Report of the
High Income Countries Regional Dialogue of the Global Commission on HIV and the Law

Oakland, United States of America, 16-17 September 2011
Regional Issue Briefs and video of the High Income Countries Regional Dialogue are available on the Commission's website at www.hivlawcommission.org.

Oakland, United States of America, 16-17 September 2011
## Contents

<table>
<thead>
<tr>
<th>Acknowledgements</th>
<th>v</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abbreviations</td>
<td>vi</td>
</tr>
<tr>
<td>1. Introduction</td>
<td>1</td>
</tr>
<tr>
<td>2. HIV, the law and human rights</td>
<td>4</td>
</tr>
<tr>
<td>3. Drug use and the law</td>
<td>6</td>
</tr>
<tr>
<td>3.1 Laws</td>
<td>6</td>
</tr>
<tr>
<td>3.2 Law enforcement and public health impact</td>
<td>8</td>
</tr>
<tr>
<td>3.3 Best practices and recommendations</td>
<td>9</td>
</tr>
<tr>
<td>4. Criminalisation of HIV exposure and transmission</td>
<td>10</td>
</tr>
<tr>
<td>4.1 Laws</td>
<td>10</td>
</tr>
<tr>
<td>4.2 Law enforcement</td>
<td>13</td>
</tr>
<tr>
<td>4.3 Public health impact</td>
<td>14</td>
</tr>
<tr>
<td>4.4 Best practices and recommendations</td>
<td>16</td>
</tr>
<tr>
<td>5. Access to essential medicines and Intellectual Property</td>
<td>18</td>
</tr>
<tr>
<td>5.1 Access to essential medicines</td>
<td>18</td>
</tr>
<tr>
<td>5.2 Intellectual Property laws</td>
<td>19</td>
</tr>
<tr>
<td>5.3 Best practices and recommendations</td>
<td>21</td>
</tr>
<tr>
<td>6. Sex work</td>
<td>22</td>
</tr>
<tr>
<td>6.1 Laws</td>
<td>22</td>
</tr>
<tr>
<td>6.2 Law Enforcement and Public Health Impact</td>
<td>23</td>
</tr>
<tr>
<td>6.3 Best practices and recommendations</td>
<td>26</td>
</tr>
<tr>
<td>7. Men who have sex with men and transgender people</td>
<td>29</td>
</tr>
<tr>
<td>7.1 Laws and law enforcement practices</td>
<td>29</td>
</tr>
<tr>
<td>7.2 Best practices and recommendations</td>
<td>30</td>
</tr>
<tr>
<td>8. Women</td>
<td>32</td>
</tr>
<tr>
<td>8.2 Laws and law enforcement practices</td>
<td>32</td>
</tr>
<tr>
<td>8.3 Best practices and recommendations</td>
<td>33</td>
</tr>
<tr>
<td>9. Children and young people</td>
<td>34</td>
</tr>
<tr>
<td>10. Other Issues</td>
<td>36</td>
</tr>
<tr>
<td>10.1 Race and HIV/ Racial minorities and HIV</td>
<td>36</td>
</tr>
<tr>
<td>10.2 Prisons</td>
<td>37</td>
</tr>
<tr>
<td>10.3 Travel Restrictions and Immigration</td>
<td>38</td>
</tr>
<tr>
<td>10.4 Migrants</td>
<td>39</td>
</tr>
<tr>
<td>10.5 Other areas of discrimination</td>
<td>39</td>
</tr>
<tr>
<td>Conclusion</td>
<td>41</td>
</tr>
<tr>
<td>Annex I Commissioners who attended the HIC Regional Dialogue</td>
<td>42</td>
</tr>
<tr>
<td>Annex II List of civil society participants</td>
<td>43</td>
</tr>
<tr>
<td>Annex III List of government experts</td>
<td>45</td>
</tr>
<tr>
<td>Annex IV List of observers</td>
<td>46</td>
</tr>
<tr>
<td>Annex V Dialogue Advisory Group members</td>
<td>47</td>
</tr>
</tbody>
</table>
Acknowledgements

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<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<td>ART</td>
<td>Antiretroviral Treatment</td>
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<td>EU</td>
<td>European Union</td>
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<td>FTA</td>
<td>Free Trade Agreement</td>
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<td>GFATM</td>
<td>Global Fund for AIDS, Tuberculosis and Malaria</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>IP</td>
<td>Intellectual Property</td>
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<td>LGBT</td>
<td>Lesbian, Gay, Bisexual and Transgender</td>
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<td>MSM</td>
<td>Men who have sex with men</td>
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<td>NSP</td>
<td>Needle and syringe programmes</td>
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<td>OST</td>
<td>Opioid Substitution Therapy</td>
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<td>PEPFAR</td>
<td>Presidents Emergency Plan for AIDS Relief</td>
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<td>TPPA</td>
<td>Trans-Pacific Partnership Agreement</td>
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<td>TRIPS</td>
<td>Trade Related Aspects of Intellectual Property Rights</td>
</tr>
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<td>UN</td>
<td>United Nations</td>
</tr>
<tr>
<td>USA/US</td>
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</tr>
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<td>USD</td>
<td>United States Dollars</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
</tr>
<tr>
<td>WTO</td>
<td>World Trade Organisation</td>
</tr>
</tbody>
</table>
Welcome. I would like to thank you for coming to my congressional district. I really appreciate you all being here. It is very important that we focus and also recognise that here in the United States also we have an HIV and AIDS pandemic that is really high in many communities, especially communities of colour and the African-American community.

Let me introduce my friend Congressman Jim McDermott, who is with us today. He came to the Congress before I did, and for many years he was a lone voice on Capitol Hill on HIV/AIDS issues. Congressman McDermott is a co-chair of the newly formed bi-partisan Congressional Caucus working to strengthen U.S. national and international HIV response. The deliberations and the recommendations from this Dialogue will be taken to inform the caucuses, to try to unravel some of the criminalisation and injustices in our HIV and AIDS legislation. In the past three decades, a lot has taken place in the HIV area in the United States. Now we have our domestic PEPFAR, which is the national HIV and AIDS strategy for the United States, which calls to end criminalisation of HIV transmission and exposure (which is the president’s initiative). We are working on the Bill to end all discrimination against people living with HIV. Current state and federal laws in the United States are behind the medical sciences and advances made in the HIV/AIDS area: 32 states and 2 territories in the U.S. have criminal statutes criminalising perceived exposure to HIV; additionally, prosecutions happened in at least 39 states.

The work of this Commission in the high-income countries such as the United States is extremely important. The critical piece of course is improving the social and political context, so that our efforts are effective and can reach all communities, especially vulnerable communities at most risk. We look forward to the discussion, the dialogue and the debate, and intend to move forward where we as members of Congress have a role in the Commission’s work. We look forward to recommendations of the Commission, so we can get back to Washington to do what we have to do to see justice prevails.”

- From the opening remarks of Commissioner Barbara Lee, US Congresswoman

This report summarises the proceedings and deliberations of the High Income Countries Dialogue of the Global Commission on HIV and the Law (‘the Commission’) held on 16 - 17 September 2011 in Oakland, California, USA. The report also draws from the written submissions that were made to the Commission from civil society and individual stakeholders in the high-income countries.

The Global Commission on HIV and the Law was launched in June 2010 to develop actionable, evidence-informed, and human rights-based recommendations for effective HIV responses that promote and protect the human rights of people living with, and most vulnerable to, HIV. To this end, the Commission focused on some of the most challenging legal and human rights issues in the context of HIV.
The objectives of the Global Commission were to:

- Analyse existing evidence and generate new evidence on rights and law in the context of HIV, and foster public dialogue on the need for rights-based law and policy in the context of HIV;
- Increase awareness amongst key constituencies on issues of rights and law in the context of HIV, and engage with civil society to strengthen their ability to campaign, advocate and lobby; and
- Identify clear and actionable recommendations with a concrete plan for follow-up.

The purpose of the High Income Countries Dialogue was to foster discussion between civil society constituents and government experts and further efforts to improve HIV responses, by addressing key legal barriers and promoting enabling legal environments at national, regional, and international levels. The Dialogue addressed laws, law enforcement practices, policies and access to justice in relation to HIV and related conditions, and public health approaches in this area. It examined the extent to which human rights of people living with HIV and affected groups are protected in the region, and how laws and policies facilitate or impede their access to HIV-related services.

In order to implement its mandate, the Global Commission on HIV and the Law convened seven Regional Dialogues to generate policy debate, with a view to giving a voice to the critical HIV-related human rights and legal issues in regions, and improving HIV responses by strengthening legal environments. Regional Dialogues were held for Asia-Pacific (16-17 February 2011), Caribbean (12-13 April 2011), Eastern Europe and Central Asia (18-19 May 2011), Latin America (26-27 June 2011), Middle East and North Africa (27-29 July 2011), Africa (3-4 August 2011), and High Income Countries (16-17 September 2011). The Dialogues sought to create a space where various stakeholders - individuals affected, scholars, communities, policy and law makers, judges and law enforcers – could learn from each other's experiences and arrive at ways to use the legal framework as a humane tool in the HIV response. The Dialogues presented an opportunity for those profoundly and directly affected by and vulnerable to HIV, including those whose voices are silenced by restrictive legal environments, to be heard. The Commission also learned from policymakers, legislators, judges and law enforcement officials from the regions. The Dialogues encouraged the sharing of positive examples of enabling legal and social environments for people living with HIV and those vulnerable to it, and the enabling of discussions on how the law can be used as a powerful instrument to challenge stigma, promote public health and protect human rights.

Three Commissioners of the Global Commission participated in the High Income Countries Regional Dialogue: Commissioners Barbara Lee, JVR Prasada Rao and Stephen Lewis. Mandeep Dhaliwal, Vivek Divan and Sofia Gruskin were members of the Technical Advisory Group who were present at the dialogue.

The experiences and knowledge shared at the Regional Dialogue helped to shape the Commission’s thinking and recommendations, and inform the Commission’s Final Report.

Focus and scope of the Regional Dialogue

The Regional Dialogue was informed by written and video submissions received prior to the Dialogue. Civil society organisations and affected individuals were invited to make submissions in relation to the following areas:

1. Laws and practices that effectively criminalise people living with, and vulnerable to, HIV;
2. Laws and practices that mitigate or sustain violence and discrimination as lived by women;
3. Laws and practices that facilitate or impede HIV-related treatment access; and
4. Issues of law and HIV pertaining to children.

The Commission's work was also informed by four Regional Issue Briefs with specific focuses on High Income countries.

Countries included in the Dialogue were: Austria, Belgium, Canada, Denmark, Finland, France, Germany, Greece, Ireland, Iceland, Israel, Italy, Netherlands, Norway, Portugal, Spain, Sweden, Switzerland, United
Kingdom of Great Britain and Northern Ireland, and the United States of America.

**How the Regional Dialogue was conducted**

The High Income Countries Dialogue was moderated by Nisha Pillai. It was preceded by the civil society and government preparatory meeting on 16 September 2011, where civil society groups and government representatives met separately with Commissioners, the Commission Secretariat, the moderator and others, to assess their expectations for the Dialogue, provide background on the process being undertaken by the Global Commission on HIV and the Law, and to prepare to effectively interact with each other in a constructive and meaningful way on the following day.

The Regional Dialogue was conducted in the style of a moderated ‘town hall’ meeting. A list of the participants in the Regional Dialogue is provided in Annexes I through IV.

The Dialogue started with the moderator providing a brief introduction and welcoming the participants. Jeffrey O’Malley, Director of UNDP’s HIV Practice at the Bureau for Development Policy, New York, provided welcoming comments and updates regarding the work of the Commission. Commissioner Barbara Lee welcomed participants to Oakland and the USA, and provided observations on the importance of the Commission’s work to high-income countries, and the U.S. in particular. She discussed the seriousness of the HIV epidemic among certain communities in the US. Thereafter, the moderator asked regional experts, civil society groups and affected populations to provide context on HIV and the law in the region.

Civil society participants in the Regional Dialogue were selected on the basis of written submissions made to the Commission based on a prior call put out by the Commission Secretariat. Additionally, other participants were invited based on suggestions made by a Dialogue Advisory Group. A list of the Dialogue Advisory Group members is also available in Annex IV.
The dialogue opened with the discussion on the link between HIV, the law and human rights, and the role law and human rights have to play in effective HIV responses.

The participants remarked that issues of HIV and the law are globally important and that the creation of enabling and responsive legal and policy environments remains paramount, even in high-income countries participating in the Dialogue. As elsewhere in the world, legal and policy frameworks in the high income countries may play positive or negative roles in achieving public health goals, and in protecting of the rights of people living with HIV and key populations at higher risk.

The law can be used in different ways: it can facilitate public health responses, or impede them. The law can be used to challenge outdated and discriminatory practices which take root in tradition and habit, but which are counterproductive for an effective HIV response. There are countless examples and evidence of how HIV and the law come together. Laws have a remarkable impact on whether HIV is transmitted or treated, and HIV has driven legal reform in a wide range of areas, both regressive and progressive.1

It has long since been acknowledged that there is an association between law, human rights and the HIV/AIDS epidemic. Now that the science, technological practices for delivering services, and overall funding for HIV/AIDS programmes exist, society is better placed to respond to the epidemic. However, there are also dangers - financial resources are drying out and there is fatigue, not only among donors, but also among people who are at risk. The advantage of the advances that have been made is under threat and progress achieved in recent years is in danger of regressing rapidly. Without continued funding, individuals currently receiving treatment may face the elimination of necessary medical services and programmes. The urgent need to develop a sustainable and targeted HIV response requires an examination of legal environments and human rights protections. By focusing on making astute legal changes, governments can achieve a more sustainable and effective response. The right laws will make programmes more effective; the wrong laws will waste scarce resources and encourage retrograde measures.2

HIV is not evenly distributed across the globe, as racial and ethnic minorities, vulnerable groups and marginalised populations bear disproportionately higher burdens, for a number of reasons linked to stigma and discrimination. HIV in high-income countries is unfortunately the infliction of the poor and marginalised. The participants noted the important role that stigma continues to play in the response to HIV in the legal field - in terms of which laws are passed, how laws are informed, and how they are implemented. Stigma in relation to HIV is exacerbated by a moral component, which is hardest to combat. The law can and should be used as a shield, to protect vulnerable people, persons living with HIV, men who have sex with men (MSM), sex workers, people who use drugs, and others.3

1 Sandra Chu, Canadian HIV/AIDS Legal Network, Canada.
2 Jeffrey O’Malley, Director, HIV Practice, Bureau for Development Policy, UNDP
3 Edwin Bernard, HIV Policy Consultant, Germany
The linkages between HIV and the law are evident in three remarkable recent cases before Canadian courts. In *R. v. D.C. / R. v. Mabior*, the Supreme Court of Canada will soon grapple with how to delineate the criminal liability of those who have sex without disclosing their HIV-positive status to their partners, a question that has not been before this Court since 1998, when the science concerning viral load was not available, and the question of condom use was not posed.

