The rights of people living with HIV and AIDS; the right to freedom from discrimination; vulnerable groups.

Hearing European Parliament, Brussels, December 11, 2008

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I. Introduction.

Good morning everyone.

It is an honor to speak to you today about why protecting human rights of socially marginalized people must be central to the struggle against HIV.
A few days ago I left the ICASA HIV/AIDS conference in Dakar, Senegal, where I spoke to many people living with HV from a range of African countries. For my presentation I draw upon their experiences because they were inspirational to me.

Yesterday the world celebrated the 60th Anniversary of the UN Declaration of Human Rights. Center to the meaning of human rights is the principle of universality. Human rights are for all people, nobody excluded. They are indivisible.

Unfortunately there are many governments around the world that treat human rights like a menu in a restaurant. They pick and choose what they like, but they don't respect the rights of socially marginalized groups – those whose social status marks them for discrimination, repression, and violence.[RS1].

In my presentation I would like to focus on a few of the most vulnerable categories in relation to HIV and AIDS: **Men having Sex with Men (MSM), women, injecting drug users, and people affected by the criminalization of HIV transmission. Needless to say, these are overlapping not exclusive populations. In closing I will speak about the Yogyakarta Principles as offering a way to ensure and protect the fundamental rights of marginalized populations.**

II. MSM and HIV and AIDS.

Although HIV is widespread among men who have sex with men in many countries, in many regions, HIV/AIDS is transmitted primarily through heterosexual sex,. However, because HIV is considered a "gay disease" in many parts of the world, many people who do not engage in homosexual sex think that they have no reason to worry about HIV, or they shun HIV-related information and services because they are afraid of stigma or abuse. Conversely, because some countries do not acknowledge the existence of lesbian, gay, bisexual, and transgender (LGBT) people, HIV and AIDS awareness and healthcare programs target only heterosexual individuals, effectively denying HIV information for many men who have sex with men and women who have sex with women.

When MSM or gay, lesbian, and transgender people do seek treatment or prevention services, they often face institutional discrimination by healthcare professionals who provide substandard services and sometimes refuse to treat them. The fear that healthcare workers will disclose their sexual orientation and put them at risk of homophobic violence by others keeps many from seeking healthcare services altogether. More than 85 countries still uphold anti-sodomy laws that criminalize consensual homosexual conduct between men and often

between women, impeding access to HIV/AIDS services by placing people at risk of legal penalties.

According to data from UNAIDS it is estimated that at least 5-10 % of HIV infections worldwide occur through sex between men, though this figure varies considerably between countries and regions. In the United States 50% of new HIV-infections occur within the homosexual community. Especially in communities where homosexuality is not accepted, MSM also have sex with women, while living their clandestine lives. So it is clear that also girls and women are at risk.

On the converse, UNAIDS experience reveals that recognition of the rights of people with different sexual identities both in law and practice, combined with sufficient, scaled-up HIV programming to address HIV and health needs are necessary and complementary components for a successful HIV response. Worldwide, anecdotal evidence highlights that in many countries where sex between males is not criminalized and where stigma and discrimination have been reduced, MSM are more likely to take up HIV prevention, Care and Support and Treatment Services.

In 7 countries in the world, homosexual behavior is a capital crime. In about 77 countries it is criminalized with prison sentences up to life imprisonment. In such a context homosexual men and women are afraid to come out of the closet. They do not want to incriminate themselves. and become outcasts in their society. The criminalization of homosexual conduct makes these groups more vulnerable to HIV, even as it drives them underground.

[I would delete the Uganda example – it's too long and includes too many names. See attached OHCHR submission for other examples.]

Let me give you the example of **Egypt.** Waves of arrests led to the detention of homosexual men earlier this year. While in jail, doctors joined the witch-hunt and performed mandatory AIDS-tests without the consent of the detainees. The result of the test and the answers to the questions the doctors asked, were included as evidence in the criminal files. Doctors from Egypt's Forensic Medical Authority performed forcible and abusive anal examinations on the men to "prove" they had had sex with other men. The prisoners who were tested HIV-positive were held in hospitals, chained to their beds, for months. The arrests are still going on.
This is no climate for an effective HIV response.

