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GENERAL INFORMATION

The Russian NAMES Fund is officially registered on March 5, 1993 as a charitable non-governmental organization. Registration certificate no. 1749.

The Russian NAMES Fund works actively in Moscow, St. Petersburg, the Moscow, Rostov and Leningrad regions and has its representatives in 40 regions of the Russian Federation. 11 staff members and over 200 volunteers work in the Central office, branches, and representative offices of the Fund.

The activities of **the Russian NAMES Fund** are financed by grants, monetary and in-kind donations from organisations and individuals.

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THE RUSSIAN NAMES FUND (OVERVIEW OF THE ORGANISATION)



The Russian NAMES Fund is a national non-governmental charitable organization educating the public about HIV epidemic, providing social and psychological support for people with HIV/AIDS and their families, and promoting an effective and non-discriminatory HIV public policy in Russia.

The goal of the Russian NAMES Fund is to provide every Russian citizen with access to adequate information and support in the context of the HIV epidemic.

The activities of the Russian NAMES Fund promote the involvement of people with HIV/AIDS and those from vulnerable groups into the fight against AIDS, co-operation between individuals, NGOs, businesses and governmental institutions, and support the development of the anti-AIDS movement in the Russian Federation.

PROGRAMS OF THE FUND

Counselling of people with HIV/AIDS

Every day in the office, AIDS Centers or by phone, professional consultants provide psychological support, help to resolve legal and social problems, provide the brandnew reliable information. The service works with people with HIV/AIDS, their families and friends to help them to overcome loneliness and social isolation. The consultants organize regular meetings with medical workers to promote better relations between health professionals and their patients.

Support groups

Self-help groups meet twice a month to discuss different issues of life with HIV/AIDS. People with long-term HIV help those who learned of their HIV-positive status just recently to adjust themselves to the life with HIV/AIDS. Trained social workers help to organize the meetings and to conduct them.

Monitoring the human rights in context of the AIDS epidemic

A group of experts of the Russian NAMES Fund monitor and evaluate the Russian legislation on AIDS, ensure the human rights in the context of the AIDS epidemic, inform the public about the facts of human rights violation. This group gives free advice and helps to protect people's rights.

AIDS prevention

The Russian NAMES Fund organizes actions, concerts, QUILT exhibitions, meetings etc. in order to change the society's attitude to AIDS, to promote everyone's awareness of personal risk of HIV infection. The Fund encourages easy public access to methods of HIV prevention. A group of volunteers regularly distribute educational and prevention materials among vulnerable groups: adolescents, women, men who have sex with men, sex workers, drug users.

PROGRAMS OF THE FUND

Publications on AIDS

The Russian NAMES Fund publishes and distributes informational and educational printed materials: booklets, brochures, leaflets and posters. The Fund publishes *INFO-plus*, a bi-monthly journal on AIDS which examines different issues related to the development of the AIDS epidemic in Russia and around the world.

Involving media into the fight against AIDS

Regular collection and distribution to media of the latest and reliable information about the important events around the AIDS epidemic in Russia and abroad and different opinions on resolving the problems connected with the development of the epidemic. Preparation of the social advertisement on AIDS and its publication in media. Meetings with journalists to involve them into the education and HIV prevention and into the change of attitude of Russian citizens towards AIDS.

Meetings on AIDS

Monthly discussion meetings for employees and volunteers of non-governmental and governmental organizations, journalists, people living with HIV/AIDS, as well as anyone else interested. Participation of the specialists from different fields enables to obtain more detailed information on various aspects of AIDS, to share opinions and experience.

Education and exchange of experience

The Russian NAMES Fund organizes educational seminars, trainings and internships for employees and volunteers of non-governmental organizations, journalists, social and medical workers. The education is carried out by trainers of the NAMES Fund and specialists from other Russian and foreign organizations. The Russian NAMES Fund holds conferences for organizations working in the sphere of AIDS to share experience, discuss problems and develop joint strategies.



AIDS infoshare's work on the prevention of the HIV infection amongst students of the Moscow Police Academy.

The Administration of the academy approached our organisation with a request to conduct informal discussions with their students on the subject of HIV/AIDS prevention. The very fact that we were approached is significant and shows the change in attitudes towards the problem of AIDS in our society. Just one year ago, directors of schools and institutes informed us that these problems would never touch their students. Today, it is they themselves who are initiating prevention work. The main themes on the agenda were AIDS, drugs, prostitution and safe sex; the discussions were very interesting. The audience made quite an impression: young people aged between 16-18 years and all in uniform. There were moments when the hall would explode with laughter, and the next minute there would be tense silence when every word spoken by the trainer was greedily soaked up by those taking part. The informal style of the information's presentation at first intrigued, and then encouraged them to take an active role in the discussion. The young men paid particular attention when the topic turned to drugs. It is no secret that drugs are no longer in the realm of the unknown for young people in Russia. There were a lot of questions, especially about safe sexual behaviour, where good quality condoms can be bought, and what firms are reputable. After each discussion group, there was not even one condom left on our stand.

This opportunity to work with future policemen is a good chance to take yet another step towards a democratic society. We parted with the feeling that there remains a lot left to talk about in the next academic year.

As usual AIDS infoshare is indebted to the tireless work of our volunteers, without whose help we couldn't have achieved half the work we have. We have been lucky enough to have had an international mix of

volunteers, coming from Kenya, the UK, the States and of course Russia, so life has stayed interesting in the office. A big thank you to Rachel and Lauren who organised a group of Russian and American students to distribute condoms and brochures for World AIDS Day around bars and clubs in Moscow. Thanks to their initiative we have managed to continue this activity every month and have a regular group of Russian students who enthusiastically take part, ensuring that safe sex messages are reaching those who really need to know.

Thank you as well to another Rachel, this time from the UK, who has been working hard with us on the brochure for sex workers as well as compiling all the materials in preparation for the conference. We also welcome Maria who has just started volunteering with us and already proved herself invaluable in translating materials for the Conference.

We finally thank Natasha and Tania for their work in the library. Their help is essential, enabling us to distribute materials ordered through the catalogue system. There are many people around Russia grateful to them as well as us.

AIDS infoshare Web Page

<http://www.openweb.ru/windows/infoshare>

We are proud to announce the introduction of our AIDS infoshare/ infoshare international Russian language web page. It is one of the few Russian web pages dedicated entirely to issues relating to HIV infection and AIDS as well as human rights within the health care system.

On our page you will be able to:

- find out the most recent data about the HIV/AIDS situation in Russia and around the world
- choose interesting materials from AIDS infoshare's library on HIV/AIDS and human rights in the Russian health care system
- find useful organizations through our data base, which contains information about Russian and international organizations working in the area of HIV/AIDS prevention and the issue of human rights in health care
- familiarize yourself with a set of 100 Russian and International laws about human rights in health care
- find out more about current projects at AIDS infoshare
- learn the results of research carried out in Russia about human rights in health care, take part in discussions on certain themes, and find out the opinion of representatives from other organizations and individuals

"Krugly Stol" New Russian Language Journal for Organizations working in the area of prevention of HIV/AIDS

In November of 1997, AIDS infoshare sent out the first edition of a quarterly journal for organisations working in the area of HIV/AIDS prevention. The English translation of the title is "Round Table." This name was chosen because the journal provides a forum through which medical specialists and NGOs can exchange information on the wide variety of themes that HIV/AIDS entails. While the majority of Russian language literature about HIV/AIDS targeting professionals working in the area of HIV/AIDS prevention, consists of scientific medical texts, "Round Table" strives to couple medical news with information on other aspects of the epidemic including social, political, human rights etc. Selected articles from the journal can be read in the special English-language edition of the journal that was produced for the International AIDS Conference in Geneva.

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СПИД инфосвязь

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AIDS infoshare Responds to Increasing Demands for its Services

The incidence of HIV in the Russian Federation has increased by nearly 300% since the Vancouver AIDS Conference in 1996. Political, social and economic turmoil make both care and prevention problematic in this region. Russia has however, recently seen a dramatic increase in activity in fields related to HIV/AIDS by governmental organizations in as well as local and international NGOs. AIDS infoshare, by expanding its research initiatives, training activities, social and information services, is providing people and organizations, who are affected by the rapidly developing epidemic, with the information and skills they need to combat the epidemic and associated human rights problems.

As new projects are being initiated, the demand for and the generation of relevant information about the situation in Russia is increasing. AIDS infoshare facilitates information exchange through its ever growing document delivery service, our recently opened Russian language web page, our journal "Round Table" and other publications.

One of the types of information that is rarely available is on the social research conducted in Russia. Although the information provided by social research is vital to the planning and evaluation of prevention and care programs in Russia, the use of social research in health improvement initiatives is a new phenomenon. We have conducted research in such areas as: human rights violations in the health care system; the culture of commercial sex work in Moscow; knowledge, attitudes and informational needs of NGOs and medical professionals; and activities of Russian organizations working in the area of HIV/AIDS. The results of this research are not only used by us in needs assessment, planning and evaluation of its projects but are used by other organizations made available to them through our information services.

Training and skills development are vital to the success of Russian professionals in combating this growing epidemic. We are currently expanding our data base of professional Russian-speaking trainers and consultants by including training of trainers in our projects. We have already provided trainers to UN organizations, the Russian Ministry of Health as well as local and international NGOs. Trainers and consultants are available to speak about such topics as HIV/AIDS prevention, planning and information management, project evaluation, grant writing, social research, NGO management and pre and post test counseling.

As the number of people living with HIV grows, so does the need for social services and support. AIDS infoshare, through our social services, will continue to provide people affected by HIV/AIDS with the information and skills they need to maintain their health, human rights and employment by providing necessary literature, referrals to available services, and workshops.

In this time of intense change and development, a concentrated and coordinated effort in Russia is required by its governmental structures and NGOs, as well as international organizations. We will continue to support this effort and to provide the services necessary to minimize the harm caused by the HIV epidemic.

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Collaborating Organisations:

Medecins sans Frontieres
World Health Organisation/ UNAIDS
United States Centers for Disease Control and Prevention
Mobilisation Against AIDS
Ministry of Health of the Russian Federation
ALBA (Moscow)
Association of Don's Doctors
Venera -Press
Belorussian Fund Stop-AIDS
Centre for the Formation of Sexual Culture
Institute of Narcology MH RF
Cheliabinsk Fund "Take Care"
Future without AIDS
Gospodin Velikii Novgorod Anti-AIDS
Hera (Moscow)
International Protection
Novosibirsk AIDS Centre
Penza Regional Association against AIDS
Tomsk regional Fondation "Siberian AIDS-Aid"
Siberian Initiative (Barnaul)
St Petersburg Midwifery College
Together Against AIDS
Tula Association of Social Workers
Union of Women of Russia
We and You
Women's Unity

Support:

Medecins sans Frontieres
Johnson & Johnson
United States Agency for International Development
UK Department for International Development
World Learning
Civic Initiatives Programme/ Safe the Children
World Health Organisation
Ministry of Health of the Russian Federation
Apple Computer Community Grants Programme
Technotex USA
Microdyn
International Women's Club
Action for Russia's Children
Press Centre and Club Moscow
Embassy of the Netherlands
Mac Studios

Big Thanks to Shona

AIDS infoshare is saying goodbye to Shona, who is leaving the office after five years to further her studies and pursue a degree in Public Health. Her time at AIDS infoshare has been spent successfully building up and organising our library, which started as a pile of books on the floor and now plays a key role in the work of AIDS infoshare. Without Shona's continuous hard work and dedication, the library would not be where it is today. She will be sorely missed by everyone at AIDS infoshare and infoshare international, but we all wish her well and hope she will return one day as a consultant in information management and organisation.



Wellcome to Web Page - <http://www.openweb.ru/windows/infoshare>

Basic HIV facts about Russia



Prior to its dissolution in 1991, the Soviet Union was virtually isolated from the influences of the West. In the early years of the epidemic in America, news about the "Western problem" of AIDS was frequently in the Soviet Press. As homosexual activity was illegal under Soviet Law, officials had confidence that HIV would never be a problem in their country. This changed in 1987, when 279 children were discovered to have been infected in hospitals through unsterilized equipment and reused syringes.

By the end of 1994, there were 1,323 people who tested HIV positive on Russian soil. 460 of these were foreigners who were deported. Of the Russian nationals who were infected, one-fifth had died by September 1996. An interesting note is that, of 139 people who have died, 110 of these deaths were due to AIDS-related complications. The other 29 deaths were reported by the government as "unfortunate accidents or suicides".

Today, according to official statistics, issued on 31 April 1998, there are 7,782 people currently living in Russia who are HIV positive. Of these, 5,160 are men, 1,516 are women and the remaining are children under the age of 16 years. From this figure, 310 people have been diagnosed with "AIDS". A total of 287 people of all those infected have already died, 87 of which were children.

The most common route of transmission in Russia today is through intravenous drug use. By the end of 1997, the number of people who had been infected with HIV in this way was 3,390. In comparison with statistics from 31 December 1993, when there were no registered cases of HIV infection through drug use, this figure is increasing alarmingly quickly. Transmission through heterosexual contact is the second most common route of transmission, with statistics stating that 550 people have been infected through heterosexual contact. It is interesting to draw a comparison here with the situation in the West. The most common route of transmission in America and Great Britain is still through homosexual contact. But in Russia, official statistics show that by 31 December 1997, the number of people infected with HIV through homosexual contact was 490, making this the third most common route of transmission.

Since these figures have been issued by the government, they only reflect the number of infected people who are actually registered and possess the correct documents. In reality, the situation is quite different and the number of people infected is much higher and increasing at a steady rate.

The vastness of the territory and the diversity of the population of Russia has made HIV/AIDS prevention and education efforts difficult. Initially, all prevention messages came from the government and were typically based on fear campaigns and discrimination against homosexuals. By the end of 1995, there were approximately 30 non-governmental organisations involved in HIV/AIDS prevention, education and support in Russia.

Political and economic instability, organised crime, and epidemics of more acute infectious diseases have diverted attention from AIDS. HIV/AIDS is not yet a priority in the countries of the former Soviet Union for neither the citizens nor the government. With few exceptions, the average citizen is still without basic facts about HIV/AIDS, partly due to misinformation in the media and lack of public discussion.

High quality condoms are available in the large cities, but remain unavailable in much of the country. Even so, there is little is known about the importance of checking for the expiry date, buying lubricated condoms and ensuring that the condoms have not been stored in a warm place, thus ruining the latex.

Predicting the future of HIV/AIDS in the region is impossible without more accurate statistics and research in to several areas. However, it is imperative that the government acknowledges the connection between HIV transmission and human rights, other areas of public health, information flow, and an adequate standard of living for their citizens.



AIDS infoshare's Project with Sex Workers

For the past year and a half AIDS infoshare has been working with women who work in Russia's commercial sex industry. There are up to 30,000 sex workers currently working in Moscow, the majority of whom are from provincial towns or other former Soviet republics, who for economic reasons come to the capital. They have very little information about HIV/AIDS or other STDs since education on these subjects in schools is limited and as they are working illegally in Moscow they are not entitled to free health care and tend to avoid authority for fear of arrest. The information that is available in clinics is sparse. As a result, many people find themselves infected with an STD and do not have the necessary information to know how to prevent it from happening again. There is also little freedom within the structure they work to ensure they can negotiate safe sex. Currently, AIDS infoshare is providing help and advice to these women on how to protect themselves from HIV/AIDS and other STDs, as well as how to work more safely in the sex industry. This is done through outreach work, written information and workshops. We have invited consultants to Moscow, who have run workshops not only for the women themselves, but also for doctors and health professionals who work with this group in Moscow. We have discovered that one of the obstacles preventing accurate information being given to these women is the prejudice they face within the health system.

We are currently compiling a brochure specifically for sex workers with relevant information and a list of clinics and doctors whom they can approach for reliable treatment and counselling. Our future plans include expanding our outreach work and opening a hotline providing information on health services and offering a counselling service.

Big Thanks to Lucy



AIDS infoshare is also saying goodbye to Lucy this year. She is returning to England in September in order to pursue her education and do a masters degree in Public Health. She has been with AIDS infoshare for two years and has worked successfully as our coordinator for special programmes. Some of her achievements include international fundraising and working with the London Lighthouse to try and establish a drop-in centre. The majority of her time, however, has been devoted to running Moscow's first prevention program targeting sex workers. This has entailed carrying out a needs assessment and building up a realistic profile of the commercial sex industry in Moscow. Her dedication and continuous hard work on this project has culminated in the publication of a health awareness brochure, written specifically for Moscow's sex workers.

It is obvious that Lucy will be very much missed by everyone at AIDS infoshare and infoshare international, but we wish her every success in her new life and hope that she, too, will return to AIDS infoshare in the future. In the meantime, we will be very pleased if she wants to continue her good work from England!

AIDS Infoshare Library

Answers Increasing Demand for Information on HIV/AIDS

As the number of people living with HIV in Russia grows, so does the demand for information about all aspects of the epidemic. The AIDS infoshare library has, for four years, run Russia's only document delivery service on HIV/AIDS related themes. In partnership with MSF-



Holland and with the expert advice of a consultant from AHRTAG, AIDS infoshare

is planning to streamline its information services to make its materials more directly accessible to professionals working in HIV/AIDS related field. New strategies are based on analysis of research conducted on the informational activity of governmental and non-governmental organizations working in fields related to HIV/AIDS. Moreover, AIDS infoshare is planning to open its doors to people in Moscow requiring information about HIV/AIDS and a special section of the library will be created to cater to the needs of people living with HIV and others affected by the epidemic.

Training in Pre and Post



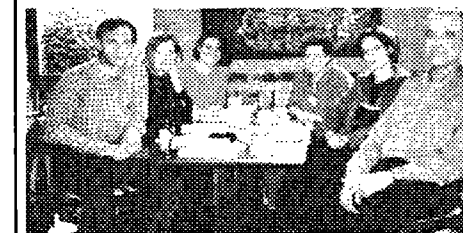
Test Counselling for Russian Medical Professionals

Although it is required by Russian Federal law that citizens have access to free anonymous HIV testing with pre and post test counselling, such counselling is rarely offered in Russian medical facilities and practitioners are not trained in counselling skills through the official medical education system.

AIDS infoshare is in the process of creating a model for training medical professionals in pre and post test counselling in cooperation with Medecines Sans Frontiers - Holland and the Russian Ministry of Health. Research conducted by AIDS infoshare in 1997 and 1998 on the knowledge and attitudes of medical professionals has shown that there is a significant lack of information available to medical professionals on social and psychological issues related to HIV/AIDS prevention. Moreover it became clear that methodology and skills in counselling have yet to be introduced to professionals obligated by law to conduct pre and post test counselling. Some profes-

sionals were not even aware that such a law existed.

AIDS infoshare has therefore distributed sets of information concerning the effectiveness of counselling in HIV prevention, counselling methodologies, psychological and social aspects of special population groups, testing and human rights issues to professionals from various fields who conduct HIV antibody testing. Recently, several Russian medical professionals from Novosibirsk and Rostov-on-Don were trained to be trainers in counselling and communication skills. They will soon conduct training in their own regions and will be available to Ministry of Health bodies, in particular, the Institute for Continued Education for Medical Professionals.



