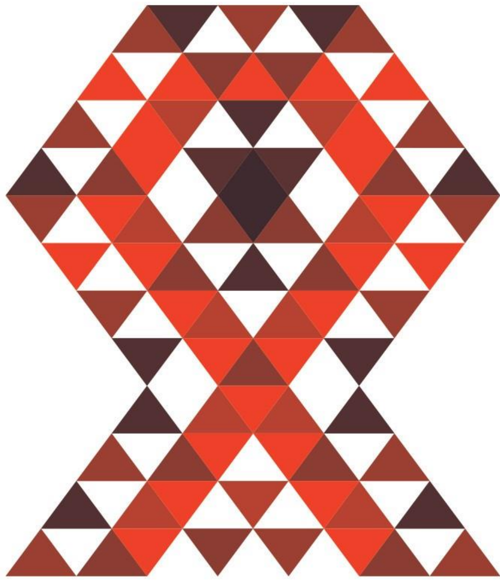

AIDS 2016

DURBAN, SOUTH AFRICA JULY 18–22, 2016

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Review of legal issues discussed at the 21st International AIDS Conference, Durban, July 2016

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ACRONYMS

ART	Antiretroviral therapy
IAS	The International AIDS Society
KAPs	Key affected populations
LEAHN	Law Enforcement and HIV Network
LGBTIQ	Lesbian, gay, bisexual, transgender/transsexual, intersex and queer/questioning
MSM	Men who have sex with men
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PLHIV	People living with HIV
PrEP	Pre-exposure prophylaxis
PWID	People who inject drugs
SANAC	South African National AIDS Council
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

BACKGROUND TO THIS REPORT

The 21st International AIDS Conference (AIDS2016) was held in Durban, South Africa from 18 – 22 July 2016. The conference theme, *Access Equity Rights Now,* echoed the spirit of the first International AIDS Conference held in South Africa (and in a developing country), in Durban, July 2000.[1]

This report reviews the Conference sessions to: (i) confirm priorities for the effective use of law to prevent and manage HIV effectively; (ii) assess the issue of "HIV exceptionalism" and its impact on appropriate legal strategies for prevention of HIV, and; (iii) identify evidence supporting a "human rights" approach to HIV and its implications for the scaling up of funding for human rights programs.

The report is limited to first-hand attendance at a selection of sessions at which HIV law and policy were discussed. It is not intended to be a comprehensive review of all law or human rights-related content available to delegates, nor an overview of the entire Conference.

This report was written by Natasha Naude, and reviewed by David Patterson, IDLO Manager / Advisor, Health Programs and by Professor Roger Magnusson, Professor of Health Law & Governance, Sydney Law School, The University of Sydney. IDLO acknowledges the financial support of the University of Sydney for Ms Naude to attend the Conference.

Further information about IDLO's participation at the Conference is available on the IDLO website.[2]

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[1] http://www.aids2016.org/

[2] http://www.idlo.int/news/events/idlo-durban-aids2016-conference

EXECUTIVE SUMMARY

The overriding view of the Conference participants at sessions on criminal law, law enforcement, policing and other legal responses to HIV was that stigmatizing or punitive laws should be reformed or repealed. However, it was also generally agreed that the law reform process is slow – too slow – and that other measures can and must be taken where the legal environment has a negative impact on the HIV response. In particular, justice sector actors can be made more aware of the public policy and public health arguments for the appropriate exercise of discretion in the application of the law. Rather than advocate for law reform in the shorter term, therefore, it may be more productive to focus on the justice sector actors who are interpreting and applying the law.

Participants also raised questions about whether law reform, if and when it happens, will actually achieve the desired outcomes. Laws can result in unintended consequences, and attitudes do not change simply because laws do.

The Conference also addressed the issues of HIV exceptionalism, noting that in the longer term, HIV prevention and treatment initiatives may need to be integrated into broader health services. Similarly, with legal measures, there may be advantages in moving away from HIV specific protections and promoting reforms within the context of broader rights issues.

On the issue of evidence for scaled up human rights programs, there are still challenges in demonstrating the cost-effectiveness of rights-based approaches when compared with other public health interventions, such as widespread (opt-out) screening. Part of the challenge has been that rights-based approaches have an internal validation, as they are based on the principles of international law developed over many decades. However, the health economists who influence major HIV and other health funding are less impressed by legal obligations than data on effectiveness and cost-effectiveness. However, we don't yet have the necessary models and data to make the case for the necessary investments in law and human rights programs.

To develop the enabling legal environments necessary to attain the 90-90-90 targets and to end AIDS by 2030, we need to make the case for scaled up investments in human rights programs. More research is required on the causal links between successful human rights and legal interventions, and reduced HIV incidence and increased treatment adherence. Then we also need to show that these programs are cost-effective when compared with other interventions.

KEY MESSAGES ON HIV, LAW AND HUMAN RIGHTS

The following key messages on law and human rights were identified at the Conference:

1. We cannot meet 90-90-90 targets without scaling up HIV prevention among key affected populations. We can only reduce HIV incidence among key affected populations (KAPs) if we also address related stigma and discrimination. The law has a crucial role to play, but in many countries the law is often an obstacle rather than an aid in the HIV response.

2. We need to change the discourse about criminalization to avoid the inaccurate conflation of identity and criminality. Legal frameworks which inhibit the HIV response typically criminalize conduct, not identity. For example, homosexual acts may be illegal, whereas the fact of being lesbian, gay, bisexual, transgender/transsexual, intersex or queer/questioning (LGBTIQ) is not. The same is true for injecting drug users and sex workers.

