HUMAN RIGHTS LAW AND HIV/AIDS: PREVENTION AND TREATMENT IN AJK

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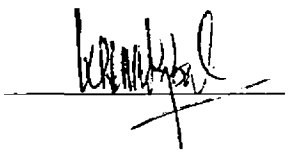

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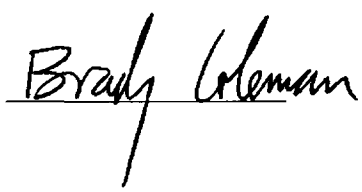

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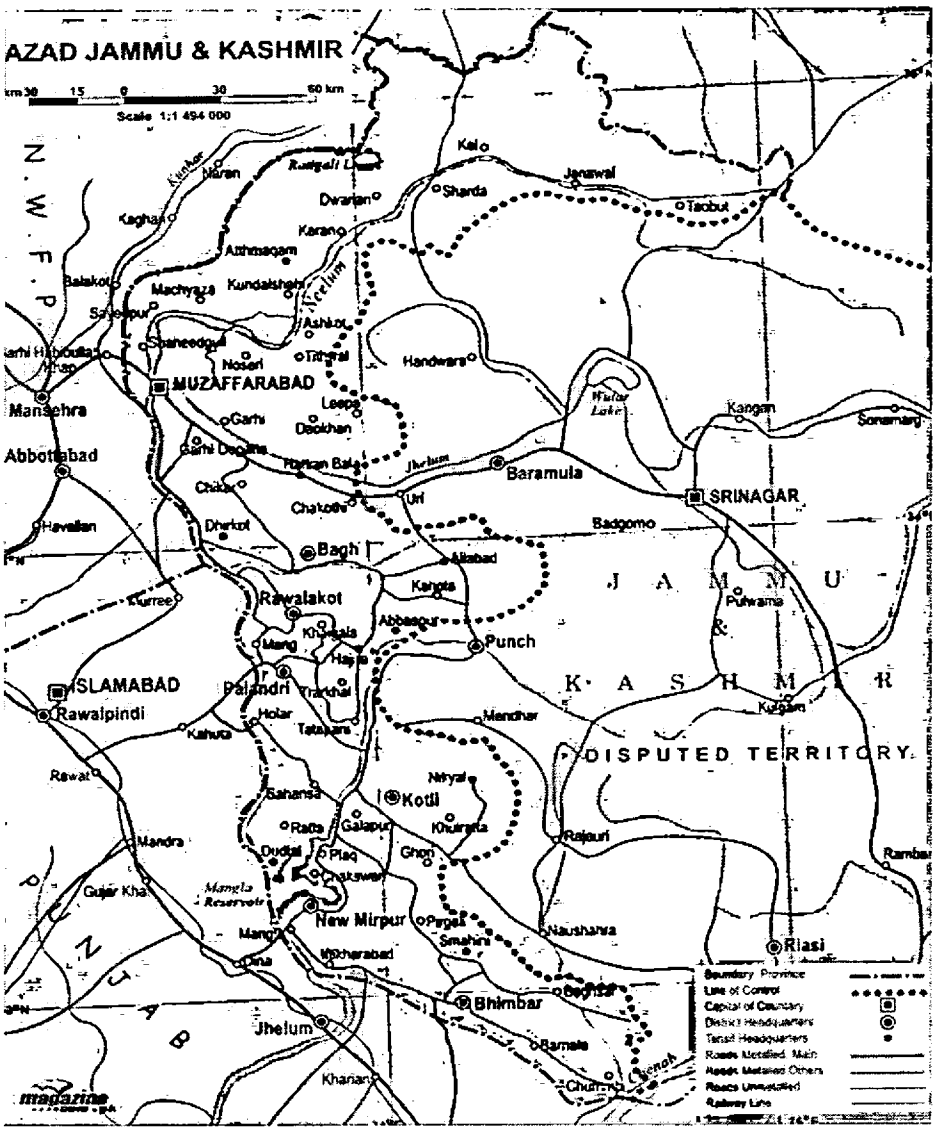
THE STATE OF AZAD JAMMU AND KASHMIR (AJK)



Introduction:

The state of Azad Jammu and Kashmir is comprised of an area of 13,297 square kilometers. According to the 1998 population census, the state of Azad Jammu & Kashmir had a population of 2.973 million, which estimated to have grown to 3.8 million in 2006. Almost 100% population is Muslim. The Rural to Urban ratio is 88:12. The State is an independent jurisdiction and it has its own Legislative Assembly, Supreme and High Courts.

TABLE OF CONTENTS

LIST OF TABLES

TABLE OF CASES

DEDICATION

This effort is dedicated to the Sacred Prophet (SWS) who has given us a clear and unprecedented human rights approach and documents, to all those people who are trying for the best availability of human rights to the world for its prosperity and to those innocent souls infected, in their mother's wombs or while infant, by HIV/AIDS even without knowledge of their vulnerability and surety to death.

ACKNOWLEDGEMENTS

All prays be to Allah (SWT) by Whose grace and help this work was completed. After that I would pay a tribute to my parents who are assisting and affording every kind of trouble to sponsor my studies, till the time, since childhood. Now I must say very special thanks to my honorable teachers and staff of the Faculty of Shariah and Law, IIUI, by their guidance I become able to think, understand and write an idea to conclude my LLM degree. With best regards to Sir *Imran Ahsan Nayazee* who was the major source of inspiration for research and writings and the leading researcher and my mentor Dr. *Muhammad Munir* whose affection and advises make me able to elaborate myself. Also, especial regards for Sir *Muhammad Mushtaq*, Sir *Amjad Mehmood* and Mr. *Usman Karim Khan* who have taught us and always give courage by their association. I can't forget the cooperation of staff and members of higher studies, especially Mr. *Attaullah Mahmood*, to finish this job. The recommendations of Prof. Dr. *Brady S. Coleman* (internal examiner) and Dr. *Khurshid Iqbal* (external examiner) had played a vital role to refine my ideas for best utilization of the modern research techniques. Their instructions helped me a lot to enhance the quality of writing this study particularly and research in future generally. At the end I would conclude with pray for my friends because those are my actual strength, their admiration and company always "make" me up, alive and brave. Finally, I would say many thanks to the officials of the concerned departments of AJK and Federal governments for their cooperation during my work.

ABSTRACT

HUMAN RIGHTS LAW AND HIV/AIDS: PREVENTION AND TREATMENT IN AJK

by

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Advisor: Dr. Muhammad Munir

This study attempts to explore the relevance of international human rights law in the response to the HIV/AIDS epidemic at national and international levels. Public health advocates can use arguments based on this body of law to promote responses to HIV/AIDS that reflect sound public health principles and documented best practices. Development assistance is increasingly linked to rights-based approaches, such as participatory processes, and strategic alliances between health professionals, organizations of people living with HIV/AIDS, and affected communities.

The study elaborates the prevalence of HIV/AIDS in the State of Azad Jammu and Kashmir and focuses upon the required procedures and frameworks for the prevention and treatment of the pandemic. It also explains the ways and methods for this purpose adopted by rest of the world in accordance to human rights approach under the umbrella of international law. It also highlights the protection issues of vulnerable groups like MSM, CSWs, IDUs, children, women, eunuchs (*hijras*) and PLWHAs. It is argued that legal and human rights advocacy strategies are increasingly productive and necessary.

It denotes some Islamic provisions and teachings for the sake of prevention of sexually transmitted diseases generally and HIV/AIDS particularly.

Finally, this research concludes that the above mentioned goals and objectives demand an immediate legislation and administrative framework, in international context of human rights, for prevention and treatment of HIV/AIDS, from Legislative Assembly of AJK to reduce and overcome the risk and vulnerability of the epidemic for the population at large and the vulnerable groups.

INTRODUCTION

Human immunodeficiency virus (HIV) results acquired immune deficiency syndrome (AIDS) which is a wide spread disease all over the globe. The people vulnerable to HIV infection and the impact of AIDS are often characterized by economic and social disadvantage and discrimination, which leads to the observation that in each society, those people--who before the arrival of HIV/AIDS were marginalized, stigmatized or discriminated against--become overtime those at highest risk of HIV infection. The impact, determinants, and scope of pandemic, of HIV/AIDS, in social, epidemiological, and human terms have been substantially documented. We know how the virus is transmitted, the effectiveness of prevention strategies in individuals and populations and how to slow disease progression in those infected with the virus. Unfortunately, the HIV/AIDS epidemic nears the end of its third decade, which has gained a pandemic status and the discovery and refinements of strategies to prevent and treat HIV remain critical. Recent reports provide hope that the pandemic possibly will be slowing in some regions, while continuing to flow in others.

In this regard this study is an initiative towards the sensitivity of the issue in Azad Jammu & Kashmir (AJK). So, the thesis statement of the research says,

> *"International human rights law recognizes the rights and gives protection to individuals suffering from HIV/AIDS thus AJK Assembly should enact these recommendations through domestic legislation, to prevent this disease and, to provide care, support and treatment to the persons living with HIV/AIDS. This enactment will be helpful to remove the threats of the epidemic from the vulnerability of population and sensitivity of the region."*

The above mention research question is elaborated in this thesis under titled, 'Human Rights Law and HIV/AIDS: Prevention and Treatment in AJK" and the scheme of study is as follows.

In first chapter the occurrence, presence and the vulnerability of HIV/AIDS spread in the region is discussed. Here the brief explanation of the situation of vulnerability in current scenario is present too. This chapter also elaborates the importance of the issue and the requirement of a quick response against the threats. Further it requires a comprehensive legislation to coup with epidemic.

The second chapter examines the dynamic role of law as a means, and potential barrier, for implementing successful public health interventions. It would be a basic study systematically assessing the state of laws affecting HIV/AIDS worldwide, drawing on a variety of legal traditions such as common law, civil law and *Shariah*. It shows that laws help to ensure that public health agencies have the tools they require for effective prevention and treatment. They can form socio-economic entitlements, like the right to property ownership, education, work, health, and life. Laws can also defend persons living with HIV/AIDS from stigma, social risks, and other undesirable consequences by respecting privacy and prohibiting unwarranted discrimination. This chapter analyzes the role of law in the world at large to resolve the issue of prevention and treatment of HIV/AIDS.

Chapter number three tells the human rights approaches and Islamic concepts on the aforesaid issue. This study also sets an effort to establish some guiding principles for legislation on prevention and treatment of HIV/AIDS in AJK. It also highlights that the promotion and protection of human rights are necessary to empower individuals and communities to respond to HIV/AIDS, to reduce vulnerability to HIV infection and to lessen the adverse impact of HIV/AIDS on those affected.

In chapter four it is tried to explain that the legal framework for the prevention and treatment of HIV/AIDS and for the protection of human rights of PLWHA is a basic requirement from any legislative body for better results to achieve international standards. Therefore, it is recommended here that AJK should carry out legislation on this particular issue in accordance to the guiding principles from international and regional context. It also discusses the minimum requirements and some of effective factors for this legislation for AJK.

The chapter five is based on conclusion of the research that shows affirmation towards the thesis statement. This study is a humble effort to establish the requirement of legislation on HIV/AIDS prevention and treatment in AJK. And by this effort the objective and aim of assistance and advocacy of the people living with HIV/AIDS is tried to address. As the motto of the study is; '*We must hate disease, not the patient!*' so, a reader will be a best judge to tell the fact whether this effort got success in its aim.

CHAPTER 1

OCCURRENCE, DEVELOPMENT, VULNERABILITY, AND PREVENTIVE MEASURES OF HIV/AIDS IN THE REGION

A. INTRODUCTION

Human immunodeficiency virus (HIV) results acquired immune deficiency syndrome (AIDS)[1] which is a wide spread disease all over the globe. The Joint United Nations Programme on HIV/AIDS and World Health Organization estimated that AIDS had killed almost twenty five million people between the beginning of the epidemic (1981) and the end of 2001, that another forty million people were living with HIV/AIDS by the end of 2001. The people vulnerable to HIV infection and the impact of AIDS are often characterized by economic and social disadvantage and discrimination, which leads to the observation that in each society, those people--who before the arrival of HIV/AIDS were marginalized, stigmatized or discriminated against--become overtime those at highest risk of HIV infection. At the present thirty three (33.4) million people live with HIV/AIDS on the globe.[2]The impact, determinants, and scope of pandemic, of HIV/AIDS, in social, epidemiological, and human terms have been substantially documented. We know how the virus is transmitted, the effectiveness of prevention strategies in individuals and populations and how to slow disease progression in those infected with the virus. Yet, in almost all of the developing and transitional countries,

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[1] For more details see annex A, Medical Facts.

[2] Joint United Nation Programme on HIV/AIDS and World Health Organization, *Report on AIDS Epidemic* (Geneva: UNAIDS & World Health Organization, 2008), 7, http://data.unaids.org/pub /Report/2009 /JC1700_Epi_Updates_2009_en.pdf (accessed March 2, 2010).

where, a majority of new cases occurring, the response has been ineffective to stop and reverse the tide of infection. HIV/AIDS is now presented as an immense challenge to international peace and development.

The continued escalation of infection needs a coherent social epidemiology (The branch of epidemiology[3] that studies the social distribution and social determinants of health that is, specific features of, and pathways by which, societal conditions affect health) that understands the pandemic in its historical, political and international legal context. Following diagrams will show the death rates worldwide.

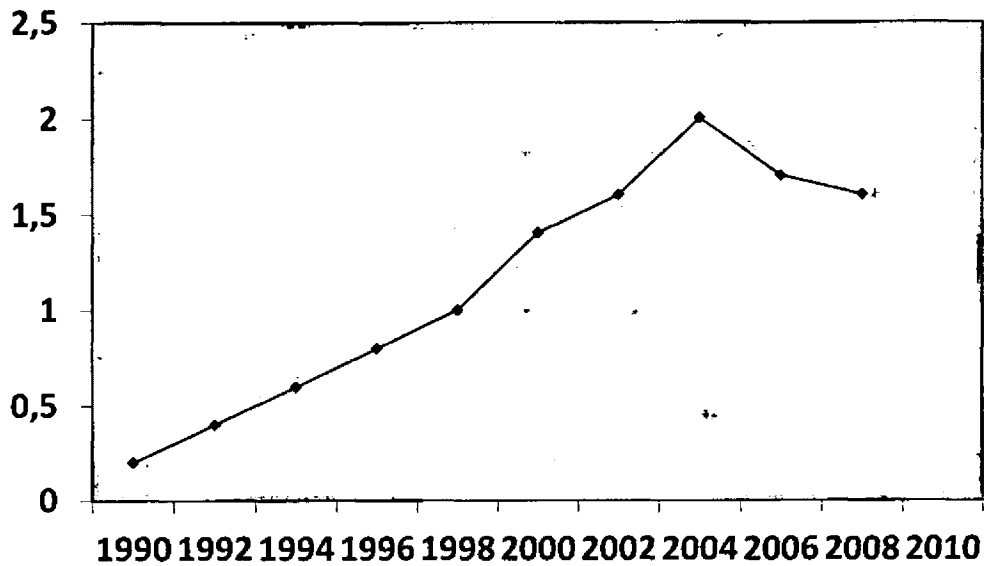

Figure 1.1: Deaths Rate of the World Due to AIDS by Year in 2008[4]

[3] Epidemiology is the study of patterns of health and illness and associated factors at the population level. It is the cornerstone method of public health research, and helps inform evidence-based medicine for identifying risk factors for disease and determining optimal treatment approaches to clinical practice and for preventative medicine. In the study of communicable and non-communicable diseases, epidemiologists are involved in outbreak investigation to study design, data collection, statistical analysis, documentation of results and submission for publication.

[4] Country Progress reports are available on the UNAIDS website, http://www.unaids.org/en/KnowledgeCentre/HIVData/CountryProgress/2007CountryProgressAllCountries.asp (accessed on, June 2, 2010).

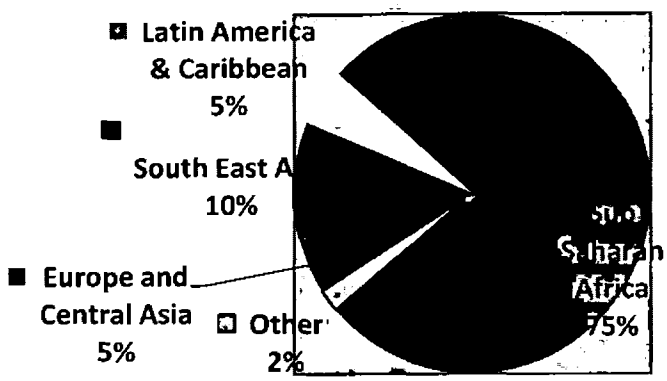

Figure 1.2: Deaths Percentage Due to AIDS by Region in 2008[5]

AJK does not have a high number of reported HIV/AIDS cases, but a number of vulnerabilities and patterns of hazardous behaviors signal the need to take action now, before it is too late to craft a difference to the course of the epidemic. Toward that end the AJK has to establish a strategy to control HIV/AIDS epidemic. To achieve this goal we need an immediate legislation in AJK. This study will may help to create such law.

B. History of HIV/AIDS in AJK

The first case of AIDS in a Kashmiri citizen was reported in 1990at Lahore. During the late 1990s, it became obvious that an increasing number of persons, frequently men, were becoming infected with HIV while living or traveling abroad. Upon their return to Kashmir, some of these men afterward infected their wives who, in several cases, passed on the infection to their children. In 1995, the first recognized transmission of HIV infection through breastfeeding in Kashmir was reported in the city of Rawalpindi.

[5] Ibid.

During current decade, cases of HIV and AIDS began to appear among groups such as CSWs, drug abusers and jail inmates.

S. No.	Year	HIV	AIDS
1	2003	21	03
2	2004	07	04
3	2005	13	01
4	2006	17	03
5	2007	14	01
6	2008	23	06*
	Total	**95**	**18**

*Full bloom AIDS cases

Table 1.1: Year Wise HIV/AIDS Cases in AJK[6]

The increased rates of infection among these groups are expected to have facilitated, at least to some extent, a further dissemination of HIV into the general population.

1. Initial Stages

Since the official recognition of the first case in 1990, the number of formally reported HIV infections and AIDS cases has grown up to 160 (as of September 2000).[7] Heterosexual transmission denotes the majority thirty seven (37) percent of described HIV cases, with the next most frequent mode of transmission eighteen (18) percent being associated to infection through contaminated blood or blood products. The remainder of the reported HIV cases is related with infection through injecting drug use four (4) percent, homosexual or bisexual sex six (6) percent, and mother to child transmission more than one (1.3) percent. Transmission modes for thirty five (35) percent of the described HIV cases are unknown. Unfortunately, most spectators believe that the number of described cases represents only the "tip of the iceberg", and that the number of actual cases may be far greater than official reports suggest.

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[6] This table of information is collected from Department of Health and HIV/AIDS Prevention Project Azad Kashmir, Muzzafferabad (the capital of AJK), in April 7, 2009.

[7] See, Kashmir AIDS Consortium, http://www.pnac.net.pk/KAC.asp (accessed June 14, 2010).

S. No.	Name of District	Number of patients	Remarks
1	Bagh	04	----
2	Kotli	06	Two Expire
3	Muzaffarabad	03	----
4	Neelum	01	----
5	Pallandri/Sudhnuti	02	----
6	Rawalakot	11	One Expire
	Total	**27**	**Three Expire**

Table 1.2: Details of Patients under Care and Treatment in PIMS Islamabad, 2009.[8]

2. Development and Current Situation

Under this study we will analyze the current situation of the epidemic through some areas of consideration. A brief introduction for each priority area is presented as follows:

a) Response

It is very important to develop stronger, more effective and multisectoral partnerships at all levels in the struggle against HIV/AIDS in AJK. Toward that end, the overall collective response must be extended to take account of the participation of a much wider group of HIV/AIDS stakeholders in both the public and private sectors. Government leadership in this regard is critical; while political will and commitment to the nation's efforts against HIV/AIDS have been feeble in the past, it is now essential to rally support for the nation's response to the epidemic at the highest political levels.[9] Improvements in multisectoral involvement and commitment might be reached through intensive advocacy efforts with political leadership at all levels in various sectors, international exchanges, and the sharing of national and international 'best practices' experiences.

[8] Referred Cases by Department of Health AJK to PIMS Islamabad, information collected from HIV/AIDS Prevention Project Azad Kashmir, Muzzafferabad, in April 7, 2009.

[9] See, Kashmir AIDS Consortium, http://www.pnac.net.pk/KAC.asp (accessed June 14, 2010).

Problems:

1. Weak response amongst policy makers in their recognition of HIV/AIDS as a real threat to public health.
2. Varying level of political commitment and limited financial support for government activities at 'district'[10] level.
3. Frequent changes in the federal government and in provincial programme management.
4. Little non-health sector involvement.
5. Imperfect private sector involvement.
6. Limited funding for NGO HIV/AIDS activities.
7. Low levels of funding for the social sector in general.
8. Lack of fully elaborated strategies and action plans for programme management.
9. General lack of access to information and resources on HIV/AIDS.
10. Dearth of human resources within the public and private sectors.

b) Vulnerable and High Risk Groups

While state's concentration on the issue of HIV/AIDS must be on the reduction of the vulnerability of all of its citizens, in a situation of low prevalence[11]/high risk, it is vital to focus intervention efforts on groups who are especially vulnerable or at higher risk of HIV infection. Though such a focus will help to protect these specific groups from HIV, yet it will also help to shield the members of the general public who intermingle with those who are at higher risk or who are especially vulnerable. Thus, early and

[10] **Districts** are a type of administrative division and total number of districts in AJK is ten (10). These districts are local administrative units inherited from the British Rule. They comprise villages, towns and cities. A district is headed by deputy commissioner, who is the administrative officer appointed by the government.

[11] For more details, see glossary at the end.

concerted stroke to prevent the spread of HIV in higher risk and vulnerable groups may work to prevent the detonation of a more generalized epidemic.

Male and female CSWs, IDUs, MSM and migrant workers are all thought to be at heightened risk for HIV/AIDS. Over time, other groups may also emerge as being at special risk or especially vulnerable.

Experience from around the world point out that unprotected sexual activity with multiple partners fuels the spread of HIV, and the limited evidence[12] available in AJK suggests that CSWs and MSM frequently engage in unprotected sexual activity. Migrant workers and other itinerant populations are vulnerable because they usually travel without their wives or other usual partners, and, far from home, they engage in risky sexual behaviors with unfamiliar persons.

Though injecting drug use is not yet the most preferential method of drug abuse in state, injecting is thought to be on the rise. IDUs are at risk of HIV infection through the widespread sharing of contaminated needles; in addition, fresh reports suggest that IDUs also engage in unsecured sexual activity, often with CSWs.

In AJK, there is very little documentation about the particular risks and vulnerabilities of these groups; thus, a first important step will be to learn more about their specific risks and vulnerabilities. Because such groups are often very difficult to get access to, the development of innovative approaches is significant to programme success. In addition, and because of the need to achieve the high levels of coverage necessary to remove a generalized epidemic, the sharing of experiences and lessons learned is of paramount importance in order to reproduce successful initiatives.

[12] A Survey Conducted by, for more details See, Kashmir AIDS Consortium, http://www.pnac.net.pk/KAC.asp (accessed June 14, 2010).

Problems:

1. Very little locally-generated data is accessible regarding the behaviors and practices which place certain populations in AJK at higher risk, and there is presently little epidemiological information about groups at higher risk.
2. Due to social and cultural restraints which inhibit a high degree of frank speaking, HIV/AIDS messages on print and electronic media are so general in nature that they do not meet the particular requirements of higher risk populations.
3. Many groups at higher risk are intricate to approach for HIV/AIDS prevention interventions due to their illegal status, marginal social status and/or limited education.
4. Little public support for initiatives designed to grant assistance to some highly vulnerable groups such as CSWs and IDUs.
5. Limited financial funds for the development of effective interventions for groups at higher risk.

c) Youth

AJK has an unusually young overall population, with sixty-three percent of the state's population below the age of twenty five years.[13] In the context of HIV/AIDS prevention, itis especially important to think about that the very people who are most likely to become infected in AJK are the younger members of society, who represent the future leadership and economic stamina of the nation. There is very little documentation about the extent to which these young people engage in behaviors

[13] Information is taken from Demographical Survey Conducted by Population Department AJK, 2006.

which may put them at risk of HIV infection, or about young people's STI/HIV/AIDS attentiveness levels.

However, the available evidence indicates that, while some young persons may possess limited knowledge concerning reproductive/sexual health and HIV/AIDS, the majority of young people do not have even the most basic knowledge. When they do possess some degree of knowledge, very often it is inaccurate or inadequate. In addition, myths and misconceptions regarding sexuality, STIs, and reproductive health in general are commonplace. Parents and teachers are often uncomfortable or are otherwise not ready to talk with young people about issues associated to sexual and reproductive health, and consequently youth rely on information gleaned from the mass media or from their peers—both of which sources are likely to offer faulty or incomplete information. In addition, sexual and reproductive health services are not straightforwardly accessible by young people, due to restraints on their mobility, denial by caregivers that such services are needed, and/or the stigma attached to care seeking for issues related to sexual and reproductive health.

Clearly, young people are the pre-eminent source of information regarding their own perceptions of their sexual and reproductive health needs. For this reason, interventions designed to deal with those needs should benefit from the vigorous involvement of young people themselves, from the conceptual phases through implementation and evaluation. It is also obvious, however, that involving young people in the design and implementation of HIV/AIDS initiatives will necessitate a great deal of support from their parents, teachers, and other influential adults. Finally, in order to make real progress in this area, it will be essential to join the support of local level community leaders and policymakers in the formation of an environment

in which young people have access to the information and services they require to protect themselves from HIV/AIDS.

Problems:

1. Societal confrontation to open discussion of sexuality with young people.
2. Out-of-school youth are often difficult to contact for intervention purposes because they are not an organized group.
3. Many young people, especially those that are out of school, cannot read and for that reason are hard to reach with IEC materials that rely on written messages.
4. Parents and teachers often do not possess sufficient knowledge themselves, or are unwilling to participate in telling information regarding HIV/AIDS or other sexual and reproductive health issues to young people.

d) Blood and Blood Product Safety

Blood transfusion is the most important area of concern with regards to HIV/AIDS prevention and control in AJK. A relatively high prevalence of both 'hepatitis B and C'[14] infection in the general population suggests that hazardous blood transfusion practices and poor infection control are likely to make an important contribution to the further rapid spread of these infections and of HIV/AIDS among the general population. By maintaining safe blood transfusion services throughout the state, all transmission of HIV and other blood borne infections due to blood transfusion might be eliminated.

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[14] **Hepatitis** is an inflammation of the liver. **Hepatitis B** is an infectious illness caused by hepatitis B virus. Transmission of hepatitis B virus results from exposure to infectious blood or body fluids. The acute illness causes liver inflammation, vomiting, jaundice and rarely, death. Chronic hepatitis B may eventually cause liver cirrhosis and liver cancer—a fatal disease with very poor response to current chemotherapy. **Hepatitis C** is also an infectious disease affecting the liver, caused by the hepatitis C virus. The hepatitis C virus spreads by blood-to-blood contact. These infections are preventable by vaccination. Those who develop cirrhosis or liver cancer may require a liver transplant, and the virus universally recurs after transplantation.

Despite the Government's best efforts to regulate blood donation, commercial blood donors are still a momentous source of blood used for transfusion, and the screening of blood for HIV infection is still far from universal. The Prime minister's AIDS Control Programme launched a mechanism for the procurement and supply of HIV and hepatitis B screening kits as early as 2005, but there is still an enormous deal of room for improvement in the system.

Problems:

1. Lack of organizational and logistic support at remote transfusion centers.
2. High screening cost per test.
3. Lack of sustained and uninterrupted supply of screening kits for the public sector from the PM (AJK) AIDS Programme.
4. Poor infrastructure at many blood banks.
5. No regulatory body to assure the specificity, sensitivity, and reproducibility of screening assays used in the region.
6. Absence of quality assurance and quality assessment programme for HIV and other blood borne infections.
7. Poor allocation of finances for screening of blood in hospital-based blood banks.
8. No postgraduate degree or certification courses in blood transfusion medicine.
9. Limited career opportunities for lab technologists concerned blood transfusion.
10. Lack of cooperation, coordination, and liaison between voluntary, private, and public sector blood banks.
11. Lack of technical infrastructure and skill for blood transfusion services.

12. Insufficient motivation of blood transfusion staff to actively organize and participate in voluntary blood donation drives.
13. Limited appreciation in the general population that family alone cannot look after the needs of all patients, and that their usual donations of blood can serve to ensure the protected supply of blood and discourage commercial blood donation.
14. Few organized efforts to motivate, educate, and retain voluntary donors.
15. Poor enrollment of voluntary blood donors.
16. Inadequate facilities for preparation of blood components and an irrational utilize of whole blood.

e) Surveillance and Research

While the AIDS Control Programme has established an HIV/AIDS surveillance system, and a small number of behavioral research activities on HIV/AIDS-related issues have been implemented, it is clear that in order to develop a well-informed response to the epidemic we require to know far more than we recognize now. Gaps in knowledge include those: connected to STI/HIV/AIDS infection levels, related to sexual behavior and HIV/AIDS awareness levels in the general population, and other specific issues related to the risks and vulnerabilities of groups at higher risk.

Problems:

1. Low levels of funding and priority for HIV/AIDS research, which inhibits effective decision making.
2. Limitations in the surveillance system, in component due to limited resource allocation, which hinder programme implementation and planning.
3. No existing systematic mechanism for the compilation of behavioral data.
4. Frequent changes of qualified staff of the surveillance centers.

5. Lack of trained staff in HIV/AIDS related research especially in public sector.
6. No information clearinghouse is present for the systematic collection and dissemination of HIV/AIDS related data.

C. Legislative Ineffectiveness

Personal awareness and understanding of reproductive health issues is limited, and often erroneous, among the men and women of AJK due in part to the generally low levels of education, and also due to their inadequate access to effective reproductive health services. Men and women alike are often unaware of the differences between reproductive and reproductive and sexual 'disease' and sexual 'health'. When they do become aware of a probable sexual or reproductive problem, they often seek care from conventional healers (*hakims*) or from one of the many unregulated 'sex clinics' in the informal health sector. In this regard, legislation is required to pursue the following categories.

1. Preventive Measures

STIs are significant to consider for two reasons: first, they can be seen as indicators of unsafe sexual practices, and second, some of these infections formulate the infected person more susceptible to HIV due to the existence of genital ulcers and other lesions. In addition, if gone untreated, these infections can result in a wide variety of serious conditions, diseases, and outcomes (including but not limited to ectopic pregnancies[15], pelvic inflammatory disease[16], and fertility problems[17]).

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[15] **Ectopic pregnancy** is a complication of pregnancy in which the pregnancy implants outside the uterine cavity. With rare exceptions, ectopic pregnancies are not viable. Ectopic means "out of place." In an ectopic pregnancy, a fertilized egg has implanted outside the uterus. So, the egg can also implant in the ovary, abdomen, or the cervix, so you may see these referred to as cervical or abdominal pregnancies. In a normal pregnancy, the fertilized egg enters the uterus and settles into the uterine lining where it has plenty of room to divide and grow.

[16] **Pelvic inflammatory disease** is a generic term for inflammation of the uterus, fallopian tubes, and/or ovaries as it progresses to scar formation with adhesions to nearby tissues and organs. This may lead to infections.

The general lack of research and information regarding the level and nature of infections that are sexually transmitted among AJK's general population crafts it impossible to accurately assess the impact of STIs or their relative increase or decrease over time. Health care professionals normally believe, however, that the occurrence of STIs in AJK may be increasing due to the relatively widespread presence of risk behaviors.

2. Care and Support

Though the number of reported HIV/AIDS cases in AJK is currently low yet it is clear that with the course of time there will be an increasing number of people infected or affected by HIV/AIDS in need of high-quality counseling, clinical care, and other social services. It is important that health workers and other social service providers in both the public and private sectors are learning to identify the needs of PLWHA, and to respond to those needs appropriately. It is also obvious that effective care and support programmes can only be developed through the close involvement of PLWHA themselves, because they are best capable to define their own service needs. It is unlikely that it will be necessary to increase new service facilities; rather, it is essential to take advantage of already existing health and social services, and toughen them where necessary. That said, it is also true that new efforts, particularly in the area of home care and support services, can and should be commenced in response to PLWHA needs.

Counseling is significant to HIV/AIDS prevention efforts, and additionally provides an entry point for access to individuals who are in call for assistance. At this time,

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[17] **Fertility problem** or **Infertility** primarily refers to the biological inability of a person to contribute to conception. Infertility may also refer to the state of a woman who is unable to carry a pregnancy to full term. There are many biological causes of infertility, some which may be bypassed with medical intervention. Women who are fertile experience a natural period of fertility before and during ovulation, and they are naturally infertile during the rest of the menstrual cycle.

there is very little formal counseling of any kind being offered in AJK's health system: however, because rising numbers of people are likely to be diagnosed with HIV over the coming years, it is vital that confidential counseling services are established and appropriately included into the health system as soon as possible.

In addition, it is very important that stigma and discrimination toward PLWHA be challenged at every level and at each opportunity. At this time, only anecdotal evidence attests to the subsistence of discrimination headed for those who are infected with HIV and their families and support systems. However, it is likely that in the absence of major efforts to relieve general public fears and misgivings, combined with concrete examples of the provision of care and support for PLWHA, occurrence of discrimination and stigma will increasingly happen.

Finally, it is important to get ready for the moment when the epidemic has taken on proportions which will result in the more frequent demand for effective services related to mother-to-child transmission. Because these services (including high-quality VCT, the appropriate use of anti-retrovirals, and the provision of appropriate treatment & support for pregnant HIV+ women) may take some time to put into place, it is imperative to begin preparations now.

