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Report by the PCB NGO representative

Document prepared by the PCB NGO Representatives

Additional documents for this item: *none*

Action required at this meeting - the Programme Coordinating Board is invited to:

Paragraph 79.

- a. *Call upon* Member States with the support of UNAIDS to:
 - i. identify key areas of focus within a country's justice system to integrate key human rights-based programmes into national AIDS strategies, and to ensure that these programmes are costed, resourced, implemented, monitored and evaluated - such programmes to include: empowering people living with HIV (PLHIV) and civil society to strengthen the voice of affected communities in policy and law dialogues; reducing HIV-related stigma and discrimination; providing legal aid and legal literacy; reforming laws; training police, prosecutors and judges on non-discrimination of PLHIV and those vulnerable to HIV; addressing gender-based violence; and training health-care workers on non-discrimination, informed consent, and confidentiality – and to *request* UNAIDS to use its reporting under the Unified Budget Results and Accountability Framework specifically in the first year report back to monitor progress and strengthen rights-based programmes as part of national AIDS strategies;
 - ii. repeal HIV-specific laws that criminalize HIV non-disclosure, exposure or transmission, relying on existing criminal law in cases of intentional transmission;
- b. *Request* Member States with UNAIDS support, and with the inclusion of persons who use drugs, to repeal criminal and administrative liabilities for drug use and for possession of drugs for personal use; and to adopt policies that promote needle and syringe programmes and opioid substitution therapy programmes, including in prison settings;
- c. *Request* Member States, with support from UNAIDS, to:
 - i. take steps to decriminalize sex work by removing laws and policies that prevent sex workers from accessing safe places to live and work and reduce their access to health services, justice, and labour rights (including local ordinances, state level regulations, and others);
 - ii. take necessary steps to repeal laws that criminalize or punish consensual same-sex behaviours among adults, preferred gender identities and non-conforming gender expressions so that everyone, irrespective of sexual orientation, sexual identity, gender identity or gender expression can realize their basic health and human rights, including access to HIV-related and other health services without fear of ridicule, blackmail, harassment, arrest, or violence;
 - iii. take actions to safeguard the sexual and reproductive rights of people living with HIV, particularly women, and to review and ensure that laws promote people living with HIV's access to services and commodities as well as working to promote access to justice as part of the fulfillment of their sexual and reproductive rights. This includes eliminating violations of the sexual and reproductive rights of women living with HIV/AIDS, such as forced sterilization, lack of provision of contraceptive methods or access to safe abortion;

d. Calls on UNAIDS to:

- i. work with donors and Member States to ensure the strengthening of legal literacy programmes, specifically increasing funding to NGOs that provide legal aid programmes and support in interpreting law for those living with and vulnerable to HIV in their primary language;
- ii. support Member States to review national policy and develop guidance and tools to address the needs and vulnerability of all populations at risk, including women and girls, sex workers, LGBTI, migrants, and youth in light of punitive laws and access to HIV prevention, treatment, care and support. This work should be undertaken in consultation with key affected population groups, review existing best practices in order to share, adapt and scale up successful work, and be highlighted in the first annual review of the Unified Budget Results and Accountability Framework.

Cost implications for decisions: *none*

***This report is dedicated to the memories of Robert Carr and
Marcel van Soest***

I INTRODUCTION

1. This year's NGO Programme Coordinating Board Report focusing on legal issues and HIV responses builds upon the work of the 2009 and 2010 Programme Coordinating Board Reports. As the NGO Delegation works to represent the experiences and needs of its civil society colleagues and constituencies, this Programme Coordinating Board Report is based on a series of focus group discussions with civil society structured around understanding the personal experiences of those involved, the common trends and difficulties encountered and the solutions needed in order to increase access to HIV prevention, treatment, care and support services.
2. In 2009, the NGO Delegation undertook an online survey to understand key barriers to universal access. The majority of responses pointed to the rampant stigma and discrimination that:
 - fuel the epidemic;
 - limit access to services and care; and
 - further isolates people living with HIV and marginalized groups vulnerable to HIV infection.
3. In 2010, the NGO Delegation focused specifically on stigma and discrimination and consulted civil society about how stigma and discrimination impact access to HIV prevention and care services. In that survey, respondents highlighted:
 - confidentiality issues, notably in healthcare settings
 - the negative attitudes of many healthcare workers; and
 - the compounding impact HIV-related stigma with being associated with an already stigmatized population group.

In addition, many of the more than 1000 respondents to the 2010 consultation noted the challenge of punitive laws in responding to HIV.

II METHODOLOGY

4. The strong response in the 2010 consultation, coupled with the work this year of the Global Commission on HIV and the Law, led to the decision by the NGO Delegation to focus its annual report on the importance of the legal environment to national HIV responses. In order to complement the information from last year's report, as well as the wealth of testimonies presented to the Commission's regional dialogues, the NGO Delegation conducted a series of 27 focus groups, involving more than 240 participants from every region of the world.¹
5. The focus groups were run by NGO Delegates or civil society facilitators and included people living with, and at risk of, HIV who were members of marginalized populations who typically face challenges in accessing HIV services. Participants were guided in a discussion around ten questions, focused on: their knowledge and experience with the legal environment; their personal experiences in the use and enforcement of laws and their ability to access to legal support if needed; and their coping mechanisms in stigmatizing situations as well as their suggested solutions.² The feedback is based on the knowledge and perceptions of participants, which varied from limited (and not always

¹ An overview of participant characteristics is provided in Table 1 below, with more detailed information on the [NGO Delegation website](http://unaidspcbngo.org/) (<http://unaidspcbngo.org/>).

² The ten key questions used in the focus groups can be found on the [NGO Delegation website](http://unaidspcbngo.org/) (<http://unaidspcbngo.org/>).

correct) to those with a great deal of expertise on HIV and the law. The majority of participants were familiar with the Global Commission but had not taken part in regional dialogues (with the exception of the focus group held in southern Africa). The majority of participants were speaking from an individual perspective although almost one quarter of all participants identified as service providers. Regional focus groups, by necessity, took place in certain countries; hence, countries are named when participants spoke directly about their national laws or specific experience. As focus groups were not held in every country, not every country is addressed.

6. The NGO Delegation wishes to thank all the participants, facilitators, note-takers and advisors who took part in developing this Report, and commend their bravery in discussing a difficult issue.³
7. The feedback gathered strongly correlates to the primary issues and recommendations that emerged in last year's Report. Confidentiality issues, the negative and dismissive attitudes of healthcare providers and the seemingly arbitrary enforcement of protective measures were raised as pressing concerns in every region. Every focus group mentioned the need for education, awareness or sensitisation around HIV. They noted that stigma and discrimination are not created by law, rather law – and law enforcement – is influenced by judgemental attitudes that have pervaded society. Consequently in many cases law is reinforcing this stigma. Therefore, not only should there be training for law enforcement and legal actors but such education, awareness or sensitisation programmes should permeate across society in order to change people's perceptions of those living with and vulnerable to HIV. This feedback is especially relevant to the work of UNAIDS as key findings underscore the fact that the strategic goals of the current UNAIDS Strategy cannot be met without a supportive legal environment in which all stakeholders have access to information and justice.

³ The Delegation also wishes to thank the advisory group, including the UNAIDS Human Rights Reference Group, that supported the development of the methodology, questions and report. The full list of acknowledgements can be found on the [NGO Delegation website](http://unaidspcbngo.org/) (<http://unaidspcbngo.org/>).

	Africa	Asia & the Pacific	Europe	Latin America & Caribbean	North America	MENA	Total
Gender							
Male	21	25	5	22	25	18	116
Female	10	10	9	15	58	5	107
Transgender male					1		1
Transgender female	1	2		6	11		20
No data					4		4
Total Gender	32	37	14	43	99	23	248

Self-Indicated Persons Living With HIV

Men	5	9	5	9	20	6	54
Women	5		6	10	42	4	67
Transgender females	1	1			7		9
Total PLHIV	11	10	11	19	69	10	130

Self-Identification⁴

Gay men/men who have sex with men	15	6		10	19	13	63
Lesbian/women who have sex with women	3	1		2	3	1	10
Sex workers	3	7	1	5	3	4	23
People who use drugs		22	7	5	14		48
People with disabilities		1	2		22		25
Young people	2	4			1	7	14
Migrants/Refugees		3	3		4	1	11
Displaced persons					2		2
People with histories of incarceration	1	1	3		5	3	13
Other ⁵	3			1	7	2	13

III KEY FINDINGS AND RECOMMENDATIONS

Key Findings

- Despite the diversity of settings, the focus group participants shared many common experiences. There was consensus that lack of adequate knowledge of HIV fuels stigma and discrimination. This, in turn, hampers enforcement of potentially protective laws.

⁴ Individuals could associate with more than one population.

⁵ People self-identified beyond choices, for example as bisexual, grandparent, or senior.

Citing cases that included the arrest of gay or transgender men for “looking effeminate” and the “corrective” rape of lesbian women, participants were clear that protective laws are insufficient to guarantee security without an environment that respects human rights, and in which people know their rights and can claim them with supportive attitudes of families, communities and the legal system. In addition, participants from all regions stressed that punitive laws and policies – in the guise of HIV-related criminal laws and prosecutions and/or laws that criminalize behaviours or identities – appear to impede access to HIV prevention, treatment, care and support.

Key finding 1: HIV-related stigma, as well as a lack of understanding about behaviours and identities that are different from the mainstream, fuel discrimination in society and in the criminal justice system, and create an environment for punitive, rather than protective, laws.