On www.hrw.org/lgbt you can find much more information about Egypt and Uganda and many other countries.

V. Criminalization of HIV transmission

Many countries throughout the world criminalize exposure to or transmission of HIV. In fact, these laws are widespread in the global North and have been widely used – including in several of these United States.

[I think it important to use an example from the global North, where these laws have been used, in addition to or instead the example below. While the model law in Africa has potential to do damage by inscribing broad criminalization provisions in national laws in many countries (and has been adopted in some), I'm not aware of prosecutions based on this law as yet. By contrast, there have been a wealth of prosecutions for HIV "exposure" – including spitting -- in places like the US, Canada, the UK (among others) that already have done significant harm. I've attached Edwin Cameron's plenary speech from the Mexico City AIDS Conference about criminalization, which mentions a recent awful Texas case that you should mention.]One so called "model" statute that criminalizes HIV transmission has been adopted by as many as 11 African countries. The model law requires those who knew they have HIV to inform "any sexual contact" in advance- without defining "sexual contact". In the majority of cases the virus spreads when two adults have consensual sex, while neither of them knows that one has HIV. Criminalization will not stand in the way of the vast majority of HIV transmissions.

What is needed is not criminalization but effective prevention, protection against discrimination, reduced stigma, strong leadership and role models and greater access to testing and treatment. These laws criminalizing HIV transmissions are counterproductive. In Sierra Leone for instance the law requires a person who is aware of the fact that he /she is living with HIV to "take all reasonable measures and precautions to prevent transmission of HIV to others". The law explicitly covers a pregnant woman. She can be jailed if she did not take reasonable measures to prevent transmitting HIV to her foetus.
Mostly women are aware of their status because most testing occurs at ante natal healthcare sites. So these bad laws victimize, oppress and endanger women; they drive women away from access to HIV prevention and treatment.

IV. Women.

The HIV pandemic is taking a catastrophic toll on women and girls throughout the world. Women and girls account for about half of all people living with HIV in the world, and the majority of people living with HIV in sub-Saharan Africa. The rising number of HIV infections among women and girls is directly related to violence against them, and to their unequal social, legal, and economic status.

Gender-based violence and discrimination against women are widely recognized as factors that fuel the HIV pandemic, yet their impact on treatment has scarcely been explored. Human Rights Watch's research has found that gender-based abuses put women at risk of HIV, impede women's ability to access HIV information and testing and to start or continue using lifesaving antiretroviral therapy, and that governments have failed to recognize and adequately address the ways in which such abuses hinder women's HIV treatment.

VI. Injecting drug users.

Outside of sub-Saharan African, nearly one-third of all new HIV infections can be traced to the sharing of contaminated syringes by people who inject drugs. And within sub-Saharan Africa, injection drug use is increasing.

International health and drug-control agencies - including the UN Office on Drugs and Crime, UNAIDS, and the World Health Organization - all endorse comprehensive harm reduction services, including needle and syringe exchange and medication-assisted therapy (for example, with methadone), both inside and outside prisons, as essential to address HIV among people who use drugs.

Yet harm reduction services remain out of reach for the vast majority of drug users worldwide.
In many countries police routinely interfere with HIV prevention information and services for drug users, including by harassing, beating and arresting drug users and outreach workers at needle exchange points and at pharmacies. Methadone and buprenorphine therapy are banned or not used in at least a dozen eastern European and central Asian countries, which have a significant percentage of injection drug users . Such state-sponsored interference with harm reduction services drives drug users away from lifesaving HIV services, and undermines efforts to curb the spread of HIV and indirectly furthers the structural social factors (discrimination, stigma and isolation) associated with it.

III. The Yogyakarta Principles.

States have the obligation to provide the best health care possible to all people.

The Yogyakarta Principles, a set of principles on the application of international human rights law in relation to sexual orientation and gender identity, codify all existing human rights. See www.yogyakartaprinciples.org

Principle 17.
Everyone has the right to the highest attainable standard of physical and mental health, without discrimination on the basis of sexual orientation or gender identity.

