 and in the draft National HIV Prevention Programme for 2011–2015. The National Action Plan on Universal Access to HIV Prevention, Treatment, Care and Support in Belarus for 2009–2010, includes such activities as “improvement of access to STI diagnostics and treatment for MSM; access to quality condoms and lubricants for 10,000 MSM; provision of information and peer education on HIV/AIDS/STI prevention.” In the National HIV/AIDS Programme of Georgia, MSM are defined as a high-risk group on which certain activities are focused. In Russia, the overall coverage by prevention activities is very low. According to the 2007 National Report, only 16.83% of MSM were covered by prevention activities.

The coverage by HIV prevention programmes is very low in most of the assessed countries. Only four countries have data on the percentage of the covered MSM population. HIV prevention programmes in Armenia cover 12% of MSM population; in the Russian Federation, 16.8% of MSM population from 10 prioritised regions are covered; in Ukraine, 16% (using annual coverage data); and in Belarus, 23% (using cumulative data).²⁵⁹ In most of the assessed countries, programmes for care and support, psychological support and advocacy are pilot programmes or cover only a small region. There are no care and support programmes specifically targeting HIV-positive MSM at country level. Most of the selected countries have several HIV-positive MSM self-help groups, yet there is a lack of policy guidance for HIV interventions for MSM on the regional level that comprehensively focuses on prevention, treatment, care and support.

The majority of countries had one MSM-service or LGBT organisation working in this area (with two in Albania). In contrast, Russia and Ukraine had many more, 10 and 22 respectively. Activities are implemented mostly on a pilot basis by NGOs with international funding.²⁶⁰ In

²⁵⁷ International HIV/AIDS Alliance (2010), *Men having sex with men in Eastern Europe: Implications of a Hidden HIV Epidemic, Regional Analysis Report* at p.24.

²⁵⁸ The National HIV/AIDS Strategy of Azerbaijan for 2007–2011, the MSM population is not identified as a separate vulnerable group.

²⁵⁹ To compare with other regions, a 2006 survey of the coverage of HIV interventions in 15 Asia-Pacific countries estimated that targeted prevention programmes reached less than 8%. International HIV/AIDS Alliance (2010), *Men having sex with men in Eastern Europe: Implications of a Hidden HIV Epidemic, Regional Analysis Report* at p. 34.

²⁶⁰ *Ibid.* at p. 33.

Albania, there are no data on what measures are being taken by the country to overcome homophobia and develop tolerance in a multicultural environment.

The Law

Laws criminalizing homosexuality were abolished in some countries relatively recently (1990-2000). Homosexuality is criminalised in two assessed countries – Turkmenistan (Article 135 of the Criminal Code) and Uzbekistan (Article 120 of the Criminal Code). In Turkmenistan this offence is punishable by imprisonment for up to two years, with or without an obligation to reside in a certain area for the period from two to five years.

There are no marriage rights or civil partnerships for same sex couples in any of the researched countries, except Croatia. In most of the countries family is defined as a voluntary union between a man and woman. In Moldova, same-sex partnership is forbidden by law. Croatia is the only country which legally recognizes same-sex couples' right to informal unions. This recognition is still limited in scope in comparison to the rights enjoyed by heterosexual couples, as the Law on Same Sex Civil Unions, provides for: (a) the right to be supported by one's partner in case of incapacity for work, or in case of unemployment, even if the relationship has ended; (b) the right to put to order legal and property relations regarding either existing or future joint property; and (c) the right to protection against discrimination on the grounds of sexual orientation.²⁶¹ Given the fact that such cohabitation is informal, prior to exercising these rights following a disagreement among partners, it is necessary to determine the existence of the same-sex union in non-contentious proceedings, and that can entail significant difficulties in practice. There is also protection from family violence, based on changes introduced into the Law on Protection against Family Violence, which gives the right to protection against violent behavior within a family, in cases when a same-sex partner commits the violence.²⁶²

All the constitutions of the countries in the region guarantee the respect of human rights. Since most of the countries have no special legislation on discrimination based on sexual orientation, general anti-discrimination provisions should theoretically be applicable.

This analysis could not find legislation or standards concerning the protection of gender identity and the rights of transgender people. Change of gender/sex reassignment procedures are governed by special documents of Ministries of Health.

In Croatia, Serbia and Montenegro, criminal prohibition of discrimination exists, with "open-ended" definitions of discrimination,²⁶³ in which sexual orientation and gender identity are not explicitly included, but could be interpreted as included. In Bosnia and Herzegovina, the

²⁶¹ Official Gazette no. 116/03.

²⁶² UN Theme Group on HIV/AIDS (2011), *Report on the work of the of the National Consultant for HIV/AIDS and human rights in 2010, Croatia* at p.38 (Article 7; Official Gazette no. 147/09).

²⁶³ UNDP (2010), *Report exploring the link between MSM with homophobia and HIV/AIDS in countries: Bosnia and Herzegovina, Croatia, Montenegro and Serbia*.

provision is closed but contains terms of sexual orientation.²⁶⁴ In February 2010, the Parliament of Albania adopted a comprehensive anti-discrimination law which bans discrimination on the grounds of sexual orientation and gender identity.²⁶⁵ The law bans discrimination in all areas, including employment, the provision of goods and services, education, health care and housing.²⁶⁶ According to some information, in Moldova, the draft Anti-Discrimination Law was withdrawn from the parliament in 2010, as a result of opposition from religious groups to the inclusion of sexual orientation as a protected ground.