International Partnerships AIDS infoshare and London Lighthouse

Needs assessment for a drop-in centre for people living with HIV/AIDS in Moscow

The purpose of the project is to assess the current care and support services available to people living with HIV and AIDS in Moscow and undertake a needs assessment for additional services to be provided via a proposed drop-in centre. People living with HIV/AIDS are central to the needs assessment, in order that they can influence policy, develop services and actively contribute to the decision making process.

The research has been conducted through focus groups and in depth interviews. Focus groups have been conducted amongst vulnerable population groups, men who have sex with men, female sex workers and IV drug users, plus research into social care that is currently available in Moscow including the benefits system, housing, discrimination and human rights for people living with HIV/AIDS.

At the time of this article going to print the first consultancy visit had taken place and Gennady Roshchupkin and Marina Nikitina from AIDS infoshare had conducted their placement visit in London. They had the opportunity to see how organisations and individuals are facing the second decade of HIV in the UK.

Our initial conclusions from our research is that HIV/AIDS is still a fairly low priority for many people in Moscow, even

those whose behaviour is of a high risk (drug users, sex workers, gay men). Other, more immediate, health issues such as hepatitis are of greater concern.. HIV is still seen as something that affects "other people".

Currently, neither the number of people living with HIV nor the funding available suggests that a large drop-in/rehabilitation centre would be appropriate at this time. Instead our assessment indicates that it would be useful to expand our services to include a telephone hotline service, a small drop-in centre providing training, peer education and support groups and an open access library. This would complement the current services available from other NGOs in Moscow and help to provide technical and informational support to health professionals and NGOs working in the field and to individuals affected by the epidemic.

Currently AIDS infoshare is seeking donations of any size and quantity to open this much needed service in Moscow. Please contact Lena or Lucy if you are interested in helping out. Our contact information can be found on the front cover.

Women's Rights in Public Health

In April 1997, AIDS infoshare began its project "Women's Rights in Public



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Health". Ten women's organisations from Moscow took part in the project. The aim of the project was to highlight the most frequent cases of violations of women's rights in the Health Service and to attempt to define the reasons behind them.

Under socialism, the rights of the citizens were less vulnerable. Every citizen had the right to free education, medical help, a place to live and also the right to work. With the break up of the Soviet Union, core changes occurred especially in the Health Service where the quality of free medical help became practically unacceptable and private medicine were unaffordable for the "middle" class. Although the middle class as it was in Russia also died with the arrival of democracy, more than 70% of the population now live below the bread line.

But despite so many discouraging prognoses, in the majority of cases, ignorance of ones rights and duties on the part of medical professionals appear to be the reasons behind the violations of a citizens rights. AIDS infoshare is attempting to instigate the dissemination of knowledge for the women of Moscow with regards to their rights in the Health Service to give them the tools to defend themselves whilst the government is unable to.

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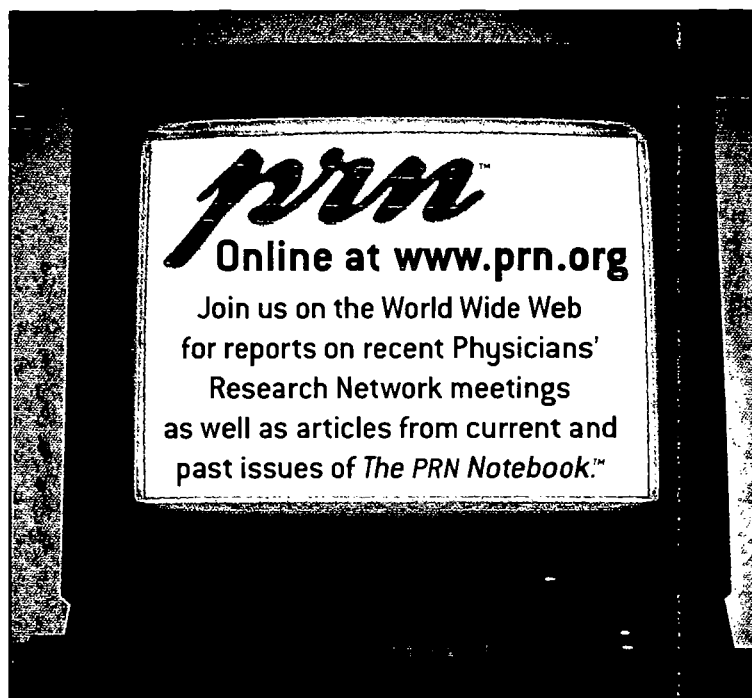


The Mission of Physicians' Research Network

Our mission is to provide ongoing peer support to physicians providing comprehensive care to HIV patients who, like the patients they serve, face many issues of clinical uncertainty. PRN is committed to improving the diagnosis, management and prevention of all aspects of HIV disease and its complications, and to enhancing the broad spectrum of skills utilized by its physician members.

Monthly Educational Meetings

PRN is a not-for-profit organization founded in 1990 in New York City. Today, numbering well over 300, our member physicians serve tens of thousands of HIV patients in private practices, clinics, hospitals and research facilities in the New York City area. Our monthly meetings provide peer support and education, bringing together clinicians with diverse backgrounds to focus on shared issues of clinical and scientific importance. We offer innovative educational programs with presentations by distinguished physicians and scientists, chosen solely by PRN to give member physicians access to the most current and unbiased information on the diagnosis and management of HIV disease. Aiming for the cutting edge of treatment and research, we have established a reputation for spotlighting the most innovative and influential leaders in the field of HIV treatment and research.



Here are some of the presentations that are or will be available in *The PRN Notebook™* and at our web site...

Michael A. Polis, MD, MPH
Restoration of Clinical Immunity—Can We Safely Withdraw Therapy for Opportunistic Infections?

Arlene D. Bardeguet, MD, FACOG
HIV Infection in Pregnant Women

Michael S. Saag, MD
New Insights Into HIV Pathogenesis: Implications for Use of Antiretroviral Therapy

Calvin J. Cohen, MD, MS
Optimizing the Use of Antivirals: A Work in Progress

Donald Kotler, MD
Nutritional Alterations During Combination Antiretroviral Therapy

Joseph J. Eron, Jr., MD
The Effects of Antiretroviral Therapy on HIV in Genital Secretions: Implications for Transmission

Spyros Kalams, MD
Association of HIV-Specific CTL with Helper Responses in Subjects with Control of Viremia

Roy Gulick, MD, MPH
New Antiretroviral Agents

David D. Ho, MD and Martin H. Markowitz, MD
Viral And Lymphocyte Dynamics in HIV Infection: An Update

Robert F. Siliciano, MD, PhD
Latent Reservoirs For HIV-1: Implications for Treatment and Virus Eradication

Rafick-Pierre Sékaly, PhD
Measuring Reconstitution of the T-cell Receptor Repertoire in HIV Infection

Richard T. D'Aquila, MD
Antiretroviral Resistance: Implications for Treatment

John W. Mellors, MD
Combination Protease Inhibitor Therapy

Dorothy N. Friedberg, MD
CMV Retinitis: New Management Strategies

Rachel A. Royce, MPH, PhD
Host Factors in the Sexual Transmission of HIV

Charles W. Flexner, MD
Understanding and Managing Drug Interactions

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**International Gay and Lesbian
Human Rights Commission**



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International Jurisprudence and Policy Precedents Regarding Sexual Orientation

**Prepared by the International Gay and Lesbian Human Rights Commission,
April 1997**

A number of inter-governmental organizations, international conferences, and non-governmental organizations working in the context of international and regional human rights protections have recognized the duty of governments to protect persons against discrimination based on sexual orientation or sexual identity.

United Nations

- **The U.N. Commission on Human Rights (CHR)**, comprised of government representatives, investigates and addresses a wide range of human rights issues, both in regard to specific countries and regarding general themes. The Commission has addressed the human rights of sexual orientation using various forums and mechanisms:

- 1) In 1996 the **CHR** included for the first time reference to homosexuals as a protected class in a resolution on the human rights of persons living with HIV/AIDS. This decision was influenced by two communications delivered by the **Joint United Nations Programme on HIV/AIDS (UNAIDS)** to the CHR's Sub-Commission on Prevention of Discrimination and Protection of Minorities. The resolution issued by the CHR addresses the forms of discrimination suffered by people living with HIV and AIDS, and it calls for U.N. agencies and member states to counter discrimination and ensure the full human rights and freedoms of people affected by HIV/AIDS. The resolution states in part that "persons suffering from disadvantaged socioeconomic or legal status" are especially "vulnerable to the risk of HIV infection... and that they suffer disproportionately from the economic and social consequences of the HIV/AIDS epidemic." The resolution twice mentions "men who are homosexual" among those who are disproportionately affected by the epidemic. The same resolution reconfirms "that the term 'other status' in non-discrimination provisions in international human rights texts should be interpreted to cover health status, including HIV/AIDS." (E/CN.4/Sub.2/1996/L.21)

- 2) The **CHR** can also appoint Special Rapporteurs to investigate particular human rights problems or abuses. In 1987 the Commission's Sub-Commission on Prevention of Discrimination and Protection of Minorities initiated such a special report on the legal and social problems of sexual minorities, including male prostitution. While this report signaled the interest of the CHR in these important issues, the report itself was poorly researched and was criticized by the Sub-Commission for being superficial and arriving at dubious conclusions. (E/CN.4/Sub.2/1988/31) More recently, the human rights of sexual minorities have been mentioned by Special Rapporteurs investigating abuses in Iran, Romania, and Colombia. In 1994 and 1995 two reports described the action of death squads who target sexual minorities for "social cleansing" in Colombia (E/CN.4/1995/50/Add.1 and E/CN.4/1995/111). Also in 1995, a report described the situation of a prisoner in Romania who was arrested and beaten for being gay (E/CN.4/1995/34). In 1996 a report listed sodomy among the crimes punishable by death in Iran, and noted that this law is enforced (E/CN.4/1996/59).

- 3) Organizations and individuals outside the United Nations can bring human rights abuses to the attention of the **CHR** by filing petitions called "Resolution 1503 communications." The Commission has received a number of such petitions regarding the human rights of gay men and lesbians.

United Nations—continued

- The **U.N. Human Rights Committee (HRC)**, comprised of independent experts, is the body charged with monitoring the steps taken by state parties to carry out their obligations to protect human rights as guaranteed by the **International Covenant on Civil and Political Rights (ICCPR)**. As part of their responsibility, the HRC can hear and issue opinions on cases filed by individuals alleging violations of their rights.

On April 4, 1994, the **HRC** ruled in the case of *Nicholas Toonen v. Australia* that a statute of the Australian state of Tasmania prohibiting sexual contact between consenting adult men in private is a violation of fundamental human rights.

With 101 signatories, the ICCPR is one of the most important international human rights treaties. Article 17 of the ICCPR guarantees the right to privacy. Article 2(1) of the ICCPR provides that the rights and freedoms guaranteed in the ICCPR must be protected for all persons, *without discrimination*. Article 2(1) states, in part, "Each State Party to the present Covenant undertakes to respect and to ensure to all individuals within its territory and subject to its jurisdiction the rights recognized in the present Covenant, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status." Article 26 also prohibits discrimination—based on the same language as Article 2—and takes the matter of discrimination a step further by declaring a right to equality *independent* of guarantees made in the ICCPR. Article 26 reads, in part, "All persons are equal before the law and are entitled without any discrimination to the equal protection of the law." (G.A. Res. 2200A [XXI], U.N. GAOR, Supp. No. 16, at 52, U.N. Doc. A/6316 [1966], 999 U.N.T.S. 171)

Nicholas Toonen brought a complaint before the HRC, charging that Australia had violated its obligations under Articles 2, 17, and 26 of the ICCPR by allowing the state of Tasmania to maintain legislation prohibiting sexual contact between consenting adult males. On April 4, 1994, the HRC ruled that the Tasmanian law contradicts Article 17 (right to privacy) and Article 2 (non-discrimination) of the ICCPR. The Committee did not consider Article 26 in making its decision, but did state that the protected category of "sex" in Article 2 of the ICCPR "is to be taken as including sexual orientation." (U.N. Doc. CCPR/c/50/D/488/1992 [1994])

- Since the *Toonen* decision, the **U.N. Human Rights Committee** has included a concern with laws that outlaw homosexual contact in its reports on state parties' compliance with the ICCPR. In 1995 the Committee censured the United States for the sodomy laws carried on the books of several U.S. states, stating its concern regarding "[s]erious infringement of private life in some states which classify as a criminal offense sexual relations between adult consenting partners of the same sex carried out in private, and the consequences thereof for their enjoyment of other human rights without discrimination." (U.N. GAOR, U.N. Doc. CCPR/C/79/Add 50, 6 Apr. 1995)
- In 1993 the **U.N. Human Rights Committee** criticized Romania for maintaining discriminatory laws, including sodomy laws that codify discrimination against sexual minorities. (CCPR/C/79/Add.30)
- In October 1996 the **U.N. Human Rights Committee** heard submissions from a representative of the Hong Kong Human Rights Monitor—an NGO based in Hong Kong—concerning the urgent need for anti-discrimination legislation in Hong Kong that would provide legal protection for many social groups, including bisexuals, gay men, and lesbians. In its report on Hong Kong's compliance with the ICCPR, it is expected that the HRC will repeat criticism it expressed in 1995 that steps should be taken to ensure equal protection and non-discrimination for sexual minorities. (CCPR/C/79/Add.57)

United Nations Programmes

- In 1996 the **International Labour Office (ILO)** conducted a Special Survey on the application of the ILO's Discrimination (Employment and Occupation) Convention, 1958 (No. 111) in which it examined issues of discrimination in employment based on sexual orientation. The ILO's Committee of Experts on the Application of Conventions and Recommendations recommended that sexual orientation be included in a new protocol that would extend application of the 1958 Convention to this and other grounds. (III4B\281-11G.E95/v.3).
- In 1991 the **U.N. Education, Scientific and Cultural Organization (UNESCO)** accepted a petition to review a case of human rights violations against the editor of a lesbian periodical published in Greece. Decision 104/EX (1978) of the UNESCO Executive Board calls upon UNESCO to examine human rights violations in the areas of education, culture, science, information, and communication. UNESCO ended its investigation of the case of Irene Petropolous, who had been charged by the Greek government with publishing "indecent" material, when Ms. Petropolous was acquitted by a Greek court.
- In 1991 the **U.N. Development Program (UNDP)** introduced a Human Freedom Index in its Human Development Report. This Index ranked 88 countries by 40 indicators of democracy such as press freedom, rule of law, the right to travel and the personal right to conduct homosexual relations between consenting adults. Because many developing countries objected to the inclusion of human rights in a UNDP index, the Human Freedom Index was replaced by a Political Freedom Index, and the UNDP stopped publishing the ratings of individual states.
- In May 1991, the **World Health Organization (WHO)** voted to delete homosexuality from its International Classification of Diseases; this change became effective in January, 1993. (Chapter V, code 302)

United Nations High Commissioner for Refugees

- Since April 1993 the **U.N. High Commission for Refugees (UNHCR)** has recognized in several Advisory Opinions that gays and lesbians qualify as members of a "particular social group" for the purposes of the 1951 Convention and the 1967 Protocol Relating to the Status of Refugees. In its publication "Protecting Refugees," the UNHCR states: "Homosexuals may be eligible for refugee status on the basis of persecution because of their membership of a particular social group. It is the policy of UNHCR that persons facing attack, inhumane treatment, or serious discrimination because of their homosexuality, and whose governments are unable or unwilling to protect them, should be recognized as refugees." (UNHCR/PI/Q&A-UK1.PM5/Feb. 1996) For more information, please request a copy of the IGLHRC Fact Sheet on immigration and asylum.

United Nations Conferences

- At the **Fourth World Conference on Women (Beijing, 1995)** there was substantive and sustained discussion about including references to "sexual orientation" in the **Platform for Action**. The draft version of the Platform included four references, including one calling on governments to eliminate discrimination in employment, and one calling on governments to provide legal protections against discrimination. The Conference did not reach consensus on inclusion of sexual orientation language, but the final Platform for Action does include recognition that women and men must be able to decide freely on all matters relating to their sexuality free from coercion, discrimination or violence. Israel, South Africa, and the United States have indicated that they interpret language in the Platform for Action to advocate human rights protections for all women no matter their sexual orientation. (A/CONF 177/20) In addition, the **Economic Council of Europe Regional Platform for Action** for the Beijing Conference includes as one of its basic principles that the promotion, protection, and realization of the human rights of women must "reflect the full diversity of women, recognizing that many women face additional barriers because of such factors as their race, language, ethnicity, culture, religion, sexual orientation, disability, socio-economic class or status as indigenous people," and directs governments to include lesbian organizations in developing and implementing strategies for the advancement of women. (E/ECE/RW/HLM8)

- The Plan of Action of the **International Conference on Population and Development** (Cairo, 1994) acknowledges the necessity of recognizing the diversity of family structures that exist in the world today. (A/CONF 171/13)
- The Global Plan of Action of the **Habitat II Summit** (Istanbul, 1996) reinforces anti-discrimination language of the Beijing Platform and other U.N. documents by including "other status" in clauses which guarantee protection from discrimination in housing and human settlements.

Regional Human Rights Bodies

Council of Europe

The Council of Europe encourages respect for human rights among member states through a treaty—the **European Convention for the Protection of Human Rights and Fundamental Freedoms**—and through resolutions of its Parliamentary Assembly.

- Complaints of human rights violations under the **European Convention** are adjudicated by the **European Court of Human Rights** in Strasbourg. The European Convention establishes a right to privacy (Article 8), and the European Court of Human Rights has ruled that state signatories to the European Convention cannot criminalize same-sex sexual relations because such laws violate the personal right to privacy. The European Court articulated this decision in relation to sodomy laws in Northern Ireland (*Dudgeon v. United Kingdom*, 4 Eur. H.R. Rep. 149 [1981]), Ireland (*Norris v. Ireland*, 13 Eur. H.R. Rep. 186 [1991]), and Cyprus (*Modinos v. Cyprus*, 16 Eur. H.R. Rep. 485 [1993]). Ireland and Northern Ireland repealed their sodomy laws; Cyprus has, to date, failed to comply with the Court ruling.
- In February 1997 the **European Court of Human Rights** had the opportunity to extend its ruling on the European Convention's privacy guarantee in a case concerning adult consensual sadomasochistic sexual activity (SM). In the so-called "Spanner case" three British men asked the court to review the actions of the British government, which in 1990 convicted them of assault for engaging in consensual SM activities in private. In arriving at its decision in favor of the UK the Court did not focus on questions surrounding the fairness of the British investigation and prosecution of the men, but considered the narrower issue of whether a state could restrict consensual SM in the interests of public health (*Laskey, Jaggard and Brown v. the United Kingdom*, case no. 109/1995/615/703-705). Advocates for sexual privacy expect the issue of SM to continue to arise in human rights contexts in the future.
- In April 1992 the **European Court of Human Rights** found that France had violated the human rights of a transsexual when its courts refused to alter a birth certificate after the person had undergone gender reassignment surgery. The Court based its ruling on the right of a person to have respect for her or his private life (Article 8 of the Convention), and indicated that a birth certificate should record the change in a transsexual's name and sex.
- In 1981 the Parliamentary Assembly of the **Council of Europe** condemned discrimination against homosexuals. (Recommendation 924 and Resolution 756). This parliamentary action provided an additional legislative context for the European Court of Human Rights to consider in deciding the cases of *Dudgeon*, *Norris*, and *Modinos* (see above). In 1993 members of the Parliamentary Assembly adopted Declaration No. 277 calling for an end to discrimination against homosexuals in former Communist countries.