In the recommendations the Yogyakarta Principles advice that States shall take all necessary legislative, administrative and other measures to ensure enjoyment of this right and to ensure that all persons have access to healthcare facilities, goods and services.
Clearly, Egypt and Uganda violate this Principle.

But also other countries.

In countries where a different sexual orientation or gender identity is met by social stigma, like in Russia or other eastern European countries, vulnerable groups like Men having Sex with Men (MSM) will not be easily reached by AIDS-workers.

Principles 3, 7, 19, 20, 21, 22, 25 and 27.
In order to obtain equal rights and be refrained from discrimination governments should allow the LGBT-community to organize, to express their opinion, to express their sexual orientation without repercussions, to grant them freedom of assembly and movement. Rights the LGBT-community does not have in Russia at the moment. Capacity building and empowerment of the LGBT community is benevolent for health issues in any given country.

When new policies will be developed to include MSM, but also other vulnerable groups like transgenders, sexworkers and injecting drug users in health programs, it is crucial that one realizes that these are distinct groups, each with their own history and social codes. Each group requires specific attention. Effective policies can only be developed with the input of the groups themselves in order to obtain the highest attainable standard of physical and mental health as described in principle 17.

Training nurses, doctors and other health care workers at particular venues to improve their out-reach and diagnose skills for STI and HIV work with MSM is an effective translation of the human rights principle that national programs should recognize and respond the needs of the most marginalized.

Organizations involved in planning global and regional HIV responses like Country Coordinating Mechanisms and National AIDS Control plans must ensure that HIV-related services are available to MSM and that funds dedicated to these services at the national level are proportional to the impact of HIV on MSM in that country. National AIDS Commissions and other bodies should monitor the way the money is spent.

In order to develop adequate policies it is important to include MSM in national surveillance and independent epidemiological and behavioral research studies.

Such an approach amounts to the highest attainable standard of physical and mental health as listed in Principle 17 of the Yogyakarta Principles.

Conclusion:

Next week, on December 15th, 2008 more than 55 countries from all over the world will read a statement at the General Assembly of the UN in New York to address human rights violations based on sexual orientation and gender identity.

This statement builds on a long record of UN action to defend the rights of lesbian, gay, bisexual, and transgender people. In its 1994 decision in *Toonen v Australia,* the UN Human Rights Committee—which interprets the International Covenant on Civil and Political Rights (ICCPR), one of the UN's core human rights treaties—held that human rights law prohibits discrimination based on sexual orientation. The Committee also noted that criminalization of homosexual practices hampered HIV prevention "by driving underground many of the people at risk of infection." The Committee has thus urged states to bar discrimination based on sexual orientationSince then, the UN's human rights mechanisms have condemned violations based on sexual orientation and gender identity, including killings, torture, rape, violence, disappearances, and discrimination in many areas of life. UN treaty bodies have called on states to end discrimination in law and policy.

In the spirit of the Universal Declaration of Human Rights we need to make sure that there will be ***universal*** access to HIV prevention, treatment, care and support. No groups of people excluded.

We need multiple strategies to realize this basic human right.

Human Rights Watch calls upon the European Parliament to use its influence within Europe, but also within third countries to :

- stimulate a human rights approach with a particular emphasis on ensuring that the most marginalized and most at risk populations are ensured equal access to, and thus can benefit from, national HIV responses,

- address the situation of women so they won't be as vulnerable to HIV/AIDS anymore,

- stop criminalizing people based on their status – based on their sexual orientation and gender identity; because of their HIV-positive status; or because they are identified as drug users – and take concrete steps to remedy the social exclusion and marginalization members of these groups, which puts them at highest risk of HIV. As Jonathan Mann, the first director of the World Health Organization's Global Programme on AIDS, first recognized in a sustained way, respect for, and protection of, the rights of all people is essential to HIV prevention and treatment, and thus critical to protecting the health of all.

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