In Russia too, discrimination based on sexual orientation is not included in anti-discrimination provisions. Government authorities and law enforcement agencies rarely act on cases of violence or threat of violence towards gay, lesbian and transgender people when these threats are related to their sexual identity. In the past few years stigmatisation of MSM/LGBT people has increased, attitudes which are reflected in public statements made by politicians, and the consistent prohibition of pride parades. Some Russian municipal and regional authorities are openly and officially campaigning against “promotion of homosexuality” by attempting to put a legislative ban on such “promotion”, actions which limit freedom of thought, freedom of expression, access to information and distribution of information.²⁶⁷

In Armenia, homosexual men are discharged from military service, which is legally justified by article 12 of the Law of the Republic of Armenia “On Military Service.” According to the relevant article, citizens considered unfit for military service on health grounds are discharged from compulsory military service by the republican drafting commission and taken off military books. An internal Decree of the Republic of Armenia Defense Ministry based on this article stipulates discharge of gays from compulsory military service by characterizing their sexual orientation as an illness.²⁶⁸

Enforcement of anti-discrimination laws

MSM in various countries of the region report physical violence (10% of MSM in Georgia) and psychological violence and harassment (as high as 70% in Serbia) due to sexual orientation. In 2008-2010, Human Rights Watch documented hate crimes, violence and murders of LGBT people, especially transgender people, in Turkey. Since 2008, there have been at least 10 murders of transgender people, not all of which have been adequately investigated by the police.²⁶⁹

²⁶⁴ Ibid.

²⁶⁵ According to the report by the International HIV/AIDS Alliance, Albania also has undertaken some steps to legalize same-sex partnerships. International HIV/AIDS Alliance (2010), *Men having sex with men in Eastern Europe: Implications of a Hidden HIV Epidemic, Regional Analysis Report*

²⁶⁶ Ibid. at p. 48.

²⁶⁷ Ibid.

²⁶⁸ Ibid.

²⁶⁹ Human Rights Watch (2010), Letter to Turkish Government on Violence and Murders Targeting Transgender People, www.hrw.org.

The biggest challenge for MSM is stigma in society, media, and even in health care settings. There is a high level of stigmatisation and discrimination of MSM by healthcare workers. According to the report on Moldova, MSM are afraid to benefit from healthcare services because of stigma and discrimination based on sexual orientation.

In Armenia, less than 5% of MSM are covered by prevention programmes. There is no legal counseling for MSM. Programmes of free and anonymous STI diagnosis for MSM are implemented, but only among a limited target group and are not implemented in all territories and regions of Armenia. Psychological counseling for MSM is implemented, but the target group is insufficiently informed about the availability of this service. There are no target programmes for HIV positive MSM.

In Croatia and Serbia, there are reports from recent years about inadequate police action in cases of violence against MSM and Transgender people (TG) people. Although MSM and TG people report they have been victims of hate crimes, a significant number of them decide not to report the incidents to the police or public prosecutors. Police misconduct is common in cases of violence against MSM and TG people. Victims of violence and discrimination are faced with rude and offensive behaviour of police officers. In Croatia, for example, if an incident was to be reported to the police, in the majority of cases a proper criminal investigation would not be done and police would not even send a report to the prosecutor's office. Furthermore, police officers recognize violence against LGBT people as misdemeanors against public peace and order rather than as relevant criminal offences, resulting in under-reporting of incidents to prosecutor's office. In the majority of cases the police are unable to identify perpetrators and no criminal prosecution is initiated. Although the number of reported incidents is increasing each year, only in Croatia and Serbia does evidence of prosecutions exist. In all countries of the region, material and process criminal legislation is enacted to provide protection from criminal offences, while there are also available remedies through civil legislation.²⁷⁰ Police are often reluctant to protect people during pride parades.

Victims of violence usually seek retribution at the early stages of criminal prosecution (identifying perpetrators, investigation, etc.), while they may become reluctant to participate in further proceedings. Many victims of violence have no trust in rule of law and do not believe that their cases will be successful.²⁷¹

Regarding implementation of the above mentioned anti-discrimination legislation, there have been a few examples in Croatia. The Croatian Ombudswoman for Gender Equality participates in the implementation of the Anti-Discrimination Act. According to her 2009 Annual Report, there have been a few individual complaints concerning discrimination on the ground of sexual orientation. Civil society organisations reported on several cases of discrimination, usually connected with violence. One case of discrimination at the workplace was successfully solved;

²⁷⁰ UNDP (2010), *Report exploring the link between MSM with homophobia and HIV/AIDS in countries: Bosnia and Herzegovina, Croatia, Montenegro and Serbia* at p. 29.

²⁷¹ Ibid.

however, there have not been any civil judicial proceedings in cases of discrimination initiated in 2009.²⁷²

There are also some anecdotal reports of forced treatment of LGBT people, including psychiatric treatment.

Areas of concern

- 1) MSM and TG face human rights violations, hate crimes, discrimination and stigmatisation. Homophobia pushes people away from services and contributes to their marginalization.
- 2) There is a lack of de jure protection (anti-discrimination laws) for LGBT people and no recognition of same sex marriage and benefits.
- 3) MSM and TG people face lack of access to HIV prevention services and treatment.
- 4) Consensual sex among same sex adults is criminalised in two countries of the region.
- 5) Pathologisation of homosexuality continues, despite the repeal of laws decriminalizing homosexuality.
- 6) The knowledge base on the situation of transgender people is extremely poor.

²⁷² Ibid. at p. 37-38.



11. People in Prisons and Detention Facilities

The region has one of the highest rates of people in prison in the world. Russia has the world's second largest prison population rate: 629 per 100,000 of the national population. Among the highest rates are also Belarus (468) and Georgia (415). Kazakhstan's prison population rate is the highest in Central Asia: 378 (per 100,000 population). In Turkey it is 142 per 100,000²⁷³ whereas the median rate in Asia is 53 per 100,000.

Criminal and legalistic approaches to substance use emphasise incarceration and punishment over treatment and prevention. Large numbers are imprisoned for drug-related offences. High levels of incarceration have been associated with a wide range of negative consequences for those incarcerated and for their communities.²⁷⁴ According to the Lancet, in Russia, by late 2002 the registered number of people living with HIV or AIDS in the penal system exceeded 36,000 (4% of the prison population), and accounted for about 20% of all known cases of HIV in the country. In most countries of the European Region, rates of HIV infection are many times higher among prisoners than in the population at large. Studies in European countries have found great variations in the rates of HIV infection among prisoners. Rates are generally higher in Eastern Europe, especially the Russian Federation (4% in 2002) and Ukraine (7% in 2000).²⁷⁵ According to Russia's UNGASS Country Progress Report for 2010, the number of HIV-positive people in Russian prisons is rising. At the end of 2009 there were 55,964 HIV-positive persons (11% of all persons living with HIV). HIV prevalence among prisoners is 6,4%.²⁷⁶ The HIV situation within prisons is exacerbated by high rates of tuberculosis (often multi-drug resistant), sexually transmitted infections and hepatitis B and C.²⁷⁷

HCV prevalence is even higher.²⁷⁸ Using data from 26 Eastern European and Central Asian countries, Stuckler and colleagues calculated that each percentage point increase in the incarceration rate (after controlling for tuberculosis infrastructure, HIV prevalence, and economic and demographic variables) was associated with an increase in population-level

²⁷³ Walmsley, R. (2010), *World Prison Population List* (eighth edition), International Centre for Prison Studies.

