



GLOBAL COMMISSION ON

HIV and the LAW

RISKS, RIGHTS & HEALTH

JULY 2012

ERRATUM

- In the originally published version of “Risks, Rights and Health”, the following sentence was included on p 41: “In New Zealand, sex work has recently been prosecuted under the same law that officially decriminalizes it.” The sentence is not accurate and has been deleted from current on-line versions of the report. It will not be included in hard copies of the report distributed in the future.
- At the time of the original publication of “Risks, Rights and Health”, the European Parliament had not yet made a final decision on whether or not to ratify the Anti-Counterfeiting Trade Agreement (ACTA). Subsequent to original publication, the EU Parliament made a decision on 4 July 2012 to not ratify the agreement. On-line versions of “Risks, Rights and Health” now include the following additional sentence on p. 82: “*ACTA caused such controversy that on 4 July 2012, the European Parliament declined to ratify European Union participation in the Agreement.*”
- The ILO Recommendation concerning HIV and AIDS and the World of Work 2010 (no. 200) is applicable to all workers. The standard establishes key human rights principles to guide HIV responses in formal and informal work settings. These principles include non-discrimination and gender equality, particularly non-discriminatory access to HIV-related prevention, treatment, care and support services for all workers. The recommendation calls for governments to take measures to provide for effective protections against HIV-related discrimination and provide for their effective and transparent implementation. Sex workers are not excluded from the scope and application of this recommendation.

The content, analysis, opinions and policy recommendations contained in this publication do not necessarily reflect the views of the United Nations Development Programme.

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ABOUT THE GLOBAL COMMISSION ON HIV AND THE LAW

The Global Commission on HIV and the Law consisted of fourteen distinguished individuals who advocate on issues of HIV, public health, law and development. Fernando Henrique Cardoso, former president of Brazil, chaired the Commission.

The Commission's unique convening power allowed it to focus on high-impact issues of HIV and the law, which have important ramifications for global health and development. The Commission advocated for evidence and human rights based legal environments for effective and efficient HIV responses.

The life experiences of the Commissioners gave them a formidable ability to access a wide cross-section of society. This means they are well placed to influence change on complex issues that require the engagement of multiple stakeholders across a range of sectors.



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ABOUT THE COMMISSION'S REPORT

"HIV and the Law: Risks, Rights & Health" is the Commission's flagship publication. Released in July 2012, the report presents public health, human rights and legal analysis and makes recommendations for law and policy makers, civil society, development partners and private sector actors involved in crafting a sustainable global response to HIV.

PREFACE

The end of the global AIDS epidemic is within our reach. This will only be possible if science and action are accompanied by a tangible commitment to respecting human dignity and ending injustice.

Law prohibits or permits specific behaviours, and in so doing, it shapes politics, economics and society. The law can be a human good that makes a material difference in people's lives. It is therefore not surprising that law has the power to bridge the gap between vulnerability and resilience to HIV.

We came together as a group of individuals from diverse backgrounds, experiences and continents to examine the role of the law in effective HIV responses. What we share is our abiding commitment to public health and social justice. We have listened with humility to hundreds of accounts describing the effects of law on HIV. In many instances, we have been overwhelmed by how archaic, insensitive laws are violating human rights, challenging rational public health responses and eroding social fabric. At other times, we have been moved by those who demonstrate courage and conviction to protect those most vulnerable in our societies.

Many would say that the law can be complex and challenging and is best left alone. Our experience during this Commission has shown us a very different perspective. We have been encouraged by how frank and constructive dialogue on controversial issues can sometimes quickly lead to progressive law reform, the effective defence of legislation or better enforcement of existing laws. Even in environments where formal legal change is a slow and arduous process, we have witnessed countries taking action to strengthen access to justice and challenge stigma and discrimination.

As we listened and learned over the past eighteen months, many of us found our perspectives and opinions changing on a range of complex issues. Ultimately, we chose to be guided in our final recommendations by the courage and humanity of those who have died of AIDS and the thirty four million strong who live on with HIV.

This report presents persuasive evidence and recommendations that can save lives, save money and help end the AIDS epidemic. The recommendations appeal to what is common to all our cultures and communities—the innate humanity of recognising and respecting the inherent worth and dignity of all individuals. This report may make a great many people uncomfortable—hopefully uncomfortable enough to take action. Undoubtedly, different countries will prioritise different recommendations. Each country needs to develop its own road map for reform, depending on its legal and political environment. Nevertheless, we are confident that all of the recommendations are relevant in every country of the world, given that the drivers of the HIV epidemic exist all over the world. The time has come to act on these recommendations. We cannot continue to let people suffer and die because of inequality, ignorance, intolerance and indifference. The cost of inaction is simply too high.



Fernando Henrique Cardoso

Chair, Global Commission on HIV and the Law

ACKNOWLEDGMENTS

The Global Commission on HIV and the Law is an independent body, established at the request of the Programme Coordinating Board of the Joint United Nations Programme on HIV/AIDS (UNAIDS) and supported by a Secretariat based at the United Nations Development Programme (UNDP). This report reflects the views and conclusions of the Commission, as well as its recommendations to countries, civil society actors, the private sector and the United Nations.

First and foremost, the Commission expresses its gratitude to the 1000 plus individuals who made written and oral submissions and who shared their knowledge and experience with such generosity. This report pays tribute to their courage and humanity in seeking a world that is fundamentally more just.

The Commission would like to express its appreciation for the leadership of Helen Clark (Administrator, UNDP) and Michel Sidibé (Executive Director, UNAIDS).

The Commission's work has been ably guided by the contribution and commitment of its Technical Advisory Group: *The Hon. Michael Kirby (Co-chair), Allehone Mulugeta Abebe (Co-chair), Aziza Ahmed, Jonathan Berger, Chris Beyrer, Scott Burris, Joanne Csete, Mandeep Dhaliwal, Sophie Dilmitis, Vivek Divan, Richard Elliott, Sofia Gruskin, Wendy Isaack, Rick Lines, Annie Madden, Kevin Moody, Vitit Muntarbhorn, Cheryl Overs, JVR Prasada Rao, Tracy Robinson, Purna Sen, Susan Timberlake, Matthew Weait.*

The Commission warmly acknowledges the support of its Secretariat under the leadership of Jeffrey O'Malley (Director, HIV/AIDS Practice, UNDP) and Mandeep Dhaliwal (Cluster Leader: Human Rights & Governance, HIV/AIDS Group, UNDP). Vivek Divan, Ian Mungall and Emilie Pradichit were the Secretariat's unflagging core and the Commission is grateful for their hard work and dedication. The Commission also acknowledges the valuable contributions of the numerous staff, consultants, interns and volunteers who supported their work over the last eighteen months,^a with particular appreciation for Judith Levine, the report's lead author. The Commission also wishes to express its appreciation for the support of the Joint UN Programme on HIV/AIDS.

The Commission is grateful to Edwin Cameron, who was a Commissioner. In light of his obligations as a judge of the Constitutional Court of South Africa, he did not contribute to any of the substantive decisions of the Commission. Because of his judicial duties, he decided to officially step down as a Commissioner at the end of 2011.

Financial support for the Commission was generously provided by the American Jewish World Service (AJWS), Australian Agency for International Development (AusAID), Ford Foundation, Health Canada – International Affairs, Norwegian Agency for Development Cooperation (Norad), Office of the High Commissioner for Human Rights, Open Society Foundations, Swedish International Development Cooperation Agency (Sida), UNDP, UNFPA, UNICEF and the UNAIDS Secretariat.

^a Imam Ahmed, Nada Al Riahi, Fattouh Al-Shazly, Natalie Amar, Tenu Avafia, Zeinab Badawi, Brook Baker, Ahmad Balah, Stefan Baral, Tim Barnett, Asmita Basu, Glenn Betteridge, Kim Blankenship, Dominic Bocci, Ludo Bok, Jennifer Branscombe, Andrei Brighidin, Meagan Burrows, Robert Carr, Jorge Chediek, Jessica Chiu, Cliff Cortez, Megan Cribbs, Joachim da Silva Paiva Fernandes, Emma Day, Miguel Darcy, Daniel de Castro, Karen de Meritens, Martine Dennis, Reeti Desai, Amy Edwards, Ehab El Kharrat, Mohamed El Said, Wahid Ferchichi, Susana Fried, Jorge Gestoso, John Godwin, Laura Goldsmith, Catherine Grant, Moustapha Gueye, Theira Guzman, Vera Hakim, Lisa Hamelmann, Brianna Harrison, Adela Hive, Amy Kapczynski, Yelena Khanga, Boyan Konstantinov, Ernesto Kraus, Jelena Kucelin, Patricia Kunderát, Krista Lauer, Virginie Leclerc, John Macauley, Lerato Mahlaole, Keletso Makofane, Allan Maleche, Arnold Madikwe, Christina Magill, Alice Miller, Chris Molomo, Godfrey Maringa, Tania Martins Fidalgo, Rumbidzai Maweni, Kathleen Meara, Ratna Menon, Khadija Moalla, Bechir N'Daw, Alyaa Nabil, Mariana Nerpil, Cecilia Oh, Fredda Olivares, Norma Garcia de Paredes, Andrea Pastorelli, Deena Patel, Nisha Pillai, Tonia Poteat, David Ragonetti, Nadia Rasheed, Jirair Ratevosian, Janaina Reis, Jenny Rouse, David Ruiz, Amitrajit Saha, Rohan Sajjani, Margaret Sakatsie, Karin Santi, Nashida Sattar, Eric Sawyer, Aaron Scheinwald, Diana Schirca, Tilly Sellers, Edmund Settle, Ji-Eun Seong, Svati Shah, Shonali Shome, Anthony So, Ann Strode, Ashwini Sukthankar, Mohan Sundararaj, Ala Svet, Maria Tallarico, Dudley Tarlton, Dimitri Teresh, Christos Tsentas, Cheikh Traore, Kazayuki Uji, Leah Utyasheva, Nadeah Vali, Marta Vallejo, Marcel van Soest, Pierre-Etienne Vannier, Bhikshuni Weisbrot, Daniel Wolfe and Ajcharawan Yubolkosol.

ABBREVIATIONS

ACTA	Anti-Counterfeiting Trade Agreement
ADA	Americans with Disabilities Act
AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CRC	Convention on the Rights of the Child
EECA	Eastern Europe and Central Asia
EPA	Economic Partnership Agreement
EU	European Union
FGM	Female Genital Mutilation
FTA	Free Trade Agreement
HIV	Human Immunodeficiency Virus
ICESCR	International Convention on Economic, Social and Cultural Rights
ICW	International Community of Women with HIV
ILGA	International Lesbian and Gay Association
ILO	International Labour Organisation
IOM	International Organisation for Migration
IP	Intellectual Property
LDC	Least Developed Countries
LGBT	Lesbian, Gay, Bisexual and Transgender
MAT	Medication Assisted Treatment
MDG	Millennium Development Goal
MENA	Middle East and North Africa

MSM	Men Who Have Sex with Men
NGO	Non-Governmental Organisation
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	People Living with HIV
PMTCT	Preventing Mother-to-Child Transmission
R&D	Research and Development
SEP	Syringe Exchange Programmes
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TPPA	Transpacific Partnership Agreement
TRIPS	Trade-Related Aspects of Intellectual Property Rights
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UN DESA	United Nations Department of Economic and Social Affairs
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development
WHO	World Health Organization
WIPO	World Intellectual Property Organisation
WTO	World Trade Organization

EXECUTIVE SUMMARY

In just three decades, over 30 million people have died of AIDS, and 34 million more have been infected with HIV. The HIV epidemic has become one of the greatest public health challenges of our time. It is also a crisis of law, human rights and social justice. The good news is that we now have all the evidence and tools we need to radically slow new HIV infections and stop HIV-related deaths. Paradoxically, this comes at a time when bad laws and other political obstacles are standing in the way of success.

34 million people are living with HIV, 7,400 are newly infected daily and 1.8 million died in 2010 alone. The legal environment—laws, enforcement and justice systems—has immense potential to better the lives of HIV-positive people and to help turn the crisis around. International law and treaties that protect equality of access to health care and prohibit discrimination—including that based on health or legal status—underpin the salutary power of national laws.

But nations have squandered the potential of the legal system. Worse, punitive laws, discriminatory and brutal policing and denial of access to justice for people with and at risk of acquiring HIV are fueling the epidemic. These legal practices create and punish vulnerability. They promote risky behaviour, hinder people from accessing prevention tools and treatment, and exacerbate the stigma and social inequalities that make people more vulnerable to HIV infection and illness. HIV-positive people—be they parents or spouses, sex workers or health workers, lovers or assailants—interact intimately with others, who in turn interact with others in ever-larger circles, from the community to the globe. From public health to national wealth, social solidarity to equality and justice, HIV affects everyone. The prevention, treatment and care of HIV—and the protection and promotion of

the human rights of those who live with it—are everyone's responsibility.

The Global Commission on HIV and the Law

undertook 18 months of extensive research, consultation, analysis and deliberation. Its sources included the testimony of more than 700 people most affected by HIV-related legal environments from 140 countries, in addition to expert submissions and the large body of scholarship on HIV, health and the law.

The Commission's findings offer cause for both distress and hope for people living with or at risk for HIV. In June 2011, 192 countries committed to reviewing legislation and creating enabling legal and social environments that support effective and efficient HIV responses. The Commission's recommendations offer guidance to governments and international bodies in shaping laws and legal practices that are science based, pragmatic, humane and just. The findings and recommendations also offer advocacy tools for people living with HIV, civil society, and communities affected by HIV. The recommendations take into account the fact that many laws exist for purposes beyond public health, such as the maintenance of order, public safety and the regulation of trade. But they place the highest priority on creating legal environments that defend and promote internationally recognised human rights and legal norms.

Among the Commission's findings:

- 123 countries have legislation to outlaw discrimination based on HIV; 112 legally protect at least some populations based on their vulnerability to HIV. But these laws are often ignored, laxly enforced or aggressively flouted.

- In over 60 countries it is a crime to expose another person to HIV or to transmit it, especially through sex. At least 600 individuals living with HIV in 24 countries have been convicted under HIV-specific or general criminal laws (due to underreporting, these estimates are conservative). Such laws do not increase safer sex practices. Instead, they discourage people from getting tested or treated, in fear of being prosecuted for passing HIV to lovers or children.
- Women and girls make up half of the global population of people living with HIV. Laws and legally condoned customs—from genital mutilation to denial of property rights—produce profound gender inequality; domestic violence also robs women and girls of personal power. These factors undermine women's and girls' ability to protect themselves from HIV infection and cope with its consequences.
- Where sex education, harm reduction and comprehensive reproductive and HIV services are accessible to youth, young people's rates of HIV and other sexually transmitted infections (STIs) drop. These interventions are rare, however, and in both developed and developing nations, the denial of the realities of young people's lives is reflected in the high physical, emotional and social toll of HIV among the young.
- In many countries, the law (either on the books or on the streets) dehumanises many of those at highest risk for HIV: sex workers, transgender people, men who have sex with men (MSM), people who use drugs, prisoners and migrants. Rather than providing protection, the law renders these "key populations" all the more vulnerable to HIV. Contradictory to international human rights standards, 78 countries—particularly

governments influenced by conservative interpretations of religion—make same-sex activity a criminal offence, with penalties ranging from whipping to execution. Similarly, laws prohibiting—or interpreted by police or courts as prohibiting—gender nonconformity, defined vaguely and broadly, are often cruelly enforced. The criminalisation of sex work, drug use and harm reduction measures create climates in which civilian and police violence is rife and legal redress for victims impossible. Fear of arrest drives key populations underground, away from HIV and harm reduction programmes. Incarceration and compulsory detention exposes detainees to sexual assault and unsafe injection practices, while condoms are contraband and harm reduction measures (including antiretroviral medicines) are denied.

- A growing body of international trade law and the over-reach of intellectual property (IP) protections are impeding the production and distribution of low-cost generic drugs. IP protection is supposed to provide an incentive for innovation but experience has shown that the current laws are failing to promote innovation that serves the medical needs of the poor. The fallout from these regulations—in particular the TRIPS framework—has exposed the central role of excessive IP protections in exacerbating the lack of access to HIV treatment and other essential medicines. The situation is most dire in low- and middle-income countries but reverberates through high-income countries as well. Provisions allowing some low- and middle-income countries exceptions to and relaxations of these rules could help alleviate the crisis, but pressure against their use is substantial. A small number of countries have been able to take advantage of the few international legal flexibilities that exist.

The Commission has found reason for hope. There are instances where legal and justice systems have played constructive roles in responding to HIV, by respecting, protecting and fulfilling human rights. To some such an approach may seem a paradox—the AIDS paradox.^b But compelling evidence shows that it is the way to reduce the toll of HIV.

- Where the police cooperate with community workers, condom use can increase and violence and HIV infection among sex workers can decrease. Where governments promulgate harm reduction, such as clean needle distribution programmes and safe injection sites, HIV infection rates among people who use drugs can drop significantly.
- Effective legal aid can make justice and equality a reality for people living with HIV, and this can contribute to better health outcomes. Advocates can creatively use traditional law in progressive ways to promote women's rights and health. Court actions and legislative initiatives, informed by fairness and pragmatism, can help nations shrug off the yoke of misconceived criminalisation, introduce gender-sensitive sexual assault law and recognise the sexual autonomy of young people.
- Despite international pressures to prioritise trade over public health, some governments and civil society groups are using the law to ensure access to affordable medicines, while exploring new incentives for medical research and development.

These successes can be—and need to be—expanded. It will take money and will. Donors, whose giving has flagged, must step up and reverse this trend, especially if the latest advances

in science and in prevention programming are to benefit those in need. Countries must honour international human rights and national legal obligations. Where laws do not enhance human well-being and where laws do not respond to contemporary realities, they must be repealed and replaced by those that do. For justice and dignity, human rights and human life, the world can afford no less.

To ensure an effective, sustainable response to HIV that is consistent with human rights obligations, the Commission forcefully calls for governments, civil society and international bodies to:

- Outlaw all forms of discrimination and violence directed against those who are vulnerable to or living with HIV or are perceived to be HIV-positive. Ensure that existing human rights commitments and constitutional guarantees are enforced.
- Repeal punitive laws and enact laws that facilitate and enable effective responses to HIV prevention, care and treatment services for all who need them. Enact no laws that explicitly criminalise HIV transmission, exposure or non-disclosure of HIV status, which are counterproductive.

^b According to The Hon. Michael Kirby, the AIDS paradox can be described as follows: "It is a paradox, one of the most effective laws we can offer to combat the spread of HIV is the protection of persons living with HIV, and those about them, from discrimination. This is a paradox because the community expects laws to protect the uninfected from the infected. Yet, at least at this stage of this epidemic, we must protect the infected too. We must do so because of reasons of basic human rights. But if they do not convince, we must do so for the sake of the whole community which has a common cause in the containment of the spread of HIV."

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- Work with the guardians of customary and religious law to promote traditions and religious practice that promote rights and acceptance of diversity and that protect privacy.
 - Decriminalise private and consensual adult sexual behaviours, including same-sex sexual acts and voluntary sex work.
 - Prosecute the perpetrators of sexual violence, including marital rape and rape related to conflict, whether perpetrated against females, males, or transgender people.
 - Abolish all mandatory HIV-related registration, testing, and forced treatment regimens. Facilitate access to sexual and reproductive health services and stop forced abortion and coerced sterilisation of HIV-positive women and girls.
 - Reform approaches towards drug use. Rather than punishing people who use drugs but do no harm to others, governments must offer them access to effective HIV and health services, including harm reduction programmes and voluntary, evidence-based treatment for drug dependence.
 - Enforce laws against all forms of child sexual abuse and sexual exploitation, clearly differentiating such crimes from consensual adult sex work.
 - Ensure that the enforcement of laws against human trafficking is carefully targeted to punish those who use force, dishonesty or coercion to procure people into commercial sex, or who abuse migrant sex workers through debt bondage, violence or deprivation of liberty. Laws against human trafficking must be used to prohibit sexual exploitation, but they must not be used against adults involved in consensual sex work.
 - In matters relating to HIV and the law, offer the same standard of protection to migrants, visitors and residents who are not citizens as is extended to citizens. Restrictions that prohibit people living with HIV from entering a country and/or regulations that mandate HIV tests for foreigners within a country should be repealed.
 - Enforce a legal framework that ensures social protection for children living with and affected by HIV and AIDS. Laws must protect guardianship, property and inheritance rights, and access to age-appropriate, comprehensive sex education, health and reproductive services.
 - Develop an effective IP regime for pharmaceutical products. Such a regime must be consistent with international human rights law and public health needs, while safeguarding the justifiable rights of inventors.

The Commission forcefully calls for a renewed and vigorous international collaboration in response to HIV.

It calls on donors, civil society and the UN to hold governments accountable to their human rights commitments. It urges groups outside government to develop and implement humane, workable HIV-related policies and practices and to fund action on law reform, law enforcement and access to justice. Such efforts should include educating people about their rights and the law, preventing violence as well as challenging the stigma and discrimination within families, communities and workplaces that continue to feed a worldwide epidemic that should have ended long ago.

INTRODUCTION: CAN LAWS SAVE LIVES?

The law alone cannot stop AIDS. Nor can the law alone be blamed when HIV responses are inadequate. But the legal environment can play a powerful role in the well-being of people living with HIV and those vulnerable to HIV. Good laws, fully resourced and rigorously enforced, can widen access to prevention and health care services, improve the quality of treatment, enhance social support for people affected by the epidemic, protect human rights that are vital to survival and save the public money.

Every community in every country is home or host to people living with HIV. At the end of 2010, they numbered 34 million; alongside them are millions more at risk of infection.¹ And although prevention and treatment have improved to a heartening degree over the past decade, almost 7,400 new people are infected each day. Only half of adults and a quarter of children eligible for life-saving anti-retroviral treatment under WHO guidelines received that care in 2010. That year, 1.8 million people died of AIDS-related causes.²

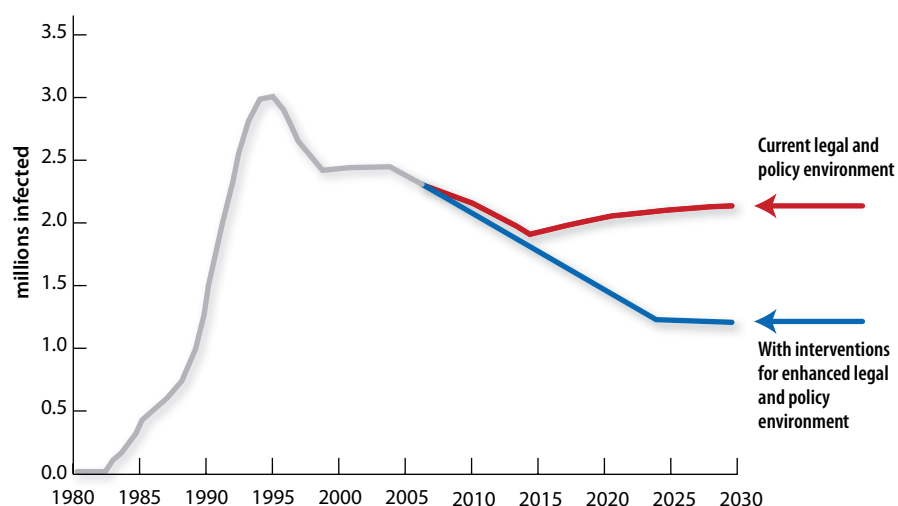
The law and its institutions can protect the dignity of all people living with HIV, and in so doing fortify those most vulnerable to HIV, so-called “key populations”;^c such as sex workers, MSM, transgender people, prisoners and migrants. The law can open the doors to justice when these people’s rights are trampled. By ensuring access to property and protection from all forms of violence, the law can improve women’s lives and give them the power and independence they need to preserve their health and that of their children.

WHY THE LAW MATTERS

Annual number of new HIV infections among adults aged 15–49

- historical trend
- current trend
- structural change*

* change to legal and policy environment



Source: Results for Development Institute, Costs & Choices: Financing the Long-Term Fight Against AIDS, An aids2031 Project, 2010.

^c According to the International HIV/AIDS Alliance, key populations are groups of people who are more likely to be exposed to HIV or to transmit it and whose engagement is critical to a successful HIV response. In all countries, key populations include people living with HIV. In most settings, men who have sex with men, transgender people, people who inject drugs and sex workers and their clients are at higher risk of exposure to HIV than other groups.

But the law can also do grave harm to the bodies and spirits of people living with HIV. It can perpetrate discrimination and isolate the people most vulnerable to HIV from the programmes that would help them to avoid or cope with the virus. By dividing people into criminals and victims or sinful and innocent, the legal environment can destroy the social, political, and economic solidarity that is necessary to overcome this global epidemic. Indeed, the world could have halted the HIV epidemic over a decade ago, sparing millions of lives and billions of dollars, but the political will and courage to do so was and is lacking.

What works? An effective HIV vaccine or cure would be a “game changer”, and scientists are working to find one. Meanwhile, as experience and evidence have taught us, much can be done even without a medical miracle. The combination of appropriate prevention and broadly available treatment can significantly rein in and even halt the spread of new infections. With therapy, most people with HIV can remain healthy and productive for decades. Each of these chips away at the number of deaths—mostly, at modest cost.³

But even as governments and international donors invest millions to combat HIV, around the globe many legal environments are hindering rather than helping HIV responses. Indeed, in many instances public health programmes to combat HIV are undermined by laws that criminalise the very practices the public health efforts promote and depend on—such as distributing clean needles and opioid substitution therapy to people who use drugs, providing condoms and harm reduction measures to prisoners, or supporting the free association of sex workers for the purposes of mutual support and education. If lawmakers do not amend these laws so that all resources are

marshalled against the same enemy—HIV, not people living with HIV—the virus will be the victor and the world’s people, especially its most vulnerable, the vanquished.

It is in this context that the Programme Coordinating Board of the Joint UN Programme on HIV/AIDS called on UNDP to establish the Global Commission on HIV and the Law (the Commission).⁴ An independent body chaired by Fernando Henrique Cardoso, former president of Brazil,⁵ the Commission comprises 14 eminent individuals from across the world and is supported by a Technical Advisory Group of people living with HIV, members of affected communities and experts on law, public health, human rights and HIV.

Based on an analysis of where the law could transform the AIDS response and send HIV epidemics into decline, the Commission focused its inquiry on: (1) laws and practices that criminalise those living with and most vulnerable to HIV; (2) laws and practices that sustain or mitigate violence and discrimination against women; (3) laws and practices that facilitate or impede access to HIV-related treatment; and (4) issues of law pertaining to children and young people in the context of HIV.

The law often seems abstract and distant, and it can be hard to comprehend. But the plain truth about the law comes through in the words of the people who informed the Commission’s inquiry. For people living with HIV, for their families and communities, for key populations and those vulnerable to HIV, the law is neither abstract nor distant. It is police harassment or clean needles, prison cells or self-help groups—the law is the torturer’s fist or the healer’s hand.



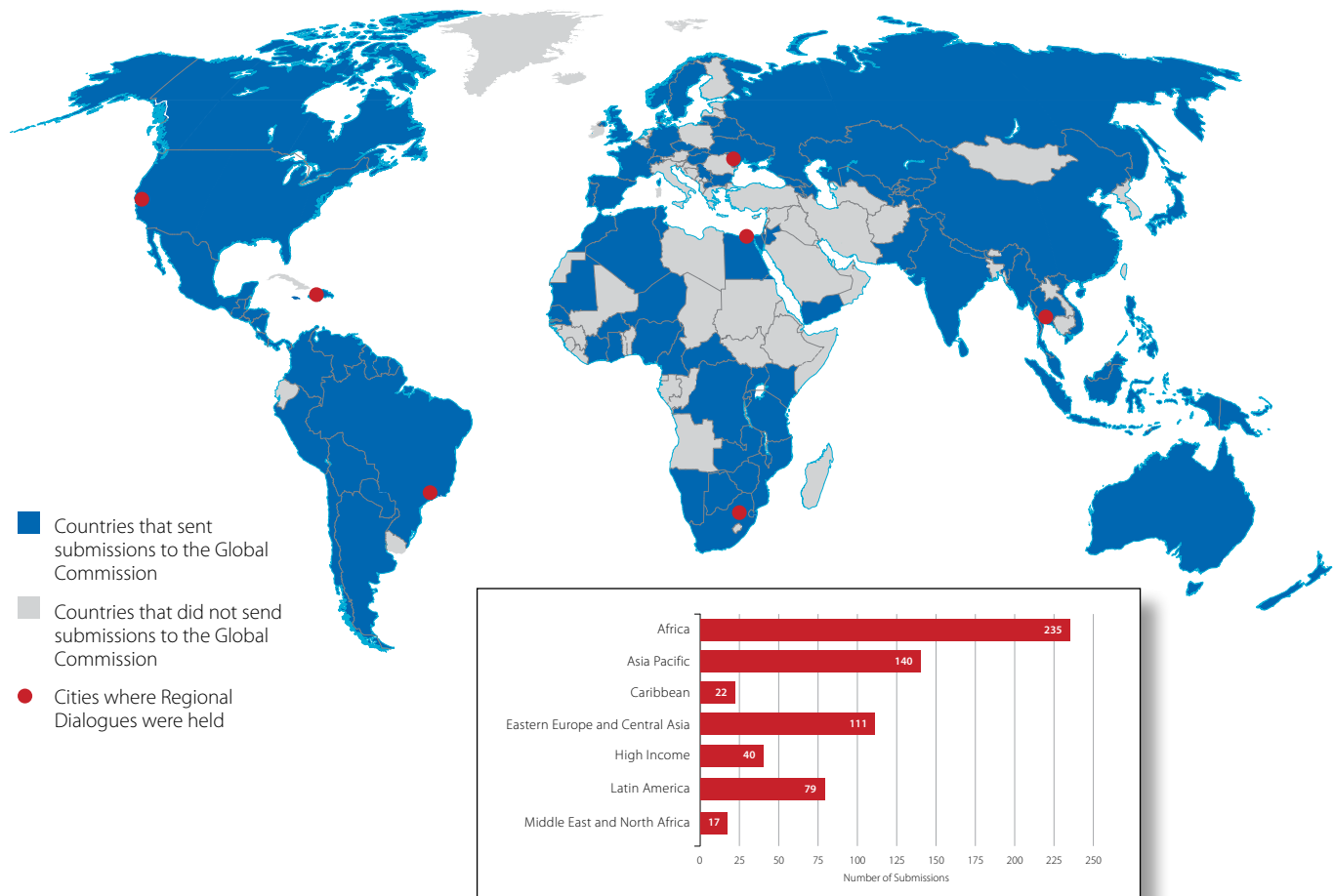
HOW THE COMMISSION REACHED ITS CONCLUSIONS

The Global Commission on HIV and the Law undertook a broad and rigorous process of research, analysis and deliberation. The Commission used public health data, legal analysis, qualitative research, and community consultations to build an understanding of how legal environments influence HIV epidemics. Conscious that laws exist for important reasons that go beyond public health—the protection and promotion of human rights, maintaining public order and safety and the regulation of trade—the Commission also examined the degree to which HIV-related law, on the books and in practice, is consistent with human rights and other legal norms.

The Commission was supported by a Technical Advisory Group,⁶ which reviewed and analysed existing public health and legal evidence and also commissioned original analysis. This process was complemented by extensive consultation, resulting in the review of 680 written submissions from over 1,000 authors in 140 countries. Seven regional dialogues⁷ were convened (the largest of which was in Africa) to share and deliberate on evidence and experience. Through these dialogues, Commissioners heard the voices of over 700 people most affected by HIV-related law, including people living with HIV, people who had been prosecuted for HIV-related offences, prison directors, police officials, ministers of justice, health and home affairs, public health officials and religious leaders. Specialist submissions were sought from legal, human rights, and women's organisations, pharmaceutical manufacturers and religious scholars. Finally, the Commissioners reflected on the considerable body of analysis and findings directly related to HIV and health in existing human rights scholarship, including the work of Special Rapporteurs on the "Right to Highest Attainable Standard of Health" and "Violence Against Women". Except in the cases where confidentiality was requested, the written submissions⁸ and dialogue proceedings, discussion papers and sources are available on www.hivlawcommission.org.

Together, these sources provided compelling evidence of the critical relevance of law to HIV and the inextricable linkages between the respect for human dignity and effective, sustainable HIV responses. The Commission's recommendations are therefore rooted in both solid public health evidence and human rights norms. Most recommendations are directed to "countries", embracing not just Heads of State, Parliamentarians and other political actors, but also the judiciary, agents of law enforcement, municipal authorities, the private sector and civil society. States have a specific obligation to protect and promote human rights, but only a concerted effort from the whole of society will truly advance public health and social justice.

WRITTEN SUBMISSIONS RECEIVED BY THE COMMISSION



Note: Total Submissions: 680. 644 submissions were received for Regional Dialogues and 36 specialist submissions were received from experts and specialist organisations on HIV, health and the law.

Sources: Submissions received from November 2010 to October 2011. This includes all submissions for the Regional Dialogues and the Specialist Submissions. The world map has been inspired from AIDS-Free World.

AGAINST DISCRIMINATION

Health and Dignity Through Law



Source: UNDP/Sarah Mwilima/Namibia

HUMAN RIGHTS: THE PILLARS OF EQUALITY

Equality and non-discrimination, inviolable in every key international human rights agreement, are the pillars on which all other human rights rest.⁹ So, although there is no binding international law expressly prohibiting discrimination on the basis of HIV status, those two principles guide and support the denunciation of discrimination related to HIV status and against the people it affects.

NATIONAL LEGISLATION AND COURT ACTIONS

Every country has some kind of legal framework to protect and promote human rights and challenge discriminatory practices. Many have ratified one or more of the nine core international human rights treaties¹⁰ or various regional human rights treaties.¹¹ Many go further to outlaw HIV-related discrimination. The Member States of the UN General Assembly, in the 2011 Declaration of Commitment on HIV/AIDS and the 2006 and 2011 Political Declarations on

In 2009 I met my status. I was invited to be on TV as I was a professional footballer. My girlfriend's father saw this interview, the girl told me he didn't know about HIV and told her he couldn't accept the relationship. Her father (a police officer) came to arrest me at my house at 7am. I knew some of my rights so they just beat me up and put me in a cell in the police station. It was very bad. They just kept me in detention until an association of human rights marched to the police station and then I was freed. This story impressed my life. I could be bitter but I will fight to the end.