In *Canada (Attorney General) v. PHS Community Services* (2011) the Supreme Court of Canada dealt with the constitutionality of a supervised injection site in Vancouver, British Columbia. It acknowledged the HIV and hepatitis C epidemics in the Downtown Eastside (where the supervised injection site is located) and noted the evidence demonstrating that the facility reduced the sharing of used injection equipment, before ultimately deciding that the site saved lives and should be permitted to continue to operate.

Finally, in the 2010 in the Ontario Superior Court of Justice decision *Bedford v. Canada*, a trial judge struck down three provisions of Canada’s *Criminal Code* related to sex work after finding those provisions to be unconstitutional. While HIV was not a primary consideration before the trial court, research has demonstrated the impact the criminalization of sex work has had on the health of sex workers, which includes making it harder for sex workers and their clients to negotiate safer sex and protect themselves. The hotly contested case, which was before the province’s appellate court in 2011, will likely advance to the Supreme Court of Canada.

*Sandra Chu, Canadian HIV/AIDS Legal Network*
Discussion of issues related to drug use and the law, and their intersection with the HIV epidemic, began with an overview of the laws that currently relate to drug use. Many countries participating in the Dialogue respond to drug use by adopting laws that criminalise possession of small amounts of drugs, and possession of drug use paraphernalia. As the discussion revealed, these measures never lead to the desired result of stopping drug use, but instead severely inhibit effective HIV responses.

3.1. Laws

Participants described the legal and policy framework in North America and Europe. They discussed how drug laws impede harm reduction and HIV prevention, and detailed the impact of these policies on the HIV epidemic. Many participants talked about the devastating effect that the “war on drugs” has had on the HIV response and the lives and health of people who use drugs, not only in the US, but in all countries included within the scope of the Dialogue. In most of these contexts, governments choose to stigmatise and criminalise people who use drugs, who consequently face extreme health and economic outcomes. The increased HIV burden is one of the most significant outcomes, but not the only result of the war on drugs.

1) In the USA, where drug laws are enacted by the states, the situation differs with regards to actual law and policy, but in general the approach to drugs and drug users in the entire country is punitive. Robert Childs, from the North Carolina Harm Reduction Coalition, talked about the restrictive legal and policy environment in his state. North Carolina has laws that criminalise the possession of drug paraphernalia (such as injecting equipment and crack pipes) and institute criminal liability for the possession of small amounts of drugs or other drug related offences - sending many people to prison. The restrictive paraphernalia laws prevent access to harm reduction measures, such as needle and syringe programmes (NSP) and the distribution and exchange of crack smoking pipes. This makes harm reduction efforts in North Carolina de facto illegal - five people were recently arrested for harm reduction activities. In Louisiana, drug paraphernalia laws make it a crime to possess or use a syringe for the injection of

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4 Please note that in reference to ‘Europe’ this report refers to high-income countries that were included for discussion at this Dialogue. They are listed in the Introduction.
5 Laura Thomas, San Francisco Drug Policy Alliance, USA
6 North Carolina’s drug paraphernalia laws (NC Rev. Statute 90.113.20) make it a crime to possess or use a syringe for injection of controlled substances; syringes with drug residue may be used as evidence of a crime. These laws limit the expansion of needle and syringe exchange programmes (NSP) throughout the state, despite well-established evidence that access to sterile syringes reduces HIV transmission among injecting drug users. Despite the federal ban on funding NSPs being lifted in 2009, North Carolina is unable to apply for federal funding that would permit expansion of these programmes. See the submission of the North Carolina Harm Reduction Coalition, USA.
7 There is evidence that a big proportion of people living with HIV in the U.S. (up to 25%) acquired HIV because of a lack of syringes. The lack of pipes for cocaine inhalation is also a big issue - in North Carolina there is 1 pipe for 50 people who share it. Robert Childs, North Carolina Harm Reduction Coalition, USA.
controlled substances; syringes with drug residue may be used as evidence of a crime. In California, there is also no legal access to sterile syringes and other drug paraphernalia. Participants from the US explained that these are often political decisions, as local politicians believe in the outdated notion that giving people syringes encourages drug injecting behaviour.8

2) In Canada, there has been a lot of recent debate about drugs and drug use. For several years, the government had been trying to close Insite, the supervised injection site located in the province of British Columbia (BC). Insite is unique in that it is the only supervised injection site in North America, and, as such, is one of the most reviewed medical interventions in this sphere. It has been reviewed in medical journals on numerous occasions, its effectiveness evaluated, assessed and proven. It has been found that this intervention is successful in lowering syringe sharing, without leading to negative consequences. An official from the BC Ministry of Health has acknowledged that Insite is an evidence-based health service, which is meeting the needs of marginalised people.9 In Canada, provinces are responsible for the delivery of public health legislation and services under constitutional mandate. In recognition of these facts, in 2011 the Supreme Court of Canada decided to uphold the decision of the Provincial Court of BC, allowing Insite to continue operating under exemption from the federal drug laws.10

3) In Europe there are several negative and positive examples of harm reduction, but generally laws and policies tend to enable effective HIV responses. Many interventions have been developed in response to HIV and drug use. For example, supervised injection facilities exist in 60 cities across Europe; several countries have heroin prescriptions for people who are dependent on drugs; and all countries have NSP and opioid substitution treatments (OST). However, the US and Europe continue to struggle with making political and legal environments more supportive of harm reduction interventions, and adopting a public health approach to drugs and drug use.11 Portugal, which underwent a dramatic change in drug law and policy through de facto decriminalisation of drugs and drug use in 2001, is a truly positive example. The change involved not only decriminalisation of drug use and possession of small amounts for personal consumption per se, but an overall shift towards the public health approach. There were fears in Portugal about the possible effects of this shift, all of which have proven to be incorrect. The situation currently is as follows: if a person is caught in possession of illicit drugs, this person is referred to the Dissuasion Commission. If a person has a drug dependence problem, he/she is sent for drug dependence treatment. The impact has been very positive - although the overall consumption of drugs has risen following an all-European trend, problematic drug use has fallen, as has school drug use. In terms of public health and HIV, there have been additional positive developments - HIV among people who inject drugs has fallen, along with the overall number of drug-related deaths.

On decriminalisation: Participants debated the idea of decriminalising drugs. Many participants emphasised that a shift from criminalisation to a public health approach was necessary to effectively respond to HIV in relation to people who use drugs.

A representative from the Transform Drug Policy Foundation pointed toward a disconnect, possibly rooted in ideological differences, in relation to harm reduction measures in Europe - there are supportive harm reduction policies and practices on the one hand, yet the majority of the region also preserves punitive law and policy, thus creating a position of tension. As the response to drug use and people who use drugs remains situated within the punitive criminal justice policy framework, it often creates various risks and harms surrounding both HIV and drug use generally. This framework stigmatises and marginalises key populations at higher risk, encourages various risk taking behaviours such as syringe sharing, and pushes people into unhygienic environments. Decriminalisation in this context means moving from criminal to administrative or civil law sanctions, i.e. fines, removal of passports, suspension of driving licences, and referral to voluntary

8 Laura Thomas, San Francisco Drug Policy Alliance, USA.
9 Warren O’Briain, Communicable Disease, Harm Reduction and Mental Health Promotion, British Columbia Ministry of Health, Canada.
10 Ibid.
11 Steve Rolles, Transform Drug Policy Foundation, UK
drug dependence treatment. Congressman Jim McDermott from the US reflected that in thinking about drug control and drug prohibition, there is a need to think about the cost, cost-effectiveness and efficacy of these interventions. What are we getting from the war on drugs? Does it protect society? Are the funds spent on it worth it? What is the public benefit from it? All the available evidence points to a clear path ahead that turns from ‘the war on drugs’ to drug use as a public health issue. However, changing the law and the entire paradigm is difficult in any country, especially in the USA. Working on law reform at the federal level is difficult. An economic argument may be a sound one if one wants to change policy i.e. asking voters if they want to spend money on jails; inquiring whether it would be better if significant expenses were incurred on education rather than on correctional facilities.

3.2. Law enforcement and public health impact

Restrictive laws regarding possession of small amounts of illicit drugs, and laws against possession of drug paraphernalia in the majority of high income countries, result in high de facto criminalisation of people who use drugs, depriving them of life-saving services, and access to essential human rights, such as the right to health. The impact of these laws on broader public health is just as devastating.

A punitive legal environment, where people may get arrested and convicted for very small amounts of drugs, leads to the US having the highest incarceration rate in the world, with a large amount of associated negative consequences. According to participants, there is plenty of evidence of the devastating effect that incarceration has on people, including the fact that many people end up using drugs when they are incarcerated. The prison system in the US is overcrowded, and instead of spending money on pre-release rehabilitation and reintegration programmes for ex-prisoners, the government tends to build more prisons, using limited tax payer resources that could be spent more efficiently. When people are finally released from prisons, their human rights are severely affected as a result of incarceration - they do not get social assistance such as food stamps, they lose their right to vote, and they may have trouble finding housing or employment, especially if they use drugs. As one participant mentioned, with the change of the paradigm and the end of the war on drugs, not only will the costs of the prison system be reduced, but the cost of health care emergency services will also decrease.

A participant from North Carolina mentioned that, although this state permitted pharmacists to sell syringes, it also allowed the pharmacists’ discretion in the transaction. Thus, many people who use drugs are rejected when they try to purchase clean needles. Also, African-Americans are less likely than white people to be sold syringes at commercial pharmacies. These policies deny equitable access of life-saving materials to the very persons who need them the most, thereby exacerbating their risk of acquiring HIV.

Many people living with HIV in the US also experience problems with drug dependence and are not getting the requisite treatment. Legal barriers make it difficult for people with low incomes who are drug dependent to access affordable and evidence-based drug dependence treatment services. Overdose is prevalent, but naloxone, the life-saving medicine administered in case of overdose, is not widely available. Also, because people who seek treatment in case of overdose may get arrested for drug-related offences, they avoid seeking medical help.

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12 Steve Rolles, Transform Drug Policy Foundation, UK
13 Cecilia Chung, San Francisco (CA), USA.
14 Robert Childs, North Carolina Harm Reduction Coalition, USA.
15 While Medicaid in North Carolina covers some drug dependence treatment, eligibility is very limited, as non-elderly, non-disabled adults without children are excluded from Medicaid coverage. For working parents and their children to be eligible for Medicaid, annual family income must be no more than 49% of the federal poverty level, or $8,971.90 for a family a three. This leaves many people in North Carolina, where one out of six residents live below the federal poverty level, without access to drug treatment. Because many community mental health centers do not take clients who are uninsured, many people are unable to access drug treatment in the state, thus leaving them vulnerable to acquiring HIV or the inability to manage the disease if they are already infected. From the submission of Robert Childs, North Carolina Harm Reduction Coalition, USA.
3.3. Best practices and recommendations

The following is the summary of recommendations and suggestions expressed by participants, and in the submissions received by the Commission:

1) Decriminalisation of possession of small amounts of illicit drugs for personal consumption was the most frequently suggested reform, that all participants felt is urgently needed in high income countries.

2) Several participants felt that there is an urgent need for a paradigm shift, rejecting the failed ‘war on drugs’ approach, which is not only ineffective, but actively harmful, and moving towards a public health and human rights-based approach. There is a need to have the courage to go beyond moral positions and get away from politics, and look at the science, follow the evidence, and challenge taboos; there is a need to expand safer injection rooms and heroin prescription, NSP, and OST, including in prisons.16

3) Racial disparities in arrest, sentencing and incarceration need to be addressed, as well as the underlying historic and societal reasons for them.17

16 Steve Rolles, Transform Drug Policy Foundation, UK
17 Deon Haywood, Women with a Vision, USA
"[One] should not say that an act offends the common consciousness because it is criminal, but that it is criminal because it offends that consciousness. We do not condemn it because it is a crime, but it is a crime because we condemn it."

- Emile Durkheim

The issue of criminalisation of HIV non-disclosure, exposure and transmission was among the most actively discussed topics during the Dialogue, reflecting the large number of submissions that the Commission received on this issue for the High Income Countries Dialogue. Indeed, there have been a number of prosecutions for HIV non-disclosure, exposure and transmission in many parts of the high-income world, more so than in all other regions of the world. For example, in Africa, where the burden of HIV is much higher, the number of prosecutions directed at people living with HIV is insignificant.

Participants discussed the reasons for this disproportionate number. They noted many problems with the laws and prosecutions related to HIV non-disclosure, exposure and transmission: arbitrariness of prosecutions, the low or non-existing level of risk, the low standard of proof, essential components, such as intent, being disregarded, and very lengthy sentences which are at odds with sentences for other offences.

4.1. Laws

Participants described their country’s laws and policies in relation to HIV non-disclosure, exposure and transmission. In the UK, for example, there are two jurisdictions. England and Wales use Victorian general assault laws to prosecute transmission only. Scotland prosecutes for both transmission and exposure under general laws. In Sweden, a general criminal law is also used, as there are no specific HIV laws. There is also the Communicable Diseases Law, which obliges everyone to disclose a communicable disease, the definition of which includes HIV. Intent or factual transmission is of no relevance. In Sweden, a notorious example includes the case of an HIV-positive mother giving birth to two children and not disclosing her status at the hospital. There was no transmission to the children, and despite the fact that she had been on medication, and there was no actual risk to the children because of her low viral load, she was charged with non-disclosure years after giving birth, and sentenced to 2.5 years for putting her children at risk of HIV.

