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HIV/AIDS AND THE RULE OF LAW
Rights Here, Right Now



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Introduction

Why Rights, Why Here, and Why Now?

By Shelley D. Hayes

The HIV/AIDS pandemic presents a stark example of the nexus between human rights and health. This first became evident when government responses to HIV/AIDS subjected people living with the disease to violations of their rights to liberty, privacy, freedom of association, nondiscrimination, and equality before the law.

—Lesley Stone and Lawrence O. Gostin, *Human Rights* magazine, Fall 2004

The nexus between human rights and HIV/AIDS is much the same today as it was in 2004 when this magazine last focused on the issue.

And, yet, every day brings new challenges to the forefront as lawyers and their allies strive to address the continuing legacy of the virus. In the pages that follow, we hope to shine a light on the human rights issues at home and around the globe that continue to fuel this epidemic.

Speaking broadly, human rights are concerned with defining the relationship between individuals and the State. The modern human rights movement dates back sixty years to the adoption of the Universal Declaration of Human Rights by the newly created United Nations on December 10, 1948. It is an aspirational document, growing out of the atrocities of World War II. A number of international human rights treaties further expand the rights set out in the declaration.

HIV is the retrovirus—one that incorporates its genetic code into host cells—that causes AIDS by infecting the T or “fighter” cells of the immune system. Although many scientists believe that HIV has been with us since the 1950s, it is undisputed that by 1982 it had been detected on five continents. Yet, despite nearly thirty years on the world stage, and billions of dollars allocated to its eradication, HIV now has burrowed deep into the fabric of our lives. In many resource-rich countries, its presence is not obvious, existing as it does just below a cloak of prosperity. In many resource-poor countries, HIV seems to be everywhere. In both, there rests in the State an obligation to ensure that “Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services” (Art. 25, Universal Declaration of Human Rights). And, in both, populations made vulnerable by the happenstance of birth or immutable characteristics, or by what some may view as non-normative behaviors, find that the actions of the State are lacking as the risk of premature death from AIDS is ever increasing.

While HIV knows no boundaries in whom it attacks, since the beginning of the epidemic, racial, ethnic, and sexual minority groups have been disproportionately affected, now making up the majority of new AIDS cases, new HIV infections, people living with HIV/AIDS, and deaths from AIDS, largely due to the social determinants that affect disease outcomes. Those social determinants include socioeconomic status, discrimination by social grouping, housing, transportation, access to services, and others. It is no accident, then, that some African countries, parts of Central America, and the Caribbean are experiencing a “generalized” HIV epidemic—one in which more than 1 percent of the population is HIV-positive. Here at home, more than 1 million people currently are living with HIV, with more than 56,000 new infections

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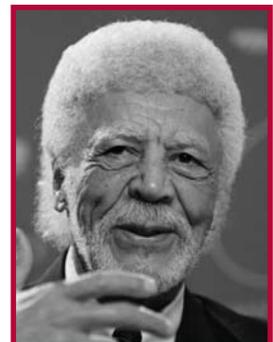
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Rights Here, Right Now

By Julio Montaner and Brigitte Schmied

An estimated 25,000 participants will soon gather in Vienna for the XVIII International AIDS Conference (AIDS 2010) under the banner of Rights Here, Right Now, declaring the fundamental importance of protecting and promoting human rights as a prerequisite to a successful response to HIV. This year also marks the deadline world leaders set for attaining universal access to HIV prevention, treatment, care, and support. Just as the lack of financial resources has been a major barrier toward achieving this goal, human rights violations and the absence of legal protections have also significantly hindered progress.

Vienna was selected as the site for AIDS 2010 in large part because of its proximity to Eastern Europe and Central Asia (EECA), home to the world's fastest-growing HIV epidemic, and a region where the role of human rights violations in fueling the epidemic is clearly evident. People who inject drugs, sex workers, women, people in detention, and men who have sex with men (MSM) all bear the brunt of discriminatory policies and programs that too often deny them access to the HIV services they need. People who inject drugs represent more than 80 percent of HIV cases in EECA, but only 14 percent of those receiving antiretrovirals. HARM REDUCTION DEVELOPMENTS 2008: COUNTRIES WITH INJECTION-DRIVEN HIV EPIDEMICS (2008). Recent field assessments in five EECA countries also found that women who use drugs face gender-specific barriers to accessing harm-reduction and drug-treatment services. WOMEN, HARM REDUCTION, AND HIV: KEY FINDINGS FROM AZERBAIJAN, GEORGIA, KYRGYZSTAN, RUSSIA, AND UKRAINE (2009). Turning its back on those at greatest risk for infection, the Russian government refuses to support a network of successful HIV prevention and harm-reduction programs known as the GLOBUS Project, which has averted

an estimated 37,000 HIV infections. Meanwhile, the "war on drugs" has had little appreciable effect on demand, while criminalizing addiction.

AIDS 2010 is an opportunity to examine not only the region's significant human rights challenges, but also the impact of programs and policies in the region that are rooted in a human rights framework. Ukraine, for example, is making major efforts to scale up opioid substitution therapy (OST) to reach 20,000 people by 2013, and in Kyrgyzstan a nationwide scale-up of OST, including pilot OST in prisons, is underway. Russia's own dramatic scale-up of HIV treatment is also a model for other countries.

Of course, the role of human rights violations in the spread and devastation of HIV goes well beyond EECA, circling the entire globe. As a result of their political, social, economic, and sexual subordination, women now account for almost half of all HIV infections globally and the majority of infections in sub-Saharan Africa. Many women living with HIV face discrimination, stigma, and violence on a daily basis. RALF JÜRGENS AND JONATHAN COHEN, HUMAN RIGHTS AND HIV: NOW MORE THAN EVER (2009). Inadequate access to reproductive health services remains a major barrier to HIV prevention among women. And, although efficient methods to prevent vertical transmission exist, children are still being born with HIV.

The effort to further criminalize homosexuality in Uganda is among the most recent and public examples of the very real threats to MSM and other sexual minorities in countries around the world—threats that criminalize their sexuality and place them at increased risk for HIV, making it less likely that they will seek treatment and care.

Despite the recent change in U.S. law, the still-common restrictions

on the freedom of movement and residence of people living with HIV around the world perpetuate stigma and discrimination, running counter to all scientific evidence and sound public health practice. (See www.hivrestrictions.org.)

More than 650 organizations and networks around the world have endorsed the joint statement Human Rights and HIV: Now More than Ever, which states: "In every regional and country consultation on universal access, obstacles such as these have been cited as major barriers to achieving the goal of universal access. Yet in national responses to HIV and AIDS, hardly any political commitment, funding, or programming is dedicated to overcoming them." This situation must change. With all eyes upon Vienna, AIDS 2010 will expand awareness of the human rights impediments to universal access and identify strategies to generate the commitment, funding, and programming to overcome them.

All people living with HIV and those at risk for infection have the right to dignity and self-determination. They have the right to equal access to health care and lifesaving prevention and treatment programs, and the right to HIV interventions based on evidence rather than ideology.

The role of human rights violations in the HIV epidemic is well documented, as are the remedies. Our collective efforts must now be focused on building the political and societal will to ensure that human rights are a central tenet of the response to HIV. It is our profound hope that AIDS 2010 will prove a pivotal moment in such efforts.

Julio Montaner is the chair of AIDS 2010 and director of the BC Centre for Excellence in HIV/AIDS in Vancouver, Canada. Brigitte Schmied is local conference co-chair and president of the Austrian AIDS Society in Vienna.

Cross-Disciplinary Collaborations as Tools to Protect the Right to Health

By Evelyn P. Tomaszewski

Collaboration begins with an idea or problem that is understood to be broader than the individual practitioner or organization. Collaborations provide the opportunity to work with others with shared or similar values, and to leverage resources to attain a collectively agreed-upon goal. Successful collaborations include mutual relationships and goals, a collectively identified structure, and sharing of resources and rewards. *See ORAU, COLLABORATION: WHAT MAKES IT WORK (2005).*

Cross-disciplinary collaborations provide the opportunity to build alliances across professions and between communities. Whether from the field of law, medicine, engineering, or social sciences, human rights advocates bring a set of core values and beliefs that can be used to build a bridge between professional communities. For example, lawyers are guided by the concept that justice is based upon the rule of law grounded in respect for the dignity and the capacity of the individual. Social work practice is rooted in the values of service to community and social justice, the belief of the dignity and worth of the person, the importance of human relationships, and professional integrity and competence. *NASW CODE OF ETHICS (2008)*. Promoting social justice and social change with and on behalf of clients requires an understanding that the term “client” includes individuals, families, groups, organizations, and communities.

The right to health is recognized worldwide. This right is increasingly understood to more broadly include the diverse rights that relate to health. According to the World Health Organization, advocating for and protecting human rights is linked to promoting and protecting health, and the promotion of human rights is a fundamental tenet of ef-

fectively addressing HIV/AIDS. Yet addressing these diverse rights and working to promote health and well-being requires the efforts of more than one person or a single group or profession. Successful collaborations build upon individual and professional connections, and include mutual relationships and goals, a collectively identified structure, and sharing of resources and rewards.

The belief that health is a basic human right set the stage for a cross-disciplinary collaboration—initiated by the ABA AIDS Coordinating Committee (www.abanet.org/AIDS)—that brought together representatives from professional associations and guilds, nongovernmental organizations working in the United States and globally, U.S. government and academic institutions, and faith-based organizations and international corporations, as well as individual HIV/AIDS advocates and consumers. Collaborative partners wanted to create the opportunity to build bridges between colleagues currently addressing HIV human rights and those practitioners who do not identify their day-to-day work as addressing HIV/AIDS or health. A series of forums, held within the larger ABA Midyear Meeting, as well as stand-alone conferences, were organized to allow participants to fully explore cutting-edge legal issues surrounding HIV prevention, treatment, access to care, and other critical practice areas.

One example is the conference that was held in fall 2009, HIV/AIDS and the Rule of Law: Human Rights at Home and Abroad. Experts addressed innovative HIV screening initiatives and the impact of policies limiting access to HIV/AIDS and tuberculosis treatment and international trade issues during the “Access to HIV Treatment and Care at

Home and Abroad” panel. During the “Most-at-Risk Populations” panel, speakers discussed the impact of racial and ethnic disparities in access to prevention, care, and treatment, while panelists for the “Faith-based Approaches to the HIV/AIDS Pandemic” addressed the cultural context of HIV/AIDS services and faith-based programs, including the impact of discrimination experienced by persons living with HIV/AIDS because of religious or spiritual beliefs. “HIV/AIDS, Human Rights, and Corporate Responsibilities” panelists highlighted private-public partnerships and the corporate communities engaging in international response to the HIV pandemic, and the “Bridging the Medical and Legal Communities for People Living with HIV/AIDS” panel highlighted model collaborations between communities and successful supportive policy developments that bridge the legal and medical communities. Throughout the program, panel moderators engaged the audience in dialogue drawn from the shared collaborative vision: health (including HIV/AIDS) as a human right.

This example demonstrates how cross-disciplinary education can be used as a tool to build opportunities to help our own colleagues engage in and understand HIV/AIDS as a public health pandemic that mandates an active and broad-based response from diverse professional communities. Collaborative partners hope to expand and transform this tool through participation in professional and consumer-focused meetings hosted by domestic and international societies and associations.

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Universal Access and Human Rights For Women and Girls, Too

By Shelley D. Hayes, Bambi W. Gaddist, and Andre W. Rawls

HIV is the leading cause of death and disease in women of reproductive age around the world. Thus it is that the 2009 World AIDS Day Theme, Universal Access and Human Rights, was particularly applicable to the plight of women and girls in resource-rich and resource-limited countries alike. Below we hope to illustrate some of the ways in which culture, history, and laws combine to deny women and girls equal access to HIV prevention and care. Also in this issue, Amanda Kloer describes how modern-day sex trafficking—most often of women and girls—adds another dimension to the intractable nature of HIV in its third decade (see page 8).

The first chapter of this story is told in the numbers. The Joint United Nations Programme on HIV/AIDS (UNAIDS) estimates that in 2007 one-half of the estimated 33 million people living with HIV worldwide—between 14.2 and 16.9 million—were women. In 2008, 60 percent of people living with HIV in sub-Saharan Africa were women. Young women, and girls in particular, comprise a growing proportion of those living with HIV/AIDS in Asia, Eastern Europe, and Latin America. In the Caribbean, 43 percent of those living with HIV/AIDS are young women and girls. Here in the United States, women with AIDS make up a growing portion of those living with HIV/AIDS. In 1992, women accounted for only about 14 percent of adults and adolescents living with AIDS in this country, but by the end of 2008, the proportion had grown to 26 percent. The U.S. Centers for Disease Control and Prevention (CDC) estimates that in 2008 approximately 280,000



At an “Igat Hope” (There’s Hope) workshop in Port Moresby, Papua New Guinea, HIV/AIDS patients, like Kila, learn to become community spokespeople.