9. HIV-related stigma, manifested as social hostility, prejudice and discrimination, can result in the unfair and unjust treatment of an individual based on his or her real or perceived HIV status, and affect how people at risk of HIV (key populations) consider their own risks and willingness to test for the virus.
10. Along with personal and/or religious views, lack of basic knowledge about the routes and risks of HIV transmission often lies at the root of HIV-related stigma. Such stigma not only fuels negative reactions from the general public, but also influences how healthcare workers, key actors in the justice system, and politicians and policymakers feel about people living with HIV (PLHIV) and key populations.
11. Last year’s NGO Report highlighted the widespread stigma associated with being perceived as HIV-positive, as well as how that stigma and subsequent discrimination was compounded for individuals associated with a marginalized group. Between 56 and 61% of more than 1000 respondents in last year’s report experienced stigma and/or discrimination when accessing sexual and reproductive health services or prevention, treatment, care and support services. Between 35 and 41% of participants reported that they were afraid to access or denied these services.
12. In the context of this year’s consultation on HIV and the legal environment, participants cited strong feelings of alienation from the legal system and experiences of harassment, extortion and physical violence from law enforcement officers. However, such experiences of isolation, ridicule and in some cases, harassment, were also perpetrated by family and community members and healthcare professionals, suggesting a continuum of HIV-related and societal stigma against marginalized populations that is reflected and reinforced by the legal system.
13. **Misinformation about HIV in the general population** reinforces such stigma, especially in settings where there is strong cultural and social disapproval around sexuality other than heterosexuality, as well as in places where fundamental religious influence is strong.

“People don’t know what HIV or addiction is. That is the real problem. Police should receive trainings on how to behave with people who use drugs. Authorities should receive training on what is addiction and HIV and get serious about doing something for it. HIV is not a problem only bounded to [Injecting Drug Users] IDUs, it is a problem for whole society.” - Asian participant

14. One of the key findings from last year's report was echoed here - **insensitive or unprofessional treatment at health clinics and hospitals discourages people from seeking care**. Participants spoke especially about issues of confidentiality and the lack of trust in healthcare professionals based on experiences in accessing care and treatment services.
15. Women living with HIV in Latin America reported violations of their sexual and reproductive rights, such as forced sterilization, the denial or lack of provision of contraceptive methods or access to safe abortion as a result of lack of compliance with existing protective laws. They stressed that in places where laws guaranteeing sexual and reproductive rights, especially for women living with HIV, are not provided for, legal reforms are needed to protect those rights.
16. Transgender persons, sex workers, gay men and other men who have sex with men, and people who use drugs all reported negative experiences of healthcare providers. They talked about the strong stigma on the part of healthcare workers, which they felt resulted in discrimination against them in healthcare settings. Many report avoidance rather than dealing with such treatment.

"Médecins du Monde knows well about the case of X, who was HIV+. He had injected in the groin and was losing a lot of blood when the outreach team arrived. The team took him to the nearest hospital, but he was refused access because he was looking like a drug user. He was close to dying when thanks to pressure on the director, he was finally allowed in the operation room. When the hospital team heard he was HIV+, they instantly dropped all their material and ran away. I remember that even the tube was still in his mouth. We tried to take him to another private hospital but he died some minutes later in the car." - Asian participant

17. Despite protective laws in Canada, such as the Ontario Human Rights Code and the Canadian Human Rights Act, participants from Canada's Latino gay community reported discrimination at healthcare centres based on their race or immigration status.
18. Participants in the Middle East talked about their **lack of confidence in the ability of healthcare providers to keep their HIV-positive status confidential**; others in North America raised fears around name-based reporting. The US system offers guidelines for confidentiality; however, all states are now implementing name-based reporting, some of which have already been subpoenaed or requested for use in criminal cases of HIV transmission.⁶ Respondents from Eastern Europe and New Zealand also expressed concern about the difficulty of having a stigmatizing label removed once an individual is documented in the system (for example, removing a label that identifies an individual as a person who uses drugs). Criminal laws and the potential role that healthcare providers can play in prosecutions have added more distrust to an already precarious relationship.
19. **The legal systems in many countries do not seem to be well-versed in HIV.** Participants talked about the limitations of judicial systems in many places. Asian participants in particular (outside of the Pacific) talked about the lack of due process or proper court trial. However, judicial ignorance regarding HIV is not limited to any particular setting.

⁶ Sean Strub, GNP+ North America, email discussion (2011). For discussions on name based reporting, see: "Battling HIV on Many Fronts," *New England Journal of Medicine* 338 (1998), 198; UNAIDS, [The Role of Name-Based Notification in Public Health and HIV Surveillance](#), (July 2000); and Center for Disease Control, [HIV Infection Reporting](#), (Aug 2010).

“There was an HIV criminalization case in Ontario a couple of years ago – there was a witness [living with HIV] in a trial and the judge ordered the witness to stand away from them, there was a mask used, and there was cleaning of the court room. And this was just for a witness – imagine the accused.” – North American participant⁷

20. **HIV-related stigma is often exacerbated by the media**, which often sensationalizes HIV, exaggerating its risks or harms, and ignoring scientific fact. In North America and Western Europe, where prosecutions for HIV non-disclosure, exposure and transmission take place most frequently, PLHIV report exaggerated and frightening media portrayals of people living with HIV, violating privacy by publicly identifying the accused, or obscuring impartiality via negative media portrayals and fear mongering.

Key finding 2: Punitive laws and policies⁸ – including criminalization of HIV non-disclosure, exposure and transmission; criminalization of sex between men, sex work, and drug use; and repressive laws and policies that impact women and girls, transgender and intersex individuals and migrants – undermine HIV responses by discouraging both access to HIV-related services and HIV-service utilization.

21. In line with last year’s NGO report, focus group participants highlighted that many people with HIV, or at risk of acquiring HIV, are not seeking or attending HIV-related services. This is true especially for individuals whose behaviour has been criminalized, due to the fear of discrimination, ill-treatment or prosecution.
22. **Criminalization of HIV non-disclosure, exposure or transmission** appears to discourage testing, as many participants talked about the belief that it is “better” not to know your status because it can be used to prosecute you. Some participants in these focus groups, notably amongst gay men and other men who have sex with men, expressed strong fears of going to jail for HIV exposure or transmission. Participants from African communities in the UK agreed that many people in their community would rather not know their status so they can use ignorance of their HIV-positive status as a defence in case of prosecution.
23. One respondent from Tanzania reported negative impacts after the enactment of the HIV and AIDS Prevention Control Act 28 of 2008, which under its section 47 states that “any person who intentionally transmits HIV to another person commits an offence, and on conviction shall be liable to imprisonment to a term of not less than five years and not exceeding twelve years or to both.” Her organization noticed that people increasingly refrained from seeking health services if they suspected that they were suffering from HIV-related health complications, because they feared getting to know their status as they could be blamed by their partners for ‘intentionally’ infecting them. She added that they also encountered incidents where women accessing prevention of vertical transmission services were afraid of being forced to disclose their HIV status to their partners or of having health care workers disclose their status to their partners before they were ready to do so. Section 16 of the law allows that the results of an HIV test may be released to a spouse or sexual partner of a person testing positive or being prosecuted for intentional HIV transmission. The respondent reported that, often, when women tested positive for HIV, they wanted to hide their HIV status and went as far as

⁷ See Tracey Tyler, “[Judge’s Ignorance of AIDS Draws Fire](#),” *The Toronto Star*, 30 January 2008.

⁸ This includes heightened criminal charges or enhanced sentencing for persons who are HIV positive and charged with a crime.

switching to another hospital or health facility for services or delivering children with the support of traditional birth attendants.

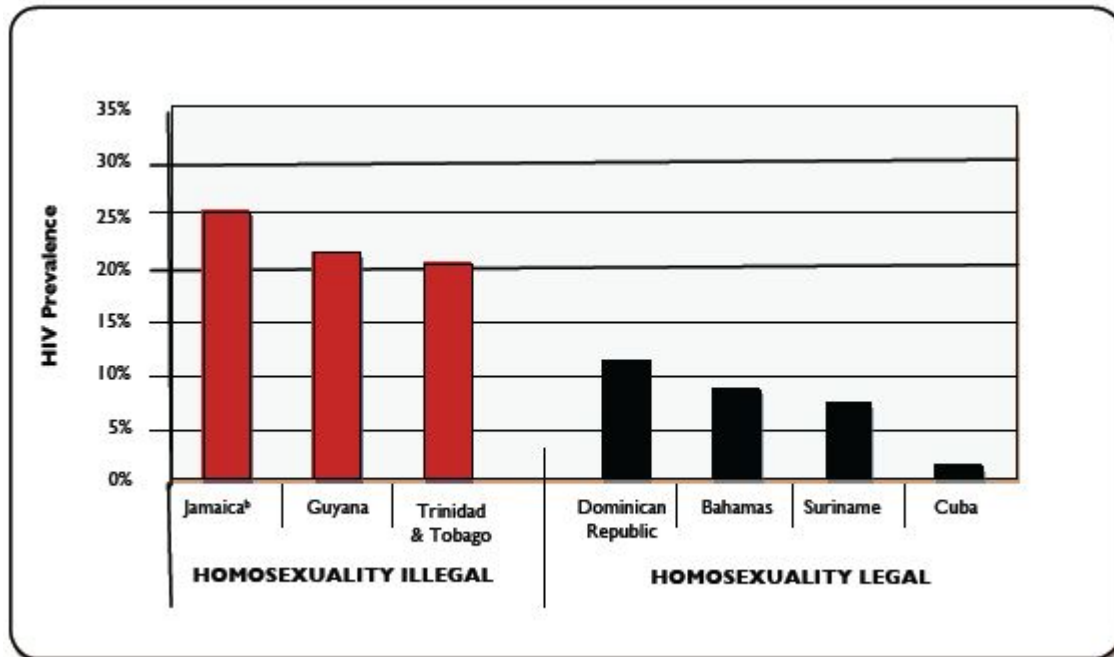
24. Women's fears of being prosecuted or treated differently when pregnant are not limited to jurisdictions with broad or vague HIV-specific criminal laws. In one recent case in the US state of Maine, one judge interpreted the state's responsibility as needing to incarcerate the mother beyond her defined sentence for possessing a fake social security card to last the length of her pregnancy to ensure her adherence to her antiretroviral treatment.⁹
25. Advocacy of civil society groups has been instrumental in educating those in the legal system and in overturning sentences such as the one above, where positive education and support has resulted in corrective legal measures. In this case, the woman's sentence extension was appealed and overturned.
26. **The criminalization of homosexuality** is also preventing affected populations from accessing HIV testing and other sexual health services. Seventy-six countries still criminalize homosexual behaviour, and repressive laws that punish same sex behaviours were mentioned in all regions of the world. Focus groups specifically comprising gay men and other men who have sex with men were held in North America, the Middle East and Latin America and the Caribbean. Men who have sex with men can be prosecuted under sodomy laws, which is still punishable by death in seven countries.¹⁰ Various parts of the penal codes in Zambia, Kenya, Malawi and Botswana criminalize homosexuality, which makes prevention a challenge. Participants in this consultation talked about fear, harassment, black mail and public humiliation.