In Austria, laws criminalising bodily harm are used, as well as the Law on Communicable Diseases. The application of this law differs from the application of provisions on causing bodily harm, as transmission is not necessary. Mere exposure is sufficient, as the law criminalises “creating danger to transmit,” and protects
“public health” in general rather than the health of another individual person. In fact, both parties are guilty, because they are considered to be endangering public health. Therefore, consent to sexual intercourse is not a defence, and disclosure of one’s status is not enough.21

Canada, with a total of 130 people charged for not disclosing their HIV-positive status to sexual partners, is considered one of the leaders in prosecuting persons living with HIV. There are no specific HIV-related crimes in the Criminal Code. Existing Criminal Code offences of sexual assault or aggravated sexual assault are applied, and recently Canada has been using more and more serious provisions to prosecute HIV non-disclosure, exposure and transmission. A charge of aggravated sexual assault carries a maximum penalty of life imprisonment, and conditional sentencing is not an option. Some people have been charged and/or convicted for having protected or oral sex alone. In 2009, a person living with HIV was convicted for the first time in Canada (and possibly the world) of first-degree murder for not disclosing his HIV status before having unprotected sex. In August 2011, he became the first person in Canada declared a “dangerous offender” for conduct related to HIV non-disclosure. On a more positive note, two recent decisions by the Courts of Appeal of Manitoba and Quebec ruled that when a condom is used or when a person has an undetectable viral load, there is no significant risk of transmission, and thus no duty to disclose should be required. The Supreme Court of Canada is scheduled to hear the prosecution’s appeal in at least one (and perhaps both) of these cases in 2012.22

The following are examples of disproportionate state reaction to a risk of HIV exposure and transmission in the United States:

- A Texas man is serving a thirty-five-year sentence for spitting at a police officer while having HIV; an activity that medical experts agree is not a method of HIV transmission.
- In Oregon, a 23-year-old man was sentenced to over seven years in prison after pleading guilty to unprotected sex without disclosure of his HIV status to a man he met on Manhunt.com.
- A man in Ohio is serving forty years for failing to disclose to his girlfriend that he was HIV-positive, despite his contention that she knew he was positive and only went to the prosecutor after he stopped dating her and moved in with another woman.
- In April 2009, a young gay man in Iowa was sentenced to twenty-five years in prison after he failed to disclose his HIV status to a one-time sexual partner he met online, despite using a condom during sex. Though his sentence was later reduced to probation, the requirement that he complete a sex offender treatment program and register as a sex offender severely restricted his activities and prevented him from spending unsupervised time with his niece and nephew – even though his purported crime involved consensual sex with another adult.
- In Georgia, a woman was sentenced to eight years in prison, despite publication of her HIV status on the front page of the newspaper and the testimony of two individuals that her sexual partner was aware of her HIV status.
- In Michigan, a man, who allegedly had HIV, was charged under the bioterrorism law because he was involved in an altercation with his neighbor during which biting occurred, under the theory that having HIV is the same as possession of a biological weapon.

From the submission of Scott A. Schoettes, Lambda Legal Defense & Education Fund, USA

In the US, where the legislative subject in question is within the authority of the states, there are a large number of different laws and approaches. Thirty-four US states and two territories have HIV-specific criminal laws. Many of those without HIV-specific laws use felony offences such as aggravated assault, reckless

21 Helmut Graupner, Attorney, Expert on Criminal Law linked to Department of Justice, Austria
22 From the submission of the Canadian HIV/AIDS Legal Network, Canada
endangerment and attempted murder to prosecute people accused of sex without prior disclosure of HIV status, or in some cases, for hurling saliva at a law enforcement officer. The new National HIV Prevention Strategy discourages states from adopting laws criminalising HIV transmission but it does not call directly for their repeal.23

Lambda Legal Defense & Education Fund prepared a snapshot of criminalising HIV laws in the US, which showed that 26 states have HIV-specific criminal law. Six states have no specific laws, but have HIV-specific prosecutions under general criminal laws. An additional seven states have HIV-specific statutes, but there have been no HIV-specific prosecutions. In the rest of the states, the available information showed that there are no HIV-specific criminal laws, and there have been no prosecutions under general criminal laws.24 Prosecutions for HIV exposure and transmission have been recorded in 32 states to date.25

According to the Center for HIV Law and Policy/ Positive Justice Project, USA, it is not intentional transmission but intentional sex while HIV-positive that is the focus of these state laws. The common denominator is that the person being charged knows that s/he is HIV-positive. Actual transmission is rarely necessary for being charged, and frequently does not even occur. Exposure without disclosure is enough to become a convicted felon or designated sex offender, barred from unsupervised contact, even with young relatives. Over just the last 2.5 years, at least 120 Americans have found themselves behind bars and/or on sex offender registries because of these laws. It appears that relationship break-ups account for some of the accusations and charges of HIV non-disclosure and exposure. There has been no comparable criminal law response to that afforded to HIV.26

As the Lambda Legal Defense & Education Fund noted, HIV criminalisation laws in the US are not uniform, although there are a few things that are generally true about them:27

1) The requirement of intent has been lost. Many of these laws were supposedly created to provide a way to prosecute people for intentionally transmitting - or attempting to transmit - HIV, but proof of intent is not required during prosecutions.

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

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

4) Finally, many of these laws do not make using protection, such as a condom, a defence. So the very behaviour that should be encouraged for everyone – safer sex – is not even mentioned, much less encouraged, by these laws. Instead, the message being sent is that a person can rely on their partner to reveal his or her HIV status, and that decisions about engaging in sexual contact and/or using safer sex practices can be based on whether that person's partner tells him or her that he or she has HIV.28

It was noted that unfortunately this trend of criminalisation is being imported to other regions and countries of the world. The replication of repressive laws related to HIV non-disclosure, exposure and transmission has happened in the last five years. In 2005, none of the heavily affected countries in Africa had similar laws, and now more than 16 countries do.

23 From the submission of Anna Forbes, Sex Workers Project, Urban Justice Coalition, USA
24 Scott Schoettes, Lambda Legal Defense & Education Fund, USA, see http://www.lambdalegal.org/publications/fs_hiv-criminalization
25 Ibid.
26 Catherine Hanssens, Executive Director, The Center for HIV Law and Policy/Positive Justice Project, USA
27 Scott A. Schoettes, Lambda Legal Defense & Education Fund, USA
28 Ibid.
4.2. Law enforcement

During the Dialogue, it was noted that high levels of arbitrariness, stigma and prejudice informed the laying of charges, prosecutions and sentencing for HIV non-disclosure, exposure and transmission. The fact that socially marginalized persons or people with few resources are prosecuted most often reflects the disproportionate effect of the wider epidemiology of HIV on poorer people. This marginalisation is further accentuated due to the absence of access to quality legal aid, which prevents people who are already stigmatised from obtaining full access to justice.

Criminalising the transmission of HIV harms already marginalised communities facing heightened risk of HIV infection - including migrants, women, MSM, sex workers and people who use drugs. In the UK, prosecutions reaching court are disproportionately of migrant heterosexual men. Only two women have been successfully convicted; and despite over two thirds of transmissions in the UK being between MSM, only one gay man has been successfully convicted. In all there have been thirteen convictions in eighteen individual cases (two men were prosecuted more than once due to appeals). Migrant heterosexual men are the least likely to test and the most likely to be diagnosed late, yet they are the most prosecuted.29

A sex workers project in New York City noted that laws criminalising HIV exposure and transmission are often applied selectively against sex workers. Fifteen states in the US have special laws that designate prostitution as an aggravating feature in sentencing. In 2010, the new law in Tennessee created a felony aggravated prostitution charge if an HIV-positive person engaged in sex work. The actual act of HIV transmission is not a requirement for a sex worker to be guilty of an offence, which is punishable by three to 15 years in prison. According to reports, thirty-nine women have already been convicted. Laws like this interact with laws in 20 US states that require mandatory HIV testing. When mandatory or compulsory testing is performed, as a rule, there is no counseling or confidentiality, and results may be released without consent to public offices and the general public.30

Another feature of HIV-related prosecutions in the US and in Europe is the disproportionate application of the law. People with HIV are singled out, and the consequences are harsh and greater as compared to other types offences or harm. Catherine Hanssens, from the Center for HIV Law and Policy, presented a comparison of sentences in cases of HIV non-disclosure versus other offences. In California, a sentence for homicide was half of what was seen for convictions related to HIV exposure, even if there was no actual transmission or risk of transmission.31 For example, almost 40% of fatal traffic crashes are attributable to alcohol impairment, yet a number of state laws impose far less severe penalties than those imposed for risk of HIV transmission. A first-time “driving under influence” offence in Illinois is a misdemeanor, with a jail sentence of no more than a year and a fine of up to USD 2,500. But for a first-time offender under the Illinois criminal HIV exposure statute, conviction is a felony, with a sentence of three to seven years and a fine of up to USD 25,000. Even more alarming, in a number of states, exposing someone to HIV through consensual sex or other means can produce a far more severe punishment than killing someone with a car. In Oklahoma, the maximum sentence for HIV exposure is five times that of vehicular homicide (five years versus one year), and two times as severe in California (eight years versus four). In Arkansas, if one kills one's partner with a car, one can get up to five years in prison; if one is HIV-positive and inserts one's finger or any object into one's partner's genital area, one can get up to 30 years. In Ohio, the typical sentence for vehicular homicide is six months imprisonment; yet a man who allegedly failed to disclose his HIV status to his partner was convicted as a sex offender and sentenced to 16 years in prison.32

In HIV-related prosecutions, actual transmission is very rarely a factor. Prosecutions do not take into account the actual risk either.33 In Canada, a woman was prosecuted for not disclosing her status in the case of a one-off sexual encounter. She insisted on using a condom, which broke, after which she told her partner that she was HIV-positive. The police released her name and picture, warning the public that she frequented

29  From the submission of Terrence Higgins Trust, UK
30  Sienna Baskin, Sex Workers Project, Urban Justice Coalition, USA
31  Catherine Hanssens, The Center for HIV Law and Policy, USA
32  Ibid.
33  Sean Strub, Global Network of People Living with HIV (GNP+), USA
bars to find men, thus indicating that equal standards of privacy are not applicable to people living with HIV. She was first charged with assault (general provision), which was then altered to aggravated sexual assault, a provision that exists to prosecute forced sex that endangers a complainant’s life. Even rape cases are not considered to be aggravated sexual assault, but as per the law, life is even more endangered if there is ‘significant risk’ of transmission HIV.34

In Canada and the US, if a person is convicted of HIV non-disclosure, exposure or transmission, he or she becomes registered as a sexual offender, along with people convicted of rape and child molestation. In the US, being put on a sex offender registry means that postcards will be sent to people in the neighbourhood, photographs printed in local papers, and notes posted in schools. This leads to a host of other negative consequences, including grave violations of privacy, potential difficulties in finding housing, possible discrimination in employment, and in many other spheres. Several participants thought that these laws had become proxies for homophobia and a form of creating a viral underclass through legislation.35

4.3. Public health impact

Many participants shared their understanding, vision and experiences with the very drastic impact criminalisation has on every person living with HIV. As described above, punitive laws and their implementation not only have devastating effects for individuals, but they also have negative consequences for public health goals.

The most significant consequence of criminalisation is that it drives the epidemic and leads to more HIV infections. It was pointed out that criminalisation of non-disclosure, exposure and transmission is a significant factor in enhancing HIV-related stigma. External stigma, misconceptions, and internalised stigma are all exacerbated by criminalisation (particularly through media coverage), and all serve to discourage disclosure. This in turn makes individuals more vulnerable to prosecution, trapping them in a vicious cycle of secrecy and fear. Prosecutions dissuade people from getting treatment or testing, and if people do not know their HIV-positive status, they cannot be held accountable for HIV non-disclosure. Knowledge becomes crime - the situation ‘take the test and face arrest’ becomes a tremendous barrier to getting health care.36 It was said that the criminal law erased and eroded a significant amount of work that HIV activists have managed to achieve in changing people’s perceptions of HIV.37

Criminalisation fails to take into account the external and internal barriers to disclosure, as well as the shared responsibility for consensual sex. It puts responsibility solely on persons living with HIV, and is detrimental to the general public, as people expect their partners, persons living with HIV, to disclose. It creates a false sense of security, and puts the responsibility for HIV transmission on someone who is already a member of the underclass, feeling marginalised and disadvantaged.38 As participants underlined, promoting safer sex choices for everyone, whether positive or negative, would have a far more significant impact on the reduction of HIV transmission than attempts to criminalise the virus.39

According to a participant from Sweden, the impact of criminalisation in the country is huge: people must disclose their status in health care facilities, which makes many people avoid going to health professionals because of fear of disclosure of their status, especially if they live in smaller communities. The fact that every sexual experience has to be preceded by disclosure impacts the health of persons living with HIV: people get depressed, cannot take responsibility, and feel isolated. Talking about one’s status is hard because people are afraid of the loss of confidentiality, rejection, ostracism, and discrimination.

As Brook Kelly from the US Positive Women’s Network underlined, incarceration as a result of prosecution for

34 Stéphanie Clavaz-Loranger, COCQ-SIDA, Canada
35 Sean Strub, Global Network of People Living with HIV (GNP+), USA
36 Ibid.
37 Richard Wilson, Vice-chair, American Bar Association AIDS Coordinating Committee
38 Kevin Peter Osborne, International Planned Parenthood Federation, UK
39 From the submission of Kevin Peter Osborne, International Planned Parenthood Federation, UK. See also submission of Vanessa Johnson, National Association of People with AIDS (NAPWA), USA
exposure and transmission is the worst thing that can happen to persons living with HIV. Health care in US prisons is poor. When people are released, if they were getting health care from the government, this health care may not be re-instated. People are left without medical care, and are therefore more likely to transmit, creating a vicious cycle. Their access to housing, food, other social assistance, and voting rights, are all most likely to be impacted as a result of incarceration.40

The deportation of foreigners is another result of these prosecutions. In Canada, a lot of criminal cases for HIV non-disclosure are against immigrants. As a result, there is a danger that people may be sent back to their countries of origin, the impact of which is very serious, especially in countries where HIV is endemic, and care and treatment is not available.41

Criminalisation of HIV non-disclosure has a devastating impact on children that were born with HIV. In countries where there is no comprehensive sex education in schools, criminalisation of HIV may have an especially strong impact on the developing sexuality of these youth. They may feel that they are responsible for other young people’s behaviours; the burden of responsibility on them is huge, having a crippling effect on their sexuality.42 Additionally, for people who are prosecuted and have children, it is very difficult to regain custody of the children.

Criminalisation has an impact on sex workers as well. In some countries in Europe, where sex work is legal, there are practices of mandatory HIV and sexually transmitted infections testing. As a participant observed, the exclusion of HIV-positive individuals serves to enable clients to practice unsafe sex.43

With such huge amounts of prosecutions for non-disclosure of HIV status, the participants felt that it was important to discuss what disclosure is and how to prove it. As Stéphanie Claivaz-Loranger of COCQ-SIDA from Canada pointed out, surveys of people living with HIV showed that a significant number of people living with HIV encountered a situation where they thought that they disclosed, but their partners later claimed that they did not understand their disclosure. This fact makes many people interested in the ways to prove disclosure. COCQ-SIDA was even asked to draft a sample contract that people living with HIV may ask their partners to sign and to use as proof of disclosure. The organisation decided not to do it, in order to avoid the situation where signing a contract with every partner becomes an accepted standard practice.44 In this context it was also pointed out that many revenge cases against persons living with HIV result from the break-up of relationships.