3. Human rights are universal – all persons should have the same human rights, under international, regional and national laws, irrespective of their conduct. This issue is fundamental to the rule of law yet is sometimes lost in debates on the role of the law in the HIV response.

4. The language of criminalization which positions women as victims in need of protection must be challenged, and the concepts of mutual responsibility stigma reduction must be reinforced. We need to address the range of factors that increase women and adolescent girls' vulnerability to HIV. To achieve this, we gender-sensitive analyses and responses.

5. Criminalization of conduct associated with KAPs undermines the HIV response in different ways. For example, such criminal laws:

    - Deter KAPs from seeking HIV testing or accessing treatment;
    - Normalize police abuse of and violence against KAPs;
    - Result in imprisonment and inability to access clean needles or adequate HIV treatment;
    - Deter sex workers from carrying and hence using condoms for fear they will be used as evidence of sex work.

    There is no evidence that such criminal laws assist the HIV response by reducing new infections. To the contrary, research indicates that such criminal laws impede HIV prevention and treatment access.

6. There is evidence that laws which specifically criminalize HIV exposure and transmission are an ineffective deterrent and harm public health efforts. Nonetheless, the number of jurisdictions with such laws has increased globally. In applying these laws, police and the courts rarely consider the efficacy of HIV treatments, including combination anti-retroviral therapy (ART) and resulting viral load suppression and current scientific evidence of the minimal risk of transmission. Legislators, the police and the judiciary must be better informed of the minimal risk of HIV transmission when viral load is suppressed through medication.

7. Anti-discrimination laws have the potential to protect vulnerable people. However, specific legislative references to HIV should be approached with caution to avoid unintended consequences. Some jurisdictions have used wider language in anti-discrimination laws, for example to address discrimination based on blood-borne diseases more generally.

8. Law reform is often a slow process. Other, strategic ways in which legal responses can be made more effective must be explored and implemented. These include police training, judicial seminars, and the implementation of harm reduction policies. The last can include, for example, the referral of drug users to treatment rather than imprisonment. Most often such approaches have economic as well as public health benefits.

9. Other strategies include peer-led, collaborative mentoring programs that empower and help people living with HIV (PLHIV) understand their rights. These can encourage PLHIV to access and stay linked to care, treatment and support. By improving treatment adherence, infectivity, and hence the risk of new infections, is also reduced.

AIDS2016 – an activist AIDS Conference with a focus on law and rights

The Conference theme was framed as a 'call to action'…

…to all 'HIV stakeholders to unite and overcome injustices caused by violence and the exclusion of people on the basis of gender, class, race, nationality, age, geographic location, sexual orientation and HIV status; and to repeal laws that infringe on people's human rights and deny communities the ability to participate in the world as equals.

The conference objectives included:

- to promote HIV responses designed to address needs of at risk/key populations;
- to promote activism and community mobilization which holds leaders, industry, and governments accountable and increases commitment to an evidence-based, human-rights-affirming HIV and AIDS response; and
- to advance an agenda for HIV which includes cross-cutting issues of criminalization, gender-based violence, sexual and reproductive health, rights, and stigma and discrimination, and keeps people living with HIV at the center of the HIV response.[1]

While only two of the conference action items and objectives mentioned above refer specifically to laws and criminalization of HIV, legal responses – laws, policies and practices – have a significant impact on each of them.

Prior to the Conference, the International AIDS Society, which organized the Conference, launched 'The Second Durban Declaration' – urging delegates to focus on five key scientific advances and five key structural barriers. The barriers included 'Address gender inequality and empower young women and girls' and 'Challenge laws, policies and practices that stigmatize and discriminate against people living with HIV and key populations'.
(http://www.iasociety.org/Second-Durban-Declaration)

INTRODUCTION

Worldwide, people living with HIV (PLHIV) and other key affected populations (KAPs) such as men who have sex with men (MSM), transgender people, sex workers, people who inject drugs (PWID) and prisoners are frequently stigmatized and discriminated against; subjected to laws that criminalize their behavior; and harassed and abused by police. As a result, KAPs often have a disproportionately high HIV prevalence when compared with the rest of the population, and the highest rates of new infections. In many contexts women and girls, and other populations such as migrants, are also population groups at higher risk of HIV infection.

Countries will certainly fail to achieve the 90-90-90 targets (see box) if they do not adequately address the rights of these at-risk communities.

AIDS2016 included a track titled 'Social and Political Research, Law, Policy and Human Rights.' The inappropriate application of the criminal law and its impact on the HIV response has been considered widely in the past. AIDS2016 included opportunities to share positive strategies and success stories addressing, for example, policing, harm reduction and law reform. Pre-conference sessions included two separate full-day events dedicated to the criminal law: HIV Justice Worldwide, *Beyond Blame: Challenging HIV Criminalization* and Ford Foundation and AIDS Accountability International, *Challenging Criminalization Globally*.

90-90-90 - an ambitious treatment target to help end the AIDS epidemic

Many of the conference presentations referred to the UNAIDS 2020 treatment target:
By 2020

- 90% of all people living with HIV will know their HIV status.
- 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy.
- 90% of all people receiving antiretroviral therapy will have viral suppression.