Problems:

1. Complexity in identification and follow-up of PLWHA due to flaws in the surveillance system and limited health contributor awareness about signs of HIV infection and the appropriate response.
2. Limited advocacy at the policy maker's level for cure and support of PLWHA.
3. Low level of political and common public awareness about the needs of PLWHA.

4. Fear and stigma related to HIV/AIDS which leads to discriminatory practices and segregation of PLWHA.
5. Lack of PLWHA networks or support groups.
6. Inadequate or prohibitively costly stocks of treatment medications.
7. Lack of health care and social worker proficiency in clinical management and counseling.
8. Financial restraints of the government health system.

D. CAUSES AND RESULTS

In order to maintain AJK's current situation of 'low prevalence/high risk', it is very important that the nation's citizens are provided with the skills, information, and tools that they must protect themselves from becoming infected with HIV. First, the public needs to be informed concerning the risks posed by HIV/AIDS, about all of the means that HIV can be transmitted, and about how HIV transmission can be prevented. This means not only that consideration must be raised regarding sexual transmission, but also regarding mother to- child transmission, and transmission through exposure to contaminated blood and blood products (including through unsafe injections, transfusion, and exposure to contaminated instruments used for tattooing, barbering, illicit drug use, and piercing).

The public also requests to be made aware about other STIs (including the role of STIs in the spread of HIV), and of the need to produce a supportive environment for PLWHA. Next, the public needs to be empowered in the course of skills development in communication and decision making in order to put their fresh knowledge to use. Finally, equipped with new knowledge and skills, they require having ready access to the means for tumbling their HIV risk. The preventive measures only are applicable against any issue (especially infections and diseases) when one is able to know the

means and ways to reduce its prevalence. To better know the causes of HIV risk and their results we need to categorize these issues into following sub links.

1. General Awareness

It is crucially important to raise awareness amongst the community of health care providers together the formal and informal sectors about HIV/AIDS; health care providers are frequently a 'front line' resource in awareness lifting campaigns, and can play a significant role in helping people to change risky behaviors. To do this effectively, they require an enabling environment; it is thus important that community and religious leaders comprehend the issues and support their efforts. Likewise, the media can play a vital role in raising public awareness about HIV/AIDS, but in order to do so they necessitate the accurate information about prevention and about the status and trends of HIV/AIDS in the state. Official authorization to broadcast such information will be crucial.

Finally, a high level of sensitization of policy makers is also necessary in order to gain their support for and participation in HIV/AIDS prevention labors. It is not compulsory that new organizations and networks be developed to meet the challenges related to raising common public awareness about HIV/AIDS. It is far more efficient to build HIV/AIDS prevention and awareness-raising mechanism into already existing initiatives of the health sector as well as of supplementary sectors as appropriate. In this way, optimal use will be accomplished of the valuable, but limited, human and financial resources available at present for HIV/AIDS prevention in AJK.

2. Infection Control

HIV and other blood borne infections can be transmitted in the health care setting from health care workers to patients, from patients to other patients, or from patients

to health care workers.[18] In addition to the risks linked to the transfusion of HIV-infected blood, this can take place through the use and re-use of contaminated instruments, needle sticks contact, or with infected blood.

Throughout the state there is widespread use of inadequately sterilized or unsterilized syringes, needles, and other medical instruments and equipment.[19] Adherence to universal safety precautions and infection control measures in laboratories and clinics is poor, and this is true in both the non-formal and formal health care sectors. In many hospitals and clinics there are frequent shortages of properly sterilized or disposable needles and syringes. Because of generally poor sterilization and infection control measures, the indiscriminate use of injections represents a potential for the further rapid spread of HIV contamination throughout the area.

In addition, it is estimated that only sixty (60) percent of the population have access to the formal health care system and many (through personal necessity or preference) resort to the use of *hakims*, or conventional healers. It is not uncommon for clinics in villages to be operated by self-described 'doctors' who may actually have no formal or little medical training. This reliance upon ill-equipped practitioners may compound the risk of further infection due to their lack of knowledge and the possibility of derisory infection control during their therapeutic actions.

The establishment of clear infection control guidelines, and the sensitization of health care providers on the appropriate use of these guidelines, will be imperative to the control of HIV and other blood-borne infections in the health care setting. Similarly, providers in the non-formal health care setting should be made aware of the precautions that they can take to shield themselves and their clients. All health care providers have to be equipped with an understanding of the risks connected to

[18] Frank Peter, *Challenging Inequalities in Health: From Ethics to Action* (New York: Oxford University Press, 2001), 24–33.

[19] See, Kashmir AIDS Consortium, http://www.pnac.net.pk/KAC.asp (accessed June 14, 2010).

improper infection control, and of the precautions they are supposed to take to minimize those risks.

Problems:

1. Limited understanding about the requirement for multisectoral involvement in HIV/AIDS prevention activities.
2. Low literacy rate amongst the general population, and especially among women.
3. Resistance from certain segments of society, and from some religious and political leaders, to explicit safer sex messages.
4. Some limitations in access of the more marginalized classes to the media (especially electronic media).
5. Very limited coordination between the Government AIDS & other relevant programmes and NGOs.
6. Limited resources at the district level for and enhanced IEC campaign.
7. Stigma of HIV which disheartens people from seeking advice and support.
8. Lack of sensitized and trained staff at the district level for an enhanced IEC campaign.
9. No policies or guidelines currently exist for infection control.
10. Generally pitiable facilities for waste disposal in health care facilities.
11. Gender barriers in the society which disadvantage women in decision-making and having access to services.
12. Demand for the services of quacks and unqualified practitioners who possess inadequate knowledge about, and don't practice, infection control in remote areas.

13. Low level of awareness about and adherence to sterilization measures and universal precautions in health care settings.

E. Risk Factors and Vulnerability

There are few considerable factors which are creating a risk of enhancing probability of prevalence of HIV/AIDS in AJK. Some of those are in a bit detail in coming paragraphs.

1. The Socioeconomic Aspect

While HIV prevalence appears to be low in Kashmir presently, the presence of a number of vulnerabilities and risky behavioral patterns suggest the need for prioritized, urgent, and coordinated stroke to curtail the emergence of a widespread pandemic.

Poverty, gender inequalities and low levels of education and literacy all contribute to HIV susceptibility in the society. Other, connected factors that can increase vulnerability at the individual level take account of unemployment, social exclusion or marginalization, physical and/or mental mistreatment, and gender-based discrimination.

a) Poverty

Poverty is a major development anxiety in this area, and may be achief facilitating factor in the further spread of HIV infection in the state. While estimates differ, recent documentation suggests that poverty is irrefutably on the rise in some parts of AJK, and that there are a huge number of households that fall beneath the poverty line.

It is important to note that the poor suffer not just limitations in revenue; they also lack basic conveniences and amenities which provide a meaningful existence. For

instance, limitations in access to health and education curtail their ability to find work. which in turn limits their capability to make improvements in their lives. Notably. such limitations also augment the likelihood that those who are most vulnerable are the least capable to protect themselves from HIV infection, and, once grubby, are the least able to gain access to the health and social support that is required.

b) Gender Inequalities

Gender inequalities may also play a key role in the additional spread of HIV/AIDS in Kashmir. Women in broad-range have lower socioeconomic status, less decision-making power, and less mobility than do men, all of which contributes to their HIV vulnerability. For example, because of gender disparities in educational enrolment, the female literacy rate in AJK is much lower than that of males, thirty five (35) percent for women as compared to fifty nine (59) percent for men.[20] Thus, while illiteracy at hand is an obstacle for HIV/AIDS prevention efforts in general, it is much difficult to reach women than men with information about how they can shelter themselves from HIV infection. Women also are under-represented in the formal work force, which, combined with their lower literacy rate and educational levels, strengthen their economic and social dependency on men. Additionally, restrictions on mobility often make it difficult for women to attain access to health and social services, as well as access to basic reproductive health care. Finally, in situations where their decision-making authority is restricted, it is unlikely that all women are equipped with the skills required to negotiate with their partners for safer sexual practices.

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[20] Asad Ullah Khan, *Report on Economic Survey 2004-2005*(Muzzafferabad: Population Welfare Department of AJK, 2005), 7.

2. Situations of Special Risk and Especially Vulnerable Groups

While the danger of HIV/AIDS in AJK is set against a backdrop of poverty, gender inequalities, and low levels of literacy, the common public is also vulnerable to HIV/AIDS due to a number of specific situations of risk. First: it is important to note that any person, who slots in unprotected sexual activity, especially with several partners, is at risk of contracting or transmitting HIV. The peril of sexual transmission of HIV infection is augmented in AJK by the rarity of condom use and by ineffective management of other, more common, STIs.

Next, the collection and transfusion of blood and blood products, the use and re-use of unsterilized medical instruments (especially syringes and needles) and the generally low level of consideration to standard infection control procedures are important potential avenues for the spread of HIV in AJK's general population. The indiscriminate use of blood transfusions and of needles in both the formal and informal health sectors is common. In addition, standard procedures for infection control in health care settings are often not strictly followed.

Some individuals and groups of people are especially susceptible to HIV/AIDS due to their particular behavior patterns, social status, or other special characteristics. For instance, the economic and social disadvantages experienced by women in AJK sometimes consequence in their involvement in livelihood strategies which increase their vulnerability to HIV and other STIs.

Female CSWs and female migrant workers are often exploited and abused, and have little alternatives due to their low social status and limitations in legal protection. Other women of all economic and social classes countenance varying degrees of discriminatory and repressive behavior which not only decrease their life chances, but also make them vulnerable to HIV infection.

Kashmiri youth, like young people the world over, are also susceptible to HIV infection. Adolescence is a time when young people may be inquisitive about sex and drugs, are forming their habits and values, and are heavily subjective by their peers. In addition, AJK's high unemployment levels, the comparatively easy availability of drugs, and economic frustration can all influence young people to employ in unsafe behaviors which may put them at increased risk of HIV infection.

IDUs are at a high risk of acquiring HIV and other blood borne infections because they often resort to unsafe practices such as needle and syringe sharing. Although smoking and inhalation, 'chasing the dragon,' are still the most persistent forms of drug abuse in AJK, injecting drug use is thought to be gradually more common, especially in the large urban areas of the State. In addition to the risks associated with needle and syringe sharing, infected injecting drug users can pretense a risk to others through sexual transmission.

While there is little documentation about the extent to which men engage in sexual activity with other men in AJK, the limited evidence[21] available suggests that such activity does occur throughout the state. Anecdotal evidence indicates that sexual activity between men occurs comparatively recurrently in boys' hostels and jails; additionally, research suggests that sex between men is often practiced among long distance truck drivers. Finally, there is a small but highly mobile population of transvestites, transsexuals and eunuchs known as the *hijras,* who are famous to engage in unsafe sexual practices.

Mobility and migration can create conditions in which people become susceptible to infection. It is commonplace in AJK for men to travel away from their homes to find

[21] Introduction to Pakistan's Federal Ministry of Health established National AIDS Control Programme (NACP) in 1986-87 which is based at National Institute of Health, Islamabad, http://www.nacp.gov.pk/library/reports/Surveillance%20&%20Research/HIVAIDS%20Surveillanc%20ProjectHASP/HIV%20Second%20Generation%20Surveillance%20in%20Pakistan%20%20Round%202%20Report%202006-07.pdf (accessed July 1o, 2010).

work, either within the country or abroad. This separation from their spouses, families and communities can result in isolation and loneliness, and can lead migrants to engage in social and sexual practices that put them at risk of exposure to HIV. In addition, though there is virtually no documentation of the HIV/AIDS-related risks experienced by the large numbers of refugees in AJK, but global experience suggests that this population may be highly vulnerable to HIV.[22]

A large number of persons are living abroad especially in Gulf and Europe. The foremost concern with the people who are in sex free zones of the world, those can easily transmit their viruses on their arrival to their homes. It is because of that we cannot analyze their HIV status, until they communicate. Our immigration system does not operates any medical analysis of alien or of our own citizens when they, apply for visa or, travel to our country.

Another factor of HIV and AIDS prevalence to our area is the transportation of goods by truckers from all territories of Pakistan to AJK. Where, according to WHO and NACP, one hundred and sixty five thousand (165000) cases of HIV/AIDS are reported yet.[23] And most probably the actual number is beyond expectations. Lack of safe sex education is also a basic problem for both sister states.

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[22] Anna Popinchalk, "HIV/AIDS Services for Refugees in Egypt", http://www.fmreview.org/FMR pdfs/FMR31/69-70.pdf (accessed October 5, 2010); International Conference on AIDS, *Rural refugees in Uganda: their Vulnerability to HIV/AIDS* (Uganda: Makerere University of Kampala, 1996), 11, http://gateway.nlm.nih.gov/Meeting Abstracts /ma?f=102225539.html (accessed October 5, 2010); What Factors Make Some Populations more Vulnerable to HIV and AIDS? http://www.e-alliance.ch/en/l/hivaids/prevention/what-makes-some-populations-more-vulnerable-to-hiv (accessed October 5, 2010); Professor Moruf L Adelekan, *Rapid Assessment of Substance Use and HIV Vulnerability in Kakuma Refugee Camp and Surrounding Community, Kakuma,* (Kenya: Part of a Joint UNHCR/WHO Project on Rapid Assessment of Substance Use in Conflict-Affected and Displaced Populations, 2006), http://www.aidsandemergencies.org/cms/documents/Refugees_Rapid _Assess ment_Substance_Use.pdf (accessed October 5, 2010); UK Consortium on AIDS & International Development, Report of the Seminar on NGO Action for Refugees, Displaced People and their Vulnerability to HIV/AIDS (London: UK NGO AIDS Consortium, 1997), 28, http://www. reliefweb.int/rw/lib.nsf/db900sid/LGEL-5SEDQY/$file/ukcon-ref-96.pdf?openelement (accessed Oct. 5, 2010).

[23] World Health Organization, *HIV and AIDS Estimates* (Islamabad: World Health Organization, 2008), 2, http://apps.who.int/globalatlas/predefmedReports/EFS2008/full/EFS2008_PK.pdf (accessed July 7, 2010).

3. Internal Displacement of a Huge Population during Earthquake 2005

The last and the most horrible point of consideration is the partial displacement of people, in near past as a result of the Earth quake 2005, in Jammu and Kashmir. Earthquake of October 8, 2005, was unprecedented. Never since its foundation has the country as a whole been confronted with a disaster of such a magnitude – 73,338 people were killed; 128,304 were injured; and 3.5 million were displaced. As 350,000people moved to two hundred IDP camps spread over the length and breadth of the nine affected districts of AJK and Khyber Pakhtunkhaw, it appeared that a public health nightmare was in the making.[24] Initial assessments indicated that the vast majority of the population was engaged in open defecation which posed a significant health risk. This displacement and new settlements of public in such a great number can result a burst in spread of HIV and AIDS in fore coming future.

The earthquake has inflamed vulnerability to HIV/AIDS in many ways. The huge emergency medical operation to give medical relief to the hundreds of thousands of injured, missing little room for screening of blood and sterilizing of instruments. When one side there are hundreds of injured driving into the hospitals and on the other side there long lines people willing to donate blood, it was not possible for the hospital authorities to make sure safety. Another main factor is the rise in poverty, which invariably leads to amplified risky behaviors in terms of HIV/AIDS. Many women who been left without bread earners in their family may have turn to sex industry for their own endurance and that of their families. The orphaned children can also easily become targets of child sexual abuse. The circumstances get grimmer as one continues to explore the situation even further.

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[24] Syed Zaheer Hussain Gardezi, *Fountains of Life: Rebuilding Water and Sanitation Systems in Earthquake-affected Areas in Pakistan* (Earthquake Reconstruction& Rehabilitation Authority (ERRA), 2007), 3, http://www.erra.gov.pk (accessed March 14, 2010).

Though there was solid evidence of the prevalence of the high risk behaviours and low awareness levels in AJK even prior to the earthquake, the situation has aggravated dramatically after the devastating earthquake of 8th October 2005. Vulnerability has increased manifold but on the other hand there is not a single service of any kind including VCT Centre, Blood Testing or Counselling Centre in public or in NGO sector. There is not a single project for any susceptible group by any NGO in any district of AJK. There exists an enormous gap in the HIV situation and the services available for the vulnerable groups and for the PLWHA. The government program for HIV and AIDS in AJK is also in budding stages and there is almost no work going on the ground. The NGOs which are operational in AJK are facing the problems of resources (both human and financial), capacity, and support. All these factors have contributed significantly in increasing the vulnerability of common people in general and marginalised groups in particular.

F. THE COLLECTIVE RESPONSE IN JURISDICTIONS OF PAKISTAN AND AJK

In 1988, shortly after the finding of the first HIV/AIDS case in the country, the MOH of the Government of Pakistan established NACP, based at Pakistan's NIH.[25] The foremost government-funded programme plan for the NACP was developed and budgeted for an era of three years in 1990, and by 1994 the work of the NACP was extended through the approval of a PC-1[26] for an improved financial assurance for the years 1994-97. By the end of June 1997, a sum of only about fifteen (15) percent of the

[25] Introduction to Pakistan's Federal Ministry of Health established National AIDS Control Programme (NACP) in 1986-87 which is based at National Institute of Health, Islamabad, http://www.nacp.gov.pk/library/reports/Surveillance%20&%20Research/HIVAIDS%20Surveillanc%20ProjectHASP/HIV%20Second%20Generation%20Surveillance%20in%20Pakistan%20%20Round%202%20Report%202006-07.pdf (accessed July 1o, 2010).

[26] PC-1is a Performa of Government of Pakistan planning commission for development projects in social sectors like education, training and manpower, health, nutrition, family planning & social welfare, science & technology, water supply & sewerage, culture, sports, tourism & youth, mass media, governance, and research etc.

actual requirement had been prepared available to the NACP. Despite the program's inclusion in the SAP (designed to improve government expenditure in the social sector) since 1997, and due to a numerous issues (including the country's increasingly complicated economic situation), budgetary allocations have not corresponding the program requirements.

Despite these budgetary confines, the NACP has played an important role in the foundation of awareness about HIV/AIDS in Pakistan through an extensive wide-ranging public awareness campaign. This effort has integrated the publication of educational materials, many different types of educational events and workshops, and an electronic media campaign.

The NACP has also organized provincial implementation units in each province, and a system of surveillance centers throughout the country. Other major achievements include the sensitization of health workers throughout the country on a diversity of HIV/AIDS-related issues, and the founding and provision of flawed funding support to the provincial implementation units. Local and international NGOs have made imperative contributions to the nation's response to HIV/AIDS, and have been particularly important in reaching inhabitants that are especially difficult to reach. Because very few of these NGOs receive momentous donor funding, they generally rely upon self-financing mechanisms or contributions from the communities they serve; thus, their activities are comparatively limited in scope.

1. HIV and AIDS Estimates in Pakistan

The estimates and data given in the following tables relate to 2001 and 2007 unless stated otherwise. The estimates produced by UNAIDS/WHO are based on methods

and on parameters that are informed by advice specified by the UNAIDS Reference Group on HIV/AIDS Estimates, Modeling and Projections.

These estimates have been formed and compiled by UNAIDS and WHO.[27]

Demographic Data	Year	Estimate	Source
Total population (thousands)	2007	163 902	UN Population Division
Population aged 15-49 (thousands)	2007	85 305	UN Population Division
Female population aged 15-24 (thousands)	2007	17 915	UN Population Division
Annual population growth rate (%)	2005-2010	2.1	UN Population Division
% of population in urban areas	2007	36	UN Population Division
Crude birth rate (births per 1000 pop.)	2007	27.0	UN Population Division
Crude death rate (deaths per 1000 pop.)	2007	7.1	UN Population Division
Maternal mortality ratio (per 100 000 live births)	2005	320	WHO, UNICEF, UNFPA and The World Bank, 2007
Life expectancy at birth (years)	2006	63	World Health Statistics 2008, WHO
Total fertility rate (per woman)	2006	3.6	WHO Statistical Information System (WHOSIS)
Infant mortality rate (per 1000 live births)	2006	78	World Health Statistics 2008, WHO
Under 5 mortality rate (per 1000 live births)	2006	97	World Health Statistics 2008, WHO

Table 1.2: Demographic Data of the Pakistan[28]

[27] World Health Organization, *HIV and AIDS Estimates* (Islamabad: World Health Organization, 2008), http://apps.who.int/globalatlas/predefinedReports/EFS2008/full/EFS2008_PK.pdf (accessed July 7, 2010).

[28] The table of information is taken from World Health Organization, *HIV and AIDS Estimates* (Islamabad: World Health Organization, 2008), http://apps.who.int/globalatlas/predefinedReports /EFS2008/full/EFS2008_PK.pdf (accessed July 7, 2010).

Following estimates have been formed and compiled by UNAIDS and WHO.

	2001	2007
Adults (15+) and children	51 000	96 000
Low estimate	37 000	69 000
High estimate	79 000	150 000
Adults (15+)	50 000	94 000
Low estimate	36 000	68 000
High estimate	77 000	150 000
Children (0–14)	-----	-----
Low estimate	-----	-----
High estimate	-----	-----
Adult rate (15–49) (%)	<0.1	0.1
Low estimate	-----	<0.1
High estimate	0.1	0.2
Women (15+)	13 000	27 000
Low estimate	9 100	19 000
High estimate	21 000	42 000

Table 1.3: Estimated Number of Adults and Children Living with HIV in Pakistan[29]

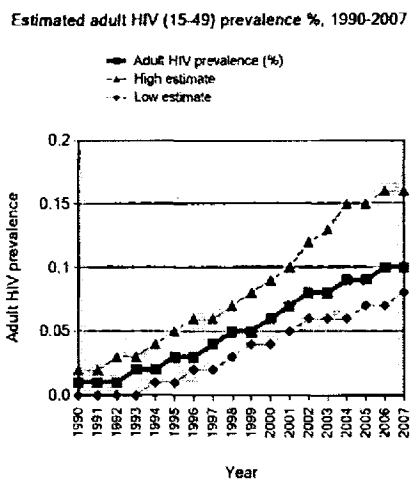

Figure 1.3: Estimated Adult (15-49) HIV Prevalence Percentage During 1990-2007[30]

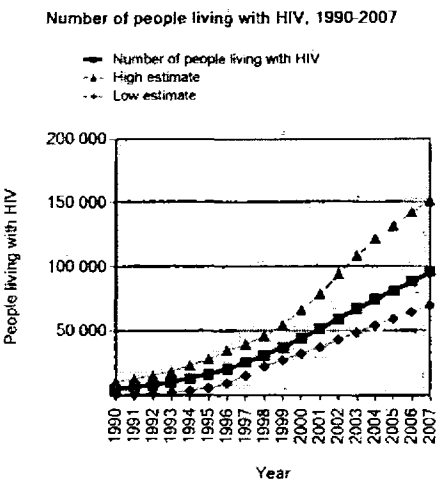

Figure 1.4 :Percentage for Number of PLWHA in Pakistan During 1990-2007[31]

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[29] Ibid., 2.
[30] Ibid.
[31] Ibid.

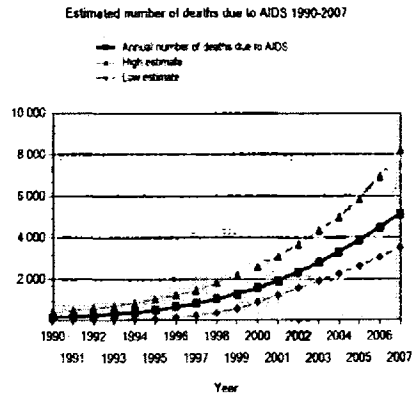

Figure 1.5: Estimated Rate of Deaths Due to AIDS from 1990-2007[32]

"The estimates tell us the cruelness of a health challenge called AIDS, which kills people indiscriminately. And gives us the 'principle of equality' to treat the persons on the world."

	2001	**2007**
Adults and children	1900	5100
Low estimate	1200	3500
High estimate	3100	8200

Table 1.4: Estimated Number of Deaths Due to AIDS[33]

In recent years, donor funds for HIV/AIDS in Pakistan have been awfully limited. Nevertheless, a number of UN system agencies and some bilateral donors have responded to the need for better donor involvement in the fight against HIV/AIDS, either through the provision of direct support to the GOP or NGOs for distinct HIV/AIDS initiatives or through SAP.

2. Process for Strategic Planning

The population of AJK is in direct concern with Pakistan's other areas in many ways like by trading and transportation of goods. So the issue of HIV/AIDS prevalence in Pakistan is directly influential upon the population of state of Jammu and Kashmir. In accordance to the solution of the problem, like Federal Legislature, we have to make a law with relation to HIV/AIDS for AJK.

In Pakistan, the national response to HIV/AIDS is organized by the MOH's National AIDS Control Program, which is a federal-level program supported by implementation entities at the provincial level functional under Provincial Departments of Health. Therefore, initial strategic planning efforts have been

[32] Ibid., 3.
[33] Ibid.

embarked on for the central level, with momentous input from key provincial cohorts. One advantage of this type of centralized planning process is that such an approach will make easy the assimilation of HIV/AIDS prevention strategies into the plans of other government departments and ministries.

3. Situation and Response Analysis

The expansion of a sound HIV/AIDS strategy should be learned by a comprehensive understanding of the occurrence and trends of HIV/AIDS, the vulnerabilities and models of behaviors which place people at higher risk of infection, and how HIV/AIDS stakeholders right through the country have responded. In 1999, the NACP, with support from UNAIDS, attached a multisectoral team of experts to investigate these issues. The resulting document, "HIV/AIDS in Pakistan: a Situation and Response Analysis" has been shared extensively throughout the country, and has formed the basis for the subsequent planning discussions.

4. Strategic Framework Formulation

Pakistan's National HIV/AIDS Strategic Framework is intended to lead the activities of the full range of HIV/AIDS stakeholders in the country. These stakeholders include government departments and ministries, CBOs/NGOs, private companies, professional associations, researchers, trusts, donors and foundations, and people living with HIV/AIDS. Each of these groups has a different interest in the fight against HIV/AIDS, and they contribute to this fight in diverse ways.

Because of the need to bring all of these key groups into partnership in the response to the pandemic, it is necessary that they have actively participated in the formulation of the nation's strategic framework. The participation of a broad range of partners will lead to enhanced feelings of ownership, will smooth the progress of an expanded response, and will help in resource mobilization.

With this mindset, a group of approximately hundred stakeholders from all through the country were brought together in May 2000 by the NACP (with financial and technical support from UNAIDS) to elaborate the broad lines of the National Strategic Framework.

During those meetings, consensus was reached regarding the priority areas of the Framework, and initial sketches for each priority area were elaborated. In addition, drafting committees were ascertained for the further development of each priority area.

These drafting committees came together again in June 2000 to persist their priority area work. Some drafting committees worked together independently thereafter, until the plan document was completed. The draft strategic framework was then circulated widely to the initial stakeholder group, modifications were made, and the concluding draft was submitted to the MOH in December 2000. The document was endorsed by the MOH in March 2001.

The function of the national HIV/AIDS strategic framework is to augment and expand the nation's response to the risk of HIV/AIDS. It is envisaged as a guide for the wide array of stakeholders who are involved in, or who crave to be involved in, the response to the epidemic. It establishes elementary principles and identifies obvious priority areas where amplified attention is likely to have the greatest impact on preventing the further spread of HIV/AIDS in Pakistan, and on tumbling the impact of the epidemic for those communities, families, and individuals that are already affected.

The NHASF is underpinned by a number of essential guiding principles which support and provide direction for the framework's more specific goals, strategies, objectives, and activities. These guiding principles are founded upon ethical and

moral values which are held to be significant throughout Pakistan, in combination with best professional practice (globally and locally) in preventing HIV/AIDS. Those are also definitely rooted in the basic law of the land, as alive in the Constitution of Pakistan. Thus, the framework draws strength from both the body of information developed globally and from the country's unique social context. Consequently, efforts of all stakeholders achieved many objectives. For example the legislation[34] on prevention and treatment of HIV/AIDS was passed by the Parliament in 2007.

G. FOLLOW UP PLAN IN AJK

The purpose of prevention of the disease and its treatment cannot be achieved without an effective legal framework. It will help out the medical officials, NGOs and PLWAs to work against the pandemic by availing privileges and authorization. The coming paragraphs and the chapters, in this regard, will describe the role of law and human rights approach to meet the requirements regarding the issue.

1. Indispensable Remedies

A comprehensive strategic framework is required by interventions recognized through a broad consultative planning process, and that form the foundation of the national response to HIV/AIDS. The strategic framework may address the following areas by ensuring a well-coordinated, effective, and sustainable multisectoral response to HIV/AIDS in AJK:

1. To reduce risk of HIV infection amongst vulnerable and high-risk groups;
2. To reduce the defenselessness of young citizens to HIV/AIDS;

[34] See, Annex C for more details.

3. To lessen the prevalence and prevent the transmission of STIs both as an considerable public health issue in its own right and as part of the effort to reduce HIV transmission;
4. To expand the knowledge base in order to assist planning, implementation and evaluation of STI/HIV/AIDS programmes;
5. To reduce the hazard of transmission of HIV and other blood borne infections through blood transfusion;
6. To reduce the risk of infection amongst the general public through an enhance in awareness stages;
7. To improve the quality of life for PLWHA through the provision of excellence care and support (meeting their social, medical, and at times material needs), and ensuring a protected environment for all people infected and affected by HIV/AIDS; and
8. To prevent spread of HIV in formal and non-formal health care situations through improving knowledge about and compliance with universal precautions.

2. Call for Action

AJK is at crucial juncture in its response to the threat of HIV/AIDS. Though HIV prevalence is still thought to be low, the population is vulnerable to increases in infection in many ways. Clearly, there is no room for complacency and the time to take action is now.

H. Conclusion

This study demands a legal and administrative framework representing the collective efforts of many of the state's HIV/AIDS stakeholders to plan for and initiate a

prioritized, urgent, and strategic agenda for action before an important window of opportunity is lost.

CHAPTER 2

LAW AS A TOOL: A WORLDWIDE ASSESSMENT OF PREVENTION AND TREATMENT FOR HIV/AIDS

A. INTRODUCTION

In first chapter it is tried to elaborate that there is a serious concern with HIV/AIDS presence in the areas of AJK and its surroundings. Moreover the most critical point is the situation of vulnerability for PLWHAs and the public at large against the HIV/AIDS epidemic. It is also a point of concern that the prevention of the epidemic must be exercised through a proper legislation. In this regard one has to observe the worldwide techniques for reduction of vulnerability of population and preservation of rights of PLWHAs. So, the following chapter will discuss the world wide view of prevention and treatment of HIV/AIDS in a legal or legislative prospective.

The HIV and AIDS epidemic nears the end of its third decade, which has gained a pandemic status. The discovery and refinements of strategies to prevent and treat HIV remain critical. Recent reports provide hope that the pandemic possibly will be slowing in some regions, while continuing to flow in others.[1] Advances in treatment and intervention strategies have prolonged thousands of lives from death and reduced

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[1] Joint United Nations Programme on HIV/AIDS and World Health Organization, *AIDS Epidemic Update Report No. UNAIDS/07.27E/JC1322E* (Geneva: UNAIDS & World Health Organization, 2007), 1, http://data.unaids.Org/pub/EPISlides/2007/2007_epiupdate_en.pdf (accessed March 1, 2010);

Prof. Rajesh Kumar and Others, "Trends in HIV-1 in Young Adults in South India from 2000 to 2004: A Prevalence Study," *The Lancet,* 367(accessed April 10, 2008), 1164–1172, http://www.thelancet.com/search/results?searchTerm=Trends+in+HIV1+in+Young+Adults+in+South+India+from+2000+to+2004%3A+A+Prevalence+Study&fieldName=AllFields&journalFromWhichSearchStarted=lancet (accessed March 2, 2010).

the incidence of HIV infection in some countries.[2] Despite this progress, the pandemic continues to exact a huge global toll on life and health. An estimated twenty five (25) million people have died from the virus and approximately thirty three (33) million people are currently living with HIV worldwide. Millions of others are at risk of infection in the next decade, including many vulnerable groups such as women, children, MSM, and CSWs (including eunuchs/*hijras*).

The HIV/AIDS pandemic has had an influential effect on the lives of people, communities, nations and the world. It has exacted a disproportionate burden on the most disadvantaged populations, both within developing and developed states.[3] Additionally, the pandemic has been marked by deep injustices and global inequalities. Human rights violations, social and political barriers to prevention and treatment help to fuel the spread of infection and exacerbate its harmful outcomes.

This chapter examines the dynamic role of law as a means, and potential barrier, for implementing successful public health interventions. It would be a basic study systematically assessing the state of laws affecting HIV/AIDS worldwide, drawing on a variety of legal traditions such as common law, civil law and *Shariah*.[4] Law of every account affects persons living with, or at risk of, HIV/AIDS; this statement get

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[2] Rajesh Kumar and Others, "Trends in HIV-1 in Young Adults in South India from 2000 to 2004: A Prevalence Study," *The Lancet*, 367(April, 2008), 1173–1174, http://www.thelancet.com/search/results?SearchTerm=Trends+in+HIV-1+in+Young+Adults+in+South+India+from+2000+to+2004%3A+A+Pre-valence+Study&fieldName=AllFields&journalFromWhichSearchStarted=lancet (accessed March 2, 2010).

[3] President's Emergency Plan for AIDS Relief (PEPFAR), *U.S. Five Year Global HIV/AIDS Strategy* (New York: President's Emergency Plan for AIDS Relief, 2004), 2, http://docs.google.com/viewer?a=v&q=cache:OZj3KeS05DQJ:ouagadougou.usembassy.gov/pdfs/pepfar.pdf+President%E2%80%99s+Emergeny+Plan+for+AIDS+Relief+%28PEPFAR%29,+U.S.+Five+Year+Global+HIV/AIDS+Strategy+2004&hl=en&gl=pk&pid=bl&srcid=ADGEESggwqBCr30tU343oljw7Fn34FCrPuKLzMORMjU9jcIO3Ekx_lmOZmKckxfeNtMWRjqYO9bBArF5Gm71zLgHG0L4yofUSquBRegNy6kpkGUljUL52mf6dyNFglgASRSjyeFf6f&sig=AHIEtbSuX3v6TEZkjWogb5YWdDNGFb9S7g (accessed March 2, 2010).