European Union

Human rights issues are addressed in the European Union by its legislative body (the **European Parliament**) and by its judicial body (the **European Court of Justice**). These bodies act to secure human rights primarily in relation to economic issues (like protection from discrimination in the workplace).

- In 1982 The **European Parliament** directed its Committee on Social Affairs and Employment to investigate sexual discrimination at the workplace. The Committee issued the "Squarcialupi Report", on the basis of which the European Parliament adopted in March 1994 a "Resolution on Sexual Discrimination

at the Workplace." This resolution urges member states to "abolish any laws which make homosexual acts between consenting adults liable to punishment" and to "apply the same age of consent as for heterosexual acts." The resolution further calls on the Commission of the European Community to "renew its efforts with regard to dismissals to ensure that [...] certain individuals are not unfairly treated for reasons relating to their private life", to "submit proposals to ensure that no cases arise in the Member States of discrimination against homosexuals with regard to access to employment and working conditions" and to invite Member States to identify "any discrimination against homosexuals with regard to employment, housing and other social problems." (OJ 1984 C 104/45).

- In response to the landmark "Roth Report," in February 1994 the **European Parliament** adopted a resolution that calls on member states to: abolish all laws that criminalize homosexual activity; equalize age of consent laws for all sexual activity, whether homosexual or heterosexual; end unequal treatment of homosexuals in social security systems, adoption laws, inheritance laws, and housing and criminal law; take measures to reduce violence against homosexuals and prosecute those who commit such violence; initiate campaigns to combat social discrimination against homosexuals; and provide funding to homosexual social and cultural organizations. The resolution specifically calls on the United Kingdom to repeal its discriminatory law regarding the so-called "promotion" of homosexuality, and seeks a recommendation from the Commission of the European Community that gay men and lesbians be guaranteed full and equal rights of marriage (registration of their partnerships) and parenting (adopting children and serving as foster parents). (Resolution of equal rights for homosexuals and lesbians in the European Community, OJ 1994 C 61/40, Res. No A3-0028/94, 8 Feb. 1994)

- In May 1995 the **European Parliament** resolved that the Treaty of the European Union should ban discrimination based on sexual orientation, and the EP extended domestic partner benefits to its gay and lesbian employees.

- In September 1996 the **European Parliament** approved another resolution meant to reaffirm its earlier call for member states to end all discrimination based on sexual orientation. (Res. No. A4-0223/96)

- On 30 April 1996, the **European Court of Justice** in Luxembourg ruled that Cornwall College, Redruth, UK, violated the non-discrimination provisions of the European Union's Equal Treatment Directive (no. 76/207/EEC, 9 February 1976) when it dismissed a British transsexual who had undergone gender reassignment surgery. The Court ruled that the Directive, which requires the EU member states to prohibit direct or indirect discrimination in employment on the grounds of sex also covers cases of discrimination on the grounds that a person has changed sex. (P.v.S. and Cornwall County Council, Case C-13/94)

- The **European Court of Justice** is preparing to hear another case from the United Kingdom that could end the ban on gay members of the British armed forces. A gay British man argues that his dismissal from the British Navy is a breach of the European Union's Equal Treatment Directive, because to dismiss a person based on the sex of his partner is a form of sex discrimination.

CSCE/OSCE

- During the 1992 meeting of the **Conference on Security and Cooperation in Europe (CSCE)** in Helsinki, Norway introduced a motion asking member states "to take steps to prohibit the promotion of hatred or contempt against homosexuals and their organizations..." (In a 1991 CSCE meeting in Moscow, five member states referred to lesbian and gay rights without advancing resolutions: Canada, Denmark, Norway, Finland, and Sweden.) In November 1992 a representative of the International Gay and Lesbian Association (ILGA) spoke in the final plenary session of the CSCE Expert Seminar on Tolerance in Warsaw, and in the following year another ILGA representative addressed the CSCE Implementation Meeting on Human Dimensions in Warsaw. The final report of this 1993 meeting noted that participants discussed discrimination against homosexuals and that "CSCE commitments in the area of non-discrimination cover homosexuals as well. Suggestions were made that discriminatory State policies against homosexuals, and criminalizing legislation, should be eliminated." (Quoted in ILGA Bulletin 5, 1993.) ILGA has continued to participate in CSCE meetings as a non-governmental organization, including the 1994 meeting at which CSCE became the **Organization for Security and Cooperation in Europe (OSCE)**. The Parliamentary Assembly of the OSCE passed a declaration in Ottawa in 1995

that calls on member states to provide equal protection against discrimination for all people, and that includes sexual orientation among the grounds specifically protected from discrimination.

Non-Governmental Organizations

The decisions and actions taken by the following organizations exemplify the sort of human rights advocacy in which many non-governmental organizations are currently involved:

- In 1991 **Amnesty International** decided to include in its definition of prisoners of conscience those individuals who have been incarcerated for their actual or presumed homosexuality.
- Since 1993, the **International Human Rights Law Group** has been working to promote the application of international human rights standards to persons facing violence or discrimination because of their sexual identity or sexual orientation.
- In 1994 **Human Rights Watch** declared that it opposes "state-sponsored and state-tolerated violence, detention and prosecution of individuals because of their sexual identity, sexual orientation or private sexual practices."
- In 1995 the **International Planned Parenthood Federation** approved its "Charter on Sexual and Reproductive Rights" which recognizes, among other rights, the rights of women to privacy, to equality and to freedom from all forms of discrimination. In this document the IPPF includes sexual orientation among the grounds it advocates should be protected from discrimination in the provision of information, health care, and reproductive health services.

The information contained in this fact sheet is drawn from Douglas Sanders, "Getting Lesbian and Gay Issues on the International Human Rights Agenda," *Human Rights Quarterly* 18 (1996) 67-106, "Promoting Lesbian and Gay Rights through International Human Rights Law," New York: Center for Constitutional Rights, James D. Wilets, "International Human Rights Law and Sexual Orientation," *Hastings International and Comparative Law Review* Vol 18, No. 1, 1-120, James D. Wilets, "Using International Law to Vindicate the Civil Rights of Gays and Lesbians in United States Courts," *Columbia Human Rights Law Review*, Fall 1995, Vol 27, No. 1, 33-56, Laurence R. Helfer and Alice M. Miller, "Sexual Orientation and Human Rights: Toward a United States and Transnational Jurisprudence," *Harvard Human Rights Journal*, Spring 1996, Vol 9, 61-103, communications with the Magnus Hirschfeld Center for Human Rights and other human rights organizations, and IGLHRC files. **Please contact IGLHRC with any new information that can be used to update this fact sheet.** IGLHRC, 1360 Mission Street, San Francisco, CA 94103, tel. 415-255-8680, fax 415-255-8662, e-mail iglhrc@iglhrc.org, website www.iglhrc.org.

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International Gay and Lesbian Human Rights Commission



I G L H R C

why we exist:

EVERY DAY,

in countries throughout the world, the fundamental human rights of lesbians, gay men, bisexuals, transgendered people, and people with HIV and AIDS are violated. These abuses include: murder • incarceration • forced psychiatric "treatment" • torture • arbitrary arrest and detention • denial of the freedoms of association, press, and movement • denial of the right to seek refuge/asylum • immigration restrictions • forced marriage • the revocation of parental rights • and numerous other forms of discrimination.



I G L H R C

OUR MISSION:

The mission of IGLHRC is to protect and advance the human rights of actual and perceived sexual minorities and people living with HIV.

what we do:

Respond to Emergencies

Through our Action Alerts, we mobilize individuals all over the world to send thousands of letters and faxes to address urgent rights violations and legal efforts to protect and advance lesbian and gay rights. The Alerts are published in English, French and Spanish.

Strengthen the Grassroots Gay and Lesbian Movement Internationally

We provide various kinds of technical assistance to grassroots groups worldwide, and offer trainings, workshops, and other forms of information exchange, particularly for activists from the developing world.

Assist Political Asylum Claims

We provide legal documentation, referrals, and other types of support services to individuals fleeing their home countries due to persecution on the basis of sexual orientation, gender identity, or HIV sero-status.

Serve as an Information Clearinghouse

We collect information on the situations of sexual minorities on every continent through relationships we have built with activists around the world. We also maintain a contact database of grassroots gay and lesbian and AIDS groups worldwide. We share this information as appropriate with activists, attorneys, researchers, the media, and others, and publish reports on rights violations against sexual minorities. We are working to make more of our nonconfidential information available electronically through the world wide web.



I G L H R C

Change Institutional Structures

We work to make governments more aware of and respectful of the rights of their lesbian and gay citizens. We also pressure major human rights organizations and other international bodies that monitor human rights abuses (like the United Nations) to include rights violations against sexual minorities and people with HIV and AIDS in their work.

Educate about Human Rights Violations

We inform and educate the general public, the media, and funders of human rights work about human rights violations against sexual minorities and people with HIV and AIDS. Silence and invisibility encourage these abuses, but an informed public, working with an informed human rights community, can put an end to them.

apply directly to the CCSS to receive the medications. However, he also predicted that the CCSS is likely to seek strategies to avoid providing the medications to persons who have not actually filed suits.

Because of fears of discrimination, as well as concern about rejection from family members, most AIDS patients here have been unwilling to file petitions or make their plight publicly known. William García visited his CCSS physician, Ignacio Salom on Friday and received the prescription which he needs in order to receive the medications. Activists hope that the CCSS pharmacy will fill the prescription early next week.

Those interested in receiving further information on these cases can contact:

Asociación Triángulo Rosa
Apartado Postal 1619 - 4050
Alajuela COSTA RICA
Tel. 506-234-241, 223-1370
Fax 506-223-3964
Email: rastern@sol.racsas.co.c, atrirosa@sol.racsas.co.cr

NEW CATHOLIC CHURCH IN MEXICO SPREADS MISINFORMATION ABOUT CONDOMS

In an extremely dangerous response to the Mexican government's latest condom campaign, the Catholic church has launched, with assistance from the anti-abortion group Pro-VIDA, a very aggressive campaign against condoms. The group has been using false data and twisting information to "prove" the ineffectiveness of condoms, stating that they have a "40%" failure rate. This aggressive counter-campaign started because CONASIDA (the government's National AIDS Prevention and Control Program) launched, for the first time in recent history, a frank and straightforward public prevention and awareness-raising campaign targeting adolescents. The campaign includes displaying the word CONDOM prominently in giant billboards, on the public transportation system, and television and radio advertisements. The condom promotion campaign of CONASIDA is backed by Mexican AIDS NGOs (non-governmental organizations), by progressive intellectuals, and by political parties, among them the PRI (Partido Revolucionario Institucional) and PRD (Partido de la Revolución Democrática).

Pro-VIDA is suing CONASIDA and the Secretary of Health, Dr. Juan Ramón de la Fuente in an attempt to end CONASIDA's AIDS prevention condom campaign. Pro-VIDA's suit charges CONASIDA and Dr. de la Fuente with placing Mexican citizens at risk for not discussing monogamy and celibacy. Dr. de la Fuente has recognized Pro-VIDA's right to oppose their campaign but has remained firm in his support of the campaign. Monsignor Norberto Rivera, Archbishop of Mexico, is at the same time demanding the government include the following warning on condom wrappers "This product may be hazardous to your health."

On September 1st, Mexican President Lic. Ernesto Zedillo Ponce de León, delivered his annual address to the nation and omitted any reference to the AIDS situation in the country, despite the high incidence of HIV infection in Mexico.

Activists in Mexico have requested that letters of support be sent to:

Dr. Patricia Uribe
Executive Coordinator of CONASIDA
Calz. de Tlapan No 4585-2ndo piso
Col. Toriello Guerra
México D.F. C.P. 14050 MEXICO
Fax: 52-5-528-4220
Email: conasida@cenids.ssa.gob.mx

They also ask that respectfully worded letters be sent President Ernesto Zedillo Ponce de León requesting that he openly express his support for the official prevention initiatives of his own government.

Lic. Ernesto Zedillo Ponce de León
Presidente de la República
Palacio Nacional
México D.F. C. P. 06067 MEXICO
Fax: 52-5-515 5729

Please send all copies of letters directly to the following Mexican AIDS service organization:

Colectivo Sol
Aptd. Postal 13-320
México D.F. C.P. 03500 MEXICO
Fax: 52-5-666-6849
Email: colsol@laneta.apc.org

For those who wish to have their letters sent to Mexican media, copies of letters should also be sent to the following newsletter for persons living with AIDS in Mexico:

Letra S
Zempoala #9-205
Colonia Narvarte
México D.F. C.P. 03020 MEXICO

EMERGENCY RESPONSE NETWORK

URGENT ACTIONS ON HIV/AIDS

of the
INTERNATIONAL GAY AND LESBIAN HUMAN RIGHTS COMMISSION

NEW RUSSIAN FEDERATION: LOCAL AUTHORITIES PROPOSE POLICE SURVEILLANCE OF HOMOSEXUALS

The Health Care Department in the Russian region of Astrakhan has submitted to the regional Parliament a proposal for monitoring so-called "risk groups," as part of an AIDS-HIV prevention project. The proposal would give local authorities expanded powers to invade the privacy and restrict the freedoms of gays, lesbians, and bisexuals.

"Immediate Precautions Against HIV Infection," submitted to the local parliament by Health Care Department Director V. Yushkov, includes numerous recommendations for action. Recommendation 6.2 calls on the regional Department of the Interior—responsible for the police and militia—to "commence cooperation with medical institutions for investigation and mutual information, as well as keeping records on persons from high risk groups (i.e., drug addicts, homosexuals, prostitutes, and others)." In addition, recommendation 6.4 calls on the Department of the Interior to "oblige directions in penal colonies, prisons, and pre-trial detention units to undertake prophylaxis and strict control...over homosexual relations in penal institutions."

The first proposal not only identifies homosexuality with criminal behavior (despite the decriminalization of consensual same-sex relations throughout Russia in 1993) but mandates medical institutions to violate the confidentiality of sensitive medical information. Moreover, it would give the police—an institution which throughout the Russian Federation remains largely unreformed from its totalitarian past—unlimited power to practice surveillance and impose restrictions and harassment on vulnerable groups. It invites discrimination based on sexual orientation, which the United Nations Human Rights Committee has found to violate Article 2 of the International Covenant on Civil and Political Rights. It also contravenes the right to privacy, which is protected by Article 17 of that Covenant, as well as by Article 8 of the European Convention for the Protection of Human Rights and Fundamental Freedoms. Under the guise of protecting public health, it would actually constitute a serious threat to it; targeting segments of the population which are already legally vulnerable and socially stigmatized, the regulations would render those groups still more rationally reluctant to seek treatment or even HIV testing.

The regulation affecting prisoners would have a similar effect within the confines of already-restrictive institutions. Vaguely and generally worded, it would give prison authorities new scope to punish and crack down on prisoners or groups of prisoners toward whom they hold an animus for any reason.

Local activists call for letters of protest to the regional authorities, calling on them to withdraw the proposal. Letters should stress the above points. They can be sent to:

Mr. A. P. Guzhvin
Head of the Astrakhan Regional Administration
Fax number 7 8512 229514

Mr. V. Yushkov
Head of the Regional Health Care Department
Fax number 7 8512 220607

Please send copies of your letters by email to local activists at gayclub@glasnet.ru.

NEW ARGENTINEAN LESBIAN COUPLE DENIED PRISON VISITATION RIGHTS, HIV-POSITIVE PARTNER ALSO DENIED ADEQUATE MEDICAL ATTENTION AND MEDICATIONS

Cecilia Lecchi is currently in detention at the penitentiary in Ezeiza. She is being denied prison visitation rights with her partner, Martha Miravete Cicero. The two have been united in a commitment ceremony, celebrated with the auspices of the Gay, lesbian, Transvestite, Transsexual and Bisexual (GLTTB) Christian Center. Reverend Roberto González officiated and the two women decided to share their last names, separated by a comma. There is currently no recognition of their union under Argentinean law.

If Martha were accepted by the authorities as Cecilia's partner, she could obtain conjugal visits—which consist of two-hour intervals every 15 days—as well as family reunions on dates of special significance, a communal visit on the weekend, and two visits by friends in her visits form.

Since Martha has not received recognition as Cecilia's family she cannot take advantage of any of these opportunities to visit with Cecilia. Cecilia's mental and physical well-being have been directly affected. Cecilia, HIV positive for the last fourteen years, weighs 46 kilos (about 101 pounds), has inflamed lymph nodes and a progressive depression which is only exacerbated by her present situation. She is not receiving adequate medical attention and the medication she so desperately needs.

They and other women in their situation are fighting for their right to adequate health care, to being recognized as a family and to privacy. If successful, Cecilia and Martha could potentially serve as a precedent setting case for other lesbian couples.

Argentinean activists ask that you support Cecilia and Martha's demand that their rights as a family not be denied and that Cecilia receive the medical attention she needs. Letters and faxes can be sent to the addresses below. A sample letter has been provided. Activists ask that copies of the letters also be sent to them so that they can share these with Cecilia and Martha. Activists further suggest that people can also write letters to Cecilia and Martha at Amenaza Lesbica's address and they will deliver the letters to the couple.

Please send letters to:

WE NEED YOUR HELP - JOIN THE EMERGENCY RESPONSE NETWORK

The International Gay & Lesbian Human Rights Commission (IGLHRC) documents, monitors, and mobilizes response to human rights violations against gay men, lesbians, bisexuals, transgendered people, and people with HIV/AIDS worldwide. **Please sign up** to receive action alerts on a regular basis (via email or postal service) and become part of an international campaign to make a difference in the lives of sexual minorities all over the world. To receive by mail, please fill out the coupon below and return it to: **IGLHRC**, 1360 Mission Street, Suite 200, San Francisco, CA 94103, U.S.A.: +1-415-255-8680 (telephone), +1-415-255-8662 (fax) For email (saving printing costs, postage, and trees), write to macjordomo@iglhrc.org with the following message: For the English version: "subscribe ern-en <your first name> <your last name>". For the Spanish version: "subscribe ern-es <your first name> <your last name>". For the French version: "subscribe ern-fr <your first name> <your last name>". For example: "subscribe ern-en Jane Doe". If you would like to cancel your printed ERN subscription, write a message to iglhrc@iglhrc.org.