It has been suggested that one of the reasons for this disproportionate response to HIV is that the criminal justice system, media and health sector are misinformed about risks, responsibility and consequences for non-disclosure and exposure. Risk of HIV transmission in reality is much lower than people perceive, even in the absence of condoms and treatment. It is also known that the large majority of HIV cases are of people who are undiagnosed. Media reporting only feeds the perceptions of the public. It is often sensationalised and inaccurate, making it very hard to find an article that talks about HIV in an objective way, where the issue is contextualised, nuanced and explanations are given as to why it is hard to prove non-disclosure.45 Physicians, health officials, media workers and, most importantly, those working in the criminal justice system, need to be better informed. Regular general criminal law, where one individual attempts to harm another, should be sufficient to tackle the issue of HIV transmission.

The problems in changing the law were discussed by government experts present at the Dialogue. From the point of view of the progressive politician, this is a difficult issue to gain traction on, as it is not popular with the general public, who may be misinformed about the risks and realities of HIV transmission,. Often, politicians cannot take initiative unless their constituency insists on it. For example, US lawmakers have been trying to legislate condom distribution in federal prisons, but have had limited success, as there is no impetus from the members of the public. Education, outreach to media and public information campaigns are vital.

40  Brook Kelly, US Positive Women’s Network, USA
41  Paul Adomako, African Black Diaspora Global Network, Canada
42  Emily Hamblin, National Children’s Bureau, UK
43  Thierry Schaffauser, Network of Sex Worker Projects, UK
44  Stéphanie Claivaz-Loranger, COCQ-SIDA, Canada
45  Edwin Bernard, HIV Policy Consultant, Germany
first steps in changing people’s attitudes, and judges, lawyers and public prosecutors should all be actively involved in the discussion. It will take time for change to occur, but there are positive examples to show that it is possible.

4.4. Best practices and recommendations

Participants from the UK talked about the importance of Prosecutorial Guidance, and the success met in revising the guidelines. Catherine Murphy from the Terrence Higgins Trust recounted that between 2001 and 2007 there had been three consecutive Guidance revisions, which resulted in frequent complaints and many prosecutions. There was much evidence that the threshold was low, and there were complaints that resulted from relationship breakdowns, etc. In 2008, activists proposed a new Guidance for Crown Prosecutions which was accepted by the government, to give prosecutors a clearer understanding of the issue. As a result, a solid comprehensive approach has been adopted, which has resulted in a considerable decline in the number of prosecutions.46

Yusef Azad from the National AIDS Trust (NAT) in the UK presented a submission describing his organisation’s work on police investigation Guidance (drafted by NAT and the Association of Chief Police Officers). Both prosecutorial and investigational guidance have been used on numerous occasions to intervene in halting unfounded investigations and prevent pointless and harmful prosecutions. The Guidance provided clarity to people living with HIV as to the circumstances where criminal sanction was possible in relation to their sexual behaviour.47

A potentially positive development occurred in Spain, where a judge convicting a person for negligent transmission of hepatitis C to 200 other people underlined that the defendant knew his condition, but put at risk the lives of others, and did not do anything to prevent the transmission. Thus, the argument that a defendant took ‘efforts to reduce or eliminate the risk of transmission’ could perhaps be used as defence in some transmission cases in the future.

On the international level, there has been a significant precedent set by the European Court of Human Rights, in relation to the Russian Federation. Although this country did not take part in the present Dialogue, it was felt that this case nevertheless deserved mention, as it could have general impact on the direction of jurisprudence within member states in the future. In 2011, the European Court of Human Rights in the case Kiyutin v. Russia held that singling out HIV-positive people constitutes a human rights violation, as persons living with HIV are members of a historically disadvantaged population. The reasoning in the case is very broad, and although it specifically concerns restrictions on freedom of movement and immigration for people living with HIV, it may be applied to other issues, including the criminalisation of HIV non-disclosure, exposure and transmission. According to Helmut Graupner from Austria, as a consequence of this decision, all of Europe should make criminalisation of persons living with HIV illegal.48

Civil society groups and other stakeholders are actively working to change the situation. A submission from HIV Manifesto Norway, as well as several others, illustrates this. Recently, the Norwegian Parliament called for a national group to be formed to evaluate whether laws criminalising HIV non-disclosure, exposure and transmission should be abolished. This group is now working actively to evaluate criminalisation practices in the country. In 2010, the Norwegian Children and Youth Council, an umbrella organisation for 73 children and youth organisations in Norway, launched their North South campaign, with the goal of having HIV criminalisation abolished.49

In Denmark, where since 1994 there have been around 20 prosecutions, activists have carried out a campaign against criminalisation of HIV non-disclosure, exposure and transmission, which has resulted in the suspension of the law on criminalisation. The campaign accentuated the fact that with the new progress in medication, HIV-positive diagnosis no longer means a shorter life. In addition, there has also been progress

46 Catherine Murphy, Terrence Higgins Trust, UK
47 From the submission of Yusef Azad, National AIDS Trust, UK
48 Helmut Graupner, Attorney, Expert on Criminal Law linked to Department of Justice, Austria
49 Jan Petter Eide, HIV Manifesto, Norway
in making HIV less infectious if one is being treated. The activists made links to and worked with people who were on the side opposing criminalisation, as well as people who supported it. The campaign was supported by many groups from around the globe. This work has taken several years, but it has led to positive results. Now groups in Denmark are trying to persuade the government to comprehensively change the law.50

In Switzerland, new data on the preventive effect of antiretroviral treatment (ART), published by the Swiss Commission for HIV/AIDS in 2008, has had a great impact on criminalisation of HIV exposure and resulted in the first acquittal of an HIV-positive person in 2009. After being sentenced to 18 months of imprisonment for exposing two women to HIV (sexual intercourse without condom after which no transmission occurred), an HIV-positive man appealed to the Geneva Court of Justice. In the appeal process, the defendant’s lawyer presented the conclusions of the Swiss Commission for HIV/AIDS, stating that an HIV-positive person under effective ART can, under specific conditions, become non-infectious and have sexual intercourse without a condom, and without endangering his or her partner. It was confirmed that the appellant had an undetectable viral load when the events took place and was therefore not able to transmit the virus. This acquittal in Switzerland on the basis of the undetectable viral load of the accused is a first at the international level.51

50 Henriette Laursen, AIDS-Fondet, Denmark
51 From the submission of Deborah Glejser, Porte-parole, Coordinatrice Communication et Mobilisation, Switzerland
5.1. Access to essential medicines

This discussion started with access to ART in high-income countries. Participants remarked that the situation in rich countries is not as good as one would expect. In the US, the number of people living with HIV who need care but are not receiving it is significant. The reasons are multiple, but this gap is mainly attributed to a lack of funding, low numbers of people knowing their status, and low compliance to treatment regimens.52 There are an estimated 1.1 – 1.6 million persons living with HIV living in the US, but less than 600,000 know their status. Approximately 380,000 of those who know their status have been referred to care, but only 270,000 actually receive care. Of these people, 209,000 have a viral load of zero.

According to a participant from the US Positive Women’s Network, the waitlist for the federal drug programme, which provides HIV drugs in the US, is almost 10,000 people, with the majority of them living in the southern US. The programme is funded by the federal, state and local governments, and the pharmaceutical industry. However, state governments and the pharmaceutical industry do not always provide their share of funds, and the federal government has not been able to fill in the gaps.53

Another issue in the US is that in order to get government assistance with ART, one needs to be below the poverty line. In North Carolina, almost one-third of the state’s population is uninsured, and consequently does not get HIV-related health care. The insurance provided by employers does not usually cover HIV medication. For many people, this means that their only option is to choose to live under the poverty line, and sometimes be unemployed, as without government assistance they simply cannot afford their HIV medication.

According to Dialogue participants, access to treatment in the European Union (EU) is not bad, but could be improved. There are generally no waiting lists to receive treatment. In Sweden, for example, it is reported that 90% of all persons living with HIV now have access to treatment. The remaining 10% have low viral loads and do not need treatment. However, there are other problems. For example, the right combination of ART and access to quality treatments is affected due to the economic crisis, as health care systems strive to save money. In Spain, there are cases of hospitals changing ART regimens, prescribing patients cheaper generic drugs without medical necessity. Another problem prevalent in several countries is the absence of free health care access for illegal/undocumented migrants, which detrimentally affects both individual and public health.54

People who are incarcerated or detained have problems accessing health care and getting or adhering to their HIV medication. It is hard to take medication at prescribed times, as prison rules do not make concessions for persons living with HIV. The medication may be confiscated and the communication between health care professionals inside and outside of prisons is very poor, as doctors inside and outside do not know how long

52 Eric Sawyer, UNAIDS, USA. Florida has the largest wait list in the country.
53 Brook Kelly, US Positive Women’s Network, USA
54 Joakim Berlin, HIV-Sweden, Sweden
5.2. Intellectual Property laws

The 99% reduction in the price of first line ART over the last ten years has facilitated a global revolution enabling access to HIV treatment, as generic competition has reduced the price of ARTs drastically (in the case of stavudine, prices dropped from USD 10,000 per patient a year to USD 68). There is now a need to see the extension of this reduction to new generation ART. Once prices drop, governments can start providing these medications for free. Currently, the high price of the second and third line of drugs compromises the ability of the health sector to provide other services, including prevention. The availability of affordable ART is a critical ingredient if the target of treating 15 million people living with HIV is to be achieved by 2015. Adopting the right legal policy in relation to intellectual property (IP) can enhance access to ART. On the other hand, legislation based on a Trade Related Aspects of Intellectual Property Rights (TRIPS)-plus approach can raise many obstacles to accessing medicines. The last ten years have seen huge progress, with millions of people receiving ART, but many hurdles remain or continue to be introduced, such as EU trade agreements with India, a country with a strong generic pharmaceutical industry. Such measures pose a real threat to the production of generic medicines, which compromises access to affordable ART.

Despite the fact that most funding for ART globally comes from high-income countries, both the EU and the US government are trying to export their internal regulatory framework to the rest of the world. The insistence on strict enforcement of patent laws and the imposition of other measures contributes to making ART more expensive. As the discussion pointed out, this move is being pushed by pharmaceutical companies. According to The World Trade Organisation’s (WTO) TRIPS requirements, most countries had to implement full IP protection by 2005, and countries spent a lot of money doing so. Added to this regime, high-income countries have imposed free trade agreements (FTA) and continue to do so, in order to push more stringent IP requirements on developing countries with the aim of obtaining trade stipulations over and above those required by TRIPS.

In order to assure continued access to affordable ART, the following have been proposed by treatment activists, some of who made representations and participated in the Dialogue:

Revision of the 30th August 2003 decision: According to TRIPS, compulsory licenses shall be issued “predominantly for the supply of the domestic market.” In August 2003, the WTO General Council adopted an interim waiver to this provision, amounting to permission for countries producing generic versions of patented products to export the products to eligible importing countries, without having to limit the exported amount. However, the decision made the process to receive this waiver cumbersome, time-consuming and, as such, unworkable. It was said that the mechanism is unrealistic as it was based on a drug-by-drug, country-by-country, and case-by-case decision-making process, and not a flexible system, which could be applied to respond rapidly to changing circumstances.

This problematic revision has been incorporated into several national laws. To implement the 30th August decision, Canada adopted Bill C-9, which came into force on 14 May 2005, creating Canada’s Access to Medicines regime. This law complicated an already complex mechanism, through its numerous additional requirements. This unduly complicated method inhibited the process of issuing compulsory licences for ART for export to other countries, making access to ART even more difficult.

Avoiding TRIPS plus policies and FTAs: In recent years, developed countries, particularly the US and the EU, have been pushing for others countries to adopt a variety of TRIPS-plus measures through bilateral pressure, trade and investment agreements (e.g. the Trans Pacific Partnership, EU-ASEAN FTA), and WTO accession agreements.
packages. These TRIPS-plus measures include data exclusivity provisions, patent term extension, patent linkage, and limits to TRIPS flexibilities, such as compulsory licensing, patentability criteria, and extensive provisions on IP enforcement. These provisions, if adopted and implemented in national laws (which some countries have), will adversely impact access to affordable generics.

A major obstacle in using the flexibilities is the pressure from developed countries. For instance, the Trade Act of the US requires the US Trade Representative (USTR) to publish an annual report that identifies countries that deny adequate and effective protection of IP, or that deny fair and equitable market access to US persons that rely on IP protection. To comply with this Act, the USTR issues an annual Special 301 Report that lists countries as being “Priority Foreign Countries” or as being on the Watch or Priority Watch Lists. These lists are a way of threatening countries to adopt legal or policy changes. Every year the USTR includes multiple countries in the Special 301 Report. This includes countries that make use of TRIPS flexibilities. As a result, few developing countries have shown willingness to make full use of the flexibilities that are available.

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

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

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

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

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

From the submission of Sangeeta Shashikant, Third World Network, Switzerland

In the FTA negotiations between the EU and the Association of Southeast Asian Nations (ASEAN) as a group, the EU has demanded a number of TRIPS-plus provisions that would make medicines more expensive, including a five-year extension of the patent period and data exclusivity. Health Action International closely followed one of the first EU FTAs exporting to a regime in the Andean community (Bolivia, Colombia, Ecuador, Peru). The EU was proposing data exclusivity measures, patent extension measures, and enforcement of IP property, which would have led to a restriction of generics. Eventually these measures were excluded from the agreement; they would have had a devastating impact on access to medicines and the health budgets of these countries. While the markets in these countries are not that important for the EU, these measures were being pushed through in order to set a precedent.

One of the participants mentioned that the measures proposed by the EU in negotiating a FTA with Canada may cost the Canadian health system USD 2.5 billion extra, if the country agrees to what the EU is proposing (to add another 5 years to data exclusivity requirements). This would mean that generic drugs would not be able to enter the Canadian market for an additional 5 years, which would increase the cost of medicines in the domestic market considerably.