[4] L. Gostin, *The AIDS Pandemic: Complacency, Injustice and Unfulfilled Expectations* (Chapel Hill: The University of North Carolina Press, 2004), 72; Kent A. Sepkowitz, "One Disease Two Epidemics - AIDS at 25," *The New England Journal of Medicine*, 354(June, 2006), 2411-2414, http://content.nejm.org/cgi/reprint/354/23/2411.pdf (accessed March 2, 2010).

proved in coming paragraphs. Law operates at the national and local levels through legislation and judicial decisions, regulations, statutes, and constitutions. Laws moreover operate at the regional and international levels through treaties and less formal instruments. Laws help to ensure that public health agencies have the tools they require for effective prevention and treatment. They can form socio-economic entitlements, like the right to property ownership, education, work, health, and life.[5] Laws can also defend persons living with HIV/AIDS from stigma, social risks, and other undesirable consequences by respecting privacy and prohibiting unwarranted discrimination. However, in many countries, laws craft legal barriers to effective interventions. These laws may impose criminal penalties on persons living with HIV/AIDS and allow discrimination beside sex workers or injecting drug users. For example, sex work is equal to fornication and that is prohibited in *Shariah.* Therefore many Islamic countries like Iran, Pakistan and Saudi Arabia have been band sex work. But the sex industries in many shapes are present in these countries. In case of Pakistan we found the existence of sex workers through an open convention in 2009 at Karachi.[6] Unfortunately no legal protection and legislation is available this for this industry in Pakistan so as in AJK. In this chapter we will try to analyze the role of law in the world at large to resolve the issue of prevention and treatment of HIV/AIDS.

B. PUBLIC HEALTH POWERS ON THE GLOBE

Since the commencement of the pandemic, laws authorizing public health powers have been a cornerstone of initiatives to combat HIV and AIDS. Public health efforts have encompassed numerous strategies, including:

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5 Gable and others, *Legal Aspects of HIV/AIDS: A Guide for Policy and Law reform* (Washington DC: World Bank Group, 2007), 17, http://siteresources.worldbank.org/INTHIVAIDS/Resources/375798-1103 037153392/LegalAspectsOfHIVAIDS.pdf (accessed March 1, 2010).

6 Farhat Firdous and Abbas Naqvi, Karachi Sex Workers Dying Unchecked, Monday, December 04, 2006 (Karachi: Daily Times), http://www.dailytimes.com.pk/default.asp?page=2006%5C12%5C04%5Cstory_4-12-2006_pg1_7 (accessed April 5, 2010).

1. Assessing the occurrence and prevalence of HIV infection and AIDS (surveillance, case finding, screening and reporting).

2. Prevention of transmission (communication, counseling, education, and access to prophylaxis).

3. Case management and treatment of infected individuals.[7]

Public health prevention and treatment are essential for stemming the spread of HIV because effective vaccines still do not exist[8] and expensive antiretroviral drugs are out of the reach of most people who need them. The power of public health organizations in different areas, are critically examined below.

1. Testing and Screening: Would it be Voluntary, Routine or Mandatory?

Testing and screening have been highly controversial since the beginning of the epidemic, with disagreements over whether they should be voluntary, routine or mandatory.[9] Mandatory testing is rarely used and widely damned for its coercive impact on individual autonomy. Routine HIV screening, in distinction, is the systematic offering of a test, for example, when a patient enters a hospital. There are two forms of routine screening: 'opt-out' screening, where all patients are tested unless they particularly decline; and 'opt-in' screening, where patients are only tested if they explicitly agree.[10] The Joint United Nations Programme on HIV/ AIDS, the

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7 Zita Lazzarini and Larry Ogalthorpe Gostin, "Human Rights and Public Health in the AIDS Pandemic," *Human Rights Quarterly*, 20(February 1998), 194-195, http://muse.jhu.edu/login?uri=/journals/human_rights_quarterly/v020/20.1br_gostin.pdf (accessed January 4, 2010).

8 Thomas R. Frieden and others, "Applying Public Health Principles to the HIV Epidemic," *The New England Journal of Medicine*, 353(May, 2005), 2397–2402, http://content.nejm.org/cgi/reprint/353/23/2402.pdf (accessed January 17, 2010).

9 Robert Steinbrook, "One Step Forward, Two Steps Back - Will There Ever Be an AIDS Vaccine?" *The New England Journal of Medicine*, 357 (June, 2007), 2653–2655, http://content.nejm.org/cgi/reprint/35/26 /2655.pdf (accessed January 11, 2010).

10 Lawrence O. Gostin, "HIV Screening in Health Care Settings: Public Health and Civil Liberties in Conflict," *Journal of the American Medical Association*, 296(October 25, 2006), 2023–2025, http://jama.ama-assn.org/cgi/reprint/296/16/2023?maxtoshow=&hits=10&RESULTFORMAT=&fulltext=HIV+Screening+in+Health+Care+Settings%3A+Public+Health+and+Civil+Liberties+in+Conflict&searched=1&FIRSTINDEX=0&resourcetype=HWCIT (accessed December 12, 2009).

World Health Organization[11] and the US Centers for Disease Control and Prevention support routine opt-out HIV screening.[12] Some developing countries such as Botswana have adopted routine opt-out screening,[13] while others have adopted routine opt-in screening [14] or voluntary screening where patients must affirmatively request an HIV test.[15]

2. HIV and AIDS Reporting: Why Names, Unique Identifiers or Anonymous?

Most countries have extensively adopted AIDS reporting by name, but by the time individuals are diagnosed with AIDS, they have already been infected for many years. Consequently, public health organizations have suggested named HIV reporting as an extra timely way to monitor the epidemic.[16] However, named HIV exposure raises privacy concerns, with advocates claiming that it deters people from being tested. Jurisdictions vary in their approach to HIV reporting, with some requiring names to avoid duplication,[17] others requiring a unique identifier to protect privacy[18] and still

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11 Joint United Nations Programme on HIV/AIDS and World Health Organization. *Policy Statement on HIV Testing* (Geneva: UNAIDS & WHO, 2008), 1, http://data.unaids.org/UNAdocs/hivtestingpolicy_en.pdf (accessed December 25, 09).

12 Stuart Rennie and Frieda Behets, "Desperately Seeking Targets: The Ethics of Routine HIV Testing in Low-Income Countries," *Bulletin of the World Health Organization,* 84 (2006), 52–57, http://www.Scielosp.org/pdf/bwho/v84n1/v84n1a14.pdf (accessed January 12, 2010).

13 Bernard M. Branson and others, "Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings," *Morbidity and Mortality Weekly Report,* 55(2006), 1–17, http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm?s_cid=rr5514a1_e (accessed December 17, 2009).

14 Botswana Centers for Disease Control and Prevention, "Introduction of Routine HIV Testing in Prenatal Care," *Morbidity and Mortality Weekly Report,* 53(2004), 1083–1086, http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5346a2.htm (accessed December 17, 2009).

15 F. Baiden and others, "Review of Antenatal-linked Voluntary Counseling and HIV Testing in Sub-Saharan Africa: Lessons and Options for Ghana," *Ghana Medical Journal,* 39(March 2005), 8–13, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1790809/pdf/GMJ3901-0008.pdf/?tool=pmcentrez (accessed Jan. 12, 2010).

16 See, Article L-2121–1 of *Code of Public Health of France*; Section 18(2) of A noted Code of Maryland/Health-General (Maryland: Division of State Documents-Maryland), http://mlis.state.md.us (accessed November 26, 2009).

17 L.O. Gostin, J. Ward and A.C Baker, "National HIV Case Reporting for the United States: A Defining Moment in the History of the Epidemic," *The New England Journal of Medicine,* 337(October 1997), 1162–1167, http://content.nejm.org/cgi/content/full/337/16/1162 (accessed November 21, 2009).

others authorizing nameless reporting.[19] Some jurisdictions present more than one of these options simultaneously.

3. Partner Notification: an HIV Track

Legal authorization for partner notification is also used to facilitate public health professionals to trail and prevent HIV infection. Partner notification permits health officials to inquire about information for an infected person's sexual and needle-sharing partners. Once these partners are recognized, many national laws and international guidance documents give confidence infected persons to voluntarily inform their partners of the risk of HIV infection.[20] If an infected individual is unwilling or powerless to notify partners (and in some countries, even without such a refusal) physicians or government health officials may be legally authorized to do so instead, as in Malawi and Singapore.[21] In difference, governments in Tanzania and Bangladesh prohibit disclosure without consent.[22]

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[18] A. Malek, *Training Manual for Counselors: HIV Voluntary Counseling and Testing (*North Carolina: Family Health International and United Nations Population Fund Agency for Egypt, 2007), 7, http://www. fhi.org/NR/rdonlyres/ezjy6u6zq2pnh5x5qpka4j7i5jf3gkrpylsn56qtrzdxcon45m4hqfrk4wi 5teuajd6arlkudgtiue/VCTmanualYFCs.pdf; 2007 (accessed December 22, 09).

[19] Kaiser Family Foundation, *HIV Testing in the United States: HIV/AIDS Policy Fact Sheet* (Washington DC: Kaiser Family Foundation, 2006), 9, http://www.kff.org/hivaids/upload/3029-071.pdf (accessed December 20, 2009).

[20] Lawrence O. Gostin and James G. Hodge, "Piercing the Veil of Secrecy in HIV/AIDS and Other Sexually Transmitted Diseases: Theories of Privacy and Disclosure in Partner Notification," *Duke Journal of Gender Law and Policy,* 5:9 (February 1998), 9-88, http://www.law.duke.edu/shell /cite.pl?5+Duke+J.+Gender+L.+&+Pol%27y+9 (accessed December 21, 2009).

[21] Government of Malawi, *National HIV/AIDS Policy 2003: A Call for Renewed Action* (Malawi: Office of the President and Cabinet Government of Malawi, 2003), http://www.aidsmalawi.org.mw /content documents/Malawi%20National%20 HIVAIDS %20Policy.pdf (accessed January 01, 10);

Control of AIDS and HIV Infection, in Infectious Diseases Act 2003 (Singapore: Government of Singapore), http://agcvldb4. agc.gov.sg (accessed November 11, 09).

[22] Government of Tanzania, *National Policy on HIV/AIDS 2003* (Tanzania: Prime Minister's Office Government of Tanzania, 3003), http://www.ilo.org/public/english/protection/trav/aids/laws/Tan zanianactionalpolicy.pdf (accessed November 11, 09);

Government of Bangladesh, *National policy on HIV/AIDS and STD related issues1996* (Bangladesh: National AIDS Committee and Directorate General of Health Services Ministry of Health and Family Welfare, 1998), http://www.ilo.org/public/English/protection/trav/aids/laws/bangledeshna tionalpolicy.pdf (accessed January 21, 10).

C. Laws and Policies for Different Aspects Regarding HIV/AIDS

Laws in many countries prop up education campaigns about HIV transmission and discourage risk behaviors such as unprotected sexual intercourse and needle sharing. There are some legal areas of interest regarding HIV and AIDS prevention and treatment such as information and education. For example, laws in the Philippines may penalize those who provide inaccurate information about how HIV infection is transmitted, or which exploits susceptible people with exaggerated claims of prevention or cure.[23] Further explanation can be visited as follows.

1. How Laws and Policies Effect Harm reduction?

Providing way in to appropriate resources of individual prophylaxis, such as male and female condoms, may diminish the risk of HIV transmission and is supported under many national laws and policies.[24] Some countries, however, limit condom access and use by restricting information about condoms, failing to allot resources to purchase condoms or criminalizing condom possession. AIDS advocates have criticized the USA for undermining access to condoms under its President's Emergency Plan for AIDS Relief program, which mandates that one third of prevention financial support be used for 'abstinence only' education.[25]

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[23] See, Section 18 of *The Philippines AIDS Prevention and Control Act 1998* (Manila: Philippine Government, 2008), http://hivaidsclearinghouse.unesco.org/ev_en.php?ID¼2050_201&ID2¼DO_TOPIC;1998 (accessed November 16, 09).

[24] See, Section 11 of *The Philippines AIDS Prevention and Control Act 1998* (Manila: Philippine Government), http://hivaidsclearinghouse.unesco.org/ev_en.php?ID¼2050_201&ID2¼DO_TOPIC;1998 (accessed October 07, 09).

[25] United States Agency for Development, *HIV/STI Prevention and Condoms* (Washington D.C.: USAID, 2005), 3, http://www.usaid.gov/our_work/global_health/aids/TechAreas/preventioncondomfactssheet.html; 2005 (accessed December 26, 2009).

Thailand and several other countries legally require sex workers to make use of condoms during sexual intercourse.[26]

2. Laws of Effective Access to Medical Treatment

Laws often endorse treatment and care of persons living with HIV/AIDS, including guaranteeing access to establish HIV therapies such as antiretroviral medications. Some countries specifically make sure access to ARVs to prevent prenatal transmission of HIV. Global human rights treaties and many national constitutions and statutes demand that treatment be provided under the rights to health,[27] to life[28] and to gain from advancements in science,[29] as interpreted by courts.[30] Furthermore, many countries have adopted laws and policies that found HIV treatment campaigns and support services for persons living with HIV.[31] Nevertheless, many jurisdictions do not provide enough legal support or grant for population-wide treatment programmes due to political or resource-based constraints. In addition, patent laws

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[26] Joint United Nations Programme on HIV/AIDS, *Evaluation of the 100% Condom Use Programme in Thailand: Case Study* (Washington D.C.: UNAIDS, 2000), 10, http://data.unaids.org/Publications /IRC-pub01/JC275-100pCondom_en.pdf; 2000 (accessed December 26, 2009);

World Health Organization, *Experiences of 100% Condom Use Programme in Selected Countries of Asia* (Geneva: World Health Organization, 2004), 4, http://www.wpro.who.int/publications/pub_9290 610921.htm;2004 (accessed December 26, 2009);

See, Section 19 of *HIV/AIDS/STD Strategic Plan for South Africa 2000–2005* (South Africa: Ministry of Health, 2000), 2, http://www.info.gov.za/otherdocs/2000/aidsplan2000.pdf;2000 (accessed November 07, 2009).

[27] See, article 12 of *The International Covenant on Economic, Social, and Cultural Rights 1966.*

[28] See, article 6 of *The International Covenant on Civil and Political Rights 1966.*

[29] See, article 15(b) of *The International Covenant on Economic, Social, and Cultural Rights 1966.*

[30] See, South African Constitutional Court's Judgment on July 5, 2002, *Minister of Health and others v. Treatment Action Campaign and others* SA 721(CC), 135, http://196.41.167.18/uhtbin/ hyperion-image/J-CCT8-02A (accessed December 28, 2009).

[31] United States Government Accountability Office, *Global health: Spending Requirement Presents Challenges for Allocating Prevention Funding under the President's Emergency Plan for AIDS Relief* (Washington D.C.: Government Accountability Office, 2006), 395, http://www.gao.gov/new.items /d06395.pdf;2006 (accessed December 26, 2009).

and trade agreements behind intellectual property interests may limit access to the higher medications in many countries.[32]

3. Does Law Reduce Social Risk: Privacy and Antidiscrimination?

From the inception of the HIV/AIDS pandemic, privacy has been of dominant concern. Grounded in legal, ethical and human rights principles of independence and justice, privacy require those persons:

(1) Have the right not to have their health position disclosed without their consent;

(2) Are entitled to make health and other personal decisions without intrusion; and; (3) Have a right to manage others' access, use and disclosure of their HIV/AIDS health data.

Respect for privacy and associated duties of confidentiality protects individuals with, or at risk of, HIV/AIDS from stigma and discrimination[33] that can result from unauthorized discovery of a person's HIV/AIDS status, recognition of risk behaviors, or participation in HIV/AIDS public health programmes or research.[34] The de-trop discrimination against persons with HIV in healthcare or research dimension has been

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[32] Lorraine Gallagher, "Access to Medicines in Developing Countries-Compulsory Licensing for Export: A Significant Step Forward or Merely Symbolic?" (Master of European Studies thss., College of Europe: Bruges Campus, 2004), http://62.102. 106.100/Objects/2/Files/EFPIAaward20052.pdf (accessed February 12, 2010).

[33] Joint United Nations Programme on HIV/AIDS, *Protocol for the Identification of Discrimination Against People Living With HIV* (Geneva: UNAIDS, 2000), 2;
Futures Group International Policy Project, *National and Sector HIV/AIDS Policies in the Member States of the Southern Africa Development Community* (Washington D.C.: Futures Group International Policy Project, 2002), 93;
J. Galvao, "Brazil and Access to HIV/AIDS Drugs: A Question of Human Rights and Public Health," *American Journal of Public Health* 95, (2005), 1110–1116.

[34] D.D. Reidpath and K.Y. Chan, "HIV Discrimination: Integrating the Results from a Six-Country Situational Analysis in the Asia Pacific," *AIDS Care*, 17 (2005), 195–204;
Pan American Health Organization, *Understanding and Responding to HIV/AIDS Related Stigma and Stigma and Discrimination in the Health Sector* (Washington D.C.: Pan American Health Organization, 2003), 23.

an expected, well-documented outcome of privacy infringements.[35] Failure to protect privacy effectively foils vulnerable individuals, particularly women,[36] from seeking health services or embroiling in public health campaigns or HIV/AIDS research.[37] Consequently, laws in a lot of countries protect individuals alive with, or at risk of, HIV/AIDS from privacy infringements and related discrimination.[38] International human rights law,[39] national constitutions and legislation in some states blatantly prohibit discrimination based on HIV status.[40] The Philippines prohibits health organizations from discriminating against persons with HIV or those merely 'supposed or suspected of having HIV.[41] In other countries, persons with HIV/AIDS are protected through comprehensive privacy and anti-discrimination laws, such as the HIPAA of United State of America which is called as Privacy Rule[42] and Americans with Disabilities Act.[43] These wide laws are analyzed to enshrine HIV

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35 A.D. Asante, "Scaling up HIV Prevention: Why Routine or Mandatory Testing is not Feasible for Sub-Saharan Africa," *Bulletin of the World Health Organization*, 85 (August 2007), 644–646, http://www. who.int/bulletin/volumes/85/8/06-037671/en/index.html, 2007;85 (accessed January 12, 2010).

36 International Center for Research on Women, *HIV/AIDS Stigma: Finding Solutions to Strengthen HIV/AIDS Programs* (Washington D.C.: International Center for Research on Women, 2006), 7.

37 United Kingdom National AIDS Trust, *HIV-Related Stigma and Discrimination: Proposals from the National AIDS Trust for the Government Action Plan* (London: UK National AIDS Trust, 2006), 6.

38 Joint United Nations Programme on HIV/AIDS, *Research Studies from India and Uganda, HIV and AIDS-Related Discrimination, Stigmatization and Denial*, (Geneva: UNAIDS, 2000), 5-9;

M. Schuster and others, "Perceived Discrimination in Clinical Care in a Nationally Representative Sample of HIV-Infected Adults Receiving Health Care," *Journal of General Internal Medicine*, 20 (July 2005), 807-813, especially; 809-810.

39 United Nations, International Convention on Civil and Political Rights 1976, http://www2.ohchr. org/english/law/ccpr.htm; 1976 (accessed December 08, 2009).

40 Philippines, *AIDS Control and Prevention Act of 1998*, http://hivaidsclearinghouse.Unesco.org /even.php?ID¼2050_ 201&ID2¼DO_TOPIC (accessed January 8, 2010);
Cambodia, *Law of Prevention and Control of HIV/AIDS*, http://www.ilo.org/public/english/protectio n/trav/aids/laws/cambodia1.pdf (accessed January 8, 2010);

South Africa, Schedule 5(c) of *Promotion of Equality and Prevention Unfair Discrimination Act* No. 4(2000), http://www.polity.org.za/html/govdocs/ legislation/2000/act4.pdf (accessed January 8, 2010).

41 See, Section 40 of *AIDS Control and Prevention Act of 1998*, Philippines, http://hivaidscl earinghouse.unesco.org/ev_en.php?ID¼2050_201&ID2¼DO_TOPIC (accessed January 8, 2010).

42 See, Part 160 of, 45, Code of Federal Regulations of U.S.A. *The Health Insurance Portability and Accountability Act 1996.*

43 See, Section 12101, 42, of United States Code, *Americans with Disabilities Act 1990.*

asymptomatic status, AIDS and associated disabilities through international declarations,[44] legislation[45] or judicial decisions.[46] Regardless of the need for strong HIV/AIDS legal protections, there is anxiety between individual expectations of privacy and communal desires to access exacting data to encourage the public's health. The obtaining and use of personal HIV/AIDS data are essential to advancing societal health during biomedical research, examination, epidemiological studies, treatment and prevention. Legal and ethical 'rights to know' of persons (for example, sexual and injecting drug user partners) who may be at risk of disclosure may legally takeover individual privacy in a number of instances. Attempts to set of scales these common and personal interests can entail significant trade-offs. Healthcare professionals, researchers and community health officials have physically powerful legal and ethical reasons to attain, use and unveil individual HIV/AIDS information intended for surveillance, partner notification or research. However, laws naturally require that they adhere to confidentiality and security procedures to prevent intentional or negligent privacy breaches and consequential potential discrimination.[47]

4. Is HIV a Criminal Status?

A lot of countries have recognized criminal penalties for individuals living with HIV/AIDS for engaging in behaviors that hazard transmission of HIV infection. Designed to reflect public morality or dishearten socially undesirable behaviors, these

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[44] See, *Resolution* 49/1999 of the *United Nations Commission on Human Rights*.

[45] *Disability Discrimination Act of United Kingdom* (London: Office of Public Sector Information, 2005), http://www.Opsi .gov.uk/acts/acts2005/20050013.htm (accessed January 8, 2010).

[46] An example of such judicial decisions is a case decided by the Supreme Court of the United States. *Bragdon v. Abbott* [1998], 524 U.S. 624, as quoted in;

A. Nunn, E. Da Fonseca and S. Gruskin, *Changing Global Essential Medicines Norms to Improve Access to AIDS Treatment: Lessons from Brazil*, vol. 4 (Boston: Global Public Health, 2009), 139.

[47] L. Gable and others, *Legal Aspects of HIV/AIDS: A Guide for Policy and Law Reform* (Washington D.C.: World Bank Group, 2007), 12;

Joint United Nations Programme on HIV/AIDS, Geneva, *Report on the Global AIDS Epidemic* (Geneva: UNAIDS, 2006), 3, http://www.unaids.org/en/HIV_data/2006GlobalReport/default.asp; 2006 (accessed January 12, 2010).

laws are often imposed selectively against vulnerable communities or those who seek testing, treatment or services. The special effects can drive these persons underground, denying them access to public health or healthcare services and contributing to augment HIV/ AIDS morbidity and mortality. Countries like Saudi Arabia, Iran, and Sudan penalize certain sexual acts (for example, oral or anal sex) flanked by agreeable adults, regardless of gender.[48] Although impartial on their face, these laws may turn out to be guises for discrimination through selective enforcement against MSM, sex workers and victims of sexual mistreatment.[49] MSM may face harsh penalties including corporal abuse, imprisonment and death. While some other countries have increasingly discarded these laws or limited their discriminatory function. For example, many states of USA repealed their sodomy laws following the 2003 Supreme Court verdict, *Lawrence v. Texas*,[50] which invalidated criminal penalties of Texas against sodomy. A few national criminal laws planned to protect vulnerable populations, particularly women and children, from sexual violence or exploitation are not sound enforced. International human rights law deemed that women and children should not be subjected toward sexual violence.[51] A lot of jurisdictions criminalize prostitution, rape, incest, domestic abuse and sexual harassment.[52] On the other hand, punishments may be weak or insufficient.[53] In

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[48] International Gay and Lesbian Human Rights Commission, *Where Having Sex is a Crime: Criminalization and Decriminalization of Homosexual Acts* (New York: International Gay and Lesbian Human Rights Commission, 2003), 7-9, http://www.iglhrc.org/site/iglhrc/content.php?type¼1&id¼77; 2003 (accessed January 12, 2010).

[49] Lance Gable and others, *Legal Aspects of HIV/AIDS: A Guide for Policy and Law Reform* (Washington D.C.: World Bank Group, 2007), 87-115.

[50] See, Supreme Court of United States, *Lawrence v. Texas*, 539 U.S. 558 (2003), as quoted in; A. Nunn, E. Da Fonseca and S. Gruskin, *Changing Global Essential Medicines Norms to Improve Access to AIDS Treatment: Lessons from Brazil*, vol. 4 (Boston: Global Public Health, 2009), 131.

[51] Lance Gable and others, *Legal Aspects of HIV/AIDS: A Guide for Policy and Law Reform* (Washington D.C.: World Bank Group, 2007), 119-128.

[52] Peter Gordon and Kate Crehan, *Dying of Sadness: Gender, Sexual Violence and the HIV Epidemic* (London: United Nations Development Programme, 1999), 2-5, http://www.undp.org/hiv/publications /gender/violencee.htm; 1999 (accessed January 12, 2010);

addition, innate gender biases may persuade against women from reporting marital rape or other acts of sexual violence.[54] Criminal laws addressing sexual and economic exploitation, and associated commercial sex work involving millions of women and children globally,[55] proscribe related activities such as solicitation, exchange of sex for money, management of sex workers and procurement. These laws are reflection to reduce transmission of HIV and other sexually transmitted diseases among sex workers, who usually have radically higher rates of HIV infection than the general population.[56] Conversely, these laws can actually impede public health efforts to reach commercial sex workers because of their doubts of prosecution and stigmatization.[57] Without treatment options, knowledge of HIV risks or the ability to negotiate safer sex, millions of commercial sex workers are at heightened risk of

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Amnesty International, *Women, HIV/AIDS, and Human Rights* (New York: Amnesty International, 2004), 6, http://web.amnesty.org/library/Index/ENGACT770842004;2004 (accessed December 24, 2009).

53 See, *Domestic Violence Act* 116 of 1998 of South Africa, http://www.info.gov.za/gazette/acts/1998/a116-98.pdf (accessed December 21, 2009);

Elisabeth Malkin and Ginger Thompson, "Mexican Court Says Sex Attack by a Husband is Still a Rape," *The New York Times* (Michigan ed.) 17 November 2005, p. 3;

Forum for Women, Law and Development v. Ministry of Law, 55 Nepali Supreme Court, 2058 (2001–2002), http://www.fwld.org.np/marrape.html (accessed December 24, 2009);

Sexual Offences Act 2001 of Zimbabwe, http://www.kubatana.net/html/archive/legisl/010817sexoff.asp?sector¼LEGISL (accessed January 8, 2010).

54 Andree Gacoin, *Policy Paralysis: A Call for Action on HIV/AIDS-Related Human Rights Abuses against Women and Girls in Africa* (London: Human Rights Watch, 2003), 2, http://www.hrw.org/reports/2003/africa1203/9.htm #_Toc56508501; 2006 (accessed January 8, 2010);

Saurabh Mishra and Sarvesh Singh, *Marital Rape – Myth, Reality, and Need for Criminalization; Feminist Studies and Law Relating to Women, Criminal and Sexual Offences*, vol. 12 (Lucknow: Eastern Book Company, 2003), 7, http://www.ebc-india.com/lawyer/articles/645.htm; 1998–2005 (accessed January 8, 2010).

55 Joint United Nations Programme on HIV/AIDS, Geneva, *Report on the Global AIDS Epidemic At Risk and Neglected Sex Workers* (Geneva: UNAIDS, 2006), 105–110;

United Nations Children's Fund, *Excluded and Invisible: The State of The World's Children* (New York: UNICEF Publication Section, 2005), 1-85, especially 43-85, http://www.unicef.org/sowc06/pdfs/sowc06_ fullreport.pdf; 2006 (accessed January 8, 2010).

56 Joint United Nations Programme on HIV/AIDS, *Sex Work and HIV/AIDS: Technical Update* (Washington D.C.: UNAIDS, 2002) 3, http://data.unaids.org/Publications/IRC-pub02/JC705-SexWork-TU_en.pdf; 2002 (accessed January 9, 2010).

57 Prof. Michael L Pekart, "Sex-Work Harm Reduction," *The Lancet*, 366 (December 2005), 2123.

contracting and spreading human immunodeficiency virus. UNAIDS[58] and some countries (For example; Brazil, Kenya, Bangladesh, Greece, Latvia, New Zealand[59] and Australia) have supported decriminalization and subsequent regulation of commercial sex work that does not involve victimizing individuals.[60]

D. Law Being a Global Tool for Treatment and Prevention of HIV/AIDS

Global assessment of HIV/AIDS laws reveals manifold roles and potential for prevention of HIV transmission and the treatment of persons alive with HIV/AIDS. Legislation and regulation can support human rights, together with the right to life, health and sharing in the benefits of science. Moreover, laws can make a framework that undercuts (or supports) public health interventions. The legislative response to the pandemic in early sixteen years can be observed in following tables.

Australia	Germany	New Zealand
Austria	Greece	Norway
Denmark	Israel	Sweden
France	Italy	Turkey

Table 2.1: Countries who Introduced Significant Legislation on HIV/AIDS, as of 31 December 1985

Albania	China	Honduras	Mongolia	South Africa
Algeria	Colombia	Hong Kong	Morocco	Spain
Andorra	Comoros	Hungary	Mozambique	Sweden
Angola	Costa Rica	Iceland	Myanmar	Switzerland
Argentina	Croatia	India	Netherlands	Syria
Australia	Cuba	Indonesia	New Zealand	Taiwan
Austria	Cyprus	Iraq	Niger	Tanzania
Bahamas	Czech Republic	Israel	Norway	Thailand
Bahrain	Denmark	Italy	Oman	Togo
Barbados	Djibouti	Japan	Panama	Tunisia

[58] Joint United Nations Programme on HIV/AIDS and Inter-Parliamentary Union, *Handbook for Legislators on HIV/AIDS, Law and Human Rights Action to Combat HIV/AIDS in View of its Devastating Human, Economic and Social Impact* (Geneva: UNAIDS and Inter-Parliamentary Union, 1999), http://www.ipu.org/PDF/publications/aids_en.pdf;1999 (accessed January 8, 2010).

[59] *Prostitution Reform Act* 2003 of New Zealand, http://www.legislation.govt.nz/act/public/2003/0028/latest/DLM197815.html?search¼ts_act_prostitution_resel&sr¼1 (accessed January 1, 2010).

[60] Joint United Nations Programme on HIV/AIDS, *Sex Work and HIV/AIDS: Technical Update* (Washington D.C.: UNAIDS, 2002), http://data.unaids.org/Publications/IRC-pub02/JC705-SexWork-TU_ en.pdf; 2002 (accessed January 1, 2010).

Belarus	Dominican Rep.	Jordan	Paraguay	Turkey
Belgium	Ecuador	Kazakhstan	Peru	Turkmenistan
Belize	Egypt	Kenya	Philippines	Uganda
Benin	El Salvador	Kyrgyzstan	Poland	Ukraine
Bermuda	Equatorial	Guinea Latvia	Portugal	United Kingdom
Bolivia	Estonia	Lebanon	Rep. of Korea	United State
Brazil	Finland	Libya	Romania	Uruguay
Brunei Darussalam	France	Liechtenstein	Russia	Uzbekistan
Bulgaria	Gabon	Luxembourg	Rwanda	Venezuela
Burkina Fasso	Germany	Madagascar	St. Lucia	Viet Nam
Burundi	Greece	Malaysia	Sao Tome & Pr.	(Yugoslavia)
Cameroon	Grenada	Malta	Saudi Arabia	Zimbabwe
Canada	Guatemala	Mauritius	Senegal	
Chade	Guinea	Mexico	Singapore	
Chile	Haiti	Monaco	Slovakia	

Table 2.2: Countries those Introduced Significant Legislation on HIV/AIDS, as of 31 December 1995

Laws can proceed as a remedial measure to reduce social risk by altering attitudes, fostering discussion, reducing stigma and empowering vulnerable members of society to protect themselves aligned with infection and discrimination. We can conclude here with several key recommendations on how to operate laws to respond to the pandemic and get better the lives of persons living with, or at risk of, HIV/AIDS.

In that era of new exposure of AIDS only 217 jurisdictions had legislated regarding its prevention and treatment. As a result of which 1,022 legal instruments were formulated for HIV/AIDS throughout the world. While after 1995 to current date the process of its legislation get speedy by awareness of the pandemic and its harmful outcomes. Finally it has to go far in future to achieve the nullity of deaths by this disease in the world.

E. Require Prossess to Achieve Afirmative Results

Before the end of this chapter we will say that there is a variety of development in HIV/AIDS legislation yet we have to go far to achieve hundred percent results. In this regard we can derive some extensions from the above discussions to fulfill the gapes to improve the effectiveness in HIV/AIDS prevention and treatment.

1. Authorization of Public Health Strategies to Prevent and Treat HIV/AIDS

Laws should soft the progress of the prevention and treatment of HIV/ AIDS, offering systematic, non-discriminatory services to the population. The improvement of comprehensive national HIV laws and policies should keep on being a priority. Particularly, laws should empower public health officials to assess the extent of the pandemic through surveillance, screening, testing and partner notification. Routine screening should be required with explicit requirements that individuals have the right to opt-out, to receive post-test counseling if they test positive, and to receive strong privacy and antidiscrimination protections.

Laws should follow UNAIDS guidelines and 'give permission, but not require' partner notification.[61] Access to health services must comprise the accessibility of means of protection against HIV transmission such as condoms and other prophylaxis, correct information about HIV prevention and treatment, and the equitable prerequisite of effectual treatment for all individuals who need HIV care and services. Legislation and regulations ought to support expanded entrance to HIV/AIDS prevention and treatment services.