Dr. Calvete
Juez de Instrucción
Juzgado Nro. 15, Sec. 146
Talcahuano 550
(1041) Ciudad de Buenos Aires
Argentina
Director Nacional de Régimen
Pedro Lozano 4986
(1417) Ciudad de Buenos Aires
Argentina
Sr. Gustavo Plat
Procuración Penitenciaria
Av. Belgrano 1177, 2do piso
(1092) Ciudad de Buenos Aires
Argentina
Tel./Fax: 54-1-382-3324

Dr. Aparicio
Dra. Silvia Marino
Ministerio de Justicia de Política
Penitenciaria Sarmiento 329
Ciudad de Buenos Aires
Argentina
Tel/Fax: 54-1-328-7321/22
Sr. Director de la Unidad Nro. 3
del Servicio Penitenciario Federal
Circunvalación y French s/n
(1108) Ezeiza
Provincia de Buenos Aires
Argentina

Please be sure to send a copy to:

Amenaza Lésbica
Sarmiento 1287, 1ro 7
(1041) Ciudad de Buenos Aires
Argentina

UPDATE

CHILEAN HIV POSITIVE PRISONERS DIE WHILE THE STATE CONTINUES TO DENY THEM MEDICAL CARE

Despite the diligent work of Centro Lambda Chile, gay inmates who are HIV positive continue to face inhuman conditions during their imprisonment in Santiago penitentiaries. The authorities have abandoned these prisoners and refuse to respond to the demands from Centro Lambda Chile that they receive adequate medical care either within the prison hospitals or in other public health facilities when necessary. Homosexual and transvesti prisoners who are HIV positive are being held in complete isolation from the general prison population in Santiago. None of them is receiving antiretroviral medications or medical attention for opportunistic diseases.

This grave situation is not new. Back in September of 1996, Centro Lambda Chile filed the first in a series of demands, requesting improvements in the conditions of confinement of all homosexual and transvesti inmates as well as immediate medical attention for those who need it. Following the submission of this demand to prison authorities, the prisoners where transported to Colina II prison and 10 needles where used to perform the Elisa test on 37 inmates despite repeat warnings that some of the inmates were HIV positive. Of the original group of claimants, two have died since the filing of the case in 1996. Various other legal actions have been brought against the penal system in an attempt to get medical treatment and dignified living conditions for these prisoners.

Currently Chilean activists fear that inmates will continue to die if they do not receive the necessary medical attention. Gay prisoners who are now isolated in a section called Calle 3 (3rd Street) are unable to work during their confinement because this section does not include the infrastructure for them to do so. Therefore they have no way of generating resources. At the same time all inmates are charged US\$30 to receive tests which are free in all city hospitals. While the prison authorities continue to tell the media that all prisoners receive adequate medical care, the testimony of the prisoners presents a different picture. Reportedly on the few occasions when inmates have been examined, they are lined up single file, naked in a wet and ill-smelling corridor, and are then submitted to a cursory review after which they receive no prescriptions or medicines. Every time inmates have infections, they are treated with penicillin, without any consideration to the effect it may have on their already compromised immune system.

Centro Lambda Chile and MOVILH (Movimiento de Liberación Homosexual-Movement for Homosexual Liberation) have in recent weeks met with penal officials and they strongly believe that international pressure and their local lobbying and legal efforts are responsible for this outreach from the penal authorities. However in order for these efforts to result in concrete improvements in the lives of these inmates, Chilean activists request that urgent letters be sent to the appropriate authorities demanding that all HIV positive prisoners be treated with dignity and respect and that they receive medical care appropriate to their health status.

Letters should be sent to:

Señor Alex Figueroa
Ministerio de Salud
Mack Iver 541
Santiago, Chile
Fax: (56-2) 632-2405
[Ministry of Health]
E-mail: info@minsal.cl

Señor Mario Morales Mondaca
Dirección Nacional de
Gendarmería
Rosas 1274
Santiago-Chile
Fax: (56-2) 671-4936
Fax: (56-2) 695-5709

Señora Soledad Alvear
Ministerio de Justicia
[Ministry of Justice]
Morandé 107
Santiago, Chile
Fax: (56-2) 695-4588
Email: minju@reuna.cl

Please send copies of your letters to IGLHRC and to:

Centro Lambda Chile
Casilla Postal 53575
Centro de Casillas de Santiago
Santiago de Chile
or
Movimiento de Liberación Homosexual (MOVILH)
Casilla 52834,
Correo Central
Santiago CHILE
Fax: 56-2-633-5234
Email: movilh@entelchile.net

NEW PANAMANIAN AIDS ACTIVISTS DEMAND ACCESS TO MEDICATIONS

PROBIDSIDA, a foundation dedicated to the well being and dignity of people living with AIDS in Panama has initiated a campaign demanding from the Caja de Seguro Social (the government health care provider) access to new anti-retroviral therapies. Currently the Panamanian government is offering AZT despite the dangers of developing rapid resistance to other forms of medication. Members of PROBIDSIDA have had conversations with government authorities who have repeatedly refused to do anything and have told them the responsibility for creating change lies with the activists themselves.

PROBIDSIDA has asked the international community to send a strong message to Panamanian health authorities by sending letters of solidarity to the following fax numbers or addresses. If possible please indicate your organization and from what part of the world you are writing.

The text of the fax could be as follows:

“We the members of _____ support the actions proposed by PROBIDSIDA: that the “Caja de Seguro Social” of Panama and other government entities provide access to new anti-retroviral medications.”

Panamanian activists are heartened by the recent success in Costa Rica and the impact of the international involvement on the resolution of the Supreme Court case which resulted

in the provision of anti-retroviral therapies to people living with HIV/AIDS in Costa Rica. For more information on this decision, see Emergency Response Network Action Alert, Volume VI, Number 5.

Please send your letters and faxes to:

Sra. Aída de Rivera,
Ministra de Salud
Apartado 2048,
zona 1 Panamá, Rep. de Panamá
Fax No. 507-227-5276

Sr. Ernesto Pérez Balladares
Presidente de Panamá
Apartado 289,
Zona 1 Panamá, Rep. de Panamá
Fax No. 507-228-1061

Sra. Marianela Morales
Directora General Caja de
Seguro Social
Apartado 1393,
zona 1 Panamá, Rep. de Panamá
Fax No. 507-261-2208

Sr. Ricardo Lachman
Apartado 9654,
Zona 4 Panamá,
Rep. de Panamá
Fax No. 507-264-4730
E-mail: nquinter@pananet.com

PROBIDSIDA asks that copies be sent to their lawyer, or if only one letter of support can be faxed that it be faxed to him:

NEW NEW HUNGARIAN LAW ELIMINATES ANONYMOUS HIV TESTING

A law recently passed by the Hungarian Parliament has eliminated anonymous testing for HIV in the country. One of the oldest and most successful non-governmental initiatives in Hungary—an anonymous-testing clinic founded in 1989, even before the transition from authoritarian rule—is being forced to close. Other clinics modelled on it will also be shut down.

Section 15 (6) of Act XLVII of 1997, “On the Administration and Protection of Medical and Related Personal Data,” requires that, if the result of an HIV screening examination “is positive, the person involved must provide his personal identification data at the request of the provider of medical care. The person involved shall be informed of this prior to the screening examination.”

State medical authorities in Hungary have failed in the past to respect the privacy of sensitive medical information. Activists from the gay magazine MASOK have documented cases of persons—whether testing positive or negative for HIV—who were intimidated and threatened by staff at the State Institute of Venereology to reveal names of sexual contacts. They have also discovered medical files which were conspicuously labelled to indicate the subject’s homosexuality. (See IGLHRC ERN Vol. 1, no. 8, 1992.) For eight years, the Karolina Street Clinic in Budapest has provided a safe alternative to repressive state institutions, offering anonymous testing as well as counselling on HIV- and STD-related issues. Although the law always required state employees to report positive test results, the private clinic was tolerated as an “experiment.” The experiment was successful: a one-room office, it administered more HIV tests annually than did the State Institute of Venereology, indicating the degree of trust it fostered. Under the new law, it and similar clinics around the country will be closed.

The Ovegylet Foundation, a nonprofit Hungarian organization working with people living with HIV/AIDS, asks for letters of protest against the new law. Letters should point out that mandatory reporting of positive test results will only result in fewer people being tested for HIV, driving them

underground beyond the range of counselling and treatment. It will exert particular damage on communities already disproportionately affected by the epidemic, including sex workers and IV drug users as well as gay men, since these communities already face legal and social discrimination which renders them reluctant to seek assistance from state authorities. Mandatory reporting is deleterious to public health as well as dangerous to personal privacy. The new law on data protection represents a regression to an old and outmoded intrusiveness into individual autonomy. The law should be repealed. Send letters to:

Minister of Health Mihaly Kokeny Nepjoleti
Miniszterium H-1051 Budapest Arany Janos utca 6/8 HUNGARY
Fax: 361-302-0925

State Ombudsman Dr. Laszlo Majtenyi
Országgyűlési Biztosok Hivatala Adatvédelmi Biztos H-1387 Budapest Pf. 40 HUNGARY

Dr. Judit Csehak
Social and Welfare Committee of the Hungarian Parliament
Magyar Országgyűlés Szocialis es Egészségügyi Bizottsága H-1055 Budapest Kossuth Lajos ter 1-3 HUNGARY

UPDATE COSTA RICAN ACTIVISTS CELEBRATE VICTORY IN SUPREME COURT CASE RE: ACCESS TO MEDICATION

The Costa Rican Supreme Court on September 23 ruled in favor of an appeal filed by William García, a psychology graduate student who is seriously ill with AIDS. The ruling directs the government funded health care provider, the Caja Costarricense de Seguro Social (CCSS), to provide William with the retroviral medications that he needs.

The CCSS had previously refused to provide any of these medications to AIDS patients in Costa Rica, with the exception of AZT, which was given only to HIV+ pregnant women. William was denied the medication despite having suffered from repeated opportunistic infections.

The Medical Director of the CCSS, Julieta Rodríguez, had filed an affidavit with the Supreme Court stating that the new medications did not meet the criteria for inclusion in the CCSS “official list” of medications. She stated that they were highly toxic as well as “too expensive” for the government to buy.” She indicated that the price per patient would be about \$900 per month. Yet Guillermo Murillo, AIDS Coordinator for the gay/lesbian Asociación Triángulo Rosa indicated that this estimate was highly inflated. “The actual price would be more like \$500 per month, because the pharmaceutical companies are offering discounts if the government buys the medications,” he said.

Costa Rica’s largest daily newspaper, La Nación, made the ruling public in its September 25th edition and indicated that the government had to immediately begin supplying William with these medications.

A second case was decided on Friday, September 25th and involved an appeal filed by Guillermo Murillo, AIDS program coordinator for Triángulo Rosa, and two other Persons Living with AIDS. Their case had been filed last August, but may have been considered after García’s case, because none of the three are currently severely ill. Again the Judges ordered the CCSS to provide appropriate medical treatment to the plaintiffs.

The lawyer who filed both petitions, gay activist Marco Castillo, indicated that the decision opens the door for all patients with severely compromised immune systems to

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Chinese Society of Preventive Medicine-Living with Hope Organization

The Living With Hope Organization (LWH) was officially established in 1994 in Taipei of Northern Taiwan as a non-governmental organization, under the Chinese Society of Preventive Medicine. LWH operates a shelter for AIDS patients, the first and only service of its kind in Taiwan, and provides other support, care and services for people living with HIV/AIDS as well as prevention education for the public. It opened a second office in Kaohsiung of Southern Taiwan in September, 1995, and, in November, 1995, started the Taiwan AIDS Memorial Quilt Project which became the 33rd international affiliate of the NAMES Project.

Mission

1. To care for and promote the human rights of people living with HIV/AIDS by providing continuous services, help and support to them, and to reduce the degree of social and medical impact generated by the AIDS epidemic.
2. To increase public awareness and understanding of HIV/AIDS by providing prevention education and organizing prevention activities.

Programs and Services

- 1) AIDS Half-Way Home Management
- 2) Anonymous HIV Testing and Pre-Test and Post-Test Counseling
- 3) Psychological Counseling
- 4) Brief Psychotherapy
- 5) Hospital and Home Visits
- 6) Hope Monthly Newsletter
- 7) Information Hotline
- 8) Collection and Dissemination of AIDS Related Information
- 9) Volunteer Training
- 10) Education Outreach through Lectures in Communities and Media Campaign
- 11) Activity Organization
- 12) AIDS Memorial Quilt Project
- 13) Advocacy of Human Rights for PWAs

Annual Activities

- **Walking for AIDS - Because I Care**
An AIDS Walk held in December to raise community awareness and compassion for those living with HIV.
- **Lanterns of Hope and Remembrance**
A floating lantern ceremony, reflective of Chinese culture, to support and salute those who live with HIV (pink lanterns) and to remember and honor those who have died of AIDS (white lanterns).
- **AIDS Memorial Quilt Display**
LWH organized the very first display of the AIDS Memorial Quilt in Taiwan on World AIDS Day in 1995. The display will continue annually and the Quilt will be used as a means for remembrance and healing as well as a tool for prevention education to advocate human rights of PWAs and to increase public awareness of AIDS and compassion for those who are affected by it.

How YOU Can Help?

In this battle against HIV/AIDS, we need your company by sharing experiences and information with us. Whatever materials you may have in Chinese dealing with HIV/AIDS are ideal; however, materials in English are welcomed. Thank you for your time and help! We hope we will be able to share information with one another and look forward to exchanging materials and ideas. Please add us to your mailing list. Thank you. All inquiries or information and materials can be forwarded to :

**Chinese Society of Preventive Medicine-
Living With Hope Organization**

P.O. Box 2-43
Pei-Tow, Taipei
Taiwan, R.O.C.
Phone: 886-2-820-0979
Fax: 886-2-820-5837
E-mail: cspm@msl.hinet.net



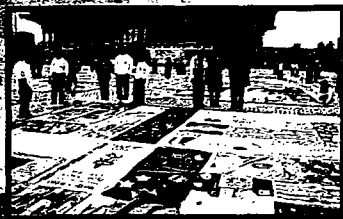
▲ Excursion Outdoor activity organized for PWAs and their family members.



▲ "Walking for AIDS, Because I Care"



▲ Floating Lantern Ceremony



▲ International AIDS Memorial Displays Opening Ceremony, outdoor display, CKS Memorial Plaza, Taipei, Dec. 1, 1995



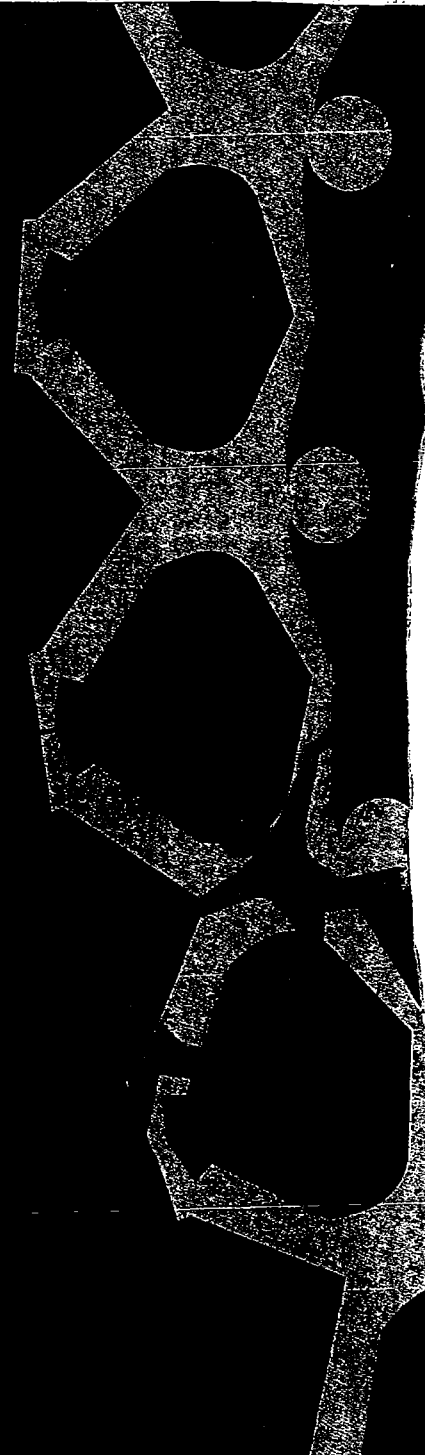
▲ International AIDS Memorial Quilt Display for display, CKS Memorial Plaza, Taipei, Dec. 3-8, 1995



▲ Volunteer training workshop



▲ AIDS Half-way Home Management



**HOW SERIOUS ARE GENDER ISSUES IN AIDS STRATEGIES AND
PROGRAMMES? ----- THE HONG KONG EXPERIENCE**

**Miss Elijah Fung
Manager
St. John's Cathedral HIV Information & Drop-In Centre
Hong Kong**

A paper presented at the Satellite Symposium "Rethinking AIDS Strategies and Programmes in Chinese Communities: Ideas and Experiences", held in conjunction with the 12th World AIDS Conference, Geneva, on 29 June 1998.

HOW SERIOUS ARE GENDER ISSUES IN AIDS STRATEGIES AND PROGRAMMES? --- THE HONG KONG EXPERIENCE

Miss Elijah Fung

Manager

St. John's Cathedral HIV Information & Drop-In Centre

HIV/AIDS SITUATION IN HONG KONG

To begin with, I would like to briefly outline the HIV/AIDS situation in Hong Kong. In Hong Kong, the first AIDS case was diagnosed in 1985. As at 31 March 1998, the total cumulative HIV/AIDS figures stood at 1005 and 322 respectively. In Hong Kong, the main route of HIV transmission is through sexual contact, mainly heterosexual sex. As the majority of the HIV infection cases are via heterosexual sex, the HIV infection rate amongst women has been rapidly increasing over the last few years. To date, a total number of 139 women have been infected. Over 90% of these infected women have been infected by their spouse or regular sexual partner(s). As predicated by the Department of Health, heterosexual sex will certainly be the main route of HIV transmission in the years to come in Hong Kong and elsewhere in the world.

CULTURE AND GENDER ISSUE

Due to historical reasons, Hong Kong is a mixture of the East and the West, shaped by both Chinese and Western culture. However, the former has a deep-rooted influence on Hong Kong people's thinking, and moral and value systems. Generally speaking, most Hong Kong people have a conservative attitude towards sex, sexuality and sex-related matters. Sex is still seen as a taboo subject and is still not discussed openly in public, or even amongst family members and friends.

With regards to gender equality, we see there is still inequality between men and women in many aspects of Hong Kong life. Although Hong Kong women enjoy a higher social status in comparison with other women in the rest of Asia, they are, however, still placed in a less advantageous position compared with men in Hong Kong. For instance, according to a survey finding conducted by The Family Planning Association of Hong Kong in 1992, 25.6% of the respondents still believed that women should be responsible for family planning.