Noubissi Charles Domingo, RéCAP+, Cameroon, Africa Regional Dialogue, 3–4 August 2011

HIV/AIDS, committed themselves to using the law to eliminate all forms of discrimination against people living with HIV.¹² The Inter-American Commission on Human Rights¹³ and the Parliamentary Assembly of the Council of Europe have also advocated for the prohibition of such discrimination.¹⁴

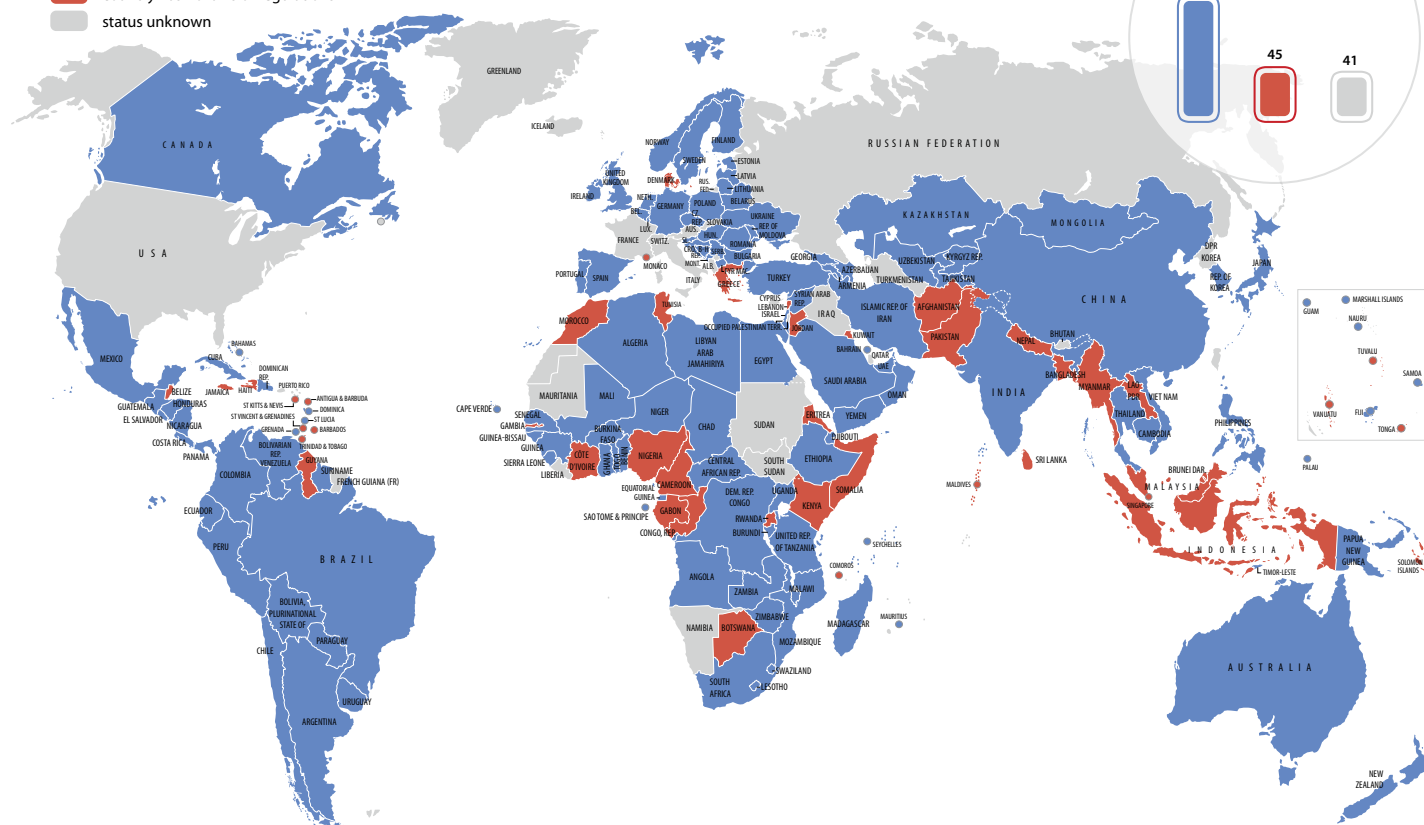
Some anti-discrimination laws find their underpinnings in national constitutions; others are built of case law or state-recognised religious law, such as the concept of privacy in Sharia. Of 168 countries reviewed by UNAIDS, 123 reported that they had passed legislation to outlaw discrimination based on HIV.¹⁵ 111 countries have specific non-discrimination laws or regulations that protect at least some specific populations based on their vulnerability to HIV.¹⁶

More precisely, advocates and lawmakers have turned to the category of “other status” as the basis of protecting the rights of HIV-positive people, actual or presumed, their children

LEGAL SHELTER

Laws to protect from HIV-related discrimination

- country has laws or regulations
- country has no laws or regulations
- status unknown



Sources: Making the Law Work for the HIV Response: UNAIDS Snapshots of laws that support or block universal access to HIV prevention, treatment, care and support, 2010; Brief for Parliamentarians on HIV and AIDS: Making the law work for the response to HIV. Inter-Parliamentary Union (IPU), UNAIDS, UNDP, 2011

THE LETTER OF THE LAW

The Philippines – AIDS Control and Prevention Act of 1998¹⁷

"[D]iscrimination, in all its forms and subtleties, against individuals with HIV or persons perceived or suspected of having HIV shall be considered inimical to individual and national interest." The Act also specifically prohibits discrimination in the workplace, schools, travel and habitation, public service, credit and insurance service, hospitals and health institutions and burial services.

The Bahamas – Employment Act of 2001¹⁸

"No employer or person acting on behalf of an employer shall discriminate against an employee or applicant for employment on the basis of race, creed, sex, marital status, political opinion, age or HIV/AIDS."

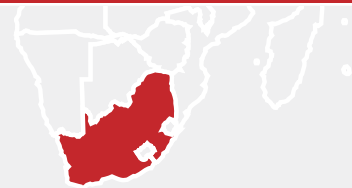
Australia – Anti-Discrimination Act of 1997¹⁹

It is unlawful for a person "by a public act, to incite hatred towards, serious contempt for, or severe ridicule of" anyone actually or thought to be HIV-positive.

ECONOMIC DEATH

*Hoffmann v. South African Airways*²⁰

South African Airways had a policy against hiring HIV-positive people as cabin attendants. The Constitutional Court of South Africa overturned the policy, ruling that the blanket exclusion of HIV-positive people from employment infringes the constitutional guarantee of equality.



People living with HIV cannot be “condemned to economic death” by the denial of equal opportunity in employment, the Court said, and added that HIV-positive people enjoy special protection from discrimination under the Employment Equity Act. In its ruling, the Court invoked the principle of *ubuntu*—a Zulu word conveying the recognition of the human worth and respect for the dignity of every person.

or parents.²¹ The UN Commission on Human Rights has repeatedly confirmed that the term “other status”—a common category in human rights law comprising unnamed classes to be protected from discrimination—should be interpreted to cover health status, including HIV status.²² Protections against discrimination on the basis of disability may also be useful for people living with HIV, even though there is no universally accepted definition of the word. Most prominently, the Convention on the Rights of Persons with Disabilities contains a “social model” of disability that is broad enough to encompass HIV or AIDS.²³

In some countries, High Courts have ruled that laws prohibiting discrimination based on disability protect people living with HIV based on their sero-status, and that this includes both actual and perceived disability.²⁴ For instance, the Supreme Court of the United States ruled that people living with HIV are protected under the Americans with Disabilities Act.²⁵

Even when there are no laws against HIV-based discrimination, national courts have often looked to constitutional guarantees of dignity

and equality to prohibit discriminatory practices. When HIV-positive people have been kept out of public swimming pools, restaurants, day-care or health services—such bans usually justified by the notion that they protect others’ health—some courts have stepped in to overrule these policies. Some courts have also invoked the rights to livelihood and equality in hiring, as well as the internationally recognised right to “the highest attainable standard of health”.

NEGLECTED ENFORCEMENT, FLOUTED LAWS

Often, legislation commits a nation to guaranteeing internationally affirmed human rights of equality, liberty and health. But for many reasons (such as lack of resources, political chaos or interpretations of religion), governments frequently fail to uphold these obligations. National legislation may prohibit discrimination, but the law is often ignored, laxly enforced or aggressively flouted. In public institutions and in their homes,²⁶ people living with HIV feel the blows of stigma, discrimination, marginalisation and verbal and physical abuse.²⁷ These experiences are often compounded by bigotry (based on sex, gender, sexual orientation, social origin, occupation, race or status as a person who uses drugs or engages in sex work) that spills

“An Ombudsman office exists in the Dominican Republic as per the Constitution, but no one was ever appointed to take office, nor have the resources for its operation been specified and provided.”

Salvador E. Estepan, Dominican Republic, Latin America Regional Dialogue, 26–27 June 2011

onto their families. The children of sex workers and people who use drugs may be tormented by other children; if a parent is HIV-positive, his or her child may be barred from school.²⁸ Many people living with HIV find there is no recourse, nowhere to register a complaint and no authority to redress the problem.

To make law real on the ground, the state must educate health care workers, legal professionals, employers and trade unionists, and school faculties about their legal responsibilities to guarantee inclusion and equality. People living with or affected by HIV must be informed of their rights. The legal ideal of non-discrimination must be defended by enforcement: prompt and affordable access to redress in cases of violations, including affordable, accessible legal services and confidentiality of proceedings.

ADVOCACY FOR EQUALITY

Where there is discrimination, increasingly, people are fighting back. Advocates are pushing to strengthen legal recognition of the rights of HIV-positive people and providing legal help to those whose rights are violated. In Algeria, for instance, the Association de Protection Contre le Sida (APCS) and Le Fond pour les Droits Humains Mondiaux (FDHM), with the support of volunteer lawyers, are bringing claims of discrimination to the courts for MSM, vulnerable women affected by HIV and migrants living in Algeria—people who would not otherwise have a voice.²⁹ At the end of

2011, the report of the Commonwealth Eminent Persons recommended that governments in the Commonwealth of Nations take steps to repeal discriminatory laws that impede effective HIV responses.³⁰

Pressure on governments has often impelled their ministries to require employers and businesses dealing with the public to treat people with HIV fairly. In early 2010, French Finance Minister Christine Lagarde directed insurance and loan companies to review and amend their pensions, health insurance, death benefits and loan disbursement policies with an eye toward reinforcing the social welfare of people living with HIV.³¹ As a result, on 1st February 2011 Christine Lagarde, Minister of Labour, Xavier Bertrand, and Minister of Social Affairs, Roselyn Bachelot, co-signed the 2011 AERAS Convention enabling access to loans, pensions, health insurances and other benefits for people living with aggravated health risks, including people living with HIV. The Convention entered into force on 1 March 2011.³² In Burkina Faso, the Ministry of Labour and Social Security and the International Labour Organization, along with employers' and workers' organisations, are creating a legal and policy framework conducive to HIV prevention and protective of workers' rights in connection with HIV and AIDS. Their efforts go beyond the formal public and private sectors to the informal economy as well.³³

RECOMMENDATIONS

To ensure an effective, sustainable response to HIV that is consistent with human rights obligations:

- 1.1. Countries must ensure that their national HIV policies, strategies, plans and programmes include effective, targeted action to support enabling legal environments, with attention to formal law, law enforcement and access to justice. Every country must repeal punitive laws and enact protective laws to protect and promote human rights, improve delivery of and access to HIV prevention and treatment, and increase the cost-effectiveness of these efforts.
- 1.2. Where they have not already done so, countries must explicitly prohibit discrimination on the basis of actual or perceived HIV status and ensure that existing human rights commitments and constitutional guarantees are enforced. Countries must also ensure that laws and regulations prohibiting discrimination and ensuring participation and the provision of information and health services protect people living with HIV, other key populations and people at risk of HIV.
- 1.3. Donors, civil society and private sector actors, and the UN should hold governments accountable to their human rights commitments. Groups outside government should develop and implement rights-based HIV-related policies and practices and fund action on HIV-related law reform, law enforcement and access to justice. Such efforts should include educating people about their rights and the law, as well as challenging stigma and discrimination within families, communities and workplaces.

PUNISHING VULNERABILITY

Criminalisation of HIV Transmission, Exposure and Non-Disclosure



Source: www.photos.com

In much of the world it is a crime to expose another person to HIV or to transmit it, especially through sex. Fundamentally unjust, morally harmful, and virtually impossible to enforce³⁴ with any semblance of fairness, such laws impose regimes of surveillance and punishment on sexually active people living with HIV;³⁵ not only in their intimate relations and reproductive and maternal lives, but also in their attempts to earn a living.

Proponents of criminalisation often claim that they are promoting public health or morality. Some may even harbour good-hearted, if wrongheaded, intentions, of safeguarding the rights and health of women. But criminalisation guarantees no one's well-being. There is no evidence that laws regulating the sexual conduct of people living with HIV change behaviour in a positive way.³⁶ Nor do such laws take into account the success of antiretroviral treatment (ART) in significantly

Despite the description . . . by legislators and prosecutors, in fact, it is not intentional transmission but intentional sex while HIV-positive that is the focus of these state laws. . . . The facts of many of these cases read like what should be relics from a less-informed past. Instead, they describe increasingly frequent current events.

Catherine Hanssens, Centre for HIV Law & Policy, U.S., High Income Countries Dialogue, 16–17 September 2011

reducing transmission risk and improving the quality of life and longevity for people with HIV.³⁷ AIDS service organisations report that the threat of prosecution neither empowers people living with HIV to avoid transmission nor motivates them to protect themselves.³⁸ Indeed, the fear of prosecution isolates them and discourages them from getting tested, participating in prevention or treatment programmes or disclosing their status to partners.³⁹ The criminal justice system fights the health care system—one repelling, the other reaching out to people vulnerable to or affected by HIV. By dividing populations into the sick and the healthy or the guilty and the innocent, criminalisation denies the complex social nature of sexual communities and fractures the shared sense of moral responsibility that is crucial to fighting the epidemic.⁴⁰

Some jurisdictions apply existing general offences to criminalise HIV exposure or transmission—from “administration of a noxious substance” (France) to attempted homicide (United States).⁴¹ Others have chosen to target HIV: the first HIV-specific laws were passed in the United States in 1987, with many other nations quickly following



Source: UNAIDS/D. Kim/Korea

suit.⁴² The past decade has seen a new wave of HIV-specific statutes, notably in sub-Saharan Africa and parts of Asia and Latin America.⁴³

Today, countries and jurisdictions in every region of the world have promulgated HIV-specific criminal statutes.⁴⁴ They're on the books in 34 states and 2 territories in the United States⁴⁵; in Africa, 27 countries have them; in Asia and the Pacific, 13; Latin America, 11; and Europe, 9.⁴⁶ According to a 2010 report by the Global Network of People Living with HIV (GNP+), at least 600 people living with HIV in 24 countries⁴⁷ have been convicted under HIV-specific or general criminal laws, with the greatest numbers reported in North America.⁴⁸

RIGHTS AND RESPONSIBILITIES

In Africa alone over the last seven years, numerous countries have adopted HIV-specific criminal legislation.⁴⁹ In every case, the irony is glaring: these laws, which purport to be based on human rights principles, in fact trample human rights. This continent-wide contradiction derives largely from the Model Law on STI/HIV/AIDS for West and Central Africa, developed at a workshop held in N'Djamena, Chad, in 2004.⁵⁰ This template, conceived as human rights legislation to combat discrimination and address HIV testing, takes a "rights and responsibilities" approach. For instance, it includes guarantees of pre- and post-testing counseling and anti-discrimination protections in employment and insurance for HIV-positive people. At the same time, it holds HIV-positive people legally responsible for disclosing their HIV status to anyone they have sex with and taking active

measures to prevent transmission. Failure to do so brings criminal sanctions.

Some jurisdictions punish exposure even if there is no transmission of HIV, and some punish transmission even if the person wears a condom; prosecutions proceed in spite of the medical near-impossibility of determining who infected whom. And, because ART significantly reduces the likelihood of transmission, it is access to treatment, not criminalisation, that is effective in reducing infection.⁵¹

WHAT GETS PROSECUTED . . .

The main "criminal activity" for people who are HIV-positive is sex, and the laws can be overly broad and the penalties draconian. For instance, Bermuda makes it a crime for people living with HIV to have any kind of sexual contact in which body fluids might pass to another person.⁵² As a consequence, two people have received ten-year sentences, though HIV was not transmitted in either case.⁵³ In Singapore, those who merely have reason to believe that they may be HIV-positive or might have been exposed to significant risk of contracting the virus face ten years' imprisonment if convicted of having sex without informing their partner of the possible risk or taking reasonable precautions against transmission.⁵⁴

But sex is not the only "crime" for which HIV-positive people may be punished. Spitting and biting have been prosecuted. Advocates worry that simply being pregnant or breastfeeding with HIV could land a woman in prison. In many penal codes these laws are extraordinary for the personal surveillance they represent and the wildly disproportionate sentences they carry.

. . . AND WHO

In 2008 in Texas, United States, an African-American mentally ill homeless man living with HIV spat at a police officer during an arrest for drunk and disorderly conduct. The jury was persuaded that his saliva was a deadly weapon,⁵⁵ and he got a thirty-five-

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

Edwin J. Bernard, Germany, High Income Countries Dialogue, 16–17 September 2011

year sentence—despite the fact that HIV cannot be transmitted by spitting. In 1988 an HIV-positive Minnesota prisoner was convicted of biting two prison guards: His mouth and teeth were found to be a “deadly and dangerous weapon.”⁵⁶

In Denmark, Estonia, Finland, Sweden and the United Kingdom, migrants and asylum seekers have been disproportionately represented among those prosecuted for HIV transmission and exposure.⁵⁷ In some jurisdictions, HIV-positive people convicted of a crime, such as rape, can face an exacerbated sentence—positive serostatus is viewed as an aggravating factor, akin to using a weapon in the crime’s commission.⁵⁸

As these last examples suggest, anti-transmission and exposure laws are often arbitrarily and disproportionately applied to those who are already considered inherently criminal⁵⁹—both reflecting and perpetuating existing social inequalities.

Sensational media coverage of HIV-transmission prosecutions exaggerates the alleged evil and dangerousness of HIV “perpetrators.” Sarah Jane Porter, a forty-three-year-old British single mother and hair salon receptionist, was convicted in 2006 and sentenced to thirty months for grievous bodily harm in transmitting HIV to her former boyfriend. The press portrayed her as a wildly promiscuous “AIDS avenger” on a rampage against black men

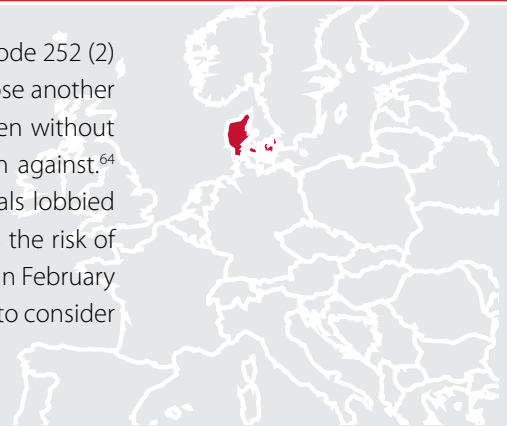
like her son’s father, from whom she had contracted HIV. The police, claiming she had dozens of potential victims, put out a nationwide call for accusers and three of the four they contacted tested negative for HIV. While describing Porter as “callous” and “manipulative”, the prosecution praised her accusers as “very articulate professional decent men who were trying to do their best in life”. Porter’s friends and neighbours, meanwhile, described a quiet, overworked mother whose boyfriend had asked for unprotected sex and whose only “crime” was her denial of her own HIV status—the reason she did not disclose it to others.⁶⁰

Although proponents often argue that criminalisation is needed to protect women, especially monogamous wives, from the risk of HIV infection by male sexual partners, in reality such laws make criminals of the same women they’re intended to protect.⁶¹ HIV-positive mothers are criminals under all of the HIV laws of West and Central Africa, which explicitly or implicitly forbid them from being pregnant or breastfeeding, lest they transmit the virus to foetus or child.⁶² The law does not acknowledge that women are frequently unable to disclose their HIV status or demand the use of a condom because they fear violence, abuse or abandonment by their husbands or partners and/or are worried that information might be used as a tool for revenge or coercion.⁶³ As for alleging the intentional transmission of HIV from a mother to a child, the concept is so unlikely as to approach absurdity.

ON SECOND THOUGHT

Denmark reconsiders its harsh law

Until 2011, Denmark had one of the harshest laws criminalizing HIV. Penal Code 252 (2) made it a crime for anyone with HIV to willfully or negligently infect or expose another to the risk of infection. This meant that a person could be found guilty even without actual transmission—exactly the sort of law that UNAIDS and UNDP warn against.⁶⁴ A coalition of people living with HIV, medical experts and legal professionals lobbied the government intensely, pointing out that ART now significantly reduces the risk of transmission and allows most HIV-positive people to live long, healthy lives. In February 2011, the government suspended the law and established a working group to consider its revision or outright repeal, based on new scientific evidence.⁶⁵



IS CRIMINALISATION EVER JUSTIFIED?

Criminalisation is justified under one condition only: where individuals maliciously and intentionally transmit or expose others with the express purpose of causing harm. But existing laws—against assault, homicide and causing bodily harm, or allowing intervention where a person is spreading communicable diseases⁶⁶—suffice to prosecute people in those exceptional cases. Defining specific HIV offences is not warranted and, in fact, violates international human rights standards. For instance, in the International Guidelines on HIV and Human Rights, Guideline 4 directs States to ensure that their criminal laws “are not misused in the context of HIV/AIDS or targeted against vulnerable groups.”⁶⁷

That said, such laws are virtually impossible to prosecute. Intentional transmission is difficult to prove in the context of consensual sex. Alleging “recklessness” or “negligent” transmission is equally problematic.⁶⁸ It requires proving the defendant’s state of mind—getting testimony from health care professionals, diaries or emails offering insight into a defendant’s thoughts. UNAIDS and UNDP have called on governments to limit criminalisation to cases where a person knows his or her HIV-positive status, acts with intent to

transmit HIV and actually transmits it. However, most Western legal systems allow the defence of consent, thus preventing the punishment of, for example, Roman Catholic husbands with HIV whose wives have consented to the risk of transmission rather than offend against religious proscriptions concerning non-procreative sex.⁶⁹

Myriad other considerations arise. Did the defendant know her HIV status?⁷⁰ Did she know how HIV is transmitted? Did she think her partner already was aware of her status or consented to unsafe sex? Was the defendant under threat of violence from the complainant and thus unable to disclose her status or practice safer sex? Was it actually the defendant who transmitted HIV to the complainant? Phylogenetic analysis^{71,d} which can establish whether the sub-type of HIV in the defendant’s body is the same as in the complainant’s, is far too costly for many low-resource countries. Additionally, it doesn’t offer incontrovertible proof of who infected whom.

DIFFERENT QUESTIONS, DIFFERENT LAWS

International bodies and national governments are starting to recognise the injustice of sprawling HIV criminalisation laws and amend them so as to zero in on intentional, malicious acts.

^d Phylogenetic analysis examines small genetic differences in HIV. Unlike human DNA, which remains stable for a lifetime, HIV’s RNA changes very rapidly, leading to a huge amount of genetic diversity. Phylogenetic analysis can only determine the degree of relatedness of two samples of HIV. It cannot create a definitive ‘match’.

UNAIDS issued recommendations that include alternative ways of phrasing some provisions in the N'Djamena model law to make them more precise.⁷² In the past few years Guinea, Togo and Senegal have revised their HIV-related legislation or adopted new laws that restrict the use of criminal law to the exceptional cases of intentional transmission.⁷³ The Finnish Expert Group on HIV has also recently initiated efforts to change the law to avoid policies that reinforce HIV-related stigma and discrimination.⁷⁴ Denmark and Norway are considering revision or repeal.⁷⁵ In 2011, Guyana's Parliamentary Select Committee rejected a bill calling for the criminalisation of HIV.⁷⁶ And Mauritius revoked criminalisation of HIV transmission.⁷⁷

Arresting HIV-positive people for seeking pleasure and intimacy is a defeatist and cynical response to the failure of nations to confront the epidemic. The sad case of Sarah Jane Porter (see discussion earlier in the chapter) raises many questions not even approached by the criminalisation response to HIV. Was her son's father aware of his HIV status and, if so, why did he persuade her to have unprotected sex and why did she consent? Why did she deny her illness and shy away from treatment? Why was she passive in defending herself in court? How can women—and men—be empowered to take care of themselves and others?

RECOMMENDATIONS

To ensure an effective, sustainable response to HIV that is consistent with human rights obligations:

- 2.1. Countries must not enact laws that explicitly criminalise HIV transmission, HIV exposure or failure to disclose HIV status. Where such laws exist, they are counterproductive and must be repealed. The provisions of model codes that have been advanced to support the enactment of such laws should be withdrawn and amended to conform to these recommendations.
- 2.2. Law enforcement authorities must not prosecute people in cases of HIV non-disclosure or exposure where no intentional or malicious HIV transmission has been proven to take place. Invoking criminal laws in cases of adult private consensual sexual activity is disproportionate and counterproductive to enhancing public health.
- 2.3. Countries must amend or repeal any law that explicitly or effectively criminalises vertical transmission of HIV⁷⁸. While the process of review and repeal is under way, governments must place moratoria on enforcement of any such laws.
- 2.4. Countries may legitimately prosecute HIV transmission that was both actual and intentional, using general criminal law, but such prosecutions should be pursued with care and require a high standard of evidence and proof.
- 2.5. The convictions of those who have been successfully prosecuted for HIV exposure, non-disclosure and transmission must be reviewed. Such convictions must be set aside or the accused immediately released from prison with pardons or similar actions to ensure that these charges do not remain on criminal or sex offender records.

CHAPTER 3

RISK + STIGMA

Key Populations^e



Source: UNAIDS/South Africa

The lived experiences of sex workers, people who use drugs and LGBT (lesbian, gay, bisexual and transgender) people show the impossibility of governments stigmatising people on one hand while simultaneously actually helping to reduce their risk of HIV transmission or exposure on the other.

Anna Forbes, Sex Workers Coalition, U.S., High Income Countries Dialogue, 16–17 September 2011

To safeguard their health and that of others, key populations—the people at greatest risk of HIV infection (including MSM, transgender people, sex workers, people who use drugs, prisoners and at-risk migrants)—must have access to effective HIV prevention and treatment and commodities such as clean needles and syringes, condoms and lubricant. Numerous international bodies call the provision of these things a human rights obligation. But a needle or a condom is only the concrete representation of what key populations (like everyone) are entitled to: the fundamental human rights of dignity, autonomy and freedom from ill

treatment, as well as the right to the highest attainable standard of physical and mental health, regardless of sexuality or legal status.⁷⁹

Countries and donors fail to invest sufficiently in the inexpensive commodities that can stop infection or the programmes to promote and distribute them, and some governments criminalise their possession. Not only do states fail to protect HIV-vulnerable people from violence or ensure their access to justice, governments stand by as their agents administer society's messages of disgust and contempt—beatings, extortion, torture, selective or arbitrary

^e According to the International HIV/AIDS Alliance, key populations are groups of people who are more likely to be exposed to HIV or to transmit it and whose engagement is critical to a successful HIV response. In all countries, key populations include people living with HIV. In most settings, men who have sex with men, transgender people, people who inject drugs and sex workers and their clients are at higher risk of exposure to HIV than other groups. See, UN Political Declaration to Shape HIV Response, International HIV/AIDS Alliance, June 17, 2011, available at: <http://www.aidsalliance.org/newsdetails.aspx?id=290951%20>.

arrest, punishment vastly disproportionate to the alleged infraction, unsafe prison conditions, and mistreatment rather than protection in cases of violence.

Such abusive practices are usually illegal, yet they persist. They are not simply the aberrant acts of a small number of poorly trained officers. In many cases, the police commit violent and discriminatory acts because the law and social attitudes at least tacitly authorise them to do so, in the name of public safety, order, or morality. When the law punishes drug use, sex work, and certain sexual behaviours and identities, key populations can neither count on the police for protection from violence nor seek legal redress when they are its victims, especially when the perpetrators are police officers. After all, under the law, the transgender person or sex worker is the “criminal”. That lack of justice reinforces

the climate of police impunity. Together, punitive laws, discriminatory enforcement and systematic bars to justice violate the basic human rights of key populations; in fact, they practically guarantee such violation.

But even where it is currently impossible to rebuild the edifice of the law, social—even legal—changes can be made. No government explicitly allows police brutality: such acts can be investigated and punished. Stigma and discrimination, similarly, can be challenged—if not by the government, then by community organisations and non-governmental organisations (NGOs). And just as the cycle of discrimination, violence and government neglect of key populations erect barriers to HIV prevention, treatment and care, these incremental changes can help to dismantle those barriers.

When I can work in safe and fair conditions. When I am free of discrimination. When I am free of labels like “immoral” or “victim”. When I am free from unethical researchers. When I am free to do my job without harassment, violence or breaking the law. When sex work is recognised as work. When we have safety, unity, respect and our rights. When I am free to choose my own way. THEN I am free to protect myself and others from HIV.

Empower Foundation, Thailand, Asia-Pacific Regional Dialogue, 16–17 February 2011

THE POWERS OF FAITH

Religion and religious communities can offer emotional succor and social support to people living with or vulnerable to HIV. Religious institutions have often been at the forefront of caring for people living with HIV, and some play important roles in prevention. But narrow and punitive interpretations of religion—especially in concert with law—can also make those most at risk more vulnerable by condemning and criminalising their identities and behaviours. Some countries cite religion to exempt themselves from international human rights guarantees of equality and prohibitions of inhumane punishment. For instance, Egypt has used its right of reservation under a number of international agreements, including CEDAW—the Convention on the Elimination of Discrimination Against Women—where it believes certain articles conflict with Sharia.⁸⁰

Recently, Ugandan Pentecostal Christian evangelicals, with help from their United States counterparts, have pushed forward a draconian Anti-Homosexuality Bill, which originally called for the death penalty in some circumstances. Similar efforts are under way in Malawi, Republic of Congo, Zambia, Zimbabwe and Moldova.⁸¹ In Latin America, some African countries, the Philippines and elsewhere, the Roman Catholic Church has blocked sex education and condom distribution and intervened to curtail the rights of HIV-positive people.⁸² And in its closing remarks at the 2011 High Level Meeting on HIV, the Holy See camouflaged blame of the HIV-positive in the language of concern for them, claiming that “the causes of [HIV/AIDS] clearly reflect a serious crisis of values.”⁸³ Subtly expressing the Church’s rejection of harm reduction and other proven pragmatic prevention strategies—and even the principle that all people are born with dignity—its spokesperson said: “Prevention first and foremost must be directed toward formation and education in responsible human behavior or, in other words, acquired human dignity.”⁸⁴ At the same time, many religious institutions have been crucial players in the HIV response. In Malaysia, where injection drug use is the main driver of HIV transmission, the Malaysian AIDS Council has partnered with the government’s Department of Islamic Development to promote evidence-based public health responses to HIV and replace ideological conservatism with pragmatism.⁸⁵ Mauritania has pledged to uphold human rights in working to reconcile the flawed but partially valuable N’Djamena model with Islam. And the Laotian Buddhist Metta Dhamma Project works with communities in HIV prevention and care and offers spiritual support to people living with HIV throughout Southeast Asia.⁸⁶

It is clear that all major religious traditions, as well as other customary legal systems, have doctrine or theology that can be used to fight discrimination and exclusion; to protect privacy and health; and to support public health measures that reduce harm to key populations, people with HIV and those around them. Unfortunately, many religious traditions also have other elements of doctrine that are cited to justify extremely harsh penalisation of prostitution, drug use and homosexual behaviour—sometimes to the point of the death penalty. Sharia may be interpreted in a way that gives men power over women. All this increases HIV vulnerability.

To alleviate suffering, religious and secular actors must work together to harmonise the practices of faith with the ideals of human rights. Such progress is possible. The notion of fundamental human rights grew out of natural law concepts, often founded on human dignity ascribed to divine characteristics of humanity.

RECOMMENDATIONS

- 3. To ensure an effective, sustainable response to HIV that is consistent with human rights obligations, countries must prohibit police violence against key populations. Countries must also support programmes that reduce stigma and discrimination against key populations and protect their rights.**

3.1 PEOPLE WHO USE DRUGS



Source: UNAIDS/Eastern Europe

I had a lot of problems with violations of human rights when I was using drugs. I was constantly pressured by the police. I have often been ill-treated only for the fact that I am a drug user and I was repeatedly tortured during interrogation. I was denied access to medical care when I was suffering from a high temperature and an abscess.

Maxim Demchenko, Light of Hope NGO – Poltava, Ukraine, Eastern Europe and Central Asia Regional Dialogue, 18–19 May 2011

Among the greatest risks of drug use is heightened exposure to HIV infection. HIV risk is particularly elevated for the approximately 16 million people worldwide who inject drugs. About 3 million are reported to already be infected with HIV, and about one in ten new HIV infections is related to injection drug use.⁸⁷ And although sharing infected needles and syringes is the most widespread route of HIV transmission amongst drug users, other drug-taking practices can also put people at risk. Sharing of some other drug paraphernalia may also share HIV, and many different kinds of drugs can lead to higher rates of sexual risk-taking.⁸⁸

HIV is not the only harm to befall people who use drugs: excessive use or addiction can inflict many other injuries to health and life. But it is not just the drugs that may endanger users, nor is it just the drugs plus the scant access users have to services for HIV and health care.⁸⁹ Punitive laws enforced against people who use drugs but do no harm to others fuel the spread of HIV and keep users from accessing services for HIV and health care.⁹⁰

HIV can be transmitted between people who use drugs through unsafe injection practices, such as sharing needles in which HIV-infected blood lingers. If HIV-positive people who use drugs have sex without a condom, the virus can be transmitted to their sexual partners. Harm reduction can make the difference between health and HIV infection—between life and death—not just for people who inject drugs but also for their sex partners and their communities. Multiple systematic reviews of evidence have shown that countries or jurisdictions that have legalised comprehensive harm reduction services have significantly reduced HIV infections among people who use drugs, compared with persistent or growing rates in countries or jurisdictions where such services are restricted or blocked by law.⁹¹

The differences can be striking, as is the case with two cities in Scotland. Edinburgh effectively prohibited the purchase and possession of syringes without a prescription in 1981 and had HIV prevalence amongst drug injectors of over 50% by

WHAT IS HARM REDUCTION?