²⁷⁴ Beyrer, B, Malinowska-Sempruch, K, Kamarulzaman, A, Kazatchkine, M, Sidibe, M, Strathdee, S.A, (2010), *Time to Act: A call for Comprehensive response to HIV in people who use drugs*, The Lancet.

²⁷⁵ Jurgens, R, Ball, A, Verster, A. (2009) *Interventions to reduce HIV transmission relating to injection drug use in prisons*, 9:57-66.

²⁷⁶ UNGASS (2010), *The Russian Federation UNGASS Country Progress Report* at p.36.

²⁷⁷ WHO, *HIV in prisons*, <http://www.euro.who.int>.

²⁷⁸ Jurgens, R, Ball, A, Verster, A, (2009) *Interventions to reduce HIV transmission relating to injection drug use in prisons*, 9: 57-66.

incidence of tuberculosis of 0,34%. Net increases in incarceration accounted for roughly three-fifths of the average increase in tuberculosis incidence from 1991-2002. The investigators' conclusion was that a reduction in imprisonment would reduce the general population's risks for both tuberculosis and multi-drug resistant (MDR) tuberculosis.²⁷⁹

Four of the study countries have needle and syringe exchange in prisons – Armenia, Kyrgyzstan, Moldova, and Belarus. At least seven – Albania, Croatia, Georgia, FYR, Macedonia, Moldova, Montenegro, Serbia, have OST in prisons.²⁸⁰ Some have plans to introduce these measures in the future. For example, Kosovo's Strategic Plan on HIV/AIDS 2009–2013 envisages the establishment of a pilot OST project that will be implemented in two prisons, with pre- and post-release arrangements with the five centres outside of prisons. The pilot intends to guarantee continuity of care to prisoners who use drugs, including those who have recently been imprisoned or released. The Plan also mentions possible establishment of syringe and needle exchange programmes in prisons. Tajikistan is considering NSP in prisons. In January 2010, the Department of Correction Affairs signed a decree on piloting NSP in prisons of the Republic of Tajikistan.

In Georgia, in 2008 the first ever OST service centre was opened in the pre-detention facility of the penitentiary system; however the centre is only operational in Tbilisi. This type of service needs to be further expanded to respond to the potential needs beyond the capital.²⁸¹ Both OST and NSP exist in prisons of Kyrgyzstan and Moldova.

The Law

Not many countries in the region have healthcare services in prisons equal to that of the general community. The health departments of most post-Soviet penitentiary systems operate under Ministries of Internal Affairs or Justice, and fail to provide adequate health care, including OST, adequate ART, voluntary drug dependence treatment and sterile injecting equipment in prisons and detention facilities. In the Uzbek penal system, the national budget is supposed to cover the costs of providing health care services to prisoners, as well as their food, clothes, and personal hygiene items. However, laundry soap is the only personal hygiene item that is provided to prisoners free of charge. Prisoners must purchase all other personal care items, including soap, toothpaste and razors. Sometimes elementary medication is lacking.²⁸² Most countries have a working group, or a body responsible for HIV prevention and treatment in prisons, and most prisons allow NGOs to provide some form of HIV prevention in penal institutions.

²⁷⁹ Ibid.

²⁸⁰ IHRA (2010), *Global State of Harm Reduction*, at p.107.

²⁸¹ UNGASS (2010), *Georgia: UNGASS Country Progress Report*.

²⁸² European Centre for Disease Prevention and Control (2010), *Implementing the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia: 2010 Progress Report* at p.2, ECDC, Stockholm.

In Russia, according to Article 29 of the *Framework Law on the Protection of Citizens' Health*, people in detention facilities, prisons and other forms of custody have the right to health care. If necessary, they have the right to free health care outside of detention centres and prisons.²⁸³

In order to implement harm reduction measures many countries will need to change their legislative and policy frameworks. For example, in Russia, Azerbaijan, Ukraine, Georgia and several Central Asian countries prison regulations prohibit prisoners from possessing sharp cutting or piercing items, but prisoners are allowed to purchase and store disinfectants, including chloramine.²⁸⁴

In Moldova, harm reduction is considered a major component of the government's anti-HIV strategy - the National Program for Prevention and Control of HIV/AIDS/STIs for 2006–2010 - which stipulates that needle exchange and methadone treatment are important elements of a comprehensive response. It explicitly says that the Ministry of Justice has to “ensure the development of activities and measures to prevent and control HIV/AIDS and STIs in penitentiary institutions through extending harm reduction programmes and substitution treatment.” The *Law on HIV/AIDS Infection Prevention 2007* also contains an article on prevention activities in penitentiary institutions, which stipulates:

“The Ministry of Justice ensures:

- a) education and training of staff and inmates, with the purpose to develop skills and knowledge on HIV/AIDS prevention, safe and responsible behaviors, pre and post voluntary testing, consent for HIV testing;
- b) harm reduction programs, including provision of bleach and needle exchange supported free of charge and condom distribution in all prisons;
- c) access to free-of-charge ART treatment and treatment for opportunistic infections.”²⁸⁵

²⁸³ Russian Federation (22 July 1993), *Framework Law on health protection of citizens* [Основы законодательства об охране здоровья граждан], , N 5487-1.

²⁸⁴ For example see: Georgia (2010), *State Law on Prisoners, UNGASS Country Progress Report*.

²⁸⁵ OSI, IHRD (2009), *Harm Reduction in Prison: The Moldova Model*, at pp. 21-22.

As mentioned earlier, the HIV laws and implementing legislation of several countries specify compulsory HIV testing of people in prisons. In Russia, Article 18 part 3 of the *Code of Execution of Criminal Punishment of the Russian Federation* stipulates compulsory treatment in prisons for drug dependent people, people with STIs and open forms of TB, as well as HIV positive people.