Inequality between the sexes and cultural barriers further make women less able to discuss and negotiate sexual matters with their partners. Besides, the biological make up of women makes them twice as likely as men to be infected with HIV. Both the lack of adequate HIV information, and weaker bargaining power for safe sex practice, make women more vulnerable to HIV infection. As heterosexual sex is the main route of HIV transmission in Hong Kong, there is a potential risk that more Hong Kong women will be infected with HIV and more babies will be born to HIV positive mothers in the years to come.

EXISTING AIDS STRATEGIES AND PROGRAMMES

To prevent more people from being infected by HIV, AIDS must be viewed not only as a health problem, but also as a social, economic and gender issue. For AIDS strategies and programs to be effective, they also need to tackle these issues.

Referring to the situation in Hong Kong, the majority of the AIDS publicity campaigns and prevention programs of the government have a similar message to all the target population – that is, be faithful to your partner, have a monogamous relationship, reduce the number of your sexual partners, use condoms, etc. The rationale behind these messages assumes the same strategies can work for all the specific groups in society, single men, single women, families, commercial sex workers, etc. To take one example, such ‘blanket’ strategies do not properly address the situation of commercial sex workers, whose source of income depends on a steady turnover of sexual partners.

Furthermore, the above strategies are also ineffective when addressing the problems of women in general. For most, their sexual partners will probably be restricted to their own husbands or, if unmarried, to one regular sexual partner. Due to cultural barriers, and social and economic issues, even when they suspect that their husbands/partners are not faithful in the relationship, they may not feel comfortable about bringing up the topic of safe sex practice. Promotion of condom use in such cases is likely to fail.

Non-governmental AIDS organisations have, since 1990, played an important role in combating the AIDS epidemic in Hong Kong. To respond to the specific needs of groups such as the gay community, drugs users, commercial sex workers and youth, many AIDS-related programmes have been designed for these groups. Thanks to the hard work of the NGOs, good results have been seen in recent years.

However, as the main route of HIV transmission in Hong Kong is now via heterosexual sex, the current AIDS strategies and programmes may not be able to address the needs of this change in ‘at risk’ groups. In recent years, Hong Kong cross-border travellers have become a new and growing ‘at risk’ group.

According to a survey carried out by the City University of Hong Kong in 1996 (see References, no. 8), one in four Hong Kong cross-border truck drivers had slept with a sex worker over the last three months while in mainland China. Besides, some of the truck drivers also engaged in extra-marital sex with mainland girlfriends or had second wives on the mainland.

Almost 90% of these respondents believed that they were unlikely to become infected with HIV. But, the majority of these men were aged between 31 and 40, and almost 80% were married with children. Therefore, not only does HIV/AIDS directly affect these cross-border truck drivers, but it also indirectly affects their wives and families.

To meet the new trend of the HIV epidemic in Hong Kong, programs and strategies should be culturally sensitive and gender specific. Economic status, educational background, ability and special needs of the target population should be considered as crucial elements in designing AIDS prevention programs. Seeking advice from target population and the inclusion of them in program development will lead to a better and more influential program and success.

RECOMMENDATIONS

1. Good and effective AIDS education and prevention programs aim at addressing such issues as sexuality, the role of gender in HIV transmission and the importance of the empowerment of women. Through training programs, women can be empowered and become more assertive in initiating safe sex practice to protect themselves. As for men, they should be taught to be more responsible and to modify their sexual behavior. The only way to effectively raise equality between men and women is to emphasize mutual respect between the sexes, and to enhance mutual understanding of each party's needs and expectations.
2. A non-discriminatory and friendly environment is essential to raise the equality of the sexes. For instance, the setting up of the Equal Opportunities Commission is one step forward in bringing about equality between men and women in Hong Kong. However, the government should also strengthen and amend existing ordinances and strengthen civic education in order to reduce existing inequalities in treatment of the sexes.
3. We must acknowledge that the Hong Kong government has put much effort into tackling the AIDS issue. However, most of Hong Kong's existing AIDS programmes have to date been supported only on a short-term basis by the government. With only short-term financial assistance, it is difficult to maintain the programmes on a continuing basis, so as to have a greater impact on the target population. In order to have more effective AIDS strategies and programmes, the government should consider making a long-term financial commitment to running costs for the programmes already in place, in addition to sponsoring the setting up of new projects based on new target-group orientation.
4. In the absence of an AIDS vaccine or treatment, collaboration, exchange of information and networking with mainland China are now essential. For example, cross-border issues can be addressed by learning from and sharing experience with one other, and collaborating in developing programmes to combat HIV/AIDS.

CONCLUSION

This Satellite Symposium is only a beginning. It serves to help us gain a better understanding of the role of culture and gender differences in AIDS prevention and strategies for the Chinese community. Experience to date leads us to believe that good AIDS strategies and programmes must address these economic, social, cultural and gender issues. Above all, good strategies and programmes must also be supported by government.

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青
鳥



總幹事
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Coordinator

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OFFICE TEL: 2770 1065 FAX: 2770 1201

ST. JOHN'S CATHEDRAL HIV INFORMATION & DROP-IN CENTRE

St. John's Cathedral HIV Information & Drop-In Centre is a non-profit making and community-based organization. Its objectives are to raise public awareness about HIV/AIDS, to befriend people who are infected by the virus, and to limit the spread of AIDS in Hong Kong.

SERVICES PROVIDED

Walk-in services

The Centre offers a "walk-in service" for the local community. Visitors can relax, make a cup of tea /coffee, browse through AIDS related books and leaflets, watch a video, seek HIV/AIDS information and receive emotional support and assistance in a comfortable and confidential environment.

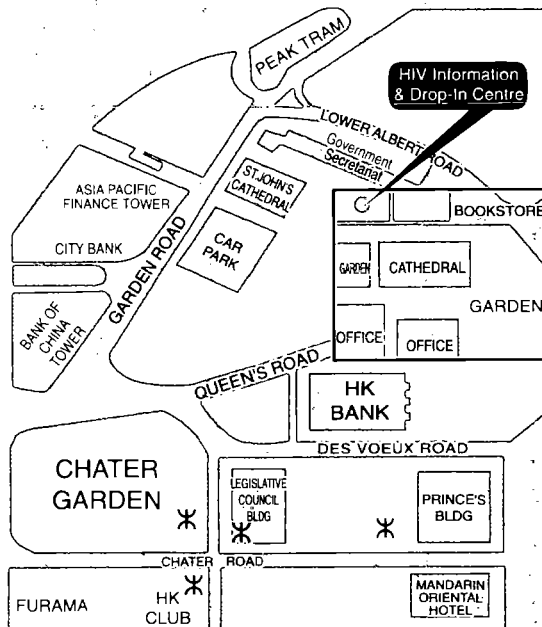
Education and awareness programmes

The Centre organizes education and awareness programmes for both community-based organizations and its volunteer workers. The Centre also sets up information booths at school fairs and exhibitions.

Women and AIDS Project

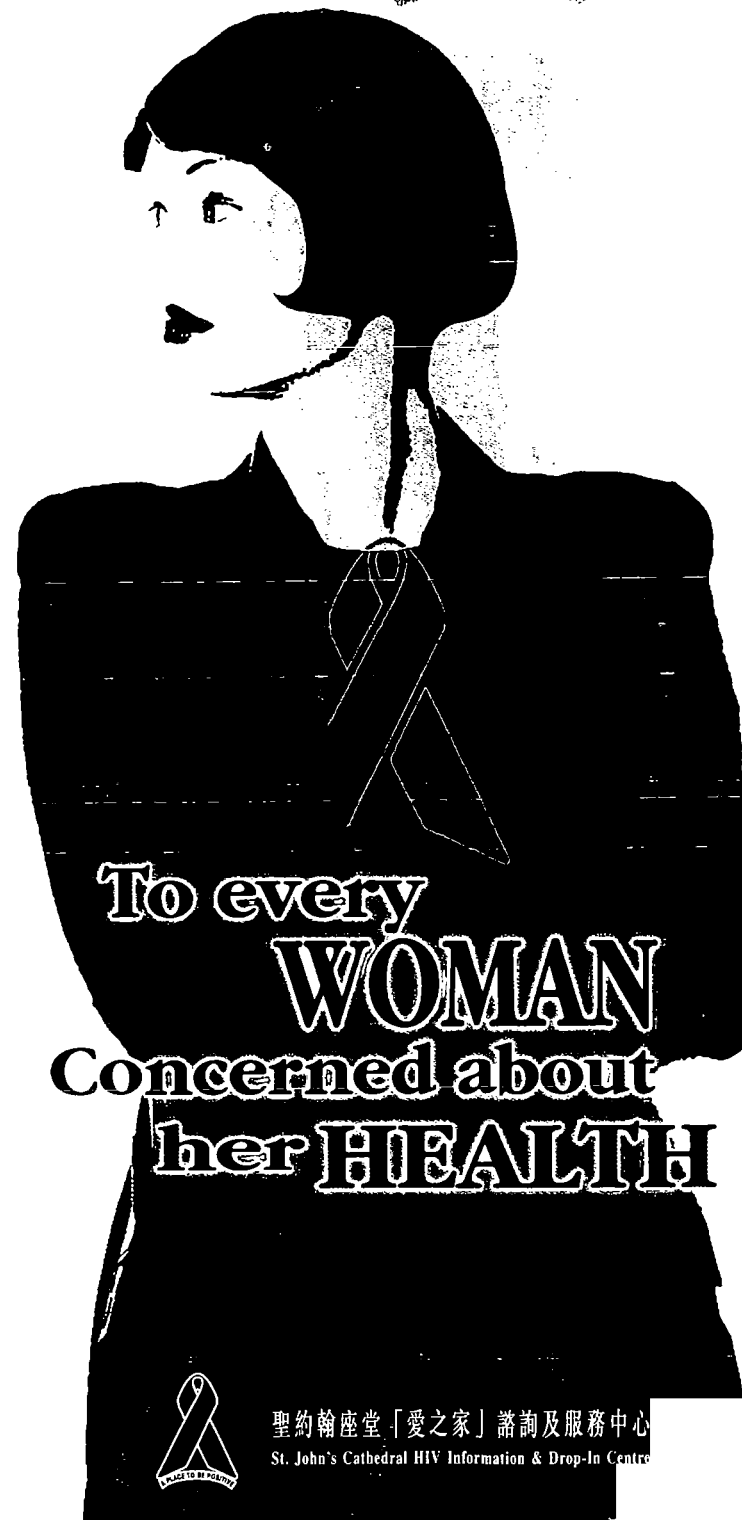
The intention of our Women and AIDS Project is to heighten women's awareness of possible implications of the AIDS epidemic, and to ensure that Hong Kong women have been given up to date HIV/AIDS information so that they can better protect themselves and their families from HIV infection.

ST. JOHN'S CATHEDRAL
HIV INFORMATION & DROP-IN CENTRE
4-8 Garden Road, Central, Hong Kong
Tel: (852) 2523 0531/2501 0653
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The HIV Information & Drop-In Centre is jointly sponsored by St. John's Cathedral and The Council For The AIDS Trust Fund

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WOMEN AND HIV/AIDS

With the worldwide increase in the incidence of HIV infection and AIDS among women, females are at increasing risk of this life threatening disease for which there is still no cure. According to the figure released by the Hong Kong Department of Health, the female to male ratio of HIV infection has increased from 1:8 in 1992, to 1:3 in 1997. This means that now there is one HIV infected woman to every three infected men. In Hong Kong, over 90% of women with HIV have been infected by their spouse or sexual partners. Thus, every female, young or old, married or single, should be aware of the risk of HIV infection. To learn more about HIV/AIDS is the most effective way to protect you and your family members from getting this disease.

WHAT IS HIV/AIDS ?

HIV (Human Immunodeficiency Virus) is a virus which attacks the body's defense system so that the body is unable to defend itself against illnesses. A person infected with HIV may stay fit for some time, but after a period of time, he/she may develop illnesses as the immune system weakens. When this happens, the person is said to have AIDS (Acquired Immune Deficiency Syndrome).

HOW DOES A WOMAN BECOME INFECTED BY HIV ?

- **SEXUAL CONTACT**
Through sexual activities (vaginal, anal or oral) without the use of condoms with someone who is already infected
- **ARTIFICIAL INSEMINATION**
Receiving sperm donation from an infected man
- **THROUGH INFECTED BLOOD/BLOOD PRODUCTS GIVEN INTRAVENOUSLY**
- **SHARING NEEDLES**
Sharing contaminated needles or equipment with an HIV infected person

HOW ABOUT YOU AND YOUR OFFSPRING?

- If you are planning for pregnancy, but you are not sure if you or your partner may be infected with HIV, both of you should consider taking the HIV Antibody Test, and getting counselling before pregnancy takes place.
- An infected woman has a 30%-50% chance of passing on HIV infection to her baby.
- If you are considering artificial insemination, be sure that the semen donor has been tested for HIV and that the test is negative.
- If you think you have been exposed to HIV during your present pregnancy, you must inform your doctor immediately. You and your baby may need special care.
- If you think your child has already been infected with HIV, you should seek medical advice and assistance without delay.

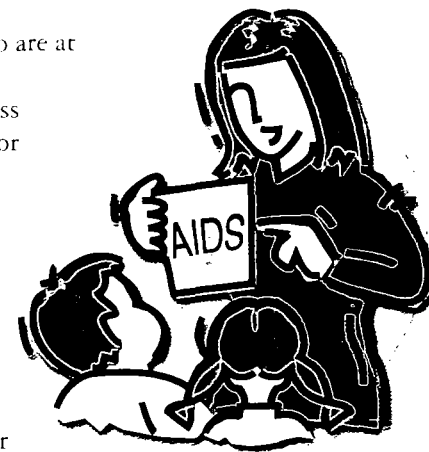


HOW CAN A WOMAN FIND OUT IF SHE IS INFECTED OR NOT ?

- You can find out by having an HIV Antibody Blood Test.
- Free and confidential testing facilities and counselling are available at the AIDS Unit, Hong Kong Department of Health (Tel:2780 2211), and at the Hong Kong AIDS Foundation (Tel: 2513 0513).
- Testing service is also available at Social Hygiene Clinics, Department of Health.
- You can also consult your private doctor for the above test.

HOW CAN A WOMAN PROTECT HERSELF FROM BEING INFECTED ?

- Learn about the transmission of HIV.
- Always avoid sharing needles or syringes .
- Be aware that the use of drugs and alcohol can seriously impair your judgment. You may then take risks which you would not normally consider.
- If you are not sure of your partner's sexual history, you can refrain from engaging in unsafe sex.
- Discuss AIDS and its prevention with your partner.
- The use of condoms can reduce the chance of HIV infection and other sexually transmitted diseases. Please note that contraceptive pills can only protect you from pregnancy but not from sexually transmitted diseases and HIV infection.
- For women who are at risk of HIV infection, discuss with a counsellor or a doctor before considering pregnancy and breast-feeding.
- Discuss safer sex and the prevention of AIDS with your children.



For more information, please call us ,
St. John's Cathedral
HIV Information & Drop-In Centre at 2523 0531.

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A PLACE TO BE POSITIVE

April 1998

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WOMEN'S COMPANION

St. John's Cathedral HIV Information & Drop-In Centre Newsletter

IN THIS ISSUE

- To every woman concerned about her health
- Readers' Column
- How does HIV/AIDS affect women?
- Women and AIDS - A Gender Issue
- Do I need a Pap Smear Test?
- HIV/AIDS statistics in Hong Kong

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Ms. Yung Wing Han, Sally

**TO EVERY WOMAN
CONCERNED ABOUT
HER HEALTH**

Miss Elijah Fung
Manager, St. John's Cathedral HIV Information & Drop-In Centre

With the worldwide increase in the incidence of HIV infection and AIDS among women, females are at increasing risk of contracting this life threatening disease for which there is still no cure. According to figures released by the Hong Kong Department of Health, the female to male ratio of HIV infection has increased from 1:8 in 1992, to 1:3 in 1997. This means that now there is one HIV infected woman to every three infected men. Over 90% of Hong Kong

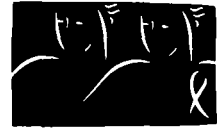
In view of the increase in HIV infection amongst the Hong Kong women, in late 1997 the St. John's Cathedral HIV Information & Drop-In Centre launched a Women and AIDS Project, with financial support from The Council For The AIDS Trust Fund. The purpose of this Project is to heighten women's awareness of possible implications of the AIDS epidemic, and to ensure that Hong Kong women are given up to date HIV/AIDS information so that they can better protect themselves and their families from HIV infection.

Since early January, 1998, we have been visiting women's centres in the New Territories and Kowloon to seek their cooperation and assistance towards the Women and AIDS Project. The initial response from the personnel of these women's centres has been supportive. They also think that there should be more AIDS awareness and education programmes for women in Hong Kong. Some groups have invited our staff to give educational talks to their members,



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HIV/AIDS and Drug Use in Prisons: Moral and Legal Responsibilities of Prison Systems

by Ralf Jürgens*

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A prisoner retains all civil rights which are not taken away expressly or by necessary implication.

- Lord Wilberforce in *Raymond v Honey* (1982)

A sentence of imprisonment should not carry with it a sentence of AIDS.

- Note, 1988

HIV/AIDS and Drug Use in Prisons: Moral and Legal Responsibilities of Prison Systems

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Introduction

This chapter briefly reviews what is known about HIV/AIDS and hepatitis C in prisons. It then presents some of the evidence of the prevalence of high-risk behaviours - in particular, injection drug use - and resulting HIV transmission behind bars. It discusses what is being done in prisons to prevent HIV infection and to reduce the harms from drug use, and shows that where harm reduction measures - such as allowing access to condoms, bleach, sterile injection equipment and methadone maintenance treatment - have been introduced, such measures have been successful, have not created any problems, and are being supported by prisoners, staff, prison administrations and the public. The chapter then briefly discusses why other measures, such as the war on drugs being waged in prisons in many countries, are counterproductive and harmful. Some of the reasons why many prison systems still oppose introduction of harm reduction measures are also addressed. The chapter concludes by arguing that harm-reduction measures in prisons are necessary to prevent the further spread of HIV in prisons, and that prison systems have a moral and legal obligation to implement them.

HIV/AIDS in Prisons: An Overview

HIV and Hepatitis C Seroprevalence

Worldwide, rates of HIV-infection in inmate populations are much higher than in the general population. They are, in general, closely related to two factors: (1) the proportion of prisoners who injected drugs prior to imprisonment; and (2) the rate of HIV infection among injection drug users in the community. The jurisdictions with the highest HIV-prevalence in prisons are areas where HIV infection in the general community is "pervasive among IV drug users, who are dramatically over-represented in correctional institutions" (Hammett, 1988, p. 26). Commenting on the situation in the United States, the US National Commission on AIDS (1991, p.10) stated that "by choosing mass imprisonment as the federal and state governments' response to the use of drugs, we have created a de facto policy of incarcerating more and more individuals with HIV infection."