“Harm reduction” refers to policies, programmes and practices aimed at reducing the harms associated with the use of illegal drugs—but not prevention or cessation of drug use itself. Harm reduction focuses on people who, for whatever reason, continue to use drugs, helping them protect their health and that of their drug-using companions, sex partners or children.⁹²

The UN General Assembly, the UN Commission on Narcotic Drugs, UN human rights bodies and specialised agencies such as the WHO recommend a comprehensive package for the prevention, treatment and care of HIV among injection-drug users, including:

- Clean-needle and syringe programmes
- Opioid substitution therapy and other evidence-based drug dependence treatment
- HIV testing and counseling
- Antiretroviral therapy
- Prevention and treatment of STIs
- Condom distribution
- Targeted information and education
- Vaccination, diagnosis and treatment of viral hepatitis
- Prevention, diagnosis and treatment of tuberculosis⁹³

1984.⁹⁴ In Glasgow, however, syringe purchase and possession was allowed, and HIV prevalence amongst drug users remained very low, between 1% and 2%.⁹⁵

INTERNATIONAL & NATIONAL DRUG LAWS

Three UN conventions govern the contemporary international drug control system. The Single Convention on Narcotic Drugs (1961) mandates that narcotic drugs (such as opium, coca, marijuana and their derivatives) be produced, distributed, possessed and used for medical and scientific purposes only.⁹⁶ The 1971 Convention on Psychotropic Substances puts similar restrictions on primarily synthetic psychotropic substances, such as amphetamines, barbiturates, benzodiazepines and psychedelics.⁹⁷ The 1988 Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances promotes co-operation among states to address the international dimension of trafficking.⁹⁸

Because drug trafficking harms society, these conventions aim to reduce the supply of drugs, largely through criminal sanctions.⁹⁹ However,

while the conventions do allow for treatment, rehabilitation and social reintegration—as opposed to punishment—the approach to people who use drugs has been predominantly repressive.¹⁰⁰ Almost everywhere, drug policy falls under the aegis of law enforcement and not of health, and outlaws individual drug possession and use. Some laws also mandate compulsory treatment for drug dependence, testing for suspected drug use and registration of drug users.¹⁰¹

Several decades of experience show that repressive drug control laws and policies fail to achieve their purported goals, whether fighting crime or reducing drug use or drug-related harm. They worsen health and contribute to increasing human rights violations against people who use drugs.¹⁰² And they decidedly do not stem HIV infection.¹⁰³

DRUG WARS AND CASUALTIES

Intentionally or not, “wars on drugs” are wars on people who use drugs, and these people face police harassment, violence and incarceration; discrimination in health care, housing,

“I also propose that you work to close ‘compulsory drug detention centers’ where many drug users are held, yet where the oversight of the courts and justice system do not extend, and where as a result violations of basic human rights are the norm. Failing to successfully ‘treat’ drug users, and resembling military boot camps where they are often housed, these Thai drug ‘rehabilitation centres’ are just an extra-judicial measure to detain people who use drugs, yet detainees enjoy fewer rights than even people in prison”.¹⁰⁴

Kamon Uppakaew, Thai AIDS Treatment Action Group, Thailand, Asia-Pacific Regional Dialogue, 16–17 February 2011

employment and schooling; and political disenfranchisement. Police officers pressed to meet arrest quotas seek out easy targets. Because they are socially, economically and legally marginalised, sometimes living on the streets or in highly policed neighborhoods, people who use drugs are easy targets.¹⁰⁵ In Georgia, drug crackdowns in 2007 resulted in 4% of Georgia’s male population being tested for drugs, many under forced conditions; 35% of these men went to prison on a drug-related charge.¹⁰⁶

In many Eastern European and Central Asian countries, people who use drugs are named on drug registers. These registers brand people who use drugs as sick and dangerous, sometimes for life (in some places, a person who quits using drugs is not removed from the register). They also may result in denial of employment, travel and immigration; loss of child custody; and police harassment.¹⁰⁷ “Rehabilitation” in countries can often be thinly veiled punishment. In Cambodia, Malaysia, China and Vietnam, many people who use drugs endure involuntary treatment in prisons or in drug detention centres. In these places, under the guise of treatment, people who use drugs undergo humiliation, beatings and forced labour—all abuses of their basic human rights.¹⁰⁸ Confinement further increases the risk of HIV transmission: inmates, who have little or no access to condoms, sterile needles and syringes or opioid substitution therapy, engage in unprotected sex and risky injecting behaviour.¹⁰⁹ Recently, Malaysia and Indonesia have rejected the “drug detention centre” approach in favour of voluntary, community-based treatment.¹¹⁰

Criminalisation of drug use undermines human rights-based HIV education, prevention and treatment, including harm reduction programmes.¹¹¹ A 2010 report reviewing harm reduction programmes in Asia found that at least one of the core services of harm reduction is prohibited under law in Cambodia, China, Lao PDR, Myanmar, Malaysia, Philippines, Afghanistan, Bangladesh, India, Maldives, Nepal and Pakistan.¹¹² In fact, many countries criminalise proven interventions such as syringe access¹¹³ and medication-assisted treatment for opioid dependence.¹¹⁴ In Russia and Thailand, people who enrol in public drug treatment programmes are added to registries—which, needless to say, discourages them from seeking treatment.¹¹⁵



Source: UN/Photo/Shehzad Noorani/HIV-positive drug user peer support group, Vietnam

“THE REHAB ARCHIPELAGO”

“Human Rights Watch has found that tens of thousands of people in government-run drug detention centres in Vietnam are held without due process for years, forced to work for little or no pay, and suffer torture and physical violence. Government-run drug detention centres, mandated to ‘treat’ and ‘rehabilitate’ drug users, are little more than forced labour camps where drug users work six days a week processing cashews, sewing garments or manufacturing other items. Refusing to work, or violating centre rules, results in punishment that in some cases is torture.”¹¹⁶

Fear of police action makes people who use drugs wary and furtive. They may avoid carrying sterile injection equipment, which is either explicitly criminalised in some countries and/or used by police as evidence of drug use.¹¹⁷ They may inject quickly to avoid detection,¹¹⁸ dispose of syringes improperly¹¹⁹ or resort to reusing needles.¹²⁰ In Russia, which records 150 new cases of HIV infection daily—7 in 10 of whom are injecting drug users¹²¹—drug treatment programmes provide no services or care related to HIV transmission through unsafe injection practices, and the State Anti-Drug Policy Strategy restricts harm reduction programmes and promotion of harm reduction within the territory of the Russian Federation, including banning opioid substitution therapy until 2020.¹²² The Network for Harm Reduction in Russia is working to delete this, and numerous other counterproductive clauses, from the plan.¹²³

“A practice allowing drug users to purchase syringes over the counter is not common when drug users fear arrest at the pharmacy. Still police officers linger nearby waiting to beat up, arrest or extort drug users seeking help.”

Pun, Nepal, for the Asia-Pacific Regional Dialogue,
16–17 February 2011

CALLING OFF THE POLICE

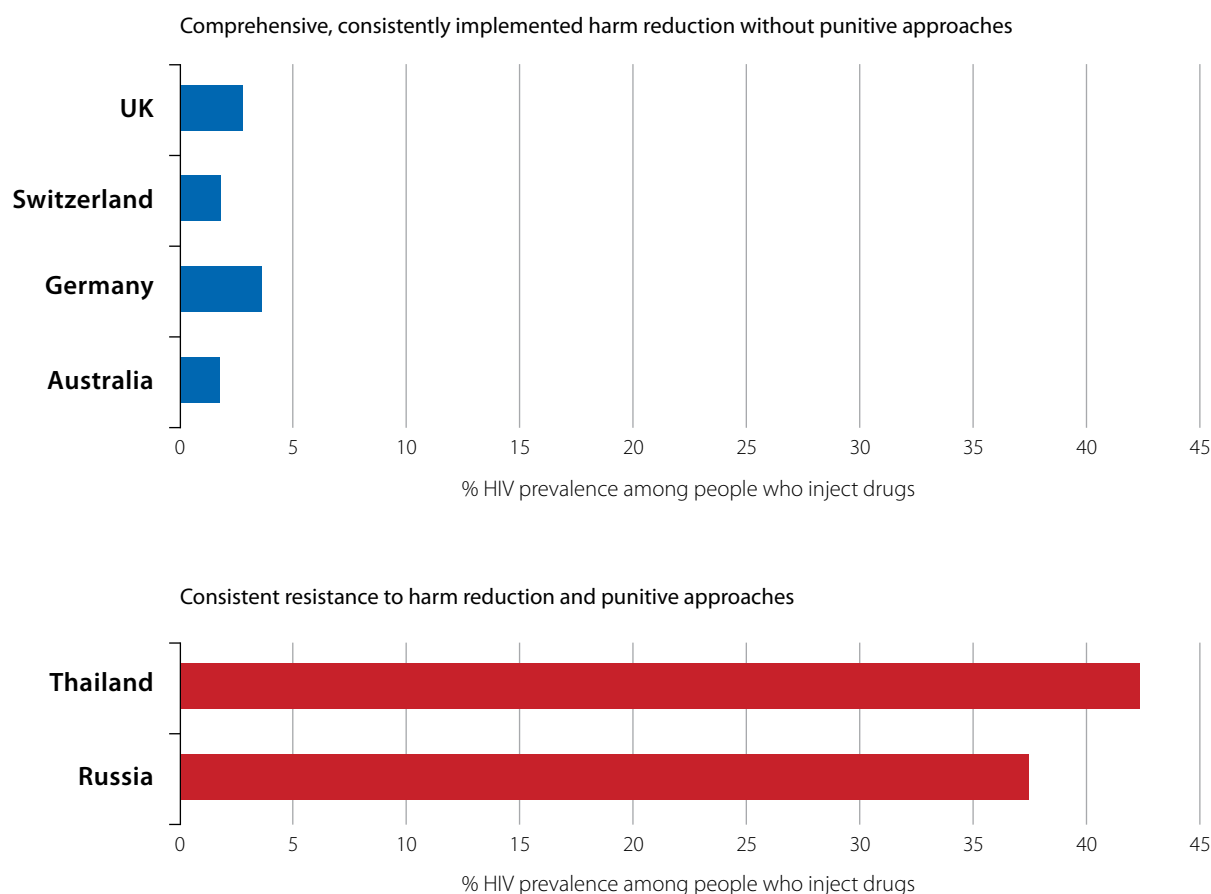
With an understanding that humane policies are more effective in combating drug-related harm and that punitive ones have adverse effects on individuals and communities, some governments are supplanting policing with public health promotion. More than half of the 158 countries and territories where injecting drug use is reported to occur have adopted such policies and programmes.

In 2010:¹²⁴

- 93 supported harm reduction in policy or practice
- 79 referred explicitly and positively to harm reduction in national policy documents
- 82 had needle and syringe exchange
- 10 had needle and syringe exchange in prisons
- 74 had opioid substitution therapy
- 39 had opioid substitution therapy in prisons
- 8 had drug consumption rooms

New Zealand’s Misuse of Drugs Amendment Act 1987 removed criminal sanctions for the sale of needles and syringes to people who inject drugs. That opened the way for those people to make use of evidence-based HIV services for people who use drugs¹²⁵—without any evidence of an increase in drug use and

MITIGATING THE HARM



Sources: War on Drugs, Report of the Global Commission on Drug Policy, 2011; Mathers B et al., for the 2007 Reference Group to the UN on HIV and Injecting Drug Use: Global epidemiology of injecting drug use and HIV among people who inject drugs: A systematic review. *The Lancet*, Volume 372, Issue 9651, 2008; Mathers B et al., HIV prevention, treatment and care for people who inject drugs: A systematic review of global, regional and country level coverage. *The Lancet*, Volume 375, Issue 9719, 2010.

possession. Australia, Germany and the United Kingdom made similar decisions, achieving low rates of HIV transmission among people who use drugs and—presuming those people might have passed the virus on—the wider population.¹²⁶ Switzerland rejected repressive drug policies and policing practices in favour of a public health approach with regulation. The result? Lower HIV rates and improved health outcomes for people who use drugs.¹²⁷ And the Islamic Republic of Iran in 2005 decided that injecting drug users should be treated as patients by the public health system. The rate of new HIV infections, which had risen until 2005, has dropped ever since.¹²⁸

The regulation of illicit drugs may have a positive impact on reducing HIV.¹²⁹ That is why some experts have argued for decriminalisation without full-out legalisation of drugs used for non-medical purposes. Under a decriminalisation framework, drug use or possession of small amounts remains prohibited by the state, but infractions fall under the aegis of civil or administrative law, and penalties are minor. Accordingly, some countries have recognised that users sometimes sell small amounts of drugs for personal support or survival; understanding that this is a far cry from a major trafficking offence, lawmakers have amended statutes to reflect the difference.¹³⁰ Brazil decriminalised the possession and consumption

LESS PUNISHMENT, LESS DRUG USE

Portugal's success

On July 1, 2001, a Portuguese law came into effect that decriminalised the possession and use of illicit drugs in small enough amounts to suggest personal use. Drug trafficking continues to be a criminal offence, and drug possession and use are still illegal, but these latter infractions incur only administrative penalties, just as a parking ticket would. Rather than prison or other criminal penalties, as earlier laws mandated, people found to be in possession of or using drugs go before a panel consisting of a psychologist, a social worker and a legal adviser. The panel may impose any of a range of sanctions, including fines, community service and suspension of professional licences. For those who are dependent on drugs, the panel may forego a sanction and instead order the person to attend an educational programme or receive treatment. The number of people on methadone and buprenorphine for drug dependency rose to 14,877 from 6,040 after decriminalisation—treatment funded with the money Portugal saves on police and prisons.¹³¹

Portugal now reports one of the lowest rates of lifetime marijuana use (that is, at least one use in a lifetime) in the EU: 8.2%, compared with 25% in the EU generally. Data also shows a drop in drug use by teens; lifetime heroin use in 16- to 18-year-olds dropped from 2.5% to 1.8%.¹³²

New HIV infections among people who use drugs fell by 17% from 1999 to 2003, while fewer people died from causes related to drug use.¹³³



of drugs for personal use in 2004, and in March 2008 its Appeals Court ruled criminal prosecution for drug possession unconstitutional.¹³⁴ And, notwithstanding its deadly war on drugs, Mexico in 2009 adopted legislation decriminalising possession of small amounts of drugs—including cocaine, marijuana, heroin, methamphetamine and LSD—for “personal and immediate use.”¹³⁵ These legal changes remove the fear of arrest and stigma and encourage people who use drugs to get tested for HIV or access treatment. Drug use has not grown in any of these countries in the wake of these legal reforms.¹³⁶

Where drug possession is still illegal, some governments have trained police to be sensitive to drug users and discouraged prosecutors from seeking criminal, especially custodial,

penalties. In 2002, at least 27 cities in Switzerland, Germany, Australia and elsewhere set up supervised sites where users can inject in a safe, hygienic environment without risk of arrest.¹³⁷ In its September 2011 decision to keep open a Vancouver injection site called Insite, the Supreme Court of Canada referred to the Canadian Charter of Rights and Freedoms, which commits the state to upholding the human rights of all people—including people who use drugs, the Court said. Noting that “successful [HIV] treatment requires acknowledgment of the difficulties of reaching a marginalised population with complex mental, physical and emotional health issues”, the Court also declared that people who use drugs should not be forced to choose between abstinence and forgoing health services.¹³⁸

RECOMMENDATIONS

To ensure an effective, sustainable response to HIV that is consistent with human rights obligations:

- 3.1 Countries must reform their approach towards drug use. Rather than punishing people who use drugs who do no harm to others, they must offer them access to effective HIV and health services, including harm reduction and voluntary, evidence-based treatment for drug dependence. Countries must:
 - 3.1.1 Shut down all compulsory drug detention centres for people who use drugs and replace them with evidence-based, voluntary services for treating drug dependence.
 - 3.1.2 Abolish national registries of drug users, mandatory and compulsory HIV testing and forced treatment for people who use drugs.
 - 3.1.3 Repeal punitive conditions such as the United States government's federal ban on funding of needle and syringe exchange programmes that inhibit access to HIV services for people who use drugs.
 - 3.1.4 Decriminalise the possession of drugs for personal use, in recognition that the net impact of such sanctions is often harmful to society.
 - 3.1.5 Take decisive action, in partnership with the UN, to review and reform relevant international laws and bodies in line with the principles outlined above, including the UN international drug control conventions: the Single Convention on Narcotic Drugs (1961); Convention on Psychotropic Substances (1971); the Convention against the Illicit Traffic in Narcotic Drugs and Psychotropic Substances (1988) and the International Narcotics Control Board.

3.2 SEX WORKERS



Source: UN Photo/Shehzad Noorani/Sex work, Thailand

The general public call us names like “AIDS carriers”, and exclude us from community activities. We face discrimination in all areas of the public including workplaces if we have other jobs. Sex workers are subject to violence from the general community, who do not view us as deserving of protection. Sex workers are often rejected by family and peers, and for transgender and HIV-positive sex workers, the stigma can be even more intense.

Friends Frangipani, Papua New Guinea, Asia-Pacific Regional Dialogue, 16–17 February 2011

Many more than 100 countries explicitly criminalise some aspect of sex work.¹³⁹ Some countries, such as most of the United States, Cuba, People's Republic of China, Iran, Vietnam and South Africa, outlaw it entirely.¹⁴⁰ Some in Western Europe, Latin America and Canada prosecute only related activities such as brothel-keeping or transporting sex workers, communicating for the purposes of prostitution, street soliciting and living off its profits. Norway and Sweden¹⁴¹ arrest the clients of sex workers but not the workers themselves. This so-called “Swedish approach” is seen as more just to sex workers, who are perceived as victims by its proponents.¹⁴² This approach has been applied in other countries and has actually resulted in grave consequences for the workers.¹⁴³

Some governments deploy anti-human-trafficking laws so broadly that they conflate voluntary and consensual exchanges of sex for money with the exploitative, coerced, often violent trafficking of people (primarily women and girls) for the purposes of sex.¹⁴⁴ Municipalities may interdict commercial

sex under the authority of vaguely worded statutes relating to “public decency”; “morality” and even rape¹⁴⁵; “nuisance” laws prohibiting loitering and vagrancy; or zoning or health regulations.¹⁴⁶ Although these statutes often do not mention the words “sex worker” or “prostitute”, they nevertheless give police wide latitude to arrest and detain sex workers and give the state legal support for making medical examinations compulsory—a fundamental human rights abuse. Sometimes, police use the mere possession of condoms as evidence of sex work.¹⁴⁷ Even if sex workers are detained only briefly, their working lives are vexed by harassment and fear. These laws codify profound discrimination; they reflect general social contempt toward female, male and transgender sex workers.

CRIMINALISATION + STIGMA = DANGER

For sex workers, especially those who are gender-nonconforming, the threat of violence—from both clients and police—is a daily reality. Criminalisation, in collusion with social stigma makes sex workers' lives more unstable, less safe

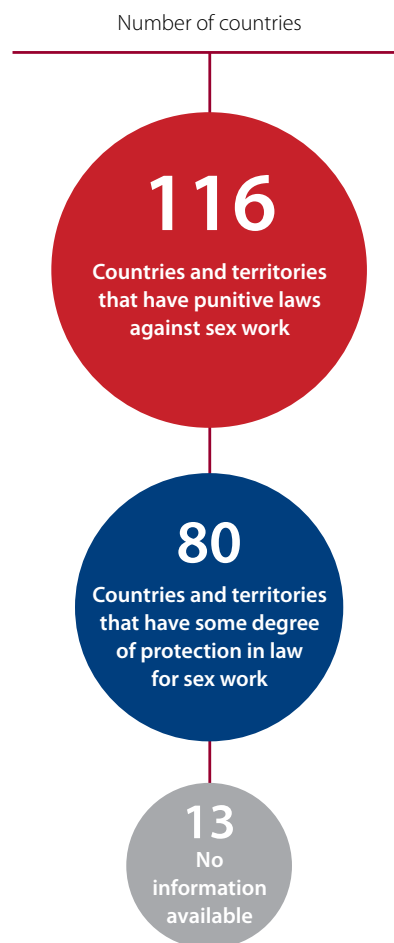
and far riskier in terms of HIV.¹⁴⁸ There is no legal protection from discrimination and abuse where sex work is criminalised.¹⁴⁹

- Laws invite police harassment and violence and push sex work underground, where it is harder to negotiate safer conditions and consistent condom use.¹⁵⁰ Some sex workers fear carrying condoms, which are used as evidence against them, sometimes as an explicit provision of law.¹⁵¹
- Police violence prevents sex workers from seeking their assistance, which ingrains a culture of more client and police violence.¹⁵²
- Stigmatised, criminalised sex workers are unable to access programmes of HIV prevention and care.¹⁵³
- Criminals and clients deploy the threat of criminal sanctions to control and exploit sex workers.¹⁵⁴
- Rape and assault are difficult to report when the sex worker fears that she will be arrested, and sexual violence heightens exposure to HIV.¹⁵⁵
- Working in the informal sector reduces sex workers' access to education and housing, thus increasing their dependence on others, including pimps.¹⁵⁶

LEGAL "NON-PERSONS"

Some laws not only criminalise sex work and the activities related to it but also deny sex workers fundamental civil entitlements. Sex workers may be unable to own or inherit property; register the births of their children; access education, justice, health care or banking services; or purchase housing or utilities. Deprived of the means by which others can make claims on elected officials, employers and service providers, sex workers experience social exclusion and entrenched poverty. And their disadvantaged position in

SEX WORK & LAW



Source: Inter-Parliamentary Union (IPU), UNAIDS, UNDP: Brief for Parliamentarians on HIV and AIDS: Making the law work for the response to HIV, 2011.

Soon as the sex was over, the man started slapping me and cuffing me up and he empty my purse and take away all my money, not just what he pay me...How could I go to the police and make a report when sex work is not really legal?

Sex worker from Guyana, Caribbean Regional Dialogue, 12–13 April 2011¹⁵⁷

negotiating access to goods and services leads to exploitation, abuse and increased vulnerability to HIV.¹⁵⁸

In such circumstances sex workers are not fully recognised as persons before the law and are rendered incapable of holding or exercising the range of human rights available to others. Swaziland provides a poignant example of law that denies the fundamental humanity of the sex worker. Section 3 (3) of the Swaziland Girls' and Women's Protection Act provides the following defence to the charge of carnal knowledge of a girl child under 16: "[A]t the time of the commission

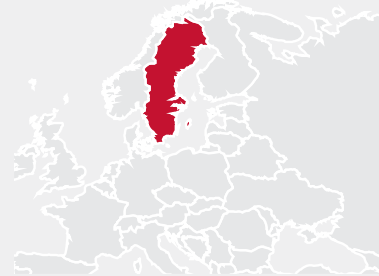
of the offence the girl was a prostitute."¹⁵⁹ Under this law, a girl under the age of 16 cannot consent to sex, regardless of whether she is a sex worker, but she also cannot claim protection from the law if someone has sex with her against her will. By granting her neither agency nor security, the law renders her a non-person.¹⁶⁰

Virtually all of these conditions of work and life increase HIV vulnerability.¹⁶¹ It is not surprising that sex workers globally are approximately eight times more likely to be infected with HIV than other adults.¹⁶² A recent study found that female sex workers in developing countries are

VICTIMISING THE "VICTIM"

The Swedish Approach

Lauded as a less punitive and more gender-sensitive legal strategy to reduce and ultimately eliminate sex work, the "Swedish approach" criminalises the client and not the worker. Based on the premise that women in sex work need protection, it regards the sex worker as the "victim" and the client as the "exploiter". Since its enactment in 1999, the law has not improved—indeed, it has worsened—the lives of sex workers.¹⁶³ The law's record so far¹⁶⁴:



Underground trade, more violence

Street-based sex work is halved in Sweden, according to the police, but the sex trade remains at pre-law levels. It has simply moved further underground,¹⁶⁵ to hotels and restaurants, as well as the Internet—and to Denmark. The Swedish State Criminal Department warns that the sex trade may now be more violent. Especially worrying is the trade in foreign women, who often fall entirely under the control of pimps.¹⁶⁶

Few prosecutions and convictions

Sweden's Alliance of Counties says that resources for social work are scarce, as the money has been siphoned to policing. In spite of over 2,000 arrests, only 59 clients have been reported suspected of buying occasional sex. Only two have been convicted, after pleading guilty. No one has been jailed, and only low fines have been imposed, as per the law. Evidence to prove a crime is nearly unattainable. Workers do not consider themselves to be victims and are almost always unwilling to testify against their clients.¹⁶⁷

Criticism and organising

The law has given impetus to the formation of a sex workers' rights organisation in Sweden, which has argued strenuously against the law.¹⁶⁸ Some Swedish authorities are demanding an evaluation of how the new legislation is affecting the underground prostitution trade.

14 times more likely to be infected with HIV than women of reproductive age.¹⁶⁹ Clients of sex workers also have sex with other partners, and sex workers have lovers and spouses and children, who in turn have sex or use drugs with others; consequently, HIV travels. High rates of infection among sex workers affect everyone.¹⁷⁰

This does not have to be the case. Where sex workers organise, where the police don't harass them and they are free to avail themselves of quality HIV services, sex workers have lower rates of STIs, more economic power and a greater ability to get education for their children.¹⁷¹

Criminal sanctions against human trafficking and commercial sexual exploitation of minors are essential—but the laws must clearly differentiate these activities from consensual adult sex work.

TRAFFICKING IN MISCONCEPTIONS

Sex work and sex trafficking are not the same. The difference is that the former is consensual whereas the latter coercive. Sex worker organisations understand sex work as a contractual arrangement where sexual services are negotiated between consenting adults. Sex work is not always a desperate or irrational act; it is a realistic choice to sell sex—in order to support a family, an education or maybe a drug habit. It is an act of agency.¹⁷²

By contrast, trafficking in persons, as defined by international and local treaties, is “the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation.”¹⁷³ Such exploitation can

include many forms of forced labour or slavery—in factories, fields, homes or brothels. Trafficking for the purposes of commercial sexual exploitation involves adults or children providing sexual services against their will, either through force or deception. A denial of agency, trafficking violates their fundamental freedoms.¹⁷⁴

Setting aside the question of whether people would choose sex work if they had better options, a point of view that casts “voluntary prostitution” as an oxymoron erases the dignity and autonomy of the sex worker in myriad ways. It turns self-directed actors into victims in need of rescue.

And yet some governments deploy anti-human-trafficking laws so broadly as to conflate consensual adult sex work with the exploitative, coerced trafficking of people (primarily women and girls) for the purposes of sex.¹⁷⁵ Indeed, negotiations in the writing of United Nations Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women And Children (2000) were riven by disputes over these definitions. Some states and NGOs argued for the language to be amended to limit the law's purview to people engaged in the international sex trade by force or coercion.¹⁷⁶ This amendment was defeated on the grounds that no victim should have to prove that she did not consent, but the language now also implies that any person selling sex is so vulnerable that she is by definition unable to consent. The definition now explicitly states that the consent of the “victim” is irrelevant to the prosecution of the trafficker.¹⁷⁷

In part as a result of this overly broad definition, governments have cracked down, often violently, on sex workers or compelled them to undergo the same kinds of brutal “rehabilitation” in detention to which drug users are subjected. Forced to work clandestinely, sex workers cannot muster the collective power to improve their wages or working conditions, enjoy the

PEPFAR's Anti-Prostitution Pledge

All organisations outside of the US receiving money under PEPFAR must sign the pledge. It reads, in part:

*"The U.S. Government is opposed to prostitution and related activities, which are inherently harmful and dehumanizing, and contribute to the phenomenon of trafficking in persons. None of the funds made available under this agreement may be used to promote or advocate the legalisation or practice of prostitution or sex trafficking."*¹⁷⁸

The pledge puts grantees in an impossible bind. If they don't sign, they are denied the funds they need to control and combat HIV. If they sign, recipient organisations are barred from supporting sex workers in taking control of their own lives—which is to say, their own health and that of their families and clients, including taking steps to avoid HIV and prevent its spread.

protection of labour law or join together in trade unions or another organisation, whose benefits include access to public health care or the empowerment to establish health services run by sex workers themselves.¹⁷⁹

International anti-human-trafficking campaigns often promote the prohibition, either intentional or effective, of proven best practices in HIV prevention. For instance, crusaders in the United States have used the influence of PEPFAR—the President's Emergency Plan for AIDS Relief, the primary vehicle of United States financial support to AIDS-combating organisations around the world—to compel other governments to accept the conflation of human trafficking with sex work by conditioning the receipt of funds on the signing of its Anti-Prostitution Pledge.¹⁸⁰ Maurice Middleberg, Vice-President of the Global Health Council, calls the pledge proof that the anti-human-trafficking agenda is an anti-prostitution agenda. He points both to the pledge's language—which calls prostitution "harmful and dehumanising" and links prostitution with human trafficking—and the way the pledge has been put into practice.¹⁸¹

Although the pledge has been legally challenged in its application within the United States and was supposed to be reviewed by the Obama administration in early 2009, it remains in full force for organisations receiving funds

under PEPFAR beyond the borders of the United States.¹⁸²

WORKPLACE RIGHTS

The International Labour Organization (ILO) has recommended that sex work be recognised as an occupation so that it can be regulated in ways that protect workers and customers.¹⁸³ Sex workers in such a framework could exercise both individual and collective initiative in affecting their economic and social conditions. The ILO's labour standard on HIV/AIDS, adopted in 2010, includes non-discriminatory access to health services and occupational safety for sex workers, including empowerment to insist on safe and protected paid sex in their workplaces.¹⁸⁴

Decriminalisation is the first step toward better working conditions—and with them, less HIV risk—and some jurisdictions have removed some penal provisions related to sex work. New Zealand's Prostitution Reform Act (2003) decriminalised prostitution, opening the way for sex workers to operate in public and in safety.¹⁸⁵ The New Zealand Prostitutes' Collective, brothel operators and the Labour Inspectorate have collaborated to develop workplace health and safety standards for sex work. Sex workers can bring employment discrimination complaints to the Human Rights Commission, and the Mediation Service on Employment adjudicates disputes.¹⁸⁶ The police support sex workers in

reporting violence. Although it applauds these advances, the Prostitutes' Collective stresses that stigma and discrimination remain and calls for law and policy to address them. Recently, the Kenya National Commission on Human Rights called for the decriminalisation of sex work.¹⁸⁷

Some national courts have recognised the rights of sex workers. A court in Bangladesh halted abusive action by police who evicted sex workers from brothels, concluding that this curtailment of their livelihood was a violation of their right to life.¹⁸⁸ Similarly, in the 2010 case *Bedford v AG Canada*, a judge struck down three provisions of the Canadian criminal code outlawing prostitution, calling them a violation of the country's Charter of Rights, as they "force prostitutes to choose between their liberty interest and their right to security of the person."¹⁸⁹ The subsequent 2012 decision of the Ontario Court of Appeal found that provisions prohibiting brothels and living off the avails of prostitution were both unconstitutional in their current form.¹⁹⁰ In 2010, the South African

Labour Appeal Court held that even though sex work was illegal, the people who do it were entitled to protection against unfair dismissal by employers.¹⁹¹

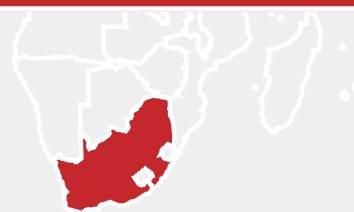
Unfortunately, decriminalisation sometimes replaces punishment with regulation, which in its details is enforced through criminal law. Greece, Latvia and parts of Australia all have mandatory and forced medical testing, a human rights abuse and thus a form of punishment.¹⁹² In the United States, Nevada is the one state where prostitution is legal. But sex work is allowed only in a few licenced brothels in rural counties. In the tourist hot spot Las Vegas, by contrast, police stings for solicitation are common, and anywhere in the state both workers and clients can be arrested for indecent exposure or "open and gross lewdness", which carry penalties of fines and jail time.^{193, 194}

According to an international labour rights advocate, "the direct regulation of sex work may or may not be implemented in ways consonant

THE DIGNITY OF ALL WORK

Kylie v Commission for Conciliation, Mediation and Arbitration and 2 others

Kylie, a sex worker who worked in a massage parlor, brought a claim before South Africa's Labour Court that she had been unfairly dismissed without a hearing and deserved compensation from her employer. The Court rejected her claim, finding that she was not entitled to protection or redress because prostitution is illegal. The courts "ought not to sanction or encourage illegal activity", it said. On appeal, however, Judge Dennis Davis ruled that Kylie could be awarded monetary compensation for her illegal firing, no matter what her job was. The Labour Relations Act (LRA) guarantees "everyone" the right to fair labour practices, he said—and everyone means everyone. The LRA's express purpose "is to advance economic development, social justice, labour, peace and the democratisation of the workplace", and he noted a purpose that is underlined by an even higher principle: the dignity of all workers. The judge opined: "As sex workers cannot be stripped of the right to be treated with dignity by their clients, it must follow that, in their other relationship—namely with their employers—the same protection should hold. Once it is recognised that they must be treated with dignity not only by their customers but by their employers, section 23 of the Constitution, which, at its core, protects the dignity of those in an employment relationship, should also be of application."¹⁹⁵





Source: IRIN/Manoocher Deghati/Sex work, Zambia

with human rights principles.”¹⁹⁶ Actual and proposed frameworks for legalised sex work have involved not only forced HIV testing but also “quarantining, shaming or even branding sex workers determined to have diseases of public health significance.”¹⁹⁷ A proposal presented to the Maharashtra, India, state legislature “would have required the registration of all prostitutes, with compulsory HIV testing; all those found to be positive would be branded with a permanent tattoo.”¹⁹⁸

POLICE COOPERATION FOR BETTER HEALTH

When the state recognises the human and civil rights of sex workers, it can deploy the police in

a radically different way. Rather than unleashing police to beat and arrest sex workers, it can put them to work alongside sex workers in enabling widespread safer sex practices. When this was done in India, condom use among sex workers rose as high as 85% in some parts of the country and HIV prevalence among sex workers fell from over 11% in 2001 to less than 4% by 2004.¹⁹⁹

In the Philippines, Action for Health Initiative (ACHIEVE) partnered with the Quezon City Health Department to bring together the police department and the association that represents entertainment establishments to talk about improving condom distribution in venues where sex is sold.²⁰⁰

Police officers are now starting to think for the first time of sex work as having implications for human rights.

African Sex Workers Alliance (ASWA) Mozambique, Africa Regional Dialogue, 3–4 August 2011

RECOMMENDATIONS

To ensure an effective, sustainable response to HIV that is consistent with human rights obligations:

3.2. Countries must reform their approach towards sex work. Rather than punishing consenting adults involved in sex work, countries must ensure safe working conditions and offer sex workers and their clients access to effective HIV and health services and commodities. Countries must:

3.2.1 Repeal laws that prohibit consenting adults to buy or sell sex, as well as laws that otherwise prohibit commercial sex, such as laws against “immoral” earnings, “living off the earnings” of prostitution and brothel-keeping. Complementary legal measures must be taken to ensure safe working conditions to sex workers.

3.2.2 Take all measures to stop police harassment and violence against sex workers.

3.2.3 Prohibit the mandatory HIV and STI testing of sex workers.

3.2.4 Ensure that the enforcement of anti-human-trafficking laws is carefully targeted to punish those who use force, dishonesty or coercion to procure people into commercial sex, or who abuse migrant sex workers through debt bondage, violence or by deprivation of liberty. Anti-human-trafficking laws must be used to prohibit sexual exploitation and they must not be used against adults involved in consensual sex work.

3.2.5 Enforce laws against all forms of child sexual abuse and sexual exploitation, clearly differentiating such crimes from consensual adult sex work.

3.2.6 Ensure that existing civil and administrative offences such as “loitering without purpose”, “public nuisance”, and “public morality” are not used to penalise sex workers and administrative laws such as “move on” powers are not used to harass sex workers.

3.2.7 Shut down all compulsory detention or “rehabilitation” centres for people involved in sex work or for children who have been sexually exploited. Instead, provide sex workers with evidence-based, voluntary, community empowerment services. Provide sexually exploited children with protection in safe and empowering family settings, selected based on the best interests of the child.

3.2.8 Repeal punitive conditions in official development assistance—such as the United States government’s PEPFAR anti-prostitution pledge and its current anti-trafficking regulations—that inhibit sex workers’ access to HIV services or their ability to form organisations in their own interests.