The 2010 report of UNODC and the Canadian HIV/AIDS Legal Network found that the penal codes of some Central Asian countries discriminate against prisoners based on HIV status and drug dependence. After serving a portion of a sentence, prisoners deemed to be of “good behavior” may be eligible to transfer from a colony with a stricter security regime to other, less strict facilities. In exceptional circumstances (e.g. death or illness of relatives) prisoners can be permitted a temporary absence from the institution, for up to 7 days (not counting travel time). Prisoners deemed to be of “good behaviour” may be permitted a temporary unescorted absence outside the penal institution, after serving not less than one-third or one-half of their term, depending on the circumstances. However, prisoners who are ordered to undergo compulsory treatment for drug dependence and prisoners with infectious diseases (including HIV) are not eligible for such entitlements.²⁸⁶

In many countries the law allows compassionate release from prison for people with serious illnesses that prevent them from serving out a custodial sentence. Generally compassionate release is available to at least some patients diagnosed with AIDS, although usually AIDS is not specifically mentioned.²⁸⁷

HIV services and harm reduction

Informational materials and condoms are distributed by NGOs in Russian prisons. In Moldova, since 1999 local NGOs have provided prisoners with HIV/AIDS education and a wide range of harm reduction services, including psychological support, counseling, and distribution of clean injection equipment and condoms. In 1999, the Order of the Penitentiary Department No.115 “On a harm reduction pilot programme to be implemented in penitentiary institutions” authorised a needle and syringe pilot project in the prison. The project was originally run by staff from the medical unit. Prisoners were required to visit the medical facility to receive safer-injection materials, condoms, and all available informational materials.

In 2005, the Penitentiary Department introduced an OST programme. Generally, more than two-thirds of adult prisoners sentenced in Moldova are incarcerated in facilities that provide access to harm reduction services. The introduction of harm reduction measures has been accompanied by a reform aimed at reducing the overall number of prisoners and people in pre-

²⁸⁶ UNODC, Canadian HIV/AIDS Legal Network (2010), *Accessibility of HIV Prevention, Treatment and Care Services for People who Use Drugs and Incarcerated People in Azerbaijan, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan: Legislative and Policy Analysis and Recommendations for Reform*.

²⁸⁷ Ibid.

trial detention, as well as other prison reforms that aim to improve conditions for prisoners and staff.²⁸⁸ In all the prisons where harm reduction services are provided, the experience has been positive—needles have never been used as weapons against prison staff or fellow prisoners, drug use has not increased, and available data suggest a reduction in HIV and hepatitis C incidence.²⁸⁹

In Russia, drug dependence treatment is very limited in prison settings including pre-trial and police detention facilities. OST is not available in prisons.²⁹⁰ The general conditions and the quality of medical help are low in pre-trial detention and prison settings, which frequently lead to degrading or inhuman treatment and pave the way for the spread of infectious diseases. In a number of cases the European Court of Human Rights has found Russia in violation of the Council of Europe Convention on Human Rights for inability to provide people in prisons and detention facilities with adequate healthcare services.²⁹¹ While illegal drugs are available and needles are shared in prisons, NSPs and OST programmes are not available.²⁹² Access to medications for treatment of HIV and tuberculosis in prisons is limited and intermittent.²⁹³

Not many services are provided to people after release. Most NGO-supported housing options for released prisoners in Kyrgyzstan allow people to stay for one month. Obtaining more permanent housing requires certain documents that many former inmates do not have. The average time required to obtain these documents is six months. This leaves released inmates facing several months without a place to live, a situation that is especially challenging for women caring for children.²⁹⁴

²⁸⁸ OSI, IHRD (2009), *Harm Reduction in Prison: The Moldova Model*, at, p. 12.

²⁸⁹ Ibid at pp. 10-11.

²⁹⁰ Andrey Rylkov Foundation for Health and Social Justice (2010), *Report to the International Committee on Economic, Social and Cultural Rights on implementation by the Russian Federation of article 12 of the International Covenant on Economic, Social and Cultural Rights as it relates to access of people who inject drugs to drug treatment and HIV prevention, care and treatment programmes*.

²⁹¹ See the following cases of the European Court of Human Rights: *Alexanyan v Russia* of 05/06/2009; *Salmanov v Russia* of 31/10/2008; *Dorokhov v Russia* of 14/05/2008; *Khudobin v Russia* of 26/01/2007; *Popov v Russia* of 11/12/2006; *Romanov v Russia* of 20/01/2006; *Kalashnikov v. Russia* of 15/10/2002 found in Andrey Rylkov Foundation for Health and Social Justice, (2010), *Report to the International Committee on Economic, Social and Cultural Rights on implementation by the Russian Federation of article 12 of the International Covenant on Economic, Social and Cultural Rights as it relates to access of people who inject drugs to drug treatment and HIV prevention, care and treatment programmes*.

²⁹² Sarang, A., Rhodes, T., Platt, L., Kirzhanova, V., Shelkovnikova, O., Volnov, V., Blagovo, D. and Rylkov, A. (2006). *Drug injecting and syringe use in the HIV risk environment of Russian penitentiary institutions: Qualitative study*, *Addiction*, 101, 1787–1796.

²⁹³ Andrey Rylkov Foundation for Health and Social Justice (2010), *Report to the International Committee on Economic, Social and Cultural Rights on implementation by the Russian Federation of article 12 of the International Covenant on Economic, Social and Cultural Rights as it relates to access of people who inject drugs to drug treatment and HIV prevention, care and treatment programmes*.

²⁹⁴ OSI (2009), *Women, Harm Reduction and HIV: Key Findings From Azerbaijan, Georgia, Kyrgyzstan, Russian and Ukraine*, at p. 39.

Drug dependence treatment

Some form of drug dependence treatment is available in the penitentiary institutions in all reviewed countries. This drug treatment is usually very limited and in many countries that deny or have not scaled up OST, it consists of detoxification programmes and occasionally limited rehabilitation. According to reports, Kyrgyzstan is one of the few former Soviet Union countries which offers methods of drug dependence treatment in the penitentiary. Treatment of drug dependence is carried out in the “Atlantis” Rehabilitation Centres, which provide psychological support, restoration of broken social relationships and 12-step programmes for people with alcohol and drug dependence in seven correctional facilities in the country.