Associated Press, AP

women were living with HIV/AIDS in the United States. Women of color in the United States are particularly affected: African American women account for 69 percent of new HIV infections in women and AIDS has become the leading cause of death for black women aged 25 to 34 years.

Across oceans, complex social and economic factors, along with cultural norms, contribute to this tragedy. A look at three geographically distinct locations around the globe, Papua New Guinea in Oceania, the African nation of Botswana, and America south of the Mason-Dixon Line, gives a startling picture of the feminization of this modern-day pandemic.

Papua New Guinea

Just north of Australia, with which it shares the Great Barrier Reef, the nation of Papua New Guinea, known as PNG, occupies the eastern half of the island of New Guinea; its neighbor to the west is Irian Jaya (the Indonesia

province of West Papua). Previously administered under the international trusteeship system following World War II, PNG became self-governing in December 1973 and achieved full independence on September 16, 1975. PNG is so richly endowed with gold, copper, oil, natural gas, and other minerals that in 2006 mineral and oil export receipts accounted for 82 percent of its gross domestic product.

PNG is a many-tiered, mountainous society with thousands of separate communities composed of only a few hundred people each. These indigenous Melanesian communities are divided by geography, language—eight hundred or more are spoken there—traditions, and customs. Conflict and internecine warfare have permeated the communities for centuries. Against that backdrop, PNG is experiencing a generalized epidemic, with HIV prevalence exceeding 1 percent in many rural areas. In some urban areas it is as much as 2 percent

and, like its American counterpart, PNG's capital city of Port Moresby has an HIV prevalence rate of 3 percent. According to the 2008 United Nations General Assembly Special Session on HIV/AIDS report for PNG, the number of infected young women is highest of any group and appears to be growing fastest.

The explanation for this disparity well may be found in PNG customary law and its indigenous cultural norms. Only a quarter-century ago, many tribes in PNG segregated men and women, with the village men living in a communal "long house" or "men's house" while each woman lived in a small house nearby with her children and, not infrequently, her pigs. Under PNG customary law, polygamy continues to be widespread, particularly in rural highland communities, where having five or more wives is not unheard of. If a man has more than one wife, each woman will have her own house and the man will alternate houses.

While, as archeologist Margaret Mead documented decades ago, in some PNG cultures land and other possessions may be passed down through the female line, it is a culture of gender inequality in the main. Violence against women in PNG has reached epidemic proportions. Current research indicates that two-thirds of PNG women experience domestic violence while 50 percent of women have experienced forced sex. Many victims also run the risk of additional assault by the police. Domestic violence is a crime in PNG, but because it is seen as a private matter, few cases are prosecuted. It has been reported that a key factor contributing to domestic abuse is the continuing practice of a prospective groom paying a bride price. In PNG, rape is punishable with imprisonment, but the willingness of some communities to settle incidents of rape through material compensation rather than through the criminal justice system results in very few actual convictions.

According to Amnesty Interna-

tional, women in PNG also continue to suffer widespread "sorcery-related" abuses. In a single province, approximately 150 women are believed to be killed each year for allegedly practicing witchcraft. Violence against women, charges of sorcery, and the State's failure to protect make for a fatal combination in PNG. The case of human rights activist Anna Benny is well known but bears repeating here. In an action typical of her, Anna once secured the release and return home of three young girls—aged seven to eleven—who had been abducted and raped during tribal fighting in PNG's Eastern Highlands. Local police had failed to intervene. Later, in November 2005, Anna's sister-in-law was being held in a house and attacked on suspicion of practicing sorcery. When Anna went to her relative's aid, both women reportedly were shot and killed. Again, the local police took no action.

Cultural devaluing of women in PNG is rampant. Women in PNG have poorer access to health-care services and lower levels of educational attainment. Most women in PNG lack access to credit while limited literacy poses barriers to their participation in the economic activities and political life of the country. When cultural mores and state inaction combine, already vulnerable women become likely hosts for HIV. So it is that the majority of people now living with HIV in PNG are women.

Botswana

Traveling west across the Pacific Ocean to the landlocked African nation of Botswana, the story continues. Once a British protectorate, the independent nation of Botswana came into existence in 1966. Botswana is bordered by South Africa, Namibia, and Zimbabwe. It is a middle-income country with an economy dominated by mineral extraction, primarily diamond mining, which accounts for 70 to 80 percent of its export earnings. More than half of its population lives in urban areas. Unlike PNG, literacy

is high and women outpace men in education. However, Botswana has the second-highest HIV/AIDS prevalence rate in Southern Africa and, indeed, is experiencing a generalized epidemic, with an HIV prevalence rate of 23.9 percent in 2007.

Here again, law and culture combine in ways that fuel the epidemic. Botswana is like PNG in that it has a dual legal system where common law and customary law exist side by side. Given that customary law courts administer most cases—about 80 percent—most of Botswana's citizens are subject to customary law. Patri-lineal inheritance is accorded legislative status in Botswana, thereby giving men control of land and property and effectively disenfranchising women where administration, disposition, enjoyment, and ownership of property are concerned. Although a recent law (the Abolition of Marital Power Act) grants married women in Botswana the right to greater participation in matters of family property, social and economic development, its provisions do not apply in traditional and religious marriages. Abuse of women in Botswana is widespread, characterized by men's culturally sanctioned entitlement to sex "on demand" and the "cultural imperative" of a woman to prove her fertility before marriage by bearing children. Domestic violence against women is not prohibited by law in Botswana, making it an ongoing and serious problem, while customary law permits husbands to discipline their wives as they would their minor children, including the use of corporal punishment.

As it does throughout Southern Africa, the HIV/AIDS epidemic in Botswana disproportionately affects women. The numbers in Botswana are staggering: overall, females in the reproductive ages have been severely affected by HIV, with one-third of all women—29.4 percent—currently living with the virus. For women aged 25 to 29, the prevalence rate is 41 percent; those aged 30 to 34 expe-

rience a prevalence rate of 43.7 percent; and those aged 35 to 39 follow with a rate of 37.8 percent.

The American South

Still traveling west, now crossing the Atlantic Ocean to the heart of the American South, history and culture tell a similar story. The United States is, of course, a high-income country, but tradition and law combine again to make the plight of women in its southern states too much like that of their sisters in PNG and Botswana. Again, a culture of human rights violations has created an HIV epidemic out of control.

It is well documented that the agrarian economy of the American South, built on rice, tobacco, and cotton, led to an insatiable drive to create systems of labor needed to farm the “golden” crops. Cheap human labor was the backbone of that economy. With the housing of African slaves came pandemics of pellagra, hookworm, tuberculosis, syphilis, yellow fever, malaria, and other communicable diseases. Many of those pandemics were found to be associated with a prevalence of dire poverty, poor nutrition, the climate, and the total legacy of slavery.

That legacy of unequal health has been carried down to the HIV/AIDS epidemic of the last quarter-century. The Southern AIDS Coalition has reported that there were 26,347 newly diagnosed cases of HIV infection in the United States in 2007. Of those new diagnoses, 51.2 percent were diagnosed in the seventeen southern states. AIDS rates among African American women in the United States have reached 39.8 per 100,000 compared to 1.8 among white women. Over 52 percent of African Americans with AIDS and 58 percent of new AIDS cases reported in 2006 among African Americans occurred in the South, yet African Americans represent only 20 percent of the South’s population.

A snapshot of South Carolina helps to tell the story of HIV in the

South. South Carolina is one of America’s original thirteen colonies. Prior to the American Revolution of 1776, its economy flourished on the production and exportation of rice and on the importation and sale of human beings: 40 percent of all African slaves reaching the British colonies passed through South Carolina, most entering through the Port of Charleston. The rights of slave women during that time were nonexistent. Take the case of James Marion Sims, a son of South Caro-

In 1999, a landmark study by the Institute of Medicine showed that the inexpensive antiretroviral drug nevirapine can reduce the risk of an HIV-infected mother transmitting HIV to her child by nearly 50 percent if one dose is administered to the mother at the onset of labor and one dose is administered to the newborn within seventy-two hours of birth.

lina who is viewed by many as a genius and the father of modern gynecology. Often neglected by his biographers, however, is the fact that he perfected his painful surgical techniques by practicing—without anesthesia—on black slave women before he performed the same procedures—with anesthesia—on white women.

African American women in present-day South Carolina fare little better than did their female ancestors. More than 4,200 women in South Carolina live with HIV/AIDS. African American women in South Carolina account for an estimated 83 percent of new HIV infections among all women in the state: they make up 17 percent of South Carolina’s total population, but comprise 26 percent of all persons living with HIV/AIDS and 29 percent of all persons diagnosed with HIV-only in the state. The Kaiser Family Foundation recently released outcomes ranks South Carolina as number one in the nation in heterosexual transmission of HIV. Similarly, the South Carolina Department of Health has confirmed that

heterosexual transmission is the most common reported risk for all women and girls, with more than 90 percent of women contracting HIV from their male partners.

Modern South Carolina law has not protected the right to health for its African American women or their children. More than fifty years ago, in 1956, the American Medical Association declared addiction to alcohol and other drugs to be a disease. Yet, South Carolina law holds that, rather than provide treatment for

women suffering from such diseases, they must be incarcerated. In the seminal case of *Whitner v. State* 492 S.E.2d 777 (S.C. 1997), *cert. denied*, 118 S. Ct. 1857 (1998), the Supreme Court of South Carolina held that a viable fetus was a “child” as used in the child abuse and endangerment statute, S.C. Code Ann. § 20-7-50 (1985), and upheld a mother’s conviction under the statute for her cocaine use during the third trimester of her pregnancy. The court noted that “[a]lthough the precise effects of maternal crack use during pregnancy are somewhat unclear, it is well documented and within the realm of public knowledge that such use can cause serious harm to the viable unborn child.” *Id.* at 10. The court therefore concluded that Whitner’s drug use unquestionably violated the child endangerment statute. *Id.* at 11.

The facts in that case are stunning. In 1989, two South Carolina states attorneys began applying the state’s child endangerment law to pregnant women whose conduct was presumed to pose a risk to fetal

health. According to her lawyers, on April 7, 1992, Cornelia Whitner, a 28-year-old African American woman, was indicted for violating § 20-7-50 by allegedly failing “to provide proper medical care for her unborn child by using crack cocaine while pregnant.” At her plea hearing, Whitner’s attorney stated that Whitner’s son, born two months previous, enjoyed good health, and that Whitner had received substance abuse counseling. Whitner, requesting assistance from

servicing her previously suspended five-year sentence.

These cases were part of a collaborative effort, launched in 1989 by the city of Charleston, among the police department, the prosecutor’s office, and the Medical University of South Carolina—a state hospital—to punish pregnant women and new mothers who tested positive for cocaine use. Under the policy, the hospital provided the city prosecutor’s office with information on pregnant and postpartum women. The prosecutor’s

and stigma and discrimination that increase people’s vulnerability to HIV infection—are not easily measured. But, as we see above, the trends are clear: human rights violations and gender inequality fuel the spread of HIV/AIDS. Where women are unequal before the law, with little to no control over their lives, their vulnerability to HIV infection increases. Where tradition and cultural mores deny women the same access to prevention and care as are granted to men, HIV spreads. Where the State and non-governmental organizations fail in their efforts at gender equity, HIV flourishes.

For example, condom use long has been recognized as an effective prevention measure in controlling the epidemic. Nearly two decades have passed since a female condom was developed that is as effective as its male counterpart. The female condom represents a tool that women, often powerless to negotiate condom use by their male partners, can use to protect themselves and their daughters. Yet, in 2008, only 35 million female condoms were distributed worldwide compared to the 10 billion male condoms distributed annually. Similarly, a recent CDC study of more than 19,500 HIV patients in this country revealed that women are less likely, if slightly so, to receive prescriptions for the most effective treatments for HIV infection.

It is time for change. And, as American health-care activist Byllye Avery has reminded us, “Acceptance and awareness are the first stages of gaining the courage to change.”

Shelley D. Hayes is chair and a founding member of the ABA AIDS Coordinating Committee and a member of the Section of Individual Rights and Responsibilities Section Council. Bambi W. Gaddist is executive director of the South Carolina AIDS Council. Andre W. Rawls is the past president of the National Alliance of State and Territorial AIDS Directors.