Particularly high rates have been reported from countries in southern Europe; for example, 26 percent in Spain and 17 percent in Italy. High figures have also been reported from France (13 percent; testing of 500 consecutive entries), Switzerland (11 percent; cross-sectional study in five prisons in the Canton of Berne) and the Netherlands (11 percent; screening of a sample of prisoners in Amsterdam). In contrast, some European countries, including Belgium, Finland, Iceland and some Länder in Germany, report low levels of HIV prevalence. Relatively low rates of HIV prevalence have also been reported from Australia. In the United States and in Canada, the geographic distribution of cases of HIV infection and AIDS is remarkably uneven. In the United States, many systems continue to have rates under one percent, while in a few rates approach or exceed 20 percent. In Canada, rates range between one and 7.7 percent (seroprevalence data are from Correctional Service Canada (CSC), 1994a, pp. 15-19; CSC, 1994b, pp. 47-79; Jürgens, 1996, appendix 2, with references).

Hepatitis C seroprevalence rates in prisons are even higher: studies revealed rates of between 28 and 40 percent in three Canadian prisons (Ford et al, 1995; Pearson et al, 1995; Prefontaine and Chaudhary, 1990; Prefontaine et al, 1994); 39 percent in prisons in Victoria, Australia, and 50 percent in New South Wales, Australia (Crofts et al, 1995; Brown, cited in Zinn, 1995); 38 percent among male inmates in prisons in Maryland, US (Vlahov et al, 1993); and 74.8 percent among IDUs in a prison for women in Vechta, Lower Saxony (Germany), compared to 2.9 percent among non-IDUs (Keppler, Nolte, and Stover, 1996).

While most hepatitis C positive inmates come to prison already infected, the potential for intramural spread is high: hepatitis C is much more easily transmitted than HIV, and transmission has been documented in prisons in Canada (Jürgens, 1996, at 46), Germany (Keppler, Nolte, and Stover, 1996), and the US (Vlahov et al, 1993).

Evidence of High-Risk Behaviours

Drug Use

An increasing number of scientific studies is providing evidence of the existence and extent of injection and other drug use in prisons. The following is an overview of some of these studies.

In Canada, a study on HIV transmission among injection drug users in Toronto found that "[o]ver eighty per cent [of the participating injection drug users] had been in jail overnight or longer since beginning to inject drugs, with twenty-five per cent of those sharing injecting equipment while in custody" (Millson, 1991). In a recent survey, almost 40 percent of 4,285 federal inmates self-reported having used drugs since arriving in their current institution (CSC, 1996a, pp.144-148), and eleven percent reported having injected an illegal/non-prescription drug; of these, only 57 percent thought that the equipment they used was clean (CSC, 1996a, p.138 and 1996b, pp.348-349).

In Australia, "[a]ll commentators agree that it [injection drug use] occurs and that needle sharing is almost always associated with IV drug use in prisons because of the lack of availability of syringes" (Heilpern and Egger, 1989, p.38 with many references). In an early survey of "HIV Risk-Taking Behaviour of Sydney Male Drug Injectors While in Prison," approximately 75 percent of respondents reported having injected drugs at least once while in prison. Of these, two thirds provided data on the frequency of sharing of injection equipment in prison, with 75 percent reporting sharing (Wodak, 1991, pp. 240-41). Other more recent studies have confirmed that HIV risk behaviours are frequent in Australian prisons (Dolan, 1994b; Dolan, forthcoming).

In the United Kingdom, a number of surveys found that the use and availability of injectable drugs greatly exceeds official estimates and that needles and syringes are commonly shared out of necessity (Thomas, 1990, pp.7-10; Pickering and Stimson, 1993; see also Bird et al, 1995, and Gore, 1995). One study found that injection drug use decreased in prisons among inmates who had been injection drug users on the outside. However, inmates were more likely to inject

in an unsafe manner when they did inject. The study concluded that imprisonment increased the risk of contracting HIV infection (Turnbull, Dolan and Stimson, 1992). This is consistent with the results of two other studies of drug using behaviour in Scottish prisons. In the first study, 11 percent of a purposive sample of 234 prisoners had injected during their current sentence, while 32 percent were injecting prior to imprisonment. However, of those who were injecting in prison, 76 percent were sharing equipment, while only 24 percent of those who were injecting prior to imprisonment were sharing (Shewan, Gemmell and Davies, 1994). In the second study, 76 of 227 prisoners (33 percent) had injected drugs at some time in their lives, and 33 (15 percent) admitted to injecting in prison. While injectors tended to use drugs on a daily basis outside prison, they would normally inject only weekly or monthly while in prison. However, all those who had injected in prison had shared equipment at least sometimes. Twenty prisoners had always shared it, compared to only two prisoners who had always shared outside (Taylor et al, 1994).

In Germany, nearly 20 percent of injection drug users who participated in a large epidemiological study were HIV-positive, and about 60 percent of them had served a prison sentence. While only 10 percent of participants with no prison experience tested HIV-positive, 26 percent of those with prison experience tested HIV-positive, and 67 percent of participants indicated that they continued to inject while in prison (CSC, 1994c, p. 60).

Sexual Activity

Although in prisons sexual activity is generally considered to be a less significant risk factor than sharing of injection equipment, it also puts prisoners at risk of contracting HIV infection. Homosexual activity occurs inside prisons, as it does outside, as a consequence of preferred sexual orientation. In addition, prison life produces conditions that encourage the establishment of homosexual relationships within the institution (Thomas, 1990, p.5). The prevalence of sexual activity in prison is difficult to estimate, but is based on such factors as whether the accommodation is single-cell or dormitory, the duration of the sentence, the security classification and the extent to which conjugal visits are permitted (Heilpern and Egger, 1989, p.40 with reference). Studies of sexual contact in prison have shown "inmate involvement to vary greatly" (Saum, 1995). In a recent study in state prisons and city jails in New York (Mahon, 1996), prisoners and former prisoners reported frequent instances of unprotected sex behind bars. One woman summarized the prevalence and range of sexual activity described by participants in the study when she stated:

Male CO's are having sex with females. Female CO's are having sex with female inmates, and the male inmates are having sex with male inmates. Male inmates are having sex with female inmates. There's all kinds, it's a smorgasbord up there.

In Canada, six percent of federal inmates self-reported having had sex with another inmate; of these, only 33 percent reported using condoms (CSC, 1996c).

Tattooing and Piercing

It has been said that "[o]utside tattooing is not thought to present much of a risk of HIV transmission because the needles are sterilised, but in prison tattooing is a social activity and involves sharing needles which may make it risky" (Curran, McHugh, Nooney, 1989, at 35). Similarly, Heilpern and Egger (1989) stated:

It is difficult to estimate how much tattooing occurs in prisons although the visible evidence is often quite striking. Because the activity is illegal it is almost certainly conducted with non-sterile equipment.

In Canada, 45 percent of federal inmates reported having had a tattoo done in prison, and 17 percent reported having been pierced (CSC, 1996a).

Evidence of HIV Transmission

Until recently, few data were available on how many prisoners become infected while in prison, and the data that were available - mostly from studies undertaken in the United States (for a review of five studies, see Parts, 1991) - suggested that "transmission does occur in correctional facilities, but at quite low rates" (Hammett et al., 1993, p.43). This was sometimes used to argue that HIV transmission in prisons is rare, and that consequently there is no need for increased prevention efforts.

However, most of the studies that have reported relatively low levels of HIV transmission in prison were conducted early in the HIV epidemic and sampled long-term prisoners who would have been at less risk of infection than short-term prisoners (Dolan, 1997/98). The extent of HIV infection occurring in prisons may have been underestimated. In more recent years, evidence of HIV transmission in prisons in the United States (Mutter et al, 1994), Australia (Dolan et al., 1994a; Dolan et al., 1996a), and other countries (Wright et al., 1994) has been published. In 1994, a study undertaken in Glenochil prison for adult male offenders in Scotland provided definitive evidence that outbreaks of HIV infection can and will occur in prisons unless HIV prevention is taken seriously. Following the diagnosis of two apparently recent seroconversions to HIV infection among prisoners, prisoners were offered confidential counselling and testing for HIV. Of 227 inmates counselled, 76 had a history of injecting; 33 of these admitted injecting in Glenochil, while 43 admitted having injected at some point in their lives, but not in Glenochil. Of the latter, 34 were tested, but none tested positive. In contrast, of the 33 inmates who declared that they had injected in Glenochil prison, 27 were tested and 12 were found to be HIV-positive; the remaining 15 tested negative but were still in the window period. A further two Glenochil injectors had been diagnosed HIV-positive two months previously, giving a total of 14 HIV-positive drug injectors. Of the 14 HIV-positive inmates, definitive evidence of HIV transmission in prison existed for eight inmates. Another six infections also possibly occurred in prison, but acquisition of infection outside prison could not be ruled out. The true number of infections was probably even higher: it has been calculated that the total number of prisoners

infected in prison during that period could lie between 22 and 43 inmates (Taylor et al., 1994; see also Christie, 1995; Taylor et al, 1995). Following the outbreak, 12 HIV-positive inmates and 10 other drug injectors were interviewed about their risk behaviours in prison. From the interviews emerged a vivid description of random sharing with a limited number of needles and syringes, which were mostly blunt, broken, or fashioned out of a variety of materials (Taylor and Goldberg, 1996).

HIV Prevention

Initially, responding to the issues raised by HIV/AIDS and drug use in prisons was very slow. Only small steps were made to develop policies and to provide educational programs for staff and prisoners. In many systems, prisoners with HIV infection or AIDS were segregated from the rest of the prison population and were subject to a variety of discriminatory measures. Neither condoms nor bleach were made available to prisoners, and educational programs often appeared inadequate or insufficient.

However, in recent years a growing number of prison systems have started undertaking efforts to address HIV/AIDS and drug use in prisons. Often this was done only after they were confronted with sharp increases in the numbers of prisoners with HIV/AIDS in their custody. Some systems have made condoms, bleach, and even sterile injection equipment and methadone maintenance treatment available, abandoned segregation policies, and introduced better educational programs delivered or supplemented by community-based outside organizations and/or peers.

The following section describes some of the harm reduction measures introduced behind bars.

Condoms

According to the World Health Organization's network on HIV/AIDS in prison, 23 of 52 prison systems surveyed late in 1991 allowed condom distribution (Harding and Schaller, 1992, p.767). Significantly, no system that has adopted a policy of making condoms available in prisons has reversed the policy, and the number of systems that make condoms available continues to grow every year.

In some systems, however, making condoms available in prisons is still opposed on the grounds that sexual activity is illegal in public and that prisons are public spaces. Other systems make condoms available only through prison medical services, upon the express request of a prisoner, although national and international recommendations agree that condoms should be made easily and discreetly available (see, eg, CSC 1994a, at 58-58).

In an important recent development, in New South Wales in Australia, 50 prisoners launched a legal action against the state for non-provision of condoms (*Prisoners A to XX inclusive v State of NSW*; see Jürgens, 1996, at 48). Their lawyer noted that "[i]t is no proper part of the

punishment of prisoners that their access to preventative means to protect their health is impeded." Since then, at least in part because of the legal action, the NSW government decided to make condoms available, initially in three prisons on a trial basis, but later also in other prisons and on a permanent basis.

Bleach

As reported by Harding and Schaller (1992b, Table 4.1), 16 of 52 systems surveyed late in 1991 made bleach available to prisoners, often accompanied by instruction on how to clean needles. However, results of an Australian study - the first in the world to allow the independent monitoring of a bleach distribution program for prisoners - provide evidence of the limitations of making bleach available in prisons for syringe decontamination (Dolan et al, 1994b). The study found that three years after the distribution of bleach began, 62 percent of inmates still found it difficult to gain access to it, and pointed out other shortcomings of a syringe disinfecting program, such as uncertainty about whether other bloodborne viruses can be effectively and rapidly decontaminated from injecting equipment with the use of bleach. It concluded that other prevention measures need to be explored and that one such measure that requires consideration is piloting a syringe exchange program in prisons. One year later, a follow-up study found that there had been improvement in access to bleach from the first study. Nevertheless, it found shortcomings in the bleach program and again recommended that consideration be given to a pilot study of syringe exchange in prisons (Dolan et al, 1996b at 23).

Sterile Injection Equipment

Particularly because of the questionable efficacy of bleach in destroying HIV and other viruses (US Department of Health & Human Services, 1993), providing sterile needles to inmates has been widely recommended. In Canada, the Expert Committee on AIDS and Prisons (ECAP) observed that the scarcity of drug-injection equipment in correctional facilities almost guarantees that inmates who persist in drug-injecting behaviour will share their equipment (CSC, 1994a, at 77):

Some injection drug users have stated that the only time they ever shared needles was during imprisonment and that they would not otherwise have done so. Access to clean drug-injection equipment would ensure that inmates would not have to share their equipment.

The Committee concluded that making injection equipment available in prisons would be "inevitable" (CSC, 1994a).

Recently, an increasing number of prisons worldwide has established – or is planning to do so in the near future – needle and syringe exchange or distribution programs.

In Switzerland, distribution of sterile injection equipment has been a reality in some prisons since 1993. Sterile injection equipment first became available to inmates in 1993, at Oberschöngrün prison for men, a minimum-security institution housing approximately 75

prisoners. Dr Probst, a part-time medical officer working at Oberschöngrün was faced with the ethical dilemma of as many as 15 of 70 inmates regularly injecting drugs, with no adequate preventive measures:

Unlike most of his fellow prison doctors, all of whom feel obliged to compromise their ethical and public health principles daily, Probst began distributing sterile injection material without informing the prison director. When this courageous but apparently foolhardy gesture was discovered, the director, instead of firing Probst on the spot, listened to his arguments about prevention of HIV and hepatitis, as well as injection-site abscesses, and sought approval from the Cantonal authorities to sanction the distribution of needles and syringes. Thus, the world's first distribution of injection material inside prison began as an act of medical disobedience (Nelles and Harding, 1995).

Three years later, distribution is ongoing, has never resulted in any negative consequences, and is supported by prisoners, staff, and the prison administration. According to the warden, Mr Fäh, initial scepticism by front-line staff has been replaced by their full support (Jürgens, 1996, at 59):

Staff have realized that distribution of sterile injection equipment is in their own interest. They feel safer now than before the distribution started. Three years ago, they were always afraid of sticking themselves with a hidden needle during cell searches. Now, inmates are allowed to keep needles, but only in a glass in their medical cabinet over their sink. No staff has suffered needle-stick injuries since 1993.

About 700 sterile injection units are handed out yearly by Dr Probst, at a cost of only 400 Swiss francs (approximately US\$350), "much less than would be the costs of caring for the cases of hepatitis and abscesses we avoid by handing out sterile equipment" (ibid). From the physician, who comes to the institution once every week, inmates can obtain more than one injection unit at a time, and distribution is not undertaken on a strict one-for-one basis. As emphasized by Mr Fäh,

it is more important to make sure that prisoners who are injection drug users can always use sterile equipment than to insist on a one-for-one exchange scheme. We have a fairly good return rate, and are not concerned about not all equipment being returned to Dr Probst. What we do care about is safety of staff – and staff has not been exposed to any hidden needles.

In June 1994, another Swiss prison - Hindelbank institution for women in the Canton of Berne - started a one-year pilot AIDS prevention program including needle distribution. Hindelbank houses up to 110 inmates, of whom the majority have been sentenced for narcotics offenses.

One year after it started, Hindelbank's needle-distribution program was scientifically evaluated by external experts, demonstrating clear positive results: the health status of prisoners improved; no new cases of infection with HIV or hepatitis occurred; an important decrease in needle sharing was observed; there was no increase in drug consumption; and needles were not used as weapons (Nelles and Fuhrer, 1995). During one year, 5335 needles were distributed, an average of 14 per day. Their utilization seemed to depend primarily upon two factors: the availability of drugs, and prisoners' capacity to purchase them. Importantly, the evaluation showed that only about 20 percent of staff did not agree with the installation of the needle distribution machines. The report concluded by saying that (*ibid*, at 19),

the feasibility of distributing needles and syringes, the positive consequences it had on the sharing of needles, and the considerable acceptance of the project by inmates and staff ... lead to the conclusion that the distribution of sterile needles and syringes could also be justified in other prisons.

Following the evaluation, a decision was taken to continue the program at Hindelbank. One year later, a follow-up evaluation confirmed that there was neither evidence of needle misuse nor an increase in drug consumption. The sterile needle distribution program continued to run without complications (Nachevaluation, 1997). Other prisons have since started, or are planning to start, their own programs (for more details, see Jürgens, 1996, at 60-66; Jürgens, 1997). In Switzerland, distribution of sterile injection equipment to injection drug users started in at least one prison for men in Geneva on 1 March 1996, in the prison of Realta in the Canton of Grisons on 3 February 1997, and in three more prisons in the Canton of Berne in early 1998 (Editor, 1998). In Germany, it started at Vechta (Lower Saxony), a women's prison with 170 inmates; at a men's prison with 230 inmates in Lingen (Lower Saxony) (for a preliminary review, see Jacob and Stöver, 1997); at a men's prison with a capacity of 300 in Hamburg in May 1996; and in Berlin, the Senator of Justice has expressed her intention to start it in a prison for women. In Spain, it is being piloted at the Trinidad Youth Prison in Barcelona and Basaure Prison near Bilbao. In Austria, according to an announcement made by Dr Jörg Pont at the 3rd European Conference on AIDS and Drug Use in Prisons in February 1997, it will be piloted in at least one prison (Jürgens, 1997). Finally, in Australia, a study concluded that needle and syringe exchange is feasible (Rutter et al, 1996).

The experience of the prisons where sterile injection equipment has been made available has shown that it can be made available in a manner that is non-threatening to staff and indeed seems to have increased staff's safety; it has further shown that staff can be brought to understand that making sterile injection equipment available to inmates does not mean condoning drug use and "giving up" on drug use in prisons, but is a pragmatic health measure. Because staff don't feel threatened by the distribution of sterile injection equipment, and because they understand the rationale behind it, they are supportive of it.

There is not one, but several models of distribution of sterile injection equipment. Thus far, every institution has chosen its own model: installation of dispensing machines, one-for-one

exchange, or distribution through the physician or health-care services. This shows that what can and should be done in a particular institution depends on many factors, including, but not limited to, the size of the institution, the extent of injecting drug use, the security level, whether it is a prison for men or for women, the commitment of health-care staff, and the "stability" of the relations between staff and inmates. A measure such as making sterile injection equipment available could not, and does not necessarily have to be, introduced in all institutions at the same time and in the same fashion, but can be undertaken immediately, easily, and at low cost, with good results, in some institutions. In other institutions, other measures may be more feasible and are being introduced, such as methadone maintenance programs or the establishment of drug-free wings.