The US is also known for making severe TRIPS-plus demands on negotiating partners. The World Health Organisation’s (WHO) model estimates that such demands, when applied, for example, to Colombia, would require an extra USD 1.5 billion to be spent on medicines every year by 2030. If this amount was not spent, Colombians would have to reduce their medicine consumption by 44% by 2030. When Guatemala introduced data exclusivity due to its US FTA, the monopoly allowed the IP owner to charge USD 84.56 for

60 Ibid.
the medicine, instead of USD 0.01 for the generic version of the same medicine.

Recently, the US has engaged in negotiating an Asia-Pacific Regional Trade Agreement known as the Trans-Pacific Partnership Agreement (TPPA). Currently, there are eight partners to this agreement, but eventually the agreement is intended to reach beyond these countries to the entire Asia-Pacific Economic Cooperation (APEC) region. The US has put forward the strictest and harshest IP measures, which would: (1) make it easier to patent anything, even minor innovations, and to change delivery mechanisms with the same active ingredients; (2) eliminate all anti-abuse measures and pre-grant oppositions, which are there to weed out wrong IP claims.

In relation to trade-related negotiations that have such a significant impact on people’s health, it is imperative to have a more transparent and informed debate; the public needs to know how and why these deals are negotiated, and governments and parliamentarians who do not quite understand the consequences of these deals – due to lack of interest or ignorance – also need to be educated. Indeed, accountability and transparency are urgently needed in the process of these negotiations.

A representative of the Global Fund for AIDS, Tuberculosis and Malaria (GFATM), which, along with the US Presidents Emergency Plan for AIDS Relief (PEPFAR), is a major global donor, noted that for his organisation, the cost of medicines is of profound importance, as high cost of essential medicines may have potentially devastating impacts on global health. In present times, when resources are tight, and stock-outs take place, it is of paramount importance to ensure that people who receive medicines now will continue to have access to them, and that the cost of new generation ART is precluded from dramatically increasing.

The participant pointed out that there is some optimism about the critical role that elected representatives play in influencing this issue. A potential opportunity for treatment advocates lies in the form of a Parliamentary Declaration that emerged from a GFATM meeting in June 2011 in Sao Paulo, Brazil, which was supported by members of parliaments from all over the world. The Declaration insists on accountability, transparency and responsibility of elected representatives in adopting trade agreements. It states that because of these agreements, commitments achieved in Doha are being lost. It encourages parliamentarians to resist pressures such as the TPPA, and it calls for transparency in negotiations, education, and outreach to parliamentarians.

### 5.3. Best practices and recommendations

Several participants expressed their views on their expectations from the report of the Commission, including:

- a strong statement asking parliamentarians to reject TRIPS-plus provisions and unfavorable conditions imposed through FTAs that compromise access to affordable medicine;
- a finding that emphasises the need to delink innovations from the price of medicines - innovations systems require greater comprehensiveness, and IP cannot be considered a proxy for innovation;
- and a research and development treaty that forces governments to contribute a part of their gross domestic product to research and development – after all, many inventions that are marketed by profit seeking companies are funded by tax payer money.

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61 Paul Adomako, African Black Diaspora Global Network, Canada
62 Svend Robinson, Global Fund for AIDS, TB & Malaria, Switzerland/Canada
The vigorous discussion regarding legal issues related to sex work and HIV at the Dialogue was reflective of the many submissions received on this topic by the Commission, testifying to the importance of the issue.

6.1. Laws

Sex work (and activities associated with it) is criminalised in several high-income countries. The so-called ‘end demand model’ or the ‘Nordic model’, which criminalises the customer rather than the provider of services, has been replicated after its origins in Sweden. This model sees and presents sex workers as victims in need of being rescued, under the presumption that no one engages in sex work voluntarily. In 2009, the Norwegian government adopted a law very similar to the one in Sweden, which banned purchase of sex as part of anti-trafficking measures in order to regulate and fight trafficking. A change in the paradigm has been seen - where sex work was previously viewed as a social problem which should be met with social services and harm reduction programmes, it is now predominantly seen as a criminal problem with an increased focus on human trafficking and crime control. In the high-income countries context, it appears that legislators widely perceive voluntary adult sex work and the purchase of sexual services as negative things, needing to be exterminated. Additionally, although sex work itself is not criminal, all activities connected with it are - one cannot work in an apartment (as the owner of the apartment may be liable for the offence of pimping) or in groups, hire security personnel, etc. Through these policies, the Swedish and US governments advocate their understanding internationally, leading to devastating health and social consequences, particularly with respect to the HIV response.64

In countries with such policies, there is ‘zero tolerance’ towards sex work, with HIV prevention seen as a low priority. There are few or no harm reduction measures (giving out condoms is seen as encouraging sex work), and the system presents sex workers with only one option – to exit the sex industry. There is evidence that service providers have negative attitudes to harm reduction measures, believing that if sex workers make money they should be able to purchase condoms themselves. Indeed, participants emphasised that the only way for sex workers to obtain services was to play the role of the victim. Within such an environment, the police control sex worker communities - they can seize condoms and lubricants and use them as evidence in criminal proceedings, they are allowed to arrest sex workers, and they consistently raid apartments and places of work.65

A participant from Canada informed the meeting that although purchase of sex in the country is legal, everything surrounding it that could make sex workers safer and their work conditions more favorable is criminalised, thereby rendering sex workers vulnerable to violence and HIV. In reality, this means that sex

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64 Anna-Louise Crago, Stella, Canada
65 Astrid Renland, Prostituerets Interesseorganisasjon i Norge, Norway. (Intervention via Skype)
work remains criminalised, albeit indirectly, through provisions against keeping or transporting a person to a “bawdy house”, “living on the avails” of prostitution by someone else, and “communicating in public for the purposes of prostitution.”\textsuperscript{66} The laws effectively criminalise brothel owners and agency owners, and sex workers working together, where (one or more) sex workers have their names on the lease or bills. The laws also effectively criminalise clients on the streets, in indoor venues that are used more than once for sex work, and clients of escorts who communicate their desire for services. These laws also affect sex workers on the street, sex workers working indoors from the same location more than once, and sex workers moving from venue to venue who communicate their services over the phone or in public.\textsuperscript{67}

Sex work is criminalised via a patchwork of laws across the US, except in parts of Nevada, where it is tightly regulated. According to a joint submission from the US, sex workers live with the threat of double prosecution - under one set of laws, which criminalise sex work, and another, which criminalise HIV exposure or transmission. In fifteen US states, penalties for HIV-specific offences are further enhanced for those convicted of selling (and, infrequently, of buying) sex while HIV-positive.\textsuperscript{68} Sex work that occurs in public spaces is also often policed under legislation prohibiting loitering, public nuisance, trespassing or “failure to obey” a police officer’s directive to move along. Some states in the US mandate minimum sentences so that judges are required to incarcerate people convicted for prostitution-related offenses. Some states have sentencing guidelines and judicial practices making a third charge for prostitution-related offenses a felony. People arrested for solicitation or other prostitution charges in many jurisdictions in the US are mandated to undergo tests for HIV, and people testing HIV-positive can face significant penalties and incarceration because of their HIV status.\textsuperscript{69} The state of Louisiana uses an 1805 law which bans oral and anal sex as “crimes against nature” in order to enhance sex worker prosecutions. Sex workers convicted of breaking this law are charged with felonies, issued longer jail sentences, and forced to register as sex offenders.

6.2. Law enforcement and public health impact

The evidence shows that the results of these punitive approaches are highly detrimental for sex workers, and bear significant negative public health impacts. Criminalisation of activities associated with sex work contributes to people’s risk of experiencing violence and other threats to their health and safety. Sex workers are prevented from adequately screening clients, from working indoors in a protected environment, and from associating with others (including bodyguards), as they are forced to work in more secluded areas to avoid police detection and prosecution, and from accessing health services. In Canada, these risks are borne disproportionately by street-based sex workers, who largely tend to be transgender persons, aboriginal persons, or people with drug dependence.

Sweden’s law has led to a situation where clients have even more control, as the space for negotiations is highly limited. This is especially so for migrant workers. The ‘end demand’ model results in a great deal of money being spent on police presence on the streets and the prosecution of people for loitering, pushing them away from the streets and services. A very similar situation is occurring in Norway - as a result of legislative change, prostitution has become more invisible, leaving sex workers more isolated and stigmatised, which negatively affects their ability to assess risk while working. The result is that sex workers are prone to increasingly dangerous working conditions. Sex workers have been forced to work alone, visit clients at their home, or at a hotel.\textsuperscript{70} They report having less control over relations with clients and having less negotiation

\textsuperscript{66} Canadian Criminal Code (s. 210 to 213). From the submissions of Anna Louise Crago, Stella, and the Canadian HIV/AIDS Legal Network, Canada
\textsuperscript{67} From the submission of Anna Louise Crago, Stella, Canada
\textsuperscript{68} From the submission of Anna Forbes, Sex Workers Project, Urban Justice Coalition, USA
\textsuperscript{69} From the submission of Penelope Saunders, Joint submission on behalf of Best Practices Policy Project and for Kiesha McCurtis, Sharmus Outlaw and Cristine Sardina of the Desiree Alliance, USA.
\textsuperscript{70} A participant researcher from St. James Infirmary in San Francisco informed the meeting of a study of 15,000 sex workers, which showed higher rates of HIV and sexually transmitted infections among sex workers working independently, than those who worked collectively. Lower rates of heart diseases, and other conditions were also associated with collective work, indicating that working collectively provides better health outcomes for sex workers - Naomi Alkers, UNAIDS Sex Work Advisory Group, USA
opportunities about the price of services and usage of condoms.71

All in all, as a representative from Canada mentioned, criminalisation and the conflation of sex work with trafficking results in the “degradation of working conditions,” as pressure comes from police, and puts sex workers in worse conditions, where the risks of violence, HIV and human rights violations are more likely. Landlords who know of sex work taking place in their properties may be liable. Furthermore, if criminal activity is occurring in one of their rental properties (such as someone “being found in a bawdy house”), landlords have grounds to terminate a lease immediately. As a result, sex workers working from home face precarious housing situations. A record of eviction can further impede finding new housing. A lack of secure and stable housing increases women’s risk of violence and impedes efforts to move away from violent situations or relationships. Property owners do not want to be seen as brothel owners, often disallowing sex workers to possess condoms on premises. Such laws compromise the ability of sex workers to hold on to housing.72

It was also mentioned that criminalisation of clients has disproportionate effects on women working on the streets, who are a priori more vulnerable to HIV, violence and other abuses. When clients and sex workers move indoors, sex workers that remain on the street are often in worse conditions, as they have fewer clients, they are drug users, migrants, etc. They are forced to hide and their negotiation time is shortened; if they get beaten or attacked they are in isolated in areas where no help is available when they seek it.73 In the US, street-based sex workers are also the most vulnerable groups. Female, male, or transgender street-based sex workers are frequently impoverished persons of colour. They are at high risk of violence from clients and the police, as well as homelessness, addiction, and HIV. As they can be arrested at any time, and negotiations with clients regarding prices and condom use are often hastily conducted to facilitate getting off the street before being observed and arrested.74

Under current law in New York City, San Francisco, and Washington, D.C., and among other cities in “high income” countries, police and prosecutors use condoms to prove prostitution-related offenses despite these metropolitan areas having some of the highest HIV prevalence rates in the nation.

Sex workers who are most dependent on income from prostitution are more vulnerable to pressure from customers who do not want to use condoms. The police have also turned harm reduction measures into evidence of crime. The result is that sex workers are more reluctant to take precautions that could be used as evidence of prostitution, such as carrying condoms and lubricant, and accessing information about social services, etc.

In some US states, possession of condoms can be used as evidence of intent to engage in sex work. There is no legal limit to the number of condoms an individual can carry, but reports from three major cities (New York, Washington DC, and San Francisco) document that law enforcement officers routinely confiscate condoms from suspected sex workers, sometimes submitting them as ‘evidence,’ and sometimes arresting people based solely on their possession of condoms. Transgender women, homeless women of colour, and others commonly profiled as doing sex work, are especially targeted by this practice.75

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71 From the submission of Astrid Renland,Prostituertes Interesseorganisasjon i Norge, Norway
72 The laws against bawdy-houses preclude opening a non-profit centre where women working in the most dangerous conditions (the street, the crack houses/shooting galleries) could bring their clients and provide services in a safe place with functioning security and social workers and nurses on-site available if women need assistance or support. Bawdy-house laws also preclude development of adequate short-term and long-term housing options for women who do sex work and use drugs. From the submission of Anna-Louise Crago, Stella, Canada.
73 From the submission of Anna-Louise Crago, Stella, Canada
74 From the submission of Anna Forbes, Sex Workers Project, Urban Justice Coalition, USA
75 In New York, S323/A1008 is a bill in the legislature that would provide “that possession of a condom may not be received in evidence in any trial, hearing or proceeding as evidence of prostitution.” Prior versions of this bill were introduced in each of New York’s last five legislative sessions. Each time, they remained trapped in a legislative committee and failed to reach the full legislature for debate or a vote. From the submission of Anna Forbes, Sex Workers Project, Urban Justice Coalition, USA.
An activist from New Orleans painted a grim picture of the situation in the southern US. In Louisiana, sex workers charged with the “crime against nature” (i.e. sex work) are registered as sex offenders and must carry a driver’s license with the label ‘sex offender’ printed on it. In other states, sex offender registries are generally comprised almost entirely of men, but because of this law, three quarters of those on Louisiana’s registry are now women, most of whom (80%) are African-American. There are over 500 women registered as sex offenders. There are additional problems for sex workers who have drug convictions - there are no pre-release programmes for women, let alone for the lesbian, gay, bisexual and transgender (LGBT) community or drug users. Women often go in and out of prison, because sex work is all they can do to support themselves, and police have the discretion to decide who is a sex worker and who is not. It is even harder for transgender women, who are considered to be sex workers only because they are transgender.76

Sex offenders remain on the registry for a minimum of ten years. During this time, they are barred from certain kinds of employment, and most other employers are unwilling to hire them. As felons, they do not qualify for public housing assistance or educational loans in Louisiana, and are ineligible for food stamps under some circumstances. These factors combine to make it extremely difficult for women on the registry to find legal ways to support their families, increasing their likelihood of having to continue to do sex work, live in poverty, and be deprived of prevention and sexual health options - all risk factors for HIV.

Young people and sex work: One participant touched upon issues important to young people engaged in sex work.77 According to a representative from Streetwise and Safe, in New York City, 30-50% of homeless youth trade sex. MSM and transgender youth are more likely to be involved in the sex trade. While the problems described above are relevant to all people involved in sex work, youth face heightened vulnerability, due to their age, low access to health care services, and need of parental or guardian consent to access services.