Moreover, laws should advance research into supplementary prevention and treatment methods together with the development of effective microbicides[62] and vaccines. Countries should ensure that burdensome patent and trade laws do not slow down access to essential medications.

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[61] See, Paragraph 20(g) of *International Guidelines on HIV/AIDS and Human Rights* (Geneva: UNAIDS), http://data.unaids.org/publications/IRC-pub07/jc1252-internguidlines_en.pdf (accessed January 19, 2010).

[62] A **microbicide** is any compound or substance whose purpose is to reduce the infectivity of microbes, such as viruses or bacteria.Microbicides are compounds that can be applied inside the vagina or rectum to protect against sexually transmitted infections (STIs) including HIV. They can be formulated as gels, creams, films, or suppositories. Microbicides may or may not have spermicidal activity (contraceptive effect). At present, an effective microbicide is not available.

2. Promotion of Harm Reduction Strategies

Policy makers should rescind laws that make it more difficult for individuals to protect themselves, and others, from infection, such as laws that criminalize or impede the use of sterile injection equipment and condoms. These and other harm diminution strategies can reduce the load of HIV/AIDS. Rather than creating barriers, the law should fashion it easier for individuals to shrink their exposure to infection if they have sex or use drugs.

3. Fulfillment of Human Rights their Protection and Respect

Laws should make stronger a human rights framework with the intention of guarantees fundamental rights and reduces the societal burdens of discrimination, stigma and social opprobrium that often accompany HIV/AIDS. Human rights protections appropriate to HIV/AIDS can be reinforced by insertion of human rights principles in national laws as well as international treaties.[63] Indeed, HIV legislation that does not protect basic human rights may weaken public health efforts to struggle against the disease.[64] National legislation should explicitly be familiar with key human rights protections such as the rights to health, life, privacy, to form a family, to be liberated from discrimination and to benefit from advances in science. Legal acknowledgment of property and inheritance rights, as well as rights to education and work, are significant to protect women and children from becoming more vulnerable to societal pressures that increase their risk of HIV transmission. Human rights protections should be introduced into HIV/AIDS legislation or, instruction directly or, existing human rights provisions may be interpreted to encompass protections related

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63 Lance Gable, "The Proliferation of Human Rights in Global Health Governance," *The Journal of Law, Medicine and Ethics*, 35 (2007), 534–544.

64 Richard Pearshouse, "Legislation Contagion: The Spread of Problematic New HIV Laws in Western Africa," *HIV/AIDS Policy and Law Review*, 12 (December 2007), 6–11.

to HIV/AIDS. Litigation has been required in some cases, Like South Africa, to force governments to protect human rights with respect to HIV/AIDS, including the right to health.[65]

4. Laws must Eliminate Discrimination, Injustice and Exploitation

Laws should also disallow unwarranted discrimination on the basis of HIV status and reduce stigma and disparate treatment. Antidiscrimination laws should throw out differential treatment in healthcare settings, the workplace, and accessing education or reasonable housing. Laws should forbid limits on property ownership based on HIV status or other categories (as example; race, gender, nationality, or sexual orientation) that be inclined to marginalize vulnerable populations. National governments should pass and enforce protective legislation to prohibit sexual exploitation and trafficking against women and children.

5. Reformation in Unnecessary Punitive Laws

Laws that punish persons solely because they are living with HIV/AIDS through criminal penalties and other punitive policies should be transformed. Infection by HIV/AIDS is a disability, not a crime. Merely those autonomous persons whose intentional or reckless actions can be demonstrated to with intent place others at risk of infection should be subject to possible criminal sanctions. Even then, the use of criminal laws can hinder public health objectives. Adopting a positive approach of education, harm reduction and improved access to prevention information and services should replace the use of criminal laws for persons living with HIV/AIDS. Law can be an important tool in the fight against HIV nationally and globally. It can authorize public health professionals to effectively prevent and treat HIV infection,

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[65] See, South African Constitutional Court's Judgment on July 5, 2002, *Minister of Health and Others v. Treatment Action Campaign and others* SA 721(CC), 135, http://196.41.167.18/uhtbin /hyperion-image/J-CCT8-02A (accessed December 28, 2009).

reduce the harms caused by risk behaviors, defend privacy and protect against discrimination, and uphold fundamental human rights.

F. CONCLUSION

This chapter elaborates the dynamic role of law as a means, and potential barrier, for implementing successful public health interventions. It is a basic study systematically assessing the state of laws affecting HIV/AIDS worldwide, drawing on a variety of legal traditions such as common law, civil law and *Shariah*.

Laws operate at the national and local levels through legislation and judicial decisions, regulations, statutes, and constitutions. Laws moreover operate at the regional and international levels through treaties and less formal instruments. Laws help to ensure that public health agencies have the tools they require for effective prevention and treatment. They can form socio-economic entitlements, like the right to property ownership, education, work, health, and life. Laws can also defend persons living with HIV/AIDS from stigma, social risks, and other undesirable consequences by respecting privacy and prohibiting unwarranted discrimination. Laws can effect harm reduction and can enhance the efficiency in access to medical treatment for individuals.

This chapter shows that law is being used as a tool for treatment and prevention of HIV/AIDS globally. This study also suggests some strategies for public health to fulfill human rights protection and respect. It also refers some reformations in unnecessary punitive laws. Finally it requires a detailed discussion on human rights and HIV/AIDS.

CHAPTER 3

HUMAN RIGHTS LAW, ISAM, AND HIV/AIDS IN INTERNATIONAL CONTEXT: A GUIDELINE FOR AJK

A. ITRODUCTION

In previous chapter laws and their global role towards prevention and treatment of HIV/AIDS is assessed. While, in current chapter the human rights approach and Islamic concepts on the aforesaid issue will remain under discussion. This study will also set an effort to establish some guiding principles for legislation on prevention and treatment of HIV/AIDS in AJK.

Human rights are fundamental to any response to HIV/AIDS. This principle has been recognized, by international community, since the first global AIDS strategy was developed in 1987. Human rights and public health share the common goal of promoting and protecting the well-being of all individuals. The promotion and protection of human rights are necessary to empower individuals and communities to respond to HIV/AIDS, to reduce vulnerability to HIV infection and to lessen the adverse impact of HIV/AIDS on those affected.

The incidence and spread of HIV/AIDS are disproportionately high among groups who already suffer from a lack of human rights protection, and experience discrimination. This includes groups that have been marginalized economically, socially, culturally and; for example, IDUs, sex workers and MSM. People living with HIV/AIDS or those affected by it will not seek treatment, testing, counseling, and support if this means facing discrimination, stigma, and lack of confidentiality or

other negative consequences. Discriminatory measures and other coercive proceedings drive away the people most in want of services. When human rights are protected, civil society organizations working on HIV/AIDS are able to respond to the pandemic more effectively, fewer people become infected, and PLWHA and their communities can better cope with the disease.

Human rights[1] encompass civil, political, economic, social and cultural rights. These are found in international law, through treaties and declarations, such as the Universal Declaration of Human Rights. In addition, there are some other tools which contain useful standards such as the International Guidelines[2] on HIV/AIDS and Human Rights and the Declaration of Commitment on HIV/AIDS, adopted at the UN General Assembly Special Session on HIV/AIDS (2001). While:

> "Human Rights are universal legal guarantees protecting individuals and groups against actions that interfere with fundamental freedoms and human dignity. Some of the most important characteristics of human rights are that they are: guaranteed by international standards; legally protected; focus on the dignity of the human being; oblige states and state actors; cannot be waived or taken away; are interdependent and interrelated; and are universal."[3]

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[1] There are two famous documents regarding human rights, a brief introduction is as follows:

1). The **International Covenant on Civil and Political Rights (ICCPR)** is a multilateral treaty adopted by the United Nations General Assembly on December 16, 1966, and in force from March 23, 1976. It commits its parties to respect the civil and political rights of individuals, including the right to life, freedom of religion, freedom of speech, freedom of assembly, electoral rights and rights to due process and a fair trial. As of December 2010, the Covenant had 72 signatories and 167 parties. The ICCPR is part of the International Bill of Human Rights, along with the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the Universal Declaration of Human Rights (UDHR).The ICCPR is monitored by the Human Rights Committee (a separate body to the Human Rights Council), which reviews regular reports of States parties on how the rights are being implemented. States must report initially one year after acceding to the Covenant and then whenever the Committee requests (usually every four years). The Committee meets in Geneva or New York and normally holds three sessions per year.

2). The **International Covenant on Economic, Social and Cultural Rights** (ICESCR) is a multilateral treaty adopted by the United Nations General Assembly on December 16, 1966, and in force from January 3, 1976. It commits its parties to work toward the granting of economic, social, and cultural rights (ESCR) to individuals, including labor rights and the right to health, the right to education, and the right to an adequate standard of living. As of December, 2008, the Covenant had 160 parties. A further six countries had signed, but not yet ratified the Covenant. The ICESCR is part of the International Bill of Human Rights, along with the Universal Declaration of Human Rights (UDHR) and the International Covenant on Civil and Political Rights (ICCPR), including the latter's first and second Optional Protocols. The Covenant is monitored by the UN Committee on Economic, Social and Cultural Rights.

[2] See, Annex B for more details.

[3] Administrative Committee on Coordination, *The United Nations System and Human Rights: Guidelines and Information for the Resident Coordinator System* (Geneva: Consultative Committee on

We understand human rights and HIV/AIDS to work together in three separate, but related ways. These are:

Accountability: Human rights provide a system for holding governments accountable for their actions;

Advocacy: Governments are responsible for what they do, do not do, and should do for their populations. This enables activists to engage in a wide range of advocacy actions targeted towards securing human rights enjoyment and protection for people living with and affected by HIV/AIDS and all other groups vulnerable to HIV infection;

Approaches to Programming: Human rights-based approaches to programming aim to integrate human rights principles such as nondiscrimination, equality and participation, including the greater participation of PLWHA, into the response at local, national and international levels.

This chapter explains how HIV/AIDS and human rights are related and is divided into three main sections: Accountability, Advocacy and Approaches to programming. Each section defines the issue and provides some examples. This chapter is a quick and useful guideline, as well as a framework to carry HIV/AIDS and human rights actions forward.

B. Human Rights and HIV/AIDS: Accountability

Governments, by agreeing to the various international human rights treaties and conventions, are accountable for promoting and protecting the human rights of their inhabitants. They can do so by adopting appropriate legal policies, national laws,

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Programme and Operational Questions, March 2000), 7, http://www.unfpa.org/derechos/docs/res_coord_guidelines.pdf (accessed February 15, 2010).

institutions and processes. Human rights law defines the relationship between individuals and governments; it concerns a government's obligations to individuals and populations. Every person can make a claim arising as a matter of his or her rights and entitlements, not as a result of privilege or special favor.

1. Evolution of Treaties in International Human Rights Law

The formally recognized human rights are found in the Universal Declaration of Human Rights (1948) and the two key international treaties: the International Covenant on Economic, Social and Cultural Rights (1966), and the International Covenant on Civil and Political Rights (1966). Other important treaties further describe and elaborate human rights in particular contexts: International Convention on the Elimination of All Forms of Racial Discrimination (1965), the International Convention on the Elimination of All Forms of Discrimination against Women (1979), and the Convention on the Rights of the Child (1989).

The 1948 Universal Declaration of Human Rights is not a legally binding document. However, it is the foundation for the modern human rights movement. All the nations of the world have endorsed UDHR and it expresses their common recognition about what rights are, and why they should exist for all people everywhere. There is an argument that the UDHR has attained the status of customary international law.

2. HIV/AIDS Concerning Human Rights Law

Human rights are enumerated in international UN human rights treaties.[4] None of human rights treaties expressly identifies HIV/AIDS, but all human rights elaborated in these treaties can promote accountability in HIV/AIDS related issues. Human rights relevant to HIV/AIDS identified in these treaties, and elaborated by other documents

[4] See, United Nations Human Rights Treaties, http://www.unhchr.ch/tbs/doc.nsf (accessed February 25, 2010).

include (but are not limited to) the right to equality and non-discrimination, to health, to security of the person and liberty, to privacy, to receive, seek, and impart information, to found a family and marry, to work, and the right to freedom of expression, movement, and association.

All these rights have particular importance in the context of HIV/AIDS and would imply that no person can be discriminated against on the basis of his/her HIV status.

Treaties are contracts between governments. When governments sign and then ratify them, they become 'binding,' that is, they require governments to uphold and implement the rights contained in the treaties. Governments are also required to report to the UN treaty monitoring bodies every few years, on the progress made, and obstacles encountered, in fulfilling their obligations.

Treaty monitoring bodies review government reports on their progress in implementing the treaties and issue concluding observations to them. In addition, by issuing general comments and/or recommendations they help governments understand their obligations under the treaties. Concluding observations and general comments do not force governments to act; rather they give guidance to governments.

Declarations and resolutions have moral force; persuasive value. Further, they establish standards for each government to measure its policies and actions against. An example includes the resolution passed in April 2004 by the commission on human rights recognizing that access to HIV treatment is fundamental to progressively achieving the right to health and calls on governments and international bodies to take specific steps to enable such access. An important set of declarations comes from a series of UN conferences - especially the 2001 UN general assembly

special session on HIV/AIDS that led to the adoption of the Declaration of Commitment.[5]

The International Guidelines on HIV/AIDS and Human Rights identify actions that governments should take to respond to HIV/AIDS based on their agreed to obligations arising from international human rights law. The Guidelines were developed through a consultative and participatory process involving government representatives, human rights advocates and PLWHA. Although the Guidelines do not have the legal status of a treaty, yet they have authenticity and governments are urged to adopt them.

For example, the right to health includes non-discriminatory access to quality health care services by all, irrespective of profession, race, age, gender, and sexual orientation.

3. HIV/AIDS, Human Rights, and Government's Obligations

As mention above, there is a big list of documents and declarations for preservation of rights of people living with HIV/AIDS but it is also a fact that the rights and duties are meaningless without the sanctions from respective states or their governments to preserve and assist them. In this particular case we also need to elaborate the obligations of governments regarding their acts for the preservation of rights of PLWHAs.

Governments' obligations towards human rights are understood in three ways: obligations to respect, protect, and fulfill rights. To respect a right means that a government cannot violate human rights directly in laws, policies, programs or practices. For example, governments cannot arbitrarily deny HIV infected prisoners the same standard of medical care that is offered to other prisoners.

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[5] Declaration of Commitment on HIV/AIDS, http://www.un.org/ga/aids/docs/aress262.pdf (accessed May 6, 2010).

To protect a right means that governments must prevent violations by others and provide affordable and accessible redress. For example, states must ensure that private employers do not discriminate against HIV infected employees, and provide avenues for redress if they are fired because of their HIV status.

To fulfill a right means that governments must take measures that move towards the realization of rights. These measures should be budgetary, legislative, and administrative, could include some other types of action. For example, a state may adopt a policy to provide antiretroviral treatment to all individuals in need, yet due to resource constraints, be able to cover only a small percentage of the population. The government should take measures to progressively extend coverage i.e., soliciting support from donors and/or reassessing budget priorities.

Governments cannot ignore their human rights obligations. When a government ratifies a treaty, it agrees to ensure that its national-level laws, policies, and actions are compatible with the rights defined in that treaty. Governments cannot make the excuse that they do not have sufficient resources to fulfill human rights. They must take some steps towards the realization of the rights through measures such as enacting laws, taking budgetary and administrative actions, as already mentioned. This is known as 'progressive realization,' and governments must move quickly and effectively toward the realization of all human rights.

Example: India; the Lawyers Collective, HIV/AIDS Unit, responds specifically to the legal needs of people living with HIV/AIDS. It has filed a series of petitions before the courts in India on behalf of PLWHA whose rights have been violated. For example, the lawyer's collective filed a writ petition with the Bombay High Court on behalf of a person who was removed from employment from a public sector corporation because of his HIV status. The High Court agreed with the petitioner and

directed that the individual be reinstated and be paid compensation for the period of his non-employment with the corporation.[6]

In 1999, the Supreme Court of Venezuela established that the Ministry of Health was in violation of the right to health, right to life and the right to have access to scientific advances as guaranteed by the Venezuelan constitution. The court ordered the provision of antiretroviral medications, treatments for opportunistic infections and diagnostic testing – all free of charge – to all PLWHA in Venezuela.[7]

In another case the National AIDS Prevention and Control Act of the Philippines was a result of an extensive campaign by a coalition of Philippine NGOs and human rights lawyers over several years that held the state accountable for recognizing the rights of vulnerable groups. This ultimately led to the passage of the Act. Among other things the Act requires written informed consent for HIV testing and prohibits compulsory HIV testing. It also guarantees the right to confidentiality, prohibits discrimination on the basis of actual, perceived or suspected HIV status in schools, employment, credit and insurance, travel, public service, health care and burial services.[8]

4. International Monitoring System for Human Rights of PLWHA

At the international level, treaty monitoring committees, help to hold governments accountable for non-compliance or failure to implement their human rights obligations. Governments submit reports to the committees, describing how they are

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[6] International Council of AIDS Service Organizations, *HIV/AIDS and Human Rights: Stories from the Frontlines* (Toronto: ICASO,1999), 9,http://www.icaso.org/publications/stories_frontlines_en.pdf (accessed June 10, 2010).

[7] Sumita Banerjee and Mary Ann, *Torres In-Country Monitoring of The Implementation of The Declaration of Commitment Adopted at The UN General Assembly Special Session on HIV/AIDS, A Four Country Pilot Study* (Toronto: International Council of AIDS Service Organizations,2004), 16,http://www.icaso.org/publications/UNGASS_in-country_pilot.pdf (accessed February 23, 2010).

[8] See, *The National AIDS Prevention and Control Act, 1998, of Philippines* (Manila: Ministry of Law, 2000), http://www2.doh.gov.ph/naspcp/download/policies/PNAC_RA8504.pdf (accessed March 2, 2010).

upholding the rights in the treaty. A committee thereafter issues concluding observations – that is, what it thinks of the government's actions, and suggests to the government what additional measures it should take.

In 1996, the Committee on the Rights of the Child issued a concluding observation to the Government of Argentina, regarding the health of adolescents, which "noted with concern the growing number of cases of HIV/AIDS among the youth, notwithstanding the existing National Plan of Action for HIV/AIDS," and recommended that it should "review and reactivate its programs against HIV/AIDS and increase its efforts to promote adolescent health policies and seek 'technical cooperation from, among others, like UNFPA, UNICEF, WHO and UNAIDS."[9]

Governmental accountability at the international level is also created through 'treaty body general comments or recommendations.' The general comment on the right to the highest attainable standard of health, for example, spells out how health care services, including those for HIV/AIDS, need to be accessible to all, including the most marginalized and vulnerable populations.

5. International Conferences and Sessions for Accountability

Also vital to the accountability of governments in relation to HIV/AIDS, have been the series of international conferences held under the auspices of the United Nations. These conferences have, to a great degree, helped to define the content of many of the rights necessary for prevention, care, treatment, and mitigation of the impact of HIV/AIDS. Out of each of these conference processes has come a declaration and program of action, technically 'non-binding, but nevertheless indicating the

[9] United Nations Department of Economic and Social Affairs, *Committee on the Rights of the Child* (Geneva: United Nations, 1996), http://www.un.org/documents/ga/res/51/ares51-77.htm (accessed June 15, 2010).

governments' political commitment. These commitments have helped create new approaches for considering the extent of government accountability for HIV/AIDS.

Of special interest is the Declaration of Commitment on HIV/AIDS adopted at the UN General Assembly Special Session on HIV/AIDS in 2001.[10]The Declaration of Commitment sets, among other things, time bound targets for prevention and access to essential medicines, as well as for eliminating discrimination. It also holds governments accountable for their specific commitments, particularly on the greater participation of people living with HIV/AIDS and attention to women and other vulnerable groups. It can be used as a benchmark for assessing what governments have done (or not done) to promote and protect human rights in the context of HIV/AIDS.

The CARICOM Governments incorporated some of the DOC's targets into the Caribbean Regional Strategic Framework against HIV/AIDS soon after the UNGASS on HIV/AIDS. This demonstrates CARICOM's recognition of its accountability for implementing the DOC. Further, the Caucus[11] of Ministers for Health mandated the CARICOM Secretariat to engage in negotiations with pharmaceutical companies for a single regional price for antiretroviral drugs. Regional negotiations led to the signing of an agreement in 2002 for ARV medications.[12]

While in Mexico; MEXSIDA, a coalition of HIV/AIDS NGOs, asked the Government to provide funding for a special office to be established within MEXSIDA. The office

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[10] UNAIDS, *Keeping the Promise Summary of the Declaration of Commitment on HIV/AIDS* (New York: United Nations General Assembly Special Session on HIV/AIDS, 2001), http://data.unaids.org/pub/report/2002/jc668-keepingpromise_en.pdf (accessed March 11, 2010).

[11] In United States politics and government, *caucus* has several distinct but related meanings. One meaning is a meeting of members of a political party or subgroup to coordinate members' actions, choose group policy, or nominate candidates for various offices.

[12] ICASO, *Stories from the Frontlines: Experiences and Lessons Learned in the First Two Years of Advocacy around the Declaration of Commitment* (Toronto: ICASO, 2003), 21, http://www.icaso.org/publications/stories_frontlines_en.pdf (accessed July 3, 2010).

would monitor the actions of the National AIDS Program in implementing the commitments contained in the DOC and would also promote the declaration throughout Mexico. This they pointed out was necessary for the government to be accountable to its people for implementing the DOC in a transparent manner where an independent body could measure the government's progress. The government accepted the concept.[13]

6. Sources of Law, as Guiding Principle, and Response

The International Guidelines on HIV/AIDS and Human Rights[14] is another important source for helping to hold governments accountable. The 'twelve guidelines'[15] take existing human rights norms and mold them into a series of practical, concrete measures that states can adopt to respond to the HIV/AIDS pandemic. Generally, the guidelines attempt to translate international human rights standards into application at the national level by:

1. Promoting governmental responsibility for multi-sectoral coordination.
2. Promoting reform of laws and legal support services (focusing on children, women, and vulnerable groups).

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[13] ICASO, *Update on the UNGASS Declaration of Commitment on HIV/AIDS* (Toronto: ICASO, 2002), http://www.comminit.com/en/node/181106/347 (accessed July 10, 2010).

[14] See, Annex B for more details.

[15] Brief introduction: The International Guidelines were developed in 1996, adopted in 1998 and revised in 2002. The Guidelines contain action-oriented measures to promote and protect human rights and to achieve HIV-related public health goals. The International Guidelines are **not** a UN document; hence, there is **NO** enforceability or reference to the guidelines in the UNGASS Declaration or other UN documents. However, the UN Commission on Human Rights has asked all member states to report on their progress in promoting and implementing the Guidelines. The Guidelines cover 12 thematic areas:

Guideline 1: National Framework
Guideline 2: Community Partnerships
Guideline 3: Public Health laws
Guideline 4: Criminal Law and Correctional Services
Guideline 5: Anti-discrimination laws
Guideline 6: Prevention, Treatment, Care and Support
Guideline 7: Legal Support Services
Guideline 8: Women, Children and Other Vulnerable Groups
Guideline 9: Changing Discriminatory Attitudes
Guideline 10: Public and Private Sector Support
Guideline 11: State Monitoring and Enforcement of Human Rights
Guideline 12: International Cooperation

3. Supporting involvement and participation of private and community sectors in the response.

The South African Human Rights Commission was the first national human rights body in the world to publicly endorse and adopt the International Guidelines on HIV/AIDS and Human Rights. Further, the commission addressed HIV/AIDS as a human rights issue at its first national conference. One of the outcomes of the conference was a resolution stating that discrimination against PLWHA violated the South African constitution. This was made possible due to the efforts of the AIDS Legal Network/AIDS Law Project South Africa, which held the government accountable for upholding its political commitment in implementing the Guidelines.[16]

C. Human Rights and HIV/AIDS: Advocacy

The relationship between HIV/AIDS and human rights highlights the ways in which people vulnerable to human rights violations and neglect are more vulnerable to HIV/AIDS infection; and if infected, do not have access to appropriate quality care and treatment. Vulnerable groups include children, migrants, women, refugees, injecting drug users, men who have sex with men, sex workers and all other marginalized populations.

To raise awareness about the links between HIV/AIDS and human rights, and to change existing practices, HIV/AIDS and human rights activists turn to advocacy. This is perhaps the most common use and understanding of human rights in the context of HIV/AIDS. Advocacy often depends on researching, documenting and then denouncing abuses through campaigns and published reports. Human rights groups and HIV/AIDS activists document human rights abuses related to HIV/AIDS and call

[16] ICASO, *An Advocate's Guide to the International Guidelines on HIV/AIDS and Human Rights* (Toronto: ICASO, 1999), 9, http://www.icaso.org/publications/Advocates_Guide_EN.pdf (accessed July 11, 2010).

attention to them. They also work to provide a broader understanding of what human rights mean. In other words, advocacy campaigns can take an acknowledged human right, such as the right to the highest attainable standard of health and build on its accepted understanding to achieve, for instance, increased access to HIV treatment and other essential medications.

1. Community Mobilization on Relevant Issues

Advocacy is a process that is aimed at mobilizing community action on an issue of concern to change policies, attitudes, actions, and laws for the betterment of people affected by that issue. ICASO has developed a framework for advocacy campaigns that involves eight steps:

1. Select the problem or issue that needs to be addressed.
2. Analyze and research the problem or issue.
3. Build up specific objectives for the advocacy campaign.
4. Identify the targets.
5. Identify the resources.
6. Identify the allies.
7. Create an action plan.
8. Implement, monitor and evaluate.

2. Human Rights and Role of Governments for Different Treaties

Advocacy can happen at the international level, before the UN treaty monitoring committees. It can also extend across the entire range of documents and resolutions relating to the UN (as discussed earlier). For example, activists can ask governments for information on how they are meeting their targets under DOC, or how they are

implementing the International Guidelines on HIV/AIDS and Human Rights in their programs and policies.

Peru has added the declaration of commitment in all its background documentation for its advocacy campaigns for better access to treatment and medical care and to ensure the critical importance of a multi-sectoral response to the AIDS pandemic.

The organization also presented a document to the ministry of health, highlighting the need for multi-sectoral participation in the preparation of a proposal to the Global Fund.

As a result, NGOs were included in the country coordinating mechanism and jointly, with the government, prepared and submitted a proposal to the Global Fund.[17]

AIDS Law Unit (Legal Assistance Center), Namibia has used the declaration to make an argument to the government for access to treatment in Namibia. The 'unit' has also used the declaration in its information and strategy meetings on this topic with other AIDS service organizations and people living with HIV/AIDS.[18]

ACCSI, Venezuela compiled a list of the commitments in the DOC and sent this along with a letter to the ministry of health holding the government responsible to develop a work plan to implement the commitments in line with its obligation. Recognizing that implementation of the DOC is a governmental process with active civil society participation. ACCSI offered to assist the MOH to design strategies to meet the targets contained in the DOC.

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[17] ICASO, *Stories from the Frontlines: Experiences and Lessons Learned in the First Two Years of Advocacy around the Declaration of Commitment* (Toronto: ICASO, 2003), 29, http://www.icaso.org/publications/stories_frontlines_en.pdf (accessed July 3, 2010).

[18] ICASO, *Update on the UNGASS Declaration of Commitment on HIV/AIDS* (Toronto: ICASO, 2002), 7, http://www.comminit.com/en/node/181106/347 (accessed July 10, 2010).

As a result, the MOH invited the NGO sector to submit projects that would complement the existing national strategic plan on HIV/AIDS and enable Venezuela to meet at least some of the commitments.[19]

3. Courts and HIV/AIDS

Advocacy can occur at the national level through concrete steps, for example, by pushing the national courts to determine if under the country's constitution, there is a right to receive lifesaving treatment. Advocacy can also be a reminder, for wealthier countries to fulfill their international responsibilities and commitments.

A comprehensive advocacy campaign led by the community sector eventually caused one of Israel's four private sector health insurance providers to cover ARV medications used by people living with HIV/AIDS. Part of the advocacy strategy included a lawsuit by ten PLWHA against the government and the health insurance providers, alleging that they had failed in their duty to take care of people's health. The court issued a temporary order requiring health insurance providers to make ARV available.

Two weeks later the government agreed to include the seven new drugs in the list of drugs to be subsidized. In 1998, the government decided to categorize AIDS as a severe disease which meant that all new HIV and AIDS treatment approved by the government would be available free of charge. This was an example of how advocacy can lead to greater accountability.[20]

The Canadian government removed a much criticized advantage for brand name drug firms in a major change to get HIV/AIDS medications to poor nations. While in the amendment, the government backed away from the 'right of refusal' provision that

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[19] Ibid., 8.

[20] ICASO, *HIV/AIDS and Human Rights: Stories from the Frontlines* (Toronto: ICASO, 1999), 1, http://www.icaso.org/publications/stories_frontlines_en.pdf (accessed July 12, 2010).

would have given the more expensive, patent drug manufacturers the first right to supply AIDS drugs to developing countries, thereby making it difficult for the manufacturers of less expensive, generic drugs to be the suppliers.

This action was due to a systematic advocacy campaign, spearheaded by a number of groups and individuals, including Stephen Lewis and members of the Global Treatment Access Group.[21]

4. Involvement of Affected Persons

Advocacy efforts have relied on action at the community level, where they can draw on grassroots social movements, and have strong public education components. Community-based efforts that raise awareness about the connections between HIV/AIDS and human rights directly with stakeholders, including individuals and groups who own the human rights, as well as those with obligations to respect, protect, and fulfill those rights, through publications, workshops, educational programs and other sorts of events can be effective.

ICASO has developed an easy-to-read version of the International Guidelines on HIV/AIDS and Human Rights for NGOs and CBOs. In addition, ICASO has developed an 'advocate's guide' consisting of a series of articles on how to use the international guidelines to do advocacy work in the area of HIV/AIDS and human rights.

This document has been widely used in workshops and other forums to build the capacity of NGOs and CBOs to do advocacy. It contains success stories from the community sector which can help motivate NGOs and CBOs to continue to advocate and pressure their governments to fulfill their obligations.[22]

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[21] See, Toronto Star, and http://www.aidslaw.ca/Maincontent/issues/cts/patent-amend.htm (accessed June 25, 2010).

Zambia AIDS Law Research and Advocacy Network believe that successful HIV/AIDS interventions are those that protect and promote the rights of people living with HIV/AIDS. ZARAN has been involved in a number of advocacy and litigation activities. In 2000, the Network of Zambian People Living with AIDS established a Human Rights Referral Center with the objective of, among other things, educating PLWHA on HIV/AIDS and human rights and educating the public about the human rights of PLWHA.

The center refers cases of HIV/AIDS human rights abuses to appropriate referral partners who offer free legal redress and/or social services. ZARAN is one of the center's referral partners that is involved in advocating for PLWHA whose rights have been abused or violated by employers or prospective employers.

The Southern African AIDS Trust based in Harare,[23] Zimbabwe, promotes and financially assists community-based prevention, and supports responses to the HIV/AIDS pandemic in eleven (11) southern African countries in conjunction with partner organizations. In the beginning SAT has many difficulties from its partners in responding to HIV/AIDS-related human rights abuses in their work. Several partners requested assistance to build their skills and capacity in this area.

In response, SAT developed a series of workshops that demonstrated the linkage between HIV, human rights, child rights, and gender issues in practical terms. The workshops identify the laws, both national and customary that can be applied to enhance the lives of PLWHA through advocacy campaigns for legal reforms.

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[22] Canadian HIV/AIDS Legal Network, "HIV/AIDS and the Law: New Challenges" *HIV/AIDS Policy and Law Newsletter*, 5:2 (May 2000), 1, http://www.aidslaw.ca/publications/interfaces/downloadFile.Php?ref=824 (accessed June 8, 2010).

[23] The Southern African AIDS Trust, "Southern Africa HIV and AIDS Information Dissemination Service" *SAT AIDS News*, 12:2 (September 2003), 221.

5. Role of Media

A major partner whose presence in the campaign is carrying a key role for awareness and advocacy is media. Media strategies and campaigns harmonize and are important to every aspects of human rights advocacy work.

For example, the All-Ukrainian Network of PLWHA has used the media for their human rights advocacy work. They were the first to speak openly on television about their HIV status, thus giving a human rights angle to the HIV/AIDS problem in order to change stereotypes.

The All-Ukrainian Network successfully promoted participation of an HIV positive woman in a TV program, without taboos, on a major Ukrainian TV channel. Several network members participated in the program, 'that's My Opinion.'

Through such advocacy campaigns, the network was attempting to educate the general population and to remove the stigma and stereotypes that people living with HIV/AIDS often face.[24]

D. Human Rights and HIV/AIDS: Approaches to Programming

Human rights-based approaches to HIV/AIDS programming help realize human rights themselves as well as improve access to HIV/AIDS health care services, treatment, and information.

Policies, responses, and programs are likely to be inclusive, sustainable, effective, and more meaningful for people living with and affected by HIV/AIDS, as they are based on the normative frame of international human rights.

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[24] ICASO, *In-Country Monitoring of the Implementation of the Declaration of Commitment adopted at the UN General Assembly Special Session on HIV/AIDS*(Ukraine; HIV/AIDS Alliance Ukraine, 2004), 3,http://www.icaso.org/publications/UNGASS_in-country_pilot.pdf (accessed June 17, 2010).

There is no single definition of a human rights-based approach to HIV/AIDS programming but we can say, "A rights-based approach implies being guided by the needs and rights of the community while simultaneously empowering those same communities to broaden their participation and strengthen their relationships with law, policy makers and partner organizations."[25]

However, any approach must include the full participation of people living with HIV/AIDS and vulnerable groups; and address factors such as gender and power relations, race, religion, and sexual orientation in their efforts.