I declare to you that woman must not depend upon the protection of man, but must be taught to protect herself, and there I take my stand.

—Susan B. Anthony

the court, is reported to have said, “I need some help, your honor.” Although Whitner and her attorney emphasized both the need and Whitner’s desire for inpatient treatment, the court reportedly responded, “I think I’ll just let her go to jail.” The court then sentenced her to eight years in prison.

In a companion case, the state indicted Malissa Ann Crawley, a 31-year-old African American woman, on a charge of child neglect based on her pregnancy and substance dependency. On the advice of her court-appointed attorney, Crawley pled guilty. The Court of General Sessions then sentenced Crawley to five years in prison, which it then suspended to five years probation. Subsequently, Crawley’s boyfriend assaulted her and an altercation ensued. Even though she was the victim of abuse, the state charged Crawley with criminal domestic violence. Not informed of the defense of self-defense or, indeed, of any defenses, and ignorant of the ramifications of a guilty plea, Crawley pled guilty for a second time. As a result of that plea, the court found that she had violated her probation and issued an order that she begin

office then maintained detailed lists containing a woman’s name, drug test result, and other confidential information, including whether she “had AIDS” or had had an abortion. After more than a decade in place, the U.S. Supreme Court invalidated the policy. In *Ferguson v. City of Charleston*, 532 U.S.67 (2001), the U.S. Supreme Court held that a state hospital’s performance of a diagnostic test to obtain evidence of a patient’s criminal conduct for law enforcement purposes is an unreasonable search, in violation of the Fourth Amendment to the U.S. Constitution, if the patient has not consented to the procedure. The Court noted specifically that “the policy made no mention of any change in the prenatal care of such patients, nor did it prescribe any special treatment for the newborns,” presumably thus allowing known HIV infections to go untreated. Meanwhile, one-third of all persons estimated to be living with AIDS in South Carolina in 2007 were women.

UNAIDS has recognized that the “drivers” of this epidemic—structural and social factors, such as gender inequality, human rights violations,

Sex Trafficking and HIV/AIDS

A Deadly Junction for Women and Girls

By Amanda Kloer

“A way out of no way, it’s flesh out of flesh, it’s courage that cries out at night;
A way out of no way, it’s flesh out of flesh, it’s bravery kept out of sight;
A way out of no way, it’s too much to ask, it’s too much of a task for any one woman.”—“Oughta Be A Woman,” by Sweet Honey in the Rock



Associated Press, AP

Women rescued from brothels in Indian cities line up to identify an alleged trafficker.

The nexus of the global epidemics of sex trafficking and HIV/AIDS primarily manifests in the lives of women and girls. This intersection exists in sex trafficking victims’ increased vulnerability to HIV infection, the proliferation of HIV infection through sex trafficking, and the perceived and actual clashes between HIV and sex trafficking prevention efforts. Holistically addressing these intersecting issues entails framing the elimination of sex trafficking as a tool to reduce HIV transmission. This article explores this deadly junction for women and girls and proposes tools to address it.

The direct and individual impact of sex trafficking and HIV on girls and women is illustrated by the experience of “Gita” (not her real name). Gita grew up in India, and was sold into sexual slavery by a family mem-

ber when she was twelve years old. When she arrived at the brothel in Mumbai, she was locked in a room, raped, tortured, and abused until she was deemed sufficiently obedient. When the brothel owners began selling Gita, she was threatened with death if she refused to have sex with a customer. Most days she was forced to have sex with ten to twenty men. The brothel did not provide condoms, and she was not able to control which of her customers chose to practice safer sex. During her early teens, Gita contracted HIV from a customer. However, she was not allowed to seek testing or treatment and was forced to continue having unprotected sex with several men per day for several more years. Finally, Gita managed to escape to a local anti-trafficking organization and is now living in a shelter and receiving

HIV treatment and counseling.

Gita contracted HIV as a direct result of her status as a victim of sex trafficking. She also, unknowingly and unintentionally, may have spread HIV to customers who bought her after she became infected. If Gita were never trafficked, she may not have ever become infected with HIV and, in turn, transmitted it to the men who bought her and their future sex partners. Preventing this multiplier effect of HIV transmission catalyzed by sex trafficking involves fighting two global phenomena—a deadly disease and a highly complex and lucrative criminal industry, both of which disproportionately affect girls and women around the world.

Sex Trafficking Victims’ Increased Vulnerability

According to U.S. law, sex trafficking is a form of modern-day slavery in which a commercial sex act is induced by force, fraud, or coercion, *or* in which the person induced to perform such an act is under eighteen years of age. Precise statistics for the number of women and girls trafficked in the commercial sex industry are difficult to obtain. However, the U.S. Department of State estimates that up to 900,000 people are trafficked across international borders each year, the majority of whom are women and girls forced into commercial sex industries. *See* U.S. DEPARTMENT OF STATE TRAFFICKING IN PERSONS REPORT (June 2003). International Labor Organization data indicates that 1.39 million girls and women are victims of sex trafficking at any given time. *See* U.S. DEPARTMENT OF STATE TRAFFICKING IN PERSON REPORT (June 2009).

Sex trafficking is a global epi-

demic, and cases of forced prostitution and sex trafficking have been identified in almost every country in the world. The United Nations Children's Fund estimates that in the past thirty years, more than 30 million women and children in Asia have been victimized in the commercial sex industry. *See* United Nations Children's Fund press release (2006). In Latin America, the International Organization for Migration estimates that the sex trafficking of women and girls is a \$16 million-a-year business. *See* Association for Women's Rights in Development, "Sex Trafficking Now a \$16 Billion Business in Latin America" (2008). The scourge of sex trafficking also plagues Europe, Africa, and Australia. Even in the United States, the National Center for Missing and Exploited Children estimates that up to 100,000 American children are at risk for sex trafficking each year, and 83 percent of the 1,200 human trafficking allegations made to the U.S. Department of Justice in 2007 were sex trafficking cases. *See* THE HUMAN TRAFFICKING DATA COLLECTION AND REPORTING PROJECT (2010).

It is important to note, however, that women and girls also are trafficked into industries other than the commercial sex industry, including agricultural work, factory work, domestic servitude, and the service industry. They may be at increased risk of HIV transmission as well, because trafficked women in all industries become more vulnerable to sexual assault and rape and may not be able to access testing and treatment for HIV during their enslavement.

Sex trafficking victims, however, are at significantly increased risk for contracting HIV for a number of reasons directly related to the nature of their forced servitude. Sex trafficking victims are modern-day slaves, and thus are unable to make choices about or control some aspects of their lives, including their sexual activity. They are forced to sell sex acts on the street, in hotels, through escort agencies, at broth-

els, and many other places where they don't have access to safer sex tools. Even when trafficking victims are held in brothels or other places where condoms are made available, they may not be able to enforce condom usage and other safer sex practices. Women and girls enslaved in commercial sex also are forced to endure sex with multiple partners, many of whom may also have had unprotected sex with multiple partners, which increases victims' risk of contracting HIV. They further must endure the riskiest types of unprotected sex, such as anal sex, injurious sadomasochism, and violently abusive sex, which increases their risk of transmission. Often injuries inflicted during violent sex are not allowed to heal properly, as traffickers force victims to continue to serve men without seeking medical attention. As a result, trafficked women may have high-risk, unprotected sex with multiple partners despite having open genital cuts and abrasions.

It is difficult to determine how many sexual partners an "average" trafficking victim might have over the course of her captivity. Reports from nongovernmental organizations vary greatly, with some reporting only a handful of customers per day, others up to forty or fifty per day. However, between five and ten customers per day is often considered a conservative figure. If a victim is forced to have sex with only five customers per day, six days per week for one year, she will have had sexual contact with 1,560 men that year. Without the ability to enforce safer sex practices or screen potential partners for STDs, this much sexual contact clearly puts the victim at a heightened risk for contracting HIV.

Another risk factor for trafficked females is their age. According to the U.S. Department of Justice, the average age of entry into prostitution is twelve to fourteen years old, and every child under eighteen in prostitution in the United States and many other countries is considered by law a sex trafficking victim.

Children and young teens sold into prostitution are at a greater risk for contracting HIV because their smaller, still-developing bodies are more susceptible to the genital tearing that often leads to HIV transmission during sexual intercourse. Because trafficked children in prostitution are even less likely to be in control of choices than adults, they may have less opportunity to insist on safer sex practices. Worse still, some men seek ever younger children for sex, based on the warped belief that there is less risk of HIV transmission with a younger partner. In turn, younger children are being recruited into prostitution, which provides a longer period during which they can become HIV-infected.

Sex Trafficking as a Facilitator of Global HIV Transmission

While trafficked women and girls are individually at an increased risk for contracting HIV, sex trafficking as an international phenomenon is also a catalyst and facilitator of large-scale HIV transmission. According to AIDS prevention organization AVERT, in some parts of the world, such as West Africa, the AIDS epidemic appears to be driven in part by the commercial sex industry, including the abuse of those trafficked into it. AVERT found that 27.1 percent of people in the commercial sex industry in Dakar, Senegal, were infected with HIV in 2005. *See* AVERT, "Aids and Prostitution" (2010). Other studies have found commercial sex to be a significant factor in the AIDS epidemics in Ghana, Togo, and Burkina Faso. *Id.* Similarly, a 2008 study out of the Harvard School of Public Health found that 38 percent of women trafficked from Nepal to India for sex were returned to Nepal HIV-positive. *See* HARVARD PUBLIC HEALTH REVIEW, TRAFFICKED (2007). In the United States, there are both high rates of sexual exploitation of African American teen girls within the commercial sex industry and by family members and high rates of HIV infection among

African American females. In addition to the sexual risk factors, high rates of injection drug use within the commercial sex industry also increase the risk of infection and transmission on a global scale.

Human trafficking within the commercial sex industry, however, greatly exacerbates the spread of HIV infections. Traffickers frequently transport victims between cities or countries to both disorient the victims and provide “fresh faces” for the men who buy sexual services from them. For example, “Corina” was trafficked in her home country of Moldova, where she likely contracted HIV. Her trafficker then sold her in London, Prague, New York, and Miami for a month each to have sex with ten to twenty men per night. As a trafficking victim, Corina was unable to seek testing or treatment for her HIV, and may have unknowingly and unwillingly spread the disease. Corina also began using drugs to mask the pain of sexual slavery. Women and girls trafficked for sex may turn to drugs and alcohol, including injection drugs, thus increasing their risk of infection and widespread transmission.

Another example of how sex trafficking can spread HIV is the cultural belief in some parts of the world that sex with a virgin can cure HIV or AIDS. HIV-positive men who believe this myth will seek out traffickers to procure a virgin for them, often a child. They then have unprotected sex with that virgin, and in the process will sometimes transmit the disease. However, the transmission factor of this encounter is multiplied exponentially, because after this sexual contact, the man, thinking himself cured, may have unprotected sex with other partners. The child he used, now possibly infected, will often continue to be trafficked for sex. In these cases, HIV transmission is not merely a byproduct of sex with a trafficking victim, but is the impetus for the trafficking and the sexual contact. It is also an action that can spread the disease exponentially.

Human trafficking has also been implicated as a possible catalyst for the mutation of HIV into multiple subtypes. Dr. Chris Beyer of Johns Hopkins University has linked sex trafficking to both the spread and mutation of HIV, stating that the commercial sex industry in general, and sex trafficking in particular, are facilitating the global dispersion of various (and possibly drug-resistant) HIV subtypes. Another factor in the creation of mutations is inconsistent treatment for people infected with HIV. Even those few trafficking victims who are able to seek testing and treatment for their HIV may suffer repeated interruptions in care because of lack of access, lack of education, or re-trafficking. The role of sex trafficking in the mutation of HIV is extremely dangerous and must be recognized in the global fight against AIDS.

The Clash of HIV and Trafficking Prevention Efforts

One reason the intersection of sex trafficking and HIV may be under-examined is the tension between those groups conducting HIV prevention and treatment initiatives, and those groups conducting human trafficking prevention or rescue operations. Historically, HIV prevention programs have focused on harm-reduction models, which involve supplying brothels and women in prostitution with condoms, access to HIV tests, and other tools to prevent infection and transmission of the virus. This model of prevention sometimes entails allowing illegal commercial sex enterprises to operate without involving the local authorities, based on the philosophy that cooperation with the commercial sex industry is the best technique for preserving the safety of those in it. Human trafficking raids and prevention activities, however, have historically focused on identifying human trafficking within the commercial sex industry as a criminal activity and arresting the perpetrators and facilitators of that crime. HIV prevention organizations have sometimes seen anti-trafficking raids in brothels

or red-light districts as disrupting HIV outreach and prevention or harming local relationships. Anti-trafficking organizations have sometimes seen HIV prevention as ineffective in assisting trafficking victims, and seen relationship-building within the commercial sex industry as neglecting to address the criminal components of sex trafficking within it.