When the law creates an environment against gay men, then it is very difficult for people to engage in their health in a way that recognizes their sexual identity and to be in a culture that fully supports them. – North American participant

27. Participants in the Caribbean made it clear that if laws against homosexuality were repealed, their sense of safety would be enhanced, and *"We would not be afraid to go and get regular check-ups."* Indeed, a review of data reveals lower rates of HIV in countries in the Caribbean where homosexuality is legal. When people are openly able to express themselves and claim their rights, they are also better able to care for themselves.
28. The following chart compares HIV prevalence rates among men who have sex with men in countries that criminalize homosexuality versus countries that do not criminalize homosexuality in the Caribbean region. As seen here, HIV rates are much higher among MSM in countries that criminalize same-sex behavior. Punitive legal environments can drive MSM behaviors underground and serve to block access to health information and services, resulting in negative health outcomes and higher HIV rates.

⁹ This was subsequently appealed and overturned but focus group participants cited this as law. See: See: Judy Harrison, *Bangor Daily News*, "[Judge Jails Woman Until Baby is Born](#)," (9 June 2009) and "[Jail Time Cut for Pregnant Illegal Alien](#)," (15 June 2009) [Accessed via [Criminal HIV Transmission](#)]

¹⁰ As of May 2010, homosexuality is punishable by death in seven countries: Iran, Mauritania, Saudi Arabia, Sudan and Yemen, and parts of Nigeria and Somalia. See The International Lesbian, Gay, Bisexual, Trans and Intersex Association (ILGA), [State-sponsored Homophobia: A World Survey of Laws Criminalizing Same-Sex Sexual Acts Between Consenting Adults](#), (May 2011).



Source: MSMGF, "Social Discrimination Against Men Who Have Sex With Men: Implications for HIV Policy and Programs," (May 2010) [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].

29. **Transgender persons** reported that the lack of legal recognition of their preferred gender identity and the lack of protective frameworks against discrimination blocks access to HIV and health-related services. As reported by participants in NGO Delegation consultations this year and last year, these services are not adapted to the unique health and HIV needs of transgender persons, and healthcare providers remain for the most part ill-equipped and insensitive to these needs. Furthermore, most public systems fail to recognize non-conforming gender roles and expressions or preferred gender identities but instead view gender as dichotomous (male and female) and as being only congruent with assigned gender at birth. This puts transgender people at greater risk of discrimination, abuse and harassment in settings such as drug treatment programs, detention centers, and prisons, where individuals are divided by sex as viewed by the country's policy.

30. A transgender participant from the Caribbean explained:

"They have laws that can get us in more than one way. Firstly, they will say that we are homosexuals and that is grounds on which to arrest us. Second, they will say that we are impersonating other persons, using other names than those on our birth certificates and that is deceit."

31. Even before taking concerns about HIV criminalization into the picture, lesbian, gay, bisexual, transgender and intersex persons (LGBTI) already face legal charges, heinous crimes and, in some cases, murder for being identified as gay or transgender.¹¹ Legal

¹¹ See The Daily Kos, "[Homophobia Unchained](#)," (18 March 2011); International HIV/AIDS Alliance, "[Special Report: Transphobia and Hate Crimes in Guatemala](#)," (6 April 2010); International Gay and Lesbian Human Rights Commission (IGLHRC), "[Three Murders in Two Weeks: Protest the Killings of LGBTI People in Honduras](#)," (10 January 2011); SentiDog, "[Report: 260 Homosexuals Were Murdered in Brazil in 2010](#)," (5 April 2011); and Trans-Respect versus Trans-Phobia Worldwide, "[Transgender Europe's Trans Murder Monitoring Project Reveals More Than 500 Reported Murders of Trans People in the Last 3 Years](#)," (May 2011).

recourse or protection against such human rights abuses is virtually non-existent in most parts of the world.

32. **Criminalizing sex work**, or in places where sex work is legal, criminalizing places of work and ways of working, increases a sex worker's vulnerability to violence. Denying safe places to work results in lack of protection for sex workers and criminalizing their behaviour inhibits their access to health care.
33. Key populations are affected by sexual offences legislation and laws which criminalize sex between men, drug use and sex work, particularly when these laws include clients and those who earn a living practicing sex work, including their children and dependent relatives. Laws against loitering, "rogues and vagabonds", solicitation and public indecency were also cited by African, US and Asian participants as being used to arrest sex workers, even in settings where sex work is not criminalized.
34. In Canada, where street workers are more likely to be people who use drugs, aboriginal or transgender persons, the court system is still deliberating whether aspects of the criminal code that criminalize keeping or transporting a person to a "bawdy house", "living on the avails" of prostitution by someone else, and "communicating in public for the purposes of prostitution" violate constitutional rights to freedom of expression and to security of the person.¹²
35. The fact that sex work is criminalized in most of the participating countries was cited as a clear deterrent to access support and HIV-related health services. Law in some cases worked to discourage testing, such as in the United States, where solicitation is a misdemeanour, but if a sex worker has tested positive for HIV or is forcibly tested upon arrest and tests positive, he or she can have an enhanced sentence¹³ and in some states, such as Colorado, sex workers who know they are living with HIV can be charged with a felony¹⁴.
36. **The criminalization of drug use** also has a major impact on the ability of people who use drugs to access HIV prevention. While harm reduction methods such as clean needle exchange and opioid substitution therapy (OST) are proven to prevent HIV amongst persons who use drugs, focus group participants in Eastern Europe, Asia, North American and Africa made it clear that harm reduction strategies are not adequately available to them.
37. In addition enforcement of laws against people who use drugs was pointed out by Eastern European and North African participants as being high and the punishment often disproportionately severe for the offense. In a study carried out in northern Morocco, more than 300 people who use drugs talked about their experiences: 82% had been incarcerated; 87% reported police violence used against them and 50% reported human rights violations by medical personnel.¹⁵ When asked more about police abuse, 83% reported recurrent harassment, 65% illegal practices, and 6% inhumane treatment while in detention.

"We had jobs before. Most of us lost our jobs due to drug use and stigmatization. If the Government were allowing more methadone we could go back to our families and work again to support them. I was a carpenter and lost my job because of

¹² Canadian HIV/AIDS Legal Network, Submission to the Global Commission on HIV and the Law, August 2011.

¹³ David W. Webber, *AIDS and the Law*, 4th ed. (Aspen Publishers, 2010), 7-40-7-43.

¹⁴ AVERT, "[Criminal Transmission of HIV](#)".

¹⁵ Association de lutte contre le sida (ALCS) & Open Society Institute, "For a New Approach Toward Drug Users, Based on Health and Human Rights," National Conference, Morocco (26 October 2011).

imprisonment due to my drug habit. I've seen how methadone helps to go back to a normal life. I had tried detox so many times before. My family paid so much for me to be cured. I know that methadone could give me another chance.” – Asian participant

38. **Repressive laws and policies towards women and girls** also impact their ability to access HIV services. Women’s vulnerability to HIV is increased due to biological factors as well as social factors such as gender inequality, which keep women in a subordinate position in relation to men. Women are often less able to negotiate condom use or refuse sex even with intimate partners, partly because of threats or acts of violence and coercion. Stigma and discrimination faced by women also means that positive HIV serostatus may increase their risk of suffering violence if they are “blamed” for HIV infection as they are the first to know.¹⁶ This is especially problematic because women are more likely to know their status due to pre-natal testing. For this reason, women and girls are likely to fear the repercussions of laws that prosecute for HIV exposure and transmission, especially those already subject to domestic violence.¹⁷ Potential criminalization of transmitting to a partner or child will not empower women or encourage women to test. Some specific factors increasing women’s vulnerability to HIV that must be addressed include outdated inheritance and marriage laws, as highlighted by African participants, and cultural norms that make it more difficult for women to negotiate condom use, as highlighted by African diaspora participants.
39. **Repressive laws and policies towards migrants** are creating barriers to accessing HIV services, treatment, care and support. African and Black migrant populations, both with legal status and without, discussed their fear of both criminal and immigration laws that could potentially lead to deportation.
40. Migrants and undocumented workers reported being afraid to seek HIV-related health services because they are unclear how HIV-related criminal laws impact on migration laws. For example, in Canada, the link between conviction for HIV non-disclosure and potential deportation from the country created additional concerns for immigrants and refugees from the African and black Diaspora communities involved in the consultation. It is likely that fear of deportation or accusations of non-disclosure are preventing undocumented persons from accessing healthcare.
41. In Asia, undocumented migrants and ethnic minorities are subject to laws and policies that legitimize denial of access to some services. Migrant workers, including sex workers, cited being commonly exposed to mandatory testing, despite international guidelines against such practice, and when found positive, denied treatment and sent home. Some noted detrimental consequences due to lack of access to treatment. In a number of countries in the region, PLHIV who were non-nationals were denied entry, stay or residence.
42. Participants in Eastern Europe and in Asia talked about coverage of medical services being linked to an individual’s residence, which means persons in unstable living conditions, including people who use drugs, migrants and undocumented workers, are limited in their ability to access care. Participants talked about freedom of movement being denied in places such as South Korea where PLHIV have to register when they move to a new location so the government can track their whereabouts. Failure to do so can mean the loss of the person’s access to government-supported treatment.

¹⁶ Mabel Bianco and Florencia Aranda, [Vínculos Silenciados: Violencia y VIH en las Mujeres: Una Mirada a la Situación Actual en América Latina y el Caribe](#), [Silenced Links: Violence and HIV in Women: A Look at the Current Situation in Latin America and the Caribbean] (2009).

¹⁷ ATHENA Network, [10 Reasons Why Criminalization of HIV Exposure or Transmission Harms Women](#), (2009).

Key finding 3: Legal protections for people living with HIV and key affected populations are insufficient or unenforced, and their experience of law enforcement is overwhelmingly negative.