It was pointed out however, that at least on some levels, international and domestic legal frameworks protect youths involved in sex work. The 2nd Optional Protocol to the Convention on the Rights of the Child states that young people under the age of 18 who are involved in sex work are trafficked victims. This has been interpreted by the Monitoring Committee of the Convention to mean that minors (those under 18 years) are immune from prosecution for sex work. In its Concluding Recommendations, the Committee criticised countries like the US, which did not implement these provisions.78 Currently, according to the Federal Trafficking Victims Protection Act, youths are excluded or “immune from prosecution,” which means that proceedings take place in family court proceedings rather than juvenile criminal courts. However, on the federal level, one has to be between ages 7-16 to be immune from prosecution, which is incongruent with international standards. Immunity protection should be provided to all youths under 18 years of age. There is also a need for the 3rd Optional Protocol to put forward individual complaint procedures.

The LGBT community and sex work: Many interventions made during the Dialogue highlighted the disproportionate impact faced by transgender people in high-income countries due to the criminalisation of sex work. According to the National Center of Transgender Equality in the US, at least 11% of the transgender community reported a history of engaging in sex work for income. Transgender people are 25 times more likely to be HIV-positive, and many times more likely to be incarcerated than others. Discrimination and stigma are reasons why transgender persons are being constantly profiled as sex workers - even if they take a condom from an outreach worker, they risk immediate arrest. As a result, people do not want to accept harm reduction supplies, or even talk with outreach workers, and they do not want to get tested because of transmission and exposure laws. If transgender women get arrested, they are often thrown into male facilities, where they risk being sexually assaulted by both inmates and staff.79

Other human rights violations that have negative impacts on the HIV response: Other human rights violations

76  Deon Haywood, Women with a Vision, USA
77  Brendan Michael Conner, Streetwise and Safe, USA
78  It was pointed out that although the US is not a part of the Convention on the Rights of the Child, but nevertheless is a part to the 2nd Optional Protocol. The US had specifically negotiated on this point that it does not have to be part of the convention - Brendan Michael Conner, Streetwise and Safe, USA. The US signed but did not ratify the CRC and has become a State Party to the Optional Protocols, please see: http://www.hrw.org/news/2009/07/24/united-states-ratification-international-human-rights-treaties#_Convention_on_the_1
79  Cecilia Chung, San Francisco Human Rights Commission, USA
and breaches of HIV-related best practices in relation to sex workers were discussed during the Dialogue. According to the submission of the Sex Workers Project, 20 states in the US permit mandatory HIV testing on people arrested or convicted on charges of prostitution, solicitation or pandering. This could result in the imposition of higher penalties (including felonies) on people who are said to be engaging in sex work while living with HIV, even if they used condoms and engaged in less risky forms of sex with their partners. In nine of these states, the state was not required to provide any accompanying HIV counselling, education, treatment, or services for those testing HIV-positive. Positive test results could be released without consent - depending on the state - to the person with whom the accused had sex, the district attorney, the Mayor (in the case of the District of Columbia), state agencies, and/or the courts.80

Sex workers are also reluctant to seek out social workers and social services because they are afraid that social workers might cooperate with the police, or that contact with social services could make them more visible to the police. In the US, anti-prostitution laws and policies are used as a tool to arrest migrant sex workers and deport them. Migrant sex workers are therefore more likely than other groups of sex workers to avoid public services, and are consequently much less able to access safe sex supplies, health services, and medications.81

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

**Impact of the US anti-trafficking laws:** During the discussion about the links between sex work and effective HIV responses, the negative impact of US anti-trafficking laws was frequently mentioned. A firm view held that federal anti-trafficking policies undermine the health and rights of sex workers both domestically and internationally by requiring that organisations seeking US aid adopt a policy against sex work ("Anti-Prostitution Loyalty Oath").82 This requirement is applied to international and almost all US-based organisations seeking funds from PEPFAR. Organisations within the US have also been subject to the pledge under the Trafficking Victims Protection Reauthorization Act. These restrictions leave many organisations in a state of confusion about the kinds of services they can provide to sex workers leading, in some situations, to the shuttering of excellent harm reduction services. New forms of state-level legislation to eliminate “domestic trafficking,” focused on “ending demand” for prostitution, have been proposed and/or adopted in many US states, intensifying policing of sex workers and their clients.83

### 6.3. Best practices and recommendations

A Dialogue participant observed that the fact that the only space sex workers have in mainstream political discourse is within the HIV field is telling in itself. This means that when sex workers are murdered, affected by violence, or have their rights violated, society does not care. It is only in the context of HIV, when there is a danger of passing a disease onto ‘unsuspecting decent people,’ that society becomes more concerned with preventing this from happening. Most policies are made with the idea that sex workers are victims, deviants or criminals. Even laws that were supposedly enacted to protect sex workers have the opposite effect. Sex workers want the recognition of their work as a legitimate employment, and desire equal labour rights with other workers. Dialogue participants also stated that decriminalisation of sex work is not enough if one wants to address HIV. Sex workers also need to have the power to choose their conditions, ensure safety, and protect their labour rights in order to enforce effective HIV responses.84

There are, however, some positive developments in the legal and policy area regarding sex work. According to Deon Haywood, after three years of tireless work in Louisiana, civil society persuaded a state representative

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80 From the submission of Anna Forbes, Sex Workers Project, Urban Justice Coalition, USA
81 From the submission of Penelope Saunders, joint submission on behalf of Best Practices Policy Project and for Kiesha McCurtis, Sharmus Outlaw and Cristine Sardina of the Desiree Alliance, USA
82 According to the submission from Melissa Hope Ditmore on the impact of PEPFAR on sex workers, there are currently two legal suits against this policy in the US courts.
83 From the submission of Penelope Saunders, joint submission on behalf of Best Practices Policy Project and for Kiesha McCurtis, Sharmus Outlaw and Cristine Sardina of the Desiree Alliance, USA
84 Thierry Schaffausen, Network of Sex Worker Projects, UK
to sponsor a bill to end the sex offender registry for people engaged in sex work. The bill was supported unanimously and passed in the state legislature. However, 800 people are still on the registry, allegedly because it is too expensive to take them off.85

Anti-prostitution legislation in Canada is currently being challenged by sex workers in Ontario (Bedford v. Crown), and in British Columbia by Sex Workers of the Downtown Eastside United Against Violence (SWUAV v. Crown), who claim that the legislation infringes on sex workers’ constitutional rights to liberty and security of the person. In 2010, a judgment at the Superior Court Level in Ontario found that laws criminalising brothels and communications for the purposes of sex work force sex workers to choose between their liberty and security, and increase sex workers’ risk of violence. The court struck down these provisions as violating constitutional rights to freedom of expression and to security of the person — the latter because such provisions force sex workers into more dangerous situations and contribute to a greater risk of violence and other threats to their health and safety. The present government has since appealed the judgment.86

The Canadian group Stella has worked towards sensitising police officers, and has been able to locate certain contacts within the major crimes and sexual assault units in Montréal that take sex workers’ reports of violence respectfully. These units do not arrest sex workers for sex work, outstanding warrants for sex work/drug use, or minor crimes; do not arrest sex workers’ clients (unless they are the perpetrators of violence); and do not arrest sex workers’ bosses, managers, support staff or sex worker colleagues (unless they are the perpetrators of violence) when sex workers report violence.87 For sex workers, the knowledge that they, their clients, or their place of employment will not be criminalised if they come forward has created a sea change in women willing to report violence.

At the end of the discussion, participants representing sex worker groups presented the meeting with a ‘Sex Worker Manifesto’, which laid out their concerns and recommendations for the Commission and the legislators and policy makers in the high-income countries.

**Sex Worker Manifesto:**

- “In order to achieve a more effective and rights-based response to HIV in high-income countries, we call upon the Commission to adopt the following recommendations in which all sex worker groups and projects in this Dialogue have come to consensus:

  - Implement decriminalisation of sex work and associated practices, including decriminalisation of people who trade or sell sex; people who buy sex; and third parties such as brothel-owners, security personnel, managers, cleaning staff, intimate partners, roommates, and children of sex workers.

  - Eliminate the use of other laws to target sex workers for arrest, incarceration, punishment and deportation on a large scale. These include mandatory testing linked to sentencing enhancements and criminalisation based on HIV status, sex offender registration, drug-related offenses, and immigration restrictions on sex workers. They also include laws or by-laws/ordinances, used to remove sex workers from public space and impinging on their freedom of movement, such as vagrancy laws, no-prostitution zones, and pre-trial and probation conditions that bar sex workers from certain areas.

  - Stop misusing anti-trafficking laws to further criminalise sex workers, deport migrants, and incarcerate youth. Fund and support real and effective services for survivors of human trafficking, that includes survivors of labor trafficking, includes survivors of all genders, and does not jail or coerce survivors to participate in the criminal justice system.

  - Ensure that states provide access to sterile syringes, safer sex materials and other harm reduction materials; access to quality and confidential health care, including transgender-specific health care to people detained in prison or immigration detention. Ensure that transgender prisoners, who are detained, are held in conditions that are safe and in conditions that respect their gender identity.

85 Deon Haywood, Women with a Vision, USA
86 From the submission of Anna Louise Crago, Stella, Canada
87 Ibid.
Enforce the international legal mandate to decriminalise youth involvement in the sex trades, a mandate that no UN member state has fully implemented. Provide immunity from prosecution without conditions. End the law enforcement-focused approach to youth in the sex trades, which has resulted in mass policing, incarceration, and “rehabilitation” programs. These approaches cause exponentially higher HIV rates for state-involved youth, and interfere with services by creating criminal disincentives for providers and conditioning services on arrest. Reorient state responses toward voluntary shelter and living wage alternatives.

Ensure institutional accountability and redress for police violence against sex workers, and ensure equal protection of the law for sex workers with regard to violence.

End the discriminatory application of all of these laws to oppress specific racialised and migrant groups, such as people of African descent and Indigenous people in North America, and Roma people in Europe. This discrimination extends to gender expression or identity, especially women and transgender women.

End local, national, transnational (including UN) policies that purport to abolish sex work through initiatives to “end demand,” to raid and shut down brothels and to rehabilitate sex workers. Such measures institutionalise discrimination against sex workers with highly damaging effects on sex worker health and rights.

Prioritise and fully fund effective HIV prevention, harm reduction services, and health services for sex workers, with the understanding that sex workers are partners in combating the HIV epidemic. Ensure support for rights-based services for male sex workers, trans sex workers and youth in the sex industry.

Repeal the US Anti-Prostitution Pledge, SIDA restrictions and any other national or transnational funding restrictions that defund or prohibit health and rights services for sex workers. Countries such as the US and Sweden must cease using foreign policy tools to pressure other countries to increase repression and criminalisation of sex work.”

Other recommendations to the governments included: (a) increase financial support of sex worker-led organisations working for sex workers’ health and rights; (b) specifically fund short and long-term housing options for sex workers and/or drug users; and (c) financially support the creation of safe non-profit spaces for women to bring their clients and access health and social services.88
7. Men who have sex with men and transgender people

7.1. Laws and law enforcement practices

To emphasise the grave burden that HIV continues to place on MSM and transgender communities, a participant highlighted some alarming figures: 60% of new infections in the US are among MSM, not including those who inject drugs, and one in five MSM living in urban areas in the US lives with HIV, with one-third of these men are unaware of their status.89

Additionally, it was observed that persistent stigma and discrimination (despite the absence of laws criminalising same-sex sex), and increased access to ART have restricted the public discourse regarding the HIV epidemic among gay men. In a way, the HIV epidemic among gay men advanced the gay civil rights movement because people were forced to come out of the closet; this is not the case in present times.90 Although the prevailing perception in high-income countries is that there has been great progress on LGBT rights, this does not present the entire picture - high-income countries may have made advances in eliminating anti-sodomy legislation, but MSM and other LGBT communities still risk arrest for loitering, public nuisance, solicitation and prostitution. There is continuing animosity against same-sex marriage, frequent cases of police violence, discrimination, denial of parental rights and lack of acceptance and understanding of the LGBT community in many parts of the high-income world. There is also a lack of protection for people who are abused, harassed and unfairly targeted by police, and discriminated against in other areas of life. Until societies condemn and prohibit police practices that unfairly target these populations, the effect will be the same or similar to criminalisation under the law, as changing the law does not change the actual behaviour of law enforcement.

Transgender people: Despite the fact that some of the countries participating in the Dialogue have legislation and policies supporting sex reassignment, guaranteeing the provision of medical services associated with it, and recognising such changes in identity documents, there is a surfeit of problems in the legal recognition of transgender persons, as well as in the actual process of document change. For example, following a law introduced in Sweden in 1972, in order to change one’s gender in identity documents, one needs to be sterile and over 18 years of age. If this person has a spouse, a divorce is required. Hormonal therapy is also not provided by the government and is very expensive.91

Some participants recounted cases of police violence, hostility from the general public, brutality, discrimination, and hate crimes targeting the transgender community. Transgender people are often reluctant to report these crimes, because they do not feel safe coming forward and view reporting as futile due to law enforcement’s failure to investigate the allegations.92 As a result of societal stigma, transgender people are

89 George Ayala, Global Forum on MSM & HIV (MSMGF) & Member, Dialogue Advisory Group, USA
90 Scott Schoettes, Lambda Legal Defense & Education Fund, USA
91 Christian Antonio Mollerup, Swedish Federation for LGBT Rights, Sweden
92 Sharmus Outlaw, Best Practices Policy Project and the Desiree Alliance, USA
not accepted, are thrown out of families and ostracized; all of this has an impact on their psychological health and wellbeing. Additionally, when people face multiple layers of discrimination, such as being a transgender African-American woman, or a sex worker, the situation induces even greater marginalisation.