3.2.9 Take decisive action to review and reform relevant international law in line with the principles outlined above, including the UN Protocol to Prevent, Suppress and Punish Trafficking In Persons, Especially Women And Children (2000).

3.3 MEN WHO HAVE SEX WITH MEN



Source: International HIV/AIDS Alliance/ Kenya

Although the core international human rights treaties do not specifically mention sexual orientation as a category of protection like race or sex, MSM can be addressed under the category of “other status.”²⁰¹ International law also protects the universal right to privacy, which guards people’s sexual practices from the interference of the state. The Yogyakarta Principles on the Application of International Human Rights Law in relation to Sexual Orientation and Gender Identity, although not binding on states, provide recommendations on how existing human rights statutes should be applied in specific situations relevant to sexual minorities. For instance, the Principles recommend that the medical records of sexual minorities be “treated with confidentiality” and that states “ensure that all health service providers treat clients and their partners without discrimination on the basis of sexual orientation or gender identity.”²⁰²

There are those who argue that because sexual orientation or gender identity are not explicitly mentioned in any of the conventions and covenants, there would be no protection. My response is that such a position is untenable in legal terms, which is confirmed by the evolving jurisprudence. The principle of universality admits no exception. Human rights truly are the birth right of all human beings.

Navanethem Pillay, United Nations
High Commissioner for Human Rights

IMPRISONMENT AND EXECUTION

In defiance of international human rights standards, 78 countries make same-sex sexual activity a criminal offence, with half that number in the Commonwealth of Nations.²⁰³ Scholars trace hostility towards homosexuality and transgender people in many instances to colonialism and demonstrate that pre-colonial cultures were often much more tolerant of sexuality and gender diversity.²⁰⁴

Penalties for adult consensual sexual conduct between two men range from jail time to execution.²⁰⁵ Jamaica punishes homosexuality with up to ten years’ imprisonment. Malaysia punishes “carnal intercourse against the order of nature” with up to twenty years’ imprisonment and whipping.²⁰⁶ And several sub-Saharan African countries can impose the death penalty on men convicted of having sex with men.²⁰⁷

Even in jurisdictions where same-sex relations are not criminalised, the state extends no legal protection from discrimination on the grounds of sexual orientation; it is not uncommon for laws to allow minors to consent to “heterosexual” sex acts at younger ages than they allow minors to consent to “homosexual” acts.²⁰⁸

Progress on these issues has not been universal or sustained. In some instances, steps forward are followed by big steps backward. Uganda’s HIV response had shone as an exemplar of success. But recently a Member of Parliament proposed a draconian Anti-Homosexuality Bill, which would seriously jeopardise that programming.²⁰⁹ The law would impose penalties of life imprisonment for sexual acts between men. Through its clauses outlawing the “promotion” and “aiding and abetting” of homosexuality, it would criminalise working with MSM, thereby exposing field workers, peer educators and health care workers to arrest.²¹⁰ Criminal sanctions could also be imposed on parents, teachers or health care workers who fail to report suspicion of homosexuality. International and domestic protest nearly killed the Bill. But as of the writing of this report in March 2012, Ugandan lawmakers have revived it for debate and a vote.²¹¹

HIGH RISK

Marginalisation, together with aspects of physiology, circumstance and sexual behaviour, puts MSM at significantly heightened risk of HIV. MSM are nineteen times more likely to be infected than other adult men.²¹² For instance, MSM are among the most hidden and stigmatised of all HIV risk groups in the Middle East and North Africa.²¹³ In nearly every country that reliably collects HIV surveillance data,²¹⁴ the figures are stark.

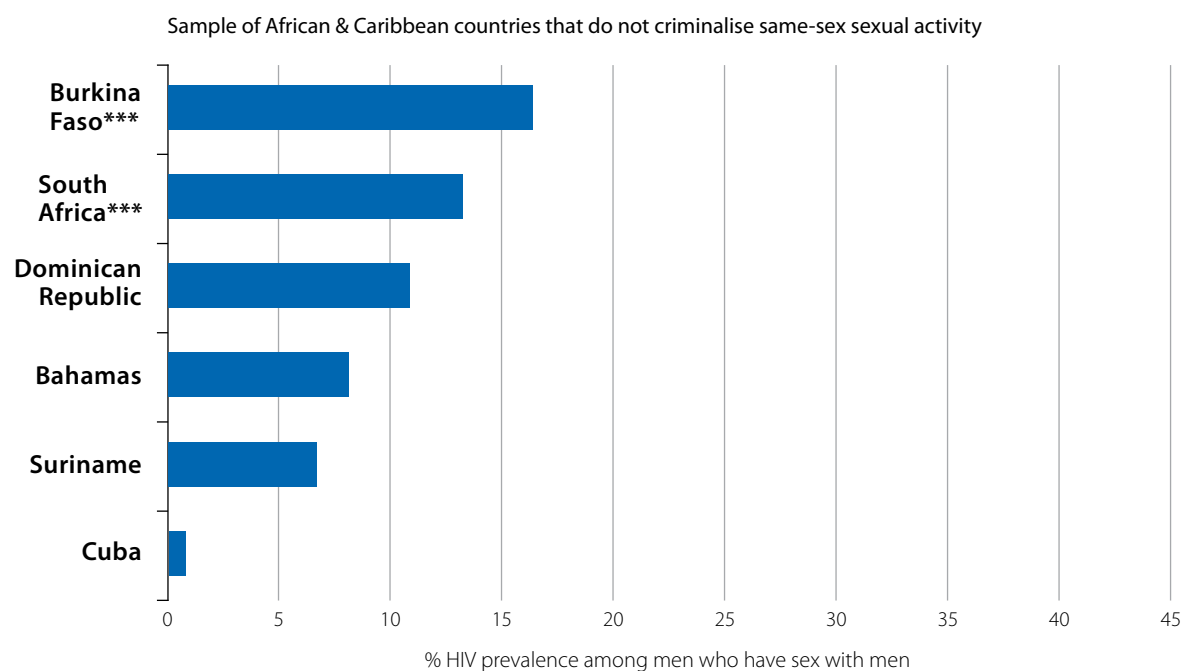
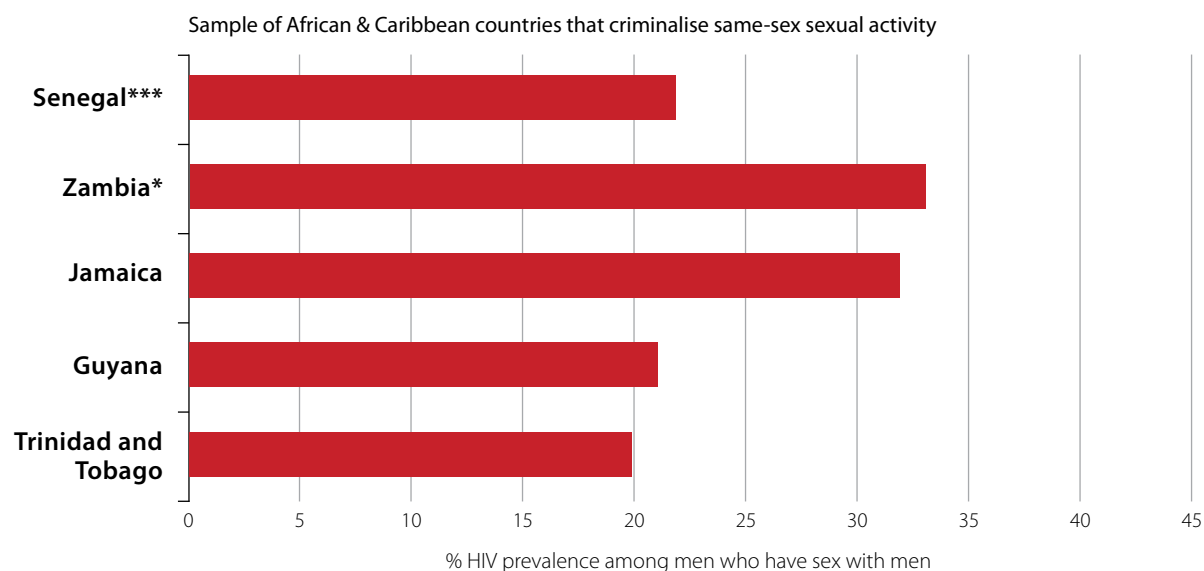
Criminalisation both causes and boosts those numbers. For example, UNAIDS reports that in the Caribbean countries where homosexuality is criminalised, almost 1 in 4 MSM is infected with HIV. In the absence of such criminal law the prevalence is only 1 in 15 among MSM.²¹⁵

Many MSM also have sex with women.²¹⁶ Although some of these men are attracted to both women and men, others only maintain concurrent heterosexual relationships to avoid stigma and abuse, particularly in environments that criminalise or stigmatise homosexuality. In other words, criminalisation of same-sex relations endangers not just MSM, but women too.²¹⁷ By contrast, evidence shows that in a range of epidemic settings, universal access to HIV services for MSM together with anti-discrimination efforts can significantly reduce infections both among those men and the wider community.²¹⁸

The discourse on same-sex sexuality is dominated by hate speech at all levels, including the highest executive level. The Zimbabwean president, Robert Mugabe is known for comparing gays and lesbians to pigs and dogs. Police harassment is a daily occurrence, and homophobia exacted by religious and traditional leaders is deemed normal.

Gays and Lesbians of Zimbabwe, Zimbabwe, Africa Regional Dialogue,
3–4 August 2011

MEN WHO HAVE SEX WITH MEN, LAW & HIV



Note: Estimated prevalence for Jamaica ranges from 25–30%.

Sources: * Data from Smith, Adrian D. et al., Men who have sex with men and HIV/AIDS in sub-Saharan Africa, Lancet, 2009.

** Data based on Baral, S. et al. A Systematic Review of HIV epidemiology and risk factors among MSM in Sub-Saharan Africa 2000–2008, International AIDS Conference, Mexico City, 2008.

*** Data based on the UNGASS Reports.

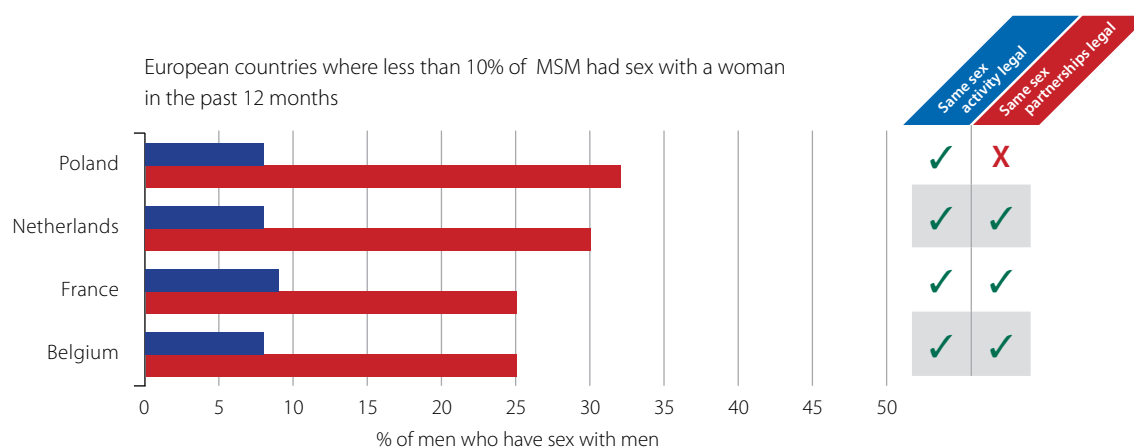
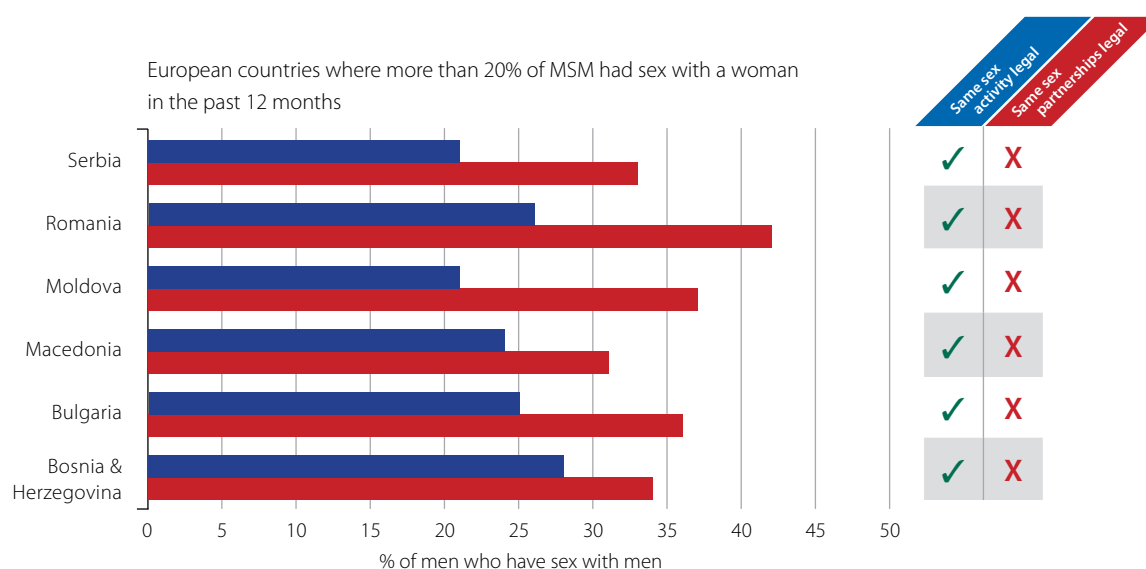
Adapted from UNAIDS Report on the global AIDS epidemic 2008 and UNAIDS Progress Report towards Universal Access to HIV Prevention, Treatment, Care and Support in the Caribbean.

INSENSITIVITY, VIOLENCE, EXCLUSION

Stigma and discrimination against MSM pervade societies, and this erodes MSM's access to HIV testing, treatment and social support. A multi-lingual global online survey of 5,000 MSM found that only 36% were able to easily access

treatment and less than a third had easy access to behavioural interventions and HIV education materials.²¹⁹ Religious law criminalising same-sex acts can decimate efforts to arrest the spread of HIV. Research shows that in Senegal after 9 MSM who were HIV prevention outreach work-

LGBT RIGHTS & HIV TRANSMISSION RISK



■ reported sex with a woman in last 12 months

■ reported possible HIV transmission risk in last 12 months

Source: European MSM Internet Survey (EMIS) 2010; ILGA-Europe's website (www.ilga-europe.org), the European Region of the International Lesbian, Gay, Bisexual, Trans and Intersex Association, accessed by UNDP in 2012.

ers were arrested and imprisoned in 2008 under a law prohibiting “acts against nature”, terror gripped MSM communities, advocacy groups disbanded, HIV information and treatment sites shut down and workers and organisers went into hiding.²²⁰

MSM hardly feel welcome at the clinic. Health care providers are not exempt from ignorance or bigotry. MSM who fear that their sexuality will not be kept confidential do not divulge that information to health care workers, and this information is critically important in HIV-related prevention and care.²²¹ Untrained health care workers respond to

MSM with contempt or hostility and sometimes refuse to treat them.²²² Where sex between men is illegal, health providers who want to offer services may worry that they will be charged with abetting a crime.²²³

Like sexworkers or people who used drugs, MSM face harassment, arrest and police brutality in countries that outlaw their behaviour. Police raid educational forums and confiscate condoms and lubricants as evidence of sex crimes and informational materials as “obscenity.”²²⁴ Even when there are no sodomy laws or other restrictive legal structures, police inflict abuse under the aegis of “public

safety”, “vagrancy” or “solicitation” laws, which give them wide leeway to harass and control MSM and the places where they may gather.²²⁵ Such places may include HIV service centres. But, even if the authorities steer away from clinics, their presence at bars and baths inhibits information-sharing and mutual support in practicing safer sex. In fact, such social institutions are where safe sex was born.

Their extraordinary vulnerability to HIV notwithstanding, MSM are left out of many national strategies to combat AIDS, such as those in the Middle East. In Algeria, although MSM worked on the planning of the national HIV responses, implementation “on the ground remains a challenge due to lack of commitment from different stakeholders (government, civil society, health professionals)”, said one Algerian submission to the Commission.²²⁶ He adds, “The law penalises homosexuality.”

SEXUAL ACCEPTANCE: TOWARD FIGHTING HIV

Thankfully, some MSM are starting to be heard. In Tunisia, for example, MSM are represented on the National Strategic Planning Committee; no doubt as a result, the 2012-2016 plan includes a call for decriminalising same-sex relations.²²⁸ Even in societies where homosexuality has traditionally not been accepted, more tolerant views are emerging. For instance, in March 2008, Siti Musdah Mulia, Islamic Scholar and Chairperson of the Indonesia Conference of Religions and Peace noted that “Homosexuality is from God and should be considered natural. It is not pushed only by passion. There is no difference. In the eyes of God, people are valued based on their piety. The essence of the religion (Islam) is to humanise humans, respect and dignify them.”²²⁹

International leaders are also beginning to speak up for equality regardless of sexual orientation or consensual sexual acts, and courts around the world are looking to both global and national human rights standards to strike down laws criminalising same-sex activity. UN Secretary-General Ban Ki-moon,²³⁰ the Commission on AIDS in Asia²³¹ and the UN Special Rapporteur on the Right to Health have all called for decriminalisation.²³² The International Guidelines on HIV/AIDS and Human Rights²³³ recommend the review of laws that prohibit sex between consenting adults (including “sodomy”) in private, “with the aim of repeal”. A number of countries also prohibit discrimination on the basis of sexual orientation.²³⁴ While some countries are moving to more punitive approaches, there is growing international consensus that the decriminalisation of homosexuality is an essential component of a comprehensive public health response to the elevated risk of HIV acquisition and transmission among men who have sex with men.

We see a pattern of violence and discrimination directed at people just because they are gay, lesbian, bisexual or transgender. There is widespread bias at jobs, schools and hospitals. And appalling violent attacks, including sexual assault. People have been imprisoned, tortured, even killed. This is a monumental tragedy for those affected—and a stain on our collective conscience. It is also a violation of international law... To those who are lesbian, gay, bisexual or transgender, let me say: You are not alone. Your struggle for an end to violence and discrimination is a shared struggle. Any attack on you is an attack on the universal values the United Nations and I have sworn to defend and uphold. Today, I stand with you ... and I call upon all countries and people to stand with you, too.

Ban Ki-moon, United Nations Secretary-General Statement to Human Rights Council, 7 March 2012²²⁷

OVERRULING CRIMINALISATION & DISCRIMINATION

Hong Kong Court of Appeal

Secretary for Justice v. Yau Yuk Lung Zigo and Lee Kam Chuen (2007)²³⁵ and **Leung T.C. William Roy v. Secretary of Justice (2006)**²³⁶: Confirmed that sexual orientation is a proscribed ground for discrimination, analogous to race and sex.

Fiji High Court

Nadan and McCoskar v. State (2005)²³⁷: Penal Code offences criminalising consensual sexual acts between adult men in private were found to have breached constitutional guarantees to personal privacy and equality.

U.S. Supreme Court

Romer v. Evans (1996)²³⁸: Found unconstitutional an amendment to the Colorado state constitution that prohibited public measures designed to protect people from discrimination based on their sexual orientation.

Lawrence v. Texas (2003)²³⁹: Struck down a Texas sodomy law, ruling that criminalisation of intimate, consensual sexual conduct infringed on liberty protected under the Constitution's Fourteenth Amendment.

Lawsuits and rulings in both national and international courts are pushing this trend forward. The United Belize Advocacy Movement (UNIBAM) filed a suit in 2010 to overturn Criminal Code Chapter 101, Section 53, which states: "Every person who has carnal intercourse against the order of nature with any person or animal shall be liable to imprisonment for 10 years."²⁴⁰

In India in 2009, citing the Universal Declaration of Human Rights and the International Covenant on Economic, Social and Cultural Rights, the Delhi High Court removed the portions of the Indian Penal Code criminalising sex between consenting adult males in private. "The Court concluded that to stigmatise or to criminalise people on account of their sexual orientation is against constitutional morality and principles of inclusiveness in the Indian Constitution."²⁴¹ In October 2011, AIDS-Free World, unbowed by Jamaica's proscription of such actions in its own courts, filed a petition at the Inter-American Commission on Human Rights (IACHR) challenging that country's anti-sodomy law. The "Offenses Against the Person Act" of

1864 criminalises consensual sexual conduct between men, as well as the "abominable crime of buggery" (anal sex) between people of any sex.²⁴² And, on Human Rights Day, 2011, in a rare allusion to the legitimacy of sexual choice as a human right, United States Secretary of State Hillary Clinton suggested that it is only a matter of time before the world comes around to recognising everyone's freedom to the consensual expression of desire, regardless of the sex of its object.²⁴³

It is not easy or popular to call for the legalisation of homosexuality in many African countries, but it is the right thing to do. It is right because it is essential to slow the spread of HIV and to ensure that human rights protections are extended to all our citizens. But it is also right because people in Africa understand that the State has far more urgent priorities than interfering in the private lives of consenting adults.

Festus Gontebanye Mogae, former President of Botswana

RECOMMENDATIONS

To ensure an effective, sustainable response to HIV that is consistent with human rights obligations:

3.3. Countries must reform their approach towards sexual diversity. Rather than punishing consenting adults involved in same-sex activity, countries must offer such people access to effective HIV and health services and commodities. Countries must:

3.3.1 Repeal all laws that criminalise consensual sex between adults of the same sex and/or laws that punish homosexual identity.

3.3.2 Respect existing civil and religious laws and guarantees relating to privacy.

3.3.3 Remove legal, regulatory and administrative barriers to the formation of community organisations by or for gay men, lesbians and/or bisexual people.

3.3.4 Amend anti-discrimination laws expressly to prohibit discrimination based on sexual orientation (as well as gender identity).

3.3.5 Promote effective measures to prevent violence against men who have sex with men.

3.4 TRANSGENDER PERSONS



Source: Robert Bourgoing/India

On 20 October 2008 at 11 A.M. the police caught five hijras [transgender women] near a traffic signal in the Girinagar police station and took them to the police station. The Assistant Commissioner of Police [ACP], H.T Ramesh beat one of them with his lathi, broke her bangles and made her bleed. Another hijra was forced to clean the floor of the police station. The police then charged them with false cases under section 341 [wrongful restraint] and 384 [extortion] of the Indian Penal Code... The police asked offensive questions and taunted the crisis intervention team who went to the police station to assist: "Take off all your clothes; let me see what you've got there? Are you a man or woman?"

Sangama, India, Asia-Pacific Regional Dialogue, 16–17 February 2011

In many countries from Mexico to Malaysia,²⁴⁴ by law or by practice, transgender persons are denied acknowledgment as legal persons. A basic part of their identity—gender—is unrecognised. There are still few governments that issue identification documents in which a person's self-identified gender may vary from his or her biological sex.²⁴⁵ Without documents, employment, health care, travel and participation in many aspects of citizenship are out of reach. In Thailand, for instance, transgender people who attempt national military conscription are dismissed under the ruling "This person's body is not in line with their birth sex."²⁴⁶

The denial of papers is one of the most concrete, bureaucratic means by which the law erases

the personhood of the transgendered. What is also prohibited in many states is the basic daily expression of self. In Guyana, cross-dressing is an offence.²⁴⁷ In Kuwait, anyone "imitating the opposite sex in any way" faces a year in prison, a substantial fine or both.²⁴⁸ It is not any specific behaviour that is criminalised, but rather physical appearance—the parameters of which Kuwaiti police may define. They commonly arrest people for "smooth skin" or "soft voice."²⁴⁹

TRANSPHOBIA AS A HEALTH RISK

These examples outline the ways the law punishes unconventional gender. Police may stand by while civilians commit acts of sexist violence against transgender people. According to the Trans Citizen Observatory of the

Santamaria Foundation of Colombia, “there were 45 registered and denounced homicides against transwomen in Santiago de Cali between 2005 and March 2011, the great majority of whom were sex workers.”²⁵⁰

Often, states effectively condone the administration of violence by law enforcers.²⁵¹ Transgender sex workers often bear the brunt of police brutality where sex work is criminalised. Beyond harassment, arrest and detention, transgender sex workers report that police extort sexual favours from them and rape and brutalise them.²⁵² As with other key populations, complaints have nowhere to be lodged and, even when channels exist, the petitions of transgender people are often ignored.²⁵³ Police abuse of transgender people has been documented and complaints have been submitted to the National Commission of Human Rights and the Public Prosecutor’s Office, Taysa Fernandes, of Ángel Azul in Honduras, told the Commission, “without any results so far. . . . We have knocked on every door without receiving any help.”²⁵⁴

All of this contributes to increased marginalisation, increased exposure to HIV and disproportionately rare use of HIV prevention, treatment, care and support services.²⁵⁵ In some countries transgender women become infected with HIV at more than seven times the national rate.²⁵⁶

Transphobia, a bigotry often encoded in the law, is a mental health risk to its victims, data show. According to some research, transgender women and men show increased levels of depression and suicidal ideation,²⁵⁸ and emotional vulnerability can translate into vulnerability to HIV.

Like other sexual minorities, transgender people²⁵⁹ encounter difficulty at health centres. A United States-based survey of over 6,000 transgender people found that:

- Up to 28% of transgender people report postponing accessing health care when they are sick out of fear of discrimination
- 19% reported being refused care due to their transgender or gender non-conforming status
- 28% reported a perception of harassment in medical settings²⁶⁰

But transgender people may never get in the clinic doors in the first place. A lack of official documentation recognising their gender identities prevents them, in many places, from registering for health care services.²⁶¹

PROGRESS

In a number of countries—including South Africa, Japan, Turkey, Belgium, Finland, Germany, Italy, Netherlands, Portugal, Romania, Spain, Sweden, United Kingdom, Mexico, Panama,

After my friend was raped by those men because she was discovered she came to me.... we went to the clinic to get post HIV exposure prophylaxis. The nurse told her to go home, take off her women's clothes and come back. She was already so traumatised she could not return. I believe that is why she is HIV-positive today.²⁵⁷

Transgender Sex Workers Cape Town, South Africa, Africa Regional Dialogue, 3–4 August 2011



Source: UNAIDS/Latin America

Uruguay, Canada (most provinces), the United States, Australia and New Zealand—lawmakers have passed legislation that recognises transgender persons and their rights.²⁶² Such rights include legal sex change, registration of identification documents in accordance with lived gender and prohibition of discrimination against people of non-conforming gender. Such rights enable transgender people to use national health care services, travel with greater ease, and expect protection from violence—all ways of reducing HIV risk or the poor health consequences of infection.²⁶³ Where explicit legal protection is not available through legislation, courts have recognised the right of people with alternative gender identities to be free from discrimination. Judgements from Fiji, Hong Kong, Nepal, Pakistan, Philippines, South Korea and other countries have explicitly noted

the links between law, stigma and the social exclusion transgender people face.²⁶⁴

In 2007 the Supreme Court of Nepal ordered the government to end the system that prevented transgender individuals from obtaining basic citizenship rights.²⁶⁵ In its ruling the court used the term “teshro Linki”—or “third gender”—to refer to transgender persons who feel neither female nor male. Among other legal changes, the judges ordered the repeal of penalties against cross-dressing. Cross-dressing, they said, is within an individual’s human right to freedom of expression. And in 2009, the Supreme Court of Pakistan held that transgender citizens should have equal rights and access to state benefits such as government financial support schemes and should enjoy protections guaranteed by the Constitution of Pakistan.²⁶⁶

SEX CHANGES

New laws recognise transgender identity

Argentina: On 9 May 2012, the Senate unanimously approved the Gender Identity Law making sex-change surgery a legal right, as a part of public or private health care plans.²⁶⁷

Uruguay: A 2009 law allows people over the age of 18 to change their name and sex on official documents.²⁶⁸

India: Since 2005, passport applicants have had the option of identifying themselves as male, female or “others”, regardless of whether they have had a sex-change operation.²⁶⁹

Portugal: In 2011 a law was enacted that regulates legal gender recognition. Under it, a person of Portuguese nationality who is over 18 can obtain his or her preferred gender using a standardised administrative procedure and a report from a multi-disciplinary medical team.²⁷⁰

RECOMMENDATIONS

To ensure an effective, sustainable response to HIV that is consistent with human rights obligations:

- 3.4. Countries must reform their approach towards transgender people. Rather than punishing transgender people, countries must offer transgender people access to effective HIV and health services and commodities as well as repealing all laws that criminalise transgender identity or associated behaviours. Countries must:
 - 3.4.1 Respect existing civil and religious laws and guarantees related to the right to privacy.
 - 3.4.2 Repeal all laws that punish cross-dressing.
 - 3.4.3 Remove legal, regulatory or administrative barriers to the formation of community organisations by or for transgender people.
 - 3.4.4 Amend national anti-discrimination laws to explicitly prohibit discrimination based on gender identity (as well as sexual orientation).
 - 3.4.5 Ensure transgender people are able to have their affirmed gender recognised in identification documents, without the need for prior medical procedures such as sterilisation, sex reassignment surgery or hormonal therapy.

3.5 PRISONERS



Source: John Steven Fernandez

10 million people are incarcerated in prisons throughout the world²⁷¹—6 countries lock up at least one in every 200 residents, with the United States leading and many others close behind.²⁷² It could be said that HIV is a cellmate to each of these inmates. Tattooing with homemade and unsterile equipment,²⁷³ drug use and needle sharing,²⁷⁴ high-risk sex and rape²⁷⁵ all contribute to HIV rates among detainees that are estimated at twice to 50 times those of general adult populations.²⁷⁶ Overcrowding abets the spread of opportunistic infections,²⁷⁷ and stress, malnutrition, violence and drugs weaken the immune system, making HIV-positive individuals more susceptible to getting ill.²⁷⁸

Various forms of discrimination conspire to heighten such risks and make the reality even graver. In the United States, people of colour and African-Americans in particular, are imprisoned at rates vastly disproportionate to their numbers in the population. Between 1980 and 1996, male and female AIDS infection rates increased the most among demographic groups

that experienced the largest increases in male incarceration rates, according to a paper from the University of Michigan's National Poverty Centre.²⁷⁹ And because most people who serve time eventually get out—and often cycle in and out—prisoners' HIV risks are shared by their communities.²⁸⁰

International human rights law recognises the prerogative of the state to deprive people of certain rights—the most obvious one being liberty—through incarceration.²⁸¹ But the human rights to humane treatment and dignity are not confiscated at the prison gate.²⁸² Detainees have a right to a standard of health care equivalent to that available outside of prisons,²⁸³ and agents of the state have an obligation to refrain from inflicting harm

The presence of the anti-buggery/gross-indecency law...precludes the distribution of condoms in Jamaican prisons with the result that the HIV prevalence rate among inmates is twice the national average. In 1997, the Commissioner of Corrections, on the advice of his prison doctor, proposed the distribution of condoms in the island's prisons but was advised that he would be aiding and abetting a criminal offence, buggery. Condoms thus remain contraband in Jamaica's prisons, although there are reports that prison warders do a thriving business trading in them. Prisoners who can't afford to pay resort to the use of plastic bags.

Maurice Tomlinson, Jamaica, Caribbean Regional Dialogue, 12–13 April 2011

on inmates.²⁸⁴ Among the rights that prison authorities are obligated to protect, and courts including the European Court of Human Rights have upheld, are those to health and life, which include adequate access to HIV prevention and health services. The majority of prison inmates do not have this access.²⁸⁵

I am certain that I was infected with both HIV and hepatitis C during my imprisonment for drug use in Chaing Mai men's prison . . . where at least ten other prisoners and I shared homemade injecting equipment fashioned out of a pen barrel and needle, to inject heroin every day for the six months I was there. There was, and still is, no clean injecting equipment available in Thai prisons, or opiate substitution therapy or sterile tattooing equipment.²⁸⁶

Thai AIDS Action Group, Thailand, Asia-Pacific Regional Dialogue,
16–17 February 2011

CONDOMS CONTRABAND

Prisoners have sex behind bars, sometimes consensual, sometimes not. It is therefore the responsibility of prison authorities to provide all prisoners with condoms, as well as punish rapists who prey on other prisoners. But in countries where sodomy is outlawed, those authorities see distributing condoms to incarcerated men as abetting a crime.²⁸⁷ A 2009 study by the AIDS and Rights Alliance of Southern Africa (ARASA) found that where same-sex conduct was criminalised, only one government distributed condoms to prisoners.²⁸⁸ Criminalisation of drug use has a similar effect: countries refrain from providing harm reduction programmes in prisons.²⁸⁹

COMMON SENSE EXONERATED

A disproportionate number of people who end up in prison use drugs, and absent any positive



Source: UN Photo/Martine Perret/Timor Leste

intervention, they continue to do so behind bars. In 2005 WHO reported, for instance, that among European prisoners, as many as 3 of 4 were regular or dependent users, and as many as 1 in 2 was a lifetime user.²⁹⁰ In prisons, unsafe drug injection practices are the leading route of HIV transmission.²⁹¹

Fortunately, the public health necessity—both for prisoners and their communities—of arresting the spread of HIV among inmates has prompted 12 countries spanning Western and Eastern Europe, the Middle East, North Africa and Central Asia²⁹² to offer syringe-exchange programmes (SEPs) in prisons; at least 39 countries provide medication-assisted treatment (MAT).²⁹³ The results are encouraging. Since the implementation of SEPs in 50 prisons in Switzerland, all but one prison reported the eradication of syringe sharing

among inmates. Evaluations of SEPs in European prisons overall indicate that drug use decreased or remained stable over time, with no new cases of HIV, hepatitis B or hepatitis C transmission reported. Opioid substitution therapies have also proven effective at reducing HIV risk behaviours in a wide range of prison environments, without negative consequences for the health of prison staff or prisoners.²⁹⁴

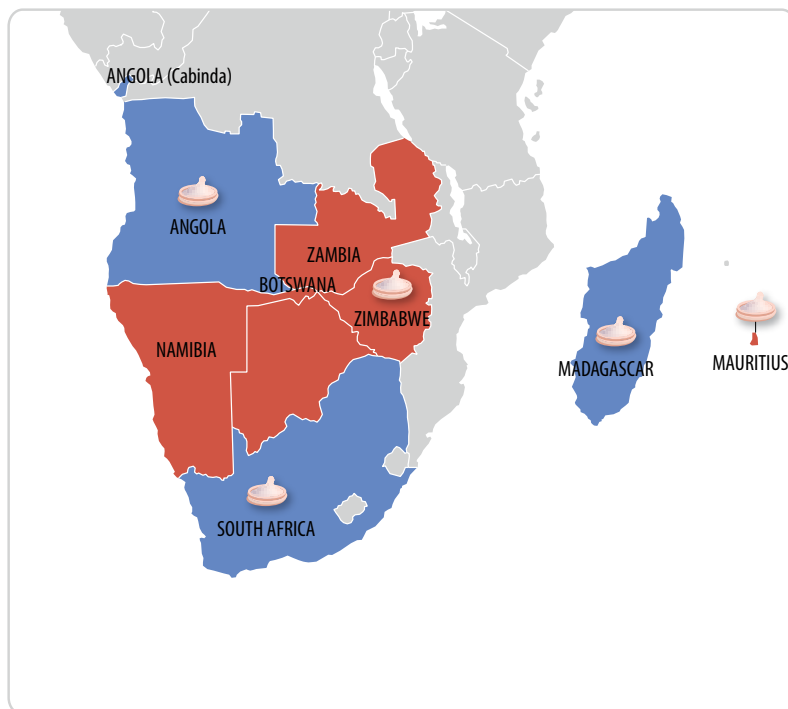
Under pressure from NGOs and other stakeholders, some governments have issued orders requiring improvements of medical care for detained persons with HIV. In Ukraine, patients in police custody must have access to substitution therapy. In the Republic of Moldova, the Ministry of Justice ordered prisons to provide confidential HIV care services, as well as transmission-preventive measures, including condoms and disinfectants for shaving, tattooing tools and injecting drug equipment.²⁹⁵

Where the state has not taken the initiative, legal actions by or on behalf of prisoners can force it to implement HIV prevention measures in prisons. For instance, in the 2000 case *Strykiwsky v. Mills and Canada*, Mr. Strykiwsky, a prisoner, sought access to methadone maintenance treatment for himself and all inmates of federal prisons who were medically eligible and wished to receive it. The respondents refused his request. He brought an application for judicial review of both that decision and the Correctional Service of Canada's on-going refusal to implement a broader methadone maintenance programme within federal prisons. Two days after the court heard Mr. Strykiwsky's case, Canada adopted such a policy for all its federal prisons. Thanks to the action of one prisoner, other inmates now can reduce their exposure to the risk of HIV.²⁹⁶

UNPROTECTED SEX BEHIND BARS

Access to condoms for prisoners in select southern African countries

- male–male sex legal
- male–male sex illegal
-  condoms provided to prisoners



Source: AIDS & Rights Alliance for Southern Africa (ARASA), HIV/AIDS & Human Rights in Southern Africa, 2009.