D.R. was imprisoned for the period of eight months in August 2010. Immediately upon his arrival in prison he asked to see the medical doctor and requested privacy in order to disclose his health status. The prison officer refused to leave the room and D.R. had to report his HCV and HIV status and the fact that he receives OST and ART. He was advised to call someone and ask them bring his medications. However, when a few hours later a friend did come to deliver the therapy, the guards refused to receive it. In a very short time the information that there was an HIV-positive person in the prison spread and all officers started wearing masks and gloves, while other prisoners avoided D.R. During the first three days he was left without both methadone and antiretroviral therapy. When D.R. was transferred to another prison the officers who received him were also wearing masks and gloves. Here the ART was obtained by the health care department. However, the person who dispensed the medications was himself a prisoner who worked as an assistant of the doctor and could have had access to his personal data. Although D.R. was not isolated and remained in the room with other prisoners, knowledge of his HIV status spread throughout the institution and he started receiving insults from the other prisoners. He was treated as someone infected with a contagious disease who needed to be quarantined. All other prisoners noticed the unusual attitude of the officials towards him, eventually rumors spread about his HIV positive status which led to a situation where D.R. felt isolated and unsafe.

Twenty days later an article titled “AIDS Panic in Idrizovo” was published in the daily newspaper making the case a sensation and quoting the following words from one prison doctor: ‘The HIV positive prisoner will in no way be placed together with the other prisoners, so that they are not brought into risk of contracting the contagious disease. (...) He will serve his time in a separate room within the infirmary’... ‘He is dangerous if as a drug addict takes heroin intravenously since AIDS is transmitted through blood’. The article also states that: ‘to the Minister of Justice it is of utmost importance that the other prisoners are protected from the risk of contracting the contagious disease. In the new prison that we are going to build, there will be separate pavilions for such cases, (...), so that they move within the pavilion and not in the other parts’.

-Submission from Macedonia to the Global Commission on HIV and the Law

However, in reality very few people in prison who need drug dependence treatment undergo it voluntarily. People continue to use drugs in prison, even if they are referred to compulsory treatment. Very few reveal their drug use/dependence and request treatment voluntarily. If drug dependence is found in a prisoner who is not referred to compulsory drug dependence treatment, s/he is offered voluntary treatment. If s/he refuses, a medical commission drafts a recommendation to a court to refer the person to compulsory treatment. Every country’s Criminal Code, Criminal Procedure Code and sometimes Penal Code includes articles providing for compulsory drug dependence treatment and these provisions are widely implemented.

Compulsory treatment is commonly ordered by the courts as part of sentencing, in addition to other criminal penalties.²⁹⁵

Court orders for compulsory treatment of drug dependence exist in the legislation of many former Soviet Union countries (at least in Russia, Belarus, Azerbaijan and all Central Asian countries). As a general rule, persons subject to compulsory treatment for alcohol or drug dependence are detained separately from other prisoners. They are housed in isolated living sections of specialised drug dependence treatment facilities. Detoxification and the alleviation of withdrawal symptoms (using tranquilizers, nootropics and vitamins) are the main types of treatment; treatment is supervised by narcologists and general practitioners.²⁹⁶

Drug testing is performed in the penitentiaries of many countries, usually to those people who are referred to compulsory drug dependence treatment or are known to be drug users. In Turkmenistan drug testing is compulsory for all prisoners.

Areas of concern

- 1) Penitentiary systems, including prisons and detention facilities lack adequate health care, including ARV and OST medication, a situation which may be worse in women's prisons.
- 2) The penitentiary system lacks internal guidelines on protecting the rights of vulnerable groups, including persons living with HIV and key populations at high risk.
- 3) Compulsory HIV testing of prisoners and sometimes compulsory drug testing are widespread, with wide provisions for compulsory drug dependence treatment, as well as compulsory treatment of HIV and STIs.
- 4) There are limited options for voluntary drug dependence treatment.
- 5) Harm reduction measures are limited, with NSP and OST existing in few prisons on pilot basis.
- 6) Discriminatory provisions remain in criminal legislation of Central Asian countries regarding limitations on rights for prisoners undergoing compulsory treatment.

²⁹⁵ Ibid. at pp. 119-120.

²⁹⁶ See more on numbers of people undergoing compulsory treatment, methods of treatment, etc. in UNODC, Canadian HIV/AIDS Legal Network (2010), *Accessibility of HIV Prevention, Treatment and Care Services for People who Use Drugs and Incarcerated People in Azerbaijan, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan: Legislative and Policy Analysis and Recommendations for Reform*.



12. Travel and Residence Restrictions and Migration

Travel and residence restrictions for people living with HIV are discriminatory and are not justified by public health protection. The HIV-related travel and residence restrictions that countries choose to impose are usually of several types: restrictions on short-term entry (less than 30 days), long-term entry (more than 90 days), conditions on entry in general and deportation of foreigners with HIV.²⁹⁷

Half of the countries in the region require HIV testing for foreign nationals and stateless persons in law and practice and impose restrictions on stay and residence permits for people living with HIV. Ten countries - Albania, Azerbaijan, Croatia, Georgia, Kosovo, Macedonia, Montenegro, Serbia, Turkey, Ukraine - do not impose any travel restrictions on people living with HIV. With the adoption of the new HIV law in 2009, Armenia removed the provision of an old law which allowed for HIV testing and deportation of foreigners diagnosed as HIV-positive. However, the Armenian law on foreigners still lists HIV infection as a condition to restrict entry, stay or residence. In Ukraine, the new 2010 HIV law removed testing and deportation of foreigners with HIV, but preserved provisions for deportation of foreigners and stateless people with HIV if their behavior endangers the health, rights and interests of citizens of Ukraine.²⁹⁸

Countries with the strictest visa regimes require an HIV-free certificate even for short stay. Russia, Kyrgyzstan and Uzbekistan impose such restrictions for stays of more than 30 days.²⁹⁹

Belarus, Bosnia and Herzegovina, Kazakhstan, Kyrgyzstan, Moldova, Russia, Tajikistan, Turkmenistan and Uzbekistan impose restrictions on long-term stays. In Belarus, the 2008 law provides that foreigners intending to stay for more than three months must present a certificate of their HIV status. Foreigners with HIV must notify the authorities of their status and receive behaviour counseling to prevent them from infecting others. Entry or residency permits

²⁹⁷ The Global Database on HIV-specific Travel and residence restrictions, <http://www.hivtravel.org> [Accessed on: 16 November 2011].