In her submission, a transgender woman from the US emphasised that transgender women face a dramatically greater risk of acquiring HIV, and often encounter problems with the criminal justice system, law enforcement and penal institutions that contribute to further transmission of HIV. In major US cities such as San Francisco, New York and Washington, D.C., there are frequent reports of police ‘profiling’ transgender women as sex workers. This leads to some community members becoming reluctant to accept condoms from outreach workers for fear that simple possession of condoms will be used as evidence against them in a criminal proceeding, placing them at the highest risk of acquiring or transmitting HIV.93

It was pointed out that historically, there have been great tensions between transgender persons and the police. According to Cecilia Chung’s submission, transgender women who are routinely placed in men’s prisons and jails are 13 times more likely than their fellow inmates to be sexually abused in prison. All transgender people are at risk of much higher rates of incessant harassment, prolonged isolation, and denial of necessary medical care in almost every detention facility in the US. Denial of necessary medical care, such as hormone therapy, is a common reality for most transgender detainees. Juvenile facilities often punish transgender youth simply for being themselves, and frequently subject transgender youth to intensive gender and sexuality policing, literally forcing gender conformity on them in the guise of a treatment plan. National standards to end prison rape in the US have been recommended, but have yet to be adopted, which leads to impunity for sexual assault in prisons.94

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

From the submission of Cecilia Chung, USA

7.2. Best practices and Recommendations

As with other topics, the discussion on MSM and transgender people reflected interrelatedness with topics such as criminalisation of HIV non-disclosure, exposure, and transmission, sex work and drug use. The recommendations by the Dialogue participants were not solely limited to a narrow understanding of LGBT issues. The most frequently repeated recommendations, universal to all participating countries, were the following:

a) Decriminalise possession of condoms; prohibit law enforcement from confiscating them, and courts from using them as evidence of a criminal offence. When it comes to carrying condoms, LGBT persons face the horrific choice between protecting themselves or providing ammunition to police and prosecutors.

b) Decriminalise HIV by eliminating HIV-specific criminal statutes and sentencing enhancements. Criminal prosecution of people who know they have HIV, for behaviours that are unremarkable for others, is a further disincentive to LGBT persons to get tested and go into care. ‘Take the test and risk arrest’ is increasingly heard on the street. Sending this message to communities most at risk is dangerous.

c) Reform processes and civil rights in relation to gender reassignment, and access to health care and other services for transgender people.

93 From the submission of Cecilia Chung, USA
94 Ibid.
d) Provide incarcerated LGBT persons with effective protection from assault, rape, discrimination, and other violations of their bodily integrity and rights. Adopt effective, enforceable standards which apply equally to all prisons, jails, and immigration detention facilities.
8.1. Laws and law enforcement practices

Most discussion at the Dialogue revolved around concerns of women living with HIV and women who are exposed to multiple layers of vulnerability and risk (in the US context). In the US, HIV is the third leading cause of death for all women aged 35-44, and the first leading cause of death for African-American women aged 25-34. One of the most important social determinants of vulnerability and risk for women in the US is poverty.95 Women are more likely than men to live in poverty; in fact, 80% of women living with HIV live on an annual income of USD 10,000 or less. This degree of poverty translates into lower quality of life, lack of quality education, and lack of affordable quality housing, all of which increase women's vulnerability to HIV and its negative consequences. HIV burden and risks are significantly higher among racial and ethnic groups than among the white population. For example, for African-American women the risk is 15 times higher than for white women; and it is four times as high for Latino women.96

According to a representative from the US Positive Women's Network, women's sexual and reproductive health rights in the US are frequently violated. Women living with HIV suffer from judgment, misinformation, and discrimination when inquiring about their sexual and reproductive choices or attempting to exercise their sexual and reproductive rights.97 There is also evidence that it is difficult to access adequate health care advice and services. The US Positive Women's Network's survey indicated that many doctors are either uninformed about HIV-positive women's reproductive options, choosing to forego any conversation about reproductive options or care for HIV-positive women, or are entirely unsupportive of an HIV-positive woman's right to reproductive choice, which includes the right to have a child. Providers are often uninformed and unsupportive due to the costs of reproductive treatment for persons living with HIV - sperm washing and artificial insemination are expensive, and are often not covered by health insurance plans, which makes safe reproduction for some HIV-positive women altogether unattainable.98

Women face abrogation of their parental rights based on HIV status. These violations include loss of child custody based solely on their HIV status, often as a result of prejudiced judicial attitudes and assumptions about HIV, poverty, and accompanying factors, but also as a result of prosecutions under HIV-specific criminalisation laws. Women who are prosecuted under these laws find it difficult or impossible to regain custody of children once they are released from prison. Additionally, there has been a rise in cases where the custody of existing children is threatened by child services agencies when an HIV-positive woman becomes,

95 Poverty in the U.S. is defined as having income of 11,000 USD or less, 10,000 for people who are over the age of 65; 22,000 for a family of four. Vanessa Johnson, National Association of People with AIDS, USA
96 Vanessa Johnson, National Association of People with AIDS, USA
97 Brook Kelly, US Positive Women's Network
98 Ibid.
or expresses the desire to become, pregnant.  

8.2. Best practices and Recommendations

Vanessa Johnson from the National Association of People with AIDS noted that the law influences larger societal conditions, which facilitate the spread of HIV. Reducing HIV health disparities among women requires focusing on their economic and social position in society. Dialogue participants noted that it is necessary to challenge national laws and policies that perpetuate economic inequality and advocate for policies which ensure that all women - particularly women of colour living with HIV, women belonging to key populations at higher risk, and female sex workers - are not discriminated against and are treated in a fair and equitable manner. It is necessary to educate healthcare providers about sexual and reproductive rights of people living with HIV, and the high probability of HIV-positive women giving birth to healthy babies.  

99  Ibid.  
100  Vanessa Johnson, National Association of People with AIDS, USA
A representative of the National Children’s Bureau from the UK discussed the difficulties and discrimination that young people and children living with HIV face. Children living with HIV are a small proportion of all persons living with HIV, and their interests are frequently overlooked. Most children living with HIV in high-income countries are infected through vertical transmission. In the UK, 80% of infected children are born to black African families, and 50% are born outside the UK. UK law states that the best interests of the child are paramount, but the realities are sometimes different. Emily Hamblin emphasised that when we look at how the law impacts people living with HIV and vulnerable groups, we need to examine how HIV impacts children, young people and young adults. When adults are negatively impacted by prevailing legal structures, their children are inevitably affected as well. Often they are told that they cannot talk about HIV at home or in schools and children do not know how HIV touches their lives. One of the key issues is that children with HIV are being denied places at schools and excluded from social activities; their confidentiality is breached and their human rights are violated.

In the US, youth populations identified as most vulnerable to HIV often report high involvement in transactional sex. For example, in New York City, involvement in transactional sex is reported at the following rates: street-involved and homeless youth (30 to 50%), young MSM (35%), and transgender minors (350% more likely to be involved). Yet, as with the situation regarding sex education, far too large a proportion of global funds is being directed at young people in the ‘general population’ - typically older males (above the age of 20) who are unmarried, have involved parents and housing, and are enrolled in schools. The absence of services targeted towards the most vulnerable youth is accompanied by obstacles such as high levels of policing and placement in state custody, making access to available services more difficult. This ‘state-involvement’ may include secure detention or involuntary commitment to group homes, foster care, and ‘rehabilitation’ centres, and is especially common for minors involved in the sex trade.

A minor involved in transactional sex in New York City has, on average, been arrested 2.5 times. As previously mentioned, while the New York Safe Harbor Act has been widely praised for decriminalising minors’ involvement in sex work, it extends only to sex work per se and is limited to youth aged 7 to 16, excluding 93% youth who are estimated to be involved. Therefore, it is recommended that the law be extended to minors arrested under ‘proxy’ charges such as loitering, false personation and criminal nuisance. Additionally, among this larger category of sex-trading minors, certain groups face disproportionate policing, with 81% of young MSM and 63% of transgender youth reporting prior arrests. In a study of transgender youth in New York City, participants reported profiling by police and verbal and sexual harassment and violence, including the extortion of sex in exchange for release from custody. Youth at risk of HIV often lack access to basic information and services to prevent HIV, in addition to independent access to testing, counselling, condoms, and treatment. But information and independent access to services will only be achieved when

101 From the submission of Brendan Michael Connor, on behalf of Streetwise and Safe, USA
being arrested is not a prerequisite for access, and law enforcement is not the referee.102

Another participant described the sex education situation in Louisiana. While Louisiana ranks 5th in the US in estimated AIDS cases and 5% of people living with HIV/AIDS are young people ages 13-24, Louisiana law does not currently require that sex education be taught in the schools at all. If it is taught, however, the law requires that it emphasise abstinence-only until marriage as the “expected standard” for all school-age children. Recent efforts to pass comprehensive sex education plans for Louisiana have failed in the state legislature. This suggests that a lack of information and knowledge about HIV and AIDS may be a direct result of the failure to provide HIV information in the public schools.103

Representatives from across high-income countries present at the Dialogue agreed that currently, attention is only paid to sex education in the school settings, for children and young people who have parents and educators. This overlooks the need to increase education services for vulnerable youth, including street-based youth, who do not have access to state-sponsored systems. Good quality sex and relationship education is needed, which is now optional in several countries covered by the Dialogue. There should be strategy and resources aimed at street-based youth to ensure that they benefit from health care services and education, including sex education.104

102 Ibid.
103 Deon Haywood, Women with A Vision of New Orleans, Louisiana, USA.
104 Emily Hamblin, National Children’s Bureau, UK.
10.1. Race and HIV/ Racial minorities and HIV

While traversing each of the issues raised at the Dialogue, regular interventions were made regarding the intersection of race, HIV and the law, and how already stigmatised and marginalised people experience more disadvantage because of their race. Participants called the Commission’s attention to the links between race, poverty, incarceration, prosecutions for HIV non-disclosure, exposure and transmission, sex work and others.

It was noted that race, and perhaps the lack of political will to tackle the problem, play a significant role in the HIV epidemic in high-income countries and globally. 67% of persons living with HIV are living in Sub-Saharan Africa, which means that the majority of persons living with HIV internationally are black. Ethnic minorities in high-income countries also face a significantly higher risk of HIV and its negative consequences.

According to the US Centers for Disease Control and Prevention, among racial/ethnic groups, African-Americans face the most severe burden of HIV and AIDS in the US. As Deon Haywood pointed out, 67% of people living with HIV in North Carolina are African-American, although African-Americans comprise only 21% of North Carolina’s population. The HIV incidence rate for African-American women is nearly 15 times as high as that for white women, and nearly four times that of Hispanic/Latino women. In Louisiana, 74% of new HIV and 78% of new AIDS cases are among people of colour, with women comprising 28% of new HIV infections.

Vulnerabilities experienced by people in relation to HIV are vastly increased for people of colour. In the US, the ‘war on drugs’ affects African-Americans disproportionately and violations of the rights of LGBT persons of African-American descent are more frequent than for the majority of the LGBT population. Additionally, at least in the US and Canada, of all prosecutions for HIV non-disclosure, exposure or transmission, a significant number of those charged have been members of African or Caribbean communities. In the province of Ontario, Canada, nearly 50% of all heterosexual men charged with HIV non-disclosure between 2004 and 2009 have been members of the African diaspora.

According to the submission of African and Caribbean Council on HIV/AIDS in Ontario, HIV vulnerability among African and Caribbean people and communities must be understood in terms of the social determinants of health: limited access to safe and affordable housing, migration status, unemployment and underemployment, gendered norms that prescribe male domination over women, a reluctance to talk about sex, sexuality and health, pervasive homophobia. These factors create barriers to accessing HIV supports and services, other social services, and education opportunities, thus shaping the experiences of people living with HIV.

105 Robert Childs, North Carolina Harm Reduction Coalition, USA
106 Kathyann Hart, AIDS Action Committee of Massachusetts, Inc, USA
107 Deon Haywood, Women with A Vision of New Orleans, Louisiana, USA
108 From the submission of Valérie Pierre-Pierre, African and Caribbean Council on HIV/AIDS in Ontario, Canada
those living with or affected by HIV. The intersectionality of gender, race, poverty, stigma, denial, fear and discrimination contributes to the exclusion and marginalization of vulnerable groups. The submission notes that deep-seated racism has long been a feature of African and Caribbean peoples’ interactions with police, courts and prisons. Dating back to the era of slavery, racist beliefs and practices have permeated criminal justice institutions.¹⁰⁹

In relation to criminalisation of HIV exposure and transmission, there are many factors, such as stigma and discrimination, racism, homophobia, sexism, power imbalances, and other determinants of health that impact an individual’s ability to disclose their HIV status. Individuals find themselves in different social positions — mediated by their sex, age, education, language, immigration status, economic security and sexuality, among other factors — which impact their ability and willingness to seek and reveal personal information and/or reduce risk.¹¹⁰ Many participants at the Dialogue agreed that until the issue of race is squarely examined in the context of HIV, problems will persist in providing an effective response.

### 10.2. Prisons

In most countries, the prevalence of HIV and hepatitis C in prisons and detention facilities is considerably higher than in the general population. There is evidence that in high-income countries same-sex sex and drug use are occurring in prisons, thus contributing to the spread of HIV and other blood borne infections. At the same time, health care services, and more importantly, harm reduction interventions, are frequently unavailable in prisons. Several high-income countries have instituted comprehensive harm reduction programmes in some or all of their prisons, but these interventions have far from universal coverage and are frequently implemented in a sub-standard way. There are also a number of high-income countries that, despite the overwhelming evidence of the high effectiveness and efficiency of prison-based harm reduction measures, refuse to implement them because of ideological or other non-scientific reasons.

As the Dialogue discussion showed, in all high-income countries, vulnerable communities and key populations at higher risk of HIV, such as sex workers, people who use drugs, and transgender people, face protracted time in prisons. Prisons are also disproportionately weighted against aboriginal people in Canada, and African-American and Latino populations in the US. Disproportionate incarceration rates contribute to a higher HIV burden among these populations. Additionally, when incarcerated, these groups are often at the bottom of the prison hierarchy, which increases their risk of HIV.