RECOMMENDATIONS

To ensure an effective, sustainable response to HIV that is consistent with human rights obligations, countries must ensure that in places of detention:

- 3.5.1 Necessary health care is available, including HIV prevention and care services, regardless of laws criminalising same-sex acts or harm reduction. Such care includes provision of condoms, comprehensive harm reduction services, voluntary and evidence-based treatment for drug dependence and ART.
- 3.5.2 Any treatment offered must satisfy international standards of quality of care in detention settings. Health care services, including those specifically related to drug use and HIV, must be evidence-based, voluntary and offered only where clinically indicated.

3.6 MIGRANTS



Source: UN Photo/Diez/Thailand

Although many developed countries in Asia and the Middle East rely on migrant workers to keep their economies functioning, they have instituted migration policies that use health as a primary criterion for permitting entry and stay of migrants for employment. The crux of these policies is that migrant workers coming from less developed countries must undergo mandatory or compulsory health testing as a screening process to identify those with any of up to twenty-two exclusionary health conditions including HIV.

CARAM, Asia-Pacific Regional Dialogue,
16–17 February 2011

In globalised economies, millions are on the move—an estimated 214 million international migrants and 740 million internal migrants worldwide.²⁹⁷ Many hardships and some opportunities compel them from their homes—wars, poverty, natural disasters; up to 86 million people a year seek work away from home.²⁹⁸ Some migrants are entitled to refugee status or have legal work permits. But millions—some of them victims of trafficking—have moved illegally. They live without official recognition in their new homes.

Migration policies—restrictions on entry, stay and residence in a country—split families and isolate people from their peers, friends and known ways. These conditions disempower people, exposing them to exploitation, changing their sexual behaviours and increasing the likelihood of unsafe practices.²⁹⁹ As a result, migrants face

a risk of HIV infection that is as much as 3 times higher than that faced by people with secure homes.³⁰⁰ Discrimination against migrants has a disproportionate impact on women, significantly increasing their vulnerability to HIV.³⁰¹ Either they migrate themselves and face HIV risks where they travel or they await their husbands' or partners' returns from temporary or episodic migrations, sometimes infected with HIV.³⁰² Furthermore, many migrants face discrimination and exclusion from health care systems, leaving them without access to treatment.³⁰³

Sovereign states may establish migration restrictions. At the same time, although the core human rights treaties do not name migrants specifically,³⁰⁴ the right to liberty of movement grants everyone the liberty to stay or to leave their countries, to move within and between states and to choose a residence.³⁰⁵

In 2010 approximately 11% of all people living with HIV in Germany were migrants, and the trend is rising. A special situation is faced by HIV-positive migrants in Germany with no residence permit. In case they are in need of treatment they have two choices: either they start an application process for a residence permit, as this is obligatory to receive treatment (and bears the risk of deportation at the same time), or they decide to stay illegally—without treatment—and risk their lives.

Internationales Abteilung Strukturelle Prävention 2, Germany, High Income Countries Dialogue, 16–17 September 2011

The rights of migrant workers, whose labour supports the global economy, have been fully articulated in numerous international conventions. The International Labour Organization's 1990 International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families,³⁰⁶ for instance, spells out the right of migrant workers and their families "to receive any medical care that is urgently required for the preservation of their life or the avoidance of irreparable harm to their health on the basis of equality of treatment with national of the State concerned."³⁰⁷

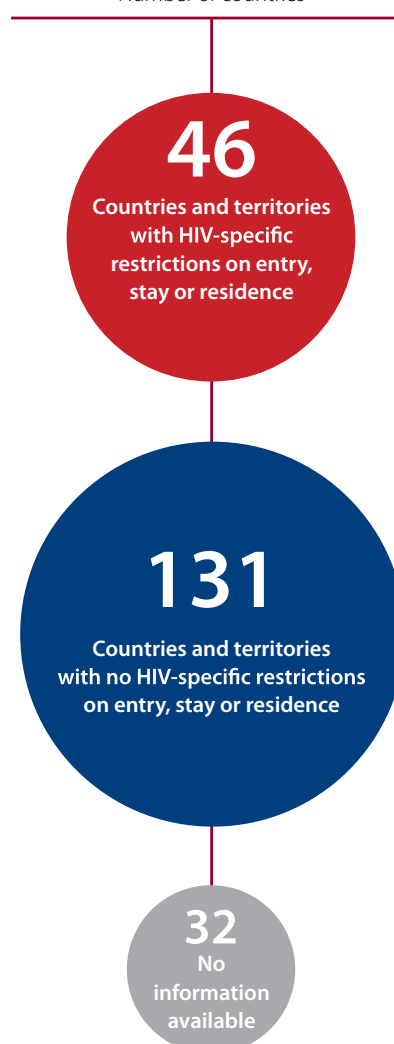
Still, immigration laws and policies erect barriers to access to HIV services for migrants. Some states, like Japan, exclude non-citizens without permanent residency from national health care systems, including HIV care programmes.³⁰⁸ Botswana denies free ART to non-citizens.³⁰⁹ In the United Kingdom's Immigration Removal Centres, where migrants can be detained indefinitely awaiting deportation or grant of asylum, there is evidence that people with HIV, many of them Africans, are also denied ART.³¹⁰ In March 2012, the United Kingdom Department of Health announced that it would make HIV treatment free for all who need it, regardless of citizenship or immigration status, as long as the person seeking treatment has been in the UK for at least 6 months.³¹¹

FALSE SECURITY

A UNAIDS review of HIV-related entry, stay and residence regulations found that 10 countries refuse entry to HIV-positive people and 22 countries deport individuals if their HIV status

HIV TRAVEL RESTRICTIONS

Number of countries



Source: Inter-Parliamentary Union (IPU), UNAIDS, UNDP: Brief for Parliamentarians on HIV and AIDS: Making the law work for the response to HIV, 2011.



Source: Fred Greaves/USA

is discovered.³¹² 11 out of 30 countries from Eastern Europe and Central Asia have HIV-specific restrictions on entry, residence or stay in their legislation, such as mandatory testing.³¹³ 10 out of 21 countries participating in the Commission's High Income Country Dialogue have a history of such policies.³¹⁴

Blanket exclusions of people living with HIV are justified on the grounds of safeguarding public health. But evidence shows they do no such thing.³¹⁵ In fact, such policies give the dangerous

mistaken impression that "outsiders" are contaminated and citizens are pure, and that their health is secure so long as the borders are secured.

Since January 2010, countries including Armenia, Ukraine, the United States, Fiji, Namibia, the People's Republic of China and the Republic of Korea have removed or lowered obstacles to the immigration of HIV-positive people.³¹⁶ But there is a long way to go before these counterproductive, xenophobic regulations are abolished everywhere.

RECOMMENDATIONS

To ensure an effective, sustainable response to HIV that is consistent with human rights obligations:

- 3.6.1 In matters relating to HIV and the law, countries should offer the same standard of protection to migrants, visitors and residents who are not citizens as they do to their own citizens.
- 3.6.2 Countries must repeal travel and other restrictions that prohibit people living with HIV from entering a country and/or regulations that mandate HIV tests for foreigners within a country.
- 3.6.3 Countries must implement regulatory reform to allow for legal registration of migrants with health services and to ensure that migrants can access the same quality of HIV prevention, treatment and care services and commodities that are available to citizens. All HIV testing and STI screening for migrants must be informed and voluntary, and all treatment and prophylaxis for migrants must be ethical and medically indicated.

GENDER AND DISEMPOWERMENT

Women



Source: AFP/Teheran

Women and girls account for half of the people living with HIV in the world; in Africa the proportion is even higher at 60%.³¹⁷ In the regions with the highest rates, HIV strikes younger women and girls particularly hard—in the Caribbean and sub-Saharan Africa, for instance, their infection rates are more than double those of young men and boys. Poverty, both of individuals and of nations, plays its part. Almost all (98%) of HIV-positive women live in developing countries,³¹⁸ and of the remaining 2% who live in developed countries, the majority are poor.³¹⁹

Although HIV is still the leading cause of death in women of reproductive age (15 to 44) globally, death associated with pregnancy and childbirth (maternal mortality) is not far behind.³²⁰ Together, the two are a deadly conspiracy: nearly 1 in 5 maternal deaths is attributable to HIV.³²¹

Why are women so vulnerable to HIV? Some of the reason is biological: younger girls especially are more susceptible to infection. But biology

Three months after the birth of my son, he developed a heart problem and it was suggested he undergo surgery. My husband refused to have himself and the son tested for HIV but I made informed decision and choice for my son. I also voluntarily asked for HIV testing at the same time. Both my son and I tested HIV-positive. I cried uncontrollably, stopped thinking properly for a second, felt disconnected and just wanted to die because it was too much to handle. My husband informed his family members who came at the hospital where I nursing my son to emotionally abuse me and vowed to never set their eyes on my son and me. His family members told him to stop supporting us in any way and he did just that until the boy died at 2 years 2 months. My husband took all my belongings and moved from the house we rented. I reported the case of property grabbing at the police station but I was harassed by the police who could not understand my position. I decided to seek the courts of law to intervene in the matter of human rights violations and property grabbing.

Judith Kateule, Zambia, Africa Regional Dialogue, 3–4 August 2011

is not destiny. It is gender inequality and discrimination that is enshrined in custom and law, and sexual and domestic violence, which may be condoned by custom and law, that rob women of power. For example, child marriage, a

practice parents often believe will protect their daughters from HIV, actually exacerbates their risks. Older husbands may be infected from other relationships, and the child brides, lacking education, experience, knowledge or the chance of economic independence, are less able to negotiate safer sex or demand fidelity. According to the UN Special Rapporteur on Violence Against Women, a demographic and health survey of 26 countries found that “the majority of sexually active girls aged 15-19 in developing countries are married, and these married adolescents tend to have higher rates of HIV infection than their peers.”³²²

In many countries, particularly in Africa and Asia, the situation for women is complicated by plural legal systems—that is, general laws that apply to matters in the public domain and codified customary/religious laws mostly concerning private and family life. Although most constitutions stipulate that constitutional law prevails when government and traditional law conflict, “customary laws and religious laws enjoy the status of binding sources of law in the vast majority of countries in the African region.”³²³ This combination of the colonial legacy and postcolonial political decisions can perpetuate or compound gender inequality and discriminatory practices that have “negative implications for [women’s] sexual health.”³²⁴

In addition to these local conflicts, national governments have made exceptions to international covenants, such as CEDAW, on the grounds that they violate religious edicts or customary practices—although some women’s rights activists dispute the assumption that Islam (or other religions) compels or condones gender discrimination.³²⁵ Women may accede to the rule of these overlapping laws and customs out of fear of ostracism or violence if they do not, or (particularly rural and uneducated women) they may embrace them for themselves and their

daughters. Still, the evidence is unequivocal: Gender inequality leaves women and girls undefended from HIV infection and diminishes their ability to cope with the consequences of illness and to care for themselves and their families.³²⁶

Although gender norms and inequality primarily harm women and girls, men and boys also can pay dearly. New data shows that the rape of males is far more prevalent in conflict zones than previously understood.³²⁷ Cultures of machismo can pressure men into having sexual partners that they might not otherwise, discourage the use of condoms or non-penetrative sex and undermine men’s motivation to seek necessary health care.³²⁸ The protection and promotion of human rights for women and girls is in everybody’s interest.

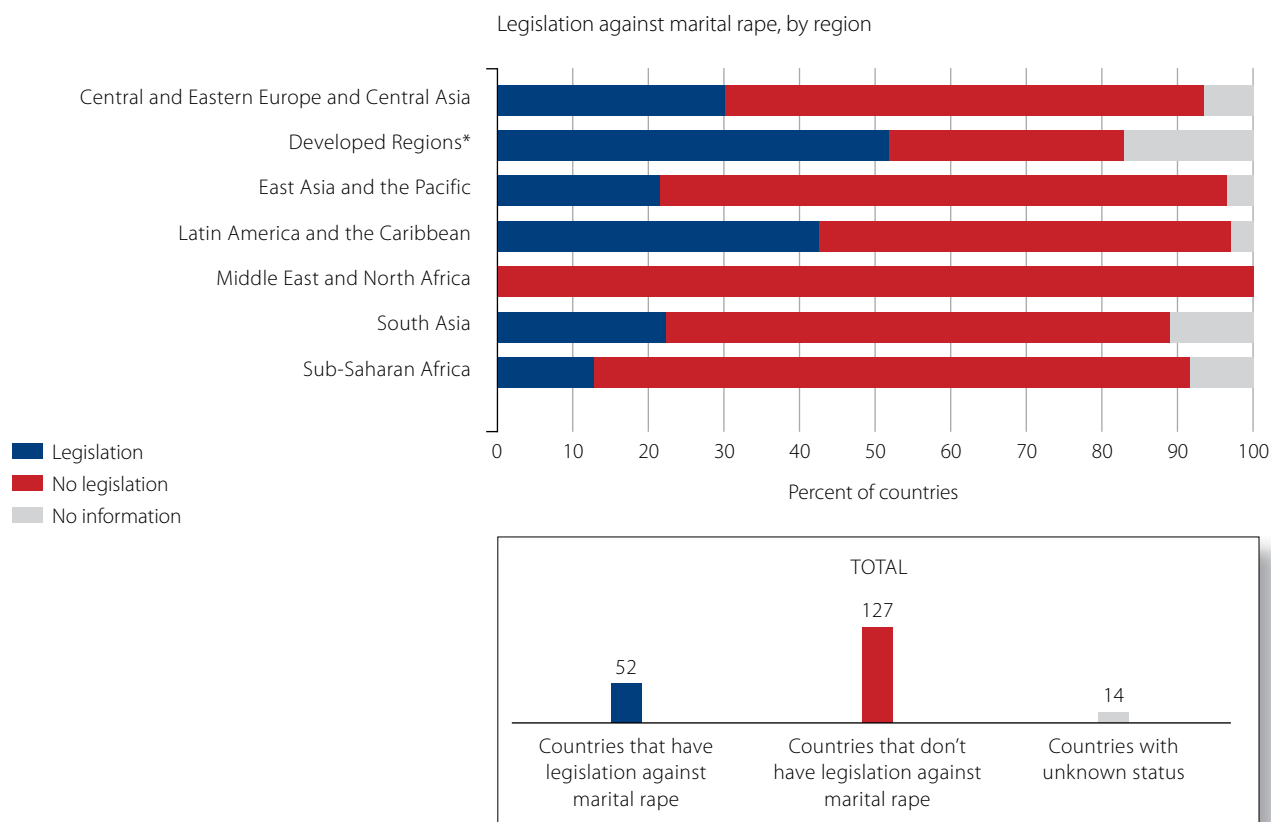
VIOLENCE AND HIV

Sexual violence is the accomplice of HIV,³²⁹ depriving women of their ability to control their



Source: Avert/South Africa

RAPE WITHIN MARRIAGE



Note: *Developed Regions include Andorra, Australia, Austria, Belgium, Canada, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Israel, Italy, Japan, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, New Zealand, Norway, Portugal, San Marino, Spain, Sweden, Switzerland, United Kingdom and the United States of America.

Source: UN Women Progress of the World's Women 2011 – 2012: In Pursuit of Justice, July 2011.

lives and thereby protect their health. In fact, a 2005 WHO study found that in “a broad range of settings”, men who were violent toward their female partners were also more likely to have multiple partners—both violence and infidelity being expressions of male privilege³³⁰—and to be infected with HIV and other STIs, putting all their female partners at risk.³³¹ But although international human rights doctrine and jurisprudence unequivocally denounce sexual violence as cruel, inhuman and degrading treatment and a form of torture,³³² and almost every nation criminalises it, the rape of women continues at alarming levels. The law plays its part in allowing violence to plague women. The legal definitions of sex crimes may preclude prosecuting some coerced acts.³³³ For instance, marriage may be an exemption or defence to the crime of rape.³³⁴ Two thirds of the world's countries currently outlaw domestic

violence, but many still do not prosecute marital rape,³³⁵ and marital rape may be defined as a less serious offence than rape outside of marriage.³³⁶ In Antigua and the Bahamas, for example, a husband who rapes his wife can be charged only with the lesser offence of sexual assault.³³⁷

Even where many forms of sexual violence are interdicted, the laws may be casually enforced or not enforced at all. Rape may be committed by police officers or uniformed service officers, making it impossible for victims to report the crimes or seek legal redress. And because the link between violence and HIV risk is not clearly acknowledged, survivors of violence fail to get timely HIV and health services, including medications to lessen the likelihood of contracting HIV.³³⁸ One submission to the Commission noted that In Chile, despite protective laws against sex-

ual violence, the lack of multi-sectoral coordination between health and justice sectors leads to fragmented and ineffective services.³³⁹

But rape is no longer just a personal crime. Increasingly it is a chief weapon of military conflict.³⁴⁰ To break the women and girls is to destroy what holds a people together—from water-carrying to community-building. The spread of HIV through rape is all too effective a way of exhausting a people's resilience for generations. Empowering women is necessary to the well-being of all people. It is crucial to fighting HIV.³⁴¹ Violence against women and girls increases their vulnerability to HIV.³⁴² Research in 4 provinces of Papua New Guinea, for example, showed a strong relationship between sexual abuse and a woman's HIV-positive status. Women in the study who reported being sexually abused in their intimate partner relationships were twice as likely to be HIV-positive as women who were not abused.³⁴³ Forced sex in childhood or adolescence has been linked with increased probability of engaging in unprotected sex, having multiple partners, participating in sex work and using illegal substances later in life—all activities presenting heightened HIV risks.³⁴⁴ This connection is particularly disturbing because young women and girls are frequently the primary targets of sexual violence.³⁴⁵ In South Africa, police statistics show that more than 40% of rape survivors who reported their assaults to the police in 2002–2003 were girls under 18 years of age, and 14% were 12 or younger.³⁴⁶

Disclosure of positive HIV status also puts women at risk and in fear of violence, as numerous submissions to the Commission attest. A gang-raped Pakistani woman discovered that she was both pregnant and HIV-positive. Her husband, who was also poor and suffering from injuries, abandoned her and her twin sons.³⁴⁷ Education and class do not necessarily insulate women from such outcomes. A Tanzanian woman described

a happy marriage to a professional man and a middle-class life. When she told him of her positive status, "he was very furious and started blaming me for our sons' illness. He exposed me to a lot of stigma and torture. My health deteriorated. . . . My husband accused me for being the cause of the death of his relatives who died of AIDS. I was also expelled from the matrimonial house that I built with my own money. The divorce courts were of no help."³⁴⁸

Women with HIV are not expected to fall pregnant. One day I could tell my doctor was angry. I had broken his trust when I said I was pregnant. He was disappointed. I had failed my doctor; I felt irresponsible and guilty. He said, "I don't want you to go through this again." So I was sterilised. I was the bad woman. I was HIV-positive. I compromised my health³⁴⁹

Nontobeko Prudence Brenda Dlamini, International Community of Women Living With HIV-Southern Africa, Africa Regional Dialogue, 3–4 August 2011

REPRODUCTIVE AND MATERNAL ILL HEALTH

Access to HIV and reproductive health services³⁵⁰ could substantially reduce both vertical transmission of HIV and maternal death. A combination of ARVs taken by a mother prenatally and during labour and breastfeeding has been shown to significantly reduce the chances of vertical transmission.³⁵¹ Contraception—along with avoidance of unwanted pregnancy—also saves lives: it averted at least 40% of maternal deaths globally in 2008. Fulfilling the current unmet needs for contraception could prevent an additional 30% of such deaths.³⁵² Yet the reproductive medical clinic is not a welcoming place for many HIV-positive women. Coercive and discriminatory practices in health care settings are rife, including forced HIV testing, breaches of confidentiality and the denial of health care services, as well as forced sterilisations and abortions.³⁵³



Source: Andrea Flynn/Namibia

Since 2001, when forced and coerced sterilisation and abortion among HIV-positive women were first documented, reports have emerged from Chile, Venezuela, Mexico, Dominican Republic, Indonesia, Kenya, Namibia, South Africa, Tanzania, Thailand, Uganda and Zambia.³⁵⁴ Some women report being denied access to HIV and health services unless they agree to abortion or sterilisation.

Where HIV exposure and transmission are criminalised, pregnant women and mothers fear getting tested or treated for HIV or having their babies tested, lest they be prosecuted for passing on the virus. Kenya's Sexual Offences Act, which criminalises HIV transmission "would effectively reduce the number of women going

for antenatal care, and most mothers will prefer to have home delivery to avoid testing and reprisal by the health care providers", said a representative of the Federation of Women Lawyers Kenya.³⁵⁵ Similarly, said an advocate from the Central African Republic, that nation's law criminalising "reckless" transmission from knowing HIV-positive persons to others "implies that mothers can no longer breastfeed their children (whilst if they do not, the child is malnourished and dies, and this is considered an abuse)."³⁵⁶

Human rights advocates have made gains against these counterproductive laws, such as the adoption of the Maputo Plan for Action³⁵⁷ and the increased availability of services to prevent vertical HIV transmission.³⁵⁸ However, few countries provide for a full range of sexual and reproductive health services to women and girls.

PROPERTY WRONGS

Without equal rights to acquire and secure property, a woman is effectively the captive of her husband and his family.

This is why numerous international covenants—including the International Covenant on Civil and Political Rights (ICCPR), the International Covenant on Economic, Social and Cultural Rights

In parts of Kenya, many widows and orphans become vulnerable to HIV when their husbands and fathers die, due to disinheritance by their families and communities, which leaves them destitute. [Many] are evicted from their rural homes and flee to urban areas where they find themselves vulnerable to further violence, including physical and sexual abuse, which increases their vulnerability to HIV. Often [they] resort to high-risk behaviour such as involuntary sex work in order to earn enough money to survive.

Allan Maleche, Kenya Legal & Ethical Issues Network on HIV and AIDS (KELIN), Kenya, Africa Regional Dialogue, 3–4 August 2011

SHARIA AND MALE PREROGATIVE IN NIGERIA³⁵⁹

The 1999 Constitution of Nigeria prohibits discrimination on the grounds of gender, but customary and religious laws continue to restrict women's rights. Nigeria is a federal republic, and each state has the authority to draft its own legislation. Certain states in the north of Nigeria follow a particular school of Sharia, which may be invoked to reinforce customs unfavourable to women, thus increasing their vulnerability to HIV.

Nigeria's Sharia recognises four main types of divorce:

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

The Penal Code of Northern Nigeria, based on their application of Sharia, allows a husband to:

- beat his wife, provided it does not rise to the level of "grievous hurt"
- withdraw economic support if his wife refuses sexual intercourse

The Kano State Sharia Penal Code requires a woman alleging rape to produce four witnesses to the rape. If the rape is not proved, she can be punished for adultery with imprisonment or flogging.

(ICESCR) and the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW)—guarantee equality between men and women in family life, marriage and its dissolution.³⁶⁰ Regional agreements also address laws and traditions that let men and their families take divorcees' or widows' property. The Protocol to the African Charter on Human Rights and People's Rights on the Right of Women in Africa specifically protects the right to "equal access to housing and to acceptable living conditions"; it requires States to "grant to women, whatever their marital status, access to adequate housing"³⁶¹ and guarantees to widows "an equitable share in the inheritance of the property of her husband" and "the right to continue to live in the matrimonial home."³⁶² The Maputo Protocol also addresses women's equal access to land and property.

Nevertheless, these international standards, or even the national statutes ratifying them, may have little or no effect. Both formal and customary marriage, property and inheritance laws, as well as unlawful "property-grabbing"—taking of a widow's house and belongings by relatives of her husband—perpetuate gross gender inequality. Women are rendered economically dependent and unable to escape, which gives husbands control over their sexual lives. Just as property inequality increases women's risk for HIV by denying her the ability to demand fidelity or condom use,³⁶³ studies from Africa and Asia also show that HIV-related stigma exacerbates property grabbing.³⁶⁴

It is not her house or land that a wife, divorcee or widow risks losing under unjust property and

inheritance laws or customs. Customary practices may make her body the property of her husband or his relatives. Accepted in a number of countries in Africa and Latin America, as well as parts of Asia and the Middle East, customary practices include early marriage and female genital mutilation,³⁶⁵ “widow inheritance”³⁶⁶ and “sexual cleansing”³⁶⁷—despite the increased risk of HIV exposure inherent in a number of these practices.³⁶⁸ Legal systems, whether governmental or traditional, generally fail to outlaw these activities. And women may either embrace them for cultural or religious reasons, or, fearing ostracism or economic ruin, feel forced to abide by them.³⁶⁹ The criminalisation of HIV transmission compounds the dangers of these practices and places women in a double-bind: if a woman is HIV-positive and then forced to have sex with her brother-in-law as a part of “widow inheritance”, she could be prosecuted for transmitting HIV to him.

RECONCILIATION

Undoing decades—even centuries—of traditions that weaken and oppress women—is a slow and incremental process. HIV both exposes pervasive gender discrimination and renders it deadlier than ever before. Some countries—Namibia, for example³⁷⁰—are taking steps to remove marital exemptions as a defence to rape. A number of African countries, including Burkina Faso, Malawi, Mozambique, Niger, Rwanda and South Africa, are also moving toward ensuring women’s equal access to land and property, some with specific reference to HIV.³⁷¹ In Tamil Nadu, India, a partnership among government, civil society and people living with HIV to provide legal services has improved access to property and land for women affected by or living with HIV.³⁷² Courts in countries such as Tanzania, Uganda and Zimbabwe have

overturned discriminatory customary and religious laws. But the new, “improved” statutes sometimes reflect the lawmakers’ reluctance to challenge customary law principles.³⁷³ Zimbabwe no longer accepts marriage to the victim as a defence for sexual crimes, for instance, but no prosecution of a husband for raping or indecently assaulting his wife can be instituted without the personal authorisation of the Attorney General.³⁷⁴ And where custom and tradition prevail, women do not feel the effects of progressive laws and judgements at the national level in their daily lives.³⁷⁵

Perhaps the most promising route to change is adaptation of traditional legal systems to promote equality for women and their children and recruitment of respected community members to mediate inheritance disputes between widows and their in-laws. The Kenya Legal and Ethical Issues Network on HIV/AIDS (KELIN) is educating elders in alternative dispute resolution approaches and training them, as well as widows and local law enforcement officials, to create awareness of human rights. According to KELIN, the approach recognises that customary law evolves and can incorporate gender equality considerations, and that local mechanisms for enforcing customary law can be strengthened to facilitate the promotion and protection of women’s rights.³⁷⁶

Inherent to the criminalisation of marital rape is the recognition that marriage is neither an irrevocable consent to sex nor a prophylactic against HIV infection, and that women—married or not—have a fundamental right to refuse sex or negotiate its terms. Without economic security and independence, women can never control their own destinies. And if they cannot, HIV transmission will not be brought to heel.

RECOMMENDATIONS

To ensure an effective, sustainable response to HIV that is consistent with human rights obligations:

- 4.1. Countries must act to end all forms of violence against women and girls, including in conflict situations and post-conflict settings. They must:
 - 4.1.1 Enact and enforce specific laws that prohibit domestic violence, rape and other forms of sexual assault, including marital rape and rape related to conflict, whether perpetrated against females, males or transgender persons.
 - 4.1.2 Take judicial or legislative steps to remove any immunity—or interpreted immunity—from prosecution for rape when the perpetrator is a married or unmarried partner.
 - 4.1.3 Fully enforce existing laws meant to protect women and girls from violence, and prosecute perpetrators of violence against women and girls to the full extent of the law.
 - 4.1.4 Formulate and implement comprehensive, fully resourced national strategies to eliminate violence against women and girls, which include robust mechanisms to prevent, investigate and punish violence. Provision of health services, including post-exposure prophylaxis, legal services and social protection for survivors of violence, must be guaranteed.
- 4.2. Countries must prohibit and governments must take measures to stop the practice of forced abortion and coerced sterilisation of HIV-positive women and girls, as well as all other forms of violence against women and girls in health care settings.
- 4.3. Countries must remove legal barriers that impede women's access to sexual and reproductive health services. They must ensure that:
 - 4.3.1 Health care workers provide women with full information on sexual and reproductive options and ensure that women can provide informed consent in all matters relating to their health. The law must ensure access to safe contraception and support women in deciding freely whether and when to have children, including the number, spacing and methods of their children's births.
 - 4.3.2 Health care workers are trained on informed consent, confidentiality and non-discrimination.
 - 4.3.3 Accessible complaints and redress mechanisms are available in health care settings.
- 4.4. Countries must reform property and inheritance laws to mandate that women and men have equal access to property and other economic resources, including credit. They must take measures to ensure that in practice property is divided without gender discrimination upon separation, divorce or death and establish a presumption of spousal co-ownership of family property. Where property and inheritance practices are influenced or determined by religious or customary legal systems, the leaders of these systems must make reforms to protect women, including widows and orphans.
- 4.5. Countries must ensure that social protection measures recognise and respond to the needs of HIV-positive women and women whose husbands have died of AIDS and that labour laws, social protection and health services respond to the needs of women who take on caregiving roles in HIV-affected households.
- 4.6. Countries must ensure that laws prohibiting early marriage are enacted and enforced.
- 4.7. The enforcers of religious and customary laws must prohibit practices that increase HIV risk, such as widow inheritance, "widow cleansing" and female genital mutilation.

THEIR WHOLE LIVES TO LIVE

Children and Youth



Source: UNDP/Burkina Faso

The reason people are vulnerable to HIV and AIDS is not because they are young, or homosexuals, or sex workers or injecting drug users. We are not somehow extra vulnerable to the virus. Yet, we carry the heaviest burden of the pandemic, because society repeatedly denies us access to sexuality education, commodities for contraception and decision-making when it comes to HIV and AIDS programmes. On the issue of rights, a lot of debate focuses on the need to strike a balance between the autonomy and universality of rights and the contexts that surround the realization of these rights. We should begin to name sexual rights without shame, as what is unnamed is more likely to be unsupported, ignored or misunderstood.

Network of Asia Pacific Youth, Asia-Pacific Regional Dialogue, 16–17 February 2011

Children and youth have the most to lose from HIV: They are far more likely to become poor or homeless, drop out of school, face discrimination and violence, see their opportunities dwindle, and grow ill and die long before their time. Their woes are many and complex and include malnutrition, expulsion from school, grieving for their parents and fearing their own mortality. But they also have the most to gain from successful HIV responses. Children and youth can be powerful agents of change in HIV prevention and in fighting stigma and discrimination.³⁷⁷

Globally, there are 3.4 million children³⁷⁸ living with HIV, roughly 16.6 million who have lost one or both parents to AIDS and millions more who have been affected.³⁷⁹ Fewer babies are being born with HIV, thanks to an increase in programmes to prevent vertical transmission. Less than one quarter of children who qualified for ART actually got it in 2010. And still 2,500 young people acquire HIV every day.³⁸⁰

Many governments have affirmed society's obligations to realise children's right to equality, provide for their survival and development, promote their best interests and give them a meaningful say in matters affecting their lives. Since its adoption in 1989, an estimated 69 countries of the 193 parties to the Convention on the Rights of the Child (CRC)³⁸¹ have enacted statutes affirming these principles. But not all governments are living up to their ideals. Few have actively promoted and funded programmes to benefit children infected or affected by HIV. Rarely does a government take full account of the realities of young people's lives—including their sexual lives.

The needs of children in the epidemic are intimately bound to those of the adults who care for them. When parents or guardians are too sick to support or care for their children, the burdens of supporting the family, running the household and caring for sick parents or siblings may fall on the children themselves.