Another issue that has caused tension between HIV prevention and anti-trafficking initiatives was the Bush administration’s policy of denying federal funding to any organization found to be “promoting prostitution.” For the better part of the last decade, “promoting prostitution” was interpreted broadly to include everything from making condoms readily accessible to offering English classes for women trying to leave the sex industry. One way this debate played out was over the effectiveness of a 2008 anti-trafficking law in Cambodia. Some anti-trafficking organizations have claimed the law has led to better identification of victims, but some HIV prevention groups have argued that it has instead increased fear and stigmatization of condom use in the commercial sex industry. However, in July 2009, the U.S. Department of Justice dropped its appeal of a 2006 court injunction prohibiting enforcement of the “anti-prostitution pledge” under U.S. global AIDS policy. This move suggests strongly that the Obama administration will not continue the Bush policy in this regard.

As the Obama era moves forward, HIV and trafficking prevention groups will need to develop new strategies—collaboratively, one hopes—for addressing their concerns in and with the commercial sex industry. Overall, HIV/AIDS heretofore has received minimal attention in the context of addressing sex trafficking, and few HIV/AIDS-focused services exist for trafficking victims. Similarly, while some HIV/AIDS plans address the role of the commercial sex industry in HIV trans-

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Human Rights and HIV Men Who Have Sex with Men

By Richard A. Wilson

It is widely known and understood that men who have sex with men (MSM) are in greater and substantially disproportionate numbers affected by HIV. This fact, combined with the structural lack of collective identity and the pervasive stigma associated with both homosexuality and HIV, presents particular human rights challenges and issues for outreach, education, testing, and treatment for MSM with HIV/AIDS.

There are several elements to the problem of HIV/AIDS and human rights for MSM: male-to-male sex or homosexuality; HIV/AIDS; discrimination and the stigma associated with each, and with both; the failure of established government and non-governmental organizations (NGOs) to reach MSM; significantly higher rates of HIV seroprevalence among MSM compared to other risk groups (with few exceptions); and the increasing criminalization of both homosexuality and HIV. Individually or in any combination, each defines and determines both public and private responses to MSM with HIV—in addressing the needs of MSM; in providing appropriate and sufficient outreach, education, care, and treatment; and in reporting and assessing the results—as well as the willingness and ability of MSM to seek education, care, or treatment, to the extent they may know it is available.

Who are MSM?

MSM is a classification that refers to behavior, not identity. The classification was coined in the early 1990s to identify and study the behavior of male-to-male sexual activity, without regard to self-identity, sexual orientation, or other characteristics.



MSM disproportionately lack access to HIV education, prevention, treatment, and care.

The classification “. . . is an inclusive public health term used to define sexual behaviors, regardless of gender identity, motivation for engaging in sex, or identification with any particular ‘community.’” *Men Who Have Sex with Men* (Family Health International, 2009) at www.fhi.org/en/Topics/men+who+have+sex+with+men+topic+page.htm.

Defined first and last by behavior—the act of sexual relations between men and not sexual orientation or gender identity—MSM includes, in addition to men who self-identify in whole or in part based upon sexual orientation (gay or bisexual men) or gender identity (transgender and intersex), men who do not so self-identify or who may consider themselves heterosexual or not, but who engage in sex with other men. It also includes men who engage in what is commonly referred to as “situational” sex, or sex that takes place in all-male environments where men are in confined or limited contact primarily or solely with other men for periods of time, such as prison, the military, or certain school environments, and “occu-

pational” sex, e.g., among male sex workers. The classification is valid and applicable across cultures and political entities. Lacking social cohesion or affinity, MSM similarly lack visibility, recognition, and political power. MSM typically do not form or inhabit discrete populations or groups—whether defined by sociopolitical, epidemiological, or other criteria—and have no known self-identity nor known political or social organization or entity, and no known assertion of rights or interests against the state.

The Problem

MSM throughout the world experience significantly higher rates of HIV seroprevalence than other risk groups, and disproportionately lack access to education, prevention, treatment, and care, at the hands of governments as well as private NGOs and religious or social welfare groups who refuse, neglect, or simply fail to acknowledge their existence, needs, and rights. The relationship between the state and MSM is mostly nonexistent. At best, it is determined and encumbered by both

Faith-Based Organizations and the HIV/AIDS Pandemic

By David P. Pusateri

Among a host of controversial issues that envelop HIV/AIDS is the role religion plays in combating and responding to the disease. Often lost in the storm of opinions is that freedom of religion and belief throughout the world is perhaps one of the most significant arrows in the human rights quiver that has been overlooked, under-examined and, frankly, too easily denigrated in the ongoing battle against HIV/AIDS. The fact that 70 percent of the world's population identify themselves as members of a faith community (according to the Joint United Nations Programme on HIV/AIDS [UNAIDS]) begs the question regarding what impact religion has on the pandemic.

This issue was front and center at a conference held last September at the University of Notre Dame—HIV and the Rule of Law: Human Rights at Home and Abroad. Co-sponsored by the American Bar Association AIDS Coordinating Committee and the Center for Civil and Human Rights at Notre Dame Law School (among others), representatives from the Muslim community, Catholic Relief Services, and the National Episcopal AIDS Coalition came together to draw attention to the role of faith-based organizations (FBOs) in the battle against AIDS and to explore how the approach of FBOs

to the HIV/AIDS pandemic could be enhanced. What is perhaps most obvious is that religious belief has a powerful impact on those affected by the disease because communities of faith play such a significant role in influencing behavior and attitudes. In Africa, Christianity and Islam, the predominant religions, have enormous followers, and the attitudes and lifestyles of members are greatly influenced by their respective religions and the values they teach. Religious leaders have the power to mold opinions and influence behavior in ways that directly affect the severity of the disease.

We all also are familiar with the negative effects of religion on the disease, in which unconstructive positions, sometimes bordering on self-righteous zealotry, are not helpful. Uganda introduced the Anti-Homosexuality Bill of 2009, which includes the death penalty for those practicing homosexuality. Influenced in part by American evangelicals, whose teachings demonize lesbian and gay people and even advocate that they can be “cured,” the bill has ignited a cultural war there. The *New York Times* reported recently that the United States, among others, is demanding that Uganda's government drop the proposed law, saying it violates human rights, although a Uganda

government official said, “Homosexuals can forget about human rights.” Jeffrey Gettleman, *Americans' Role Seen in Uganda Anti-Gay Push*, N.Y. TIMES, January 3, 2010.

When religion negatively influences legislation as it has in Uganda, stigmatization, access to one's HIV status, and treatment suffer. Speaking at the Notre Dame conference, Dr. Memoona Hasnain, author of *Cultural Approach to HIV/AIDS Harm Reduction in Muslim Countries* (HARM REDUCTION JOURNAL, 2005) and associate professor at the University of Illinois College of Medicine, pointed out that Muslim countries, previously considered relatively protected from HIV/AIDS, are today facing a rising threat. The social stigma attached to HIV/AIDS that exists in most societies is even more pronounced in Muslim cultures. As in other cultures, the stigma prevents those at risk from coming forward for counseling, testing, and treatment. Moreover, safe disclosure for persons infected with the disease often conflicts with the existing social, cultural, and religious underpinnings of Muslim societies. “In the Muslim World, religion defines culture and the culture gives meaning to every aspect of the individual's life,” writes Hasnain. Issues such as gender inequality, stigma, and misconceptions about the

the formal lack of self-identification of the group and the resistance, failure, or even refusal of public and private entities to acknowledge the existence of MSM, much less educate them and include them in their treatment schemes. This stems from prevailing or competing political, social, and religious attitudes toward homosexuality and/or sex between or among men, informed by prejudice and stigma associated

with homosexual activity in general and HIV and male-to-male sex in particular and determines the level, scope, and openness of education and outreach from government and from NGOs, including religious organizations as well as the church or broader religious community. It also determines the willingness and ability of MSM to seek education, prevention, and ultimately, testing and treatment. “There is evidence

that several factors impede access to appropriate HIV interventions [including] an unwillingness of governments to invest in the health of men who have sex with men and transgender people and the impact of social marginalization on the desire to access health-related services and on the equal access to these services as well as to social benefits.” CARY ALAN JOHNSON, OFF THE MAP: HOW HIV/AIDS PROGRAMMING IS FAIL-

disease are contentious and require particular attention when designing HIV prevention programs in Muslim communities.

According to Hasnain, some Muslim “religious scholars are taking a more flexible stance and justify the provision of the use of condoms and clean needles through the Qur’anic and Hadith passages. They reason that the sanctity of life is greater than the sin of condom use and that this strategy can be used as a short term measure, permissible under a state of emergency.” Hasnain points out that an urgent need exists for legislative and social changes to protect the legal rights of the infected and suggests that the message needs to be spread that “being a good Muslim can include taking care of those infected by HIV” and that it would be helpful in combating the spread of the disease.

Pope Benedict XVI took a widely reported different approach regarding condoms last spring when he commented that, while the Roman Catholic Church was at the forefront of the battle against AIDS in caring for those affected by the disease through its multiple health ministries, “[y]ou can’t resolve it with the distribution of condoms. On the contrary, it increases the problem.” The Pope said a responsible and moral attitude toward sex would help fight the disease. The Pope and the Roman Catholic Church’s stance, while controversial, received a positive nod of sorts from

Edward C. Green, director of the AIDS Prevention Center at the Harvard Center for Population and Development Studies, who stated that “[t]he best evidence we have supports the Pope’s comments.” Mr. Green claimed that reducing “concurrency,” or the custom of engaging in two, usually long-term, sexual relationships at the same time, was the key to successfully combating the AIDS pandemic.

What is lost in the condom debate, however, is that FBOs such as Catholic Relief Services and the National Episcopal AIDS Coalition have provided crucial support for more than two decades for HIV and AIDS ministries throughout the world. In many cases, FBOs were the first to respond to those suffering from AIDS, providing services, education, and care. Further, because they provide a significant portion of the care in developing countries, FBOs reach the most vulnerable populations living under the most difficult circumstances. FBOs have been recognized as central contributors toward assisting those suffering from the disease. In fact, a 2007 report released by the World Health Organization concluded that greater coordination and better communication was urgently needed between organizations of different faiths and the private and public health sectors. It pointed out, for instance, that 30 to 70 percent of the health infrastructure in Africa is carried out by FBOs, yet there is little coopera-

tion between these organizations and mainstream public health programs.

Religion’s voice in its communities and its ability to stimulate grassroot responses allow FBOs to have a critical role in impacting the prevalence of HIV/AIDS throughout the world. One conclusion from the Notre Dame conference was that leadership and education are urgently needed by FBOs. This conclusion was echoed by UNAIDS’ Interfaith Coalition when it distributed its *Guidelines for HIV Prevention Messages for Muslim Faith-Based Organizations in Nigeria*. In the guidelines, UNAIDS points out that HIV and AIDS prevalence in Nigeria has declined from 5.8 percent in 2001, to 5.0 percent in 2003, to 4.6 percent in 2008. The guidelines point out that this reduction was achieved, in part, by campaigns promoting morality and wholesome sexual behavior, including abstinence among young adults. UNAIDS concluded that FBOs “have contributed greatly to this achievement . . . Religious leaders are highly regarded and are always revered and referenced by their followers. Hence, religious leaders have a critical role to play in the prevention, control and impact mitigation of HIV and AIDS considering the influence and authority exerted by them.”

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ING SAME-SEX PRACTICING PEOPLE IN AFRICA (2007).

The primary human rights challenge here is the known, identifiable, and widening chasm between HIV education, prevention, and treatment and a critically substantial element of all populations at risk—MSM—and its consequence for the spread of the virus both to other men and to women, whether or not known to be at risk. The problem

works in both directions, and to the detriment of MSM: official government and nongovernment entities fail to reach out, and of those MSM who may have some education or awareness of HIV, entrenched prejudice and pervasive stigma too often prevents them from accessing available education, testing, or treatment. MSM fail to identify themselves, and the state and private entities providing HIV outreach, education, treat-

ment, and care either refuse or fail in any case to reach them.