Methadone

Many national and international organizations have recommended the introduction or expansion of MMT in prisons (see, eg, WHO, 1993; Advisory Committee on the Misuse of Drugs, 1993; Scottish Affairs Committee, 1994) and worldwide, a small but increasing number of prison systems is offering methadone maintenance treatment (MMT) to inmates (for a comprehensive review, see Dolan and Wodak, 1996). Treatment with methadone is seen as an AIDS-prevention strategy that allows people dependent on drugs an additional option to get away from needle use and sharing. As stated by Gore, the main aim of methadone maintenance,

is to help people get off injecting, not off drugs. Methadone dose reduction – with the ultimate goal of helping the client to get off drugs – is a longer term objective (cited in Jürgens, 1996, at 70).

Indeed, it has been suggested that methadone is the best available option to prevent needle sharing in prisons (McLeod, 1991, at 245, 248), and that increasing the number of places available for MMT in prisons should be considered as a matter of urgency particularly for HIV-positive drug-dependent prisoners (Heilpern and Egger, 1989, at 94).

Community MMT programs have rapidly expanded in a number of countries in recent years. There are ample data supporting their effectiveness in reducing high-risk injecting behaviour and in reducing the risk of contracting HIV. There is also compelling evidence that MMT is the most effective treatment available for heroin-dependent IDUs in the community in terms of reducing mortality, heroin consumption and criminality. Further, in most countries where it has been introduced, MMT attracts and retains more heroin injectors than any other form of treatment (Dolan and Wodak, 1996, with numerous references). Finally, there is evidence that people who are on MMT and who are forced to withdraw from methadone because they are incarcerated often "return to narcotic use, often within the prison system, and often via injection" (CSC, 1994a, at 73; Shewan, Gemmell and Davies, 1994). It has therefore been widely recommended that prisoners who were on MMT outside prison be allowed to continue it in prison.

Further, with the advent of HIV/AIDS, the arguments for offering MMT even to those who were not following such a treatment outside, are compelling: prisoners who are injection drug

users are likely to continue injecting in prison, and are more likely to share injection equipment, creating a high risk of HIV transmission among prisoners and to the public. As in the community, MMT, if made available to prisoners, has the potential of reducing injecting and syringe sharing in prisons (Dolan et al, 1996c).

Nevertheless, many prison systems are still reluctant to make MMT available, arguing that imprisonment should be a time when injection drug users are forced to abstain from drug use for their own and the community's benefit:

Methadone is considered by many correctional staff as just another mood altering drug, the provision of which further delays the necessary personal growth required to move beyond a drug centred existence (Dolan and Wodak, 1996).

In the absence of education about its rationale, some prison staff regard MMT as "pandering" to addicted prisoners by giving them free access to an opioid drug; they believe that its main rationale is the reduction of recidivism rather than the prevention of HIV transmission in prison. Some also object to MMT on moral grounds, arguing that it merely replaces one drug of dependence with another. If there were reliably effective alternative methods of achieving enduring abstinence, this would be a meagre achievement. However, there are no such alternatives:

[T]he majority of heroin-dependent patients relapse to heroin use after detoxification; and few are attracted into, and retained in drug-free treatment long enough to achieve abstinence. Any treatment [such as MMT] which retains half of those who enrol in treatment, substantially reduces their illicit opioid use and involvement in criminal activity, and improves their health and well-being is accomplishing more than 'merely' substituting one drug of dependence for another (ibid, with reference).

This has been recognized in a recent Canadian case (*R v Povilaitis*), in which a man with a long-standing, "serious heroin problem," who had committed a number of acquisitory crimes and had been in treatment, without success, several times already, was convicted to two years minus one day imprisonment - and thus to imprisonment in a provincial prison in Québec - because that prison had agreed to provide him with methadone treatment. The defense in the case had submitted that it was necessary to deal with the root causes of the man's crimes, namely his heroin addiction, and that treatment with methadone was essential to overcome that addiction. This was the first case in which an accused in a criminal case was sentenced to a term of imprisonment with the specific aim that he be allowed to undergo methadone treatment.

In another Canadian case, an HIV-positive woman undertook legal action against a provincial prison system for failing to provide her with methadone. The woman, who at the time of her sentence was on a methadone maintenance program, had been refused continuation of the treatment in prison. She petitioned the court for relief in the nature of habeas corpus (see

McLeod, 1996), arguing that, under the circumstances she found herself in, her detention was illegal. In response to the petition, and despite the position it had originally taken, the prison system arranged for a staff doctor to examine the woman, and he prescribed methadone for her. After this, she withdrew her petition. The provincial prison policy has since been changed to allow for methadone treatment of prisoners.

Heroin Maintenance Treatment

As part of the Swiss national experiment with prescribing of heroin and other drugs to users, in Oberschöngrün institution a heroin prescription program started in September 1995. Up to a maximum of eight inmates participated in the project. To be eligible for participation, inmates had to: be 20 years of age or older; have been dependent on heroin for a minimum of two years; have been in treatment, without success, in the past; have "deficits in the social sphere"; and have sufficient time left in the institution.

Participants lived in a separate unit of the institution, worked seven days a week, participated in group discussions and individual psychosocial counselling, and injected themselves with heroin three times a day under medical supervision. The main aims of the project were to: establish the feasibility of heroin maintenance in prisons; assist the institution in solving its drug-related problems; and study its advantages and disadvantages, for clients and institution, as compared to methadone maintenance.

First results derived from qualitative analyses show that prescribing heroin under medical control in prisons is feasible:

All the medical and social problems could be resolved in a satisfactory way. ... the participants experienced an improvement in their quality of life. After a few start-up problems, adapting to the requirements of the prison sentence was considered to be satisfactory by the prison staff. For the prison itself, this pilot project was a major challenge that, thanks to the extra efforts of motivated and available staff, could be carried out successfully (Kaufmann, Drelfuss and Dobler-Mikola, 1997/98).

The War on Drugs in Prisons

Despite the examples of successful harm reduction programs in prisons described above, many prison systems are still reluctant to embrace a harm reduction approach, and abstinence often remains the primary goal of their drug policy. The war on drugs, but not on AIDS, continues behind bars. The following section briefly discusses why such an approach could be counterproductive and contribute to the spread of HIV behind bars.

Measures aimed at drug use in prisons have traditionally aimed at eliminating drug use rather than at reducing the harms from it. Stress has been placed on interdiction and apprehension,

education and the treatment of addicted offenders. Some of the measures undertaken or planned, such as implementation of effective drug education, are uncontroversial and widely supported, but others have been criticized. In particular, it has been argued that drug-testing programs such as those undertaken in a number of prison systems are costly and hardly a good use of scarce resources: such programs cost more than appropriate public health responses to drug use, namely evaluated drug reduction and rehabilitation programs in all prisons, would cost (Bird, Gore, and co-signatories, 1995). Further, they are intrusive, requiring prisoners to urinate on command and in full sight of staff. And finally, they are likely to have a negative impact on efforts to reduce the harms from drug use. In theory, drug testing should reduce the amount of drug use in prisons because people should be dissuaded from using drugs through fear of disciplinary action. However, the long-term effects on levels of drug use remain to be seen. According to inmates in Canadian federal prisons, the urinalysis program may, if at all, have led to a slight decrease in drug use: according to a majority, the program had "no impact" on drug use among inmates (CSC, 1996a, at 360). Importantly, even if urinalysis programs did result in a decrease in drug use, this should not be overvalued. Reduction of drug use is an important goal, but reduction of the spread of HIV and other infections is more important: "the spread of HIV is a greater danger to individual and public health than injection drug use itself" (NAC-AIDS Working Group on HIV Infection and Injection Drug Use, 1994). In particular, there is a fear that, because of urine testing, inmates' drug use, rather than diminish, may shift from drugs (such as marijuana) that are detectable in urine for up to one month, to drugs (such as cocaine, heroin, PCP and LSD) that have much shorter windows of detection. As a result, injection drug use may increase, and with it the risk of HIV transmission and other harms from drug use (Riley 1995; Kommission, 1995). Canadian prisoners confirm that this is happening (Jürgens, 1996, at 24, with reference):

We agree that urinalysis testing is encouraging some inmates to change their drug of choice from marijuana and hashish to harder drugs like cocaine and heroin because they are flushed out of your system faster, thus making random detection much harder. There is also a good portion of inmates that really do not care and will take their chances with random testing. In my opinion, this strategy is not reducing the amount of drugs in prison, instead it is increasing the amount of "hard" drugs available.

Addressing Prison System's Concerns

Prison systems and governments have argued that harm reduction measures cannot be introduced in prisons for safety reasons, and that making them available would mean condoning sexual activity and drug use in prisons. This section will address these concerns and point out that introduction of harm reduction measures in prisons is in the interest of all concerned - prisoners, staff, the prison administration, and the public; and that it does not mean condoning sexual activity and drug use.

The Perceived Conflict of Values Between the Penal System and Medical Care

Correction is a public safety (law enforcement) rather than a public health activity (Brewer, 1991), and prison life is not organized on the basis of care, but of coercion. Outside the prison setting, it has long been recognized that coercive interventions are counter-productive in controlling HIV transmission and its consequences; that HIV/AIDS interventions need to be based on respect for persons and their rights and dignity; and that personal responsibility has to be encouraged. Prevention of disease and the provision of medical care in prisons, however, require reconciling or balancing a medical model of prevention, diagnosis, care and treatment with the correctional requirements of custody and control (Dubler, 1990, p.365). The punitiveness inherent in the prison system, and security concerns, have often been seen as obstacles to effective prevention of HIV/AIDS in prisons.

However, the promotion of health in prisons does not necessarily entail lessening of the safety and the security of prisons. The interest of prisoners in being given access to the means necessary to protect them from contracting HIV infection are compatible with the interest of staff in their security in the workplace and of prison authorities in the maintenance of safety and order in the institutions. Indeed, promotion of health in the prison population and the education of both prisoners and staff may be the best ways to create safety and security (PASAN, 1992, p.3). Any measure undertaken now to prevent the spread of HIV infection will benefit prisoners, staff, and the public. First, it will protect the health of prisoners, who should not, by reason of their imprisonment, be exposed to the risk of a deadly condition. Second, it will protect staff in correctional institutions. Lowering the prevalence of infections in prisons means that the risk of exposure to these infections will also be lowered. Importantly, the experience of those countries that have made condoms, bleach, and sterile injection equipment available to inmates has shown that this can be done with the cooperation and support of staff, taking staff's security concerns into account. Finally, measures to prevent the spread of HIV infection in prisons also protect the public. Indeed, they are mandated by a sound public health policy. Most inmates are in prison only for relatively short periods of time and are then released into their communities. In order to protect the general population, HIV/AIDS prevention measures need to be available in prisons, as they are outside.

Condoning Drug Use or Condoning HIV Transmission?

Many prisoners are in prison because of drug offenses or because of drug-related offenses. Preventing their drug use is seen as an important part of their rehabilitation. In the eyes of many, acknowledging that drug use is a reality in prisons, would be to acknowledge that prison authorities have failed:

And doesn't this mean that the government is basically admitting defeat - saying it can't control illegal drug use in prisons ...? (*Edmonton Sun*, 1994)

Another argument that is often used is that making condoms, bleach, or sterile needles available to inmates would mean condoning behaviour that is illegal in prisons. Far from condoning sexual activity and drug use in prisons, however, making available to inmates the means that are necessary to protect them from HIV transmission acknowledges that protection of prisoners' health, rather than elimination of drug use, needs to be the primary objective of drug policy in prisons. As the Scottish report on Drug Use and Prisons pointed out, "the idea of a drug free prison does not seem to be any more realistic than the idea of a drug free society," and "stability may actually be better achieved by moving beyond this concept" (Shewan, Gemmell, and Davies, 1994, at 24).

Furthermore, introducing harm-reduction measures is not incompatible with a goal to reduce drug use in prisons: making sterile needles available to drug users has not led to an increase in drug use, but to a decrease in the number of injection drug users contracting HIV and other infections (see, eg, Centers for Disease Control and Prevention, 1993, at iii-vii; Wodak, 1996). Similarly, making methadone available to some users does not mean giving up on the ultimate goal of getting people off drugs; rather, it is a realistic acknowledgment that for some users this requires time, and that they need an option that will allow them to break the drug-and-crime cycle, reduce their contact with the black market, link with needed services, and reduce the risk of their becoming infected with HIV.

On the other hand, refusing to make condoms and bleach or sterile needles available to inmates, knowing that activities likely to transmit HIV are prevalent in prisons, could be seen as condoning the spread of HIV among prisoners and to the community at large. As stated by Martin Lachat, Interim Director of Hindelbank institution,

[t]he transmission of HIV or any other serious disease cannot be tolerated. Given that all we can do is restrict, not suppress, the entry of drugs, we feel it is our responsibility to at least provide sterile syringes to inmates. The ambiguity of our mandate leads to a contradiction that we have to live with (Lachat, 1994).

This has been recognized by police forces in many countries, which, although continuing their fight against drugs, allow and even promote needle exchanges and other harm-reduction approaches. As the Head of the Merseyside Police Drug Squad has stated (cited in Riley, 1994, p.156):

As police officers, part of our oath is to protect life. In the drugs field that policy must include saving life as well as enforcing the law. Clearly, we must reach injectors and get them the help they require, but in the meantime we must try and keep them healthy, for we are their police as well ... People can be cured of drug addiction, but at the moment they cannot be cured of AIDS.

A Moral and Legal Obligation to Act?

Because of the reluctance of many prison systems to provide prisoners with the means that would allow them to protect themselves against contracting HIV, a question has been raised about whether governments and prison systems have a moral and legal obligation to provide such means, even if prisoners "voluntarily" engage in illegal or forbidden behaviours (drug use and sexual activity). Can they be held liable for not providing condoms, bleach, and sterile needles and for the resulting transmission of HIV in prisons?

Literature Review

Two early US articles argue that HIV/AIDS prevention programs have a constitutionally mandated place within prison systems, born out of prisoners' right to personal security. According to the first (Note, 1988), prison officials who ignore the risk and fail to respond to it with appropriate protective policies violate the constitutional proscription against cruel and unusual punishment. The second also addresses the question of prison authorities' liability for HIV transmission in prisons (Note, 1989). However, both suggest that coercive measures be taken to prevent the spread of HIV, and do not mention the possibility of making condoms, bleach, and sterile needles accessible to prisoners: the latter argues that "[s]egregating inmates with AIDS in medical infirmaries and housing seropositive and ARC inmates together provides protection to all inmates"; the former recommends that prison officials take "affirmative action consisting of mass screening, privilege-conscious segregation, and informative training."

However, such coercive measures have been rejected by the vast majority of the other authors and reports, which argue that they are not only overly intrusive, but also costly and ineffective in curbing the spread of HIV. For example, Parts (1991, at 217; see also Dubler, 1990, at 389; Comment, 1989, at 354; Coughlin, 1988, at 63, 66; Note, 1987, at 288-89) rejects testing and segregation and, instead, argues that prison officials need to

take affirmative steps to prevent the transmission of AIDS, including establishment of AIDS prevention programs entailing provision of condoms to sexually active inmates and clean needles or bleach for cleaning needles to inmates who use intravenous drugs.

According to Parts, "in light of the threat presented by AIDS, specific effective preventive health measures are more than just a good idea; they are constitutionally required." The World Health Organization also emphasizes that "[a]ll prisoners have the right to receive health care, *including preventive measures*, equivalent to that available in the community without discrimination" [emphasis added], and that the general principles adopted by national AIDS programs "should apply equally to prisons as to the general community" (WHO, 1993). Acknowledging this so-called equivalency principle, the Swiss Federal Office of Justice concludes that provision of sterile syringes in prisons is judicially admissible and compatible with a responsible health

policy: "If prison establishments wish to fulfil their duty to provide medical assistance, the provision of syringes and disinfectants is recommended" (Federal Office of Justice, 1992). Another legal opinion prepared in Switzerland in 1994 agrees and suggests that the state has "a duty to make sure that persons dependent on drugs are provided with sterile injection equipment while in detention" (Wehrlin, 1994). Similarly, the commission mandated, by the Senator for Justice of Hamburg, Germany, with the development of a drug policy for prisons, concluded that "the state has a legal obligation to care for prisoners in its custody," and that this includes not only "activities directed at caring for the sick, but measures directed at preventing threats to the health and well-being of prisoners" (Kommission, 1995, at 61).

International Law

By its very nature, imprisonment involves the loss of the right to liberty. However, a prisoner "retains all civil rights which are not taken away expressly or by necessary implication" (Lord Wilberforce in *Raymond v Honey* (1982), cited in Shaw, *Prisoners' Rights*, in Sieghart, 1988, at 40). In particular, prisoners, as every other person, have "a right to the highest attainable level of physical and mental health" (El-Badry, 1989, at 11, with reference to the Constitution of the World Health Organization and Art 25, Universal Declaration of Human Rights; Art 12, International Covenant on Social, Economic and Cultural Rights; Art 11, American Declaration of the Rights and Duties of Man; Art 11, European Social Charter; Art 16, African Charter on Human and Peoples' Rights, etc.): the states' duty toward health, which includes giving people the means to protect themselves from exposure to HIV, does not end at the gates of prisons.

International recommendations on HIV/AIDS and drug use in prisons all stress the importance of prevention of transmission of HIV in prisons, and suggest that condoms and sterile needles or bleach should be available to prisoners (see, e.g. WHO, 1987; WHO, 1993; Council of Europe, 1988, paras. 14A(i) to 14A(viii); United Nations, 1990, p. 167; UNAIDS, 1997). In particular, according to the 1993 WHO Guidelines on HIV/AIDS in Prisons, preventive measures for HIV/AIDS in prisons should be complementary to and compatible with those in the community; and prison administrations have a responsibility to define and put in place policies and practices that will create a safer environment and diminish the risk of transmission of HIV to prisoners and staff alike (WHO, 1993, at 1-2).

Legal Action Undertaken by Prisoners

It is being increasingly argued that law (constitutional law, the law of negligence, and criminal law) could be used to force prison systems to introduce long-overdue harm-reduction measures, or to hold them liable for not providing them and for the resulting transmission of HIV in prisons (for an overview, see Jürgens, 1996, at 81-94 and appendices 1 and 2).

Prisoners have shown a willingness to take action against government inaction by initiating legal

action in order to obtain access to condoms (see *supra*) and to methadone treatment (see *supra*). This has provided the catalyst necessary for the institution of long-recommended changes. Courts have not even had to pronounce themselves on the substantive issues raised in the cases: governments and correctional authorities, at least in part because of the cases, have acted before the courts forced them to do so, and have made condoms and methadone treatment available.

Further, in at least two cases, Australian prisoners initiated legal action to secure damages for having contracted HIV in prison. The first prisoner seroconverted while in a maximum-security institution in Queensland and launched an action for damages for negligence against the Queensland Corrective Services Commission (Kennedy, 1995). The second prisoner testified from his hospital bed that he had contracted HIV while under the control and custody of the New South Wales prison authorities, and instituted a negligence claim against the authorities for failing to provide him with access to condoms and sterile syringes while he was incarcerated. Because he died shortly after the commencement of the pre-trial hearing and left no estate or dependants, the case ended with his passing (Malkin, 1997).