These factors, individually or in combination, influence the extent to which individuals and communities are protected from discrimination, exclusion and inequality, and whether they are able to make and carry-out free and informed decisions about their lives, including their ability to access services.

Human rights-based approaches to HIV/AIDS integrate mechanisms for full participation and decision-making of affected communities, in order to promote the autonomy and empowerment of individuals living with and affected by HIV/AIDS.

Human rights can be used to support more effective HIV/AIDS interventions. Central to a human rights-based approach to HIV/AIDS are the principles of participation, equality and non-discrimination. Each is relevant to the strategies and approaches to reducing the vulnerability, risk, and impact of HIV/AIDS on individuals and populations.

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[25] Agency for Co-Operation and Research in Development, *Mainstreaming HIV/AIDS Using a Community Led Rights-Based Approach* (Tanzania: ACORD HASAP Publication, 2003), 7, http://acordinternational.org/silo/files/mainstreaming-hivaids-using-a-community-led-rights-based-approach-a-case-study-of-acord-tanzania.pdf (accessed June 21, 2019).

The first-hand experience and knowledge of people living with HIV/AIDS provides the expertise necessary to reduce stigma and discrimination in the design and implementation, as well as in the oversight, of HIV/AIDS programs.

The Program on International Health and Human Rights undertakes research in order to better understand and apply human rights based approaches to HIV/AIDS. Recently, HIV testing has surfaced as a health and human rights concern, particularly in the context of 'scaling up' the response.

The program is responding to ensure a combined HIV/AIDS and human rights approach which seeks to develop and implement strategies, actions, and policies aimed at achieving the highest possible health benefits while upholding the international legal obligation to respect, protect, and fulfill human rights.[26] We can examine some approaches as follow.

1. Global Response to Programming

Human rights-based approaches to programming are keys to the successful scaling up of the response to HIV/AIDS. For example, the existence of the global fund to fight against AIDS, Tuberculosis and Malaria, the announcement of WHO's initiative to provide ARVs for three (3) million people by the year 2005, and the United States Government's announcement to substantially increase its global funding for HIV/AIDS over the next five years, are all welcome developments in so far as more resources are potentially available. However, as welcome as accessible antiretroviral medication may be for a country, if the policy for ARV provision does not prevent discrimination in terms of access, people who might benefit may not come forward.

[26] See, The François-Xavier Bagnoud Center for Health and Human Rights, http://www.harvardfxbcenter.org/about.php (accessed June 23, 2010).

The United Nations Joint Program on HIV/AIDS has had a long-term commitment to developing human rights-based approaches in responding to HIV/AIDS. It recognizes that a rights-based approach can help mitigate the impact of HIV/AIDS as it allows for the creation of a supportive policy, cultural, legal, and social environment in which people infected or affected by HIV/AIDS are able to participate in, contribute to and enjoy economic, political, cultural, and social development despite their HIV status.[27]

2. Country's National, Regional, and International Approaches

Individual countries have good right-based approaches to fight AIDS. The response, will be discussed, in coming paragraphs is a courageous activity for any state that has to establish a legal framework under human rights approach to overcome the problem arises by HIV/AIDS.

For example CAREUK, in its programming at country level, explicitly uses a rights based approach, which it defines as programs guided by a human rights focus on respecting human dignity, achieving fairness in opportunities and equal treatment for all and strengthening the ability of local communities to access resources and services. CARE projects address HIV/AIDS in more than two dozen high prevalence countries, where they work with local partners to reduce the spread of HIV/AIDS, provide care and support for those affected, and find lasting solutions to wider social and economic problems that exacerbate the HIV/AIDS crisis.[28]

In India, a small intervention program for sex workers initiated by a government institution, All India Institute of Hygiene and Public Health, and NGOs in Sonagachi,[29] grew into a powerful human rights-based program. The Sonagachi

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27 See, http://www.unaids.org/en/in+focus/hiv_aids_human_rights.asp (accessed April 14, 2010).
28 See, http://www.careinternational.org.uk/cares_work/how/rba.htm (accessed April 15, 2010).
29 It is a place belongs to Calcutta, India.

STD/HIV Intervention Program was designed to prevent HIV and STDs among sex workers through condom promotion, clinical services, and IEC, and support by a team of peer educators. SHIP early on realized that sex workers were themselves the most excellent agents of change to fight AIDS: by recognizing human dignity, not allowing their occupation as sex workers to keep out them and equally allowing them to participate in all interventions, including decision making.[30]

3. HIV/AIDS-Related Rights: A Framework for Action

A human rights based approach to HIV/AIDS requires all governments to fulfill their obligations under international human rights law, at all the three levels, named; respect, protect and fulfill. HIV-positive persons are stigmatized in modern-day society. They are the victims of all forms of discrimination in educational institutes, work-places, and even in religious communities. The main reason for this reality is that the disease is perceived to be the consequence of undesirable sexual and moral behavior or other 'bad habits'.

In African societies, it is at times illustrated as the "sickness of bad people. Discrimination and stigmatization are the most hindering factors in the prevention and treatment of HIV/AIDS. If such people experience exclusion and are afraid of having their identity revealed, they are less likely to pursue care, treatment, and counseling, to have access to health information and to cooperate with AIDS prevention programs.

One reason for the stigmatization of HIV-infected people is that they are coming from communities which are already marginalized; as such suffering from and the sufferers of discrimination. The data prove those persons such as the jobless, the homeless, the

[30] ICASO, "HIV/AIDS and Human Rights Stories from the Frontlines" *Sexual Health Exchange*, 2 (June, 1999), 11, http://www.icaso.org/publications/stories_frontlines_en.pdf (accessed May 9, 2010).

poor, homosexuals, drug addicts, and sex workers are more prone to HIV infection. In the USA it was these already outcaste groups who unsecured the disease first. They then tolerate the load of the stigmatization attached to their social group. They are usually the people with little entrance to treatment, medical care, and information. Therefore this disease necessitates any agenda for action to take into account the convergence of the three situations highlighted above in which people live in a world with HIV/AIDS – infected, affected and vulnerable. Minimum human rights preservation is demanded from government in the following table.

GOVERNMENTS OBLIGATIONS WITH RESPECT TO HIV			
	People infected with HIV	People affected by HIV	People vulnerable to HIV
RESPECT	Government to refrain from directly violating HIV-positive people's rights on the basis of their HIV status.	Government to refrain from directly violating the rights of people affected by HIV.	Government to refrain from directly violating the rights of people/groups vulnerable to HIV.
PROTECT	Government responsible for preventing rights violations by non-state actors against HIV-positive people and for providing some legal means of redress.	Government responsible for prevention rights violations by non-state actors that would increase the burden of HIV on affected people, and for providing some legal means of redress.	Government responsible for preventing rights violations by non-state actors that may increase people's/groups' vulnerability to HIV, and for providing some legal means of redress.
FULFIL	Government to take administrative, legislative, judicial and other measures towards the realization of the rights of HIV-positive people.	Government to take administrative, legislative, judicial and other measures towards the realization of the rights of people affected by HIV.	Government to take administrative, legislative, judicial and other measures towards the realization of the rights of people/groups in order to minimize their vulnerability to HIV.

Table 3.1: A Summary of Framework for Action[31]

[31] HIV and Human Rights Law, page 3, http://www.aidsrightsproject.org.uk/pdfs/HIVandHuman Rights2LEGALFRAMEWORK.pdf (accessed March 7, 2010).

The protection of human rights is essential to safeguard human dignity in the context of HIV and AIDS and to ensure a productive and effective rights-based response to the pandemic. This response requires the accomplishment of all human rights, social and cultural, economic, civil and political, and fundamental freedoms of all people living with, vulnerable to, and/or affected by HIV/AIDS, in accordance with existing international human rights standards.

E. ISLAMIC VALUES AND ETHICS TO PREVENT HIV/AIDS

Islam is a complete code of life,[32] its basic principles, values, and regulations deal with every aspect of human life. It combines both the spiritual and material approaches into a harmonious and balanced life.

The practices and values which Islam demands from its followers are so comprehensive that those cover all issues of both the worlds. Teachings of Islam provide solutions for all kinds of diseases in general and HIV/AIDS in particular.[33]

STIs and especially HIV/AIDS are the subject of sexual regulations under the Islamic preventions. Islamic values prohibit sexual relationships outside the bounds of matrimony, and also provide guidelines for hindering against sexual impropriety in society.

The translated Quranic verses in this regard are as follows:

> "Nor come near to *zina* (illicit sexual intercourse): For it is a shameful (deed), and an evil, opening the road (to other evils)."[34](*Bani-Israil,* 17:32)

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[32] Rifki Rosyad, *A Question for True Islam: A Study of Islamic Resurgence Movement among the Youth in Bandung Indonesia* (Australia: University Printing Servises, ANU), 2006, http://books.google.com/books?id=Pr7VfsGW7OUC&lpg=PP1&dq=inauthor%3A%22Rifki%20Rosyad%22&hl=ar&pg=PP4#v=onepage&q&f=true (accessed March 10, 2010).

[33] Dr. Farouk Amod, *Religion and HIV/AIDS*(Durban: The Islamic Medical Association of South Africa, 2006), 57.

This verse prohibits any conduct or behavior which can develop or promote any sexual impropriety in society. That's why Islam does not allow un-restrained inter-mingling of men and women in order to avoid any forms of inducement.

In this regard Quran says:

> "Say to the believing men that they should lower their gaze and guard their modesty: that will make for greater purity for them..."[35](*Al-Noor*, 24:30)

> "And say to the believing women that they should lower their gaze and guard their modesty; they should not display their beauty and ornaments except what (must ordinarily) appear thereof..."[36](*Al-Noor*, 24:31)

So, Islam prescribes a pattern of life for both men and women in order to prevent unnecessary sexual excitement or temptation. It preserves the dignity of men and women by forbidding all forms of sexual harassment and exploitation.

1. Promotion of Family System

Islam allows the requirements for the natural urges of human beings and it has created lawful and healthy channels for their fulfillment. It promotes marriage to develop a healthy moral society. The Holy Quran says:

> "And marry those among you who are single..."[37](*Al-Noor*, 24:32)

The institution of marriage thus offers a protection to spouses from HIV/AIDS because it allows sexual relationship between them and forbids with others out of wedlock. As the research shows that having sexual relationship before marriage or having extramarital relationship will make a person vulnerable to contract STIs or HIV/AIDS.

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[34] Abdullah Yusuf Ali, *Translation and Commentary of the Holy Quran* (Islamabad: Da'wah Academy, International Islamic University, 2002), 517.

[35] Ibid.,650.

[36] Ibid.

[37] Ibid., 651.

2. Prohibitions for Prevention of STIs in Islam

Islamic laws are embodied with many prohibitory acts. Like other religion it also restricts homosexuality and lesbianism as this practice goes against the human nature. The Holy Quran says:

> "Do you commit lewdness such as no people no people in creation (ever) committed before you? For you practice your lusts on men in preference to women: you are indeed a people transgressing beyond bonds."[38](*Al- Araf,* 7:80)

One of the research groups believes the theory that the AIDS is a classic blood borne viral disease like hepatitis B. In both, AIDS and hepatitis B, anal intercourse (homosexuality) is a causative factor.[39] Quran prohibits this unnatural act, so it is better to avoid homosexuality rather to wait for another experience as STI.

Another factor to spread HIV/AIDS is drug injections, and drug users are one of the most vulnerable groups. Islam forbids the taking of any intoxicant including alcohol, drugs or, any substance that cloud our senses or judgment. The Holy Quran says:

> "O you, who, believe! Intoxicants and gambling, (dedication of) stones, and (divination by) arrows, are an abomination (evil), of *Shaitn*'s (devil) handiwork. Eschew (shun) such evil that you may prosper."[40](*Al Maida,* 5:90)

The mainstreaming of Islamic rules is necessary for a program designed in a Muslim society. Because Islam, as a way of life, has shown it's built in safety mechanisms and protections from all kinds of social ills.

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[38] Ibid., 273.

[39] Dr. Farouk Amod, *Religion and HIV/AIDS* (Durban: The Islamic Medical Association of South Africa, 2006), 66.

[40] Abdullah Yusuf Ali, *Translation and Commentary of the Holy Quran* (Islamabad: Da'wah Academy, International Islamic University, 2002), 207.

F. CONCLUSION

In this chapter the human rights approach and Islamic concepts on the prevention and treatment of HIV/AIDS are discussed. This study has also set an effort to establish some guiding principles for legislation on prevention and treatment of HIV/AIDS in AJK. It is tried to elaborate the principle that Human rights are fundamental to any response to HIV/AIDS. It is also shown that the human rights and public health share the common goal of promoting and protecting the well-being of all individuals. The promotion and protection of human rights are necessary to empower individuals and communities to respond, to HIV/AIDS, to reduce vulnerability to HIV infection and to lessen the adverse impact of HIV/AIDS on those affected.

This study highlights the experience discrimination for groups that have been marginalized economically, socially, culturally and; for example, IDUs, sex workers and MSM. People living with HIV/AIDS or those affected by it will not seek treatment, testing, counseling, and support if this means facing discrimination, stigma, and lack of confidentiality or other negative consequences.

Human rights and HIV/AIDS to work together in three separate, but related ways like accountability, advocacy and approaches to Programming. When human rights are protected, civil society organizations working on HIV/AIDS are able to respond to the pandemic more effectively, fewer people become infected, and PLWHA and their communities can better cope with the disease.

CHAPTER 4

LEGISLATION ON HIV/AIDS ITS PREVENTION, TREATMENT, AND PROTECTION OF PLWHA IN AJK

A. INTRODUCTION

As prelude in previous chapters we got to know that legal framework for the prevention and treatment of HIV/AIDS and for the protection of human rights of PLWHA is a basic requirement from any legislative body for better results to achieve international standards. Therefore, it is the need of the hour that AJK should carry out legislation on this particular issue in accordance to the guiding principles from international and regional context. Here, in this chapter, we will discuss the minimum requirements and some of effective factors for this legislation.

B. HIV/AIDS AND INTERNATIONAL HUMAN RIGHTS LAW

Jonathan Mann,[1] the first Director of the WHO's Global Programme on AIDS, identified the international law of human rights as an ample framework to which public health practitioners could fasten responsibility for tackling the underlying causes of HIV/ AIDS, trauma and other threats to health. As summarize below, such a 'rights-based approach' to public health in general, and HIV/AIDS in particular, ropes sound public health practice by providing additional tools to motivate governments to take action to achieve public health goals. Rights considerations can help and

[1] Jonathan Mann,"Human Rights and AIDS: The Future of the Pandemic," *Health and human rights*, (1999), 221.

facilitate the setting and monitoring of public health targets and endow with a complementary language to recognize failures, or incipient failures, of public health programs.[2] The rights based approach also offer links with other social movements that employ the same language—for example, the women's movement, the efforts of indigenous peoples and the movement of people working to guard the environment.

In 1996, an international specialist consultation group called together by office of the High Commissioner for Human Rights and UNAIDS the, which included human rights experts, representatives of national AIDS programs, people living with HIV/AIDS, and NGOs, arranged guidelines for states on the application of international human rights law in the context of HIV/AIDS.[3]

The guidelines, consisting of twelve succinct paragraphs, were included in the report of the consultation tabled at the fifty third session of the Commission on Human Rights in 1997.[4]

The Commission welcomed the report and invited states to regard the guidelines (now known as the International Guidelines on HIV/AIDS and Human Rights).[5] Subsequent resolutions in 1999 and 2001 inquire states to report on measures taken, where appropriate, to support and implement these guidelines,[6] and tools have been

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[2] Ibid.

[3] An introduction of these guidelines is present in Annex B.

[4] United Nations, *Second International Consultation on HIV/AIDS and Human Rights* (Geneva: Office of the High Commissioner for Human Rights,1996), 23-25;United Nations, *Report of the Secretary General* (Geneva: United Nations, 1997); This report was edited and re-issued as *HIV/AIDS and Human Rights: International Guidelines* (Geneva: UNAIDS and Office of the High Commissioner for Human Rights, 1998).

[5] United Nations High Commissioner for Human Rights, *The Protection of Human Rights in the Context of Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS)*(Geneva: Office of the United Nations High Commissioner for Human Rights, 1997).

[6] United Nations High Commissioner for Human Rights, *The Protection of Human Rights in the Context of Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS)* (Geneva: Office of the United Nations High Commissioner for Human Rights, 1999), 3;United Nations High Commissioner for Human Rights, *The Protection of Human Rights in the Context of Human*

organized to help specific groups implement the guidelines in their areas of responsibility.[7]

The commentary that go along with the guidelines concentrates on many-sided issues in parts such as disclosure and confidentiality of HIV status by relating international legal standards to these problems.

The guidelines note that the international law of human rights allows states to impose limitations on assured personal freedoms, such as the right to liberty of movement, but only where the state can establish that the restriction is:

1. Provided for and carried out in accordance with the law, i.e. according to specific legislation that is precise, clear, and accessible, so that it is reasonably foreseeable that individuals will standardize their conduct accordingly.
2. Based on a legitimate interest, as described in the provisions guaranteeing the rights.
3. Proportional to that interest and constituting the least invasive and least restrictive measure available and essentially achieving that interest in a democratic society, i.e. established in a decision-making course of action consistent with the rule of law.[8]

Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS)(Geneva: Office of the United Nations High Commissioner for Human Rights, 200), 7.

[7] UNAIDS and Inter-Parliamentary Union, *Handbook for Legislators on HIV/AIDS, Law and Human Rights*(Geneva: UNAIDS, 1999), 13; International Council of AIDS Service Organizations, *An Advocate's Guide to The International Guidelines on HIV/AIDS and Human Rights*(Toronto: ICASO, 1999), 21.

[8] United Nations, *Second International Consultation on HIV/AIDS and Human Rights* (Geneva: Office of the High Commissioner for Human Rights,1996), 23-25;United Nations, *Report of the Secretary-General* (Geneva: United Nations, 1997), 37;UNAIDS, *HIV/AIDS and Human Rights: International Guidelines*(Geneva: UNAIDS and Office of the High Commissioner for Human Rights, 1998).

For example, the guidelines envision circumstances in which public health legislation might legitimately authorize health care professionals to inform their patients' sexual cohorts of the HIV status of the patients.[9]

By requiring strict legal processes for any limitations on the rights of people infected, however, the guidelines are a sign of the 'public health rationale' for preventing discrimination aligned with people living with HIV/AIDS.[10] In 2002, UNAIDS and the High Commission for Human Rights held another international consultation to revise the sixth guideline, which addresses access to treatment, prevention, care and support.[11] The revised guidelines recommend that domestic legislation incorporates, safeguards, and flexibilities in international agreements, such as intellectual property agreements, to endorse and ensure access to HIV/AIDS treatment, prevention, care, and support for all.[12]

In accumulation to international human rights law, other international legal agreements also persuade the spread and impact of HIV/AIDS. For example, the agreements of the WTO, such as those that manage the terms of trade and other matters connecting its members, very much influence national income and the allocation of income within and between countries, and hence influence the capital available to governments for successful prevention, treatment, and care.

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[9] Ibid.; UNAIDS, *HIV/AIDS and Human Rights: International Guidelines*(Geneva: UNAIDS and Office of the High Commissioner for Human Rights, 1998),9.

[10] Ibid., 6; Kirby J, "Human Rights And The HIV Paradox" *The Lancet*,348 (April, 1996), 1217-1218.

[11] UNAIDS, *HIV/AIDS and Human Rights: International Guidelines*(Geneva: UNAIDS and Office of the High Commissioner for Human Rights, 1998), 10.

[12] Ibid., 12; Office of the United Nations High Commissioner for Human Rights and the Joint United Nations Programme on HIV/AIDS, *Third International Consultation on HIV/AIDS and Human Rights*(Geneva: OHCHR and UNAIDS, 2002), 34; Reon Elliott, *Trips and Rights: International Human Rights Law, Access to Medicines, and the Interpretation of the WTO Agreement on Trade-Related Aspects of Intellectual Property Rights*(Montreal: Canadian HIV/AIDS Legal Network and AIDS Law Project, 2001),6, http://www.aidslaw.ca/Maincontent/issues/cts/TRIPS-brief.htm (accessed July 12, 2010).

C. THE INTERNATIONAL LEGAL CONTEXT FOR LEGISLATION

The final step along the path to make sure that all HIV/AIDS-related service delivery and research is ethical and that the human rights of PLWHAs and vulnerable groups are being watched over in all spheres of life is to make sure the enactment and enforcement of legislation designed for this purpose.

Guidelines and Codes of Conduct give direction to the endeavor and are essential convenient tools, but legislation cements the commitment of the country. Around the world, following are best practice examples of countries which have moved toward their legislatures:

1. The "Hong Kong Disability Discrimination Ordinance" enacted in 1995, covers HIV/AIDS in provisions of both medical expenses including the provision of ARV drugs, accommodation mechanisms and assistance to file complaints against discrimination on grounds of HIV status.[13]
2. The Philippines has adopted the "AIDS Prevention and Control Act" in 1998,requiring written well-versed consent and prohibiting compulsory HIV testing, prohibiting discrimination, establishing universal precautions, mandating HIV/AIDS information as a health service, guaranteeing the right to confidentiality, requiring specific programmes in work place and educational authorities to assimilate HIV/AIDS prevention information, identifying the role and utilizing the experience of affected individuals in IEC, community based services, health care, and self-help programmes.[14]

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[13] Office of the High Commissioner on Human Rights, *Expert Meeting on HIV/AIDS and Human Rights in Asia-Pacific* (Bangkok: United Nations Asia-Pacific Regional Office, 2004), 17.

[14] UNAIDS, *Handbook for Legislators on HIV/AIDS, Law and Human Rights* (Geneva: Inter-Parliamentary Union, 1999), 23, http://www.unaids.org/en/in+focus/hivaids_human_rights/related+publiccations+.asp (accessed July 9, 2010).

3. Several countries have enacted general antidiscrimination legislation which prohibits inequitable and irrelevant distinctions being made on specific grounds, including disability.[15]
4. In the Netherlands, the Penal Code provides for proceedings on the basis of violation of professional confidentiality.

   The European Court of Human Rights has found that the publication of a person's identity and HIV status can infringe the right to respect for private and family life.[16]
5. Several countries have introduced syringe and needle exchange programme and substitution therapy for IDUs with legislative authorization.[17]
6. Many jurisdictions have repealed laws penalizing sexual minorities (as MSM) involving consenting adults, like the Russian Federation in 1992, South Africa in1996.[18]
7. Many countries have Press Councils where individuals may craft complaints against the media's portrayal of their story.[19]
8. In December 2008, Pakistan has also processed a legislation named; HIV/AIDS Prevention and Treatment Act, 2008.[20]

D. THE NEED FOR STRENGTHENING OF LEGISLATION

A national response to control the HIV epidemic calls for a multisectoral involvement and an enabling environment guaranteed by an adequate legislation in all sectors. Therefore, Ministry of Health AJK has to start work propositions to revise the legislation regarding public health and this effort must be joined by all sectors.

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15 Ibid., 26.
16 Ibid., 27.
17 Ibid.
18 Ibid., 30
19 Ibid., 32.
20 This particular Act is attached here as Annex C.

The following examples illustrate the need for such an act:

1. Lapses in confidentiality and the lack of codes of conduct, with various examples of name and photos of PLWHAs published in media.
2. The high levels of stigma and discrimination for PLWHAs and high risk groups within the public and even within families.
3. The boycott of PLWHAs businesses, and discrimination in working places.
4. Misbehaviors with PLWHAs by health professionals.
5. The vulnerability of women in particular to protect themselves when the husband is HIV positive or affianced in high risk behavior, to access services dependent on decision by male.
6. The right to privacy and family life for PLWHAs.

In Azad Jammu and Kashmir, for the moment no HIV/AIDS specific act of legislation ensures that individual rights are guaranteed to guard vulnerable persons, PLWHAs and their families. At least, considerations written below must be followed by the legislator:

- Certain individual rights guaranteed by law to shield PLWHAs and their families from discrimination and stigmatization.
- A comprehensive national HIV/AIDS prevention law so that the systems must be in place to make sure effective implementation as well as successful action in respect of violations or noncompliance.

Moreover, the fact remains that high risk groups have doubtful legal status in AJK and are hence often liable for prosecution. This raises the question of how to define their legal human rights in accessing unambiguous services. This can be partially answered through pursuing the enactment and enforcement of appropriate legislation.

With regard to HIV/AIDS, any legislation needs to draw on a clear understanding and awareness of the status of the HIV epidemic in AJK now, as well as future projections, so that it remains relevant.

The legislation has to take into account the urgent need for comprehensive interventions, to weigh their pertinence in view of their benefits, now and in the future, and to protect their implementation.

E. The Need for Regulatory Mechanisms

The next step in the process of ensuring protection of persons living with HIV/AIDS and susceptible groups under the law is to make certain its application and respect. This requires supporting regulatory mechanisms. In AJK, standard mechanisms for audits are not yet established and abuses often cannot be documented or repressed. The following points can help to counteract this:

1. The development of public-private partnerships in all interventions connected to HIV and AIDS to provide a two-way oversight mechanism.
2. The acknowledgement of the crucial function that community leaders and religious scholars can contribute to transform public attitudes towards PLWHAs and high risk populations.
3. The development of relevant policies in all divisions to address and help contain human rights violations faced by PLWHAs and vulnerable groups.
4. Ensuring the involvement of representatives from the PLWHAs and high risk groups for the duration of project development. This is essential in empowering the communities mainly affected by the disease and in monitoring human rights with regards to HIV and AIDS.
5. The inclusion of compensation for sufferers of human rights violations as a part of the legislation.

6. The development of 'Codes of Conduct' for professionals and their monitoring with subjugation of violations in all sectors (especially in health and media).
7. An aggressive information campaign for the general population to diminish stigma, and discrimination, and favor an enabling environment.

F. Recommendations Regarding Relevant Areas of Work

There are some basic requirements, if followed the HIV/AIDS prevention and treatment can be supplemented by numerous goals. To fulfill these requirements we must follow the coming recommendations in many relevant areas as described below.

1. Refinement in Public Health Laws

Any legal structure, system, or framework recommends some regulations for the treatment and prevention of any disease. Whereas the most concerned area is health sector or the public health department for this objective. In public health sector we need a huge list to follow the international guidelines. Though it is tough but we may able to minimize the risk by minor modifications and developments in ethical approach of health officials and by small variations in some codes. Here we describe some basic information to accelerate the process of prevention and treatment of HIV/AIDS. A few points and suggestions for the refinement in public health are discussed as follows:

1. Blood safety assurance.
2. Confidentiality of information or notification of test results acquired by the public health authorities.
3. Ensure the access to the means of prevention of disease for every patient.
4. Voluntary testing and counseling with a manifestation of prohibition of mandatory and compulsory HIV testing.

5. Adaptation of maximum universal precautions control for the issue.

2. Therapeutic Goods, Treatment, and Ethical Research on HIV/AID

As written earlier that the treatment for any disease is one of the fundamental right for all human being in any state.

In case of PLWHAs we must be more careful because a little mistake here can cause an imminent threat to public at large.

For the sac of preventing this disaster we have to provide immediate treatment as in the following manner:

1. By providing access to care and availability of support to the patients;
2. By providing access to affordable HIV/AIDS medication;
3. By ensuring safe and efficacious therapeutic goods;
4. By enhancing and promoting ethical human research; and
5. By improving quality of HIV test kits and condoms etc.

3. Equality, Privacy Legislation, Anti-Discrimination, and Communication

Elimination of social discrimination on the bases of HIV status is one of the major concerning areas. Yet we may not be able to achieve the require results without addressing the following agenda:

1. Equal legal status of men and women at every stage of age while acquiring finances, property, relationships and work.
2. Administration of anti-discrimination and privacy protections.
3. Privacy protection for HIV related data.
4. Conditions of allowance for the partner notification.
5. Protection of vulnerable groups aligned with discrimination with wide jurisdiction.

6. Expression rights and censorship or broadcasting.
7. Assembly, association and movement rights.

4. Variation Required in Criminal Law

As a major part of legislation we have to amend or modify many criminal laws prevailing in the state to reduce the risk and for the better prevention and treatment of HIV/AIDS. The most relevant areas and statutes are as under:

1. Protection against sexual and other violence must available in an adequate manner in law.
2. Modification require in laws related to rehabilitation, harm reduction, and drug abuse.
3. Need to remove conditions allowing restriction on living circumstances and detention.
4. Availability of certain right of legal representation at any jurisdiction.

5. HIV/AIDS and Employment Law

As describe above that discrimination on the bases of HIV/AIDS is against the basic human rights purposes.

To eliminate this discrimination and for the protection of PLWHAs, we have to modify employment law for every job in the state by considering and ensuring the following points:

1. Availability of employment security and social security from any risk.
2. Confirm the abolition of exclusion of HIV positive workers.
3. Maintenance of confidentiality in the place of job or work.
4. Ensure the removal of any prohibition of HIV screening at any job.
5. Provision of relief for complaints against health professionals.

6. HIV/AIDS and Effective Prisons Laws

As studied earlier that there are many issues regarding HIV status AIDS prevention for a person in prison. We can reduce these problems by providing and ensuring following considerations in prisons laws:

1. Compassionate early release or diversion on health conditions.
2. Protection against involuntary acts and confidentiality of information.
3. Parity of access to prevention and care in prisons.
4. Lack of compulsory testing and segregation.
5. Availability of means of prevention in prison.

7. Awareness for HIV/AIDS and Basic Sex Education

Awareness of the virus, its spread and the disease to public at large must be a prime concern of the officials and policy makers. While, basic sex education, especially for youth, its compulsory addition in syllabus on school level to reduce the sexual abuse among children is one of the big issues to be solved. So that it will helpful to overcome an exclusive means of spreading HIV/AIDS. In religious schools (*dinimadrassas*), primary sex education and awareness is available[21], to some extent, as a part of their curriculum. For example the chapters regarding cleanliness (*Tahara*)[22], puberty (*Balugha*)[23], and sexual intercourse (*Jmaa*)[24] are the subjects of

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[21] Books in this matters are referred as; *Qadoori*; *Al-Hidaya*; *Tafseer-e-Jalalain*; and; *Noorr-ul-Izza*.

[22] The supplementary titles of *Tahara* are *Istinja* (the washing of anus, penis and vagina after secretion of waists materials from the body), *Wadhu* (ablution for prayers and worships), and *Ghusal* (bath). In most of the situations where the above mention practices are obligatory are sex based or related to sexual organs.

[23] Discussions regarding puberty (*Balugha*) include menstruation (*Haiz*) in females, ejaculation (*Manni, Muzzi, Wadhi*, and *Ahtalaam)* in males, and development of sexual or reproductive organs are based on sexual orientation.

[24] Sexual intercourse with sex partners (wives etc) is also a part of syllabus for its method and precautions and prohibitions. Like during menstruation (*Haiz*) and bleeding (*Nafoos*) after having birth

sex education either directly or indirectly. While, on the other hand, the modern school systems are lacking this phenomena so they need to follow the religious schools, at least, for the reduction of high rate of the issue. If government and NGOs dealing with education sector will initiate the steps it will be more channelize, organize, and result oriented as compare to any other individual effort.

8. Create a Supportive Environment of Effective Risk Reduction through Advocacy

The purpose of harm reduction is obtainable by another factor that government will provide the means to increase assistance with religious influential to persuade their support for and contribution in HIV/AIDS prevention and treatment, and support programs for susceptible and high-risk factions.

Advocacy is also necessary by policy maker, authorities, and service providers at all ranks and in multiple sectors for the intention to:

1. Increase their awareness about the special HIV/AIDS-related requirements of susceptible and high-risk groups;

2. Gain their support for programs designed to set up those requirements; and

3. Ensure suitable attention to those requirements in central and district sectoral action and development plans (including consideration to legislation and conventions as necessary).

Make certain involvement of local communities for advocacy to persuade their support for and contribution in HIV/AIDS deterrence, treatment, and support initiatives for susceptible and high-risk groups, and to reduce discrimination and stigmatization aligned with these groups.

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to child for females. Prohibition of adultery, anal or oral sex, homosexuality, and masturbation is also a about basic sex education.

9. Preservation of Religious Values

Religion is an essential part of our society and people follows its values to a large extent. On this side we need to remove every kind of miscommunication regarding HIV/AIDS. We have to realize the people that AIDS is a disease and effected person is a patient. Patient is not capable of any hatred or any other discriminated attitudes rather care, support, and attention as Islam prescribes for any other patient.

By preserving Islamic values we become able to get many changes for the prevention of disease without discrimination or any other social behavior against AIDS patient.

10. Build Coordination with International Bodies Working on the Issue

Last but not the least point of consideration is that there must be a well-established coordination among government officials, NGOs, and international agencies of different organizations working on HIV/AIDS prevention and treatment. By this cooperation we can avail the practical exposure of those persons who have traveled many effected areas. So, their help in the light of international human rights law will lead us to the ultimate standards and norms for the betterment of people living with or effected by HIV/AIDS.

G. Conclusion

After the study this is being known that legal framework for the prevention and treatment of HIV/AIDS and for the protection of human rights of PLWHA is a basic requirement from any legislative body for better results to achieve international standards. Therefore, it is the need of the hour that AJK should carry out legislation on this particular issue in accordance to the guiding principles from international and regional context. This chapter strongly recommends a quick response in this regard. And finally concludes with a few minimum requirements for this legislation.

CONCLUSION

The sequence of the HIV/AIDS pandemic has demonstrated that public health struggle to control and prevent its increase is more feasible and be successful in public health terms. Such as; fall in HIV incidence, better condition of life for PLWHA and if programs and policies protect and assist human rights. PLWHA, their relatives and friends, their communities, international/national decision and policy makers, health professionals and the public at large all comprehend the elementary linkages between human rights and HIV/AIDS. The importance of bringing HIV/AIDS programs and policies to harmonize with international human rights law is largely acknowledged, but, unfortunately, seldom agreed in reality. Service providers, program managers and policy makers, must be more relaxed while using human rights standards and norms to lead and bound their measures in all forms distressing the response to HIV/AIDS. Supporters must feel more contented to use international human rights law in retaining these officials answerable when they become fading to do so.