History

On June 27, 2001, the United Nations General Assembly, meeting in Special Session (UNGASS), promulgated a comprehensive call to action on human rights and global efforts to combat the spread of HIV/AIDS, including specific goals to be met within ten years. The Declaration of

Ex-Offenders' Right to Health HIV/AIDS and Reentry

By **Natasha H. Williams**

According to Lauren E. Glaze and Thomas P. Bonczar of the Bureau of Justice Statistics (PROBATION AND PAROLE IN THE UNITED STATES, 2008, available at <http://bjs.ojp.usdoj.gov/content/pub/pdf/ppus08.pdf>), in 2008 more than 7.3 million people were in prison, jail, on probation, or on parole. This number is equivalent to 1 in every 31 adults. Of those, more than 2.3 million men and women were incarcerated in local jails and state or federal prisons—the rough equivalent of 1 out of every 133 U.S. residents. WILLIAM J. SABOL, HEATHER C. WEST, AND MATTHEW COOPER, PRISONERS IN 2008, available at <http://bjs.ojp.usdoj.gov/content/pub/pdf/p08.pdf>. Furthermore, The Sentencing Project estimated that more than 700,000 individuals will be released each year from prisons (CRIMINAL JUSTICE PRIMER: POLICY PRIORITIES FOR THE 111TH CONGRESS 2009, available at www.sentencingproject.org/doc/publications/cjprimer2009.pdf)

and The Urban Institute estimated that 230,000 will be released from jails each week. AMY L. SOLOMON ET AL., LIFE AFTER LOCKUP: IMPROVING REENTRY FROM JAIL TO THE COMMUNITY (May 2008), available at www.urbaninstitute.org/UploadedPDF/411660_life_after_lockup.pdf.

The prevalence of communicable and chronic diseases among prisoners during incarceration and upon release demonstrates the severity and extent of unmet health-care needs—especially for those with HIV/AIDS. The National Commission on Correctional Health Care reported that, of prisoners released in 1996, 155,000 had hepatitis B infection, 1.4 million were infected with hepatitis C, and 566,000 had latent tuberculosis infection. In addition, in 1995, 8.5 percent of inmates suffered from asthma, an estimated 5 percent from diabetes, and more than 18 percent from hypertension. THE HEALTH STATUS OF SOON-TO BE-RELEASED

INMATES: A REPORT TO CONGRESS (March 2002), available at [www.ncchc.org/stbr/Volume1/Health%20Status%20\(vol%201\).pdf](http://www.ncchc.org/stbr/Volume1/Health%20Status%20(vol%201).pdf).

According to the Bureau of Justice Statistics, in 2007 the overall rate of estimated confirmed AIDS cases among the state and federal prison population was “more than 2 times the rate in the general population.” LAURA M. MARUSCHAK, HIV IN PRISONS, 2007–08, 3 (Jan. 2010), available at <http://bjs.ojp.usdoj.gov/content/pub/pdf/hivp08.pdf>. In 2008, 21,987 people in state or federal prisons were known to be HIV-positive or had confirmed AIDS. This number includes 1.5 percent (20,075) of male inmates and 1.9 percent (1,912) of female inmates. During 2007, nearly three-quarters (73 percent) of state prisoners “who died of AIDS-related illness were ages 35 to 54.” Black non-Hispanic inmates accounted for nearly two-thirds (65 percent) of state inmates who died from AIDS-related causes.

Commitment on HIV/AIDS (DoC) proclaimed that the “[r]ealisation of human rights and fundamental freedoms for all is essential to reduce vulnerability to HIV/AIDS” and established “targets and goals based on human rights law and principles in four areas: prevention (of new infections); provision of improved care, support and treatment for those infected with and affected by HIV/AIDS; reduction of vulnerability; and mitigation of the social and economic impact of HIV/AIDS” (see www.un.org/ga/aids/coverage/FinalDeclarationHIVAIDS.html). This included, for example, specific targets to be met within two years:

58. By 2003, enact, strengthen or enforce as appropriate legislation, regulations and other measures to

eliminate all forms of discrimination against, and to ensure the full enjoyment of all human rights and fundamental freedoms by people living with HIV/AIDS and members of vulnerable groups; in particular to ensure their access to, inter alia education, inheritance, employment, health care, social and health services, prevention, support, treatment, information and legal protection, while respecting their privacy and confidentiality; and develop strategies to combat stigma and social exclusion connected with the epidemic. *Id.*

At the last International AIDS Conference, in August 2008 in Mexico City, it was reported that

HIV prevalence among men who have sex with men has been found to be as high as 25% in Ghana, 30% in Jamaica, 43% in coastal Kenya

and 25% in Thailand. Among transgender people, HIV prevalence is thought to be even higher. . . . over 25% among transgender people in three Latin American countries and prevalences ranging from 10% to 42% in five Asian countries.” UNAIDS, UNAIDS ACTION FRAMEWORK: UNIVERSAL ACCESS FOR MEN WHO HAVE SEX WITH MEN AND TRANSGENDER PEOPLE, http://data.unaids.org/pub/Report/2009/jc1720_action_framework_msm_en.pdf.

As recently as March 2010, the U.S. Centers for Disease Control reported that “the rate of new HIV diagnoses among MSM is more than 44 times that of other men, and more than 40 times that of women.” *CDC Analysis Provides New Look at Disproportionate Impact of HIV and Syphilis Among U.S. Gay and Bi-*

Inside prisons, the risk behaviors for the transmission of HIV are unprotected sex, either consensually or by force, and the sharing of injecting, tattooing, and piercing equipment. It is imperative that inmates receive a continuum of care and counseling not only while they are incarcerated but also once they return home. Because many of those released do not have health insurance or Medicaid coverage (reinstitution of their benefits can take weeks to months—if they are eligible at all), they do not have medical care or medication. Pre-release planning to manage HIV/AIDS could ensure that networks for payment and facilitated access to services be in place before an individual's return to the community.

Moreover, reentry programs can serve as essential linkages to community resources and a source of health care and counseling. Reentry program models that combine one-stop onsite health services with access to social services can provide one-on-one HIV counseling; access to health services where clients can pick up their medications and receive medical care; and assistance to address the contextual barriers that

may impact HIV risk behaviors such as substance abuse, mental health, employment, and housing needs for those formerly incarcerated returning to the community.

Additional recommendations to stem the spread of HIV/AIDS within the correctional population while incarcerated and upon return to the community include:

- voluntary HIV screening followed with pre- and post-counseling and medical referrals for treatment;
- ensuring the confidentiality of HIV test results of prisoners;
- making condoms, bleaching kits, and sterile syringes available in correctional settings;
- initiating prevention education at onset of incarceration, during incarceration, at pre-release, and upon community reentry;
- pre-release and discharge planning;
- forming partnerships between department of corrections, public health departments, community-based organizations, community health providers and the community itself to ensure linkages to treatment and prevention services in the community; and

- developing prevention interventions that address the issues of housing, employment, health-care access, and education to address contextual factors that may impact HIV risk behaviors.

The social, economic, and health consequences of incarceration can no longer be ignored. The correctional population's health and the public's health are intimately intertwined. The men and women returning home to their families and our communities are our mothers, fathers, uncles, aunts, brothers, and sisters. Addressing the health needs of this vulnerable population is not only the right thing to do but also the necessary thing to do, because to do otherwise puts our viability as a society at stake. If we do not act earnestly, decisively, and compassionately, the public health crisis and health-care costs that will emerge will decimate our public health and health-care infrastructure and our communities, and will mortgage future generations.

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sexual Men, www.cdc.gov/nchhstp/Newsroom/msmpressrelease.html.

Because of underreporting and, in many instances, a lack of acknowledgment of the existence of the risk group, of the problem, or of any rights or interests of MSM, actual and meaningfully comparative data on MSM and HIV/AIDS education, testing, and treatment is, at best, substantially deficient. The data from one country to another—from simple reporting of what efforts are being initiated, to quantifying what percentage of MSM are or are not being reached, by governments and NGOs—is substantially inconsistent. Whatever reporting is made, it is not good: it both confirms the higher HIV seroprevalence among MSM as well as their lack of access to HIV

education, testing, treatment, and care. This is true with regard to both outreach and feedback. Reporting in 2007, the Global HIV Prevention Working Group, convened by the Bill & Melinda Gates Foundation and the Henry J. Kaiser Family Foundation, estimated that HIV prevention services reach only 9 percent of MSM. The Global HIV Prevention Working Group, *BRINGING HIV PREVENTION TO SCALE: AN URGENT GLOBAL PRIORITY* (2007). Similarly, in 2006 and again in 2008, the United Nations estimated that “Globally, less than one in 20 men who have sex with men have access to the HIV prevention, treatment and care services they need.” *UNAIDS, REPORT ON THE GLOBAL AIDS EPIDEMIC*, Joint United Nations Programme on HIV/

AIDS, Geneva (2006). Also in 2008, amfAR (The Foundation for AIDS Research) reported that “on the percentage of men who have sex with men receiving HIV prevention services show that . . . 71% of countries did not report on this indicator, [and] where information was reported, access to HIV services for men who have sex with men varied from 12% in Africa to 43% in Latin America.” *SPECIAL REPORT: MSM, HIV, AND THE ROAD TO UNIVERSAL ACCESS—HOW FAR HAVE WE COME?*, http://data.unaids.org/pub/report/2009/jc1720_action_framework_msm_en.pdf (emphasis added).

Stigma, HIV/AIDS, and MSM

Stigma drives this issue, and it is manifold. It includes and is fueled by social

disapproval of homosexuality, fear of HIV, and, arguably, the influence one has on the other. Moreover, the stigma of HIV alone carries with it a mostly inexorable threshold (and often unspoken) presumption in much of the world that HIV seroconversion—at least among men—necessarily results from male-to-male sex.

The prevailing prejudice and social stigma surrounding male-to-male sexual activity and homosexuality, and HIV, at once defines, informs—and indeed, inhibits—HIV education and prevention among MSM throughout the world and the behavior of men seeking sex with men. This prejudice affects their willingness and ability to seek, find, and access established programs for HIV prevention, care, and treatment, and significantly complicates any structural or institutional attempts, both within as well as across political states, to reach them. Deeply entrenched social, political, and religious animus toward sexual activity between men and homosexuals, as well as HIV/AIDS, leads to pervasive stigma associated with each. Stigma surrounds and attaches to self-identification of homosexual behavior or identity, and is prevalent and pervasive among MSM—whether or not they self-identify with homosexual orientation—from social settings or societies where homosexuality is either illegal or at least not acceptable under any acknowledged circumstances, to those where it has gained greater acceptance and social integration. Prejudice and stigma inhibit and limit both outreach to and equal treatment of MSM, and cause them to limit their actions in seeking, much less availing themselves of, what programs or strategies may exist. Further, stigma, and its consequences—from social ostracism to criminal prosecution and imprisonment for mere status as homosexual—discourages MSM from even casual association with homosexual identity or with established HIV outreach and education, where it is widely presumed—partic-

ularly among men—that HIV infection is *per se* associated with male-to-male sexual activity. Thus, stigma attaches to both sexual orientation and HIV status, causing widespread fear among MSM that they be identified by either, and risk condemnation, social ostracism, or even criminal sanction where homosexuality remains punishable by criminal and religious law, and where transmission of HIV is becoming increasingly criminalized even in so-called western democracies that may have decriminalized, to a great extent, male-to-male sexual activity.

Further, prejudice and stigma are not limited to official, government efforts to reach MSM. Private groups, NGOs, and particularly religious entities continue to fail to acknowledge or accept the existence of homosexuals, or the incidence of MSM among their groups, excluding MSM from established HIV programs they may otherwise implement, and limiting the reporting of efforts to reach MSM.

The human rights crisis results from both the unequal treatment of MSM in HIV/AIDS strategies caused by prejudice and stigma as well as foreseeable consequences of this failure, including both the resulting disproportionate effect of the pandemic on MSM, and the increased exposure to those who may unknowingly or unwittingly engage in sexual activity with them, particularly women. The abysmal official failure to reach MSM and the underreporting of efforts to do so, where they exist, and of the efficacy of such efforts, are in significant part a direct consequence of the stigma surrounding homosexuality, HIV, and the combination of the two. Although these problems are neither new nor unknown, little has changed since the UNGASS 2001 DoC and its specific call to action on human rights and HIV.

MSM and Women

Complicating the lack of self-identification among MSM is the

known fact that a substantial—again, neither accurately measured nor quantified—portion of MSM also (and often primarily) have sex with women, typically in marital relationships. “Overall, the HIV epidemic among men who have sex with men contributes significantly to wider HIV epidemics. In most countries of the world, the majority of men who have sex with men also have sex with women.” UNAIDS, *UNAIDS ACTION FRAMEWORK: UNIVERSAL ACCESS FOR MEN WHO HAVE SEX WITH MEN AND TRANSGENDER PEOPLE*, data.unaids.org/pub/report/2009/jc1720_action_framework_msm_en.pdf. “As men who have sex with men may also have sex with women, if infected they can transmit the virus to their female partners or wives.” UNAIDS Policy Brief, *HIV AND SEX BETWEEN MEN* (2006), at http://data.unaids.org/publications/irc-pub07/jc1269-policybrief-msm_en.pdf.