²⁹⁸ UNODC, Canadian HIV/AIDS Legal Network (2010), *Accessibility of HIV Prevention, Treatment and Care Services for People who Use Drugs and Incarcerated People in Azerbaijan, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan: Legislative and Policy Analysis and Recommendations for Reform..* See also *Law of Ukraine on Prevention of AIDS and Social Protection of Population*.

²⁹⁹ The Global Database on HIV-specific Travel and residence restrictions, at <http://www.hivtravel.org>, [Accessed on: 16 November 2011].

are granted to people with HIV, and there are no regulations on deportation or expulsion of people with HIV.

Moldova, Russia, Kazakhstan and Turkmenistan have legal 'de jure' provisions for the deportation of foreigners with HIV. These provisions may not always be observed (see below).

In Kazakhstan, all foreign citizens entering the country for longer than six months (including for permanent residence) must undergo a mandatory HIV test. A person with HIV will not be deported unless he or she avoids HIV testing or "preventative observation" (although the law provides for the deportation of foreigners with HIV). In Kyrgyzstan, the law mandates HIV testing for foreign citizens and stateless persons on arrival in the country and on an annual basis. Non-citizens are subject to deportation if they attempt to evade this test. In Turkmenistan, non-citizens who are HIV-positive will be denied a visa or a residence permit and are subject to deportation. Similarly, in Uzbekistan, the national HIV law provides that foreigners who are HIV-positive will be deported, while "HIV-free" certificates are required for obtaining a visa. According to the Uzbekistan country report, the procedure for deportation is not regulated by legislation; however, in practice territorial health bodies submit the information to the Ministry of Foreign Affairs, which arranges deportation.³⁰⁰ In Tajikistan, in 2008, amendments to the national HIV law removed the deportation provision, although mandatory testing of foreigners remains in the law.

In Russia, HIV testing is required for multiple-entry visas and long-term stays (more than three months). Foreign nationals found to be HIV-positive must leave the country within three months. A certification of HIV-negative status is also required for application for temporary residence. According to the Constitution Court of the Russian Federation, relevant authorities and courts may take into account family status, health status of a person with HIV and other exceptional circumstances with humanitarian considerations in mind when deciding whether to deport or to allow temporary residence. In any case, such a person is not relieved from the responsibility to observe the required measures to prevent HIV transmission.³⁰¹ In the 2010 case before the European Court of Human Rights, *Kiyutin v. Russian Federation*, an HIV-positive Uzbek national living in Russia and married to a Russian woman applied for a residence permit was refused by the Russian authorities. He alleged violations of articles 8, 13, 14 and 15 of the

³⁰⁰ Ministry of Health, Order *On HIV prevention in the Republic of Kazakhstan*, Order No.10 (19 February 2007). Law *On HIV/AIDS in the Kyrgyz Republic*, Law No. 149 (13 August 2005), Article 8; Kyrgyzstan, Government Resolution *Rules for medical examination to detect HIV, medical registration and observation of people with positive and ambiguous HIV tests in the Kyrgyz Republic*, No. 296, 25 April 2006. Law *On counteracting HIV*, Article 9. 480 Law *On Migration*, Articles 15 and 18. 481 Law *On prevention of illnesses caused by human immunodeficiency virus (HIV)*, Articles 6 and 12. 482 Government of Tajikistan, Resolution No. 406 (1 October 2004) found in UNODC, Canadian HIV/AIDS Legal Network (2010), *Accessibility of HIV Prevention, Treatment and Care Services for People who Use Drugs and Incarcerated People in Azerbaijan, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan: Legislative and Policy Analysis and Recommendations for Reform*.at p. 125.

³⁰¹ Определение Конституционного Суда РФ от 12.05.2006 N 155-О.

European Convention on Human Rights. The Court found Russia in violation of Article 14 (the prohibition of discrimination) in conjunction with Article 8 (the right to family life).³⁰²

In Turkmenistan, the rules are similar to those in Russia. In addition, foreigners and stateless persons who refuse testing or preventive examination are expelled from Turkmenistan. The Law on Migration establishes that where a person without citizenship is drug dependent, this can be the basis for canceling or refusing issuance of a visa or residence permit.³⁰³

Issues relating to internal and external migrants relate not only to HIV prevention but also to the provision of treatment and care. Non-citizens or stateless persons in the majority of the countries do not have access to free health care services. People without identification documents (including internal migrants) also face difficulties accessing medical care as most HIV care facilities provide care only to those with an official residence permit. Neither prevention nor treatment services are adapted to the language and cultural needs of migrants. The threat of deportation serves to deter migrants from accessing medical services. In many countries, undocumented migrants have difficulties accessing essential health care services, such as ART, information on prevention and others.³⁰⁴ Sometimes there are no materials on HIV prevention in other languages apart from the national language.

Areas of concern

- 1) Discrimination against people living with HIV in choosing their place of residence and travel.
- 2) Deportation of foreigners found to be HIV positive.
- 3) Lack of access to prevention and treatment services for migrants.
- 4) Legal barriers to HIV-related services for internal and international migrants.

³⁰² European Court of Human Rights, *Kiyutin v. Russia*, (Application no. 2700/10), Judgment 10 March 2011.

³⁰³ The Republic of Turkmenistan, *Law On migration*, Article 15., found in UNODC, Canadian HIV/AIDS Legal Network (2010), *Accessibility of HIV Prevention, Treatment and Care Services for People who Use Drugs and Incarcerated People in Azerbaijan, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan: Legislative and Policy Analysis and Recommendations for Reform* at p. 127.

³⁰⁴ European Centre for Disease Control (2010), *Implementing the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia: 2010 Progress Report*, at p. 2.