The learning of human rights concepts and procedures requires building information and education through awareness promotions, as well as by set of courses for school learning and professional education. It will, moreover, necessitate information exchange and well-built collaboration connecting health workers/officials and those who work for human rights. When people become enough aware about human rights, they will recognize the problems for which the connection between HIV/AIDS and human rights treatment and prevention is significant, and act accordingly.

This study gives brief conclusions at the end of every chapter but here an overall conclusion will be set as follows. A composite study of all considerations on ethics in HIV/AIDS service delivery and research intended at developing medical codes of conduct and ethical practices strained that such achievement needs to be developed in all areas and to be sustained by an adequate legislation.

The following are the finale recommendations for a revision of the legislation. The existing laws, policies and codes of conduct, and their impact on creating an enabling environment to control the HIV/AIDS pandemic should be reviewed, a multisectoral committee including representatives of public private sector (population, health, women development education, youth, labor, uniformed personnel, tourism, human rights and law and PLWHAs and high risk groups) should be constituted to draft a legislation for a facilitating environment which will be presented at central level. Strong advocacy among policy makers and politicians should be developed on the need for implementing legislation to address discrimination and stigma, HIV/AIDS prevention and access to services for PLWHAs and vulnerable persons (IDUs, CSWs, migrants, sexual minorities, mobile and uniform groups, orphans, women, and children).

The vulnerability of women must be unquestionably acknowledged and addressed and resources for empowering them should be developed, religious scholars and community leaders should be concerned in modifying public attitudes.

A network of PLWHA organizations and a national association of PLWHA should be established to provide them a stronger voice. Information and awareness at all levels in the general population should be improved about the HIV pandemic in AJK, and the negative impact of stigma and discrimination on its control.

ANNEXES

ANNEX A

MEDICAL FACTS

AIDS is the end stage of infection with the human immunodeficiency virus (HIV-1and, less commonly, HIV-2). The virus was first isolated in 1983 and since 1985 HIV tests have been available. These generally test for antibodies to the virus, rather than the virus itself. The virus cannot be transmitted by casual contact.

The virus is transmitted through:

1. sexual intercourse;
2. re-use of contaminated needles and syringes, whether through medical procedures or injecting drug use;
3. breast-feeding from mother to child or prenatally; and
4. transfusion of contaminated blood or blood products.

Peaks of infectivity are thought to coincide with periods of high viral loads, during the initial acute stage of infection and the very end of the asymptomatic period.

Worldwide, sexual transmission accounts for about 75% of cases, and three-quarters of those are through heterosexual sex and one quarter through sex between men. The main barrier method to prevent transmission of HIV during penetrative sex is the traditional "male" condom, and the recently developed "female" condom. Work is still continuing on the development of an effective microbicide for vaginal and/or rectal administration to decrease the risk of HIV and STD transmission.[1]

It is critically important to develop prevention methods that are controlled by the receptive sexual partner to overcome barriers of negotiating safer sex where there is an imbalance of power. The presence of untreated symptomatic sexually transmitted

[1]UNAIDS, "Microbicides for HIV Prevention, "*Technical Update*, (Geneva: UNAIDS),April 1998.

diseases (e.g. herpes and syphilis) is a significant co-factor, as genital ulcers are thought to enhance the risk of transmission per exposure. An estimated 340 million new cases of infection with STDs occurred around the world in 1995 according to WHO estimates.[2]

After transmission, which is accompanied by a week or two of flu-like symptoms (the primary or acute stage), there is a "window period" of about 6 to 12 weeks when antibodies to the virus have not yet been produced.

HIV infection is asymptomatic for 10years on average, although this period may be as short as five to seven years in some developing countries because of generally poorer health and nutritional status, as well as lack of treatment for opportunistic infections like tuberculosis (which causes around 30% of all AIDS deaths).[3]

The disease then destroys the immune system in the vast majority of cases, leaving people vulnerable to opportunistic diseases (such as pneumonia and AIDS-associated cancers) which are usually fatal within 6 to 24months, depending on availability of treatment.

Although antiretroviral combination therapy[4] has had promising results in industrialized countries, it is far from afford able in most of the developing world at present.[5]

A.1. Recent Initiatives in Vaccine Development and Access toTreatment

The IPU Windhoek Resolution identified major concerns with delays in the development of a vaccine, and the gap between access to treatments between

[2] *The public health approach to STD control*, UNAIDS, Technical Update, May 1998.
[3] *HIV-related opportunistic diseases*, UNAIDS, Technical Update, October 1998.
[4] See *Access to drugs*, UNAIDS Technical Update, October 1998 and *Nine Guidance Modules on Antiretroviral Treatments*, WHO, Geneva, 1998.
[5] *Confronting AIDS: Public Priorities in a Global Epidemic*, A World Bank Policy Research Report, Oxford University Press, 1997, Chapter 1.

developed and developing countries. This section describes recent initiatives taken by UNAIDS and others to begin addressing these issues.

1. Vaccine Development

In developing countries, where 95% of HIV/AIDS cases have occurred, antiretroviral treatment is too expensive to be widely implemented, although some improvements inaccessibility have been made (see below). The development of a vaccine to prevent acquisition of HIV, or progression of disease in those already infected, is the most realistic means to stem the pandemic in the long term (with information, education, prevention and care programmes continuing in the meantime).

The development of a safe, effective and affordable vaccine is one of five global UNAIDS objectives, and several of the program's activities are directed towards achieving this urgent goal. UNAIDS advocates for the rapid development of vaccines appropriate for developing countries, and promotes their clinical evaluation, with the highest scientific and ethical standards. UNAIDS provides independent and authoritative scientific and ethical advice to countries considering the conduct of human trials.

As part of its normative role, UNAIDS has recently developed, through a nine-month process of broad consultation and consensus building involving 200 people from over30 countries, ethical guidelines for the conduct of these trials which complement the1993 CIOMS[6] and WHO International Ethical Guidelines for Biomedical Research Involving Human Subjects. Dr. *Peter Piot,* Executive Director of UNAIDS, said that the guidelines heralded a new era of cooperation and capacity-building between countries:

[6]Council for International Organizations of Medical Science.

> "We have come to a new era in which paternalism and resource imbalance is being replaced by empowerment indecision-making and equality in partnership between sponsors and hosts of scientific research."

UNAIDS also assists selected developing countries to build their capacity to conduct vaccine research activities. UNAIDS-sponsored National AIDS Vaccine Plans are being implemented in Brazil, Thailand and Uganda, and other countries are initiating the same process. These plans provide guidance on policy, procedures and specific recommendations for vaccine-related research. In addition to several Phase I/II vaccinetrials that have been conducted in the USA and Europe, several small-scale (Phase I/II) HIV vaccine trials have also been conducted in Brazil and Thailand, and will start shortly in Uganda. The first large-scale Phase III efficacy trial has started in Thailand, and is expected to start soon in the USA. All these activities are done in close collaboration and partnership with national authorities and scientists in developing countries, international AIDS-research bodies, the pharmaceutical industry, and NGOs such as the International AIDS Vaccine Initiative (IAVI).

At the Denver Summit of G8 nations there was agreement to act urgently in response to the challenge by the US President to develop a vaccine within a decade.[7] Similarly the Birmingham Summit of G8 nations pledged international effort to reduce the pandemic through vaccine development, preventative programmes, appropriate therapy and support for UNAIDS. IAVI has recently launched a campaign for the creation of a Global HIV Vaccine Purchase Fund and the World Bank is currently exploring different potential models.[8]

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[7]para 33, Denver Summit of the G8 Nations, Communique, 22 June 1997.
[8]*IAVI Newsletter*, Spring 1998, p.2. (http://www.iavi.org).

2. Drug Access Initiatives

UNAIDS launched the pilot phase of the HIV Drug Access Initiative in November1997 in four developing countries – Chile, Côte d'Ivoire, Uganda, and Viet Nam.

Distribution in the first two countries was announced at the 12th World AIDS Conference on 30 June 1998 where the conference theme was 'Bridging the Gap'. The Initiative is a public-private collaborative effort whereby the pilot countries will adapt their health-care infrastructures and drug-distribution systems to the HIV context to ensure effective use and distribution of treatment drugs, and participating pharmaceutical and diagnostic companies will subsidize purchase of the drugs. Although the pilot is limited to two years, ongoing evaluation will monitor its efficiency, the improvement in overall health-care delivery, the increased number of people receiving drugs, and the impact on HIV/AIDS illnesses and death rates. Once information is obtained about ways to address obstacles to ensure effective distribution of HIV/AIDS-related drugs in developing countries, countries will be in a better position to mobilize resources for treatment. The intention is that the collective experience will provide the basis for an action plan to widen access to HIV-related drugs in the developing world.

In 1997 550,000 infants acquired HIV infection prenatally or through breast-feeding. The rate of transmission is about 25%, but the ACTG 076 clinical trial of 1994 found that, where zidovudine was given to HIV-positive women in developed countries, the risk of transmission drops to about 8%.[9] This regimen is costly as it requires several months of treatment for the mother and infant, including intravenous doses during labor. In February 1998 the US Centers for Disease Control and Prevention

[9]Connor EM, Sperling RS, Gelber R, "Reduction of maternal-infant transmission of HIV-type 1 with zidovudine treatment", *New England Journal of Medicine* 331:(1994), 1173-1180.

(CDC)announced that a short oral course of zidovudine given late in pregnancy and during delivery reduced the rate of HIV transmission to infants of infected mothers by half and is safe for use in the developing world. The study was conducted in Thailand from1996 and was one of two CDC collaborative prenatal HIV prevention studies. The other study in Abidjan (Côte d'Ivoire) is continuing, but the placebo-control arm is no longer necessary and all women in the study are now offered the short-course zidovudine regimen.

At the 12th International AIDS Conference UNAIDS and two of its Cosponsors, UNICEF and WHO, announced their support for pilot projects to reduce mother to child transmission in 11 low-income countries in Africa, Asia and Latin America where women have high rates of HIV infection. The initiative will aim to provide voluntary and confidential counseling and testing for pregnant women, antiretroviral drugs for those who learn that they are infected, better birth care, counseling about choice and provision of safe infant feeding methods. It will also provide support for HIV-positive mothers who decide not to breastfeed, which may result in stigmatization (because of the visibility of such an act in developing countries, inferences can be drawn about the mother's HIV status). Glaxo Wellcome will provide the initial supply of zidovudine in the pilot projects that will seek to support approximately 30,000HIV-infected women in about 30 different sites over the next 12-18 months. As the initiative expands, the company will offer preferential pricing to the UN agency partners and others for use in developing countries.[10]

[10]UNAIDS *Press Release*, Geneva, 29 June 1998. Glaxo Wellcome announced in March 1998 that it will provide AZT at substantially reduced cost to HIV-positive pregnant women in developing countries.

ANNEX B

INTERNATIONAL GUIDELINES ON HIV/AIDS AND HUMAN RIGHTS

The Guidelines cover 12 thematic areas:

Guideline 1: National Framework
Guideline 2: Community Partnerships
Guideline 3: Public Health laws
Guideline 4: Criminal Law and Correctional Services
Guideline 5: Anti-discrimination laws
Guideline 6: Prevention, Treatment, Care and Support
Guideline 7: Legal Support Services
Guideline 8: Women, Children and Other Vulnerable Groups
Guideline 9: Changing Discriminatory Attitudes
Guideline 10: Public and Private Sector Support
Guideline 11: State Monitoring and Enforcement of Human Rights
Guideline 12: International Cooperation

B.1. INSTITUTIONAL RESPONSIBILITIES AND PROCESSES

Guideline 1: National Framework; *States should establish an effective national frameworkfor their response to HIV/AIDS which ensures a coordinated,participatory, transparent and accountableapproach, integrating HIV/AIDS policy and programmeresponsibilities, across all branches of Government.*

Depending upon existing institutions, the level of the epidemic and institutional cultures,as well as the need to avoid overlapping of responsibilities, the followingresponses should be considered:

(a) Formation of an inter-ministerial committee to ensure integrated development andhigh-level coordination of individual ministerial national action plans and tomonitor and implement the further HIV/AIDS strategies, as set out below. In federalsystems, an intergovernmental committee should also be established withprovincial/state, as well as national representation. Each ministry should ensurethat HIV/AIDS and human rights are integrated into all its relevant plans andactivities, including:education; law and justice, including police and corrective services; science and research; employment and public service; welfare, social security and housing; immigration, indigenous populations,

foreign affairs and development Cooperation; health; treasury and finance; and defense, including armed services.

(b) Ensuring that an informed and ongoing forum exists for briefing, policy discussionand law reform to deepen the level of understanding of the epidemic,in which all political viewpoints can participate at national and subnationallevels, e.g. by establishing parliamentary or legislative committees with representationfrom major and minor political parties.

(c) Formation or strengthening of advisory bodies to advise Government on legaland ethical issues, such as a legal and ethical subcommittee of the inter-ministerialcommittee. Representation should consist of professional (public health,legal and educational, scientific, biomedical and social), religious and communitygroups, employers' and workers' organizations, NGOs and ASOs,nominees/experts and people living with HIV/AIDS.

(d) Sensitization of the judicial branch of Government, in ways consistent withjudicial independence, on the legal, ethical and human rights issues related toHIV/AIDS, including through judicial education and the development of judicialmaterials.

(e) Ongoing interaction of government branches with United Nations ThemeGroups on HIV/AIDS and other concerned international and bilateral actors toensure that governmental responses to the HIV/AIDS epidemic will continueto make the best use of assistance available from the international community.Such interaction should, inter alia, reinforce cooperation and assistance toareas related to HIV/AIDS and human rights.

Guideline 2: Supporting community partnership; *States should ensure, through political and financial support, that community consultation occurs in allphases of HIV/AIDS policy design, programme implementationand evaluation and that community organizationsare enabled to carry out their activities,including in the fields of ethics, law and human rights,effectively.*

(a) Community representation should comprise PLWHAs, CBOs, humanrights NGOs and representatives of vulnerable groups. Formal and regularmechanisms should be established to facilitate ongoing dialogue with andinput from such community representatives into HIV-related government policiesand programmes. This could be established through regular reporting bycommunity representatives to the various governments, parliamentary and judicial branches described in Guideline 1, joint workshops with community representativeson policy, planning and evaluation of Stateresponses and throughmechanisms for receiving written submissions from the community.

(b) Sufficient government funding should be allocated in order to support, sustainand enhance community organizations in areas of core support, capacitybuildingand implementation of activities, including in areas concerning HIVrelatedethics, human rights and law. Such activities might involve trainingseminars, workshops, networking, developing promotional and educationalmaterials, advising clients of their human and legal rights, referring clients torelevant grievance bodies, collecting data on human rights issues and humanrights advocacy.

B.2. Law Review, Reform and Support Services

Guideline 3: Public health legislation; *States should review and reform public health legislationto ensure that they adequately address the publichealth issues raised by HIV/AIDS, that their provisionsapplicable to casually transmitted diseases are not inappropriatelyapplied to HIV/AIDS and that they are consistentwith international human rights obligations.*

Public health legislation should contain the following components:

(a) Public health law should fund and empower public health authorities to provide acomprehensive range of services for the prevention and treatment of HIV/AIDS,including relevant information and education, access to voluntary testing and counseling,STD and sexual and reproductive health services for men and women, condomsand drug treatment, services and clean injection materials, as well as adequatetreatment for HIV/AIDS-related illnesses, including pain prophylaxis.

(b) Apart from surveillance testing and other unlinked testing done for epidemiologicalpurposes, public health legislation should ensure that HIV testing of individualsshould only be performed with the specific informed consent of that individual.Exceptions to voluntary testing would need specific judicial authorization,granted only after due evaluation of the important privacy and liberty considerationsinvolved.

(c) In view of the serious nature of HIV testing and in order to maximize preventionand care, public health legislation should ensure, whenever possible, that pre- andpost-test counseling is provided in all cases. With the introduction of home-testing,States should ensure quality control, maximize counseling and referral servicesfor those who use such tests and establish legal and support services for thosewho are the victims of misuse of such tests by others.

(d) Public health legislation should ensure that people are not subjected to coercivemeasures such as isolation, detention or quarantine on the basis of their HIV status.Where the liberty of persons living with HIV is restricted due to their illegal behavior,due process protections (e.g. notice, rights of review/appeal, fixed rather thanindeterminate periods of orders and rights of representation) should be guaranteed.

(e) Public health legislation should ensure that HIV and AIDS cases reported to publichealth authorities for epidemiological purposes are subject to strict rules ofdata protection and confidentiality.

(f) Public health legislation should ensure that information related to the HIV statusof an individual is protected from unauthorized collection, use or disclosure in thehealth-care and other settings, and that the use of HIV-related information requiresinformed consent.

(g) Public health legislation should authorize, but not require, that health-care professionalsdecide, on the basis of each individual case and ethical considerations, toinform their patients' sexual partners of the HIV status of their patient. Such adecision should only be made in accordance with the following criteria:the HIV-positive person in question has been thoroughly counseled; counseling of the HIV-positive person has failed to achieve appropriate behavioral changes; the HIV-positive person has refused to notify, or consent to the notification ofhis/her partner(s); a real risk of HIV transmission to the partner(s) exists; the HIV-positive person is given reasonable advance notice; the identity of the HIV-positive person is concealed from the partner(s), if thisis practically possible; and follow-up is provided to ensure support to those involved, as necessary.

(h) Public health legislation should ensure that the blood/tissue/organ supply is freeof HIV and other blood-borne pathogens.

(i) Public health law should require the implementation of universal infection controlprecautions in health-care and other setting involving exposure to blood and otherbodily fluids; persons working in these settings must be provided with the appropriateequipment and training to implement such precautions.

(j) Public health legislation should require that health-care workers undergo a minimumof ethics and/or human rights training in order to be licensed to practice andshould encourage professional societies of health-care workers to develop andenforce codes of conduct based on human rights and ethics, including HIV-relatedissues such as confidentiality and the duty to provide treatment.

Guideline 4: Criminal laws and correctional systems; *States should review and reform criminal laws and correctionalsystems to ensure that they are consistentwith international human rights obligations and are notmisused in the context of HIV/AIDS or targeted againstvulnerable groups.*

(a) Criminal and/or public health legislation should not include specific offencesagainst the deliberate and intentional transmission of HIV but rather shouldapply general criminal offences to these exceptional cases. Such applicationshould ensure that the elements of foreseeability, intent, causality and consentare clearly and legally established to support a guilty verdict and/or harsherpenalties.

(b) Criminal law prohibiting sexual acts (including adultery, sodomy, fornicationand commercial sexual encounters) between consenting adults in private shouldbe reviewed, with the aim of repeal. In any event, they should not be allowed toimpede provision of HIV/AIDS prevention and care services.

(c) With regard to adult sex work that involves no victimization, criminal lawshould be reviewed with the aim to decriminalize, and then legally regulate occupationalhealth and safety conditions to protect sex workers and their clients,including support for safe sex during sex work. Criminal law should not impedeprovision of HIV/AIDS prevention and care services to sex workers and theirclients. Criminal law should ensure that children and adult sex workers whohave been trafficked or otherwise coerced into sex work are protected from participationin the sex industry and are not prosecuted for such participation butrather are removed from sex work and provided with medical and psychosocialsupport services, including those related to HIV.

(d) Criminal law should not be an impediment to measures taken by States to reducethe risk of HIV transmission among injecting drug users and to provide HIV relatedcare and treatment for injecting drug users. Criminal law should bereviewed to consider:The authorization or legalization and promotion of needle and syringeexchange programmes; the repeal of laws criminalizing the possession, distribution and dispensingof needles and syringes.

(e) Prison authorities should take all necessary measures, including adequate staffing,effective surveillance and appropriate disciplinary measures, to protect prisoners from rape, sexual violence and coercion. Prison authorities should also provideprisoners (and prison staff, as appropriate), with access to HIV-related preventioninformation, education, voluntary testing and counseling, means of prevention(condoms, bleach and clean injection equipment), treatment and care and voluntaryparticipation in HIV-related clinical trials, as well as should ensure confidentiality,and should prohibit

mandatory testing, segregation and denial of access toprison facilities, privileges and release programmes for HIV positive prisoners.Compassionate early release of prisoners living with AIDS should be considered.

Guideline 5: Antidiscrimination and protective laws; *States should enact or strengthen antidiscriminationand other protective laws that protect vulnerablegroups, people living with HIV/AIDS and people withdisabilities from discrimination in both the public andprivate sectors, that will ensure privacy and confidentialityand ethics in research involving human subjects,emphasize education and conciliation and provide forspeedy and effective administrative and civil remedies.*

(a) General antidiscrimination laws should be enacted or revised to cover people livingwith asymptomatic HIV infection, people living with AIDS and those merelysuspected of HIV or AIDS. Such laws should also protect groups made more vulnerableto HIV/AIDS due to the discrimination they face. Disability laws shouldalso be enacted or revised to include HIV/AIDS in their definition of disability.Such legislation should include the following:The areas covered should be as broad as possible, including health care, socialsecurity, welfare benefits, employment, education, sport, accommodation,clubs, trade unions, qualifying bodies, access to transport and other services;Direct and indirect discrimination should be covered, as should cases whereHIV/AIDS is only one of several reasons for a discriminatory act, and prohibitingHIV/AIDS vilification should also be considered;Independent, speedy and effective legal and/or administrative procedures forseeking redress, containing such features as fast-tracking for cases where thecomplainant is terminally ill, investigatory powers to address systemic cases of discrimination in policies and procedures, ability to bring cases under pseudonymand representative complaints, including the possibility of public interestorganizations bringing cases on behalf of people living with HIV/AIDS;Exemptions for superannuation and life insurance should only relate to reasonableactuarial data, so that HIV/AIDS is not treated differently from analogousmedical conditions.

(b) Traditional and customary laws which affect the status and treatment of variousgroups of society should be reviewed in the light of antidiscrimination laws. Ifnecessary, these should be reformed to promote and protect human rights, so thatlegal remedies are made available, if such laws are misused, and information, educationand community mobilization campaigns are conducted to change theselaws and attitudes associated with them.

(c) General confidentiality and privacy laws should be enacted. HIV-related informationon individuals should be included within definitions of personal/medical datasubject to protection and should prohibit the

unauthorized use and/or publicationof HIV-related information on individuals. Privacy legislation should enable anindividual to see his or her own records and to request amendments to ensure thatsuch information is accurate, relevant, complete and up-to-date. An independentagency should be established to redress breaches of confidentiality. Provisionshould be made for professional bodies to discipline cases of breaches of confidentialityas professional misconduct under codes of conduct discussed below.Unreasonable invasion of privacy by the media could also be included as a componentof professional codes governing journalists. People living with HIV/AIDSshould be authorized to demand that their identity and privacy are protected inlegal proceedings in which information on these matters will be raised.

(d) Laws, regulations and collective agreements should be enacted or reached so as toguarantee the following workplace rights:a national policy on HIV/AIDS and the workplace agreed upon in a tripartitebody; freedom from HIV screening for employment, promotion, training or benefits; confidentiality regarding all medical information, including HIV/AIDS status; employment security for workers living with HIV until they are no longerable to work, including reasonable alternative working arrangements; defined safe practices for first aid and adequately equipped first-aid kits; protection for social security and other benefits for workers living with HIV,including life insurance, pension, health insurance, termination and death benefits adequate health care accessible in or near the workplace; adequate supplies of condoms available free to workers at the workplace; workers' participation in decision-making on workplace issues related toHIV/AIDS; access to information and educafion programmes on HIV/AIDS, as well as torelevant counseling and appropriate referral;protection from stigmatization and discrimination by colleagues, unions,employers and clients; appropriate inclusion in workers' compensation legislation of the occupationaltransmission of HIV (e.g. needle-stick injuries), addressing such mattersas the long latency period of infection, testing, counseling and confidentiality.

(e) Protective laws governing the legal and ethical protection of human participationin research, including HIV-related research, should be enacted or strengthened inrelation to:non-discriminatory selection of participants, e.g. women, children, minorities; informed consent; confidentiality of personal information; equitable access to information and benefits emanating from research; counseling, protection from discrimination, health and support services provided; during and after participation; the establishment of local and/or national ethical review committees to ensureindependent and ongoing ethical review, with participation by members of thecommunity affected, of the research project;approval for use of safe and efficacious pharmaceuticals, vaccines and medicaldevices.

(f) Antidiscrimination and protective laws should be enacted to reduce human rightsviolations against women in the context of HIV/AIDS, so as to reduce vulnerabilityof women to infection by HIV and to the impact of HIV/AIDS. In particular,laws should be reviewed and reformed to ensure equality of women regardingproperty and marital relations and access to employment and economic opportunity, so that discriminatory limitations are removed on rights to own and inheritproperty, enter into contracts and marriage, obtain credit and finance, initiate separationor divorce, equitably share assets upon divorce or separation, and retaincustody of children. Laws should also be enacted to ensure women's reproductiveand sexual rights, including the right of independent access to reproductive andSTD health information and services and means of birth control, including safeand legal abortion and the freedom to choose among these, the right to determinenumber and spacing of children, the right to demand safer sex practices and theright to legal protection from sexual violence, outside and inside marriage, includinglegal provisions for marital rape. The age of consent to sex and marriageshould be consistent for males and females and the right of women and girls torefuse marriage and sexual relations should be protected by law. The HIV statusof a parent or child should not be treated any differently from any other analogousmedical condition in making decisions regarding custody, fostering or adoption.

(g) Antidiscrimination and protective laws should be enacted to reduce human rightsviolations against children in the context of HIV/AIDS, so as to reduce the vulnerabilityof children to infection by HIV and to the impact of HIV/AIDS. Such lawsshould provide for children's access to HIV-related information, education andmeans of prevention inside and outside school, govern children's access to voluntarytesting with consent by the child or by the parent or appointed guardian, as appropriate,should protect children against mandatory testing, particularly if orphaned byHIV/AIDS, and provide for other protections in the context of orphans, includinginheritance and/or support. Such legislation should also protect children against sexualabuse, provide for their rehabilitation if abused and ensure that they are consideredvictims of wrongful behavior, not subject to penalties themselves. Protectionin the context of disability laws should also be ensured for children.

(h) Antidiscrimination and protective laws should be enacted to reduce human rightsviolations against men having sex with men, including in the context ofHIV/AIDS, in order, inter alia, to reduce the vulnerability of men who have sexwith men to infection by HIV and to the impact of HIV/AIDS. These measuresshould include providing penalties for vilification of people who engage in same sexrelationships, giving legal recognition to same-sex marriages and/or relationshipsand governing such relationships with consistent property, divorce andinheritance provisions. The age of consent to sex and marriage should be consistentfor heterosexual and homosexual relationships.

Laws and police practicesrelating to assaults against men who have sex with men should be reviewed toensure that adequate legal protection is given in these situations.

(i) Laws and regulations that provide for restrictions on the movement or associationof members of vulnerable groups in the context of HIV/AIDS should be removedin both
law (decriminalized) and law enforcement.

(j) Public health, criminal and antidiscrimination legislation should prohibit mandatoryHIV testing of targeted groups, including vulnerable groups.

Guideline 6:Regulation of goods, services and information; *States should enact legislation to provide for the regulationof HIV-related goods, services and information,so as to ensure widespread availability of qualitativeprevention measures and services, adequate HIV preventionand care information and safe and effectivemedication at an affordable price.*

(a) Laws and/or regulations should be enacted to enable implementation of a policyof widespread provision of information about HIV/AIDS through the mass media.This information should be aimed at the general public, as well as at various vulnerablegroups that may have difficulties in accessing such information.HIV/AIDS information should be effective for its designated audience and not beinappropriately subject to censorship or other broadcasting standards.

(b) Laws and/or regulations should be enacted to ensure the quality and availability ofHIV tests and counseling. If home tests and/or rapid HIV test kits are permittedon the market, they should be strictly regulated to ensure quality and accuracy. Theconsequences of loss of epidemiological information, the lack of accompanyingcounseling and the risk of unauthorized uses, such as for employment or immigration,should also be addressed. Legal and social support services should beestablished to protect individuals from abuses arising from such testing.

(c) Legal quality control of condoms should be enforced and compliance with theInternational Condom Standard should be monitored in practice. Restrictionson the availability of preventive measures, such as condoms, bleach, cleanneedles and syringes, should be repealed and the provision of these throughvending machines in appropriate locations should be considered, in the lightof the increased accessibility and anonymity afforded to clients by this methodof distribution.

(d) Duties, customs laws and value-added taxes should be revised so as to maximizeaccess to safe and effective medication at an affordable price.

(e) Consumer protection laws or other relevant legislation should be enacted orstrengthened to prevent fraudulent claims regarding the safety and efficacy ofdrugs, vaccines and medical devices, including those relating to HIV/AIDS.

Guideline 7: Legal support services;*States should implement and support legal support services*

that will educate people affected by HIV/AIDS abouttheir rights, provide free legal services to enforce thoserights, develop expertise on HIV-related legal issues andutilize means of protection in addition to the courts,such as offices of Ministries of Justice, ombudspersons,health complaint units and human rights commissions.

States should consider the following features in establishing such services:

(a) State support for legal aid systems specializing in HIV/AIDS casework, possiblyinvolving community legal aid centers and/or legal service services based in ASOs;
(b) State support or inducements (e.g. tax reduction) to private sector law firms toprovide free pro bono services to PLWHAs in areas such as antidiscrimination anddisability, health care rights (informed consent and confidentiality), property(wills, inheritance) and employment law;
(c) State support for programmes to educate, raise awareness and build self-esteemamong PLWHAs concerning their rights and/or to empower them to draft and disseminatetheir own charters/declarations of legal and human rights; State supportfor production and dissemination of HIV/AIDS legal rights brochures, resourcepersonnel directories, handbooks, practice manuals, student texts, model curriculafor law courses and continuing legal education, and newsletters to encourageinformation exchange and networking should also be provided. Such publicationscould report on case law, legislative reforms, national enforcement and monitoringsystems for human rights abuses;
(d) State support for HIV legal services and protection through a variety of offices,such as Ministries of Justice, procurator and other legal offices, health complaintunits, ombudspersons and human rights commissions.

B.3. PROMOTION OF A SUPPORTIVE AND ENABLING ENVIRONMENT

Guideline 8:Women, children and other vulnerable groups; *States should, in collaboration with and through thecommunity, promote a supportive and enabling environmentfor women, children and other vulnerablegroups by addressing underlying prejudices andinequalities through community dialogue, speciallydesigned social and health services and support tocommunity groups.*

a. States should support the establishment and sustainability of community associationscomprised of members of different vulnerable groups for peer education,empowerment, positive behavior change and social support.

b. States should support the development of adequate, accessible and effective HIVrelatedprevention and care education, information and services by and for vulnerablecommunities and should actively involve these communities in the designand implementation of these programmes.

c. States should support the establishment of national and local forums to examinethe impact of the HIV/AIDS epidemic on women. They should be multisectoral toinclude government, professional, religious and community representation andleadership and examine issues such as:the role of women at home and in public life; the sexual and reproductive rights of women and men, including women'sability to negotiate safer sex and make reproductive choices; strategies for increasing educational and economic opportunities for women; sensitizing service deliverers and improving health care and social supportservices for women; and the impact of religious and cultural traditions on women.

d. States should implement the Cairo Programme of Action of the InternationalConference on Population and Development and the Beijing Declaration andPlatform for Action of the Fourth World Conference on Women. In particular, primaryhealth services, programmes and information campaigns should contain agender perspective. Harmful traditional practices, including violence againstwomen, sexual abuse, exploitation, early marriage and female genital mutilation,should be eliminated. Positive measures, including formal and informal educationprogrammes, increased work opportunities and support services, should be established.

e. States should support women's organizations to incorporate HIV/AIDS andhuman rights issues into their programming.

f. States should ensure that all women and girls of child-bearing age have access toaccurate and comprehensive information and counseling about the prevention ofHIV transmission and the risk of vertical transmission of HIV, as well as access tothe available resources to minimize that risk, or to proceed with childbirth, if theyso choose.

g. States should ensure the access of children and adolescents to adequate healthinformation and education, including information related to HIV/AIDS preventionand care, inside and outside school, which is tailored appropriately to age level andcapacity and enables them to deal positively and responsibly with their sexuality.Such information should take into account the rights of the child to access to information,privacy, confidentiality, respect and informed consent and means of prevention,as well as the responsibilities, rights and duties of parents. Efforts to educatechildren about their rights should include the rights of persons, including children,living with HIV/AIDS.

h. States should ensure that children and adolescents have adequate access to confidentialsexual and reproductive health services, including HIV/AIDS information,counseling, testing and prevention measures such as condoms, and to social supportservices if affected by HIV/AIDS. The provision of these services to children/adolescents should reflect the appropriate balance between the rights of thechild/adolescent to be involved in decision-making according to his or her evolvingcapabilities and the rights and duties of parents/guardians for the health andwell-being of the child.

i. States should ensure that child care agencies, including adoption and foster carehomes, are trained with regard to HIV-related children's issues in order to be ableto take into account the special needs of HIV-affected children and protect themfrom mandatory testing, discrimination and abandonment.

j. States should support the implementation of specially designed and targeted HIVprevention and care programmes for those who have less access to mainstreamprogrammes due to language, poverty, social or legal or physical marginalization,e.g. minorities, migrants, indigenous peoples, refugees and internally displacedpersons, people with disabilities, prisoners, sex workers, men having sex with menand injecting drug users.