43. **Anti-discrimination laws, where they exist, are actually being undermined by HIV-related stigma and discrimination.** Participants shared many experiences of discrimination that impact on their abilities to access care, to work and to take part in community life. While some legislation is available to protect against HIV discrimination, it is limited and sometimes contradictory. For instance, participants from the Africa focus group pointed out that legislation to protect PLHIV against discrimination existed alongside laws that also criminalized HIV non-disclosure, exposure or transmission in places such as Tanzania, Zimbabwe and Kenya.
44. Participants cited feared and actual workplace discrimination. A wide form of discrimination highlighted in the 2010 NGO report – harassment and forced termination due to HIV-positive status – were discussed again in this consultation.
45. While employment is ostensibly protected from requiring an HIV-negative status, participants in the Middle East, Africa, North America and Asia all mentioned mandatory testing in order to obtain employment and the need to test HIV-negative to be able to work.
46. While participants knew of laws to protect against workplace discrimination in Africa and in North America, they also made it clear that workplace discrimination still exists and that fear of being fired or stigmatized at work influences decisions to test and disclose.¹⁸ Workplace protections, including: the elimination of mandatory testing at the hiring stage; support and sensitization training in the workplace; and prohibitions on employment termination on the basis of HIV-positive status, are not strongly enforced in any region. In places such as the United States, where employer-based insurance is common, participants stressed the worry of losing health and life insurance benefits.
47. **Participants often pointed out the asymmetry of laws and policies**, even within a country. For example, gay men in parts of the United States are protected by anti-discrimination laws, but these laws do not exist in some southern states, offering no recourse for gay men there. US participants also noted a lack of protective legal frameworks for transgender persons, which fosters discrimination, reduces employment opportunities and enables the dearth of culturally competent services.
48. People who use drugs, notably in Asia, talked about the lack of coherence between harm reduction policies and arrests for drug use and possession. Vietnam was cited as an example of the disconnect between policies at the national level and those at the district and local level. Saigon and Danang have active “zero tolerance” policies which do not meet national harm reduction policy and standards.
49. In many places around the world, proven HIV prevention methods such as clean needle exchanges and opioid substitution therapy are not available at all. Participants in Eastern Europe especially noted the dearth of funding for these programmes in the context of a lack of overall focus on HIV prevention for persons who use drugs.

¹⁸ See [2010 NGO Report](#) and Sprague, Laurel, Sara Simon and Courtenay Sprague. 2011. Employment Discrimination and HIV Stigma: Survey Results from Civil Society Organizations and People Living with HIV in Africa. *African Journal of AIDS Research* 10(3) (supplement) for more discussion.

50. In some cases, the law has been instrumental in upholding individual rights of persons who use drugs. In Canada, despite the fact that harm reduction is no longer a national strategy, the Supreme Court recently ruled to allow a supervised injection site to remain open, based on public health benefits and in line with the Charter of Rights and Freedoms.¹⁹

51. National AIDS strategies can even be the source of contradictory national policy. One participant from Cameroon pointed out the inclusion of MSM in the national AIDS strategy, at the same time that same sex behaviour is illegal:

“MSM are integrated into the strategic plan, but we continue to be arrested. This is a contradiction that questions this strategic plan, and makes us believe the plan is only used as propaganda. I do not believe in this strategic plan at all.” - Africa participant

52. **Across regions experiences with law enforcement was on the whole negative** and at worst outright abusive and violent. Rather than being protectors, police were commonly cited as threats to people living with, and those vulnerable to, HIV. Sex workers repeatedly mentioned being propositioned or being extorted to exchange sex or money to avoid arrest. For example, sex workers in Cambodia have been offered the option of paying their way out of compulsory testing by police. Men who have sex with men, sex workers and people using drugs reported high levels of harassment and abuse by law enforcement, including blackmail and physical abuse. People who use drugs in Eastern Europe reported false accusations, drug plants and “trumped-up” charges by law enforcement.

53. One comment from an Asian participant implies how necessary it is to immediately scale up training as well as accountability within some law enforcement bodies. Participants in the Thailand focus groups stressed the need for money to target understanding and impartial enforcement of the law.

“Sensitization – has taught enforcement agents to rape people with a condom... they need more sensitization about the law.” – Participant from Asia

54. The experience of participants – highlighting that such targets for arrest and extortion are linked to stigmatizing attitudes around race, ethnicity, gender, poverty and sexual orientation – matches previous findings cited in the UNAIDS/UNDP Policy Brief on HIV criminalization:

“Prosecutions and convictions are likely to be disproportionately applied to members of marginalized groups, such as sex workers, men who have sex with men and people who use drugs. These groups are often “blamed” for transmitting HIV, despite insufficient access to HIV prevention information, services or commodities, or the ability to negotiate safer behaviours with their partners due to their marginalized status.”²⁰

¹⁹ [“Vancouver’s Insite Drug Injection Clinic Will Stay Open,”](#) CBC News (30 September 2011).

²⁰ UNAIDS/UNDP, “Policy Brief: Criminalization of HIV Transmission,” (August 2008): 3, which references Human Rights Watch: *Policy Paralysis: A Call for Action on HIV/AIDS-Related Human Rights Abuses Against Women and Girls in Africa* (2003); *Rhetoric and Risk: Human Rights Abuses Impeding Ukraine’s Fight Against HIV/AIDS* (2006); *Not Enough Graves: The War on Drugs, HIV/AIDS, and Violations of Human Rights in Thailand* (2004); *Injecting Reason: Human Rights and HIV Prevention for Injection Drug Users; California: A Case Study* (2003).

Condoms

Participants in North America, Asia and the Pacific and Africa mentioned that police officials harass and arrest individuals using condoms as evidence for intent to solicit sex work. As a result, sex workers are discouraged from carrying prevention materials with them for fear of harassment and arrest.

When arrests are made and individuals end up in prison, condoms are unavailable. This leaves individuals vulnerable to sexual violence in prisons (notably female transgender persons who are put in male prison cells) at great risk of spreading or contracting HIV.

In Lesotho, a country where same-sex sex is criminalized, government officials found a way to provide condoms in male prisons. Anti-homosexuality laws are often cited as the reasons why condoms cannot be made available in prisons. However, upon realizing the rising numbers of HIV infections in its prisons, the Lesotho government found a loophole in the law and devised a way of availing condoms in prisons. "Sex between people of the same sex is against the law in Lesotho. However, we took note that being in possession of a condom is not against the law, regardless of one's sexual orientation," said Phoka Scout, a Senior Assistant Commissioner of Correctional Health with the Lesotho Correctional Services. Condoms were then struck off from the list of prohibited articles inside Lesotho's prisons. And the results? Lower rates of infections in prison settings.²¹

Lack of condoms is only one of the examples of detrimental prison conditions that show a lack of understanding around HIV; treatment interruption and even discontinuation, and the unsanitary conditions of prisons were cited by focus group participants.

55. Incarceration is leading to treatment disruption and inhumane conditions for many PLHIV. Participants talked about poor conditions in prison, including denial of antiretroviral treatment (ART). Participants frequently mentioned the lack of condoms available, due in some cases to the criminalization of sex between men, and unsanitary conditions of the prisons. In some places, PLHIV are incarcerated separately from other prisoners.

56. In South Africa, it was mentioned in several cases that arrests impacted the ability of sex workers living with HIV to continue their ART. Police there are required by policy to request and initiate access to treatment for detainees living with HIV once they are arrested. Police are also obliged to provide access to post-exposure prophylaxis (PEP) when the detainee has been raped. However, treatment services and PEP are often not given to individuals who are arrested. For example, a South African sex worker reported that she was arrested while pregnant and kept for one day without her antiretrovirals, which could have jeopardized her attempt to prevent vertical transmission of HIV to her baby. The police are also reported to have confiscated the antiretrovirals of sex workers, stating that the drugs will be used for recreational purposes. One participant from Cameroon talked about a prisoner who died within days of his release, after his ART was withheld when he was in jail. In other places ART is not available at all in prison.

*"Few months ago, one of our friends, X, who was HIV positive and on ART was put in jail because he was using drugs in the street. As there is no ART in the prison, his treatment is broken. He is still in the prison now and I'm afraid he will die from AIDS."
- Person using drugs, Asia*

²¹ Justice Kavahematui, "[Inside Prisons' Dirty Secrets](#)," *Botswana Guardian* (11 February 2011).

57. Examples of lack of access to ART were also given by respondents from North America. This discontinuity in care following arrest can result in serious health implications for people living with HIV (e.g. drug resistance leading to treatment failure), violating the human rights of people living with HIV by undermining their health and not providing timely access to care.
58. In addition, respondents from North America, Asia and Africa reported frequent arrests of female transgender sex workers, and transgender women being placed into the same jail cells as male inmates, which led to harassment or abuse by fellow prisoners. However, in recognition of the rights of transgender persons, South Africa recently amended its law to allow transgender people to change the sex on their identity cards without a sex change. This will have a significant impact on how individuals are treated if they are incarcerated.
59. Participants often commented on the lack of accountability for abuses within the system and the need for safe ways for PLHIV, women and key populations to report abuse by government or judicial agencies.²² Most participants expressed a strong desire to use the legal system for redress but only a few knew examples of case law.

Forced sterilization in Chile and Namibia: using the legal system for redress

Beyond its physical and emotional implications, forced sterilization is a violation of a woman's basic human rights. Two cases of forced sterilization are now pending in international and domestic justice systems. Both cases involve the issue of consent.

One Chilean woman is working to take her case to the Inter-American Court of Human Rights. The other involves three domestic cases in Namibia that were documented by the International Community of Women living with HIV and Namibia Women's Health Network and are being litigated by the Legal Assistance Centre in the Namibian High Court. The first Namibian case was heard in January, 2011 and currently awaits judgment. In both cases, civil society organizations helped to document abuses and support the plaintiffs.

Being sterilized, I feel like less than a woman because, for me, fertility is a vital part of being a woman. – Plaintiff in the Chilean case

Key finding 4: Individuals do not know their rights, especially as they relate to punitive and protective laws.

60. When interacting with the legal system, the majority of focus group participants were neither well-versed in the law, nor clear on its interpretation, nor knowledgeable about their rights and mechanisms that could provide redress. For these reasons, participants considered legal literacy programmes and legal aid services vital and helpful. However, many reported that the availability and comprehensiveness of these programmes were inadequate, offered only in certain regions and not in rural areas, and very difficult to access by marginalized groups.