13. Access to HIV-Related Legal Services

Access to HIV-related legal services is one effective means of protecting the rights of people living with HIV and other key populations and ensuring better access to HIV services. However, globally only 51% of countries report having legal aid systems for HIV-related cases. Although this represents an increase from 2006, when 33% of countries reported having such systems, the figure has remained the same since 2008. Legal aid systems appear to be more common in high-income countries, with 75% of countries reporting such systems; only 48% of low-income countries and 40% of lower-middle-income countries report having them.³⁰⁵

According to the legislation of the study countries, people with low income have access to free government-provided legal representation in criminal cases. Various legal services for civil law cases exist, mostly provided by NGOs or university legal clinics. In some countries, legal aid bureaus have been funded by international donors. The high level of criminalisation of people who use drugs in the region, as well as frequent police harassment, police arrest quotas and alleged corruption, lead to a situation in which people who use drugs (and other key

An NGO from Azerbaijan reported difficulties finding a lawyer, who is aware of the rights of people living with HIV at the level of local laws, and had even simple, basic knowledge of HIV. It is especially difficult in regions where it is impossible to find legal advice, and in which there is no specialist on issues related to HIV. If this work is pro bono, it is even harder to imagine the effectiveness of such defence. We recognise that non-paid legal services do not always produce expected results.

- *Submission from Rule of Law Development and Democracy, Baku, Azerbaijan*

populations) frequently need legal advice and support. Frequent inability to pay high legal fees further limits access to justice for people living with HIV and vulnerable populations. There is evidence that the high level of stigmatisation and discrimination, as well as lack of independence of the judicial system, causes reluctance on the part of legal professionals to take up such cases, even if key populations at higher risk could afford to hire them.

Another problem is that persons living with HIV and vulnerable groups frequently do not know their rights and do not know where to turn for help if legal advice is necessary. The assessment in Kyrgyzstan found that most women were unaware of their legal rights and 82% did not know it was possible to obtain free legal aid. Only 5% of assessment participants in Kyrgyzstan had accessed free legal support.³⁰⁶

³⁰⁵ UNAIDS, (2010), *Report on the Global AIDS Epidemic*, at p. 129.

³⁰⁶ OSI, (2009), *Women, Harm Reduction and HIV: Key Findings from Azerbaijan, Georgia, Kyrgyzstan, Russia and Ukraine*, at p. 52.

There is no evidence that people living with HIV are guaranteed specialised free government support in order to access justice, such as legal aid services or bureaus. Thus, legal services for people living with HIV and people belonging to higher risk groups is extremely important, and is provided by NGOs in many countries of the region. In Ukraine, NGOs provide free legal advice and representation to people living with HIV and key populations at higher risk (for example, the legal aid service in Nykolayv). In Russia, an internet service providing legal advice and support, as well as forms of documents and samples of petitions and letters has been developed, with funding of the International Harm Reduction Development Programme,

Area of concern

There is an urgent need to expand the provision of free government and non-governmental legal aid services to people living with HIV and key populations at higher risk.



Conclusion

Despite some significant achievements in prevention and treatment of HIV among the general population, there are reasons for serious concern. The HIV epidemic remains on the rise in the region, with Ukraine and Russia having the most severe and rapidly growing HIV epidemics in Europe. Uzbekistan has the largest epidemic in Central Asia and newly-reported cases of HIV infection have increased in other Central Asian countries as well.

Throughout the region of Eastern Europe and Central Asia, the HIV epidemic is spread among key populations at higher risk, whose marginalization and vulnerability to the virus are exacerbated by punitive legal, political and social environments and specifically by laws, policies and practices that criminalise these key populations. As this paper demonstrates, countries in the region have adopted general anti-discrimination and protective laws. Some countries have proclaimed their adherence to harm reduction and protection of vulnerable populations from discrimination. However, specific protective laws aimed at key populations at higher risk are lacking; the implementation of existing policies remains alarmingly low. There is an urgent need to dedicate special attention to the rights of people living with HIV and those most affected by it, so that legislation, policies and practices work for the protection of people and their health, not against it.

Punitive and coercive laws, policies and practices against people who use drugs, sex workers, people with different sexual orientations and gender identities, people in prisons and detention facilities, as well as the general lack of respect to the rights and interests of people living with HIV, present one of the most significant challenges to the effective HIV response in the region. Stigma and discrimination, lack of human rights protection and abusive implementing practices are among the main factors fueling the epidemic. Laws designed to protect these key populations at higher risk are non-existent or lacking, and although general protective laws are applicable, they are rarely enforced. HIV services and harm reduction interventions to these groups as well as the general population remain lacking.

The analysis has identified the following main areas of concern:

1. There exist barriers to access to health care services for persons living with HIV and key populations at higher risk, as well as lack of HIV prevention interventions aimed at vulnerable groups.
2. Coercive involuntary “health care” measures are not justified by public health interests, but push people away from services and contribute to their further marginalization and

stigmatisation. Such measures include involuntary HIV and STI testing, mandatory and compulsory drug dependence and STI treatment, drug user registration and others.

3. There is weak (and unenforced) protection of confidentiality, and consequent frequent breaches of it, leading to devastating consequences for people involved and dissuading them from receiving health care and social services and benefits.
4. Lack of education and training (including sensitivity training) for healthcare workers and law enforcement officials lead to stigmatisation and discrimination of persons living with HIV and key populations at higher risk. The consequences include discrimination and human rights abuses of people who use drugs, MSM, TG, sex workers in healthcare settings and by the police and other law enforcement agencies.
5. Criminalisation continues of key populations at higher risk, such as people who use drugs, sex workers, MSM. People who use drugs are heavily criminalised by punitive and coercive drug laws in the region. This in many respects is the driver of the HIV epidemic. Drug policies need to be reformed if countries are serious about stemming the HIV epidemic.
6. Lack of adequate healthcare services and HIV prevention measures (harm reduction) persists in prisons and detention facilities.
7. Lack of effective drug dependence treatment in many countries of the region persists. Government-provided, free rehabilitation services are frequently unavailable; OST is carried out on a very limited basis and is still unavailable in five countries in the region.
8. Legislative and policy restriction and limitations on human rights of persons living with HIV and key populations at higher risk are recorded throughout the region. Even when human rights laws are protective their implementation frequently leads to human rights violations.
9. The prices of antiretroviral medicines are high in most countries of the region, influenced by factors such as inadequate procurement and supply policies, corruption, but also, and increasingly so, by intellectual property protection provisions that exceed the requirements of WTO law. These provisions hinder the access of generics to the markets. In addition, prices of medicines/consumables for testing and treatment of certain co-infections, in particular Hepatitis C, are prohibitively expensive, and not accessible.