Older children, especially girls,³⁸² are often forced to leave school to care for the family.³⁸³ For girls, this is a step backward, away from economic independence in later life, and it elevates the risks of HIV acquisition. Programmes around the globe have helped support older adolescents so that they do not drop out of school. Direct cash payments in Mexico,³⁸⁴ Malawi and Tanzania have accomplished that aim; in addition, such programmes have reduced rates of teenage pregnancy, STIs and HIV.³⁸⁵

Discrimination against families living with HIV is common, as submissions to the Commission attest. Adults living with HIV may be denied visitation rights to see their children³⁸⁶; agencies prohibit HIV-positive children from living with their parents in state-sponsored housing and school and child care administrators shut the doors to HIV-positive pupils, believing they will infect others.³⁸⁷ For example, in Paraguay, “people who suffer from chronic contagious disease” are forbidden to marry or adopt.³⁸⁸ Challenging these legal obstacles is a particularly important role of NGOs. For instance, Gidnist, the Ukrainian legal aid NGO, challenged the Ukrainian court to protect the rights of an HIV-positive child who was denied access to the paternal home. Thanks to this legal action, the child’s access to his paternal home was restored and the father was ordered to pay back payments for child support.³⁸⁹

GOING HOME

When parents die, the state must ultimately ensure that their children’s human rights and legal interests are protected—the most important of which is to be cared for by responsible adults. Children who have lost parents to HIV live in diverse family systems and households (some formal, some not), so it is critical that the law recognise the parental rights and responsibilities of de facto caregivers, lest children be legally adrift, unable to access health care, education



Source: UN Photo/Shehzad Noorani/Thailand

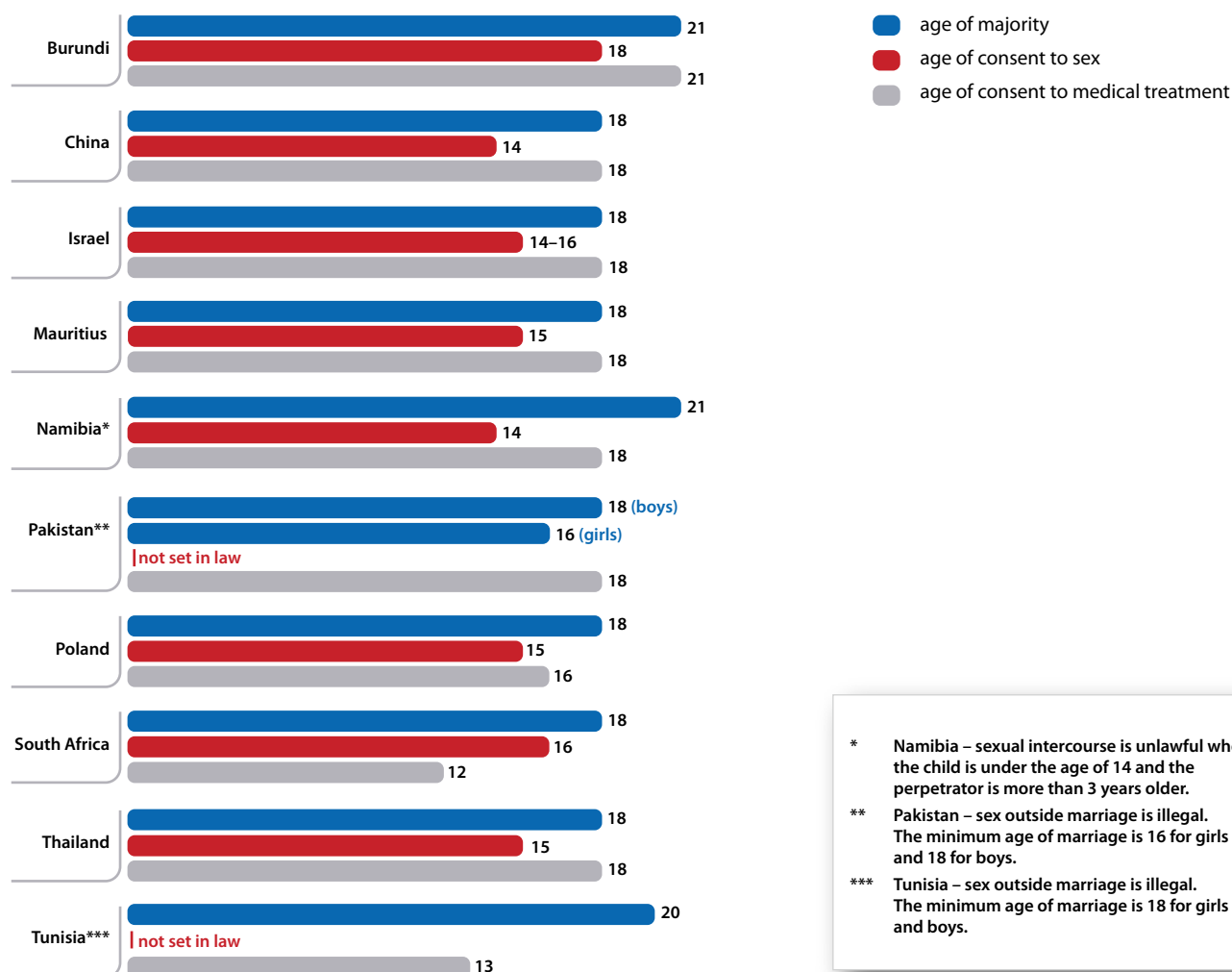
and social protection.³⁹⁰ In nearly every sub-Saharan country, according to UNICEF, relatives take in AIDS orphans—more than 90% of these children—“despite the great economic strain this has caused most households.”³⁹¹

It should not be forgotten that children orphaned by AIDS experience enormous emotional trauma. They need familial affection and normalcy in their lives. In partnership with the government, the All-Ukrainian Network of people living with HIV makes sure that HIV-positive children end up in family-based environments and that they stay in school. “By April 2011 in the Crimea, Ukraine, 6 children with HIV were brought up in foster care, 2 were adopted, 2 are under guardianship and 23 children born to HIV-infected women (affected by HIV) have found their families”, a representative of the Network told the commission.³⁹²

A positive HIV diagnosis does not render an adult incompetent to take care of children. Yet the adoption applications of HIV-positive people (or same-sex couples) are commonly rejected. In some countries discrimination of this kind has been outlawed—as of course it should be everywhere, especially when so many children affected by HIV are waiting for homes. The Americans with Disabilities Act (ADA), for instance, prohibits adoption agencies from discriminating against couples or individuals living with HIV.³⁹³

GROWING CONTRADICTIONS

Legal approaches to the evolving capacity of minors in select countries



Sources: Office of the High Commissioner for Human Rights (OHCHR), Countries Periodic Reports to the Committee on the Rights of the Child (CRC), accessed by UNDP in 2012; INTERPOL, Legislation of INTERPOL member states on sexual offences against children, accessed by UNDP in 2012; UNICEF, National HIV Counseling Guidelines for Children and Adolescents in Pakistan, 2008.

Where inheritance laws do not explicitly protect orphans and custom favours men in property ownership, the situation of AIDS orphans is dire. In Kenya, the lack of such legal protection for orphans has left them vulnerable to property grabbing by relatives under the pretext of informal guardianship.³⁹⁴ Property disputes can be interminable. In Tanzania, widows and orphans can “languish in the court corridors” for years, the Tanzania Women Lawyers Association told the Commission. “A good number meet their death before their disputes of inheritance in court are resolved.”³⁹⁵

AUTONOMY AND CONSENT

Sexually active young people—for physiological, psychological and social reasons—are particularly vulnerable to HIV. They are in urgent need of appropriate prevention information and reproductive and sexual health services, as the UN Committee on the Rights of the Child has stressed.³⁹⁶ Adolescents who are gay or lesbian or who question their gender identities have specific needs—among them the support and guidance of gay, lesbian and transgender adults. Youth living with HIV, who may become infected either by birth to HIV-positive mothers

UNSAFE PRACTICES:

How not to respond to HIV risk

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

Looking After HIV, United Kingdom, 2008³⁹⁷

or through sex or unsafe drug injection, have particularly complex needs. Focus groups with sero-positive youth in Botswana, for instance, found that they face stigma from classmates, friends and families; they may engage in risky sexual practices; and they have trouble coordinating the demands of schoolwork and health.³⁹⁸ In spite of legislation to the contrary, Botswana's youth also may be refused HIV tests without parental involvement.³⁹⁹ Research in Canada, where 13,000 adolescents and young adults are living with HIV, found that such youth "experience higher than usual rates of homelessness, sexual and physical abuse, financial difficulties, addictions, and social isolation." Nevertheless, programmes that support Canadian HIV-positive youth are scarce.⁴⁰⁰

Many states deny youth health services without parental consent.⁴⁰¹ The proponents of such laws say that they protect children (a broad category including everyone from birth to 18), but in reality fear of the disapproval and rage of their parents

leads young people to avoid getting reproductive and HIV-related services.⁴⁰² By contrast, a United States study showed a significantly higher proportion of young people volunteered for HIV testing once the legal requirement of parental consent was eliminated.⁴⁰³

Contradictory attitudes about the competency of youth to make autonomous decisions are evident in the laws that govern minors' sexual and medical lives. In a number of countries, children can lawfully have sex before the age at which they can get medical treatment without their parents' consent. In other countries the laws putatively permit children to access sexual and reproductive health services below the age of consent to sex—except that their underage sexual activities must be reported to the police if they request such services. For example, in South Africa health care workers providing such services to minors are legally compelled to report consensual, underage sex.⁴⁰⁴ Such regulations frustrate the majority of STI and HIV prevention efforts for youth.⁴⁰⁵

SEX EDUCATION: THE MISSING LINK

Age-appropriate comprehensive sex education, including information on HIV prevention, serves the health of young people. Studies show that such programmes result in more frequent condom use, fewer sexual partners and significantly reduced sexual risk-taking. No studies find that sex education leads to earlier, riskier or more prolific sexual activity.⁴⁰⁶

At present, very few laws recognise the rights of young people to education about their sexuality or the risks of HIV.⁴⁰⁷ But, given the tensions among religious, cultural and political constituencies on what sex education should be, the law can advance children's rights by

establishing minimum standards for such programmes.⁴⁰⁸

In its zeal to act in the best interests of youth, the state may intervene to the point of unintentionally harming them. Children under the guardianship of the state are subject to intense surveillance, particularly of their sex lives, and the combination of punitive HIV-related statutes, official confusion and ambivalence over youth sexuality can exacerbate the difficulties of young people living with HIV, as an investigation by the United Kingdom's Children and Young People HIV Network HIV-positive minors "looked after" by the local authorities found.⁴⁰⁹

RECOMMENDATIONS

To ensure an effective, sustainable response to HIV that is consistent with human rights obligations:

5.1. Countries must enact and enforce laws that:

5.1.1 Ensure that the birth of every child is registered. This is crucial for supporting children's access to essential services. Ensure that their rights are protected and promoted, as per the Convention on the Rights of the Child.⁴¹⁰

5.1.2 Ensure that every orphaned child is appointed an appropriate adult guardian. This includes provisions for transfer of guardianship of AIDS orphans from deceased parents to adults or older siblings who can ensure their well-being. In selecting a guardian, preference should be given to adults from the biological or extended families. HIV-positive adults who are otherwise in good health should not be prohibited from adopting children.

5.1.3 Support community-based foster care for children orphaned by AIDS as an alternative to institutionalisation, when formal adoption is not possible or appropriate.

5.1.4 Ensure HIV-sensitive social protections as required, such as direct cash transfers for affected children and their guardians.

5.1.5 Prohibit discrimination against children living with or affected by HIV, especially in the context of adoption, health and education. Take strict measures to ensure that schools do not bar or expel HIV-positive children or children from families affected by AIDS.

5.2 Countries must enact and enforce laws to ensure that children orphaned by AIDS inherit parental property. Children orphaned by AIDS should inherit regardless of their sex, HIV status or the HIV status of family members. Such enforcement includes:

5.2.1 Collaboration with the enforcers of religious and customary laws to ensure justice for children orphaned by AIDS.

5.2.2 Reconciliation of conflicts between discriminatory customary laws and traditional practices and international human rights standards to ensure compliance with international law.

5.3. Countries must enact and enforce laws ensuring the right of every child, in or out of school, to comprehensive sexual health education, so that they may protect themselves and others from HIV infection or live positively with HIV.

5.4. Sexually active young people must have confidential and independent access to health services so as to protect themselves from HIV. Therefore, countries must reform laws to ensure that the age of consent for autonomous access to HIV and sexual and reproductive health services is equal to or lower than the age of consent for sexual relations. Young people who use drugs must also have legal and safe access to HIV and health services.

MEDICINES FOR WHOM?

Intellectual Property Law and the Global Fight for Treatment



Source: APN+/Rico Gustav/India

IP policy is a critical component of substantial, continued price reductions for ARVs, and of the ability of national governments to extend the implications of lessons learned in HIV to other areas of health. The ultimate implications, of course, are measured not in technical prose, but in people's lives.

Mohammed El Said & Amy Kapczynski, Access to Medicines: The Role of Intellectual Property Law and Policy⁴¹¹

ARVs and other medicines to counteract the effects of HIV and its co-infections make the difference between health and illness, productive life and early death. Second- and third-generation ARVs and medications for co-infections such as hepatitis C remain expensive. But the prices of first-generation ARVs have fallen dramatically over the past ten years, thanks primarily to

increased marketplace competition from generic drugs. This translates into more people in low- and middle-income countries getting treatment—at the end of 2010, they numbered 6.65 million.⁴¹² And that means fewer HIV infections and related conditions, fewer deaths, fewer children orphaned due to AIDS and reduced expenditure for precariously sustained households and health systems.

ENFORCING THE RIGHT TO HEALTH

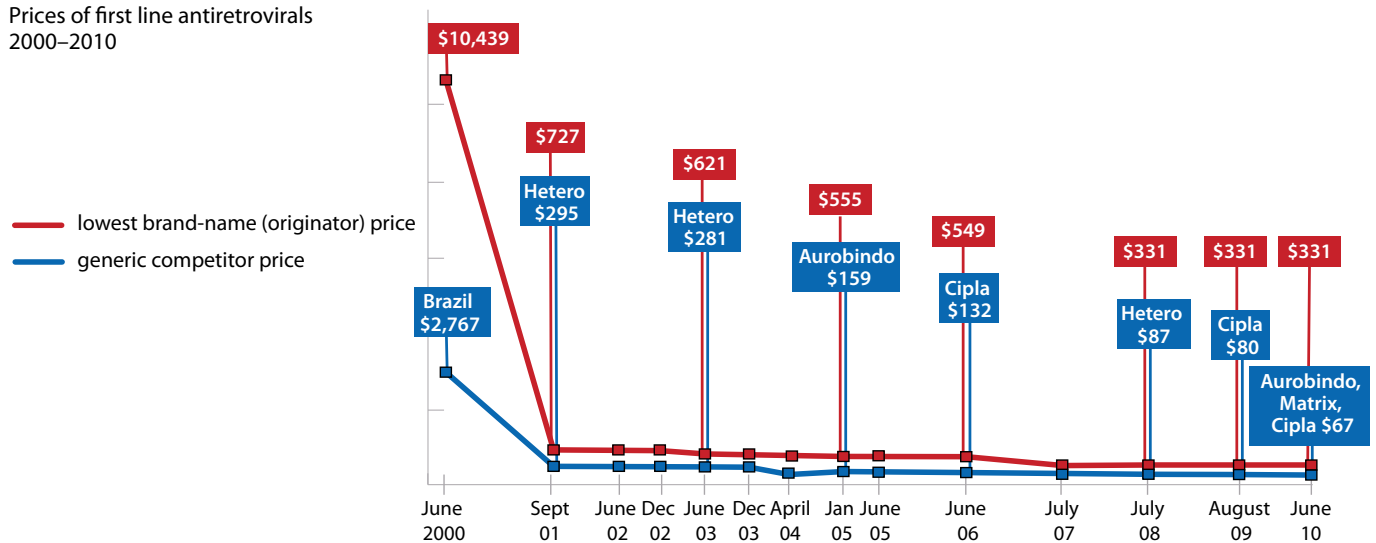
A number of countries have enacted specific laws protecting the right to health for people living with HIV or have achieved broad access to treatment through

the courts. Brazil's Constitution provides that "health care is a right of all citizens and the duty of State", and in 1996 the federal government adopted Law 9313 guaranteeing affordable access to HIV treatment. This commitment has been crucial to the success of Brazil's HIV response.⁴¹³ In numerous other instances, courts have compelled governments to comply with their public health obligations under international and domestic law. In Venezuela, the Supreme Court has ruled more than once that the government violated the constitutional right to health by failing to guarantee access to ART for people living with HIV.⁴¹⁴ In South Africa, the Treatment Access Campaign led and won a right-to-health lawsuit demanding that the government supply ARVs for the prevention of vertical transmission; indeed, the Constitutional Court went further and ordered the government to develop and implement a comprehensive program to reduce that risk.⁴¹⁵

Such legal strategies, together with global advocacy and generic competition, resulted in a 22-fold increase in ART access between 2001 and 2010.⁴¹⁶ While some pharmaceutical companies have entered into agreements to offer medicines at reduced prices, their actions cannot be credited for the dramatic rise in treatment. Rather, AIDS

GENERIC COMPETITION: MAKING ARVs AFFORDABLE

Prices of first line antiretrovirals
2000–2010



Source: Médecins Sans Frontières (MSF), *Untangling the Web of Antiretroviral Price Reductions (UTW)*, 14th edition, July 2011.

treatment activists coordinated international campaigns to boost domestic and donor funding. This, coupled with competition from generic manufacturers like Cipla's 'game-changing' offer to provide triple combination treatment for less than a dollar a day in 2001,⁴¹⁷ greatly increased treatment coverage.

In spite of this remarkable achievement, the world is in the grip of a crisis in treatment affordability and accessibility. Of those who qualify under WHO guidelines to receive these life-saving medicines, fewer than half of HIV-positive adults and less than a quarter of children in need are getting them. Moreover, resources for HIV are declining and the global economic crisis is affecting the contributions of donor countries.⁴¹⁸ The Global Fund to Fight AIDS, Tuberculosis and Malaria, one of two major financiers of the HIV response, recently announced that it had to postpone or cancel its entire next round of grants, from 2011 to 2013, because many

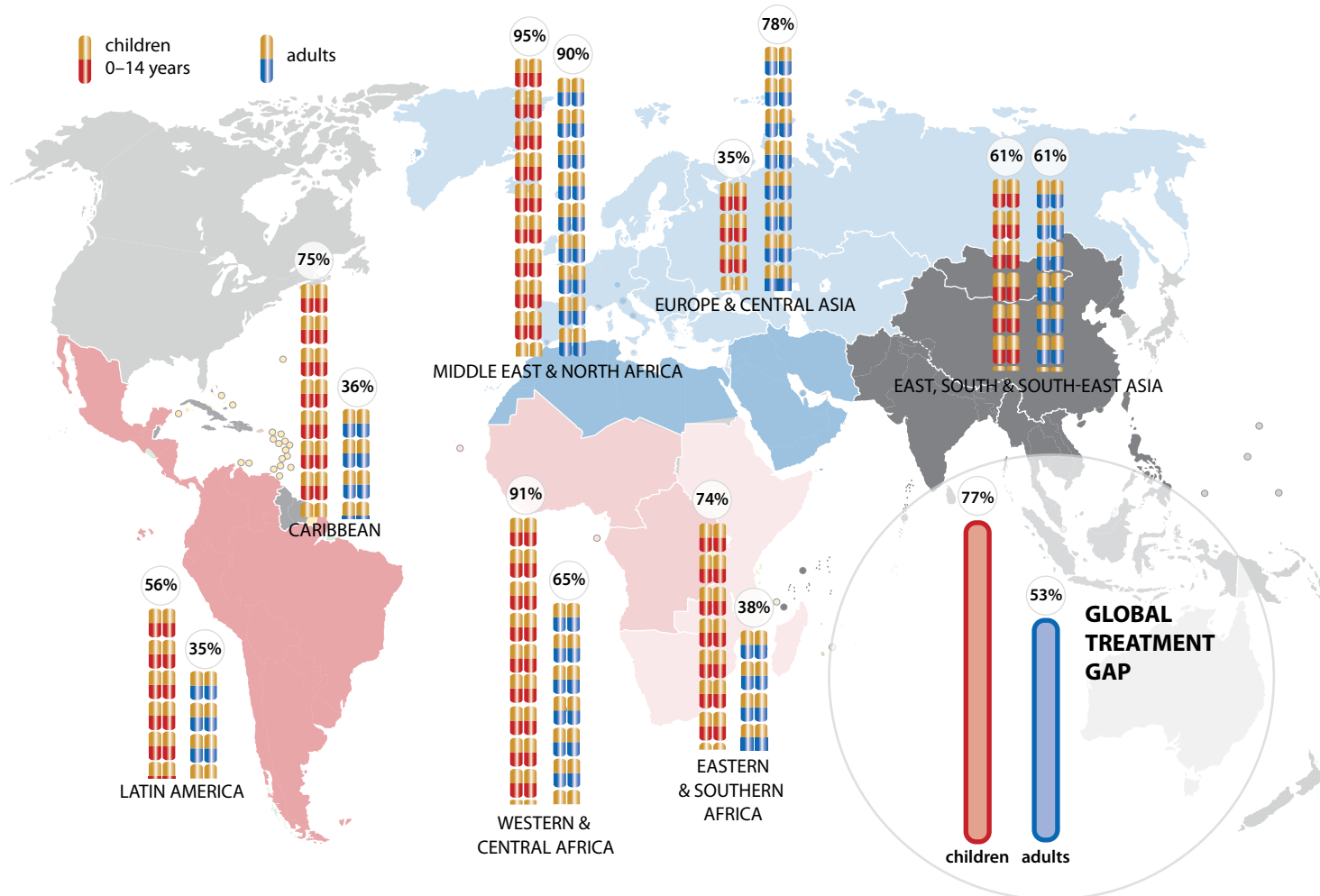
donors are not honouring their commitments.⁴¹⁹ There are also concerns about proposed cuts to PEPFAR funding for treatment.⁴²⁰ There will be a terrible price to pay in human lives. The costs of HIV prevention and care are modest, especially in comparison to the billions spent on bank bailouts or weaponry. If the global community is serious about ending the epidemic, it must spend what is required.⁴²¹

There are many reasons for this treatment gap. But a major one is the result of recent bilateral and multi-lateral trade agreements that have undoubtedly increased the power of pharmaceutical patent holders to control the prices of drugs on global markets. Governments, especially in low- and middle-income countries, cannot afford them.

Signed in 1994 and administered by the World Trade Organization (WTO), The Agreement on Trade Related Aspects of Intellectual Property

THE TREATMENT GAP

Percentage of medically eligible adults and children NOT receiving antiretroviral therapy in low- and middle-income countries at the end of 2010



Source: Global HIV/AIDS Response: Epidemic update and health sector progress towards Universal Access, Progress Report 2011. WHO, UNAIDS, UNICEF, 2011.

Rights (TRIPS) introduced IP protection and enforcement at a breadth never before seen at the multilateral level.⁴²² The HIV epidemic has exposed the serious problems of applying TRIPS to medicines and other pharmaceutical products. This has implications well beyond HIV, for

example, for non-communicable diseases which affect millions in high-, middle- and low-income countries.^f

But the trend in IP regulation continues to be away from more latitude for the production and

^f While the Commission's mandate is HIV specific, people living with HIV are often co-infected with other communicable diseases including hepatitis C and Multiple Drug Resistant Tuberculosis. There is increasing evidence of the linkages between HIV and non-communicable diseases like cancer. Studies show that people living with HIV are up to 1000 times more likely than uninfected people to be diagnosed with Kaposi sarcoma, at least 70 times more likely to be diagnosed with non-Hodgkin's lymphoma, and, among women, at least five times more likely to be diagnosed with cervical cancer. Given that similar problems around affordability and accessibility of treatment exist for communicable diseases and for a number of non-communicable diseases, the Commission's findings and recommendations on HIV-related treatment have a broader relevance to health.

distribution of necessary medicines. A number of trade and investment agreements are incorporating even more stringent IP provisions, posing a serious threat to treatment access now and in the future.

TRIPS, DOHA AND THE 30 AUGUST 2003 DECISION: A BRIEF HISTORY

Historically, countries retained the right to customise their IP laws to meet their development needs. After it declared independence, the United States, a net importer of technology at the time, did not allow foreigners to file patents⁹ for the first 37 years of nationhood. When the restriction on foreigners was eventually lifted, patent fees for foreigners were approximately tenfold higher (with an additional 65% charge for British nationals).⁴²³ Switzerland suspended its patent system from 1802 until 1888, when it re-established it under threat of trade sanctions from Germany. When a new law was passed, it contained a strong compulsory licensing^h mechanism and excluded certain products, including chemicals, from patent protection.⁴²⁴ Even as recently as the 1970s, Italy, Sweden and Switzerland did not grant patents for pharmaceutical products with Spain, only offering patent protection for pharmaceutical as late as 1992.⁴²⁵

The TRIPS Agreement was born largely as a result of United States industry lobbying for strong multilateral IP protection covering a range of

commodities.⁴²⁶ In 1986, when the negotiations leading to the agreement opened, as many as 50 countries provided no patents for pharmaceutical products.⁴²⁷ Countries were free to define many aspects of their IP regimes—for instance, to exclude entire fields of technology from patentability and determine the duration of patents in light of other public policy considerations. High- as well as low- and middle-income countries used this latitude to ensure that the interests of profit did not interfere with the maximal delivery of health care. In 1970 Brazil declared pharmaceutical products and processes non-patentable. In 1970, India implemented a similar policy that contributed to the development of a strong local pharmaceutical sector, a powerful machine of “reverse engineering” that has produced many of the generic medicines used in developing countries, and ensured that these medicines reached markets quickly and at an affordable price. Access to generics has proven critical to scaling up treatment access. For instance, in February 2001, the Indian generic manufacturer Cipla announced “a price heard around the world”, offering a first generation combination regimen for as little as \$350 per patient per year to NGOs and \$600 per patient per year to African governments.⁴²⁸ A 2010 study found that Indian generic pharmaceutical companies supply at least 80% of ARVs purchased by low- and middle-income countries, including 91% of those formulated for children.⁴²⁹

⁹ Patents confer exclusive rights granted for a limited time to an inventor for an invention - a creation of the mind that is novel, contains an inventive step and is industrially applicable. Patents were introduced to reward inventors for their work, to allow them to recuperate investments, and to stimulate innovation. Today, patents are often used to maintain exclusivity on the market, though patent exclusivity can be overcome through the use of TRIPS flexibilities.

^h Article 31 of the TRIPS Agreement recognises the right of WTO Members to use a patented product without the consent of the patent holder through “compulsory licences”, “government use orders”, or “compulsory licences to remedy anti-competitive practices”.

ⁱ Reverse engineering is the process of discovering the technological principles of a device, object, or system through analysis of its structure, function, and operation. It often involves taking a medicine or product apart and to try to make a new medicine or product that does the same thing without using or simply duplicating the original.

TRIPS imposed minimum standards for protecting and enforcing IP rights to an extent previously unseen at the global level.⁴³⁰ Today, all WTO Members, with the exception of least developed countries (LDCs), are required to provide a minimum of 20 years' patent protection in all fields of technology, without distinction based on place of invention or country of manufacture.⁴³¹ The intent of these regulations was supposedly to generate innovation and fairly balance the rights of consumers and patent holders. But for low- and middle-income countries, the adverse consequences have eclipsed any potential benefits. In essence, TRIPS imposed legally protected monopolies internationally. Limited competition resulted in higher costs for medicines.⁴³² When the product is pharmaceuticals, the outcome for poor countries with overwhelming HIV epidemics and other health challenges has been catastrophic. It is an indictment of the current international IP regime that it has not resulted in increased innovation for medicines to treat HIV co-infections such as tuberculosis, hepatitis C or related diseases that predominantly affect the poor.

USING TRIPS FLEXIBILITIES: A Snapshot of Selected Countries⁴³³

As the global economic crisis stretches on and international donor funding shrinks, national health systems are under increased pressure to reduce costs and increase both efficiencies and domestic investment. For all the shortcomings of TRIPS, certain countries still have the option of using so-called TRIPS flexibili-

ties^j to make treatment considerably more affordable.⁴³⁴ These flexibilities were re-affirmed at a WTO round in 2001 that resulted in the Doha Declaration on TRIPS and Public Health.⁴³⁵ The declaration states that TRIPS should be interpreted and implemented in light of the goal "to promote access to medicines for all." To that end, the Doha Declaration affirmed the rights of WTO Members to use "flexibilities", including the rights to define standards of patentability and to order government use of patented inventions and issue compulsory licences to increase treatment access. Governments may also use competition law and policy to remedy abuses of IP rights.⁴³⁶

In 2002, 2005 and 2007, treatment activists in South Africa used competition law to reduce the unaffordable prices of key first-generation ARVs.⁴³⁷ Between 2001 and 2006, the Brazilian government used the threat of compulsory licensing to negotiate significant price reductions for a number of ARVs. This saved the government approximately US \$1.2 billion between 2001 and 2005.⁴³⁸ In 2007, Brazil issued a compulsory licence for the important ARV efavirenz, which was being used by more than a third of the 200,000 patients receiving treatment through the national health system's HIV services. Thereafter, the price of the imported generic version of the drug dropped from US \$1.60 to US \$0.45 per dose. Thailand predicts it will realise a minimum savings of US\$ 358 million by taking advantage of TRIPS flexibilities.⁴³⁹ Indian patent authorities used provisions of the Patent

^j The TRIPS Agreement contains provisions which allow countries to pursue their public health obligations without infringing the WTO law on pharmaceutical patents (flexibilities). Scholars divide such flexibilities into three categories: preventative, remedial and enforcement related. Preventative flexibilities are the opportunity to exclude certain categories for patentability (e.g. processes), applying strict patentability criteria to avoid low-quality patents, or extending the patent term through trivial modifications, pre-grant and post grant patent oppositions. Remedial TRIPS flexibilities are: Compulsory licences and government use orders; the Bolar Exception (allows the preparation for manufacturing of a patented product before the expiration of the patent); parallel importation (allows access from cheaper sources); typical exceptions to patent rights (individual use, for experiments, etc.). Enforcement-related flexibilities focus on adhering to the minimum standards of TRIPS as far as patent infringement is concerned and not allowing unnecessary high levels of IP enforcement, especially criminal sanctions.

COUNTRY & DATE OF ISSUE	TYPE OF LICENSE & NAME OF MEDICINE	IMPACT OF COMPULSORY LICENSE
India <i>March 2012</i>	Compulsory license to locally produce generic sorafenib tosylate to treat kidney cancer and liver cancer	Price set by India's Patent Controller will result in 97% reduction
Ecuador <i>April 2010</i>	Compulsory license to import and, if necessary, locally produce generic ritonavir	Resulted in patent holder reducing price of brand medicine by 70%
Thailand <i>January 2008</i>	Government-use license for import of generic letrozole used to treat breast cancer	Projected aggregate price reductions of 96.8%
Brazil <i>May 2007</i>	Compulsory licence issued by Government to import generic efavirenz	Resulted in a 71.8 % price reduction
Thailand <i>January 2007</i>	Government-use order to import or locally produce generic lopinavir/ritonavir	Projected price reductions of 80.2% expected
Indonesia <i>October 2004</i>	Government-use order to locally manufacture generic lamivudine, nevirapine	Resulted in price reduction of 53.3%
Malaysia <i>November 2003</i>	Government-use order for the production of combination of generic stavudine + didanosine + nevirapine	Resulted in price reduction of 83%

Source: United Nations Development Programme, Bureau for Development Policy, HIV Group. 2012⁴⁴⁰

Act to reject a number of patent applications for new forms of known medicines that offer little therapeutic improvement—important not only for Indians but for the developing world as a whole, much of which uses India as its pharmacy.⁴⁴¹

In spite of their potential benefits, TRIPS flexibilities have proved insufficient in obviating the shortages of affordable medicines that TRIPS itself has contributed to creating. The TRIPS Agreement, on paper, affords flexibility as to how its obligations are implemented by national governments. Nevertheless, in practice, the attempts by low- and middle-income countries to use measures to promote access to affordable medicines have been fraught with difficulty and met with retaliation and opposition from some high-income countries and corporations.⁴⁴² For example, even though it scrupulously followed TRIPS requirements and national law, Thailand was placed on the United States Special 301 Priority Watch list for three straight years, at least in part because of having issued compulsory licences for a number of pharmaceutical products, including medicines to treat HIV, cancer and heart disease.⁴⁴³ When the government of Thailand issued a compulsory licence in 2007 on lopinavir/ritonavir (Kaletra), Abbott, the pharmaceutical company that held the patent for Kaletra, responded with an announcement that it was withdrawing multiple applications to obtain marketing approval for new drugs in Thailand, including a heat-stable version

of Kaletra.⁴⁴⁴ Similarly, when South Africa passed a law in 1997 that allowed for parallel importation of cheaper medicines,⁴⁴⁵ thirty-nine pharmaceutical companies took the government to court alleging the law violated the South African Constitution and the TRIPS Agreement. South Africa was also placed on the Section 301 Special Watch List, a move that was revoked by then President Clinton via Executive Order,⁴⁴⁶ following extensive protests by activists and legal action. The Indian government remains embroiled in litigation with the company Novartis, which is seeking to overturn the state's application of Section 3(d) of its Patent Code to reject a patent application on the Novartis cancer medicine Gleevec (imatinib mesylate).⁴⁴⁷

The Doha Declaration of 2001 also left unresolved a major problem: how to ensure access to medicines for countries that face patent bars but have limited or no domestic capacity to produce medicines locally, and thus are still dependent on medicines from countries where TRIPS rules limit exports to insufficient quantities. After 20 months of negotiation, the WTO General Council finally adopted a temporary solution: the 30 August 2003 Decision, a complicated set of regulations for overcoming these limitations. However, this decision has proven ineffective in practice. It has been used only once in more than 8 years.⁴⁴⁸ In fact, its effectiveness has been extensively questioned by low- and middle-income countries, such as Ecuador, Brazil and India, which argued at

The enforcement and application of the Anti-Counterfeit Act... will endanger the lives of Kenyan citizens afflicted with HIV and AIDS, as they will be arbitrarily denied access to affordable and essential drugs and medicine necessary to the fulfillment of the rights to life and human dignity that are enshrined in ... the Constitution of the Republic of Kenya.

Jacinta Nyachae, AIDS Law Project, Kenya, Africa Regional Dialogue, 3–4 August 2011

the WTO TRIPS Council that detailed requirements such as pill colouring, additional labelling and website tracking of shipments produced under the mechanism are costly, time consuming and a disincentive for generic manufacturers. Despite attempts to persuade countries to ratify, only a minority of WTO Members have chosen to do so. Despite these criticisms, high-income countries, including the United States, the European Union and Canada, continue to support it.⁴⁴⁹

THE OVERREACH OF IP PROTECTION

Ten years after WTO Members unanimously reaffirmed their right to use TRIPS flexibilities for public health objectives through the Doha Declaration, certain governments and pharmaceutical companies are actively undermining the right and attempts of countries to use them. While the United States, the EU and Japan, among others, continue to undermine the Doha Declaration, they are attempting to increase IP enforcement in other forums as well—including the World Health Assembly, World Intellectual Property Organization, the World Customs Union and Interpol. Some high-income countries are also demanding that developing countries adopt commitments more stringent than those in TRIPS—so-called “TRIPS-plus provisions” in bilateral or plurilateral free trade agreements.