²² For more specific recommendations, see summary of the Egyptian Anti-Stigma Forum, [Combating HIV/AIDS Related Stigma in Egypt: Situation Analysis and Advocacy Recommendations](#), (July 2010).

61. Participants agreed, however, that government-supported legal aid services are “bogged down” and “over-burdened” and unable to meet the need, particularly of vulnerable and marginalized populations most in requirement of these services.
62. As mentioned by participants of the Africa focus group, resources, both financial and human, are limited, as lawyers are not always willing to stay in the public sector and client resources to pay for such services are also restricted. Moreover, the slow pace of the judicial system means that cases take a long time to come to trial. In the meantime, when an individual is detained, holding cells and detention centres are conducive to the spread of disease, such as tuberculosis.
63. Participants in North America talked about the fact that legal aid carries less associated stigma than AIDS service organizations. Therefore, some individuals, especially refugees and asylum seekers, are more willing to go there before accessing HIV-specific health services.
64. United States-based participants knew of protective laws, such as the Americans with Disabilities Act (ADA), the Health Insurance Portability and Accountability Act (HIPAA) privacy rule and the Housing Opportunities for persons with AIDS, but did not feel that they were always enforced. Some Canadian participants were aware of the legal responsibility to disclose HIV status, but few could distinguish or explain when “significant risk” occurred, as this has not been clearly determined in the legal system²³ and is an essential factor in non-disclosure prosecutions.
65. Participants in Latin America and Africa cited their constitutions, or in some cases, bill of rights, as a strong basis for protection. Specifically, the right to health is recognized in countries such as Ecuador, Brazil, India, Uganda, South Africa and Nigeria.²⁴ This right includes the right to sexual and reproductive health, but laws guaranteeing this right are not recognized in practice, resulting in sexual and reproductive rights violations. The actualization of this right requires awareness, civil society advocacy and resources to enforce what sounds protective on paper.

IV RECOMMENDATIONS

66. The NGO delegation has presented previous recommendations to the Board that have been passed and discussed, but that have direct bearing on this issue. It is important to keep in mind the consensus of this board to:
 - End compulsory or mandatory testing;
 - End entry, stay and residence restrictions based on HIV status;
 - Train and sensitize healthcare workers;
 - Support evidence-based research to know your epidemics; and
 - Scale up support for tools to measure and decrease stigma and discrimination

The UNAIDS family has already adopted a policy against HIV-specific criminal laws.

67. The further recommendations from this year’s key findings include:

²³ See, for example, this from the [submission to the Global Commission](#) by the Canadian HIV/AIDS Legal Network, p.2: “However, what constitutes a ‘significant risk’ has as yet to be clarified by the Court. The law’s uncertainty has led to inconsistent decisions across the country and facilitated an extensive use of the criminal law.”

²⁴ For a detailed analysis of all countries’ constitutional treatment of health, see Eleanor D. Kinney and Brian Alexander Clark, “Provisions for Health and Health Care in the Constitutions of the Countries of the World,” *Cornell International Law Journal* 37 (2004): 285-355.

Recommendation 1: Support anti-stigma and HIV education campaigns designed for general populations, healthcare providers, criminal justice and law enforcement professionals, parliamentarians, and others as needed, in an effort to increase and enforce protective laws.

68. This is essential to reducing stigma and discrimination. As expressed previously by the NGO Delegation, there is an urgent need to raise general awareness about HIV and to sensitize the general public about the HIV-related needs and human rights of PLHIV and key populations, especially men who have sex with men, transgender people, women and girls, sex workers, people who use drugs, youth and migrants.

69. Parliamentarians are in positions to repeal HIV-specific laws that criminalize transmission or enact protective laws and are often the focus of advocacy, such as in the case of Southern Africa around the Southern African Development Community (SADC) Model Law.²⁵

70. To accomplish this we need to:

- Ensure and expand partnerships with civil society in order to respectfully involve PLHIV, women and key populations. It is critical to establish a partnership with civil society in bringing multiple stakeholders together during the sensitization process, especially law enforcement, the judiciary, and health workers;
- Engage the media in an effort to promote more educational and positive messaging about HIV, PLHIV and key populations, and the harm of stigma, as a strategy for demystifying and lessening the fear associated with HIV;
- Sensitize the legal system so that decisions can be made based on evidence and the most current medical information regarding HIV, rather than on fears and prejudices targeted against specific groups.

Recommendation 2: Oppose and repeal laws that criminalize HIV non-disclosure, exposure or transmission, homosexuality, gender variance, sex work and drug use.

71. As this consultation points out, in line with many others, including UNAIDS policy guidance, HIV-specific criminal laws are counterproductive and fuel stigma and discrimination. In many cases such laws are the product of misunderstanding or fear of HIV. To support this:

- Repeal HIV-specific criminal laws and severely limit HIV-related prosecutions under existing laws to those rare cases where intent to, and foreseeability of, harm, as well as lack of consent and actual transmission can be proven;
- Repeal laws that deny an individual's sexuality and criminalize same sex behaviour.
- Recognize transgender persons according to their preferred gender identity rather than the one assigned at birth;
- Scale up and fund proven harm reduction programmes to address HIV amongst people who use drugs, including OST programmes as HIV prevention;

²⁵ As a result of such efforts, the model law does not include criminalization of HIV transmission.

- Openly discuss and debate decriminalizing drug use and the possession of drugs for personal use, and evaluate how this creates a positive environment for HIV prevention; and
- Recognize sex work as an occupation requiring the same labour protection given to other occupations

Recommendation 3: Foster protective laws and knowledge of protective laws and human rights within the justice system.

72. These laws should protect PLHIV and marginalized groups and be based on human rights for all, notably the right to health. To support this, Member States can:

- Create and enact workplace protections to ensure that livelihoods are not disrupted;
- Pass and enforce laws that protect against domestic, sexual and gender-based violence for everyone including women, men who have sex with men, women who have sex with women, sex workers, PLHIV, transgender persons, people using drugs, migrants, and youth;
- Repeal outdated patriarchal laws that hinder women's rights, including inheritance rights and land ownership;
- Protect the reproductive rights of all women, which includes the end to forced sterilization, adoption refusal, the removal of children from their mothers, and programmes that discourage pregnancy among women living with HIV and adoption of programmes that protect the rights of women living with HIV to be in control of their pregnancy intentions; and
- Raise awareness among politicians, government officials, and parliamentarians about the potentially detrimental effects of free trade agreements and limitations on intellectual property on HIV treatment access and availability. Participants in Asia were especially concerned about the impact of such agreements on treatment access. They expressed the need that all persons engaged in negotiations of such treaties be aware of the potential implications.

Recommendation 4: Support and promote programmes to know your rights/laws and access justice.

73. These programmes consist of legal aid and legal literacy (know your rights and laws campaigns) and legal support for interpreting HIV-related laws, including the development of guidelines for legal and AIDS service organizations around HIV and criminal laws. These should interpret local laws, and explain impacts on other rights, such as privacy and confidentiality, immigration status, health care, etc. as well as on the HIV response.

74. Increased partnerships amongst legal aid and AIDS service organizations are important to increasing legal literacy and giving clear and accurate information to clients on their rights and the law. NGOs that provide legal aid have been instrumental in HIV and human rights based litigation, such as around forced sterilization in Namibia,²⁶ and mandatory testing in South Africa,²⁷ as well as in developing written submissions to

²⁶ Legal Assistance Centre, "[Women Living with HIV Allegedly Sterilised Without Their Informed Consent.](#)"

²⁷ See SECTION27 website: <http://www.alp.org.za/>.

sensitize judges to the needs of those living with and vulnerable to HIV.²⁸ In Scotland, an NGO worked with police to ensure that a proposal for mandatory testing for people coming from high prevalence countries did not become law. In Canada, participants credited legal aid programmes with saving lives either directly or indirectly. In Canada, legal aid is constitutionally mandated,²⁹ which could be a best practice at the country-level for all regions that participated in the focus groups.

75. NGOs that carry out legal aid and legal literacy programmes have limited resources and are in urgent need of financial and technical support. To adequately scale up such programmes will require an understanding of costs involved and where services are most needed and then dedicated funding to increase resources to legal aid services and AIDS service organizations to ensure their functioning and that outreach material is targeted to specific communities and is available in their primary language.

76. All of this work will be meaningless if legal systems and individuals involved in the legal process are not held accountable to the persons who use the system. We urge Member States to review and improve their judicial systems to ensure that they are functioning in a way that respect human rights. This means we must:

- Improve prison conditions so they are humane and conducive to good health, including improving HIV prevention (this includes condom and treatment availability);
- Protect the confidentiality of personal data, including HIV testing histories, HIV test results, drug use histories – this information should not be used to limit a person's life opportunities or as incriminating evidence;
- Recognize and address institutionalized racism and sexism throughout various legal and judicial systems worldwide, which often results in disproportionate populations of black and minority people overrepresented in the criminal and judicial system;
- Ensure that immigrants, refugees and displaced persons have access to legal services and HIV programming and services, regardless of citizenship or status; and
- Prosecute those who violate or deny the rights of others, including within the legal system.

V CONCLUSIONS

77. The finding and recommendations aim to feedback to the UNAIDS Board what participants experienced and recommended. The Board can take some concrete decisions to support the implementation of these recommendations as Member States, Cosponsors and civil society. The summary of this consultation with civil society supports the findings of other studies and feedback from the regional dialogues on HIV and the Law: progress in each of the three strategic directions of the UNAIDS Strategy requires an enabling legal environment. In order to arrive at zero new infections, zero AIDS-related deaths and zero discrimination, we need:

- Legal frameworks that are rights-based and supportive of the HIV response;

²⁸ For example, the New Zealand AIDS Foundation gave a written submission in order to educate the judge in a case; this led to subsequent case law not requiring disclosure in the case of condom use.