Guideline 9: Changing discriminatory attitudesthrough education, training and the media; *States should promote the wide and ongoing distributionof creative education, training and media programmesexplicitly designed to change attitudes of discriminationand stigmatization associated withHIV/AIDS to understanding and acceptance.*

(a) States should support appropriate entities, such as media groups, NGOs and networksof PLWHAs, to devise and distribute programming to promote respect forthe rights and dignity of PLWHAs and members of vulnerable groups, using abroad range of media (film, theatre, television, radio, print, dramatic presentations,personal testimonies, Internet, pictures, bus posters). Such programmingshould not compound stereotypes about these groups but instead dispel myths andassumptions about them by depicting them as friends, relatives, colleagues, neighborsand partners. Reassurance concerning the modes of transmission of thevirus and the safety of everyday social contact should be reinforced.

(b) States should encourage educational institutions (primary and secondary schools,universities and other technical or tertiary colleges, adult and continuing education),as well as trade unions and workplaces to include HIV/AIDS and humanrights/non-discrimination issues in relevant curricula, such as human relationships,citizenship/social studies, legal studies, health care, law enforcement, familylife and/or sex education, and welfare/counseling courses.

(c) States should support HIV-related human rights/ethics training/workshops forgovernment officials, police, prison staff, politicians, as well as village, communityand religious leaders and professionals.

(d) States should encourage the media and advertising industries to be sensitive toHIV/AIDS and human rights issues and to reduce sensationalism in reporting andinappropriate use of stereotypes, especially in relation to disadvantaged and vulnerable groups. Included in such training should be the production of usefulresources, such as handbooks containing appropriate terminology, to eliminateuse of stigmatizing language and a professional code of behavior to ensurerespect for confidentiality and privacy.

(e) States should support targeted training, peer education and information exchangefor PLWHA staff and volunteers of CBOs and ASOs and leaders of vulnerablegroups to raise their awareness of human rights and the means to enforce them.Conversely, education and training should be provided on HIV-specific humanrights issues to those working on other human rights issues.

(f) States should support the use of alternative efforts such as radio programmes orfacilitated group discussions to overcome access problems for individuals whoare located in remote or rural areas, illiterate, homeless or marginalized, withoutaccess to television, films and videos, and specific ethnic minority languages.

Guideline 10:Development of public and private sector standardsand mechanisms for implementing these standards; *States should ensure that Government and the privatesector develop codes of conduct regarding HIV/AIDSissues that translate human rights principles into codesof professional responsibility and practice, with accompanyingmechanisms to implement and enforce thesecodes.*

(a) States should require or encourage professional groups, particularly health-careprofessionals, and other private sector industries (e.g. law, insurance) to developand enforce their own codes of conduct addressing human rights issues in thecontext of HIV/AIDS. Relevant issues would include confidentiality, informedconsent to testing, the duty to treat, the duty to ensure safe workplaces, reducingvulnerability and discrimination and practical remedies for breaches/misconduct.

(b) States should require individual government portfolios to articulate how HIVrelatedhuman rights standards are met in their own policies and practices, as wellas in formal legislation and regulations, at all levels of service delivery.Coordination of these standards should occur in the national frameworkdescribed in Guideline 1 and be publicly available, after involvement of communityand professional groups in the process.

(c) States should develop or promote multisectoral mechanisms to ensure accountability.This involves the equal participation of all concerned (i.e. governmentagencies, industry representatives, professional associations, NGOs, consumers,service providers and service users). The common goal should be to raise standardsof service, strengthen linkages and communication and assure the free flowof information.

Guideline 11:State monitoring and enforcement of human rights; *States should ensure monitoring and enforcementmechanisms to guarantee HIV-related human rights,including those of people living with HIV/AIDS, theirfamilies and communities.*

(a) States should collect information on human rights and HIV/AIDS and, using thisinformation as a basis for policy and programme development and reform, reporton HIV-related human rights issues to the relevant United Nations treaty bodies aspart of their reporting obligations under human rights treaties.

(b) States should establish HIV/AIDS focal points in relevant government branches,including national AIDS programmes, police and correctional departments, thejudiciary, government health and social service providers and the military, formonitoring HIV-related human rights abuses and facilitating access to thesebranches for disadvantaged and vulnerable groups. Performance indicators orbenchmarks showing specific compliance with human rights standards should bedeveloped for relevant policies and programmes.

(c) States should provide political, material and human resources support to ASOsand CBOs for capacity-building in human rights standards development and monitoring.States should provide human rights NGOs with support for capacitybuildingin HIV-related human rights standards and monitoring.

(d) States should support the creation of independent national institutions for the promotionand protection of human rights, including HIV-related rights, such ashuman rights commissions and ombudspersons, and/or appoint HIV/AIDSombudspersons to existing or independent human rights agencies, national legalbodies and law reform commissions.

(e) States should promote HIV-related human rights in international forums andensure that they are integrated into the policies and programmes of internationalorganizations, including in United Nations human rights bodies, as well as inother agencies of the United Nations system. Furthermore, States should provideintergovernmental organizations with the material and human resources requiredto work effectively in this field.

Guideline 12: International cooperation; *States should cooperate through all relevant programmesand agencies of the United Nations system,including UNAIDS, to share knowledge and experienceconcerning HIV-related human rights issues, andshould ensure effective mechanisms to protect humanrights in the context of HIV/AIDS at the internationallevel.*

(a) The Commission on Human Rights should take note of the present Guidelinesand of the report on the Second International Consultation on HIV/AIDS andHuman Rights and request States to carefully consider and

implement theGuidelines in their national, subnational and local responses to HIV/AIDS andhuman rights.

(b) The Commission on Human Rights should request human rights treaty bodies,special reporters and representatives and its working groups to take note ofthe Guidelines and include in their activities and reports all issues arising underthe Guidelines relevant to their mandates.

(c) The Commission on Human Rights should request UNAIDS, its Cosponsors(UNICEF, UNDP, UNFPA, UNDCP, UNESCO, WHO and the World Bank) andother relevant United Nations bodies and agencies to integrate the promotion ofthe Guidelines throughout their activities.

(d) The Commission on Human Rights should appoint a special reporter onhuman rights and HIV/AIDS with the mandate, inter alia, to encourage andmonitor implementation of the Guidelines by States, as well as their promotionby the United Nations system, including

human rights bodies, where applicable.

(e) The Commission on Human Rights should encourage the United Nations HighCommissioner/Centre for Human Rights to ensure that the Guidelines are disseminatedthroughout his Office and the Centre and are incorporated into all itshuman rights activities and programmes, particularly those involving technicalcooperation, monitoring and support to human rights bodies and organs.

(f) States, in the framework of their periodic reporting obligations to United Nationstreaty monitoring bodies and under regional conventions, should report on theirimplementation of the Guidelines and other relevant HIV/AIDS-related humanrights concerns arising under the various treaties.

(g) States should ensure, at the country level, that their cooperation with UN ThemeGroups on HIV/AIDS includes promotion and implementation of the Guidelines,including the mobilization of sufficient political and financial support for suchimplementation.

(h) States should work in collaboration with UNAIDS, the United Nations HighCommissioner for Human Rights and nongovernmental and other organizationsworking in the field of human rights and HIV/AIDS to:support translation of the Guidelines into national and minority languages; create a widely accessible mechanism for communication and coordinationfor sharing information on the Guidelines and HIV-related human rights; support the development of a resource directory on international declarations/treaties, as well as policy statements and reports on HIV/AIDS andhuman rights, to strengthen support for the implementation of the Guidelines; support

multicultural education and advocacy projects on HIV/AIDS andhuman rights, including educating human rights groups on HIV/AIDS andeducating HIV/AIDS service organizations and vulnerable groups on humanrights issues, and strategies for monitoring and protecting human rights in thecontext of HIV/AIDS, using the Guidelines as an educational tool; support the creation of a mechanism to allow existing human rights organizationsand HIV/AIDS organizations to work together strategically to promoteand protect the human rights of people living with HIV/AIDS and thosevulnerable to infection, including through implementation of the Guidelines; support the creation of a mechanism to monitor and publicize human rightsabuses in the context of HIV/AIDS; support the development of a mechanism to mobilize grass-roots responses toHIV-related human rights and implementation of the Guidelines, includingexchange programmes and training among different communities, bothwithin and across regions; advocate that religious and traditional leaders take up HIV-related humanrights concerns and become part of the implementation of the Guidelines; support the development of a manual that would assist human rights andAIDS service organizations in advocating for the implementation of theGuidelines; support the identification and funding of NGOs and ASOs at country level tocoordinate a national NGO response to promote the Guidelines; support, through technical and financial assistance, national and regionalNGO networking initiatives on ethics, law and human rights to enable themto disseminate the Guidelines and advocate for their implementation.

(i) States, through regional human rights mechanisms, should promote the disseminationand implementation of the Guidelines and their integration into the work ofthese bodies.

ANNEX C

THE HIV & AIDS PREVENTION, AND TREATMENT ACT, 2007

An Act to prevent the HIV from becoming established amongst general population, particularly in most-at-risk and vulnerable populations, and to provide for the care, support and treatment of persons living with HIV and with AIDS.

WHEREAS, there is a need to prevent the HIV from becoming established general population, particularly in vulnerable populations; to provide for the care, support and treatment of persons living with HIV and AIDS; to protect vulnerable populations against stigma and discrimination on the basis of their HIV status; and to provide for increasing and scaling up prevention, care, support and treatment programs.

AND WHEREAS, discrimination on the basis of HIV status creates and sustains conditions leading to societal vulnerability for HIV infection.

AND WHEREAS, there is a need to reduce risk of HIV infection among vulnerable populations, including preventing its transmission into the general population;

AND WHEREAS, it is expedient to consolidate, amend, and enact a law to give effect to all the national and international endeavors in this respect; and to amend laws for the purposes hereafter appearing;

It is hereby enacted as follows:

CHAPTER I
PRELIMINARY

1. Short Title, Extent and Commencement.

(1). This Act may be called the HIV & AIDS Prevention, and Treatment Act, 2006.

(2) It extends to the whole of Pakistan.

(3) It shall come into force at once.

2. Definitions. In this Act, unless there is anything repugnant in the subject or context,

(a) "AIDS" means Acquired Immune Deficiency Syndrome, and is a condition characterized by a combination of signs and symptoms, caused by HIV, which attacks and weakens the body's immune system making the HIV-positive person susceptible to other life threatening conditions, or as may be defined by the National AIDS Commission from time to time;

(b) "blood bank" includes private, Government or Armed Forces blood banks maintained for the purpose of receiving, preserving, storing, analyzing and processing blood and blood products;

(c) "Children" or "Child" means a person up to the age of 18 years;

(d) Commission" or "National AIDS Commission" means the National AIDS Commission constituted under section 4;

(e) "discrimination" includes any act or omission including a policy, law, rule, practice, custom, tradition, usage, condition or situation which directly or indirectly, expressly or by effect, immediately or over a period of time imposes burdens, obligations, liabilities, disabilities or disadvantages on, or denies or withholds benefits, opportunities or advantages, from, or compels or forces the adoption of a particular course of action by any person or category of persons, based solely on a person's HIV status, actual or perceived;

(f) "health care facility" or "health care facilities" means any basic health unit, rural health centre, any hospital including a Tehsil, District, or a teaching hospital, and any private medical facility, supervised by a medical practitioner;

(g) "health workers" means any person providing services as a medical practitioner, homeopath practitioner, nurse, nutritionist, midwife, traditional birth attendant, pharmacist or dispensing chemist, hospital administrator or employee, whether professional or not, paid or not, and any other person providing such services as may be notified by the Federal Government in the official Gazette;

(h) "HIV" means 'human immunodeficiency virus', the virus that causes AIDS in humans, by infecting the cells of .the human immune

system and destroying their function, resulting in the progressive depletion of the immune system;

(i) "HIV-positive" means the presence of HIV infection as documented by the presence of HIV or HIV antibodies in the sample being tested;

(j) "HIV screening" means a systematic application of a medical procedure or answering questions or be otherwise being interviewed to determine the presence or absence of HIV or HIV antibodies to a defined population for a broad public health purpose;

(k) "HIV test" means a medical procedure used to determine the presence or absence of HIV or HIV antibodies in an individual, administered typically for diagnostic or clinical purposes;

(l) "HIV transmission" refers to the transfer of HIV from the infected person to an uninfected individual, most commonly, but not limited to, through sexual intercourse, blood transfusion, sharing of intravenous needles and during pregnancy;

(m) "HIV and AIDS prevention harm reduction services" means all quality assured, trained measures designed to mitigate the risk of HIV infection and other health, social, economic consequences of illicit drug taking and other behaviors, including:

(i) distribution of sterile needles, syringes and other equipment;

(ii) taking-in of used needles and syringes, and other equipment;

(iii) condom promotion and distribution, with education and information on their use;

(iv) information and promotion of VCT (Voluntary Counseling & Testing), and referrals for treatment of opportunistic infections and for ART (Anti-Retroviral Therapy);

(v) establishment and operation of drug treatment facilities;

(vi) establishment of drug substitution therapy programs;

(vii) referral for drug treatment and rehabilitation referral, including for drug substitution therapies and other treatments;

(viii) referral for STI (sexually transmitted infections) education, and referral for STI treatment; and

(ix) establishment of 'drop in' and mobile outreach centers for the Most at Risk Populations

(n) "informed consent" means voluntary and continuing permission of the person, whether written or verbal, or if the person is a minor, his guardian, for assessment or to receive a particular treatment based on an adequate knowledge of the purpose, nature, likely effects, and risks of that treatment, including the

likelihood of its success and any alternatives to it and the cost of treatment;

(n) "involuntary HIV Testing" refers to HIV testing imposed upon a person attended or characterized by the lack of consent, use of physical force, intimidation or any form of compulsion;

(o) "Most at Risk Populations" means populations at disproportionately high risk of HIV infection, whose members and their families often experience a lack of human rights protection, such as discrimination and/ or are otherwise marginalized by their legal or other status, which consequently may dis-empower members of these populations to avoid seeking HIV tests and other HIV infection prevention measures and to cope with HIV/ AIDS, if affected by it;

Explanation: Such populations include but are not limited to, injecting drug users, female sex workers, men who have sex with men, women vulnerable and at risk for HIV infection, children, adolescents, migrants, refugees, and internally displaced persons, people with disabilities, long distance truckers, and prisoners.

(p) "people living with HIV/AIDS" means people living with asymptomatic HIV infection, people living with AIDS and those merely suspected of HIV or AIDS;

(q) "person" means one or more individuals, partnerships, associations, unincorporated organizations, companies, cooperatives, trustees, agents or any group of persons;

(r) "prescribed" means prescribed by rules;

(s) "Provincial AIDS Commissions" means the Provincial AIDS Commissions constituted under section 4;

(t) "rules" means rules made under this Act;

(u) "post-test counseling" refers to the process of providing to the person who took the HIV test, at the time that the test result is released, risk-reduction information, partner notification and emotional support counseling, referral to relevant NGOs and establishments dealing with the issue of HIV, and other social and health safety net mechanisms;

(v) "pre-test counseling" means the process of providing individual information on the biomedical aspects of HIV/ AIDS and emotional support to any psychological implications of undergoing HIV testing and the test result itself before the person takes the test;

(w) " safe blood" means human blood or blood product which is healthy and free from HIV, Hepatitis B and C viruses or other viruses or infective agents, like malarial parasites and treponemapallidum (syphilis) and/ or such other viruses or

infective agents as the Federal Government may, by notification in the official Gazette, specify;

(x) "universal precautions" means infection control measures that prevent exposure to or reduce the risk of transmission of pathogenic agents including HIV and includes education, training, personal protective equipment such as gloves, gowns and masks, hand washing, and employing safe work practices; and

(y) "voluntary HIV testing" refers to HIV testing done on an individual who, after having undergone pre-test counseling, willingly submits himself to such test.

CHAPTER II
ESTABLISHMENT OF NATIONAL AND PROVINCIAL AIDS COMMISSIONS

3. Implementation and Monitoring.

(1) The Federal Government shall be responsible for the implementation and enforcement of this Act.

(2) Subject to the provisions of this Act, the Federal Government shall, when necessary, direct the Provincial Governments to ensure the implementation and enforcement of this Act.

(3) For the purpose of implementation and enforcement of this Act, the Federal Government shall have the following powers and functions:

a) To promulgate, and/or to direct the Provincial Governments to promulgate, such rules as are necessary or proper for the implementation of this Act and the accomplishment of its purposes and objectives;

b) To call for consultations with the Provincial Governments, and other interested persons to ensure implementation and compliance with the provisions of this Act and the rules; and

c) To exercise such other powers and functions that may be necessary for, incidental or ancillary to, the attainment of any purposes and objectives of this Act, or the rules.

(4) The Federal Government may, by notification in the official Gazette, direct that all or any of its powers and functions under this Act may, subject to such limitations, restrictions or conditions, if any, it may from time to time impose, be exercised or performed by the Provincial Governments, the National AIDS Commission, or the Provincial AIDS Commissions, as the case may be.

(5) The Federal Government may give such directions to a Provincial Government as may appear to the Federal Government to be necessary for carrying into effect in the Province any of the provisions of this Act, or of any rule, or order or direction made thereunder, or for the achievement of uniformity in respect of any matter thereto in different parts of Pakistan.

4. National AIDS Commissions & Provincial AIDS Commissions.

(1) The Federal Government shall, by notification in the official Gazette, establish a National AIDS Commission for the prevention, control, care, support and treatment of HIV and AIDS in the whole country.

(2) The Provincial Governments, in consultation with the Commission, shall constitute, by notification in the official Gazette, a Provincial AIDS Commission for each Province for the prevention, control, care, support and treatment of HIV and AIDS in their respective Provinces.

(3) The National AIDS Commission shall consist of technical experts in the field of prevention, control, care, support and treatment of HIV and AIDS, including but not limited to,

(a) The Federal Minister for Health, Government of Pakistan;

(b) The Federal Minister of Education, Government of Pakistan;
(c) The Federal Minister for Defense, Government of Pakistan;
(d) The Federal Minister for Interior, Government of Pakistan;
(e) The Federal Minister of Information, Government of Pakistan;
(f) The Federal Minister for Population, Government of Pakistan;
(g) The Federal Minister for Social Welfare, Government of Pakistan;
(h) The Federal Minister for Economic Affairs, Government of Pakistan
(i) The Secretary, Ministry of Health, Government of Pakistan;
(j) The Secretary, Ministry of Education, Government of Pakistan;
(k) The Secretary, Ministry of Defense, Government of Pakistan;
(l) The Secretary, Ministry of Interior, Government of Pakistan;
(m)The Secretary, Ministry of Information, Government of Pakistan;
(n) The Secretary, Ministry of Population, Government of Pakistan;
(o) The Secretary, Ministry of Social Welfare, Government of Pakistan;
(p) The Director General, Ministry of Health, Government of Pakistan
(q) Two persons representing NGOs (Non-Governmental Organizations) working in the field of HIV and AIDS;
(r) One person from each Province to be nominated by each Provincial Government, in consultation with the concerned Provincial AIDS Commission;
(s) Two medical practitioners nominated by the Pakistan Medical Association (PMA);
(t) One nurse nominated by the Pakistan Nursing Council (PNC);
(u) Two people living with HIV/ AIDS who shall be nominated by organizations representing people living with HIV/AIDS;
(v) One representative each from the National Assembly and Senate respectively; and
(w) Three representatives of Most at Risk Populations one of whom shall always be a female.

(4) The Provincial Governments shall decide on their own the composition of the respective Provincial AIDS Commissions. The membership of such Commissions may be based on the pattern listed in subsection (3) of section 4 above.

(5) The Commission, and the Provincial AIDS Commissions, as the case may be, shall be composed of as many members as the Federal Government and the Provincial Governments respectively may determine from time to time.

(6) The members of the Commission, and the Provincial AIDS Commissions, as the case may be, shall be nominated by the Federal Government, and the Provincial Governments respectively, who shall hold office for a term of two years, except for ex-officio members, from the date of their nomination or until their respective successor is nominated whichever is longer. The members may be re-appointed by the Government concerned.

(7) Any member may, at any time, resign his office by writing to the Federal Government, or the Provincial Government, as the case may be; or in the case of an ex officio member, shall vacate his office if the Federal Government or the Provincial

Government concerned, as the case may be, so directs. A vacancy shall be filled in the same manner as the original appointment for the balance of the unexpired term.
(8) No act done by the Commission, or the Provincial AIDS Commission, shall be invalid on the ground of the existence of any vacancy in the Commission, or the Provincial AIDS Commission, as the case may be.
(9) The Commission, and the Provincial AIDS Commission, as the case may be, may invite an expert to take part in its meetings as an observer; and may constitute committees, or hire the services of experts, consultants, or employees, for the purposes of detailed study of any specific matter before it.
(10) The members of the Commission, and the Provincial AIDS Commissions, as the case may be, shall exercise such powers as may be prescribed.

5. Administration of AIDS Commissions.
(1) The Commission shall be located for administrative purposes within the Health Division of the Government of Pakistan in Islamabad, and the Provincial AIDS Commissions shall be located within the Health Departments of their respective Provincial Governments in the Provincial capitals respectively.
(2) The Chairman Senate shall be the Chairman of the Commission while the Federal Government shall appoint the secretary of the Commission and such other officers as it deems necessary to carry out the purposes of this Act; and shall also provide the Commission with such staff as it, or the Commission, may consider necessary.
(3) The Commission shall meet as often as considered necessary by the chairman, or the Federal Government, but no less than every six months at such time and place as may be intimated by its secretary. A meeting of the Commission can also be requisitioned by any five members of the Commission by a notice in writing addressed to the Secretary who shall call such a requested meeting within 21 days of the receipt of such a notice.
(4) The secretary of the Commission shall call meetings at the direction of the chairman; maintain minutes of the meetings; certify decisions of the Commission and shall perform such other duties as may be directed by the Commission.
(5) Majority of the members of the Commission shall constitute a quorum for a meeting.
(6) The Commission may make such administrative regulations as are required for its proper conduct and functioning.
(7) The provisions of subsections (1) to (6) of section 5 shall, *ipso facto*, apply to the Provincial AIDS Commissions. The Chief Minister of the Province shall be the Chairman of the respective Provincial AIDS Commissions.

6. Powers and Functions of AIDS Commissions.
(1) Subject to the provisions of this Act, the Commission shall have the following powers and functions:

(a) To formulate and implement a National HIV and AIDS Policy, which shall be reviewed, and amended if necessary, every three years after widespread consultation;

(b) To develop and publish, in collaboration with the Provincial AIDS Commissions, a model HIV and AIDS Workplace Policy, which shall contain provisions consistent with this Act, and be reviewed every three years;

(c) To formulate, institute and implement national, and provincial HIV and AIDS-related public awareness programs;

(d) To promulgate rules providing protocols for counseling, testing, care, support, treatment tailored specifically and separately for all members of Most at Risk Populations, for children; and for women who are vulnerable and at risk for HIV infection;

(e) To monitor compliance with this Act in the prescribed manner;

(f) To receive reports of violations or other matters concerning this Act;

(g) To recommend investigation or initiation of cases against health workers and other sections of the population as prescribed in this Act and the Rules;

(h) To plan for and coordinate the dissemination of informational, educational and communication materials on the topics of HIV and of AIDS in a method as may be prescribed, and to plan continuing education courses for health workers, and others including the general public, on topics related to this Act; and

(i) To advise the Federal Government, and the Provincial Governments, on all kinds of matters relating to the prevention, control, care, support and treatment of HIV and AIDS, particularly through national or provincial education campaigns, and to itself organize such campaigns.

(2) In proceedings and inquiries before the Commission, it shall, have all the powers of a civil court under the Code of Civil Procedure,1908 (V of 1908) in respect of the following matters, namely:

(a) summoning and enforcing the attendance of witnesses and examine them on oath;

(b) discovery and production of any document;

(c) receiving evidence on affidavits;

(d) requisitioning any public record or copy thereof from any court or office; and

(e) issuing commissions for the examination of witnesses or documents.

(3) The Commission shall have power to require any person, to furnish information on such matters as, in its opinion, may be useful for, or relevant to, the subject matter of an inquiry and any person so required shall be deemed to be legally bound to furnish such information within the meaning of section 176 and section 177 of the Pakistan Penal Code, 1860 (XLV of 1860).

(4) The provisions of clauses (a) to (f) of subsection (1), and subsections (2) and (3) of section 6 shall, *ipso facto*, apply to the Provincial AIDS Commissions.

(5) If any question arises whether any matter relating to this Act, or the rules, fall within the jurisdiction of the Commission, or the Provincial AIDS Commission, or both, or more than one Provincial AIDS Commission, then such question shall be referred to the Federal Government which shall, after consultation with the Commission and the concerned Provincial AIDS Commission, decide the same. The decision of the Federal Government in this regard shall be final.

7. Right of Redress.

Nothing contained in this Chapter prohibits, limits or otherwise restricts the right of a person to other remedies provided under this Act or any other law for the time being in force to address violations of the provisions of this Act.

8. Investigation & Inspection.

(1) The Commission, or the Provincial AIDS Commissions, as the case may be, shall be empowered to designate any category of persons as inspectors to conduct inspection, investigation and prosecution for purposes of this Act, and to monitor compliance with this Act. This category of persons may be federal inspectors, and/ or the provincial inspectors, appointed under the Drugs Act, 1976 (XXXI of 1976), or other inspectors appointed under the provisions of any other law.

(2) In so far as they are not inconsistent with the provisions of this Act or the rules, the powers and functions of, and the procedure to be followed by, the inspectors as prescribed in the Drugs Act, 1976 (XXXI of 1976), shall apply, *mutatis mutandis*, to inspectors mentioned in subsection (1) of section 8, for purposes of this Act, unless the same is inconsistent with any provision of this Act, or the rules.

9. Investigation & Filing of the Case.

(1) Upon completion of the investigation and receipt of complete report, and after giving the offender an opportunity of being heard, the Commission, or the Provincial AIDS Commissions, as the case may be, shall decide as to whether institute or not to institute prosecution against the offender.

(2) If the Commission, or the Provincial AIDS Commissions, as the case may be, decide to institute the proceedings, then it shall direct the inspectors mentioned in subsection (1) of section 8 to institute prosecution against the offender for contravention of any provision of this Act, or the rules, in the Court of Session constituted under the provisions of the Code of Criminal Procedure 1898 (V of 1898).

(3) The Court shall follow the procedure prescribed in the Code of Criminal Procedure 1898 (V of 1898) for trying an offense under this Act. The offenses punishable under this Act shall be non-cognizable.

(4) A person sentenced by a Session Judge under this Act may prefer an appeal to the High Court, having jurisdiction over the concerned Court of Session, within thirty days of the judgment.

(5) The provisions of sections 5 and 12 of the Limitation Act, 1908 (IX of 1908), shall be applicable to an appeal referred to in subsection (4) of section 9.

10. Public Enforcement.

Any person whomsoever may make an application in writing to the Commission, or the Provincial AIDS Commissions, concerning contravention of any provision of this Act, or the rules. In the event the investigation reveals an offense, the Commission, or the Provincial AIDS Commissions, as the case may be, shall follow the procedure outlined for instituting prosecution against the offender in this Act, and as prescribed.

CHAPTER III
PROTECTION AGAINST DISCRIMINATION

11. Prohibition of Discrimination Based on HIV Status.
No person shall be discriminated against on the basis of his HIV status in any form in relation to any activity in the private or public sectors.

12. Prohibition of Discrimination in Private and Public Sectors of Employment.
(1) Except in accordance with this Act, it is unlawful to require, or to coerce, a person to be HIV screened for purposes of:

(a) Employment, promotion, training, or benefit, either in public or private sectors;

(b) Membership in any organization;

(c) Admission to any educational institution;

(d) Admission to any public or private place of accommodation;

(e) Marriage;

(f) Immigration to, emigration from, or citizenship of, Pakistan; or

(g) Visiting another country for any purpose whatsoever, including but not limited to, tourism, studies or work.

(2) All organizations in any public or private sector shall keep confidential the medical and personal information relating to the HIV/ AIDS status of their employees, students and members, as the case may be.

(3) Every employer shall endeavor his best to provide reasonable alternative working arrangements and the maximum possible benefits to an employee who is HIV positive and is no longer able to work.

(4) All HIV-positive employees shall receive education on HIV/ AIDS, as well as relevant counseling and appropriate referral for treatment and social services by his employer.

(5) Every workplace, public or private, having more than 50 employees, shall adopt and enforce an HIV/ AIDS Workplace Policy, which shall conform to the model HIV and AIDS Workplace Policy prepared by the Commission.

13. Prohibition of Discrimination in Private and Public Health Facilities.
(1) No person shall be required to be HIV screened for routine testing or diagnostic testing purposes by any public or private health care facility.

(2) All public and private health facilities shall maintain confidentiality of patients' medical and personal information, including their HIV/ AIDS status.

(3) No public or private health care facility shall ever deny or discontinue medical treatment of any person, based on his or any of his family member's actual or perceived HIV positive status.

14. Prohibition of Discrimination in Private and Public Education.

(1) No person, including a minor, seeking admission in a private or public educational institution shall be HIV screened, and shall ever be denied admission based solely on his HIV status.

(2) All educational institutions, whether public or private, shall maintain confidentiality of all medical and personal information relating to the HIV/ AIDS status of all its students and employees.

(3) The Federal and the Provincial Governments shall ensure that children affected by HIV/AIDS continue to access educational facilities; and shall formulate and implement programs to address issues relating to barriers to education, including school fees and other costs, faced by such children.

15. Prohibition of Discrimination in Private and Public Accommodations.

No person seeking private or public accommodation anywhere shall be screened for purposes of denying admission based on his HIV status.

16. Prohibition of Discrimination in Regard to Goods and Services.

No person shall be denied access, or provision or enjoyment of, services, goods, or benefits, in or by any public or private facility, based solely on his perceived or actual HIV status.

17. Prohibition of Vilification Based On HIV Status.

No person shall publish, propagate, advocate or communicate by words, either spoken or written, or by signs or by visible representations or otherwise, against any person on grounds of his HIV/ AIDS status.

CHAPTER IV
BEHAVIOR CHANGE COMMUNICATIONAND ADVOCACY OF HIV AND AIDS PREVENTION MEASURES

18. Need for Behavior Change Communication and Advocacy.

(1) All persons have the right to information about HIV and AIDS.

(2) All HIV and AIDS-related public awareness programs shall be disseminated widely through all forms of media, including print, electronic, mass and digital media.

(3) All HIV and AIDS-related public awareness programs, as well as behavior change communication and advocacy, shall form part of the delivery of health services by health workers and health care facilities, particularly to the members of Most at Risk Population.

(4) It shall be the duty of every health worker, and health care facility, to make available to the public, subject to the provisions of this Act, such information as is necessary in the prevention, control, as well as treatment of HIV and AIDS.

(5) Every health care facility shall enhance the knowledge and capacity of all its health workers in relation to dissemination and education of the general public about HIV and AIDS; and on other HIV-related issues such as discrimination, confidentiality, and informed consent.

19. Support for Education & Awareness Raising Programs.

Programs shall be established by the Federal Government, and the Provincial Governments, with the active cooperation of the Commission and the Provincial AIDS Commissions, to educate and raise awareness among:

(a) Persons living with HIV and AIDS;

(b) Women vulnerable and at risk for HIV;

(c) Members of Most at Risk Populations concerning their rights and generally to empower them;

(d) Among judges, judicial staff and among legal practitioners concerning the rights of protected and Most at Risk Populations, and for the purpose of encouraging the provision of legal services to enforce those rights, and to develop expertise on HIV-related legal issues among such persons.

CHAPTER V
REDUCTION OF RISK OF HIV EXPOSURE AMONG MEMBERS OF MOST AT RISK POPULATIONS

20. HIV and AIDS Prevention Services amongst Most at Risk Populations.
(1) The Commission and the Provincial AIDS Commissions shall advise the Federal Government and the Provincial Governments respectively about the possible actions that may be taken to promote individual safe behaviors, and other actions to reduce risk of exposure to HIV among members of vulnerable groups, and from them to the general population.
(2) Notwithstanding anything contained in any other law in force, providing of any product even if prohibited by law or any equipment, to implement, enforce, plan, deliver, or monitor any kind of HIV and AIDS prevention harm reduction services, shall not, in any manner, be prohibited, impeded, restricted or prevented, and shall not amount to a criminal offence, by persons working in good faith, and not to make any kind of profit whatsoever.
(3) No law enforcement or other public official shall arrest or detain, or in any manner harass, impede, restrict or otherwise prevent any person implementing or using strategies, and drug substitution therapies, in good faith, and without any motive for profit, for HIV and AIDS prevention harm reduction services in accordance with the provisions of this Act, including publishing and dissemination of materials, sterile drug equipment paraphernalia, bleach and other disinfectants, and condoms, amongst the Most at Risk Population members.
(4) The Federal Government, and the Provincial Governments, in consultation with the Commission and the Provincial AIDS Commissions, shall organize and arrange training in the field of behavior change and communication (BCC) and on HIV and AIDS prevention harm reduction services, for police and prison Commissions, and other law enforcement officials.

21. Women Vulnerable and at Risk for HIV Infection.
(1) The Federal Government may in any part of Pakistan and the Provincial Governments within the limits of a Province, in consultation with the Commission and the Provincial AIDS Commissions respectively, shall ensure introduction and implementation of strategies promoting comprehensive prevention, care and treatment of diseases affecting women and children, as well as policies to provide them access to a full range of high quality and affordable healthcare, including sexual and reproductive healthcare services.
(2) Women who have been raped or otherwise experience sexual violence, shall be provided with counseling and clinical services at public and private health care facilities. Services for rape survivors shall include post-exposure prophylaxis. Every survivor of sexual assault, whether or not they have reported the sexual assault to police, shall have access at a public health care facility to the following services on a confidential basis:

(a) Counseling;

(b) Prevention and management of STIs, including access to testing and prophylactic treatment;
(c) Prevention, treatment and management of other medical conditions or injuries associated with the sexual assault;
(d) HIV/ AIDS related counseling and treatment, if required;
(e) Follow up treatment and care; and
(f) Referrals.