The risk of HIV infection, already higher in populations of MSM than in society as a whole, is silently transferred to women, who are often unaware, frequently unwitting, and, at best, given the predominant lack of gender equality in much of the world, too often in social or political (and even religious) settings where they remain marginalized, have few resources or autonomy independent of men, or lack access or awareness to pursue whatever strategies may be available. Consequently, these women are unable, or fail, to avail themselves of appropriate education and treatment.

The result is known and foreseeable: substantially higher rates of HIV seroprevalence among MSM contributes to higher rates of infection among women who have sexual relations with them. Stefan Baral, et al., *Elevated Risk for HIV Infection among Men who have Sex with Men in Low- and Middle-Income Countries 2000–2006: A Systematic Review*, 4 PLOS MEDICINE, e339 (2007), at www.plosmedicine.org/article/info:doi/10.1371/journal.

pmed.0040339. The failure to reach MSM results in a corollary failure to reach these women.

Increasing Criminalization of HIV Transmission

Finally, increasing calls for criminalizing HIV transmission and status—primarily driven by the fear and prejudice that has accompanied the pandemic since it first appeared, as well as by longer-standing prejudice against homosexuality and male-to-male sex—now appear to be resulting from the failure of governments and NGOs to equally and adequately reach MSM in HIV outreach, education, care, and treatment. Where the ability to control or limit the spread of new infection is known, but where, among MSM, the efforts are unevenly applied and continue to fall far short of stated goals, the results are not limited to increasing and disproportionate HIV seropositivity among MSM relative to other risk groups, but in increasing calls for criminalizing both behavior and status. The efforts at criminalization are increasing, and are misplaced, and only further marginalize MSM and prevent them from seeking, or obtaining, appropriate education, care, or treatment. E. Cameron, *Criminalization of HIV Transmission: Poor Public Health Policy*, 14 HIV/AIDS POLICY & LAW REVIEW (2009).

Conclusion

The nexus between human rights and HIV is difficult to both define and address with populations of MSM. The difficulty stems from the fundamental lack of an identifiable population from culture to culture and the myriad impediments to outreach, education, testing, and treatment of persons who are at greater risk of infection than the general population, but at lesser visibility because of the stigma surrounding male-to-male sex and the social, religious, and, in much of the world, formal political disapproval of homosexuality, and sexual activity between men in particular. It is acknowledged that available education, testing, and

treatment reaches MSM significantly less than it does any other HIV risk group, even though MSM continue to have higher HIV seroprevalence than other groups. In contrast to other established goals of HIV education and prevention, organized efforts to equally reach MSM have universally failed, and this is a human rights failure of increasingly staggering proportions. This includes the foreseeable, and equally alarming, increasing HIV seropositivity among women whose only known risk of infection is from sexual relations with MSM.

In 2009, the UN published its *UN-AIDS Action Framework: Universal Access for Men Who Have Sex with Men and Transgender People*, which resulted from a comprehensive review of strategies to date and particularly since the 2001 UNGASS DoC on HIV/AIDS. The report sets forth in detail three comprehensive objectives: to “[i]mprove the human rights situation for men who have sex with men and transgender people—the cornerstone to an effective response to HIV”; to “[s]trengthen and promote the evidence base on men who have sex with men, transgender people and HIV”; and to “[s]trengthen capacity and promote partnerships to ensure broader and better responses for men who have sex with men, transgender people and HIV” (www.data.unaids.

org/pub/report/2009/jc1720_action_framework_msm_en.pdf). The objectives are supported in detail. Given the scope of the problem and the failure to date to bridge the widening gap between MSM and HIV education, access, and care, the challenge appears substantially greater than ever. It comes as little surprise to most who have followed the pandemic and who understand the unique problem of social stigma against HIV and longer-standing social disapproval of male-to-male sex, that when it comes to MSM, such efforts have met with little success.

Experience shows 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 response. Countries may choose to prioritize one or the other component but both have to fall into place to effectively deal with the epidemic as it relates to sex between men. UNAIDS Policy Brief, HIV AND SEX BETWEEN MEN (2006)

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Rapid-Onset Natural Disasters and HIV “Collateral Mortality”

By Andre W. Rawls and Shelley D. Hayes

Efforts towards Universal Access can only succeed if HIV prevention, care and treatment are included in emergency programs. HIV AND EMERGENCIES: ONE SIZE DOES NOT FIT ALL (Overseas Development Institute, 2009)

Earthquakes, hurricanes, tsunamis, tornadoes, and floods all bring pictures to mind of toppled buildings, impassable streets, broken limbs, and crushed skulls. Mothers crying for their children; children crying for their mothers. Fathers digging through rubble searching for them both. Relief workers arriving by helicopter. Doctors Without Borders. The American Red Cross. The Red Crescent. Many people die. And many are saved. Embedded in those graphic images of death and destruction and of those trying to save lives in the immediate aftermath of a rapid-onset natural disaster is the unseen and seldom-discussed “collateral mortality” that accompanies such emergencies: loss of continuity in care for those living with HIV. That loss has severe ramifications in the battle against HIV.

Antiretroviral drugs (AVRs) are medicines that prevent the reproduction of retroviruses like those that cause AIDS. Researchers believe that high levels of adherence to antiretroviral drug regimes—uninterrupted treatment—are necessary to prevent the emergence of drug-resistant viruses and to achieve suppression of HIV in an individual. Indeed, strong evidence exists that keeping the viral load—the amount of HIV nucleic acid (RNA) in a patient’s system—as low as possible for as long as possible can decrease the complications that go along with HIV disease, slow the progression from HIV infection



Associated Press, AP

Michael-Chase Creasy was one of many HIV-positive people displaced by Hurricane Katrina. With HIV services shut down following the hurricane, many HIV-positive residents didn’t know where to turn for antiretroviral drugs and treatment.

to AIDS, and prolong life. Many researchers also believe that maintaining a suppressed viral load makes an individual less likely to transmit the virus to others.

In August 2005, Hurricane Katrina—believed to be the largest natural disaster in American history—made landfall in the state of Louisiana. Hardest hit was its “Crescent City,” New Orleans. According to author Bonnie Goldman:

Until the morning of Aug. 29, New Orleans was the center for HIV care in Louisiana, with many of the state’s 15,000 HIV-positive residents. The city had the highest number of newly diagnosed cases and the second-highest HIV/AIDS case rate in the state, below only the Baton Rouge area. It is no surprise, then, that the city served as the headquarters for the Louisiana state HIV/AIDS program, or that it was the primary setting for HIV research in Louisiana. *Snapshots of Hurricane Katrina’s Effect on the AIDS Community: Louisiana* (Sept. 8, 2005) available at thebody.com.

When the storm passed, New Orleans was a deserted city, 80 percent

of which was under water. According to a Kaiser Foundation report:

[H]urricane Katrina inflicted massive damage on three of the poorest States in the country: Louisiana, with a poverty rate of 22 percent; Mississippi, with a poverty rate of 23 percent; and Alabama, with a poverty rate of 20 percent. Katrina also caused the evacuation of a major American city, where 23 percent of residents lived in poverty before the levees were breached. Of the 1.1 million Americans forced to leave their homes in New Orleans and other devastated areas, the majority appear to have relocated elsewhere within their States. Perhaps as many as half a million have been relocated to Texas and other States of refuge, many of which have high rates of poverty themselves (22 percent of Texans live in poverty). KAISER FOUNDATION, ADDRESSING THE HEALTH CARE IMPACT OF HURRICANE KATRINA (2005).

HIV/AIDS care in New Orleans was profoundly different post-Katrina, as an article by Rex Wockner reveals (*New Orleans AIDS Agencies Struggle* (Apr. 5, 2006) WINDY CITY TIMES. Beth Scalco, then director of

Louisiana's Office of Public Health HIV/AIDS Program, reported that, "Five of our 10 community-based prevention contractors basically went out of business due to heavy damage to their buildings and because they experienced a big loss of their staff in terms of people who decided not to return to New Orleans." All HIV services were shut down for several weeks after Katrina. "Some were out of service longer than others, depending on their location, if they were able to get staffing back and if they actually had any clients," according to Noel Twilbeck Jr., executive director of the NO/AIDS Task Force. In addition, Scalco reported, "In the evacuation turmoil, people often did not pack everything they needed. A lot of people also were unable to access medications [elsewhere]. It also takes some people a lot of time to re-engage with medical care, which means they could be going several months without medication." There were some individuals who stopped taking their drugs "because they had never revealed their HIV status to the friends or family members to whose homes they evacuated." As a result, some people with HIV went without their antiretroviral drugs with the attendant treatment interruptions immediately after the storm and for months thereafter, according to Scalco.

After the storm, thousands of New Orleanians spent days in the Superdome and the Convention Center without access to basic necessities. The sight of a child that caught the attention of the television cameras very vocally expressing his concern that his grandmother needed her diabetes medicine could have been echoed many times over.

Hurricane Katrina provided the public health community with a number of lessons. One of the recommendations that the Trust for America's Health (TFAH) developed was to establish clear preparedness standards for all states, explaining that preparedness varies from state to state and community to com-

munity. Yet the U.S. Department of Health and Human Services has not established clear benchmarks and objective standards for preparedness in states. Those objectives, whenever forthcoming, should focus on outcome results from real-life drills and exercises. Current benchmarks are often process-oriented and are not clear predictors of how well a state will respond to an emergency. TFAH further recommended that states upgrade surveillance systems so they meet national standards and are interoperable between jurisdictions and agencies to ensure rapid information sharing. TRUST FOR AMERICA'S HEALTH, ON THE THIRD ANNIVERSARY OF HURRICANE KATRINA, TRUST FOR AMERICA'S HEALTH QUESTIONS STATE OF NATIONAL EMERGENCY PREPAREDNESS (2008), available at <http://healthyamericans.org/newsroom/releases/?releaseid=140>. Insuring access to a stockpile of medication to address chronic illness is another of their recommendations.

With the recommendations emerging from the Katrina experience as standards, the world of health care and emergency preparedness was struck with another test. On January 13, 2010, an earthquake measuring 7.3 on the Richter scale struck Haiti, inflicting severe devastation in the capital, Port-au-Prince, and Haiti's West Province. As many as 3 million people potentially were affected by this massive earthquake. The internal damage to hospitals and health care was as devastating as the quake itself, with medical structures being unsafe for existing patients. The conditions may be even more disastrous for an already vulnerable community—Haitians living with HIV/AIDS.

UNICEF estimates that 5.6 percent of the pre-earthquake 15- to 49-year-old population was HIV-positive, including about 19,000 children. HIV/AIDS is the nation's leading contagious cause of death, making the loss of AIDS services particularly dangerous. Many of the clinics that were destroyed were HIV/AIDS clin-

ics, and many of their staff members were killed. According to reports, almost no one seemed to have access to ARVs. However, in one area of Haiti an emergency plan was in effect to address hurricanes. That plan was activated and the organization in charge was able to administer almost 900 doses of ARVs on a daily basis. Clearly, the issue of providing effective health care during emergency situations continues to present issues that are not consistently resolved, resulting in "collateral mortality."

The recommendations set out by TFAH are clear and concise. What might be added is the technology of electronic medical records with biological identification. Consider the possibility of being able to identify, by fingerprint, those who perished in Haiti. The Health Information Management Systems Society's definition of EHRs reads:

The Electronic Health Record (EHR) is a longitudinal electronic record of patient health information generated by one or more encounters in any care delivery setting. Included in this information are patient demographics, progress notes, problems, medications, vital signs, past medical history, immunizations, laboratory data, and radiology reports. The EHR automates and streamlines the clinician's workflow.

State-of-the-art technology has added the element of biological identification. Such systems currently are in development and should be incorporated into emergency-preparedness plans to guarantee the right health care during emergencies.