UNAIDS' epidemiological modelling suggests that achieving these targets by 2020 will enable the world to end the AIDS epidemic by 2030.
(http://www.unaids.org/en/resources/documents/2017/90-90-90)

LAW ENFORCEMENT AND HIV

The role of police in the HIV response received significant attention at the Conference. The International AIDS Society (IAS) and the Law Enforcement and HIV Network (LEAHN) launched a supplement of the *Journal of the International AIDS Society*, entitled "Police, Law Enforcement and HIV".[3] The Supplement contains examples of partnerships between police and civil society that are feasible and effective, and yield positive results. The IAS, IDLO and partners also hosted a roundtable with representatives of the police, civil society organizations, the donor community, medical experts, activists, and researchers, to discuss enhancing partnerships between law enforcement, criminal justice and HIV programs working with key populations in South Africa.[4]

[3] http://www.jiasociety.org/index.php/jias/issue/view/1481

[4] Scheibe, A., Naude, N., Marks, M., Patterson, D and Thomson, N. (2016) *Enhancing Partnerships between law enforcement, criminal justice and HIV programmes working with key populations: Opportunities in South Africa* (Round table meeting report)

CRIMINAL LAW: HIV EXPOSURE AND TRANSMISSION

Conference speakers from Uganda and Canada noted that exposure to fluids containing HIV during sexual intercourse may be sufficient to constitute an offence – actual HIV transmission is not needed for criminal charges in those countries. In Canada, the courts have decided that non-disclosure of HIV status vitiates consent to sexual intercourse, and hence can lead to charges of aggravated sexual assault. However, although laws criminalizing non-disclosure of HIV status, HIV exposure and transmission may have been developed with the intention of protecting people from HIV infection, their effect can be to put vulnerable people at even greater risk, as women are often first in their households to know their HIV status due to antenatal testing.

Similarly, laws that criminalize behavior (e.g. sexual conduct, sex work or drug use) also deter people at risk from being tested, resulting in disproportionately high rates of infection and deterring KAPs from accessing and being retained in care and treatment. The criminal law becomes an obstacle to frank discussions of sexual behavior and drug use in the health care provider – patient relationship.

Rates of HIV prevalence are further exacerbated when these populations are imprisoned, without access to condoms, safe injecting equipment, or ART if required. If KAPs and PLHIV cannot be linked into and retained in the HIV prevention and care continuum, the UNAIDS 90-90-90 targets will remain out of reach.

HIV EXCEPTIONALISM

When the syndrome known today as 'AIDS' was first recognized in Western countries in the early 1980s, it generated a unique public health response focused on the rights of those infected. This approach became known as 'HIV exceptionalism.'[5] Public health experts determined that the usual measures to contain an infectious epidemic: i.e., mandatory testing, isolation and quarantine, would be counter-effective in reaching the populations most at risk of HIV infection. Instead, a response based on counseling, protecting privacy and opt-in testing was recommended. These measures are believed to have been largely effective in preventing greater epidemics in the West.

HIV exceptionalism is also manifested in legal responses to HIV. Laws that protect the human rights of PLHIV, such as legislation specifically prohibiting HIV-related discrimination, are positive consequences of HIV exceptionalism.

HIV-specific laws that criminalize non-disclosure, transmission or exposure were also developed to protect people from HIV. However, the global experience has shown that punitive laws relating to non-disclosure, transmission and exposure have proven ineffective in reducing rates of new infection and instead have placed already vulnerable populations further at risk. Further, all HIV-specific laws (even where the consequences are positive) risk increasing HIV-related stigma.

Two key areas of HIV exceptionalism have been subject to debate since the concept emerged. The first concerns its applicability to all countries and contexts. While the approach was successful in keeping the HIV infection rates low in developed countries which applied it, some argue it has not been as effective at a global level.

For example, it has been suggested that an 'opt-in testing strategy' (whereby populations at greater risk of HIV infection are encouraged to be tested) is ineffective and inadequate in countries of higher

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http://www.leahn.org/wp-content/uploads/2016/10/161102-IAS-police-and-HIV-meeting-20-July-2016-report-low-res.pdf

[5] Julia H Smith and Alan Whiteside, "The History of AIDS Exceptionalism" (2010) 13 *Journal of The International AIDS Society* 47.

HIV prevalence. This is in part because stigma, discrimination or punitive criminal laws make it difficult for people to come forward for HIV testing. In these contexts, it has been suggested that there is a greater overall public benefit to adopt 'opt-out testing' (routine but non-mandatory testing of populations e.g. in antenatal and STI clinics), thus connecting more people to care and treatment.[6]

However, HIV testing can only significantly reduce new infections when populations identified as HIV-positive are retained in the treatment cascade – i.e. take ART consistently as directed – and thus attain a negligible viral load. Opt-out testing may lead to significant negative social and legal repercussions, particularly in contexts where medical confidentiality is not guaranteed. In these contexts, treatment adherence is more likely to fail. The anticipated benefits of testing and treatment need to be considered in the context of the social and legal harms that may result.

The second criticism of HIV exceptionalism is that it has resulted in disproportionate funding of discrete HIV programs, and drained resources from other diseases that result in more deaths (e.g. diarrheal diseases and tuberculosis) than AIDS in some contexts. At worst, it may have undermined health systems.

As a result of these criticisms, some countries have redirected HIV funding to other programs, indicating a shift away from prioritizing HIV as a global issue. There have also been calls for the Global Fund to Fight AIDS, Tuberculosis and Malaria to be transformed from a disease-specific fund to a more general global health fund, with HIV being only one of many health issues requiring global resources.[7]

KEY PROGRAMS AND HIV EXCEPTIONALISM

In 2012 UNAIDS released *Key Programmes to Reduce Stigma and Discrimination and Increase Access to Justice in National HIV Responses*.[8] This Guidance Note identified seven key human rights-based programs aimed at reducing stigma and discrimination and increasing access to justice. UNAIDS recommended that these programs be implemented in every national HIV response plan, as follows:

1. Stigma and discrimination reduction, using approaches such as use of community interaction and media to educate and integrate non-stigmatizing messages, and peer mobilization and support for and by PLHIV;
2. HIV-related legal services, providing legal referrals, representation and engaging traditional leaders to resolve disputes and change harmful traditional norms;
3. Monitoring and reforming laws, regulations and policies relating to HIV, to see whether they have a positive or negative impact on HIV response, advocating for reform, and promoting a legal environment that prohibits discrimination and supports access to treatment;
4. Legal literacy, to teach PLHIV about laws affecting them through awareness media campaigns, peer outreach and community mobilization;
5. Sensitization of law-makers and law enforcement agents through training for personnel, information and sensitization sessions, facilitated discussions and development of HIV in the workplace programs;
6. Training for health care providers on human rights and medical ethics related to HIV, raising awareness of health care providers of their own human rights in an HIV context, reinforcing

[6] Michael April, "Rethinking HIV Exceptionalism: The Ethics of Opt-out HIV Testing in sub-Saharan Africa" (2010) 88 *Bulletin of the World Health Organization* 703.

[7] Julia H Smith and Alan Whiteside, "The History of AIDS Exceptionalism" (2010) 13 *Journal of The International AIDS Society* 47.

[8] http://www.unaids.org/sites/default/files/media_asset/Key_Human_Rights_Programmes_en_May2012_0.pdf

importance of patient confidentiality and informed consent, ensuring health care administrators equip staff adequately and that regulators enact and implement policies that protect safety and health of patients and workers; and

7. Reducing discrimination against women in the context of HIV, by strengthening the legal and policy environment to protect women and girls from gender inequality and violence, aiming to reform property, inheritance and custody laws, supporting age-appropriate sexuality and life skills programs and integrating health services within a functioning referral system.

Conference speakers presented on a range of human rights-based programs which align with the seven key programs set out in the UNAIDS Guidance Note. Advocating for law reform is one avenue for addressing punitive and ineffective legislation, and some examples of successes included a Constitutional challenge to HIV-specific provisions in Kenya and the repeal of HIV-specific legislation in Victoria, Australia. However, it was frequently noted that legislative reform can be slow and changes to laws may bring about unintended consequences. Conference speakers gave insights into a range of initiatives offering alternatives to legislative reform, including programs aimed at sensitizing police and the judiciary in issues affecting PLHIV, promoting harm reduction measures such as enabling needle exchange programs, abolishing mandatory arrest and/or sentencing for drug use, and educating police about the human rights of sex workers and MSM and transgender populations.

Policy reforms like South Africa's *South African National Sex Worker HIV Plan 2016-2019* [9] seek to implement programs such as peer education, psychosocial support, human rights, and economic empowerment to and for sex workers, despite aspects of sex work being criminalized. Creating an enabling legal environment makes it safer for KAPs to come forward for testing and promotes access to care and treatment. An enabling legal environment monitors and censures violence and abuses against vulnerable populations by police and other state actors. It decreases stigma and discrimination and enables community healthcare initiatives and peer-led mentoring programs and opens a space for civil society organizations to advocate for PLHIV and vulnerable populations. In these ways, the effective use of law can have a positive impact on national HIV responses.

Governments, health and development agencies, and civil society organizations seeking to implement these human rights-based programs must now do so in the context of current attitudes towards HIV exceptionalism and an apparent shift from disease-specific funds to more general global health funding. To secure health funding, such health and human rights programs may be required to demonstrate the cost-benefit justification based on their impact on DALYs (Disability-Adjusted Life Years) and overall disease burden.

THE IMPACT OF LAWS, POLICIES AND POLICING

Issues of law, policy and human rights were discussed in various sessions across the conference program. Many speakers discussed particular hardships faced by PLHIV due to discriminatory and stigmatizing legislation and sought to raise awareness about the ways in which laws, policies and policing detrimentally affect KAPs and contribute to their disproportionate vulnerability to HIV infection. Many of these speakers also reported successes in implementing programs or reforms which have had a positive impact on the lives of KAPs and PLHIV, and which have potential to be replicated or expanded upon elsewhere.

[9] http://sanac.org.za/2016/03/29/south-african-national-sex-worker-hiv-plan-2016-2019/

CRIMINAL LAW AND PEOPLE LIVING WITH HIV

Examples of criminal laws affecting PLHIV include legislation which criminalizes HIV transmission, exposure and non-disclosure. Participants provided examples from various regions of criminal laws affecting PLHIV, and their repercussions.

Ms Dora Kiconco Musinguzi (Uganda Network on Law, Ethics and HIV/AIDS (UGANET), Uganda) illustrated how devastating HIV exposure laws can be by sharing the story of a Ugandan nurse, Rosemary Namubiro, who is living with HIV. Ms Namubiro was prosecuted following an alleged needle stick injury involving a patient (a child) and sentenced to four years imprisonment, even though there was no HIV transmission. Although she was released after 11 months, the prosecution and sentence perpetuated the stigma and belief that HIV positive people are dangerous.

At the time of trial Uganda had an *HIV and Aids Prevention and Control Bill*, and Ms Namubiro's case was frequently cited in support of its passing. The Ugandan *HIV and Aids Prevention and Control Act 2014* came into effect in 2014, criminalizing nondisclosure, exposure and transmission.

When in 2006 a similar law was adopted in Kenya (*HIV and Aids Prevention and Control Act 2006)*, civil society organizations successfully pursued a constitutional challenge to the provision relating to the prevention of HIV transmission (s.24). The legislation had required any person who is aware they are HIV positive to inform any sexual contact in advance of that fact.