(3) No person in charge of a health care facility providing services to a survivor of sexual assault under the provisions of this Act shall report or release information regarding the assault or the survivor to any person whomsoever without the written informed consent of the survivor of sexual assault.

(4) Rules shall be made specifying protocols for the counseling and treatment of survivors of rape or sexual assault and for the training of health workers in the implementation of such protocols.

22. Children and HIV-Positive Pregnant Women.

(1) An HIV-positive pregnant woman shall have the right to receive such counseling and information from a health care facility, whether public or private, which enables her to make a decision about her pregnancy,undertaking HIV-related treatment, and in relation to other matters affecting her health and pregnancy.

(2) No pregnant woman shall be subject to forced sterilization or abortion without her written informed consent.

(3) The Federal Government and the Provincial Governments, in consultation with the Commission and the Provincial AIDS Commissions, shall provide to children VCT (Voluntary Counseling & Testing), and referral treatment, on a confidential basis; and the identity of the child, tested for HIV, or the results of the HIV test, or of the counseling provided to such child, cannot be revealed, except in accordance with law.

(4) The Federal and the Provincial Governments shall adopt effective and appropriate measures to abolish harmful practices affecting the health of children, particularly girls, including marriages below the age of 18 years, preferential feeding and care of male children at the expense of girls.

23. Prisoners.

(1) No person in the care or custody of the State in any kind of prison may be HIV screened without his informed consent.

(2) Every person who is in the care or custody of the State in any kind of prison facility shall have the right to HIV prevention, counseling, testing and treatment services.

(3) The Provincial AIDS Commissions shall introduce strategies for HIV and AIDS Prevention Harm Reduction Services.

(4) A person in the care or custody of the State in any kind of prison, who has been exposed to the risk of HIV transmission, shall be referred immediately to a State health care facility, for HIV-related counseling, treatment or other services and shall

be entitled to, if recommended, post exposure prophylaxis and HIV-related treatment from the State.

(5) Every person in the care or custody of the State in any prison shall be entitled to receive his complete medical records upon his release or discharge.

CHAPTER VI
REDUCTION OF RISK FOR OCCUPATIONAL HIV EXPOSURE

24. Provision of Universal Precautions and Post Exposure Prophylaxis.

(1) Every health care facility, where there is a significant risk of occupational exposure to HIV, shall provide free of cost universal precautions, and post exposure prophylaxis, to all persons working in such health care facility who may be occupationally exposed to HIV and appropriate training for the use of such universal precautions.

(2) Every health care facility shall ensure that the universal precautions and the post exposure prophylaxis protocols introduced at its facility are complied with by all concerned. It shall in this regard inform all persons working in the health care facility about the details of availability of these precautions and protocols and shall make special efforts to ensure that all workers in health care facilities are trained in using and accessing them.

25. Provision of HIV related Treatment & Compensation.

Every health care facility shall provide HIV-related treatment to persons working in such institution who are occupationally exposed to and acquire HIV.

CHAPTER VII
PROMOTING SAFE BLOOD SUPPLIES

26. Screening for HIV Positive Blood and Blood Products.

(1) All blood and blood products, including organs and tissues for donation, shall be screened for HIV, and shall be disposed unless used for research purposes, in accordance with the provisions of the Islamabad Transfusion of Safe Blood Ordinance, 2002 (Ordinance LXXIII of 2002) in the Islamabad Capital Territory and in areas administered by the Federal Government, and in accordance with the provisions of the Balochistan Safe Blood Transfusion Act 2004 (Act III of 2004); the NWFP Transfusion of Safe Blood Act, 1999 (Act IX of 1999); the Punjab Transfusion of Safe Blood Ordinance 1999 (Ordinance XXXVI of 1999); and the Sindh Transfusion of Safe Blood Act 1997 (Act I of 1997) and the rules promulgated therein, in relation to the respective Province.

CHAPTER VIII
VOLUNTARY COUNSELING, TESTING, CARE, SUPPORT AND TREATMENT

27. Provision of Counseling, & Testing Regarding Determination of HIV Status.
(1) The Federal Government may in any part of Pakistan, and the Provincial Governments may within the limits of their respective Province, in consultation with the Commission and the Provincial AIDS Commissions, establish VCT (voluntary counseling and testing) centers. These centers shall conform to the following elements:

(a) Testing shall be voluntary;
(b) Pre-test counseling shall be provided;
(c) Results shall be confidential and shall be provided only to the person tested;
(d) Posttest counseling shall be provided, tailored to meet the specific needs of the person tested;
(e) HIV positive persons shall be referred to the relevant health care facility, and shall receive ongoing prevention, care, support and treatment services.

28. Voluntary Informed Consent Requirement for HIV Counseling & Testing.
(1) Voluntary written informed consent shall be obtained on a prescribed form before any HIV screening or pre-test counseling is undertaken.
(2) The informed consent in writing may be given by using a coded system.
(3) No persons, including children, should be screened for HIV when they are lodged in a governmental establishment, including but not limited to, a crisis center, an orphanage, darulaman, or similar other centers and facilities.
(4) The age of consent for HIV testing will be eighteen years. Children under this age will need the consent of their parents or guardians. In special cases, children living independently, who are not in contact with parents and who do not have a guardian, will be able to consent for HIV testing after they have been provided with age-sensitive information and counseling.

29. Exceptions to Informed Consent.
Informed consent for an HIV-related test shall not be required in the following instances:

(a) Court ordered HIV-related test when person being tested receives pre-test and post-test counseling, and when HIV-related information of that person is kept confidential and not disclosed; and
(b) Surveillance or epidemiological purposes where the HIV test is anonymous and unlinked and is not for the purpose of determining the HIV status of a person.

CHAPTER IX
SCALING UP FOR TREATMENT OF HIV INFECTION

30. Federal and Provincial Governments Scale Up Preparations.

(1) The Federal Government, and the Provincial Government, in consultation with the Commission and the Provincial AIDS Commissions, shall establish and strengthen national health and social infrastructures and health care systems in order to increase capacity to deliver HIV and AIDS prevention, control, care, support and treatment services.

(2) In consultation with HIV-positive persons and other members of Most at Risk Population, the Federal and the Provincial Governments shall maximize opportunities for the delivery of all relevant interventions for prevention, care, support and treatment of HIV and AIDS, including programs to strengthen training and capacity building of health workers and other public health Commissions.

(3) The Federal and the Provincial Governments shall take all measures to improve and ensure affordability, availability, and access, including improving management of the supply chain and procurement, of testing, treatment, care, support and counseling services, and products, and pharmaceutical and diagnostic products used to diagnose, treat and manage HIV and AIDS.

(4) The Federal Government, in consultation with the Commission, shall introduce income, sales and other tax incentives and exemptions, on HIV-related treatment and drug harm reduction programs, and goods, in order to promote its affordability, accessibility and availability to the general public.

(5) The Federal Government, in consultation with the Commission, shall ensure that the pricing of medication, diagnostics and other related technologies, is fixed in a manner which is transparent, and which makes it affordable, accessible and easily available.

(6) The Federal and the Provincial Governments shall ensure that incentives to encourage investment in research and development are provided to entities to develop, manufacture, market and distribute affordable and accessible preventive, curative and palliative care and treatment of HIV and AIDS.

31. Provision of Care, Support, & Treatment to People Living with AIDS.

(1) The Federal Government may in any part of Pakistan and the Provincial Governments shall within the limits of their respective Province, acting in collaboration with the Commission and the Provincial AIDS Commissions, shall provide, as appropriate, care, support and treatment for persons living with AIDS.

(2) In this regard, at least one hospital in the Islamabad Capital Territory, and at least one each in the provincial capital cities, shall be designed, equipped, supplied, and staffed to provide appropriate, and comprehensive services as an integrated care delivery facility for the care of persons living with HIV/ AIDS.

(3) A referral system shall be established for the care and support of persons living with HIV/ AIDS, through strengthening of services available at the governmental and non-governmental levels concerning medical diagnosis of HIV and of AIDS, the medical management, and planning for and delivery of voluntary counseling for the community, and provision of skills building training to the health workers.

(4) Goods, services and information shall be provided at designated hospitals for the curative and palliative care of HIV and AIDS and related opportunistic infections and conditions, for counseling, and for the effective and monitored use of medicines for opportunistic infections, and post exposure prophylaxis, including the following:

(a) ART (Anti-retroviral therapy);

(b) Nutritional supplements;

(c) Measures for the prevention of mother-to-child transmission; and

(d) Other safe and effective medicines, diagnostics and related technologies.

(5) Nothing shall be construed in this section, this Act or the Rules, to prevent any health care facility, whether governmental or non-governmental, from providing any kind of services in relation to care, support and treatment for persons living with AIDS anywhere in Pakistan.

32. Consumer & Legal Protection.

(1) The Federal Government, and the Provincial Governments, with the cooperation of the Commission and the Provincial AIDS Commissions, shall provide:

(a) Consumer protection against fraudulent claims for the sale, distribution, and marketing of pharmaceuticals, vaccines and medicines; and

(b) Training and capacity building of law professionals for the provision of legal services for women and children vulnerable and at risk for HIV infection and for members of other Most at Risk Populations.

CHAPTER X
REQUIREMENT OF CONFIDENTIALITY

33. Confidentiality of Information. (1)
Except as otherwise provided in this Act, all health workers, and any other person while providing services, or being associated in the course of his duties with the provision of any HIV counseling, testing, care, support or treatment services or care; or through administration of this Act or by conducting surveillance reporting, or research, shall take all reasonable steps to maintain confidentiality. Such person shall prevent disclosure of any information that another person:

(a) is or is presumed to be HIV positive;
(b) has or is presumed to have AIDS; or
(c) has been or is being tested for HIV infection.

34. Authorized Disclosure of Information.
(1) No person shall be compelled to disclose HIV-related information or any other private information concerning himself, except when a court determines by an order that the disclosure of such information is necessary for the determination of issues and in the interest of justice in a matter before it.
(2) Disclosure of HIV-related information or private information is authorized in case the disclosure is made:

(a) By a health worker to another health worker who is involved in the provision of care, treatment or counseling of a person, when such disclosure is necessary to provide care or treatment in the best interest of that person; or
(b) By an order of a court when it determines by such order that the disclosure of such information is necessary for the determination of issues and in the interest of justice in a matter before it; or
(c) In legal proceedings between persons, where the disclosure of such information is necessary in the initiation of such proceedings or for instructing counsel; or
(d) If it relates to statistical or other information of a person that could not reasonably be expected to lead to the identification of that person.

(3) Any person to whom disclosure is made under this section is prohibited from making further disclosure except as provided in this Act.

35. Partner Notification to Prevent HIV Transmission.
A health worker who is a physician or a counselor, may inform the spouse or a partner of a person under his direct care of such person's HIV-positive status only when:

(a) The HIV-positive person has been thoroughly counseled to inform such spouse and/ or partner;

(b) Counseling of the HIV-positive person has failed to achieve the appropriate behavioral changes and he is unlikely to inform his spouse and/ or partner;

(c) The health worker reasonably believes that the spouse and/ or the partner is at significant risk of transmission of HIV from such person;

(d) The health worker has given the HIV-positive person a reasonable advance notice of his intention to disclose the HIV-positive status to such spouse and/ or partner; and

(e) If unavoidable, such disclosure to the spouse/ and or partner is made in person and with appropriate counseling or referrals for counseling.

36. HIV & AIDS Prevention Harm Reduction Settings.

Any information obtained or maintained in records by a person implementing a HIV and AIDS prevention harm reduction service shall be considered to be confidential for the purpose of this Act.

CHAPTER XI
PROVISION OF LEGAL SERVICES

37. Enforcement of Legal Rights.

The Federal Government, and the Provincial Governments, in consultation with the Commission and the Provincial AIDS Commissions, shall provide free legal services to members of Most at Risk Populations to enforce their legal rights, and to help develop their expertise on HIV-related legal issues.

38. Support for Provision of Legal-Aid.

The Federal Government, and the Provincial Governments shall support legal practitioners to provide

free legal services to persons living with HIV/AIDS and for women vulnerable and at risk for HIV and members of Most at Risk Populations in all areas covered by this Act.

CHAPTER XII
PENALTIES

39. Penalties for Discrimination.

Any person who contravenes sections 11, 12, 13, 14, 15, 16 and 17, or subsection (5) of section 20, or subsection (4) of section 21, shall be punishable with fine which shall not be less than Rupees fifty thousand or more than Rupees three hundred thousand.

40. Power of Court to Pass Appropriate Orders.

(1) Notwithstanding any other law for the time being in force, in the adjudication of any proceedings, which are instituted under this Act, a court may pass appropriate orders in the circumstances of the case to:

(a) prevent breaches of the provisions of this Act; or

(b) redress breaches of the provisions of this Act by directing:

(i) specific steps, special measures or affirmative actions or both to be taken;

(ii) the withdrawal of or ceasing and desisting from committing breaches of this Act;

(iii) the employer of a person who has committed a breach of this Act to

Initiate disciplinary action against such person;

(iv) the employer of the person who has committed a breach of this Act to put the matter in the employee's Annual Confidentiality Report;

(v) the inclusion of the matter in the Annual or other report of the person who has committed a breach of this Act that is available to the public and that is filed with regulatory Commissions, where such person is a registered company, institution, society or other body;

(vi) an appropriate order of a deterrent nature, including a recommendation to the appropriate Commissions, to suspend or revoke the license of the person who has committed a breach of this Act; and/ or

(vii) any person who has committed a breach of this Act to file regular progress reports with the court regarding the implementation of the court's order.

(2) In a proceeding relating to discrimination in employment under this Act, the court shall have the power to pass any or all of the following orders:

(a) that the person discriminated against be employed;

(b) that the person discriminated against be reinstated;

(c) that the person who has discriminated make arrangements for the reasonable

accommodation of the person discriminated against; and/ or

(d) the payment of wages, allowances, benefits, perquisites and privileges that may have been lost on account of non-employment or termination.

41. Penalty for Contravention of HIV Positive Blood Related Provisions.

Failure to screen for HIV blood and blood products in accordance with the provisions of the Islamabad Transfusion of Safe Blood Ordinance, 2002 (Ordinance LXXIII of 2002) in the Islamabad Capital Territory and in areas administered by the Federal Government, and in accordance with the provisions of the Balochistan Safe Blood Transfusion Act 2004 (Act III of 2004); the NWFP Transfusion of Safe Blood Act, 1999 (Act IX of 1999); the Punjab Transfusion of Safe Blood Ordinance 1999 (Ordinance XXXVI of 1999); and the Sindh Transfusion of Safe Blood Act 1997 (Act I of 1997) and the rules promulgated therein, in relation to the respective Province, shall be punishable under the relevant and applicable law.

42. Penalty for Violation by Health Workers.

If a health workers fails to comply with any relevant provision of this Act or the Rules promulgated herein or contravenes any order, or direction, given by the Commission or the Provincial AIDS Commissions, then the Commission or the Provincial AIDS Commission, as the case may be, shall have the power to recommend in writing to the Pakistan Medical and Dental Council existing under the Medical and Dental Council Ordinance, 1962 (XXXII of 1962), to suspend, or cancel, his license for the practice of his profession or occupation, or for the pursuit of his business, or take other appropriate action as the Council considers appropriate under the circumstances of the case.

43. Penalty for Violation by a Public Health Care Facility.

If a public health care facility fails to comply with any relevant provision of this Act or the Rules promulgated herein or contravenes any order, or direction, given by the Commission or the Provincial AIDS Commissions, then the Commission or the Provincial AIDS Commission, as the case may be, shall have the power to recommend in writing to the Federal Government or the relevant Provincial Government, as the case may be, to take appropriate action against the relevant official and/ or employee in accordance with the relevant laws, rules and regulations.

44. Penalty for Violation by a Private Health Care Facility.

If a private health care facility fails to comply with any relevant provision of this Act, including but not limited to subsection (5) of section 20 and subsection (4) of section 21, or sections 22, 24, 25, 33 or 34, or the Rules promulgated herein, or contravenes any order, or direction, given by the Commission or the Provincial AIDS Commissions, then it, and every officer and director of such private health care facility who knowingly and willfully is a party to the default, shall be punishable with fine of not less than Rupees fifty thousand or more than Rupees one million.

45. Penalty for Abortion without Written Consent.
Any person who contravenes subsection (2) of section 22 shall be punishable with imprisonment extending up to one year, or fine which shall not be less than Rupees fifty thousand or more than Rupees three hundred thousand.

46. Penalty for Violation by a Prison or Police Official.
If a prison or a police official fails to comply with any relevant provision of this Act. including but not limited to, subsections (2) and (3) of section 20 and section 23, or the Rules promulgated herein or contravenes any order, or direction, given by the Commission or the Provincial AIDS Commissions, then the Commission or the Provincial AIDS Commission, as the case may be, shall have the power to recommend in writing to the Federal Government or the relevant Provincial Government, as the case may be, to take appropriate action against the relevant official in accordance with the relevant laws, rules and regulations.

47. Disobedience of Orders.
Whoever contravenes any provisions of this Act or the Rules, or of any order made thereunder, for the contravention of which no penalty is hereinbefore provided, shall be punishable with fine which may extend to Rupees ten thousand, and in the case of a continuing contravention, with a further fine which may extend to Rupees five hundred for every day on which the offender is proved to have persisted in the contravention after the date of the first conviction.

48. Responsibility of an individual for the act of a Company, or an Institution.
Where the person guilty of an offense under this Act is a company, corporation, firm or institution, every director, partner and employee of the company, firm or institution, unless he proves that the offense was committed without his knowledge or consent, shall be guilty of the offense.

49. Non-cognizable Offenses.
The offenses punishable under this Act shall be non-cognizable.

CHAPTER XIII
MISCELLANEOUS

50. Redress for Grievances of Prohibited Discrimination.
No person shall be restricted in any way from bring any proceeding under this Act against any person.

51. Additional Measures.
Nothing in this Act shall prevent the State or any other person from taking other measures for the protection, benefit or advancement of women vulnerable and at risk for HIV infection or members of Most at Risk Populations, including the greater involvement of HIV-positive persons.

52. Speedy & Effective Legal Procedures.
Independent, speedy and effective legal and/ or administrative procedures, shall be prescribed and provided for by the relevant courts, for seeking redress under the provisions of this Act, containing such features as fast-tracking for cases where the complainant is terminally ill, investigatory powers to address systemic cases of discrimination in policies and procedures, ability to bring cases under pseudonym and representative complaints, including the possibility of public interest organizations bringing cases on behalf of people living with HIV/AIDS.

53. Posting of Abstracts.
The text, as prescribed, of this Act and the Rules, shall be prominently posted and kept in
a legible condition by the employer in English and Urdu, and in the language understood by the majority of the local population, on special boards to be maintained for the purpose at or near the entrance through which the majority of the employees, patients, prisoners and the public, as the case may be, enter all health care facilities and prisons.

54. Removal of difficulties.
If any difficulty arises in giving effect to any of the provisions of this Act, the AIDS Commission may make such order, not inconsistent with the provision of this Act, as may appear to the Commission to be necessary for the purpose of removing the difficulty.

55. Power of Federal Government to Make Rules.
The Federal Government may, in consultation with the Provincial Governments and the Commission and the Provincial AIDS Commissions, by notification in the official Gazette, make rules for carrying out the purposes of this Act.

GLOSSARY

abstinence: The voluntary decision of avoiding all sexual activities that leads to an exchange of bodily fluids.

acquired immunodeficiency syndrome: (AIDS); A serious, often fatal, disease of the immune system. A severe immunological disorder is caused by the retrovirus HIV, resulting in a defect in cell-mediated immune response that is manifested by increased susceptibility to opportunistic infections and to certain rare cancers, especially Kaposi's sarcoma. It is transmitted primarily by exposure to contaminated body fluids, especially blood and semen, and through blood products especially by sexual contactor contaminated needles. The period between infection with HIV and the onset of AIDS averages 10 years. Even with treatment, most people with AIDS die within two years of developing infections or cancers that take advantage of their weakened immune systems.

acute infection: An infection causing disease with a sudden onset, severity and (often) short course.

adverse reaction: In pharmacology, any unexpected or dangerous reaction to a drug. An unwanted effect caused by the administration of a drug. The onset of the adverse reaction may be sudden or develop over time.

anal sex: Sexual activity characterized by anal stimulation or penetration with the penis, finger, objects, lips, mouth, or tongue.

antibodies: Molecules in the blood or secretary fluids that tag, destroy or neutralize bacteria, viruses or other harmful toxins.

anti-retroviral drugs: Medications for the treatment of infection by the retrovirus HIV. Different antiretroviral drugs act at various stages of the HIV life cycle. Various combinations of three or four drugs are known as HAART or Highly Active Anti-Retroviral Therapy.

antiviral: An agent that kills a virus or that suppresses its ability to replicate and, hence, inhibits its capability to multiply and reproduce.

bacterial infection: An infection caused by bacteria. The growth of many disease-causing bacteria can be halted by the use of antibiotics.

behavior change communication: A multi-level tool for promoting and sustaining risk-reducing behavior change in individuals and communities by distributing tailored health messages in a variety of communication channels.

bisexual: Relating to both sexes; Having both male and female reproductive organs (hermaphroditic);and, Relating to or having a sexual orientation to persons of either sex.

blood screening: Screening of blood for determining if it is infected with some disease or for contamination. Incase of HIV test the blood is tested for the ant-bodies of the virus.

body fluids: Any fluid in the human body, such as blood, urine, saliva, sputum (spit), tears, semen, mother's milk or vaginal secretions. Only blood, semen, mother's milk and vaginal secretions have been linked directly to the transmission of the HIV virus.

bone marrow: Soft tissue located in the cavities of the bones where blood cells such as erythrocytes, leukocytes and platelets are formed.

brothels: The places where unhealthy commercial sex services are offered; working place of sex workers.

campaigns: Different projects or activities aiming at some purpose.

cervical cancer: Cervical cancer is a malignancy of the cervix. Worldwide, it is the second most common cancer of women.

cervical fluids: Fluids secreted by the cervix of a female reproductive organ.

circumcision: Removal of the foreskin -- the foreskin is re-sected to near the coronal sulcus -- in the newborn period.

condom: Protective latex sheaths designed for contraception and protection for STIs and STDs including HIV or AIDS. These are available as male condom and female condom.

confidentiality: Surety that information given by the client will be kept in privacy.

contaminated: To make impure or unclean by contact or mixture or to expose to or permeate with radioactivity.

counseling: The act of exchanging opinions and ideas; consultation; Advice or guidance, especially as solicited from a knowledgeable person.

diagnosis: The determination of the presence of a specific disease or infection, usually accomplished bye valuating clinical symptoms and laboratory tests.

discrimination: Behavior of person based on negative judgment, means to avoid, neglect the PLWHA.

drug abuse: Habitual use of drugs to alter one's mood, emotion, or state of consciousness.

ejaculation: The moment when rhythmic contractions of the urethra cause semen to be discharged from the penis.

epidemic: A disease that spreads rapidly through a demographic segment of the human population.

erection: The firm and enlarged condition of a body organ (e.g., penis, clitoris) usually during sexual execration.

exploitation: An act that exploits or victimizes someone (treats them unfairly).

female condoms: A polyurethane sheath used for females, for contraceptive purposes or as a means of preventing STIs/HIV.

gang rape: Rape of a victim by several attackers in rapid succession; Act of non-consensual penetrative sex by more than one person.

gays: Of, relating to, or having a sexual orientation to persons of the same sex.

gender: The sex of an individual, male or female, based on reproductive anatomy.

gender discrimination: Discrimination between Men and Women on social, cultural and traditional basis.

harm reduction: A set of policy beliefs, essentially stating that some people always have and always will perform activities, such as promiscuous sex or drug use that may cause them harm.

hepatitis: An inflammation of the liver. Hepatitis is most often caused by a virus, but it can be the result of exposure to certain toxic agents, such as drugs or chemicals.

heterosexual: It is a normal behavior of having sex with opposite sex.

high risk behaviors: If someone indulges in unsafe sex, someone transfuses unscreened blood, someone use contaminated or un-sterilized syringes, so such behavior is High Risky Behavior for HIV and AIDS transmission and spreading.

high risk groups: Individuals of such groups are very risky or dangerous for HIV infections like IDUs, FSWs, MSM, Migrants, Mobile Workers, Youth, Traders, Tourist Guides' Porters and Hijras etc.

highly active anti-retroviral therapy: Highly Active Anti-Retroviral Therapy, a combination of several antiretroviral agents and has been highly effective in reducing the number of HIV particles in the bloodstream (as measured by a blood test called the viral load).

hiv status: The viral count of HIV in an individual.

hiv transmission: Transfer of HIV from one to anotherHIV-I and HIV-2. A retrovirus that causes AIDS by infecting helper T cells of the immune system.

homosexual: A behavior where people tend to have sex with the same sex, for example, gays and lesbians.

Human immunodefficiency virus: The virus that causes acquired immune deficiency syndrome; it replicates in and kills the helper T cells, thus, reducing immunity of the body against different diseases.

immune system: The complex functions of the body that recognize foreign agents or substances neutralize them and recall the response later when confronted with the same challenge.

immunity: A natural or acquired resistance to a specific disease. Im-munity may be partial or complete, long-lasting or temporary.

immunodeficiency: A deficiency of immune response or a disorder characterized by deficient immune response; classified as antibody (B cell), cellular (T cell), combined deficiency or phagocyticdys function disorders.

information, education, communication: Information communication education; usually it is called IEC material for awareness raising and social mobilization. IEC material includes Pamphlets, Leaflets, Hand bills, Posters, Banners, brochures, training manuals etc.

injective drug users: Drug addicts who take drugs through injections. These people are more likely to acquire HIV as they use a common syringe.

lesbians: A subclass of homosexuals where females have sex with females.

lubricants: Substances used to lubricate genitals for sexual activity.

male condom: A flexible sheath designed to cover the penis during sexual intercourse for contraceptive purposes or as a means of preventing STIs.

mandatory: Anything that is a compulsion (compulsory).

masturbation: A means of sexual self-pleasuring that involves stimulation of one's own genitals using hands or objects.

men who have sex with men: A term used originally for describing gay and bisexual men.

menstruation: Cyclic flow of blood out of the uterus through the vagina.

misconceptions: Wrong ideas or concepts; misunderstanding about something.

mother to child transmission: The transmission of HIV to child from mother through breast feeding.

myth: Myths are firm beliefs having no scientific reason. Here, myths mean the fake and baseless stories associated with HIV and AIDS.

pandemic: A disease prevalent throughout an entire country, continent or the whole world.

peer education: To educate, to motivate, to provide information from one pair to another pair, one peer to another peer, one friend to another friend, one co-worker to another co-worker, one IDU to another IDU, one MSM to another MSM and

one SW to another SW is called Peer. Education; It is a strategy usually for HIV and AIDS prevention projects.

penetrative sex: Sexual activity involving penetration of the penis.

primary health care: The medical care a patient receives upon first contact with the health care system, before referral elsewhere within the system.

polymerase: Any of several enzymes that catalyze the formation of DNA or RNA from precursor substances in the presence of preexisting DNA or RNA acting as templates.

polymerase chain reaction (test) (PCR): A laboratory process that selects a DNA segment from a mixture of DNA chains and rapidly replicates it; used to create a large, readily analyzed sample of a piece of DNA.

prevalence: A measure of the proportion of people in a population affected with a particular disease at a given time. In epidemiology, the *prevalence* of a disease in a statistical population is defined as the total number of cases of the disease in the population at a given time, or the total number of cases in the population, divided by the number of individuals in the population. It is used as an estimate of how common a condition is within a population over a certain period of time. It helps physicians or other health professionals to understand the probability of certain diagnoses and is routinely used by epidemiologists, health care providers, government agencies and insurers.

prophylaxis: Treatment that helps to prevent a disease or condition before it occurs or recurs.

retrovirus: HIV and other viruses that carry their genetic material in the form of RNA and that have the enzyme reverse transcriptase. Like all viruses, HIV can replicate only inside cells, commandeering the cell's machinery to reproduce. Like other retroviruses, HIV uses the enzyme called reverse transcriptase to convert its RNA into DNA, which is then integrated into the host cell DNA.

risk behaviors: Behaviors involving risk of getting HIV AND AIDS e.g. unsafe sexual and injecting practices, use of contaminates needles, blades etc.

secretions:

1. The process of secreting a substance from a cell or gland.
2. A substance, such as saliva, mucus, tears, bile, or a hormone, that is secreted.

seroconversion: Development of antibodies in blood serum as a result of infection or immunization.

sex:

1. Differentiation between Men and Women on Biological basis.
2. The sexual urge or instinct as it manifests itself in behavior.
3. Sexual intercourse.

sex workers: People who sell their bodies of provide others with sex services for favors or money.

sexual contact: Sexual intercourse or sexual activity between individuals.

sexual intercourse: Sexual activity that involves penetration of penis in vagina.

sexual partner: A sexual partner is a person with whom one engages in sex acts.

sexual transmission: Transmission by having sex (vaginal, oral, or anal) or by other sexual contact. In case of HIV it means transmitting the disease through sexual intercourse.

sexual violence: Violence induced sex, where sex is without consent.

sexuality: The state of sexual orientation; sex appeal.

sexually transmitted disease: Also called venereal disease. A contagious disease usually acquired by sexual intercourse orgenital contact. Historically, the five

venereal diseases were: gonorrhea, syphilis, chancroid, granuloma inguinale and lymphogranulomavenereum. To these have been added scabies, herpes genitalis and an orectal herpes and warts, pediculosis, trichomoniasis, genital candidiasis, molluscumcontagiosum, nonspecific urethritis, chlamydial infections, cytomegalovirus and AIDS.

she-male: The terms she-male (or chicks with dicks) refer to trans-women (male-to-female transgender or transsexual people) who have female breasts, through hormone replacement therapy and/or through breast augmentation and usually other female secondary sex characteristics, but who have not undergone genital reassignment surgery.

stigma: To consider PLWHAs as a symbol of disgrace, shame or discredit. Stigma also includes many misconceptions and myths attached with HIV and AIDS which lead to discrimination of PLWHA.

surveillance: Close or continuous observation or testing (e.g., sero-surveillance), used, among others, in epidemiology. Immunological surveillance, or immuno-surveillance, is a monitoring process of the immune system that detects and destroys neoplastic (e.g., cancerous) cells and that tends to break down in immuno-suppressed individuals.

susceptible: Vulnerable or predisposed to a disease.

syndromes: A group of symptoms and diseases that together are characteristics of a specific condition.

taboos: A ban or an inhibition resulting from social custom or emotional aversion.

tattooing: A permanent mark or design made on the skin by a process of pricking and ingraining an indelible pigment or by raising scars. It increases the danger of HIV as same instruments are used on different bodies.

third gender: People who did not fit into the existing gender categories, also known as binary gender system or hetero nor-mativity:

- female genitalia = female identity = female behavior = desire male partner.
- male genitalia = male identity = male behavior = desires female partner.

The third gender included (in modern terms): Intersexual people; Gays and lesbians; Transgendered people.

trafficking: Trafficking is a term to describe a transnational illegal activity, involving transporting usually drugs, small arms or people. The trafficking in human beings is not the same as people smuggling. A smuggler will facilitate illegal entry into a country for a fee, but on arrival at their destination, the smuggled person is free; in people trafficking, the trafficking victim is kidnapped and enslaved.

transfusion: The process of transfusing fluid (such as blood) into a blood vessel. It is the transfer of whole blood or blood products from one individual to another.

transmission: In the context of HIV disease: HIV is spread most commonly by sexual contact with an infected partner. The virus can enter the body through the mucosal lining of the vagina, vulva, penis, rectum or, very rarely, the mouth during sex. The likelihood of transmission is increased by factors that may damage these linings, especially other sexually transmitted diseases that cause ulcers or inflammation. Studies of SIV infection of the genital membranes of nonhuman primates suggest that the sentinel cells known as mucosal dendritic cells may be the first cells infected. Infected dendritic cells may migrate to lymph nodes and infect other cells. HIV also is spread through contact with infected blood, most often by the sharing of drug needles or syringes contaminated with minute quantities of blood containing the virus.

unprotected sex: Unprotected sex refers to any act of sexual intercourse in which the participants use no forms of protection from sexually transmitted diseases. It can thus be contrasted with "safe sex".

vaccine: A substance that contains antigenic components from an infectious organism. By stimulating an immune response (but not disease), it protects against subsequent infection by that organism.

vaccination:

1. Inoculation with a vaccine in order to protect against a particular disease.
2. A scar left on the skin by vaccinating.

virus: Organism composed mainly of nucleic acid within a protein coat, ranging in size from 100 to2000 angstroms (unit of length; 1 angstrom is equal to 10-10 meters); they can be seen only with an electron microscope. During the stage of their life cycle when they are free and infectious, viruses do not carry out the usual functions of living cells, such as respiration and growth; however, when they enter a living plant, animal or bacterial cell, they make use of the host cell's chemical energy and protein- and nucleic acid-synthesizing ability to replicate themselves. Viral nucleic acids are single- (or) double-stranded and may be DNA(deoxyribonucleic acid) or RNA (ribonucleic acid).After viral components are made by the infected host cell, virus particles are released; the host cell is often dissolved. Some viruses do not kill cells but transform them into a cancerous state; some cause illness and then seem to disappear, while remaining latent and later causing another, sometimes much more severe, form of disease.

vulnerability: It is a predisposition to risky behavior because of various demographic, on medical factors such as HIV and AIDS virus.

vulnerable population: Those groups of population which are more likely to be affected by HIV and AIDS because of their social behaviors are called vulnerable population, for example, injecting drugs users, female sex workers etc.

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