Such legal cases are important, but it would be "a shame if incarcerated persons were obliged to have recourse to the courts in order to claim and have recognized certain rights, in particular with regard to access to preventive means for protecting oneself against HIV transmission" (Morissette, cited in Jürgens, 1996, at 94). There can be no question that the issue of providing protective means to prisoners would be more appropriately dealt with by swift action by correctional systems than by court action.

Prisoners, however, have indicated that, if necessary, they would continue to resort to legal action. Representatives of the Inmate Committee of one Canadian federal institution expressed agreement with the idea to "pressure the authorities into supplying prisoners with a 'full range' of protective devices ... through legal means," saying that they "view the present policy concerning hypodermic syringes as a blatant disregard for human life," and that "responsibility should fall squarely on their [the authorities'] shoulders" (cited in Jürgens, 1996, at 121). Inmates from another institution said that

if I were to contract a fatal disease in prison due to negligence on the part of C.S.C. [the Correctional Service of Canada] to provide me with the necessary prevention material and education, (that we are ... entitled to on the street), I would personally hold C.S.C. fully responsible and liable (*ibid*).

Conclusion

Prisoners are the essential captive audience. With such an audience, effective HIV prevention and care programmes can be implemented. But there needs to be the political will, the knowledge, and the resources to devote to these issues.

UNAIDS calls on governments to address the needs of prisoners in a non-discriminatory and comprehensive manner.

(United Nations Commission on Human Rights, 1996)

Prison systems have a moral, but also a legal responsibility to prevent the spread of infectious diseases among inmates and to staff and the public. Currently, many systems are failing to meet this responsibility, because they are not doing all they could: measures that have been successfully undertaken outside prison with government funding and support, such as making sterile injection equipment and methadone maintenance available to injection drug users, are not being undertaken in most prisons, although some prison systems have shown that they can be introduced successfully, and receive support from prisoners, staff, prison administrations, politicians and the public.

It is to be hoped that governments and prison systems will act without prisoners having to undertake legal action to hold them responsible for the harm resulting from their refusal to provide adequate preventative means. Prisoners, even though they live behind the walls of a prison, are still part of our communities and deserve the same level of care and protection that people outside prison get. They are sentenced to prison, not to be infected:

[B]y entering prisons, prisoners are condemned to imprisonment for their crimes; they should not be condemned to HIV and AIDS. There is no doubt that governments have a moral and legal responsibility to prevent the spread of HIV among prisoners and prison staff and to care for those infected. They also have a responsibility to prevent the spread of HIV among communities. Prisoners are the community. They come from the community, they return to it. Protection of prisoners is protection of our communities (United Nations Commission on Human Rights, 1996).

If governments and prison systems do not take proper steps, they risk being condemned as irresponsible and morally negligent in the safekeeping of prisoners. As Justice Kirby stated, we owe it to the prisoners, and we owe it to the community, to protect prisoners from infection in prison:

This requires radical steps before it is too late. ... The infection of a person who is in the custody of society, because that person does not have access to ready means of self-protection and because society has preferred to turn the other way, is ... unpalatable. ... As a community we must take all proper steps to protect prison officers and prisoners alike. By protecting them we protect society (Kirby, 1991, at 19).

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Osborne Society - NYC

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June 29, 1998

THE STRATEGIES OF ADVOCATING AIDS PREVENTION AND TREATMENT IN TAIWAN: A VIEW FROM AN NGO

Since 1984, about 1,600 Taiwanese with HIV-1 infection have been reported to the Department of Health of the Republic of China (Taiwan). The main mode of transmission is sexual contact. From the early stages of Taiwan's AIDS epidemic to today, men having sex with men account for the majority of infections. However, infection rates are rising most quickly among women. Unfortunately, Taiwanese culture makes HIV tests more accessible to men. Although the current male-to-female ratio of infections is 12:1, we suspect the difference to be smaller.

Since April 1997, Taiwan's Department of Health has offered a cocktail treatment comprised of two anti-retrovirals and a protease inhibitor to all HIV-positive individuals regardless of their clinical status.

With this introduction on the Taiwanese situation, I would like to spend most of my time today focusing on three issues: First, how Living with Hope, the largest AIDS NGO in Taiwan, began working with PWAs. Secondly, I would like to discuss our strategies for educating the public about AIDS. Finally, I will talk about the methodology of offering the cocktail treatment to Taiwanese PWAs.

FROM GRASSROOTS ORGANIZATION TO NOW

Living with Hope began as a project of the Chinese Society of Preventive Medicine, a medical association created in 1987. Previously, the Chinese Society of Preventive Medicine had concentrated on promoting cervical cancer and liver cancer screening. In 1992, after the association helped organize an AIDS conference, we felt we could do more to help Taiwan's HIV-1-infected individuals. But we did not really know the needs of Taiwanese PWAs. In 1993, a group of people in the community, including some HIV-positive individuals, started a halfway house for homeless AIDS patients. This effort was completely voluntary. The founders did not receive any outside funds.

However, problems arose once the halfway house was up and running. First, of course, there was a lack of financial resources. The founders were committed in providing free care to patients, but found the costs to be overwhelming. In addition, the organization lacked structure; there was no way to protect the volunteers from refusing unreasonable requests from patient's family members. When they sought financial assistance, we took it as a great opportunity to learn more from this grassroots movement. Our alliance with the halfway house sprung from a spontaneous community movement. No organized efforts were happening on behalf of PWAs. Then, we were able to come along and demand that AIDS receive recognition as a problem in Taiwan.

So, in March 1994, we established Living with Hope under the auspices of the Chinese Society of Preventive Medicine. We were able to make some immediate changes in the halfway

home, adding an administrative system and giving the group the credibility, which came from having an already established organization over it. In Taipei, we have collaborated with the Institute of Public Health at National Yang-Ming University. In Kaohsiung, where we have another office, we work with the departments of Nursing and Public Health at Kaohsiung Medical College. The academic ties to Living with Hope are important because in the Chinese culture, education is held in high esteem, which comes from Confucian influence.

Through our affiliations with higher educational institutions, it is easier to attract full-time staff. Potential employees often have family members object to them working for an AIDS NGO because they think the work will stigmatize them, but the university affiliation does make the job more acceptable.

By forming this organization, we immediately had access to HIV patients and formed alliances with those who were HIV-positive. We also started to visit the hospitals to spread the word about the halfway house. Many PWAs have difficulties returning home. Often times, families refuse to take in their HIV-positive relatives if they did not realize they were HIV-positive prior to their stay in the hospital, especially at that time. For example, after his release, one man was kept locked in the attic by his brother, who would not let him wear clothes or leave the attic, due to the nature of his illness.

Although the halfway house benefited some people, it still had many problems. Since most of its HIV-positive leaders were interested in helping others like them, but they were not trained in social work. We had to remind them to do the tedious, but daily tasks that come with case work, such as keeping records after meeting with clients. They also had to learn job-related skills, which they did not have before. Six months after joining forces, we added a social worker to aid them in their efforts.

In exchange for teaching them these things, they have taught us about what it is like to be HIV-positive. They could tell us their needs and clarify our misconceptions. In addition, they were able to inform us of the happenings at Taipei's STD Clinic. When more women began to visit the clinic, we knew that the disease was moving into the heterosexual community.

The Department of Health gives us \$30,000 New Taiwan dollars (or about US\$1000) a month for rent of the halfway home. Eventually, we thought it would be a better use of our funding to close the halfway house and subsidize individual housing. We found that because there were such diverse interests among the PWAs, they preferred living alone instead of sharing a space. The mental health of the PWAs was better if they could concentrate on their health, rather than trying to adapt to the habits of strangers.

We also realized Taiwan needed a PWA advocacy group. When we requested government funding, the Department of Health sometimes questioned whether Living with Hope's programs were motivated by the needs of PWAs, or the needs of Living with Hope. Taiwan lacked a group that could truly represent the interests of PWAs.

In 1996, Living with Hope donated more than NT\$620,000 (US\$20,000) to establish a new group: Persons with HIV/AIDS Rights Advocacy Association. This group recently received NT\$3 million (US\$ 100,000) from United Way. Such funding means that Taiwanese society is recognizing the legitimacy of anti-AIDS efforts. With the newly-created HIV advocacy organization, Living with Hope can direct its efforts more to general public awareness and prevention. It is important to stress that the new group is a PWA rights advocacy association. It is NOT a PWA association. People cannot assume all its members have HIV. For example, the secretary-general of the organization is not HIV-positive. Because the organization needed the names of at least 100 members before the government will recognize it, we needed people to join. If it were a PWA organization, no one would dare join.

By starting this organization, we hope the friction between Living with Hope and the Department of Health will decrease. One-third of Living with Hope's budget comes from the Department of Health. Our improved relationship means Living with Hope is more likely to

continue receiving funds. In the Chinese culture, the funding agency expects loyalty from the recipient.

STRATEGIES IN EDUCATING THE PUBLIC ABOUT AIDS

In addition to our work with the halfway house, we also educate the Taiwanese community about HIV/AIDS. At the 1994 Yokohama AIDS conference, we participated in the floating lantern ceremony. To commemorate the World AIDS Day that same year, Living with Hope also decided to do one, because it was a way to show that AIDS is a concern for Chinese, as well as westerners. A temple provided us with pink and white floating lanterns; the pink represented hope for those still living with HIV and the white served to remember those who have died. About 20 people from all over the island attended the memorial. We wanted to console friends and family members, but we also hoped to attract media attention. With favorable publicity, people might realize that those who live with HIV have an identity outside of their positive status.

Even as recently as four years ago, there was much animosity towards those with HIV. We wanted to change that, but we also wanted to protect the privacy of the PWAs and their families. For the floating lantern ceremony, the journalists gladly accepted our ground rules to protect the PWAs. The response from the public was amazing. People were very moved by the event.

However, we still felt that the Taiwanese society had little compassion for PWAs. We wanted to do something that would be recognized as an international event. So in 1995, we decided to bring the NAMES quilt project to Taiwan. Since we wanted to display 72 quilts, or 576 panels, it was going to cost a lot of money. But we felt the expenditure was necessary. If it were just a small event, few people would come. It was difficult to get funding because the Ministry of Cultural Affairs thought since the quilt is related with AIDS, we should seek financial support from the Department of Health. In addition, the Taipei Fine Arts Museum where we had originally wanted to show the quilts did not consider the NAMES Project to be art. In the end, Aetna, an American insurance company, gave us the most money for our AIDS activities. The company donated NT\$1 million dollars (about US\$ 30,000), for the display in the large central plaza at Chiang Kai-Shek Memorial Hall.

At the display, we also presented 20 quilts made by Taiwanese. We found that the quilts were a great way to attract young people in understanding our cause. Through these events, which attract media and public attention, we keep AIDS in the spotlight.

The Taiwanese attitude towards HIV/AIDS is one of ignorance and misinformation, due largely to the influence of a former Minister of Health. She was openly prejudiced towards the HIV-positive population. When Magic Johnson was invited to Taiwan, she said that he was a model of promiscuity and refused to let him come to the island. In pamphlets created by the Department of Health, she said, "those with HIV would live shamefully and die ugly."

It is hard to change people's attitudes after they were introduced to AIDS through her. Therefore, it is very important for us to continue to hold awareness-raising activities. We hope to change this belief that PWAs deserve to die a horrible death. Therefore, we held a candlelight march in Taipei and Kaoshiung last month.

In addition, Living with Hope also supports protests. For example, in 1995, a public health institute in Taiwan did a Department of Health-funded study on gay men. The research was considered AIDS prevention. However, the survey asked many inappropriate questions, such as "Do you hate your mother and father?"

The local gay community was furious. After seeing the survey, people asked that some of the insensitive questions be changed, but the researcher refused. Leaders of the gay community asked others not to participate in the study. Even with their lack of participation, the report was still published, and it further damaged the image of gays in Taiwanese society. It also hampered our efforts to do HIV/AIDS outreach in the gay community. It hampered our efforts in doing HIV/AIDS prevention work with the gay community. We would like them to help us design AIDS

prevention pamphlets, but they are not interested. They worry about being further stigmatized through an association with HIV/AIDS.

We have also developed programs to work with illegal prostitutes and prisoners. In August, we will hold a sex and AIDS education workshop for senior high school students.

STRATEGIES IN GIVING HIV PATIENTS ACCESS TO PROTEASE INHIBITORS

After the Vancouver World AIDS conference in July 1996, some Taiwanese doctors proposed to the Department of Health that the cocktail treatment be offered in Taiwan. Our excitement was high. I approached Dr. Chang Hong-Jen, the head of the Bureau of Communicable Disease. He said that if this would truly help patients, we should look into giving them access to the cocktail. At that time, we already had access to AZT, ddI, ddC, and 3TC in Taiwan. Under the AIDS Prevention Law, Taiwan nationals receive free treatment and medication.

The AIDS advisory committee held many small meetings to discuss guidelines for the distribution of cocktails, as well as a central lab to do viral load testing. We also gave workshops on the treatments to the doctors of the 23 AIDS treatment centers.

Of course, we had debates over who should have access to protease inhibitors. For example, one STD consultant at the Department of Health said that keeping HIV-positive people alive longer gave them more time to spread the disease to others.

The news that David Ho, a native Taiwanese, was TIME magazine's 1996 Man of the Year gave the Department of Health a favorable impression of the cocktail treatments. They decided to apply for emergency funding from the executive branch to provide PWAs with cocktail therapy.

When David Ho visited Taiwan in February 1997 to talk about combination therapy, there was a lot of great publicity. The executive branch deposited the emergency fund to buy protease inhibitors. The executive branch agreed to emergency funding until the end of the fiscal year. Afterwards, treatment costs were covered under the regular budget of the Department of Health.

The future for PWAs in Taiwan is mixed. As of July 1, PWAs will be expected to pay into the national health insurance system in order to receive medication, even if they have no means to pay. However, the protease inhibitors have had visible benefits. Our next big challenge is implement long-term stable cocktail treatment at low or no-cost to PWAs.

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Research

for SEX WORK

This publication is the result of an open call for exchange of experiences of those active in the field of Research for Sex Work. It appears that many action groups, research institutes, public health facilities and NGOs active in the field of research of STDs/HIV/AIDS among sex workers and their clients in developing countries, are facing the same problems. We received so many reactions on our call that we thought it important to share them. This publication about peer education is the result. We hope that other publications about syndromic approach, improvement of STD/AIDS facilities for sex workers in countries with repressive policies et cetera, will follow. This publication is made by volunteers in their own time, with only small support from HIVOS, The Netherlands, for the printing costs. We hope to find a place in one of the sex workers' or AIDS networks to continue these activities, in order to contribute to capacity building of grassroot organizations and researchers.

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Research for Sex Work is a publication that can be used by researchers, sex workers, public health workers and local politicians, who professionally have to do with sex work and think they can contribute something to important discussions on research for sex work. We hope that we can quickly work from a website through which we can make the exchange of ideas and experiences function more easily. Until then you can send your reactions to:

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WHY THIS INITIATIVE IS IMPORTANT

Since the campaigns to increase global awareness of high-risk behaviour concerning HIV/AIDS infection started, there has been a lot of emphasis on behaviour change in sexuality. Condom use and faithfulness towards one partner have been promoted as means to limit the dissemination of HIV. In addition, there have been public health campaigns targeting specific groups. These include men who have sex with men, adolescents and sex workers (SWs).

Interest in sex workers has not always been focussed on the well-being of sex workers themselves, but often out of fear that they would be multipliers in the dissemination of HIV. In the wake of the campaigns to influence the behaviour of SWs much research has been done to measure the impact of certain policies or to understand the context of sex work. A lot

of this research is taking place in relative isolation. Problems and experiences in one place are hardly known in another, while there is so much to share and from which to learn. Though there are networks and platforms where there is a possibility to exchange experiences, knowledge and views, there is a need for more sharing of insights and experiences.

Appropriate interventions

International organizations have stressed the following important interventions for sex workers and their clients: appropriate STD-services, because sexually transmitted diseases (STDs) are a proven important cofactor for HIV infection, and improved and consistent condom use among SWs and their clients through health education. However, sex workers and their clients in developing countries are not always easy to reach with STD-services and

health education. This has made it difficult to develop appropriate official strategies to make STD-services and health education available for SWs and a community approach has become indispensable. There are three issues that are of immediate concern when we look at interventions and related research with regard to SWs. These are:

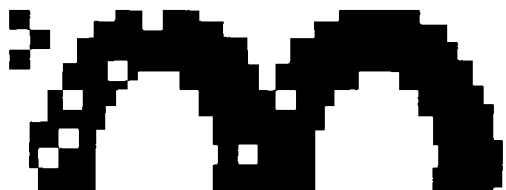
1. Peer education as the most appropriate means to educate sex workers about the importance of STD-services and condom use.
2. Improved, appropriate low-threshold STD-services for SWs, so that it becomes easier for them to attend these services.
3. Syndromic approach in countries where there are no means to develop good clinical facilities. This is the latest advice of international organizations, but will it work for sex workers?

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AIDS Society of Asia & the Pacific — newsletter

Issue 3 • June 1998 • • • • •

Editorial

In the last 10 months we have witnessed turmoil on the currency and stock markets in most countries in South-East and East Asia. All major regional currencies (except the Chinese Yuan and the Hong Kong dollar) have depreciated against the US dollar and other major currencies.

In the wake of the collapse of the regional currencies have been falls in stock and share prices, slowing down of economic growth, credit freezes and squeezes, retrenchments, pay cuts, bankruptcies, social unrest and civil disorder. It is likely that most affected countries will feel the full brunt of the economic woes only later on in 1998, and that it will be 2 to 3 years before things begin to start looking up significantly. Furthermore a serious Japanese economic crash, which many experts predict will happen, will make this forecast far too optimistic.

How will these economic troubles impact on the spread of HIV and on AIDS control programs in Asia? Firstly it is possible that health budgets will be cut; in times of need it is often the less urgent programs that will be chopped first, and these may include prevention campaigns of which HIV/STD figure prominently. Public funding for both government and non-government programs will be threatened. Private money will be harder to raise as businesses cut advertising and

asia & the Asian Economic CRISIS

promotions budgets, and private individuals roll back on donations. Non-governmental organizations will be the hardest hit in these circumstances.

The social effects of the economic downturn may also work against efforts to control HIV/AIDS. Increased poverty may enhance the conditions for the spread of HIV. Impoverished people are more likely to engage in sex work, and sex workers in financial difficulties may be more vulnerable to having unprotected sex. Loss of jobs may increase the migration of workers, who being away from home and family, may be exposed to more sexual partners. Loss of jobs may also lead to increased drug and alcohol abuse, once again providing ripe conditions for HIV transmission.

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Coordination of Action Research on AIDS and Migration



The vulnerability of migrants
to HIV/AIDS