There is an urgent need to change the legislative and policy environment as it relates to HIV and human rights in the region. The application of existing protective laws needs to be extended to persons living with HIV and key populations at higher risk. Laws, policies and practices that create barriers to effective HIV response and contribute to human rights violations and stigmatisation and discrimination of persons living with HIV and key populations at higher risk need to be reviewed and amended.

Countries of the region need to develop a public health oriented approach towards protecting intellectual property rights, which balances between protecting IP and public health obligations. Countries should be mindful of the possible negative aspects of excessive IP protection provisions on access to treatment and essential medicines in general and should integrate the TRIPS Agreement public health flexibilities in their national laws and, if needed, utilize them.

Law enforcement agencies and health care providers need to be educated and trained on non-stigmatizing approach and on human rights in general. Laws that criminalise sex work, drug use and consensual sex among adults of the same sex need to be repealed immediately. Human rights programming needs should be considered and included in all HIV-related interventions and government programmes.

APPENDIX A

A snapshot of selected laws that support or block universal access to HIV prevention, treatment, care and support³⁰⁷

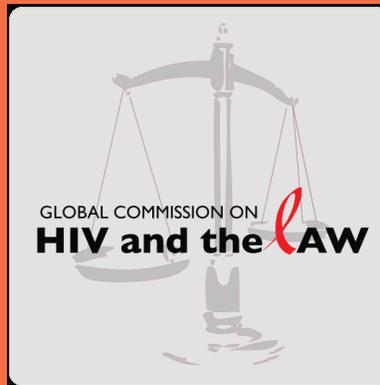
Country	Laws and regulations that protect persons living with HIV against discrimination	Laws, regulations or policies that present obstacles to HIV-related services for key populations	HIV- related restrictions on entry, stay or residence	Laws that specifically criminalize HIV transmission or exposure	Laws that criminalize same sex sexual activities between consenting adults	Laws deeming sex work (prostitution) to be illegal	Laws that impose compulsory treatment of drug dependence
Albania	-	-	No	No	No	Yes	Yes
Armenia	Yes	Yes	Contradictory info (1)	Yes	No	Yes	Yes
Azerbaijan	Yes	Yes	No	Yes	No	Yes	Yes
Belarus	Yes	Yes	Yes	Yes	No (1)	Yes	Yes
Bosnia and Herzegovina	Yes	No	Yes (1)	No	No	Yes	Yes
Croatia	Yes	Yes	No	No	No	Yes	No info

³⁰⁷ The Majority of data for this table is taken from UNAIDS, Making the Law Work for the HIV Response Poster, July 2010. The Poster also contained a column on “Non-Discrimination laws or regulations that specify protection for vulnerable sub-populations”. In this table this column is omitted, due to the fact that our analysis did not find the evidence of the factual existence of non-discrimination laws and regulations protecting key populations at higher risk in the countries that claimed to have them in the UNAIDS poster.

Country	Laws and regulations that protect persons living with HIV against discrimination	Laws, regulations or policies that present obstacles to HIV-related services for key populations	HIV- related restrictions on entry, stay or residence	Laws that specifically criminalize HIV transmission or exposure	Laws that criminalize same sex sexual activities between consenting adults	Laws deeming sex work (prostitution) to be illegal	Laws that impose compulsory treatment of drug dependence
Georgia	Yes	Yes	No	Yes	No	Yes	No info
Kazakhstan	Yes	No	Yes (1)	Yes	No	No	Yes
Kosovo	Yes (1)	Yes (1)	No	No	No	Yes	No info
Kyrgyzstan	Yes	No	Yes (1)	Yes	No	No	Yes (1)
Macedonia	Yes	Yes	No	No	No	Yes	Yes
Moldova	Yes	No	Yes	Yes	No	Yes	No info
Montenegro	Yes	Yes	No	Yes	No	Yes	Yes
Russia	Yes	Yes	Yes	Yes (1)	No	Yes	No outside of prisons (1)
Serbia	Yes	Yes	No	Yes	No	Yes	Yes
Tajikistan	Yes	No	Yes	Yes (1)	No	Yes	No outside of prisons

Country	Laws and regulations that protect persons living with HIV against discrimination	Laws, regulations or policies that present obstacles to HIV-related services for key populations	HIV- related restrictions on entry, stay or residence	Laws that specifically criminalize HIV transmission or exposure	Laws that criminalize same sex sexual activities between consenting adults	Laws deeming sex work (prostitution) to be illegal	Laws that impose compulsory treatment of drug dependence
Turkey	Yes	Yes	No	No	No	No	No info
Turkmenistan	No info	Yes (1)	Yes	Yes	Yes	Yes	Yes (1)
Ukraine	Yes	Yes	No (1)	Yes (1)	No	Yes	No info
Uzbekistan	Yes	Yes (1)	Yes	Yes	Yes	Yes	Yes (1)

15. Information, according to the research conducted for this paper. In these instances, the information differs from the UNAIDS Table. For more details and references see relevant sections of the paper.



“Every day, stigma and discrimination in all their forms bear down on women and men living with HIV, including sex workers, people who use drugs, men who have sex with men, and transgender people. Many individuals most at risk of HIV infection have been left in the shadows and marginalised, rather than being openly and usefully engaged... To halt and reverse the spread [of HIV], we need rational responses which shrug off the yoke of prejudice and stigma. We need responses which are built on the solid foundations of equality and dignity for all, and which protect and promote the rights of those who are living with HIV and those who are typically marginalised.”

-UNDP Administrator Helen Clark



UNDP is the UN’s global development network, advocating for change and connecting countries to knowledge, experience and resources to help people build a better life.

**Global Commission on HIV and the Law in Eastern Europe and Central Asia
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