In the hope of similar success, civil society organizations in Uganda have raised a challenge to laws criminalizing HIV, based on the same arguments used in Kenya. They argue the Act undermines public health objectives of HIV prevention and control and contravenes the National Guiding Principles of Public Policy and the Constitution. Further, they challenge the application of the criminal law to HIV transmission on the grounds there is no evidence this decreases new infections. However, to date there has been no change in the relevant provisions.

In Canada the Supreme Court decision of *R v Cuerrier* [1998] 2 SCR 371 set a precedent that a person who fails to disclose their positive HIV status before commencing sexual activity commits a crime. Further, transmission is not required for prosecution to occur. Later, the court made it clear in *R v Mabior* [2012] SCC 47 that even if a condom is used and there is low or no detectable viral load, failure to disclose is still a crime. Ms Cecile Kazatchkine (Canadian HIV/AIDS Legal Network, Canada) advised that more than 180 PLHIV have been charged for non-disclosure in Canada and conviction rates are high. There is no HIV-specific criminal law in Canada. Instead, failure to disclose one's HIV infection is considered a fraud vitiating consent to otherwise consensual sex. The act becomes aggravated sexual assault (aggravated due to the "significant risk of serious bodily harm" of HIV transmission). This was a law intended to protect women against sexual violence. Yet the Supreme Court's interpretation fails to recognize mutual responsibility for HIV and other disease prevention in consensual sex. Nor does it take into account scientific and medical research which indicates low viral load and condom use virtually eliminates the risk of HIV transmission. It also harms the national HIV response by deterring people from knowing their HIV status, and accessing care, treatment and support if required.

Police and prosecutors in other countries without HIV-specific laws are also charging PLHIV for non-disclosure, transmission or exposure under general criminal laws. Some countries, like Australia, also have public health laws regarding non-disclosure and exposure that allow for the detention of PLHIV identified by healthcare providers as placing others at risk. The relevant legislation is broad, and people can be held in detention and/or isolation under public health orders with rights of review varying between the different Australian States. Other relevant criminal laws include provisions for compulsory HIV testing and involuntary partner notification.

Despite recognition that disclosure laws increase stigma and discrimination, deter people from being tested, and contribute to increasing rates of new infection, Ms Laurel Sprague (HIV Justice Network, United States) presented figures that showed worldwide, 72 countries (101 jurisdictions) still have

HIV-specific criminal laws relating to HIV exposure, transmission or disclosure. In Ms Sprague's view these laws are highly problematic as it is very difficult for people facing charges to prove they have disclosed their HIV status to their sexual partners, and charges are often brought where there has been no risk of transmission (including instances of biting and spitting.)

Such applications of the criminal law are unjust. Non-disclosure and exposure laws do not take into account available scientific and medical evidence relating to HIV; are contrary to principles of legal and judicial fairness; and infringe upon human rights. Globally there has been a trend towards greater use of the criminal law in the context of HIV, and efforts to have exposure and non-disclosure laws repealed have had little success to date. Legislative reform is often slow even where governments are willing to consider it, so other opportunities for addressing the increasing application of the criminal law to HIV may prove more effective and provide swifter benefits.

As well as lobbying directly for changes to legislation, or challenging legislation in the courts, Ms Sprague noted there is a wide range of potential advocacy targets for law. To broaden perspectives and drive education and sensitization campaigns about the rights of PLHIV, the Canadian HIV/AIDS Legal Network has created a short documentary in which eight women discuss the problems of using sexual assault laws to prosecute alleged non-disclosure of HIV status.[10] These include the detrimental impact on people's understanding of what constitutes consent, notions of mutual responsibility and the willingness of individuals to be tested and know their HIV status. The interviewees conclude that the use of sexual assault laws over-extends use of criminal laws in relation to PLHIV and threatens to damage hard-won legal definitions of consent developed to protect the rights and sexual autonomy of women. A companion guide to the documentary has been developed, which suggests ways in which the film can be used to spread awareness about the laws and how people can take action via campaigning, lobbying and writing opinion pieces to push for law reform.

Ms Sprague also referred to the release of a report on driving advocacy approaches to advance HIV justice: *Advancing HIV Justice 2: Building momentum in global advocacy against HIV criminalization.* The report was written by Edwin J Bernard and Sally Cameron on behalf of the HIV Justice Network and the Global Network of People Living with HIV.[11] The publication outlines good practice examples of targeted advocacy strategies aimed at ending the inappropriate use of the criminal law to regulate and punish people living with HIV. These include providing information to the judiciary and police about HIV-related issues, including the latest medical and scientific information about the risks of transmission. It also recommends advocating for alternatives to custodial sentences; the development of programs to support and reintegrate convicted people and prevent reoffending; and promoting the prevention of risk of prosecution by helping PLHIV better understand the legal issues affecting them, and their legal rights and responsibilities.

Resources such as these assist in educating both PLHIV (legal literacy programs) and people they come into contact with, such as police, prosecutors, prison personnel and the judiciary. Resource topics include the human rights of PLHIV, and the need to eliminate discrimination and stigma so PLHIV or people at risk of HIV feel safe to seek testing and enter treatment programs without fear of prosecution.

CRIMINAL LAW AND KEY AFFECTED POPULATIONS

The criminal law also affects KAPs in a multitude of ways that impact on the HIV response. During the opening plenary, Justice Edwin Cameron (South Africa) called on governments to deliver on their human rights obligations and for the removal of laws that hinder the HIV response, including laws

[10] http://www.consentfilm.org/watch-the-film-discussion-guide/

[11] http://www.hivjustice.net/advancing2/).

criminalizing same-sex sexual conduct, and laws criminalizing sex work. He encouraged harm reduction measures, such as providing PrEP to sex workers as a national policy (c.f. The South African National AIDS Council, *South African National Sex Worker HIV Plan 2016-2019*) and the availability of needle and syringe programs for PWID.