According to the submission from the Canadian HIV/AIDS Legal Network, estimates of HIV and hepatitis C prevalence in Canadian prisons are at least ten and thirty times, respectively, the reported prevalence in the population as a whole. A 2007 national survey revealed that 15% of people incarcerated in federal prisons reported having injected illegal drugs, and almost half of those injected with a needle previously used by someone else. Despite these statistics, Canadian prisons do not provide harm reduction interventions such as prison-based NSP or safer tattooing facilities.¹¹¹

While Germany is among the European countries that have instituted harm reduction measures, such as prison-based NSP and OST, the nation is not immune from counter-productive HIV-related measures.¹¹² According to a participant from Germany, safer sex in prison is often difficult or impossible because condoms and lubricants are not anonymously available and must be prescribed by a health professional. Prisoners

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¹⁰⁹  Ibid.
¹¹⁰  Ibid.
¹¹¹  Six tattooing facilities were piloted in Canadian federal prisons from 2005–2006 to address the common practice of tattooing in prison, which is associated with a high incidence and prevalence of blood-borne infectious diseases. Despite evaluation reports indicated that the initiative reduced potential exposure to infectious diseases including HIV and hepatitis C and enhanced the health and safety of correctional officers, prisoners and the general public, the project was terminated by the new Conservative government in 2006. From the submission of the Canadian HIV/AIDS Legal Network.
¹¹²  According to Peter Wiessner from AIDS-Hilfe North Rhine Westphalia, the biggest problem in Germany is a structural one - prison health is segregated from public health system because the responsibility for prison health lays with the Ministry of Justice, not the Ministry of Health. This by definition subjects health care in prisons to different standards and requirements than health care outside of prisons. This goes against international standards which recommend that prisoners and people in detention receive equitable health care with the population outside of prisons.
usually need to request condoms from doctors or social service personnel, meaning that they have to admit that they are having sex with other prisoners. Despite the evidence that sex is frequent in prisons, a questionnaire sent to prison doctors showed that the amount of condoms they ‘prescribe’ is negligible - according to one response, 43 condoms per year for 700 prisoners.\(^\text{113}\)

There are several other significant problems that incarcerated people living with HIV face in Germany. In North Rhine Westphalia, for example, there is evidence of non-voluntary disclosure of HIV-status in prisons, as well as standards that discriminate against persons living with HIV. If a prisoner living with HIV in North Rhine Westphalia wants to share a room with other prisoners, or if he wants to participate in social activities, he needs to declare his HIV-status in written form. If he is not willing to declare it, he cannot participate in certain social activities and may be forced to remain isolated in his cell. Prisoners with HIV are very often not allowed to work in the kitchen or in the bakery, demonstrating discrimination based on HIV-status and a lack of understanding regarding methods of transmission. This leads not only to the deprivation of possible income for prisoners, but also restricts in-prison training for certain professions. Additionally, HIV-positive prisoners are sometimes excluded from recreation activities. These practices clearly violate individual rights to privacy and confidentiality, and are highly discriminatory.\(^\text{114}\)

### 10.3. Travel Restrictions and Immigration

According to the submission of David Haerry and Peter Wiessner, five out of 20 countries participating in the meeting have some form of travel and immigration restrictions for people living with HIV. Most high-income countries have reversed restrictions on short- and long-term entry for people living with HIV, but in some jurisdictions, limitations on work permits, residence and naturalisation remain.

- In Andorra, no work or residency permits are granted to people living with HIV, hepatitis, cancer or diabetes. Restrictions apply to all foreigners, including EU citizens.

- In Canada, foreigners intending to stay in Canada for more than six months have to undergo a medical examination. Since January 2002, the testing for HIV is one of the mandatory examinations. The majority of foreigners testing positive for HIV are not granted a residence permit for Canada.

- In Cyprus, foreign nationals applying for residence permits in order to work or to study must undergo a medical examination to confirm that there is no infection with HIV, hepatitis B/C or syphilis.

- In the German province of Bavaria, foreigners intending to stay for more than 180 days in Bavaria may be requested to undergo an examination for HIV, tuberculosis and syphilis. The execution of this test lies within the remit of the responsible officer and can only be done in case of concrete suspicion.

- In Israel, there are specific regulations for working migrants: the “Foreign Workers Law” requires a health check, including an HIV test. Documented migrants from endemic zones (like sub-Saharan Africa) are checked for HIV on arrival. *The Law of Return* (1948) gives the right to deny entry in the presence of transmissible diseases presenting a danger to public health.

These practices go against internationally accepted human rights standards, as they violate freedom of movement, and have no basis in public health rationale. According to the International Guidelines on HIV/AIDS and Human Rights, any restrictions based on suspected or real HIV status alone are discriminatory and cannot be justified by public health concerns, as according to current international health regulations, the only disease which requires a certificate for international travel is yellow fever. In terms of immigration, states should not single out HIV, as opposed to other comparable conditions, but should be forced to establish that high medical costs would indeed be incurred in the case of the individual seeking residency.\(^\text{115}\) It should also be taken into account that with the current advances in ART, individuals with HIV usually lead long and healthy lives, during which they make positive contributions to the economy and pay taxes.
When HIV-positive aliens are denied permission to stay in a high-income country, they face deportation, which leads to the most egregious violations of human rights. According to Paul Adomako of the African Black Diaspora Global Network on Canada, inadequate laws, procedures, polices and treatment guidelines for deportees living with HIV lead to treatment delays, interruptions, and stoppages. This diminished access to treatment can have a direct impact on health, including mental health, HIV drug resistance, diminished personal agency, and access to other basic human rights. Some deportees are returned to developing countries with reduced treatment access, inferior drug regimens, or inadequate social supports and mechanisms. Instead, high-income countries must apply the international law principle of non-refoulement (absolute prohibition on the forced departure of a person to another state where there are substantial grounds for believing that the person would be in danger of being subjected to torture or other cruel, inhuman or degrading treatment or punishment) in these cases.\textsuperscript{116}

10.4. Migrants

Although high-income countries (apart from the US) provide legal residents with free health care services, including ART, both legal and illegal migrants frequently face difficulties in accessing health care services. For example in Germany, undocumented migrants receive only emergency health care treatment. Asylum seekers, until their application is decided, have only limited access to health care services. When undocumented migrants with HIV or AIDS seek care or start the legalisation process in Germany, they may face risk of deportation. For HIV-positive asylum seekers, access to ART will only be facilitated and costs will only be covered when opportunistic infections or other life threatening conditions occur. Ironically, relatively ‘good chances’ of avoiding deportation for undocumented migrants exist if they are already in the late stages of HIV infection.\textsuperscript{117}

France has adopted an encouraging solution to addressing HIV among migrants. According to Adeline Toullier, a representative of AIDES France, French legislation protects sick aliens from deportation. Since 1998, French law has provided beneficial access to health care, and special temporary residence permits for sick foreigners who have no access to treatment in their countries of origin. This efficient and pragmatic system of protection has had positive results - after 12 years of this practice, it has not been shown to generate increased migration on therapeutic grounds or increase the cost of the social and health care system. More than 90% of sick aliens discovered their diagnoses after arrival. In 2008, 28,000 sick foreigners claimed special temporary health care permits, 6,000 of whom were HIV-positive. Thanks to residence permits, many people benefitting from the French law can live a healthy life, can work and pay taxes, and can take care of themselves and reduce HIV transmission.\textsuperscript{118}

10.5. Other areas of discrimination

According to statements made by Dialogue participants and the submissions received by the Commission, some European countries report discrimination in such areas as insurance and employment. In France, people living with HIV have difficulties accessing insurance: in order to get a mortgage, one needs to get insurance, for which an HIV test may be required. In effect, the French Insurance Code discriminates against people living with HIV. The consequences can be serious and the inability to buy a house represents a significant matter for people living with HIV, particularly those with children. Jerome Farina Cussac, a representative from SIDA Information Service, struck a hopeful note when he relayed how his organisation tried to find a way to prevent this lawful discrimination. They negotiated with insurance companies and banks, and created a compact, which is not a binding agreement, but a declaration of intention. Insurance companies have promised in all cases to make a very detailed and precise analysis of all applications, including from people living with HIV, and reach case-by-case solutions. Banks agreed to accept securities other than insurance

\textsuperscript{116} Kwaku Paul Adomako, African Black Diaspora Global Network, Canada
\textsuperscript{117} Carolin Vierneisel, Internationales Abteilung Strukturelle Prävention 2, Germany
\textsuperscript{118} Adeline Toullier, AIDES France, France.
to secure mortgages.\footnote{Jerome Farina Cussac, SIDA Information Service.} In fact, both banks and insurance companies eventually understood that such discrimination of persons living with HIV would not be good for their businesses. While the rates for people living with HIV may be higher than average rates, they remain affordable.

In a similar vein, Spanish insurance companies deny life insurance to people living with HIV and AIDS. A submission from Spain explains the work of the Legal Advisory Service of REDVIH to end this discrimination - the organisation proposes that based on actuarial evidence, insurance companies must eliminate such exclusions and take into account the circumstances of each case, as they do, for example, with other conditions and risks such as smoking.\footnote{From the submission of Belinda Hernandez, Legal Advisory Service from Human Rights Observatory of REDVIH, Spain}
Conclusion

Some overriding themes and suggestions emerged throughout discussions at the Dialogue, which were expressed by many participants. In conclusion, participants expressed the following:

- Lawmakers should ensure that laws and policies are based on evidence and science, not fear and ignorance. Such laws should be supported by efforts to create enabling environments for their effective implementation.

- Criminal law and the criminal justice system are inappropriate tools for the HIV response and should be disengaged from it and the lives of persons living with HIV and vulnerable communities. This includes the need to eliminate criminalisation of adult consensual behavior related to sex i.e. sex work and same sex relationships.

- Universal education on sexual health is imperative to ensure that all are aware of and protected from HIV transmission.

- Promoting and assuring equality could have a profound impact on the HIV epidemic - empowering women and girls, racial and ethnic minorities, LGBT persons and people in marginalised contexts such as those living with HIV, those in prisons and those who use drugs.

- Drug use should be treated as a public health concern and not a criminal issue. People who use drugs should get treatment, access to harm reduction, HIV-related services, etc. and not prison sentences.

- It is crucial to de-link essential medicines from intellectual property laws in order to ensure that the basic human right to health is attainable for all, including persons living with HIV.
Annex I: Commissioners who attended the HIC Regional Dialogue

Mr. Stephen Lewis (Canada, Co-Director of AIDS-Free World)
Mr. JVR Prasada Rao (India, former Secretary of Health)
Ms. Barbara Lee (America, Congresswoman from California’s 9th District)
## Annex II: List of civil society participants

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<thead>
<tr>
<th>NAME</th>
<th>ORGANISATION</th>
<th>COUNTRY</th>
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<td>Programme Droits et VIH</td>
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<tr>
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<td>David Lewis-Peart</td>
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<td>Jerome Farina Cussac</td>
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<td>Jorge Roquec</td>
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<td>Marielle Nakunzi</td>
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<td>Christian Antonio Mollerup</td>
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<td>Deborah Glejser</td>
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<td>Catherine Murphy</td>
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<td>Melissa Hope Ditmore</td>
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<td>Cecilia Chung</td>
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<td>Steve Rolles</td>
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<td>Dominic Bocci</td>
<td>American Society for Muslim Advancement</td>
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<tr>
<td>Vanessa Johnson</td>
<td>National Association of People with AIDS</td>
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<tr>
<td>Scott Schoettes</td>
<td>Lambda Legal Defense &amp; Education Fund</td>
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<tr>
<td>Brook Kelly</td>
<td>US Positive Women’s Network</td>
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<tr>
<td>Sienna Baskin</td>
<td>Sex Workers Project, Urban Justice Coalition</td>
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</tr>
<tr>
<td>Catherine Hanssens</td>
<td>HIV Law and Policy</td>
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</tr>
<tr>
<td>Peter Maybarduk</td>
<td>Global Access to Medicines Program Director, Public Citizen</td>
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</tr>
<tr>
<td>Sean Strub</td>
<td>Global Network of People Living with HIV (GNP+)</td>
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</tr>
<tr>
<td>Jeff Selbin</td>
<td>East Bay Community Law Center</td>
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</tr>
<tr>
<td>Linda Tam</td>
<td>East Bay Community Law Center’s HIV/AIDS Law Project</td>
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<tr>
<td>Deon Haywood</td>
<td>Women with a Vision</td>
<td>USA</td>
</tr>
<tr>
<td>Andrew Jolivette</td>
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<tr>
<td>Sophie Bloemen</td>
<td>Health Action International (HAI) Europe</td>
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</tr>
<tr>
<td>Naomi Alkers</td>
<td>UN Sex Work Advisory Group</td>
<td>USA</td>
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## Annex III: List of government experts

<table>
<thead>
<tr>
<th>NAME</th>
<th>ORGANISATION</th>
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<tbody>
<tr>
<td>Petra Bayr</td>
<td>MP, Austrian Parliament</td>
<td>AUSTRIA</td>
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<tr>
<td>Helmut Graupner</td>
<td>Attorney, Expert on Criminal Law linked to Austrian Department of Justice</td>
<td>AUSTRIA</td>
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<tr>
<td>Paul Dewar</td>
<td>MP, Canadian Parliament</td>
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<tr>
<td>Warren O’Briain</td>
<td>Communicable Disease, Harm Reduction and Mental Health Promotion, British Columbia Ministry of Health</td>
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<tr>
<td>Ciro Panessa</td>
<td>Director, Blood Borne Pathogens, British Columbia Ministry of Health</td>
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<tr>
<td>Kelly Steele</td>
<td>Policy Analyst, Health Canada</td>
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<tr>
<td>Eleni Theocharous</td>
<td>MEP, European Parliament</td>
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<tr>
<td>Elena Kamilarova</td>
<td>Directorate General for Trade, European Commission</td>
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<tr>
<td>Jani Toviola</td>
<td>MP, Finnish Parliament</td>
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<td>Francoise Castex</td>
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<td>Erik Joseffson</td>
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<tr>
<td>Heather Alcock</td>
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<tr>
<td>Dan Wohlfeiler</td>
<td>Department of Public Health, California</td>
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<tr>
<td>Jim McDermott</td>
<td>US Congressman</td>
<td>USA</td>
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<tr>
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<tr>
<td>Svend Robinson</td>
<td>Global Fund for AIDS, TB &amp; Malaria</td>
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<td>Chelsea Moore</td>
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<tr>
<td>Alice Miller</td>
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<tr>
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<tr>
<td>Sofia Gruskin</td>
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<tr>
<td>Erin Le</td>
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<tr>
<td>Yvonne Troya</td>
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<td>Tina Saladino</td>
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<tr>
<td>Amy N. Kapczynski</td>
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<tr>
<td>Allison Davenport</td>
<td>International Human Rights Law Clinic, UC Berkeley Law</td>
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<tr>
<td>Jay Purcell</td>
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<td>Sangina Patnaik</td>
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<tr>
<td>Michael Guest</td>
<td>Former US Ambassador to Romania</td>
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<tr>
<td>Dan Torres</td>
<td>Staff Attorney, Immigrant Legal Rights</td>
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## Annex V: Dialogue Advisory Group members

<table>
<thead>
<tr>
<th>NAME</th>
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<tbody>
<tr>
<td>Moono Nyambe</td>
<td>EUROPE</td>
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<tr>
<td>Michel Maietta</td>
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<td>Edwin Bernard</td>
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<td>Pauline Park</td>
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<td>Eric Sawyer</td>
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<tr>
<td>Chitra Aiyar</td>
<td>USA</td>
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<td>Rebecca Schleifer</td>
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