The Overseas Development Institute offers specific elements that it recommends states include in their preparedness plans to address rapid-onset natural disasters: (1) contingency-planning options for all situations to ensure continued supply and access to ARVs, especially in areas suffering repeated natural disasters; (2) access to food assistance for people on antiretroviral therapy; (3) access to free condoms; (4) continuation and reinforcement of anti-

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American Cities Lead the Way

HIV Testing Is for Everyone

By Marsha A. Martin

The U.S. Food and Drug Administration (FDA) approved the first test to determine the presence of HIV antibodies in humans, enzyme-linked immunosorbent assay, or ELISA, in 1985. That year, there were 5,636 deaths in the United States attributable to AIDS. The FDA approved the Western Blot, a test to confirm HIV infection, in 1986—a year in which 2,630 Americans are reported to have died from AIDS. In 1987, the FDA approved AZT (zidovudine, or Retrovir) as the first drug to treat HIV/AIDS; there were 4,135 deaths in the United States attributable to AIDS that same year. In 2002, the FDA approved the first HIV “rapid test” for use in this country. Unlike results from an ELISA, which take several days to receive, “rapid test” results are available in twenty minutes. By 2006, the FDA had approved nearly a half-dozen “rapid tests” for HIV screening and more than two dozen drugs to treat HIV. And that year, approximately 56,300 Americans were newly infected.

HIV infects white blood cells known as CD4+ cells, which are part of the body’s immune system that help fight infections. An HIV test detects antibodies to HIV or the genetic material (DNA or RNA) of HIV in the blood or another type of sample. If the test reveals that HIV infection is present (i.e., one is HIV-positive), confirmatory tests are required. HIV testing in the early years was characterized by legal requirements for specific, written, informed consent; anonymity; recommendations for significant pre- and post-test counseling; and, too often, lack of follow-up care.

Some cities in the United States have been harder hit by HIV than others. As of 2008, 3 percent of the

residents in the nation’s capital of Washington, D.C., were known to be living with HIV/AIDS, a rate three times higher than the definition of a generalized and severe HIV epidemic as defined by the U.S. Centers for Disease Control and Prevention (CDC). Oakland, California, is home to a half-million people on the east side of the San Francisco Bay. In Oakland and surrounding Alameda County, more than 7,000 AIDS cases were diagnosed among residents from 1980 to 2006. The majority were either African American (44 percent) or white (42 percent), male (86 percent), and adults ages 30 to 49 years (71 percent). Los Angeles is the second largest city in the United States, with a population of more than 3.7 million people. Estimates suggest that approximately 30,000 people in the City of Los Angeles are living with AIDS or HIV—including those who do not yet know they are infected. Houston/Harris County, Texas, had an AIDS rate of 17.8 percent in 2007. Houston’s annual rate in new HIV infections is nearly twice the national average, and although blacks and Latinos account for only 60 percent of Houston’s population in 2006, they made up 78 percent of the city’s HIV cases. Miami-Dade is located in southeastern Florida. According to the regionally based Care Resource, the Miami metropolitan area has the highest AIDS rate in the nation at 52.8 percent. It is experiencing a generalized epidemic with nearly 1.5 percent of the population of Miami living with HIV or AIDS.



A poster in the Bronx, New York.

More than 100,000 New Yorkers are living with HIV. New York City has the highest AIDS case rate in the country, with more AIDS cases than Los Angeles, San Francisco, Miami, and Washington, D.C., combined. Each year, more than 1,000 people in New York City first find out they are HIV-positive when they are already sick with AIDS and 80 percent of new AIDS diagnoses and deaths are among African Americans and Hispanics. In 2004, the Bronx, one of New York City’s five boroughs, was the poorest of America’s 435 congressional districts. The death rate from HIV in the Bronx is higher than in the rest of New York City, and a growing number of people in the Bronx (40 percent) who find out they are positive, find out the same day that they have AIDS.

American Cities Take Action

In 2006, the Department of Health in Washington, D.C., launched an aggressive HIV testing initiative to encourage all citizens between the ages of 14 and 84 to get tested for HIV. The initiative, Come Together DC—Get Screened for HIV, was the first municipal HIV testing initiative in the United States. City leadership got the community involved at the outset—government leaders, health and civic, community and government, clinics and hospitals—all were engaged; faith-based leaders were an important part of the conversation. City officials called stakeholders in for a meeting with physicians. In addition to local philanthropists, the city involved the corporate sector, 75 percent of whom are academic institutions, hospitals, and clinics. And D.C. developed a system for monitoring and evaluating the data.

Also in 2006 the CDC published *Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health Care Settings*, which called for routine screening in medical settings of all patients between the ages of 13 and 64. And while the recommendations were for health-care providers, physicians, and public health officials, AIDS service organizations and HIV advocacy organizations throughout the United States raised serious objections to the recommendations and their planned implementation. As a result of the protests and confusion over some “controversial” issues, including informed consent and mandatory screening, the aforementioned recommendations were largely ignored. In the meantime, the epidemic continued unabated, while the HIV testing recommendations were put on the shelf and ignored.

Then, in the summer of 2008, the CDC released new data showing an increase in annual HIV transmissions from an average of 40,000 new infections a year to more than 56,000 new infections. With the publication of the revised estimates of HIV trans-

mission, many in the HIV community and health sector began to rethink the need for expanded HIV testing and to develop strategies to implement the CDC’s revised recommendations. Municipal-level, citywide HIV testing—following the lead set by Washington, D.C., in 2006—has emerged as one such strategy.

Between 2006 and 2009, the high-impact jurisdictions of Oakland, Los Angeles, Houston, Miami/Dade County, and the Bronx joined Washington in scaling up HIV testing. Get Screened Oakland, Test LA—Erase Doubt.Org, Hip-Hop for HIV Test, Test Miami, and The Bronx Knows, the current municipal HIV testing scale-up initiatives in the United States, all strive to educate their citizens about HIV infection, retool public health agencies, and involve all sectors in the community in citywide public health education and macro intervention efforts.

Municipal Testing

The premise behind the municipal HIV testing initiatives is that HIV is a virus, transmission is preventable, and lifesaving medicines are available for those requiring treatment. Screening for HIV is necessary to detect the presence of the virus and to determine whether transmission/infection has occurred and whether and when to start treatment. The health sector, at the very least, should be testing people for the presence of the infectious virus, and for those whose test result is positive, engaging in treatment. To that end, U.S. Department of Health and Human Services agencies including the CDC, in partnership with the National Institutes of Health and the Health Resources Services Administration, funded a two-day think tank in late 2009 entitled Test and Treat. Why? Because, after nearly three decades, it’s now commonly accepted that HIV testing should be a routine component of regular health care. People who require treatment should have *universal* access to lifesaving medications regardless of where she or he might live.

The intervening premise is that people who know their HIV status tend to make healthier decisions. An estimated one-quarter of all individuals infected with HIV in the United States are unaware of their HIV status. Data shows that the majority of new infections result from those individuals who are unaware of their HIV status. Routine testing for HIV helps to bridge the gap between those who know their HIV serostatus and those who do not—making it easier to begin to control and prevent the spread of the virus. The summary premise is that public health evidence suggests that people who are HIV positive and are aware of their HIV serostatus are less likely to transmit the virus to others. HIV testing is the key to disease control and prevention.

As a result of these innovative HIV testing initiatives and the new CDC guidelines, the public health goals and human rights and protections of the 1980s and 1990s have necessarily been re-engineered to better respond to the realities of the HIV epidemic today. In many countries, states, and counties, informed consent laws have been revised and changed. Confidential testing and name-based reporting have replaced anonymous testing and code-based reporting. “Opt-out” testing has replaced “opt-in” testing. Risk-based targeted testing has been replaced by offering HIV testing to everyone regardless of traditionally thought-of risk factors. Pre- and post-test counseling processes have been abbreviated and HIV testing algorithms have been adapted to support rapid HIV testing protocols that reveal HIV serostatus in 15 to 30 minutes. CD4 counts of 350 have replaced CD4 counts of 200 as the recommended indication of the need for treatment. Lifesaving medications are more readily available in many communities. And the new “combination” of testing, education, treatment, and prevention interventions is believed to contribute to the reduction in the rate of HIV in communities.

Whose Business Is It?

By Denise McWilliams

The simplest definition of privacy is “that which is no one else’s business.” Unfortunately, much of what has traditionally been considered private has become the business of a great many. People’s private information is no longer sought merely because a greater understanding of their personal and unique characteristics can benefit them, but because so many others can benefit from that same understanding: people who resemble each other in some biologic or behavioral way, researchers seeking answers to diseases or conditions whose root cause is genetic, marketers trying to fine-tune product delivery, or government agencies determining which programs are successfully achieving their goals.

Absent a judicial order, the holder of private information has historically been free to decide with whom and how to share that information. The holder decided what was to be revealed, to whom, and for what direct benefit. Typically, holders would disclose private information to their doctors for treatment, to their employers for work, or to a clergyman for comfort. These transactions were simple and tended to be face-to-face, with clear parameters. This is no longer the case.

Electronic medical records (EMRs) exemplify the evolving context. EMRs clearly facilitate the aggregation of massive amounts of data about people’s experiences with particular genetic markers, diseases, medications, and other treatments. It is hard to argue against the benefits of data analysis on this level. It is quite possible that the holder could eventually realize a benefit to her own health, and even if she never realizes a direct benefit from the use of her private information she could benefit

because of knowledge gained from someone else’s private information.

Perhaps less compelling is the behavioral analysis and targeting that results from our purchasing history. Most enjoy the convenience of Amazon’s recommendations. However, it could be a small leap from Amazon recommendations to the personalized marketing depicted in the movie *Minority Report*. There, biometric identification of the hero led to an instantaneous analysis of his purchasing history, which was translated into targeted recommendations of consumer items, all as he walked past various stores in the mall of the future. For all sorts of businesses, such data is a gold mine, offering the promise of greatly enhanced sales for the full range of consumer items.

Hidden behind the promises of benefits, including financial reward, is the total disintegration of any meaningful concept of privacy. Most people are willing to disclose private information in exchange for a promised benefit. But traditional privacy protection is contingent upon not disclosing private information or restricting the disclosure to specific uses. Once private information is disclosed for any benefit, it is increasingly difficult to curtail its further disclosure.

There have been isolated examples of the harm that results from the misuse of private data in the United States, but nothing, fortunately, that rivals the seminal European experience. Nazi Germany had much to do with the shaping of Europe’s approach to privacy. Hitler’s Final Solution depended on the existence of detailed records, including census data, for its execution. Cautioned by this experience, European nations have been inclined to view privacy

as a fundamental human right and have placed significant restrictions on those who seek to use others’ personal information. The European Union has established strict standards requiring, among other safeguards, transparency, notice, a legitimacy of purpose, and proportionality. There is much to admire in the European approach, but the political situation renders its adoption in the United States highly unlikely.

Organizations from across the political spectrum have an interest in people’s private information. Corporations believe that private information can increase profits, unions look to it to increase membership, and public health officials seek to utilize it to improve health outcomes. The recent U.S. Supreme Court decision removing restrictions on corporate political spending will result in more elected officials sympathizing with organizations’ desire to maximize their access to and use of private information, and being less inclined to uphold traditional notions of privacy. All the incentives push toward a disintegration of the private sphere.

Our traditional approach of offering protection only to certain categories of information and only then when the holder keeps the information private is simply inadequate for this era. Other approaches, such as licensing, use restrictions, required de-identification of information, or strict liability for uses outside those designated by the holder need to be adopted if privacy is to have any meaning. The window for advocates to act is narrow, and we need to begin to act now.

Denise McWilliams is general counsel, AIDS Action Committee of Massachusetts, Inc. in Boston.

Municipal HIV testing initiatives are community engagement programs that work. Under the auspices of the highest elected official, such as mayor, health department director, or provincial, district, or county leader, municipal HIV testing initiatives bring renewed attention and leadership to HIV in the community. At a time when many communities, agency leaders, and advocates voice concern about HIV fatigue, municipal engagement brings an infusion of untapped energy, renewed dedication, and new opportunities for collaboration. Washington, Oakland, Los Angeles, Houston, Miami, and the Bronx all increased HIV testing between 20 and 50 percent in the first year of their initiatives.

Planning a Municipal HIV Testing Initiative

With leadership in hand, all segments of the community can become involved and re-engaged and increase the public health effectiveness of the local HIV/AIDS strategy. What follows is a suggested implementation framework checklist for planning a municipal HIV testing initiative.

- Think tank–style meeting—convene community leaders to assess and review current HIV agenda, laws, and regulations, envision change, and develop plan of action.
- Implementation task force/workgroup—identify community stakeholders to provide expertise and guidance on challenges associated with the municipal initiative.
- Community engagement plan—recruit community-based organizations, public health partners, advocacy organizations, philanthropic resources, and faith-based and private-sector leadership to assist with implementation.
- Social marketing strategy and media outreach—identify paid and pro bono public relations and media partners in order to develop an effective media strategy including web-based pro-

motions; radio, television, and video opportunities; and public venue banners, palm cards, brochures, transportation-related ad placements, billboards, and other outdoor possibilities.