²⁹ As explained by John Norquay, HIV and AIDS Legal Clinic Ontario (HALCO) lawyer: Each province makes its own decisions about what services will be covered by legal aid. In 1999, the Supreme Court of Canada discussed rights to legal aid in a case that concerned state-funded legal aid in the context of child apprehension by provincial child welfare authorities. In that case, the Court held that s. 7 of the Canadian Charter of Rights and Freedoms (which guarantees life, liberty and security of the person) in certain circumstances where an individual's "security of the person" is engaged, there will be a right to state-funded counsel, see [New Brunswick \(Minister of Health and Community Services\) v. G. \(J.\), \[1999\] 3 SCR 46](#).

- Law enforcement that does not discriminate, target and fuel violence against marginalized groups;
- Legal systems that are knowledgeable of and sensitive to HIV and public health;
- Legal systems that are accountable for the actions of individuals who work within them;
- Knowledge by people living with HIV of their rights and the laws that impact their lives, and
- Access to justice for all who need it.

78. The UNAIDS Strategy commits to addressing many of the key findings and recommendations addressed in this year's NGO Report, as it states:

“UNAIDS calls for protective laws and measures to ensure that all people benefit from HIV programmes and have access to justice, regardless of health status, gender, sexual orientation, drug use or sex work. Significant expansion of programmes that empower civil society to know and demand their rights is needed. These include programmes to reduce HIV-related stigma and discrimination, provide legal aid and legal literacy, reform laws, train police on non-discrimination, reach out to vulnerable populations, address violence against women and train health-care workers on non-discrimination, informed consent and confidentiality.”

VI ACTIONS FOR THE BOARD

79. To support the UNAIDS Strategy and further the recommendations in this report, **the Programme Coordinating Board is invited to:**

- b. *Call upon* Member States with the support of UNAIDS to:
 - iii. identify key areas of focus within a country's justice system to integrate key human rights-based programmes into national AIDS strategies, and to ensure that these programmes are costed, resourced, implemented, monitored and evaluated - such programmes to include: empowering people living with HIV (PLHIV) and civil society to strengthen the voice of affected communities in policy and law dialogues; reducing HIV-related stigma and discrimination; providing legal aid and legal literacy; reforming laws; training police, prosecutors and judges on non-discrimination of PLHIV and those vulnerable to HIV; addressing gender-based violence; and training health-care workers on non-discrimination, informed consent, and confidentiality – and to *request* UNAIDS to use its reporting under the Unified Budget Results and Accountability Framework specifically in the first year report back to monitor progress and strengthen rights-based programmes as part of national AIDS strategies;
 - iv. repeal HIV-specific laws that criminalize HIV non-disclosure, exposure or transmission, relying on existing criminal law in cases of intentional transmission;
- d. *Request* Member States with UNAIDS support, and with the inclusion of persons who use drugs, to repeal criminal and administrative liabilities for drug use and for possession of drugs for personal use; and to adopt policies that promote needle and syringe programmes and opioid substitution therapy programmes, including in prison settings;
- e. *Request* Member States, with support from UNAIDS, to:
 - iv. take steps to decriminalize sex work by removing laws and policies that prevent

sex workers from accessing safe places to live and work and reduce their access to health services, justice, and labour rights (including local ordinances, state level regulations, and others);

- v. take necessary steps to repeal laws that criminalize or punish consensual same-sex behaviours among adults, preferred gender identities and non-conforming gender expressions so that everyone, irrespective of sexual orientation, sexual identity, gender identity or gender expression can realize their basic health and human rights, including access to HIV-related and other health services without fear of ridicule, blackmail, harassment, arrest, or violence;
 - vi. take actions to safeguard the sexual and reproductive rights of people living with HIV, particularly women, and to review and ensure that laws promote people living with HIV's access to services and commodities as well as working to promote access to justice as part of the fulfillment of their sexual and reproductive rights. This includes eliminating violations of the sexual and reproductive rights of women living with HIV/AIDS, such as forced sterilization, lack of provision of contraceptive methods or access to safe abortion;
- d. Calls on UNAIDS to:
- iii. work with donors and Member States to ensure the strengthening of legal literacy programmes, specifically increasing funding to NGOs that provide legal aid programmes and support in interpreting law for those living with and vulnerable to HIV in their primary language;
 - iv. support Member States to review national policy and develop guidance and tools to address the needs and vulnerability of all populations at risk, including women and girls, sex workers, LGBTI, migrants, and youth in light of punitive laws and access to HIV prevention, treatment, care and support. This work should be undertaken in consultation with key affected population groups, review existing best practices in order to share, adapt and scale up successful work, and be highlighted in the first annual review of the Unified Budget Results and Accountability Framework.

[Annex follows]

ANNEX

DETAILED FEEDBACK FROM REGIONAL FOCUS GROUPS ON KNOWLEDGE AND ENFORCEMENT OF LAWS AFFECTING HIV

1. This annex gives more detailed information from regional focus groups regarding participants' knowledge of and experience with laws where they live. It is qualitative rather than quantitative. Last year's report found that most respondents (77%) were aware of laws to protect against stigma and discrimination, 59% said the laws were not well-known; and 78% said the laws are either not enforced or not followed. In contrast, 44% of 1115 respondents were aware of laws making it more difficult to access prevention, treatment care and support. Most comments mentioned laws prohibiting same sex behaviour and sodomy; needle exchange; and criminalization of HIV non-disclosure, exposure and transmission. Many of those are confirmed here.

Africa

Background

2. Africa is home to the controversial "model laws" on HIV that began spreading in western Africa in 2004,³⁰ following the development of the N'djamena African Model Law to address the need for "human rights legislation in that region to protect those who are infected and exposed to HIV."³¹ This model, which was replicated across west Africa (Benin; Guinea Bissau, Mali, Niger and Sierra Leone) and spread as far as southern Africa (Tanzania, Madagascar and the Democratic Republic of the Congo), requires disclosure of HIV-positive status to a "spouse or regular sexual partner" as soon as possible and at most within 6 weeks of diagnosis. In addition, it permits mandatory testing of pregnant women and "when necessary to solve a marital dispute."
3. As well, laws criminalizing drug use, sex work and homosexuality in many countries are severe. For example, in northern Nigeria, gay men can face death by stoning; in Kenya, up to 14 years in prison; and in Uganda, homosexual behaviour is punishable by life in prison.³²

Participants

4. Two focus groups were held in Africa and participants were drawn from Cameroon (more than half as a dedicated focus group was held there), Kenya, Zimbabwe, South Africa, Swaziland, Malawi, Tanzania, Nigeria, Namibia, Uganda, Zambia, Mauritius, and Botswana. They ranged in age from 23 to 60 years old and represented men who have sex with men, women who have sex with women, people living with HIV, sex workers, youth, transgender persons and former prisoners.

³⁰ The U.S. Agency for International Development (USAID) [Action for West Africa Region HIV-AIDS program](#) (AWARE) worked on legislation in Chad which began by trying to address stigma and discrimination but has in fact led to the development of "model" criminal laws for HIV. Several nations in West Africa have now adopted HIV laws based on this "model law" formulated in 2004 by AWARE. Article 36 creates an offence of wilful HIV transmission "*through any means by a person with full knowledge of his/her HIV/AIDS status to another person*". This definition is considered very broad and disregards whether disclosure or reasonable precautions took place. While previously no country criminalized transmission, there are now 27 countries with active laws. See Center for HIV Law and Policy, "[In Kato's Africa, USAID Money Spurred Spread of HIV Criminalization Laws](#)," (9 March 2011).

³¹ Canadian HIV/AIDS Legal Network, "[Legislation Contagion: The Spread of Problematic New HIV Laws in Western Africa](#)," HIV/AIDS Policy & Law Review 13 (2008): 2/3.

³² ILGA, Op. cit. 11.

Comments

5. Participants in the focus group in Africa were highly knowledgeable about the laws of their countries. This may be due to the fact that these participants were all part of the regional dialogue of the Global Commission on HIV and the Law for Africa, held in Johannesburg, and were generally more informed than the focus groups elsewhere, as many were lawyers and professionals versed in the topic.
6. As also mentioned in Ecuador and Morocco, participants made reference to their national constitutions as part of the legal framework that improves the response to HIV. South Africa's constitution was mentioned as a strong example for its anti-discrimination focus and protection of same sex couples. Specific countries, such as Zimbabwe and Kenya were mentioned as having strong Bill of Rights in their constitutions, but excluding certain groups or criminalizing sex work or "acts against nature" in their penal codes. The explicit guarantee of the right to health in the constitutions of Uganda, South Africa and Nigeria were mentioned as supporting the HIV response. Protective anti-discrimination legislation was pointed out in HIV-specific legislation in Mauritius and Tanzania.
7. While HIV-specific legislation can protect PLHIV against discrimination and thus support the HIV response, it was also mentioned as impeding the response to HIV, in cases where it contains provisions which criminalize HIV transmission, as in Tanzania. Participants mentioned issues around disclosure of HIV status, and in some cases mandatory testing for HIV as key challenges to an effective response.
8. Participants in the African consultations pointed out that they are particularly affected by sexual offences legislation and other laws which criminalize same sex, drug use and sex work. In the case of sex work, laws in some cases also criminalize clients and those who earn a living practicing sex work, which particularly affects their children and extended families. Other laws, such as those against loitering, "rogues and vagabonds," solicitation and public indecency were frequently used to arrest sex workers, even in settings where sex work is not criminalized.
9. Participants in Africa talked about outdated laws inherited from colonial rule that specifically criminalize key populations such as men who have sex with men and called for a repeal / reform of these inherited laws. Repressive drug use policies and the lack of harm reduction policies in many countries also negatively influence HIV prevention and treatment services. Finally, some participants talked about the role of oppressive fundamentalist evangelical groups in some African countries in funding reviews of legislation, particularly Constitutions, and explained that the conservative and repressive tones of the changes being proposed, would have a negative impact on the HIV response.
10. Participants in Cameroon pointed out the irony that the national AIDS programme includes men who have sex with men as a target group while outlawing them at the same time. Participants there said a lack of recognition of individual human rights makes questions of minorities more difficult.

"We do not think that prisoners may be entitled to a decent life. If human rights were respected enough in Cameroon, we would have already advanced more on the issue of homosexuality."