As well as KAPs, women in resource-limited settings are particularly vulnerable to HIV, and domestic and intimate violence compound this vulnerability. Child marriage further increases the risk of HIV transmission, so any legal response seeking to reduce HIV incidence must also tackle child marriage. In countries where criminal laws demand disclosure, women need further protection from violence so they can disclose their status safely. As noted above, women are often first in their households to know their HIV status due to antenatal testing, and are then blamed for HIV transmission to children and partners.

Maurine Murenga (The International Community of Women Living with HIV, Kenya) noted that this places women with HIV in a precarious position within their families and communities. Many women with HIV in Kenya have been forced to leave their matrimonial homes and have become homeless. Many women have had forced sterilization, coerced sterilization, or sterilization without their knowledge during caesarian delivery. Women with HIV have also been threatened with the denial of HIV treatment by health services if they refuse to be sterilized. Ms Murenga noted that women and girls continue to be subjected to rape, female genital mutilation, abuse, intimidation, stigma, rejection and disinheritance, which not only affects their risk of contracting HIV but increases its impacts.

> While we may have medically tamed AIDS, we've not "tamed the social and political determinants of HIV, particularly the overlapping determinants of which it thrives – gender, education, access to health care, access to justice".
>
> *Edwin Cameron, Constitutional Court of South Africa*

Mr Amitrajit Saha (UNDP, Ethiopia) reviewed the findings of the *Global Commission on HIV and the Law: Risks, Rights and Health* (July 2012). The Commission's Report found that medical interventions cannot stop the HIV epidemic without the support of an enabling legal environment. The Report included recommendations to:

- Legalize sex work and create safe conditions for sex workers;
- Remove criminal laws affecting MSM (e.g. sodomy laws) and remove legal barriers to forming community organizations for the MSM community;
- Repeal laws criminalizing transgender identity or associated behaviors and remove legal barriers to forming community organizations for them;
- Remove mandatory arrest requirements for PWID and ensure prisoners get access to treatment for HIV; and
- Ensure migrants have access to treatment and preventive commodities which are available to national residents.

Four years on, he noted that 13 countries still have the death penalty for same-sex sexual conduct; sex work is illegal in 109 countries and laws are widely used to harass (rather than arrest) sex workers; 15 countries still have death penalties for PWID; and 11 have compulsory detention laws. Laws that criminalize gender identity or associated behaviors prevent KAPs from accessing information, services, healthcare and commodities. The criminal law leads service providers to refuse treatment for fear of legal ramifications; violence against KAPs by state actors or non-state community actors; and to hostile, harmful policing.

Speakers presented insights from their own regions of how KAPs are disproportionately affected by HIV and the impact of unjust laws and harmful policing. While the context varies in each country, key populations globally share an extremely high risk of acquiring HIV. For example, Mr Cyriaque Yapo Ako (International Centre for Humanitarian Actions Networking and Grassroots Empowerment,

Cote D'Ivoire) noted PWID have HIV prevalence of 87% in Libya; and sex workers have HIV prevalence of 58% in Rwanda. Mr Steeve Laguerre (FHI 360/LINKAGES, Haiti) reported that HIV prevalence in Haiti is 2.2% in the general population, but 8.7% in female sex workers, and 12.9% among within the MSM community. As seen in many other examples, stigma and discrimination have a deleterious effect on uptake of HIV services within these KAPs. Ms Nittaya Phanuphak (Thai Red Cross AIDS Research Centre, Thailand) provided a case in point, as HIV testing coverage is less than 30% among MSM and transgender women in Thailand, and these populations accounted for 50% of new infections annually.

There appears to be little political will in many countries in Eastern Europe and Central Asia to recognize or consider the need to address HIV prevention among MSM, transgendered people or sex workers. Ms Jennifer Butler (UNFPA, Turkey) reported very high prevalence in these KAPs in Eastern Europe and noted that many MSM in this region are married with children. Stigma and discrimination mean many KAPs do not identify themselves as at risk of HIV infection, and do not seek HIV testing. Police violence against sex workers is a significant problem and other state-sponsored harassment and abuse is rife. Other contributing factors believed to contribute to the increasing prevalence of HIV in the region include restrictions on migration; punitive laws targeting NGOs assisting KAPs; criminalization of homosexual acts, HIV transmission, sex work and drug use; and the distribution of anti-gay propaganda. All of these factors, combined with a lack of enabling legislation and funding for HIV prevention, make it very difficult to get people at risk of HIV to get tested. Adherence and retention in health care is also very low.

Many countries still refuse to acknowledge the rights of civil society organizations representing MSM. As a result, they cannot be registered unless under the guise of an HIV organization. Mr Kenechukwu Chimobi Esom (African Men for Sexual Health and Rights (AMSHeR), South Africa) commented on the vagueness of laws across Africa affecting MSM and other same sex intimacy, which all relate to laws regulating conduct 'against the order of nature'. Homosexuality is not criminalized itself per se, but the act of sodomy is. In these countries, MSM access to condoms is still low, and access to condom-safe lube even lower. Lucinda O'Hanlon (Office of the High Commissioner for Human Rights, South Africa) reported that in countries where sodomy laws are still in place, healthcare workers are often not trained in treating anal STIs. Safer-sex counselling is often denied because healthcare providers are concerned they will be complicit in promoting illegal sexual activity.

To achieve prevention equity, HIV testing and prevention programs must be developed and delivered in ways that address the needs of populations at higher risk. KAPs experience disproportionate levels of violence, are marginalized due to stigma, and face criminal penalties due to same-sex activity, drug use and sex work. This limits their access to HIV services and makes health providers reluctant to reach out to them.