- Private-sector outreach and engagement—reach out to largest employers and private-sector corporate partners for in-kind resources and ongoing community support for HIV testing, prevention, and awareness.
- HIV-testing technical education and training—develop a testing protocol and conduct training prior to implementing the municipal initiative.
- Clinic, health center, and hospital workgroup—convene regularly scheduled meetings of the health sector in order to streamline HIV testing and enhance HIV treatment services and support.
- Data collection, monitoring, and evaluation—ensure constant program monitoring and evaluation of the initiative by partnering with current and new testing sites through the development of memoranda of understanding.

Rapid-Onset

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stigma campaigns; (5) dialogue and collaboration between actors in the humanitarian and HIV response; (6) targeting of people living with HIV for specific and long-term support; and (7) recognition that the importance of transactional sex as a way of “coping” has been underestimated and needs more policy attention.

Despite these recommendations, many government-maintained disaster-preparedness plans are silent on HIV even as they provide specific recommendations addressing cancer, deafness and hearing impairment, diabetes, hereditary blood disorders, high blood pressure, and “special

- Announcement of municipal HIV testing initiative goals—such as to make HIV testing a routine component of regular health care; identify new cases and reduce “late testing;” raise awareness about the importance, availability, and ease of HIV testing; reduce HIV transmission; and link HIV-positive persons to regular and ongoing HIV care and treatment.

It has been said that HIV is the only infectious disease that has been left to the community to identify, treat, and manage. HIV is a virus requiring medical attention and intervention, is it not? Why, then, is it acceptable for health-care providers to ignore it? Where are the human rights protections when trained health-care providers ignore guidelines and recommendations? HIV screening is for everyone, even health-care providers. They must offer the test, protect human life, and in doing so, affirm everyone’s human rights. It is the humane thing to do.

Marsha A. Martin is the director of Get Screened Oakland.

populations” (a designation in which persons living with HIV/AIDS are not included) during emergencies. Meeting their obligation to guarantee the right to health for their citizenry requires states to include persons living with HIV/AIDS in their disaster planning—be it to address natural disasters or conflict situations—without further delay. “Collateral mortality” is an unacceptable loss of life.

Andre W. Rawls is the past president of the National Alliance of State and Territorial AIDS Directors (2007). Shelley D. Hayes is chair and a founding member of the ABA AIDS Coordinating Committee and a member of the Section of Individual Rights and Responsibilities Section Council.

Introduction

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being reported each year. Our nation's capitol of Washington, D.C., with an HIV infection rate at 3 percent of the population, has the highest rate in this country and also is suffering a generalized epidemic.

In contrast to such geographically defined epidemics, when we look at sub-populations we often find a "concentrated" epidemic—where less than 1 percent of the general population but more than 5 percent of any "high risk" group is HIV-positive. A concentrated epidemic is one confined mainly to individuals who engage in high-risk behaviors, such as men who have sex with men (MSM), people who inject drugs, prisoners, and sex workers. Most-at-risk, marginalized populations have little access to HIV prevention, treatment, and care services and may be subject to additional discrimination based on their HIV status. Many vulnerable people also are subject to human trafficking and the attendant lack of even basic health care.

Whether they reside in areas of generalized epidemic, or belong to populations making up a concentrated epidemic, international organizations long have recognized that all persons are entitled to basic human rights. Those rights include, among others, the right to health, mentioned above. They include also the right to privacy established in Article 17 of the International Covenant on Civil and Political Rights, the right to liberty and security of the person found in Article 9 of the International Covenant on Civil and Political Rights, and the right to education enunciated in Article 26 of the Universal Declaration of Human Rights.

Recognizing the growing pandemic, and its effects on global development and security, multilateral organizations have led the efforts to contain it. Thus, the United Nations General

Assembly has adopted two major documents establishing significant goals in the global fight against HIV/AIDS. First, in 2000, members adopted the Millennium Development Goals (MDGs) that call for a halt to the spread of AIDS by 2015. In 2001, nations attending the United Nations General Assembly Special Session on HIV/AIDS adopted a blueprint for action in the Declaration of Commitment on HIV/AIDS (DoC). The DoC sets targets and goals based on human rights law and principles in four areas: prevention (of new infections); provision of improved care, support, and treatment for those infected with and affected by HIV/AIDS; reduction of vulnerability; and mitigation of the social and economic impact of HIV/AIDS.

Later, in 2003, the Joint United Nations Programme on HIV/AIDS and the World Health Organization established a goal of providing access to treatment to 3 million people in the developing world by 2005. When that goal went unmet (and in an effort to meet the MDGs by 2015) in 2005 at the Group of Eight Summit, and again at the United Nations General Assembly World Summit, there was a call to develop programs for HIV prevention, care, and treatment "with the aim of coming as close as possible to the goal of universal access to treatment by 2010 for all those who need it." While progress has been made in reaching that goal of universal access, it, too, remains unmet.

Reaching those goals requires states to address human rights issues through legislative or judicial action, for some jurisdictions continue to enact and enforce laws and policies that interfere with the accessibility and effectiveness of HIV-related measures for prevention and care that have been shown to be effective. Increasingly around the world there is a move to criminalize consensual sex between adults, in particular MSM and sex workers. Many states and jurisdictions also have laws that

prohibit access to clean needles for injection drug users and condom distribution for prisoners, or use residency requirements to determine access to care and treatment. Such laws fuel extant stigma and discrimination; discourage people from being tested for HIV; erect barriers to adequate HIV education; and contribute to the spread of disease.

States must, in addition to eliminating HIV-specific barriers to disease eradication, evaluate and address general laws and customs that contribute to the spread of the epidemic. Far too many persons living with HIV/AIDS are subject to discrimination because laws prohibiting it are nonexistent or not enforced. In too many jurisdictions, gender-based discrimination is left unaddressed while evidence increasingly shows a link between HIV and the denial of property and inheritance rights of women and girls.

Clearly, a confluence of human rights violations is shaping today's HIV/AIDS crisis. Worldwide we see both generalized and concentrated epidemics sharing as a common thread the State's failure adequately to insure the rights enumerated by various world bodies. In the following articles, we aim to highlight just some of the human rights to which those infected with HIV are entitled and to illuminate how their continuing denial fans the flames of this global catastrophe.

Shelley D. Hayes is chair and a founding member of the ABA AIDS Coordinating Committee and a member of the Section of Individual Rights and Responsibilities Section Council. Hayes has substantial experience in HIV/AIDS-related legal issues, both as a committee member and in private practice. Formerly a health-care and employment trial lawyer, Hayes now provides consultative services to public and private entities on human resources and employment matters, including HIV/AIDS in the workplace.

Sex Trafficking

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mission, what often are not addressed are the trafficking, forced prostitution, and sexual violence against women and girls. Despite the historical tension between anti-trafficking and HIV organizations, more common ground than not exists between them and should be pursued by both.

Ending Sex Trafficking as a Tool for Curbing the Spread of HIV

One promising practice to reduce the global epidemics of HIV and sex trafficking, as proposed by Holly Burkhalter, former U.S. Policy Director of Physicians for Human Rights, during testimony before the U.S. House of Representatives International Relations Committee, is to frame the ending of sex trafficking as a tool for preventing HIV/AIDS. This approach would be effective for a number of reasons. First, it would provide an immediate road map for anti-trafficking and HIV prevention organizations to work together. Once the positive correlation between the reduction of sex trafficking and new HIV infections is identified, groups with formerly disparate goals will have a common goal around which to unite. HIV/AIDS prevention and trafficking prevention organizations

working together to find common ground is crucial to effectively addressing both of these epidemics.

Second, the Trafficking Victims Protection Act (TVPA) can be used as a tool to convince foreign countries to address the dual epidemics of HIV and sex trafficking. When the TVPA was initially passed in 2000, it authorized the U.S. Department of State to issue an annual Trafficking in Persons Report, which places countries on “tiers” appropriate to their efforts to combat human trafficking. Countries placed on Tier 3 do not fully comply with the minimum standards of the TVPA and are not making significant efforts to do so. Pursuant to the TVPA, governments of countries on Tier 3 may be subject to certain sanctions, whereby the U.S. government may withhold non-humanitarian, non-trade-related foreign assistance. These sanctions provide additional leverage with which to convince foreign nations that eliminating sex trafficking and reducing HIV is in their national best interest—in economic, diplomatic, humanitarian, and public health terms.

Finally, the TVPA provides a framework for the collection of data on the intersection of HIV and human trafficking, including a list of countries with limited resources and significant need for human trafficking prevention; the opportunity to collect epidemiological data on the relationship between HIV transmission and sex trafficking; tools

to facilitate collaboration between HIV and trafficking prevention programs; and resources to assist victims of sex trafficking and HIV. However, the ability to fully utilize the framework provided by the TVPA to address the intersection of HIV and sex trafficking rests in the identification of common goals by advocates for both issues.

In conclusion, women and girls are the primary victims of the nexus of the global epidemics of sex trafficking and HIV/AIDS. As sex trafficking victims, women and girls are more vulnerable to HIV infection because of their lack of choice with regard to high-risk sexual activities. Similarly, HIV infection is spread through international and local sex trafficking. This intersection has not been the subject of significant scholarship, possibly in part because of the perceived and actual clashes between HIV and sex trafficking prevention efforts. However, the TVPA provides some tools for both HIV and sex trafficking advocacy groups to move forward collaboratively and identify promising practices for addressing this deadly junction, which has destroyed the lives of so many women and girls.

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humanrights hero

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the public and private sectors in partnerships and collaborations that focus upon reaching highly vulnerable communities throughout the city.

Because Get Screened Oakland is about aggressive engagement, Mayor Dellums took the lead by getting HIV tested before the press on the steps of Oakland's City Hall. In addition, Mayor Dellums put his face on billboards and in public service announcements asking the citizens of Oakland to follow his example by getting tested. Mayor Dellums remains actively involved in the project by en-

couraging other mayors to use his model and by presenting it to other cities both nationally and internationally.

The rise in testing numbers and persons entering treatment is a large indicator of Get Screened Oakland's success. Mayor Dellums's willingness to lead by example and share his model with others has not only contributed to the initiative's success, but has also placed it in position to become a national model. Ronald V. Dellums is truly an HIV Human Rights Hero.

Rev. Damon A. Powell is a theologian, artist, and social activist who resides in the city of Oakland. VaShone Huff serves as the director of Intergovernmental Affairs in the office of Mayor Ronald V. Dellums.



humanrights hero

Ronald V. Dellums

By Damon A. Powell and
VaShone Huff

In the world of HIV and AIDS there are many heroes. Scientists who despite setbacks, continue to search for a cure; doctors and nurses who work tirelessly to increase the health outcomes of their patients; and people living with HIV who continue to speak out against unfair policies and stigma. Yet even among heroes, a particular individual will stand out, and one of those individuals has been Ronald V. Dellums.

After establishing himself as a virtual icon within the world of American politics, Ronald Dellums left that world and entered the battle to combat HIV and AIDS. During his twenty-seven-year political career, Dellums had been instrumental in efforts to get the federal government to declare that Oakland, California, was under a state of emergency because of the rapid spread of HIV within the community, and then procuring some desperately needed funds to help check the spread of the virus within his hometown. But shortly after his retirement from the House he began to immerse himself in the world of HIV both nationally and internationally by becoming the president of Healthcare International Management—an organization that worked with the early South African government to develop low-cost health-care strategies. Dellums witnessed the effects of HIV and AIDS among the people of sub-Saharan Africa and began his own crusade to combat the spread of the virus. Because of his efforts, Dellums became the leading spokesperson on the tragedy of AIDS in sub-Saharan Africa and HIV's spread throughout the world. This led



Associated Press, AP

to his serving as the chair of the President's Advisory Council on HIV and AIDS, and as a board member for the organization AIDS Action. During this time, Dellums attempted to persuade leaders from around the world to commit their governments and businesses to the development of an "AIDS Marshall Plan for Africa."

Presently, Ronald Dellums serves as the mayor of Oakland, California. From the outset of his administration, he began to implement his plan to address the problem of HIV and AIDS within his community. The plan was to launch his own municipal HIV/AIDS initiative, called Get Screened Oakland. The primary goal of Get Screened Oakland is for every citizen within Oakland to know their HIV status. In order to reach this goal, Get Screened Oakland seeks to include HIV screening along with other standardized health-care screenings. This initiative not only combats stigma by normalizing HIV testing, but also opens doors for dialogue around the disease in general. Get Screened Oakland embodies a citywide approach to screening and prevention that involves both

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