Asia and the Pacific

Background

11. Asia and the Pacific is a region of vast paradoxes. At one end of the spectrum there is New Zealand as a model of progressive reform, starting with the instigation of the Homosexual Law Reform Act in 1986, which removed criminal sanctions against consensual homosexual conduct between males and thereby enabled the promotion of HIV prevention programmes.
12. New Zealand was one of the first countries in the world to initiate the needle exchange programme (NEP) in 1987.³³ More recently the Prostitute Reform Act of 2003 legalized sex work. This created a framework to protect the human rights of sex workers, promote the welfare and occupational health and safety of sex workers and to prohibit the use of prostitution for persons under the age of 18.
13. Other parts of the region are the extreme opposite. In China, Malaysia and Vietnam, drug traffickers can still be sentenced to death, while dependent drug users are considered as criminals. In countries such as Cambodia, China, Indonesia, the Lao People's Democratic Republic, Malaysia, Myanmar, Thailand and Vietnam, people who use drugs are arrested and sent to compulsory drug treatment centres, which are supervised by custodial staff, often with little involvement of trained staff or outside health agencies.³⁴
14. Almost all countries of Asia and the Pacific criminalize aspects of the sex industry, such as soliciting in public or keeping a brothel. Some countries also directly criminalize the act of sex work itself. In countries such as China, Cambodia and Vietnam, sex workers are held in detention facilities for "rehabilitation" or "re-education through labour".³⁵

Participants

15. Three focus groups were held in Asia and the Pacific and participants came from: Afghanistan (where one focus group was held with primarily homeless persons who use drugs); Australia, India, Myanmar, Nepal, Thailand; and New Zealand (where one focus group was held). They ranged in age from 23 to 61 and the majority were people who use drugs. Participants also identified as sex workers, transgender persons, youth, men who have sex with men, women who have sex with women, persons with disabilities, migrants and former prisoners.

Comments

16. Participants in Asia demonstrated a good knowledge of laws that hinder responses, particularly laws specific to their own key population group. Participants highlighted criminalization of sex work and drug possession as key issues. Laws relating to criminalization of non-disclosure, exposure or transmission were deemed to be unclear, poorly understood and poorly applied. Other issues raised included the poor protection

³³ See Health (Needle and syringes) Regulations 1987, New Zealand and [Needle Exchange Programme](#).

³⁴ WHO, Western Pacific Region, *Assessment of Compulsory Treatment of People Who Use Drugs in Cambodia, China, Malaysia and Viet Nam: An Application of Selected Human Rights Principles*, (2009).

³⁵ UNDP Asia-Pacific Regional Centre, *Report of the Asia Pacific Regional Dialogue of the Global Commission on HIV and the Law*, (Bangkok: 17 February 2011).

offered to migrants and laws restricting entry, stay, residence and deportation for non-nationals with HIV.

17. When discussing criminalization of drug use, participants highlighted repressive legal and policy environments where harm reduction services were limited or denied and a “zero tolerance” attitude towards drug use or possession exists and is used in the extreme to harm individuals. This is a major concern given that a significant proportion of the HIV epidemic in Asia is driven by unsafe injecting practices.
18. Participants from the sex worker community cited anti-trafficking laws and legislation as obstructive to the response to HIV. Participants noted that these laws were often poorly drafted and not fully understood, leading to the conflation of sex work and trafficking. As in other regions of the world, the possession of a condom is frequently seen as evidence to solicit and could lead to arrest or detainment, or physical and sexual violence.
19. Treatment access is affected by a range of laws. Participants were especially concerned by recent free trade agreements, which have the potential effect of restricting the production of generic antiretroviral drugs, and thereby reducing access to affordable medicines.
20. Asian participants reported that the enforcement of laws was often *ad hoc* and characterized by an institutionalized culture of corrupt officials with arbitrary powers. As a result, PLHIV and marginalized groups such as sex workers and people who use drugs were subject to extortion. As mentioned by participants in northern Africa, a lack of coherence between policies and laws exists in Asia. For example, harm reduction policies may exist but the authorities are unaware and may prosecute individuals for drug use.

Europe

Background

21. The GNP+ report, *Criminalization of HIV transmission in Europe*³⁶ summarized laws in Europe around HIV non-disclosure, exposure and transmission. The review showed that European legal systems use a range of laws, from HIV-specific to general criminal and public health laws. Some laws required intent, some did not, some criminalized only actual transmission, while others criminalized the risk of transmission. Furthermore, some laws criminalized “reckless” as well as “negligent” behaviour in addition to “intentional” behaviour. The report concluded that the enforcement of these laws often fell disproportionately on males from immigrant or marginalized communities.

Participants

22. Two focus groups were held in Europe, one in the UK and one in Russia. The UK group was carried out with African migrants, almost all of whom are living with HIV. Several participants also identified as persons with disabilities and one as a refugee. The participants in Eastern Europe came from Belarus, Lithuania, Russia, Tatarstan, Ukraine, and Uzbekistan and were primarily people who use drugs, but some also identified as persons living with HIV, former prisoners and a sex worker. Ages ranged between 28 and 56 years old.

³⁶ Available at <http://www.gnpplus.net/criminalisation/index.shtml>.

Comments

23. Eastern Europe:

- a. Participants in the Eastern European focus group noted constitutionally guaranteed rights to health and protection against discrimination on the basis of illness, as advances in combating HIV. Participants noted other rights that exist but are not enforced: the right to a fair trial; the right not to incriminate themselves and their families; and the right to freedom from torture and inhumane treatment.
- b. As for laws that negatively impact on HIV care, participants talked about the fact that services are only available in the locality where one has registered, so having no documentation or fixed residence means no health care. Participants also cited criminalization of HIV non-disclosure, exposure and transmission and criminalization of sex work as barriers to HIV support.
- c. Participants highlighted that despite evidence that harm reduction and substitution maintenance therapy for people who use drugs have helped to make significant progress in HIV prevention among injecting drug users, the group primarily subject to new infections, these are not widely available. Participants noted with worry that funds for prevention and access to treatment, specifically to vulnerable groups, are virtually non-existent and this will limit widespread impact. They also cited stringent drug laws and arbitrarily low levels of possession being subject to criminal prosecution as a major impediment to HIV prevention. As well, a ban on needle exchange is believed to increase needle sharing and therefore potentially the spread of HIV and hepatitis.
- d. In discussing the disproportionate length of incarceration for drug offenses, participants talked about bleak prisons conditions, such as overcrowding and the lack of medication while in detention as contributing to the spread of disease and the physical and mental deterioration of detainees.

24. Western Europe:

- a. The participants in the focus group shared their knowledge about their right to be free from discrimination especially in the workplace as a result of the Disability Discrimination Act (DDA).³⁷ However, many participants in the focus group were not clear how to access their rights under this law and questioned how enforceable it was, and who was ultimately responsible for its implementation. They were aware that civil society groups were campaigning for this law to be adhered to and put into practice by employers. However, given the gross under-employment of African migrants and the fact that a growing number of African migrants living with HIV have undetermined immigration status and therefore remain unemployed, participants were not sure how applicable this law was to them. They expressed their further concern that divulging their HIV status in the workplace could lead to being stigmatized.
- b. The participants were concerned about their rights to access antiretroviral treatment. Their understanding of the law was primarily learned by information they received from their social networks or in the media. They noted the false headlines in

³⁷ In 2005, the DDA made it unlawful to discriminate against people with HIV from the point of diagnosis. This means that those living with HIV cannot be harassed or discriminated against in recruitment; in employment terms and conditions; in chances for promotion, transfer, training or other benefits; through unfair dismissal or less favourable treatment than other workers.

newspapers and other media making allegations of health or “treatment tourism” to the UK both in general and in relation to HIV. Migrants talked about how these untrue claims have affected popular perception, and had a negative impact on government policy, particularly on entitlement to treatment and care.³⁸ People living with HIV also thought that that these changes could lead to their being denied the right to the treatment and care which is vital to their survival.³⁹ While a significant amount of policy work and advocacy has occurred in this area, most participants were not aware of or understood how to navigate access to the services they needed, due to their fear of rejection by their communities and social services.

- c. Finally most participants were aware of a number of publicized cases where African men have been prosecuted for “recklessly” transmitting HIV.⁴⁰ While the number of cases have dwindled, participants were fearful that they could be targeted for arrest or jail if they had sex with someone. One participant recounted his experience of being arrested and investigated for causing Grievous Bodily Harm,⁴¹ for allegedly passing HIV onto his partner. The individual felt harassed by the police, and lost his job and many friends due to the investigation which led to a significant psychological and emotional toll. This focus group was the first time he was able to recount his experiences.

Latin America and the Caribbean

Background

25. Countries in Latin America and the Caribbean differ in their approach to HIV and the use of law. There are HIV-specific laws in both the Caribbean and Latin America.
26. Brazil, while not the site of a focus group, is interesting to mention as it is a positive example of social solidarity, where government and civil society worked in partnership to address HIV. Specifically, Brazil worked to address its policy regarding drug users via a public health approach rather than via the criminal justice system, grounded in a right to health guaranteed in the Constitution.⁴² There is also a similar attitude in Argentina and Uruguay. The fact that the right to health is recognized as a fundamental right of all citizens and a responsibility of the government creates an obligation on the part of the government to actualize that right in most of the Latin American and Caribbean countries.
27. Legal actions and litigation for access to treatment have been taking place in the region since 1997, resulting in access to treatment in almost all the countries in the region. The participants made the point that other people living with HIV who were not members of activist groups did not know about legal aid programmes because, in general, there is little information from governments about such programmes.

³⁸ National AIDS Trust, [The myth of health Tourism](#), (2008).

³⁹ Panos London/African HIV Policy Network, [Start the Press: How African Communities in the UK Can Work with the Media to Confront HIV Stigma](#), (October 2007).

⁴⁰ The first three cases of prosecution in the UK were of Black African migrant men. See National AIDS Trust, [Table of cases of people charged with Grievous Bodily Harm under Section 20 of the Offences Against the Person Act 1861, for reckless sexual transmission of serious infections \(HIV and viral hepatitis\) in England and Wales](#), (August 2011).

⁴¹ For a discussion on its use see Dodds, et al. [“Grievous Harm? Use of the Offences Against the Person Act 1861 for sexual transmission of HIV,”](#) Briefing Paper, (October 2005).