Stepped-up enforcement

Unilateral laws and policies by a number of developed countries stymie the efforts of developing countries to broaden treatment access. For instance, the EU adopted border regulations⁴⁵⁰ that resulted in the seizure or temporary detention of at least 17 shipments of generic medicines, most of them Indian, in

2007 and 2008. The shipments were seized on the grounds that they violated patents and trademarks in Europe, even though the products were destined for countries in which they would infringe no IP rights. The result was a disruption in the supply chain of legitimate generics, including HIV medicines, and likely cost increases due to changes in shipping patterns.⁴⁵¹

Attention to IP enforcement is growing, as perverse as that may seem. One result is the recently concluded Anti-Counterfeiting Trade Agreement (ACTA), negotiated among a select group of predominantly high-income countries,⁴⁵² with very little official information made available outside the group on the substance of the negotiations.⁴⁵³ The recently signed ACTA—whose completion the G8 nations have strongly pushed—adds a layer of IP protection significantly exceeding what is required by TRIPS. It is feared this could greatly threaten treatment access.⁴⁵⁴ ACTA caused such controversy that on 4 July 2012, the European Parliament declined to ratify European Union participation in the Agreement.⁴⁵⁵

Anti-counterfeiting laws

The recent proliferation of anti-counterfeiting legislation in East Africa, promoted by multinational pharmaceutical companies, reflects the increasing conflation of generic with counterfeit drugs—substandard formulations that endanger people who take them⁴⁵⁶—and the myth that generics are inferior to originator brands. In 2008, with support and applause from the multinational pharmaceutical industry, Kenya enacted a law that purported to address drug counterfeiting, but in fact dramatically expanded IP enforcement.⁴⁵⁷ Such laws are dangerous to countries in East Africa, which rely heavily on generic medicines.⁴⁵⁸ In fact, the laws alone do nothing to

address the real problem of substandard medicines. Defective medicines mistakenly manufactured by a patent holder do not infringe the patent but are certainly public health hazards; an inspection by customs officials cannot reveal the defect. Drug quality, safety and efficacy issues have nothing to do with IP. They fall within the ambit of drug regulatory authorities and should be implemented by them.⁴⁵⁹ A recent judgment from the High Court of Kenya confirmed an earlier order preventing the implementation of the 2008 Anti-Counterfeit Act on the basis that the definition of “anti-counterfeit” within the Act did not clearly distinguish between counterfeit and generic medicines and thus could undermine access to affordable generic medicines. In her judgment, Lady Justice Ngugi ruled that intellectual property should not override the right to life, right to health and right to human dignity outlined in the 2010 Kenyan Constitution.⁴⁶⁰

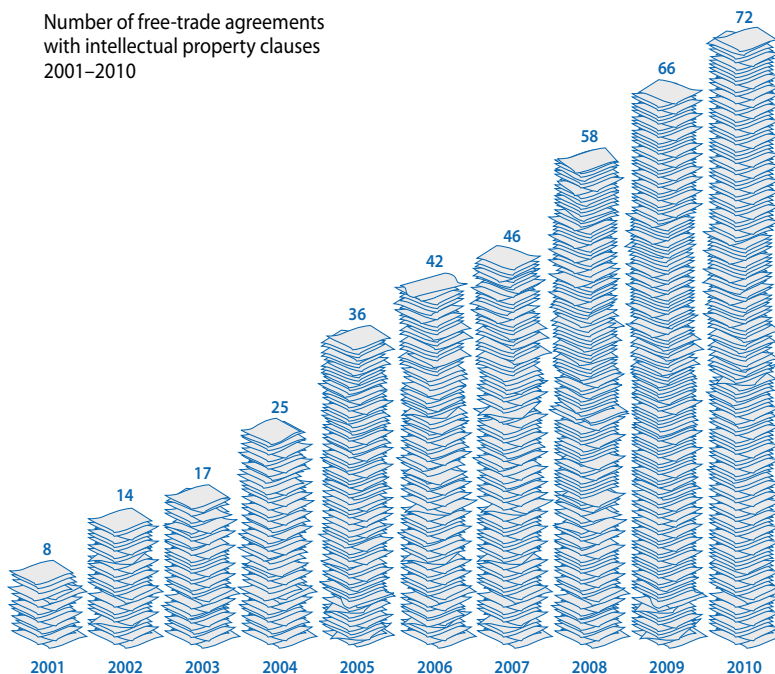
Free trade agreements

Free trade agreements (FTAs) and economic partnership agreements (EPAs) containing TRIPS-plus standards also threaten access to medicines. A case in point is the United States-promoted Transpacific Partnership Agreement (TPPA). Among other terms friendly to the United States pharmaceutical industry, the proposed patenting standards would allow patenting of new forms, new uses and new formulation of existing medicine; extend patent terms; and restrict the use of price control mechanisms. In another example, the proposed EU-India FTA would shrink the latitude of countries to adopt policies promoting the production and distribution of generic medicines. The United States trade stance, which threatens access to affordable medicines for millions of the world's poorest people, is egregious given President Barack Obama's professed commitments to increased economic equality and access to health care in the United States.

These TRIPS-plus provisions can be budget breaking, even for high-income countries.⁴⁶¹

FREE TRADE, MOUNTING CONSTRAINTS

Number of free-trade agreements with intellectual property clauses 2001–2010



Source: World Trade Organization's website (WTO: www.wto.org), accessed by UNDP in 2012.

Canada is currently negotiating an FTA with the EU that could add a projected CDN\$ 2.8-billion a year in extra costs to Canadian drug plans if various TRIPS-plus provisions are adopted.⁴⁶² For countries with limited resources, the burden can be crushing. The US-CAFTA agreement, according to some projections, will increase Costa Rica's public spending on ARVs at least 50% by 2030. Developing country governments negotiating FTAs are often forced to accept these IP terms in exchange for market access for their goods. Eager as they are for trade, low- and middle-income country governments must not be forced to exchange the “highest attainable standard of health” for access to developed country markets.

CHANGING VALUES, NEW INCENTIVES

TRIPS was meant to strike a balance between the rights of innovators and the rights of consumers. In reality, the balance has tipped dangerously in favour of the rights holders. To be sure, the research and development pipeline must remain open for future

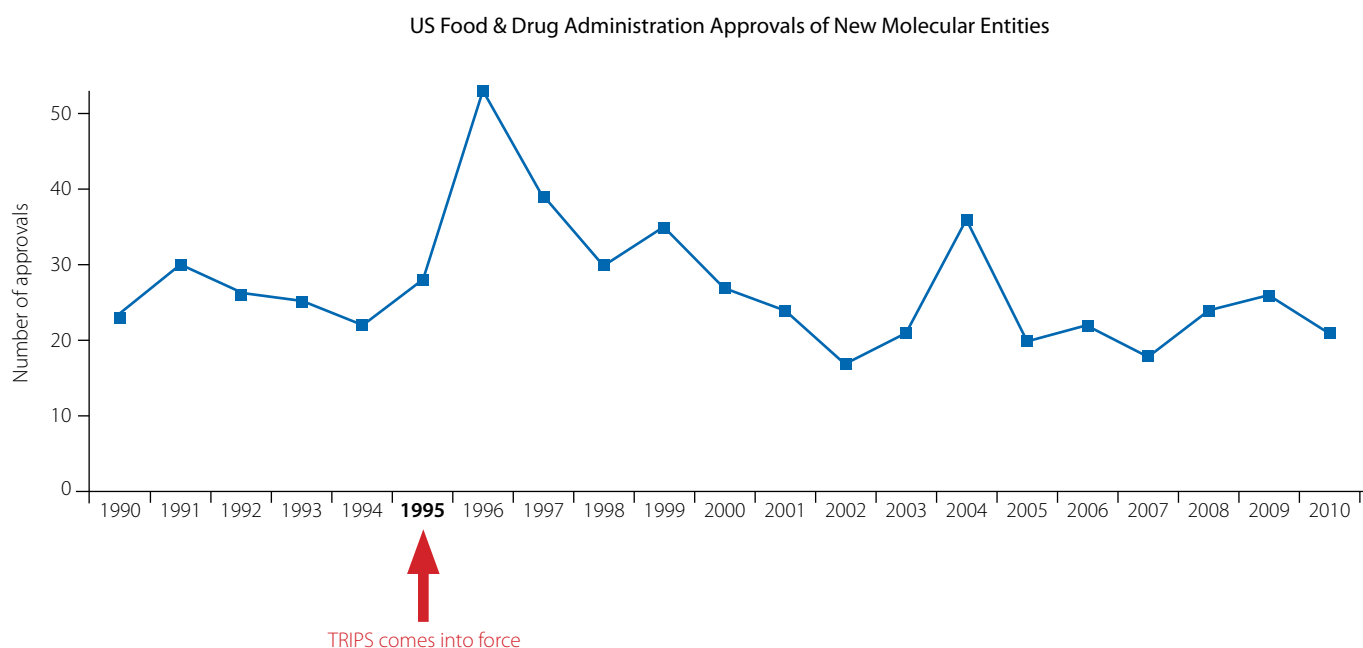
“DEAD WEIGHT COSTS” & ACTUAL DEATHS

Today's patent systems and the international agreements are intended to encourage innovation and reward inventors for their investments. But if the US experience is typical, they have not always succeeded in doing so. In other ways, however, the agreements are working as designed—that is, to enable producers of patented drugs to recover costs and generate monopoly profits by charging supra-competitive prices, which will be covered by consumers, governments or health insurance providers. What the IP regime does not factor in is that the majority of medicine purchases are made out of pocket in low- and middle-income countries by governments with limited health budgets. Accordingly, high prices create—in economic language—“dead-weight costs”, which, in the context of medicines, result in actual deaths.

treatments; current treatments for HIV infection, albeit effective, need continual improvement to make them less toxic and more effective, with less drug resistance and fewer adverse side effects. Treatments and medical technologies must be suitable for the specific needs of developing countries—such as formulations for children and diagnostics that can be used where care is dispensed, especially important where people must travel long distances to a health care provider.⁴⁶³

But there is a pernicious myth at work. The myth is that stringent IP protection and enforcement are the necessary and unique means of encouraging the development of new pharmaceutical products.⁴⁶⁴ The evidence belies this claim. What has the patent-based free market produced? Sometimes, life-saving and life-enhancing innovations, such as new drugs for hypertension and diabetes. But often, pharmaceutical companies produce boutique

BOOSTING INNOVATION?



Source: US Food and Drug Administration's website (www.fda.gov), accessed by UNDP in 2012.

drugs to address the problems of people in wealthy countries—acne, wrinkles, restless leg syndrome, erectile dysfunction—and thousands of products and processes that offer only minor modifications of existing drugs or new uses of existing ones.⁴⁶⁵ According to a report of the United States National Institute for Health Care Management, from 1989 to 2000, only 15% of all new drug approvals were for medicines that provide a significant clinical improvement.⁴⁶⁶

In the meantime, research and development (R&D) departments have neglected tropical diseases that sicken and kill millions because the potential consumers are poor. Indeed, in 2006 the WHO Commission on Intellectual Property, Innovation and Public Health asserted: “For diseases affecting millions of poor people in developing countries, patents are not a relevant factor or effective in stimulating R&D and bringing new products to the market.”⁴⁶⁷

Proposals and programmes for improving the environment for innovation and access vary. The Global Fund and the United States President’s Emergency Program for AIDS Relief (PEPFAR) have created economic incentives for the development of generic drugs where patent bars do not exist or have been overcome. With increased generic competition and economies of scale in production, prices come down.⁴⁶⁸ Recently, thirteen major pharmaceutical companies, with support from the Bill and Melinda Gates Foundation, the World Bank and other donors, pledged to invest in R&D to eliminate or control ten neglected tropical diseases in low-income countries, including river blindness and sleeping sickness, by 2020. The companies will also donate more existing drugs to countries in need.⁴⁶⁹

These are decent, modest initiatives, but they cannot pretend to undo the damage done by



Source: UNAIDS/O. O’Hanlon/Cambodia

TRIPS. Drug donations do not offer sustainable solutions; they leave the underlying problems unresolved. Innovation prize funds, a binding international treaty on R&D and open source drug discovery are initiatives that include some of the most promising proposals being studied by the Consultative Expert Working Group of the WHO.⁴⁷⁰ A recent report of the WHO Consultative Expert Working Group has called for countries to start negotiations on a binding international treaty on R&D.⁴⁷¹ These nascent ideas hold the potential to yield more collaboration or broader access. In any scenario, it is essential that low- and middle-income countries participate meaningfully in this discussion.⁴⁷²

But the crisis regarding access to medicines is not just a technical problem. It is an issue of law and politics. Many analysts question the most basic political, economic and moral assumptions underlying the reliance on TRIPS-based IP regimes as the mechanism to focus needed R&D for HIV drugs. They question whether the research silos and secrecy that mark phases of the IP-based system serve the interests of more efficient and scientifically rigorous research. They challenge the inclusion of pharmaceutical products in the same regime as movies and software and the perverse incentives in which the quest for life-saving medicines is mobilised by maximal profits for pharmaceutical monopolies rather than the unmet health needs of millions.

RECOMMENDATIONS

To ensure an effective, sustainable response to HIV that is consistent with human rights obligations:

- 6.1. The UN Secretary-General must convene a neutral, high-level body to review and assess proposals and recommend a new intellectual property regime for pharmaceutical products. Such a regime should be consistent with international human rights law and public health requirements, while safeguarding the justifiable rights of inventors. Such a body should include representation from the High Commissioner on Human Rights, WHO, WTO, UNDP, UNAIDS and WIPO, as well as the Special Rapporteur on the Right to Health, key technical agencies and experts, and private sector and civil society representatives, including people living with HIV. This re-evaluation, based on human rights, should take into account and build on efforts underway at WHO, such as its Global Strategy and Plan of Action on Public Health, Innovation, and Intellectual Property and the work of its Consultative Expert Working Group. Pending this review, the WTO Members must suspend TRIPS as it relates to essential pharmaceutical products for low- and middle-income countries.
- 6.2. High-income countries, including donors such as the United States, European Union, the European Free Trade Association countries (Iceland, Liechtenstein, Norway and Switzerland) and Japan must immediately stop pressuring low- and middle-income countries to adopt or implement TRIPS-plus measures in trade agreements that impede access to life-saving treatment.
 - 6.2.1 All countries must immediately adopt and observe a global moratorium on the inclusion of any intellectual property provisions in any international treaty that would limit the ability of countries to retain policy options to reduce the cost of HIV-related treatment. Agreements such as the Anti-Counterfeiting Trade Agreement (ACTA) must be reformed; if ACTA is not reformed to exclude such intellectual property provisions, countries should not sign it. All countries must cease unilateral practices to this same, access-limiting end.
 - 6.2.2 High-income countries must stop seeking to impose more stringent, TRIPS-plus intellectual property obligations on developing country governments. High income countries must also desist from retaliating against countries that resist adopting such TRIPS-plus measures so that they may achieve better access to treatment.
- 6.3. While the Commission recommends that WTO Members must urgently suspend TRIPS as it relates to essential pharmaceutical products for low- and middle-income countries, we recognise that such change will not happen overnight. In the interim, even though individual countries may find it difficult to act in the face of political pressure, they should, to the extent possible, incorporate and use TRIPS flexibilities, consistent with safeguards in their own national laws.
 - 6.3.1 Low- and middle-income countries must not be subject to political and legal pressure aimed at preventing them from using TRIPS flexibilities to ensure that infants, children and adolescents living with HIV have equal access to HIV diagnosis and age-appropriate treatment as adults.
 - 6.3.2 It is critical that both countries with significant manufacturing capacity and those reliant on the importation of pharmaceutical products retain the policy space to use TRIPS flexibilities as broadly and simply as they can. Low- and middle-income countries must facilitate collaboration and sharing of technical expertise in pursuing the full use of TRIPS exceptions (for instance, by issuing compulsory licences for ARVs and medicines for co-infections

such as hepatitis C). Both importer and exporter countries must adopt straightforward, easy-to-use domestic provisions to facilitate the use of TRIPS flexibilities.

6.3.3 Developing countries should desist from adopting TRIPS-plus provisions including anti-counterfeiting legislation that inaccurately conflates the problem of counterfeit or substandard medicines with generics and thus impedes access to affordable HIV-related treatment.

6.3.4 Countries must proactively use other areas of law and policy such as competition law, price control policy and procurement law which can help increase access to pharmaceutical products.

6.4. The WTO Members must indefinitely extend the exemption for LDCs from the application of TRIPS provisions in the case of pharmaceutical products. The UN and its member states must mobilise adequate resources to support LDCs to retain this policy latitude.

6.5. The August 30, 2003 Decision of the WTO General Council has not proved to be a viable solution for countries with insufficient pharmaceutical manufacturing capacity. It is essential that the system established by that decision be revised or supplemented with a new mechanism, to allow the easier import of pharmaceutical products produced under compulsory licence. WTO Members should desist from ratifying the adoption of the August 30, 2003 Decision as a new Article 31 bis of the TRIPS Agreement, and they must pursue efforts to reform or replace the system.

6.6. TRIPS has failed to encourage and reward the kind of innovation that makes more effective pharmaceutical products available to the poor, including for neglected diseases. Countries must therefore develop, agree and invest in new systems that genuinely serve this purpose, prioritising the most promising approaches including a new pharmaceutical R&D treaty and the promotion of open source discovery.

CONCLUSION

In the 21st century, HIV is a manageable chronic condition—for some. However, like other preventable and remediable afflictions such as —pneumonia, diarrhoea, malnutrition—it continues to sicken and kill far too many people who are vulnerable or marginalised.

From the beginning, the response to this epidemic has been driven by people living with HIV, populations disproportionately affected by AIDS, and their families and loved ones. Their tenacity, activism, creativity and solidarity created “safe sex” and “harm reduction”, pushed for medical and scientific advances and led to the rapid scale-up of international financing for the response to AIDS over the past decade. They provided the Commission with compelling evidence about how good laws and meaningful respect for human rights can foster the effective HIV responses necessary for sustainable development.

The world can always benefit from more evidence and from better tools and technologies. An “Investment Framework” published in 2011⁴⁷³ demonstrates that modestly increasing and better targeting financial investments in HIV responses can turn the tide on the global epidemic over the next few years. New technology would be helpful, but establishing an enabling legal environment is of paramount importance—if money is not to be wasted.

The UNAIDS Reference Group on HIV and Human Rights recently argued that the “funding crisis is the most important human rights issue in the HIV response at this time. Paradoxically, funding is being flat-lined or reduced just as science, medicine and programmes are providing the tools for success against HIV.”⁴⁷⁴ Countries and international funding organisations must restore and boost the flow of resources to the HIV response. They must craft strategies from the best public health evidence and not be driven by ideologies. They must be realistic about the exigencies of lives limited by a paucity of choices. And they must respect the experience and intelligence of people living with HIV and their advocates.

In extending foreign aid and allocating domestic resources, governments must understand that the millions they invest in humane HIV responses can be quickly negated by political and material support provided to repressive legal environments in those same countries. Multilateral trade bodies cannot operate as if medicines were commodities like software or movies. Civil society must demand that the corporate quest for profits in trade agreements be subject to the requirements of universal human rights.

The world is porous. Oil, food, digitised data, capital and conflicts flow over borders—and so, ceaselessly, do people. HIV cannot be quarantined socially, economically or medically. The Commission’s recommendations exhort governments, donors, civil society, religious institutions and the United Nations to take up their obligations as world citizens who uphold human rights and hold each other accountable in doing everything possible to end AIDS.

Governments, in creating the legal environments that will enable the most effective and humane HIV responses, must honour the commitments they have made in international human rights agreements and in their own legislative bodies, and then go



further. The three elements of legal environments—law, enforcement and access to justice—are interdependent. It is best to pursue all three in simultaneous and coordinated fashion; contradictory laws and practices have gnarled efforts to combat HIV almost as much as have laws that are hostile or absent. But where governments are fragile and resources few, it is always worthwhile to work on one or two fronts, creating space to address all three in time. And even where legal reform may be deemed too complex and challenging, governments must protect human rights, punish police violence and support programmes to challenge stigma and discrimination against people with HIV, other key populations and those who are vulnerable.

Finally, religious institutions must be inspired by their best spirits and their ideals of love, compassion and service to others - common to all of the world's spiritual traditions. If they do not, they will stand on the side of what can only be called evil: condemning others to illness and death because of their sexualities or identities, their occupations or even their frailties.

Human immunodeficiency virus: its first name is "human". To defeat it, the world and its laws must embrace and promote what every living person shares: the fragile, immensely potent human rights to equality, dignity and health.

COMMISSION'S TERMS OF REFERENCES

The law can have a profound impact on the lives of people. Many of the successes in mitigating the causes and consequences of HIV have taken root where laws have been used to protect the human rights of the marginalised and disempowered. For example, in some countries anti-discrimination laws have helped people living with HIV keep their jobs and their homes and look after their families. Laws to protect confidentiality have contributed to increasing confidence in health systems, encouraging people to learn their HIV status and to access HIV prevention and treatment. Legal guarantees of equal inheritance and property for women and girls have helped to mitigate the social and economic burdens of HIV. Still in many countries across the globe, the legal environment is presenting significant challenges for effective HIV responses, and preventing access to life-saving HIV treatment. Every day, people living with HIV, including sex workers, drug users, men who have sex with men, and transgender people, continue to suffer stigma, discrimination and violence. Laws and practices that discriminate against women or fail to protect their rights to be free from violence make women particularly vulnerable to HIV. While the rhetoric of rights based HIV responses has grown and there have been some success in advancing enabling legal frameworks in the context of HIV, human rights violations also continue with impunity. Globally, HIV responses are at a critical juncture, where an objective, independent analysis of the relationships between legal environments and HIV which provides concrete policy options for countries and communities could shape the next generation of AIDS, health and development responses. Consequently, the Programme Coordinating Board of Joint UN Programme on HIV/AIDS (UNAIDS) tasked

the United Nations Development Programme, (UNDP), on behalf of the UNAIDS family, to establish an independent Commission on HIV and the Law.

The Global Commission on HIV and the Law aims 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. The Global Commission on HIV and the Law will interrogate the relationship between legal environments, human rights and HIV. The Commission will also focus on some of the most challenging legal issues in the context of HIV, including criminalisation of HIV transmission and behaviours and practices such as drug use, sex work and same-sex relations, legal and social status of women and access to HIV prevention and treatment services. The Global Commission on HIV and the Law will contribute to ensuring that law, human rights and HIV receive the interrogation and exposition necessary to facilitate universal access to HIV prevention, treatment, care and support in order to achieve the Millennium Development Goals (MDGs). Over a period of 18 months, the Global Commission on HIV and the Law will carry out the following:

- Analyse existing evidence on the relationships between legal environments and HIV, including an assessment of the current legal environments in countries, both punitive and enabling, and their impact on the lives of people living with HIV, key populations such as sex workers, people who use drugs, men who have sex with men, transgender people, and others who are vulnerable to and affected by HIV;

- Assess the medium and long term impacts of both punitive and enabling legal environments on HIV, health and development responses at country, regional and global levels;
- Consider the perspectives and experiences of governments, law and policy makers, law enforcers, civil society including those most marginalised and affected by HIV and communities; and
- Provide evidence-informed and actionable recommendations on legislative and policy reforms that need to be adopted at country,

regional and global levels in order to mitigate the impact of HIV on individuals, households, and communities.

The findings and recommendations of the Global Commission on HIV and the Law will be summarized in a report that will be widely disseminated to national governments, civil society - especially people living with HIV and other key populations, and communities affected by HIV, the UN system especially the UNAIDS Cosponsors and UNAIDS Secretariat, and bilateral and multilateral donors, for effective implementation and monitoring.

COMMISSIONER BIOGRAPHIES

Full biographies can be found on-line at www.hivlawcommission.org

1. President Fernando Henrique Cardoso (Brazil) – Chair

Fernando Henrique was the President of Brazil from 1995 to 2002. During this time, Brazil became one of the first developing countries to provide free anti-retroviral treatment to its citizens. Prior to this, he served as the Minister of Foreign Relations and Minister of Finance. In May 2012, it was announced that Fernando Henrique Cardoso would be awarded the John W. Kluge Prize for lifetime intellectual achievement in the humanities and social sciences.

2. His Excellency Mr. Festus Gontebanye Mogae (Botswana)

Festus Gontebanye Mogae was the president of the Republic of Botswana from 1998 to 2008. During this time, Botswana became the first African country to provide free anti-retroviral treatment to its citizens. Festus Gontebanye Mogae is Chairman of Champions for a HIV-Free Generation and is credited for being one of the first African leaders to publicly take a HIV test.

3. Ms. Ana Helena Chacon-Echeverria (Costa Rica)

Ana Helena Chacon-Echeverria has been the Coordinator of the Costa Rican Parliamentary Group, Minister of Public Security and a Congresswoman. She has also been the vice-president of the Inter-American Parliamentary Group. She is a long-time advocate for women's rights and rights of disabled people.

4. Mr. Charles Chauvel (New Zealand)

Charles Chauvel is a Member of Parliament in New Zealand. He is the shadow Attorney General and the Labour Party spokesperson for Justice and Arts, Culture & Heritage. He has also served on the New Zealand Public Health Commission and was a member of the New Zealand AIDS Foundation.

5. Dr. Shereen El Feki (Egypt) – Vice Chair

Shereen El Feki is an academic, writer and broadcaster whose current research focuses on sexual and reproductive health and life in the Arab region. She was also the Healthcare Correspondent for The Economist.

6. Ms. Bience Gawanas (Namibia)

Bience Gawanas was elected as the African Union Commissioner for Social Affairs. From 1991-1996, Bience Gawanas was a full time member of the Public Service Commission of Namibia. She was appointed Ombudswoman of Namibia in 1996 and held that position until 2003.

7. Hon. Dame Carole Kidu (Papua New Guinea)

Carol Kidu is the Leader of the Opposition in Papua New Guinea. She has been a Member of Parliament since 1997 and is the only woman in the 109 member Papua New Guinea Parliament. In addition to leading key legislative reforms, she has served as Minister of Community Development.

8. The Hon. Michael Kirby (Australia)

Michael Kirby was a judge in the High Court of Australia from 1996 - 2009. He also served as the Chairman of the Australian Law Reform Commission, the President of the International Commission of Jurists and the Special Representative of the United Nations Secretary General for Human Rights in Cambodia.

9. Hon. Barbara Lee (United States)

Barbara Lee has been a member of the United States Congress for over a decade. She was a co-author of the landmark legislation that created the President's Emergency Plan for AIDS Relief and has played a pivotal role in increasing domestic funding for HIV programmes, including the Minority AIDS Initiative.

10. Mr. Stephen Lewis (Canada)

Stephen Lewis is the co-founder of AIDS Free-World, an international advocacy organisation to promote a more urgent and effective response to HIV. He was the United Nations Secretary General's Special Envoy for HIV/AIDS in Africa from 2001 - 2006. Stephen has also served as the Canadian Ambassador to the United Nations.

11. Professor Sylvia Tamale (Uganda)

Sylvia Tamale is a leading African feminist lawyer and scholar based in Uganda. She is a human rights defender and an advocate for the rights of women and marginalised communities. She has served as the Dean of the Faculty of Law at Makerere University.

12. Mr. Jon Ungphakorn (Thailand)

Jon Ungphakorn is a former Senator for Bangkok. His career has been dedicated to human rights and development issues in Thailand. He is currently the Vice-Chairperson of the Thai Foundation for AIDS Rights and a member of the Board of Governors of the Thai Public Broadcasting Service.

13. Professor Miriam K. Were (Kenya)

Miriam Were has been the Chair of the Kenya National AIDS Control Council and the African Medical and Research Foundation. She is a co-founder of UZIMA foundation - an organisation focusing on youth empowerment and HIV, and a member of Champions for a HIV-Free Generation.

14. Mr. JVR Prasada Rao (India)

– Member Secretary

Mr. JVR Prasada Rao was the Director of India's National AIDS Control Programme from 1997 - 2002. He also served as Permanent Secretary in the Ministry of Health, Government of India and the Director of the UNAIDS Regional Support Team for Asia-Pacific. Mr. JVR Prasada Rao served as the Member Secretary of the Commission on AIDS in Asia and the Commission on AIDS in the Pacific. In May 2012, he was appointed the UN Secretary-General's Special Envoy for AIDS in Asia and in the Pacific.

TECHNICAL ADVISORY GROUP BIOGRAPHIES

Full biographies can be found on-line at www.hivlawcommission.org

1. The Hon. Michael Kirby (Co-Chair)

Michael Kirby was a judge in the High Court of Australia from 1996–2009. He also served as the Chairman of the Australian Law Reform Commission, the President of the International Commission of Jurists and the Special Representative of the United Nations Secretary General for Human Rights in Cambodia.

2. Allehone Mulugeta Abebe (Co-Chair)

Allehone Mulugeta Abebe is an Ethiopian diplomat. He has a background in public health, human rights and international law. He has negotiated several multilateral, regional and international human rights instruments and resolutions. He is currently doing his doctoral research on internally displaced people in Africa.

3. Aziza Ahmed

Aziza Ahmed is Assistant Professor of Law at Northeastern University in Boston, Massachusetts. Her work focuses on issues of HIV, gender, sexuality, sexual and reproductive health and rights, and the intersection of public health and criminal law.

4. Jonathan Berger

Jonathan Berger is doing his pupillage in South Africa. He was a researcher at and head of policy and research at SECTION27, incorporating the AIDS Law Project. His Masters of Law degree focused on the relationship between access to HIV treatment, international trade law and constitutional law.

5. Chris Beyrer

Chris Beyrer is Professor of Epidemiology, International Health and Health, Behavior and Society at Johns Hopkins Bloomberg School of Public Health. He is the founder and Director of

the Centre for Public Health and Human Rights at John Hopkins.

6. Scott Burris

Scott Burris is a Professor of Law at Temple University, where he directs the Centre for Health Law, Policy and Practice, and the Robert Wood Johnson Foundation's Public Health Law Research program. His work focuses on how law influences public health, and what interventions can make laws and law enforcement healthier in practice.

7. Joanne Csete

Joanne Csete is senior program officer for the Global Drug Policy Program, Open Society Foundations (OSF). Prior to joining OSF, she was at Columbia University's Mailman School of Public Health, where her research focused on health services for marginalised and criminalised populations, especially people who use illicit drugs, sex workers, prisoners and detainees, and people living with HIV.

8. Mandeep Dhaliwal

Mandeep Dhaliwal is the Cluster Leader: Human Rights and Governance in the HIV Group at UNDP. Prior to joining UNDP, she was a senior advisor to the Dutch Royal Tropical Institute's Programme on AIDS, focusing on issues of HIV, health, human rights and law. She was the founding Coordinator of the Lawyers Collective HIV/AIDS Unit in India.

9. Sophie Dilmitis

Sophie Dilmitis has been living openly with HIV for 16 years. She has extensive experience working in the AIDS and women's movements

in Africa and globally. From 2006–2011, Sophie worked for the World YWCA as the Sexual and Reproductive Health and Rights and HIV Coordinator.

10. Vivek Divan

Vivek Divan is a lawyer from India. As the Coordinator of the Lawyers Collective HIV/AIDS Unit in India, he was part of the team which drafted India's HIV/AIDS Bill. He was also closely involved in the research and community mobilisation work for the public interest litigation challenging India's anti-sodomy law.

11. Richard Elliott

Richard Elliott is a lawyer and the Executive Director of the Canadian HIV/AIDS Legal Network. He currently holds a Community Leadership in Justice Fellowship from the Law Foundation of Ontario at the University of Toronto, Faculty of Law. Between 2001 and 2007, he was a member of the Ministerial Council on HIV/AIDS, an expert body advising Canada's Federal Minister of Health.

12. Sofia Gruskin

Sofia Gruskin directs the Program on Global Health and Human Rights at the University of Southern California, the USC Institute for Global Health, and holds appointments as Professor of Preventive Medicine at the Keck School of Medicine and as Professor of Law and Preventive Medicine at the Gould School of Law. She is also Adjunct Professor of Global Health, Department of Global Health and Population at Harvard.

13. Wendy Isaack

Wendy Isaack is a lawyer and human rights activist from South Africa. Her work has focused on women's rights, specifically violence against

women, and the rights of lesbian, gay, bisexual and transgender people. She has been actively engaged in human rights advocacy work with the African Commission on Human and Peoples' Rights.

14. Rick Lines

Rick Lines is the Executive Director of Harm Reduction International. He is known for his work on prisoners' rights, harm reduction, death penalty for drug offences, drug policy, HIV. He holds Masters Degrees in Sociology and International Human Rights Law.

15. Annie Madden

Annie Madden has been working in the areas of injecting drug use, HIV, hepatitis C, peer education and drug user representation for 20 years. She is the Executive Officer of the Australian Injecting & Illicit Drug Users League and a representative of the International Network of People who use Drugs.

16. Kevin Moody

Kevin Moody is openly living with HIV and has been the Chief Executive Officer of the Global Network of People Living with HIV since 2006. He started his career as a pharmacist in hospital and community pharmacies and has worked with the Medecins Sans Frontieres' Campaign for Access to Essential Medicines.

17. Vitit Muntarbhorn

Vitit Muntarbhorn has been working at the Chulalongkorn University's, Faculty of Law for over 30 years. He was the United Nations Special Rapporteur on the sale of children, child prostitution and child pornography from 1990 - 1994. His work focuses on human rights issues, including the rights of sexual minorities.

18. Cheryl Overs

Cheryl Overs is the founder of the Global Network of Sex Projects. As a Senior Research Fellow in the Michael Kirby Centre for Public Health and Human Rights at Monash University and a member of the Paulo Longo Research Initiative, her work focuses on the impact of economic and legal conditions on sex workers health and human rights.

19. JVR Prasada Rao (Commission Member Secretary)

Mr. JVR Prasada Rao was the Director of India's National AIDS Control Programme from 1997 - 2002. He also served as Permanent Secretary in the Ministry of Health, Government of India and the Director of the UNAIDS Regional Support Team for Asia-Pacific. Mr. JVR Prasada Rao served as the Member Secretary of the Commission on AIDS in Asia and the Commission on AIDS in the Pacific. In May 2012, he was appointed the UN Secretary-General's Special Envoy for AIDS in Asia and in the Pacific.

20. Tracey Robinson

Tracey Robinson is a Senior Lecturer in the Faculty of Law, University of the West Indies (UWI), Cavehill, Barbados. She has published in areas of family law, gender and citizenship, legal feminism, sex work, same sex sexuality, sexual harassment and intimate domestic relationships.

21. Purna Sen*

Purna Sen directs the Programme for African Leadership at the London School of Economics. She has almost thirty years' experience on work to promote social justice, most recently as Head of Human Rights for the Commonwealth Secretariat and before that as Director for the Asia-Pacific Programme at Amnesty International. Previously she taught Gender and Development at the Development Studies Institute at the London School of Economics and worked on race equality in education.

22. Susan Timberlake

Susan Timberlake is the Senior Human Rights and Law Advisor at UNAIDS. She started her career in the UN at the United Nations High Commissioner for Refugees (UNHCR) where she worked for nineteen years. At UNAIDS, her work focuses on promoting rights based approaches and enabling legal environments for HIV.

23. Matthew Weait

Matthew Weait is a Professor of Law and Policy at Birkbeck College, University of London. His work focuses on the impact of law on people living with HIV, with a particular emphasis on the legal construction of responsibility and the relationship between law and human rights. He has published widely in the field of criminal law and HIV.

* Purna Sen left the Technical Advisory Group in March 2012.