Despite the evidence that transgender populations, like other KAPs, are at a higher risk of infection, have lower enrolment and retention in treatment, and have greater rates of mortality, Mr Ako pointed out that transgender people are not included in 60% of National Strategic HIV Plans. Further, in the past the predominant discourse about HIV has focused on MSM, making it impossible in countries where laws against sodomy are in place to talk about HIV without stigmatization and discrimination. Because of the dominance of MSM and HIV in the discourse to date, very little research has been done on transgender men and lesbians and HIV.

Sex work is criminalized in many countries, which has contributed to the rise in HIV. The human rights of sex workers to access HIV prevention, care and treatment services are largely overlooked in these countries and criminalization makes it hard for sex workers to access their rights. Mr John Jeffery (Department of Justice, South Africa) made it clear that the repeal of legislation criminalizing sex work was not on the agenda in South Africa, but other legislative and diversionary programs were being considered instead. Models under review include the Nordic and French models, which criminalize the purchasing of sex rather than the selling of it. Ms Ruth Morgan Thomas (Global Network of Sex Work Projects, United Kingdom) presented research that indicated that 70% of

violence against sex workers results from state organizations such as police. The criminalization of third parties, and other tactics such as diversion programs are all deeply offensive to sex workers and deny them any autonomy and self-deliberation. She noted that the conflation of sex work and sex trafficking undermines the ability of migrants to move and perform sex work.

Establishing appropriate legal strategies for population affected by the criminal law is very difficult, and law reform is often a slow process. Even where reform takes place, new laws are ineffective without reducing stigma at the same time. For example, Ms Ishtar Lakhani (Sex Worker Education and Advocacy Taskforce (SWEAT), South Africa) noted that same sex marriage is now legal in South Africa but legalizing same sex marriage has increased hate crimes against the LGBTIQ community. Ms Lakhani pointed out that, while decriminalization of sex work is the ultimate goal, a change in laws won't necessarily mean a change in behaviors, and that other tools and strategies are also necessary to effect societal change.

GOOD PRACTICE EXAMPLES

Participants discussed many programs designed to meet the particular needs of KAPs, and which could be replicated and scaled up. Programs varied considerably in approach, from policy reform efforts aimed at governments and the judiciary, to harm-reduction needle exchange services, police sensitization training, and community-based and peer-led mentoring.

POLICY REFORM

Policy reform programs included the UNDP's development of Legal Environment Assessment Tools to assist governments, civil society and other key stakeholders to develop evidence-informed policy and strategy based on human rights considerations. The UNDP also has judicial programs, giving judges a forum to discover and discuss scientific information and case law, and helping them to make informed decisions about KAPs. National dialogues have been facilitated by the UNDP in more than 60 countries, and the UNDP has been working with government and civil society groups and NGOs to get action plans endorsed and implementation programs under way.

SEX WORK

In relation to sex work, Dr Mandeep Dhaliwal (UNDP, United Kingdom) highlighted the following successes:

- Viet Nam committed to stop detention of sex workers by 2013 after advocacy by UNAIDS, UNDP, UNFPA, UNICEF, UNODC, and WHO, supporting civil society efforts.
- In China, UNDP and UNFPA cosponsored the first Red Ribbon Forum on the rights of sex workers, and also produced policy briefs for political leaders.
- In the Democratic Republic of Congo, civil society activists successfully advocated for lubricants to be included in the national health commodities list. UNDP provided capacity building for this initiative.

Another large-scale program is the South African National Sex Worker HIV Plan, launched by the South African Deputy President and Chair of SANAC Mr Cyril Ramaphosa on 11 March 2016. The Plan aims to reduce HIV, STI and TB incidence and mortality among sex workers; and to reduce human rights violations experienced by sex workers. The plan aims to deliver six core packages of intervention: peer education; healthcare; psychosocial support; human rights; social capital building; and economic empowerment. The Global Fund to Fight AIDS, Tuberculosis and Malaria and the United States' President's Emergency Fund for AIDS Relief (PEPFAR) have funded the plan, which is

intended to reach more than 40,000 sex workers to initiate treatment, improve data mapping and surveillance, and scale up sensitization and clinical training efforts. A chapter on sex workers is being added to a manual for KAPs, which will be used to sensitize health, social, legal and other service providers in an effort to reduce stigma and discrimination experienced by sex workers. Further, an advocacy body has been established to lobby for decriminalization of sex work and to encourage and empower sex workers to participate actively in public process and discussions about law reform.

KEY AFFECTED POPULATIONS

In Senegal, Environment Development Action in the Third World (ENDA) has facilitated meetings between ministers for health and members of the judiciary to discuss responses to HIV and KAPs. Mr Daouda Diouf (ENDA, Senegal) spoke about program development targeting KAPs and aimed at increasing access to services. Civil society-led organizations are collaborating with government and human rights organizations to advance an agenda on human rights for KAPs, especially regarding access to legal services and engagement in health programs. This has resulted in religious leaders discussing human rights and KAPs with civil society organizations for the first time. Where KAPs have been arrested, ENDA has also mobilized legal assistance to keep KAPs out of detention and to encourage harm reduction responses.

STRATEGIC LITIGATION

Mr Richard Elliott (Canadian HIV/AIDS Legal Network, Canada) warned that in some cases there is little hope of changing laws via lawmakers so other approaches to drive change are necessary. For example, the Jamaican buggery laws are very disabling for HIV prevention among MSM, but there is very little appetite for law reform within the Jamaican legislature. High levels of homophobia exist in public opinion and mobilized religious groups work against reform efforts. As a result, penalties have been increased for gross indecency, and convicted people are registered as sex offenders. Where there is an independent, non-corrupt judiciary, and an institutional respect for the rule of law, then the court may help to reform laws.