⁴² See Berkman, et al., “A critical analysis of the Brazilian response to HIV/AIDS: lessons learned for controlling and mitigating the epidemic in developing countries,” *American Journal of Public Health* 95/7 (2005): 1162-72.

Participants

28. Nine focus groups were held in Latin America and the Caribbean. Three groups took place in Ecuador and focused on: men who have sex with men; transgender persons and persons living with HIV. One group was drawn from Argentina and Chile, and included women living with HIV. Five groups held in Jamaica focused on persons living with HIV; persons who use drugs (substance users as self-identified); sex workers; transgender persons; and gay, lesbian and bisexual persons. Ages ranged from 22 to 60 years old.

Comments

29. The discussion held with women living with HIV from Argentina and Chile focused on their sexual and reproductive rights. The participants were not aware of specific laws regarding criminalization of HIV non-disclosure, exposure or transmission but did know of laws regarding sexual and reproductive rights. These women highlighted the violation of their reproductive rights and of the right to plan their own families, noting that in some places, women living with HIV are still denied the right to be sexually active and to be mothers, and they are still forcibly sterilized. This group highlighted that women living with HIV do not have the right to sexual and reproductive health services or information about how to present a complaint when this right is violated.

What we are missing is attention to the sexual and reproductive rights of women in general. The scarce information that is provided in health services is so obsolete that discrimination continues to grow instead of reducing. - Latin American participant

30. Respondents in three focus groups held in Ecuador pointed to the Constitution as ensuring rights for persons living with HIV. The legal framework was seen as generally strong, but not effective in changing individual behaviour. While there is a specific HIV law, initiated in 2000 and reworked in 2006-2008, it is not yet in force. This law includes strong provisions such as protection from stigma and discrimination, and access to comprehensive and permanent care. Respondents explained that the government had not prioritized the response to HIV and AIDS or developed operational guidelines in order to implement the law, so it remained on paper only.

31. In other countries, notably in the Caribbean, it is not direct HIV legislation which inhibits key populations from accessing HIV-related services but laws that criminalize behaviours. Participants from the transgender, gay, lesbian, and bisexual communities were unanimous that sodomy laws had to be repealed. Some called it the anti-gay law while others called it the law against homosexuality. This pointed to a lack of knowledge of the actual law itself but vast familiarity with the effects of the law and its misinterpretation. In their own words, transgender and gay focus group participants portrayed their frustration:

"The police tell us already that as gay people we should not exist and that we have no rights at all. Therefore no one should even bother to listen to us or help us."

32. All groups felt very strongly that the repeal of sodomy laws would enhance their sense of safety to go to the clinics and to access services.

"We would not be afraid to go to get regular check-ups"

North America

Background

33. Canada and the United States are increasingly well-known for implementing criminal law to prosecute HIV non-disclosure, exposure and transmission. Canada had 130 known prosecutions using general assault or sexual assault statutes as of August 2011, according to the Canadian HIV/AIDS Legal Network. According to GNP+ Global Scan, “Canada was the first country to prosecute mother-to-child transmission (in 2005) and the first to try someone for murder as a result of sexual HIV transmission without disclosure (in 2008).”⁴³ In the United States, there have been at least 350 convictions for HIV non-disclosure, exposure and transmission, in at least 39 States, using either HIV-specific criminal statutes, or general criminal laws or both.⁴⁴ Sentences for as non-disclosure offences (without transmission and only the potential for exposure) or spitting and biting are often severe, and can range from 10-30 years.⁴⁵
34. In both the US and in Canada, convicted persons are also often registered as sex offenders for life, even in the absence of transmission or intent to transmit.

Participants

35. Nine focus groups were held in North America, three in Canada, four in the US and two by telephone with American and Canadian participants. Three groups in the US were held with women living with HIV which included a majority of African American women; one with service providers across community based and government organizations; one with gay men and other men who have sex with men (the majority of whom are living with HIV); one with transgender persons, and two with persons living with HIV, including people who use drugs, persons with disabilities, seniors and one two-spirited man. Ages ranged from 23 to 75 years old.

Comments

36. Participants in focus groups in the region had various levels of familiarity with laws. Knowledge of laws differed within countries and in different parts of the countries. For example, participants in the DC area of the US were well-versed in state and district level laws regarding HIV testing, while participants in parts of Canada were not well-aware of all relevant immigration and criminal laws related to HIV, nor of resources available to support them. Some Canadian participants were aware of the legal responsibility to disclose HIV status, but the lack of legal clarity around when “significant risk” occurred was of concern, as this is the essential factor in non-disclosure prosecutions. There was also a lack of awareness of how HIV status impacted other legal issues like employment benefits, immigration status, disability assistance, health insurance, and access to social support programmes.
37. United States participants knew of protective laws such as the Americans with Disabilities Act, the Health Insurance Portability and Accountability Act (HIPAA) privacy rule and the Housing Opportunities for persons with AIDS, but did not feel they were always enforced.

⁴³ The Global Network of People living with HIV/AIDS (GNP+), “[Canada](#),” Global Criminalisation Scan, (April 2010).

⁴⁴ See US Congress, *REPEAL HIV Discrimination Act H.R. 3053*.

⁴⁵ See Edwin Bernard, [Criminal HIV Transmission](#) blog and the [Positive Justice Project](#).

38. Participants in Canada reported a knowledge gap around how laws are enforced, and how laws and policies relate to one another. African and Black migrant communities in Canada were unclear as to what criminal laws and charges could be applied to HIV non-disclosure, and how HIV status impacted immigration policies for entry. New changes to the Immigration and Refugee Protection Act, specifically to the Refugee Determination Process were also discussed as a knowledge gap. Reforms to this act include a part on HIV status that could potentially support a claim to stay in Canada on humanitarian and compassionate grounds. This impact on migrants and asylum seekers is little understood and has potentially great impacts.⁴⁶
39. Participants in North America were concerned with false allegations of non-disclosure and thus how HIV non-disclosure laws could be used to take revenge on a former partner because participants felt that the courts tend to believe the HIV-negative partner. The right to privacy and concerns about confidentiality of status and information were of primary concern and underlined a distrust and reticence regarding the health care system. These sentiments were echoed by a focus group of service providers who discussed the challenges of providing clear and accurate legal advice for personal behavioural choices with regards to confidentiality, privacy, and HIV disclosure to potential sexual partners. Specifically, name-based reporting in many US states is creating concerns around confidentiality and appears to be discouraging testing.
40. Records of people who have tested positive for HIV are provided by some states to law enforcement agencies, and there are reports of fire houses receiving, from local health departments, lists of addresses where people with HIV are believed to live.⁴⁷ As repeatedly pointed out by participants in the United States, a positive status can prevent access to health and life insurance. In a country where health insurance is mainly employer-based, the fear of disclosure leading to workplace discrimination and the removal of health benefits is a great risk, especially as health care costs are high. Participants in the US dependent on the AIDS Drug Assistance Program (ADAP), which provides HIV/AIDS related prescription drugs to uninsured and underinsured individuals living with HIV/AIDS, pointed out long waiting lists to access treatment.
41. North American participants talked about criminal laws that especially affect sex workers (especially transgender sex workers who experience a great deal of stigma), people who use drugs and women (mothers). Laws already in existence against sex workers compound crimes for sex workers who are living with HIV. HIV testing is forced in prison and in some states prison sentences for sex workers testing positive once incarcerated are significantly longer.

Middle East and North Africa (MENA)

Background

42. Countries across the Middle East and North Africa feature highly repressive laws against sexual minorities. All but one Arab state in the region has a law criminalizing same sex acts, and of the seven countries worldwide that punish homosexuality by death, more than half are in the Middle East.

⁴⁶ See Canadian HIV/AIDS Legal Network, [Canada's Immigration Policy as it Affects People Living with HIV](#), (April 2011).

⁴⁷ Sean Strub, GNP+ North America, email correspondence (October 2011).

Participants

43. Two focus groups were held in the Middle East and North Africa, in Morocco with primarily men who have sex with men and who identified as transgender youth primarily, and in Yemen with individuals representing service providers, the majority of whom are living with HIV themselves. Ages ranged from 19 to 46 and the participants were overwhelmingly male. While not structured as a focus group, information from a recent civil society study with hundreds of people who use drugs in Morocco is included as it focused on interactions with law enforcement and is relevant.

Comments

44. Participants in the MENA region seemed to have limited knowledge of international laws but know of specific domestic legislation in their own communities, normally in the negative sense. In Morocco, respondents were aware of specific laws against homosexuality. In other countries of the region, 18 have laws criminalizing homosexual acts under criminal law. In countries which do not criminalize outright acts, laws that address public morality or implement Shari'a law are used to prosecute same sex behaviour.

45. Many participants reported problems with law enforcement officers and lack of support in both health care and legal settings. In the case of people who use drugs, participants report the repressive legal environment as creating mistrust in social and care services. This is especially pertinent, as HIV prevalence rates among people who use drugs are increasing.

46. Participants in Yemen talked positively about the recently passed anti-discrimination law for persons living with HIV,⁴⁸ but were not clear about how to ensure its implementation. While they spoke highly of Yemen's policy of being able to work without an HIV test, many mentioned companies that continue to test as a condition of employment. The group was concerned about testing to work abroad, such as in Saudi Arabia, where testing is mandatory before and during employment.

47. Participants in this region pointed out contradictions in laws and policies. They pointed out international treaties supporting human rights sometimes contradict national legislation which may deny those same rights to certain groups of people.

48. The morality judgment on homosexuality was a large topic of discussion in this region. Participants felt social norms which deny sexual diversity are more difficult to change than law. They impose a double penalty - fear from those around you - in addition to legal penalties.

49. Respondents mentioned cases of discrimination based solely on effeminate appearance, including arrest and refusal to treat at the hospital.

CLOSING

50. Despite different experiences, participants from all regions made it clear that interpretation of the laws was not clear enough and therefore enforcement can be influenced by the knowledge, biases, beliefs, motivation and honesty of the person in the legal system, be they a law enforcement officer, prosecutor, prison official or judge. As

⁴⁸ Law 30 passed in 2009.

the voices in this consultation have reiterated, legal environments are essential to improving access to HIV prevention, treatment, care and support.

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