SUMMARY RECOMMENDATIONS

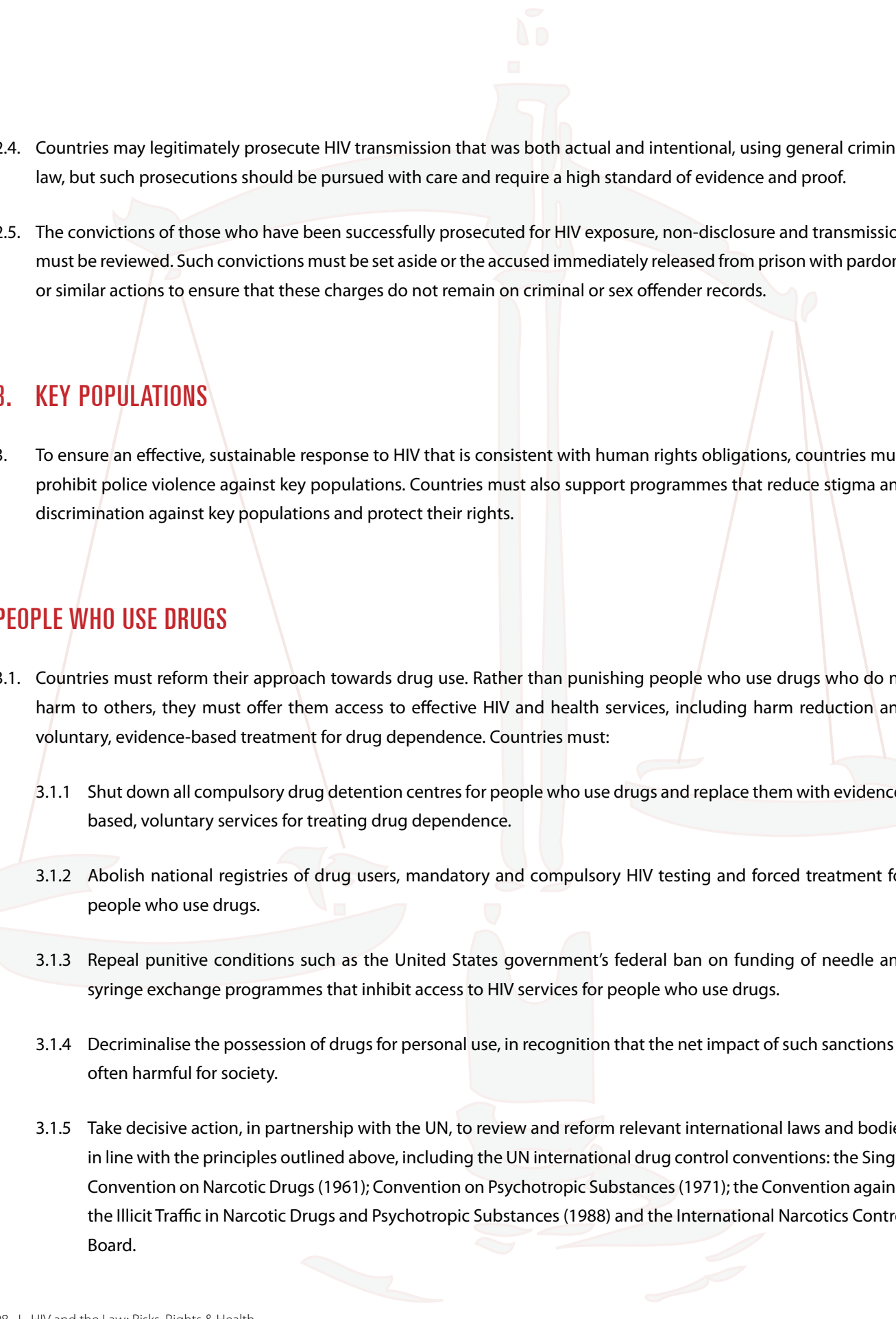
To ensure an effective, sustainable response to HIV that is consistent with human rights obligations:

1. DISCRIMINATION

- 1.1. Countries must ensure that their national HIV policies, strategies, plans and programmes include effective, targeted action to support enabling legal environments, with attention to formal law, law enforcement and access to justice. Every country must repeal punitive laws and enact protective laws to protect and promote human rights, improve delivery of and access to HIV prevention and treatment, and increase the cost-effectiveness of these efforts.
- 1.2. Where they have not already done so, countries must explicitly prohibit discrimination on the basis of actual or perceived HIV status and ensure that existing human rights commitments and constitutional guarantees are enforced. Countries must also ensure that laws and regulations prohibiting discrimination and ensuring participation and the provision of information and health services protect people living with HIV, other key populations and people at risk of HIV.
- 1.3. Donors, civil society and private sector actors, and the UN should hold governments accountable to their human rights commitments. Groups outside government should develop and implement rights-based HIV-related policies and practices and fund action on HIV-related law reform, law enforcement and access to justice. Such efforts should include educating people about their rights and the law, as well as challenging stigma and discrimination within families, communities and workplaces.

2. CRIMINALISATION OF HIV TRANSMISSION, EXPOSURE AND NON-DISCLOSURE

- 2.1. Countries must not enact laws that explicitly criminalise HIV transmission, HIV exposure or failure to disclose HIV status. Where such laws exist, they are counterproductive and must be repealed. The provisions of model codes that have been advanced to support the enactment of such laws should be withdrawn and amended to conform to these recommendations.
- 2.2. Law enforcement authorities must not prosecute people in cases of HIV non-disclosure or exposure where no intentional or malicious HIV transmission has been proven to take place. Invoking criminal laws in cases of adult private consensual sexual activity is disproportionate and counterproductive to enhancing public health.
- 2.3. Countries must amend or repeal any law that explicitly or effectively criminalises vertical transmission of HIV. While the process of review and repeal is under way, governments must place moratoria on enforcement of any such laws.

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- 2.4. Countries may legitimately prosecute HIV transmission that was both actual and intentional, using general criminal law, but such prosecutions should be pursued with care and require a high standard of evidence and proof.
- 2.5. The convictions of those who have been successfully prosecuted for HIV exposure, non-disclosure and transmission must be reviewed. Such convictions must be set aside or the accused immediately released from prison with pardons or similar actions to ensure that these charges do not remain on criminal or sex offender records.

3. KEY POPULATIONS

3. To ensure an effective, sustainable response to HIV that is consistent with human rights obligations, countries must prohibit police violence against key populations. Countries must also support programmes that reduce stigma and discrimination against key populations and protect their rights.

PEOPLE WHO USE DRUGS

- 3.1. Countries must reform their approach towards drug use. Rather than punishing people who use drugs who do no harm to others, they must offer them access to effective HIV and health services, including harm reduction and voluntary, evidence-based treatment for drug dependence. Countries must:
- 3.1.1 Shut down all compulsory drug detention centres for people who use drugs and replace them with evidence-based, voluntary services for treating drug dependence.
 - 3.1.2 Abolish national registries of drug users, mandatory and compulsory HIV testing and forced treatment for people who use drugs.
 - 3.1.3 Repeal punitive conditions such as the United States government's federal ban on funding of needle and syringe exchange programmes that inhibit access to HIV services for people who use drugs.
 - 3.1.4 Decriminalise the possession of drugs for personal use, in recognition that the net impact of such sanctions is often harmful for society.
 - 3.1.5 Take decisive action, in partnership with the UN, to review and reform relevant international laws and bodies in line with the principles outlined above, including the UN international drug control conventions: the Single Convention on Narcotic Drugs (1961); Convention on Psychotropic Substances (1971); the Convention against the Illicit Traffic in Narcotic Drugs and Psychotropic Substances (1988) and the International Narcotics Control Board.

SEX WORKERS

- 3.2. Countries must reform their approach towards sex work. Rather than punishing consenting adults involved in sex work, countries must ensure safe working conditions and offer sex workers and their clients access to effective HIV and health services and commodities. Countries must:
- 3.2.1 Repeal laws that prohibit consenting adults to buy or sell sex, as well as laws that otherwise prohibit commercial sex, such as laws against “immoral” earnings, “living off the earnings” of prostitution and brothel-keeping. Complementary legal measures must be taken to ensure safe working conditions to sex workers.
 - 3.2.2 Take all measures to stop police harassment and violence against sex workers.
 - 3.2.3 Prohibit the mandatory HIV and STI testing of sex workers.
 - 3.2.4 Ensure that the enforcement of anti-human-trafficking laws is carefully targeted to punish those who use force, dishonesty or coercion to procure people into commercial sex, or who abuse migrant sex workers through debt bondage, violence or by deprivation of liberty. Anti-human-trafficking laws must be used to prohibit sexual exploitation and they must not be used against adults involved in consensual sex work.
 - 3.2.5 Enforce laws against all forms of child sexual abuse and sexual exploitation, clearly differentiating such crimes from consensual adult sex work.
 - 3.2.6 Ensure that existing civil and administrative offences such as “loitering without purpose”, “public nuisance”, and “public morality” are not used to penalise sex workers and administrative laws such as “move on” powers are not used to harass sex workers.
 - 3.2.7 Shut down all compulsory detention or “rehabilitation” centers for people involved in sex work or for children who have been sexually exploited. Instead, provide sex workers with evidence-based, voluntary, community empowerment services. Provide sexually exploited children with protection in safe and empowering family settings, selected based on the best interests of the child.
 - 3.2.8 Repeal punitive conditions in official development assistance—such as the United States government’s PEPFAR anti-prostitution pledge and its current anti-trafficking regulations—that inhibit sex workers’ access to HIV services or their ability to form organisations in their own interests.
 - 3.2.9 Take decisive action to review and reform relevant international law in line with the principles outlined above, including the UN Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children (2000).

MEN WHO HAVE SEX WITH MEN

3.3. Countries must reform their approach towards sexual diversity. Rather than punishing consenting adults involved in same sex activity, countries must offer such people access to effective HIV and health services and commodities. Countries must:

- 3.3.1 Repeal all laws that criminalise consensual sex between adults of the same sex and/or laws that punish homosexual identity.
- 3.3.2 Respect existing civil and religious laws and guarantees relating to privacy.
- 3.3.3 Remove legal, regulatory and administrative barriers to the formation of community organisations by or for gay men, lesbians and/or bisexual people.
- 3.3.4 Amend anti-discrimination laws expressly to prohibit discrimination based on sexual orientation (as well as gender identity).
- 3.3.5 Promote effective measures to prevent violence against men who have sex with men.

TRANSGENDER PERSONS

3.4. Countries must reform their approach towards transgender people. Rather than punishing transgender people, countries must offer transgender people access to effective HIV and health services and commodities as well as repealing all laws that criminalise transgender identity or associated behaviours. Countries must:

- 3.4.1 Respect existing civil and religious laws and guarantees related to the right to privacy.
- 3.4.2 Repeal all laws that punish cross-dressing.
- 3.4.3 Remove legal, regulatory or administrative barriers to formation of community organisations by or for transgender people.
- 3.4.4 Amend national anti-discrimination laws to explicitly prohibit discrimination based on gender identity (as well as sexual orientation).
- 3.4.5 Ensure transgender people are able to have their affirmed gender recognised in identification documents, without the need for prior medical procedures such as sterilisation, sex reassignment surgery or hormonal therapy.



PRISONERS

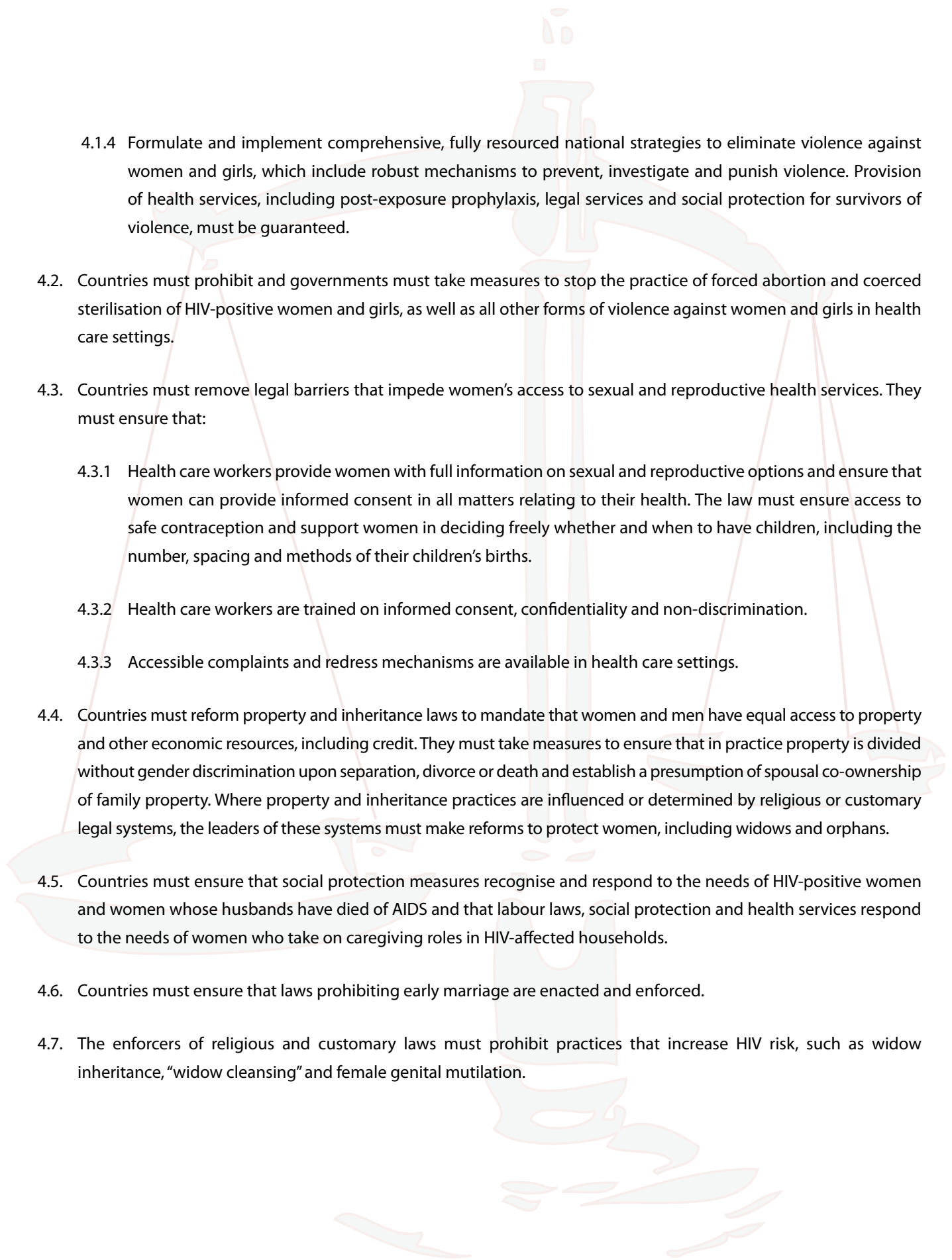
- 3.5.1 Necessary health care is available, including HIV prevention and care services, regardless of laws criminalising same-sex acts or harm reduction. Such care includes provision of condoms, comprehensive harm reduction services, voluntary and evidence-based treatment for drug dependence and ART.
- 3.5.2 Any treatment offered must satisfy international standards of quality of care in detention settings. Health care services, including those specifically related to drug use and HIV, must be evidence-based, voluntary and offered only where clinically indicated.

MIGRANTS

- 3.6.1 In matters relating to HIV and the law, countries should offer the same standard of protection to migrants, visitors and residents who are not citizens as they do to their own citizens.
- 3.6.2 Countries must repeal travel and other restrictions that prohibit people living with HIV from entering a country and/or regulations that mandate HIV tests for foreigners within a country.
- 3.6.3 Countries must implement regulatory reform to allow for legal registration of migrants with health services and to ensure that migrants can access the same quality of HIV prevention, treatment and care services and commodities that are available to citizens. All HIV testing and STI screening for migrants must be informed and voluntary, and all treatment and prophylaxis for migrants must be ethical and medically indicated.

4. WOMEN

- 4.1. Countries must act to end all forms of violence against women and girls, including in conflict situations and post-conflict settings. They must:
 - 4.1.1 Enact and enforce specific laws that prohibit domestic violence, rape and other forms of sexual assault, including marital rape and rape related to conflict, whether perpetrated against females, males or transgender persons.
 - 4.1.2 Take judicial or legislative steps to remove any immunity—or interpreted immunity—from prosecution for rape when the perpetrator is a married or unmarried partner.
 - 4.1.3 Fully enforce existing laws meant to protect women and girls from violence, and prosecute perpetrators of violence against women and girls to the full extent of the law.

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- 4.1.4 Formulate and implement comprehensive, fully resourced national strategies to eliminate violence against women and girls, which include robust mechanisms to prevent, investigate and punish violence. Provision of health services, including post-exposure prophylaxis, legal services and social protection for survivors of violence, must be guaranteed.
- 4.2. Countries must prohibit and governments must take measures to stop the practice of forced abortion and coerced sterilisation of HIV-positive women and girls, as well as all other forms of violence against women and girls in health care settings.
- 4.3. Countries must remove legal barriers that impede women's access to sexual and reproductive health services. They must ensure that:
- 4.3.1 Health care workers provide women with full information on sexual and reproductive options and ensure that women can provide informed consent in all matters relating to their health. The law must ensure access to safe contraception and support women in deciding freely whether and when to have children, including the number, spacing and methods of their children's births.
- 4.3.2 Health care workers are trained on informed consent, confidentiality and non-discrimination.
- 4.3.3 Accessible complaints and redress mechanisms are available in health care settings.
- 4.4. Countries must reform property and inheritance laws to mandate that women and men have equal access to property and other economic resources, including credit. They must take measures to ensure that in practice property is divided without gender discrimination upon separation, divorce or death and establish a presumption of spousal co-ownership of family property. Where property and inheritance practices are influenced or determined by religious or customary legal systems, the leaders of these systems must make reforms to protect women, including widows and orphans.
- 4.5. Countries must ensure that social protection measures recognise and respond to the needs of HIV-positive women and women whose husbands have died of AIDS and that labour laws, social protection and health services respond to the needs of women who take on caregiving roles in HIV-affected households.
- 4.6. Countries must ensure that laws prohibiting early marriage are enacted and enforced.
- 4.7. The enforcers of religious and customary laws must prohibit practices that increase HIV risk, such as widow inheritance, "widow cleansing" and female genital mutilation.

5. CHILDREN AND YOUTH

5.1. Countries must enact and enforce laws that:

- 5.1.1 Ensure that the birth of every child is registered. This is crucial for supporting children's access to essential services. Ensure that their rights are protected and promoted, as per the Convention on the Rights of the Child.
- 5.1.2 Ensure that every orphaned child is appointed an appropriate adult guardian. This includes provisions for transfer of guardianship of AIDS orphans from deceased parents to adults or older siblings who can ensure their well-being. In selecting a guardian, preference should be given to adults from the biological or extended families. HIV-positive adults who are otherwise in good health should not be prohibited from adopting children.
- 5.1.3 Support community-based foster care for children orphaned by AIDS as an alternative to institutionalization, when formal adoption is not possible or appropriate.
- 5.1.4 Ensure HIV-sensitive social protections as required, such as direct cash transfers for affected children and their guardians.
- 5.1.5 Prohibit discrimination against children living with or affected by HIV, especially in the context of adoption, health and education. Take strict measures to ensure that schools do not bar or expel HIV-positive children or children from families affected by AIDS.

5.2. Countries must enact and enforce laws to ensure that children orphaned by AIDS inherit parental property. Children orphaned by AIDS should inherit regardless of their sex, HIV status or the HIV status of family members. Such enforcement includes:

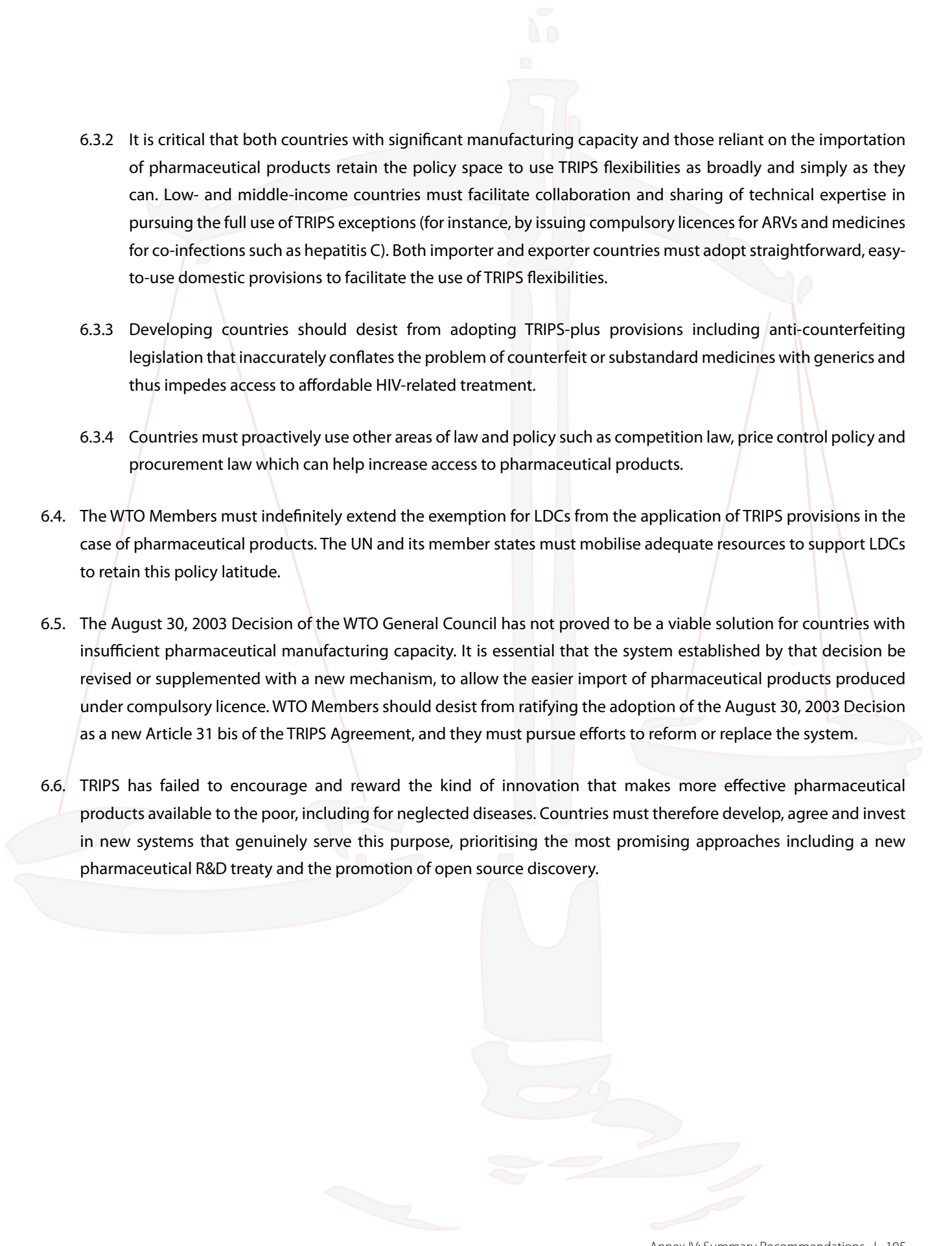
- 5.2.1 Collaboration with the enforcers of religious and customary laws to ensure justice for children orphaned by AIDS.
- 5.2.2 Reconciliation of conflicts between discriminatory customary laws and traditional practices and international human rights standards to ensure compliance with international law.

5.3. Countries must enact and enforce laws ensuring the right of every child, in or out of school, to comprehensive sexual health education, so that they may protect themselves and others from HIV infection or live positively with HIV.

5.4. Sexually active young people must have confidential and independent access to health services so as to protect themselves from HIV. Therefore, countries must reform laws to ensure that the age of consent for autonomous access to HIV and sexual and reproductive health services is equal to or lower than the age of consent for sexual relations. Young people who use drugs must also have legal and safe access to HIV and health services.

6. INTELLECTUAL PROPERTY LAW AND THE GLOBAL FIGHT FOR TREATMENT

- 6.1. The UN Secretary General must convene a neutral, high-level body to review and assess proposals and recommend a new intellectual property regime for pharmaceutical products. Such a regime should be consistent with international human rights law and public health requirements, while safeguarding the justifiable rights of inventors. Such a body should include representation from the High Commissioner on Human Rights, WHO, WTO, UNDP, UNAIDS and WIPO, as well as the Special Rapporteur on the Right to Health, key technical agencies and experts, and private sector and civil society representatives, including people living with HIV. This re-evaluation, based on human rights, should take into account and build on efforts underway at WHO, such as its Global Strategy and Plan of Action on Public Health, Innovation, and Intellectual Property and the work of its Consultative Expert Working Group. Pending this review, the WTO must suspend TRIPS as it relates to essential pharmaceutical products for low- and middle-income countries.
- 6.2. High-income countries, including donors such as the United States, European Union, the European Free Trade Association countries (Iceland, Liechtenstein, Norway and Switzerland) and Japan must immediately stop pressuring low- and middle-income countries to adopt or implement TRIPS-plus measures in trade agreements that impede access to life-saving treatment.
 - 6.2.1 All countries must immediately adopt and observe a global moratorium on the inclusion of any intellectual property provisions in any international treaty that would limit the ability of countries to retain policy options to reduce the cost of HIV-related treatment. Agreements such as the Anti-Counterfeiting Trade Agreement (ACTA) must be reformed; if ACTA is not reformed to exclude such intellectual property provisions, countries should not sign it. All countries must cease unilateral practices to this same, access-limiting end.
 - 6.2.2 High-income countries must stop seeking to impose more stringent, TRIPS-plus intellectual property obligations on developing country governments. High-income countries must also desist from retaliating against countries that resist adopting such TRIPS-plus measures so that they may achieve better access to treatment.
- 6.3. While the Commission recommends that WTO Members must urgently suspend TRIPS as it relates to essential pharmaceutical products for low and middle income countries, we recognise that such change will not happen overnight. In the interim, even though individual countries may find it difficult to act in the face of political pressure, they should, to the extent possible, incorporate and use TRIPS flexibilities, consistent with safeguards in their own national laws.
 - 6.3.1 Low- and middle-income countries must not be subject to political and legal pressure aimed at preventing them from using TRIPS flexibilities to ensure that infants, children and adolescents living with HIV have equal access to HIV diagnosis and age-appropriate treatment as adults.

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- 6.3.2 It is critical that both countries with significant manufacturing capacity and those reliant on the importation of pharmaceutical products retain the policy space to use TRIPS flexibilities as broadly and simply as they can. Low- and middle-income countries must facilitate collaboration and sharing of technical expertise in pursuing the full use of TRIPS exceptions (for instance, by issuing compulsory licences for ARVs and medicines for co-infections such as hepatitis C). Both importer and exporter countries must adopt straightforward, easy-to-use domestic provisions to facilitate the use of TRIPS flexibilities.
- 6.3.3 Developing countries should desist from adopting TRIPS-plus provisions including anti-counterfeiting legislation that inaccurately conflates the problem of counterfeit or substandard medicines with generics and thus impedes access to affordable HIV-related treatment.
- 6.3.4 Countries must proactively use other areas of law and policy such as competition law, price control policy and procurement law which can help increase access to pharmaceutical products.
- 6.4. The WTO Members must indefinitely extend the exemption for LDCs from the application of TRIPS provisions in the case of pharmaceutical products. The UN and its member states must mobilise adequate resources to support LDCs to retain this policy latitude.
- 6.5. The August 30, 2003 Decision of the WTO General Council has not proved to be a viable solution for countries with insufficient pharmaceutical manufacturing capacity. It is essential that the system established by that decision be revised or supplemented with a new mechanism, to allow the easier import of pharmaceutical products produced under compulsory licence. WTO Members should desist from ratifying the adoption of the August 30, 2003 Decision as a new Article 31 bis of the TRIPS Agreement, and they must pursue efforts to reform or replace the system.
- 6.6. TRIPS has failed to encourage and reward the kind of innovation that makes more effective pharmaceutical products available to the poor, including for neglected diseases. Countries must therefore develop, agree and invest in new systems that genuinely serve this purpose, prioritising the most promising approaches including a new pharmaceutical R&D treaty and the promotion of open source discovery.

ENDNOTES

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- 5 All information about The Global Commission on HIV and the Law can be found on the Commission's website www.hivlawcommission.org.
- 6 The Commission's Technical Advisory Group (TAG) comprises 23 leading experts on HIV, public health, gender, human rights and law, including members of communities affected by HIV. More information about the TAG is available at: www.hivlawcommission.org.
- 7 During 2011, dialogues were convened in Asia-Pacific, Caribbean, Eastern Europe and Central Asia, Latin America, Middle East & North Africa, Africa and for High Income Countries.
- 8 Written submissions were analysed using NVIVO (research software for analysis of qualitative data), in order to identify and understand key trends and patterns in the qualitative data.
- 9 UN Committee on Economic, Social and Cultural Rights, *General Comment No. 20: Non-discrimination in economic, social and cultural rights* (art. 2, para. 2, of the International Covenant on Economic, Social and Cultural Rights), E/C.12/GC/20, 2 July 2009, para. 2.
- 10 Office of the High Commissioner for Human Rights, *Universal Human Rights Instruments*. Available at: <http://www2.ohchr.org/english/law/> [Accessed on 28 March 2012]
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- 12 *Declaration of Commitment on HIV/AIDS*, United Nations General Assembly, Res/S-26/2, 27 June 2001, paras. 37 and 58; *Political Declaration on HIV/AIDS*, United Nations General Assembly, A/RES/60/262, 15 June 2006; and *Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS*, A/65/L.77 8 July 2011.
- 13 Rolando Luis Cuscul Privaral and Others affected by HIV/AIDS v. Guatemala, petition 642-03, 7 March 2005, report no. 32/05 and Jorge Odir Miranda Cortez and Others v. El Salvador, case 12.249, 20 March 2009, report no. 27/09.
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- 15 UNAIDS, (2010), *Making the Law Work for the HIV Response: A snapshot of selected laws that support or block universal access to HIV prevention, treatment, care and support*. Available at: http://www.unaids.org/en/media/unaids/contentassets/documents/priorities/20100728_HR_Poster_en.pdf [Accessed on 8 March 2012]. However, 46 per cent of countries reported having laws, regulations or policies that impede key populations at higher risk of HIV infection from accessing prevention, treatment, care and support services: United Nations General Assembly, *Report of the Secretary-General – United to end AIDS: achieving the targets of the 2011 Political Declaration*, A/66/757. Available at: http://www.unaids.org/en/media/unaids/contentassets/documents/document/2012/20120402_UNGA_A-66-757_en.pdf [Accessed on 1 May 2012].
- 16 *Ibid.*
- 17 Philippine AIDS Control and Prevention Act of 1998, Sections 2(B)(3), and 35–41.
- 18 Employment Act, Bahamas, 2001, Section 6; Gable L. et al., (2007), *Legal Aspects of HIV/AIDS: A Guide for Policy and Law Reform*, The World Bank, Washington, D.C., p. 47.

- 19 Anti-Discrimination Act, New South Wales, Australia, 1977, Section 49ZXB & C. Gable Let al. (2007), *Legal Aspects of HIV/AIDS: A Guide for Policy and Law Reform*, The World Bank, Washington, D.C., p. 47.
- 20 Hoffmann v South African Airways 2000 (2) SA 628; 2001 (10) BHR 571; (2000) 3 CHRLD 146. Available at: <http://www.equalrightstrust.org/ertdocumentbank/Hoffmann%20v%20South%20African%20Airways.pdf> [Accessed on 24 April 2012].
- 21 The right to equality and freedom from discrimination is protected by the Universal Declaration of Human Rights (1948), article 2: "Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. Furthermore, no distinction shall be made on the basis of the political, jurisdictional or international status of the country or territory to which a person belongs, whether it be independent, trust, non-self-governing or under any other limitation of sovereignty," and the International Covenant on Civil and Political Rights (1966), e.g., Article 2(1) and 26. On the question of non-discrimination, see General Comment No. 18 of the Human Rights Committee in UN doc. HRI/GEN/1/Rev.5, *Compilation of General Comments and General Recommendations adopted by Human Rights Treaty Bodies*, p. 136, para. 12.
- 22 The protection of human rights in the context of human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS), UN Commission on Human Rights, Resolution 1995/44, 3 March 1995, para. 1. See also Commission on Human Rights Resolutions 1996/43, 19 April 1996; 1999/49, 27 April 1999; 2001/51, 24 April 2001; 2003/47, 23 April 2003; 2005/84, 21 April 2005.
- 23 Article 1 of the Convention on the Rights of Persons with Disabilities states: "Persons with disabilities include those who have long term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others." Article 2 defines discrimination as: "any distinction, exclusion or restriction on the basis of disability which has the purpose or effect, on an equal basis with others, of all human rights and fundamental freedoms in the political, economic, cultural, civil or any other field." See R. Elliott, L. Utyasheva, and E. Zack, (2009), *HIV, disability and discrimination: making the links in international and domestic human rights law*, *Journal of the International AIDS Society* 12.
- 24 Québec (Commission des droits de la personne et des droits de la jeunesse) v. Montréal (City) and Québec (Commission des droits de la personne et des droits de la jeunesse) v. Boisbriand (City), 2000 SCC 27 [2000] 1 SCR 665 (Supreme Court of Canada, 2000), at para. 48.
- 25 Bragdon v. Abbott, 524 U.S. 624 (U.S. Supreme Court, 1998).
- 26 Submissions from Kelemi, RIP+, Mamadou, Ogenyi, Niang, Noubissi, Obbes, for the Africa Regional Dialogue, 3–4 August 2011; Submissions from Tamata, Thi Le Tram, Shan, Gunawan, Dela Cruz, Vijayabandara, Thanh, Suzuki, for the Asia-Pacific Regional Dialogue, 16–17 February 2011; Submission from ABWU, ABPSA, TUCA, for the Caribbean Regional Dialogue, 12–13 April 2011; Submission from Bordunis, Mardari, Lintsova, for the EECA Regional Dialogue, 18–19 May 2011; Submissions from Quiroga, Vera, Berredo and Muñoz, Arrecis, Acevedo, Rondón, Velásquez, Vasquez, Estepan, Filho, for the Latin America Regional Dialogue, 26–27 June 2011. See also, UNAIDS, *Non-Discrimination in HIV responses*, 26th Meeting of the UNAIDS Programme Coordinating Board, 22–24 June 2010, Geneva, Switzerland.
- 27 See for instance submissions from Wicomb, Kelemi, Ogenyi, for the Africa Regional Dialogue 3–4 August 2011; Submissions from Tamata, Thi Le Tram, Shan, Gunawan, Lim, Suzuki, for the Asia-Pacific Regional Dialogue, 16–17 February 2011; Submissions from Chrichlow, Augustus, Antoine, Eustache, for the Caribbean Regional Dialogue, 12–13 April 2011; Submission from Mladenovic, Untura, for the EECA Regional Dialogue, 18–19 May 2011; Submissions from Vera, Arrecis, Rondón, Almeida, Nunes and Cerqueira, Fernanda, Vasquez, for the Latin America Regional Dialogue, 26–27 June 2011. See also, UNAIDS, *Non-Discrimination in HIV responses*, 26th Meeting of the UNAIDS Programme Coordinating Board, 22–24 June 2010, Geneva, Switzerland.
- 28 See for example, the situation in Burundi from the submission from Niyongabo, for the Africa Regional Dialogue, 3–4 August 2011; and submissions from National Association of PLHA, Rajhavandra, Jeyaseelan, for the Asia-Pacific Regional Dialogue, 16–17 February 2011; Submission from One Love, for the Caribbean Regional Dialogue, 12–13 April 2011. See also Visser M., Makin JD.,

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- 194 Erratum: In the originally published version of "Risks, Rights and Health", the following sentence was included on p. 41: "In New Zealand, sex work has recently been prosecuted under the same law that officially decriminalises it." The sentence is not accurate and has been deleted from current on-line versions of the report (20 July 2012).
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