Successes in Canada include a Constitutional challenge to criminal laws relating to sex work over occupational health and safety concerns, and a Canadian Supreme Court order to re-open safer drug consumption services for PWID in Vancouver. The Supreme Court has also supported harm reduction services in prisons and mandatory prison sentences for drug use are now under legislative review. However, in Russia, courts will not recognize the overwhelming public health benefit of methadone programs despite the very high HIV prevalence in PWID. A best practice approach in these hostile legal environments involves seeking out lower level changes, e.g. having policy guidelines in place, or pushing for prosecutorial guidelines to be developed even where there is no change to statutory provisions.

POLICE

A number of sensitization programs involving police were discussed during the conference. Police come into contact with PLHIV in many ways and often with some of the most vulnerable populations affected by criminal laws, so they can play a significant role in an effective HIV response. Training police to understand and abide by harm reduction policies, despite the presence of laws criminalizing drug use, sex work or same-sex sexual conduct, has proved effective in a number of jurisdictions with high HIV prevalence amongst KAPs.

Mr Ahmed Shehata (International Development Law Organization (IDLO)) provided examples from the Middle East and North Africa where IDLO has worked with civil society organizations who engage police to obtain better outcomes in the HIV response. A large number of police in Egypt and Algeria have been trained on different aspects of HIV; Tunisian police now divert PWID to health services, rather than detain them; in Lebanon PWID organizations have had roundtable meetings with police, lawyers and other KAPs to develop strategic approaches; and in Jordan TV and other media are used to promote PLHIV rights, sending a message to both law enforcement officials and the communities they serve.

Ms Olga Belyaeva (Manager, Membership and Community Strengthening Team, Eurasian Harm Reduction Network (EHRN)) described an innovative, community-based, regional project jointly coordinated by EHRN and Eurasian Network of People Who Use Drugs (ENPUD) and the Robert Carr Foundation, aimed at challenging repressive laws affecting PWID and working with police to apply a harm reduction policy. PWID are afraid of police and of seeking help from healthcare services. To assist them, the project has 11 street lawyers deployed to help where arrests are made, and to document and analyze issues identified during arrests for the purpose of educating police. The street lawyers also provide legal advice at the time of arrest. Online interactive training modules have been prepared for police on police violence, and more than 500 people have been involved in the program over 3 years. Evidence has been gathered of violations and abuse, and police who respect human rights are encouraged to be peers to their colleagues and offered training and mentoring. Initially, the program only showed the bad side of policing, so EHRN started to showcase police who were advocates of human rights and promote the positive side of policing. This best practice approach has helped change the attitudes of police and has had a positive impact within the community, with fewer abuses now occurring.

Mr Edo Agustian (Persaudaraan Korban Napza Indonesia, Indonesia) discussed the Indonesian Drug User Network, which provides harm reduction services for PWID and KAPs e.g. MSM and transgender people across 11 provinces. They have community-led monitoring services and a peer paralegal program, which ensures PWID have access to legal services when they come into contact with police. The Network aims to ensure that responses to PWID are evidence-based, humane policies and not based solely on government regulations nor ideas of morality. They seek to develop strategic partnerships and work collaboratively with government, civil society, private sector and other stakeholders. They have also developed the first training program in Indonesia to increase awareness amongst PWID about risks of HIV, viral hepatitis, and TB co-infection.

In Ghana, police receive training on how to deal with KAPs, with a test that they must pass in order to enter the police service. Once employed, any police officer caught harassing KAPs can be sanctioned by the Minister and potentially dismissed. Mr Thomas Salifu Ndeogo (Ghana Police Hospital, Ghana) explained that to encourage police to take a harm reduction approach and not arrest sex workers for carrying condoms, all Ghanaian police carry a 'condom pouch' on their utility belts, filled with condoms. The logic behind this novel, best practice approach, is that no-one arrests police for carrying condoms, so why should they arrest others for that same reason? It helps give police a different perspective and an understanding of how to use discretion in using their arrest powers. Another example of good practice was provided by Associate Professor Lillian Artz (Gender, Health & Justice Research Unit, Faculty of Health Sciences, University of Cape Town, South Africa): despite disabling buggery laws and criminalization of sex work, Jamaica also has implemented diversity police training and officers can face disciplinary action for breaches.

In Kenya sex workers' groups have established programs involving police, which started initially as a type of community policing, with sex workers helping police to identify and locate criminals. There are now 20 police peer educators who are a point of contact if sex workers have an emergency. Mr Patrick Eba (Human Rights and Law Advisor, UNAIDS) reported that the program aims to have training about sex work included in the police national training program, to ensure police understand sex workers' rights and the community and economic benefits of respecting their human rights and

not over-policing.

Similarly, in Uganda the Uganda Harm Reduction Network (UHRN) has encouraged police officers to take a harm reduction approach to policing. Mr Wamala Twaibu (Uganda Focal Point, Law Enforcement and HIV Network (LEAHN) and Executive Director of UHRN) pointed out that Uganda has very tough drug laws. UHRN has established a community policing/neighborhood watch program so people can report crimes to the police, and police work with the community to help identify and locate criminals. UHRN also assists PWID by having face-to-face meetings when PWID are arrested, to explain the benefits of harm reduction and aim for diversion programs rather than criminal charges. Working with LEAHN has helped to get police on board and there is evidence that this approach works. UHRN aims to ensure there is a focal person in each region for sex workers and PWID, so they have a contact they can turn to.

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