

Canadian HIV/AIDS Legal Network

# HIV/AIDS POLICY & LAW REVIEW

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## Redoubling global efforts to support HIV/AIDS and human rights

The role that human rights can play in the global response to HIV/AIDS is crucial. People around the world continue to be placed at risk of HIV due to ongoing human rights violations. In this article — based on a public lecture he gave at “From Evidence and Principle to Policy and Action,” the 2<sup>nd</sup> Annual Symposium on HIV, Law and Human Rights, held on 10–12 June 2010 in Toronto, Canada — Michel Kazatchkine, Executive Director of the Global Fund to Fight AIDS, Tuberculosis and Malaria, discusses how the lack of support for programs that protect and promote human rights is one of the failures in the response to AIDS. He stresses that advocates must reinvigorate efforts for human rights and treatment and prevention for all, including for the most marginalized populations.

### Introduction

Few moments in the history of the AIDS epidemic have been as pivotal as the plenary address by the Honourable Edwin Cameron, Justice of the South African Constitutional Court and one of the most eloquent and outspoken advocates for a rights-based

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### Special Sections:

#### AIDS 2010

This issue of the *Review* includes a supplement containing a cross-section of presentations on legal, ethical and human rights issues from the XVIII International AIDS Conference, held in Vienna, in July. See page 35.



UNAIDS  
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#### Symposium on HIV, Law and Human Rights

A summary of proceedings of “From Evidence and Principle to Policy and Practice,” the 2<sup>nd</sup> Annual Symposium on HIV, Law and Human Rights, which took place from 10–12 June in Toronto. See page 65.



# Redoubling global efforts to support HIV/AIDS and human rights

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response to AIDS, which he gave at the International AIDS Conference in Durban, South Africa in 2000. It was titled “The deafening silence of AIDS.”<sup>1</sup> Following on the heels of a march of thousands through the streets of Durban, Cameron’s speech helped bring the world’s attention to the moral outrage of the failure to provide life-saving antiretroviral treatment in much of the developing world, where it was desperately needed. Building on and supporting the concerted advocacy efforts of other South African activists, the speech laid the foundation for one of the greatest human rights victories in the fight against AIDS: the global rollout of antiretroviral treatment.

Cameron appealed to the conscience of a world that was letting poor people die, and declared that governments, including his own, could not be allowed to shirk their responsibility to act. The speech crystallized sentiment in favour of providing antiretroviral treatment to those who needed it in developing countries, rather than only in high-income countries where treatment had been available for years. The broader global health and human rights movement to which the speech by Cameron belongs has led to a variety of actions, from price cuts on medicines to former UN Secretary General Kofi Annan’s call to action on AIDS and, ultimately, the creation of the Global Fund to Fight AIDS, Tuberculosis and Malaria.

At the time of this speech, ten years ago, many were sceptical that treatment could or should be provided

in the developing world, and had a long list of arguments against providing it. They said that making treatment available would be too expensive; that patients would not be able to adhere to treatment, leading to drug resistance; that the necessary infrastructure was lacking and could not be built; and that providing treatment would not be cost-effective. In other words: it could not be done and would not be worth it.

**Advocates must  
reinvigorate efforts  
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for all.**

Ultimately, all of these claims were proven wrong. Ten years later, five million people in low- and middle-income countries are on antiretroviral treatment. At least another five million people are in urgent need of treatment, but we have made huge progress compared to where we were a decade ago, or even five years ago.

## **Establishing targets for HIV treatment**

The world took action by establishing ambitious targets, such as provid-

ing treatment to three million people in developing countries by the end of 2005 and, subsequently, the goal of providing “universal access” to prevention, treatment, care and support by the end of 2010, the goal first articulated by the G8 countries and then adopted by the UN General Assembly.

The Global Fund was created to respond to the crisis and make action possible. Importantly, it took some risks and did not follow the conventional wisdom. However, I would argue that, if we want to win the fight against pandemic diseases such as AIDS, tuberculosis and malaria, we must be bold and make strategic bets — as long as we are vigilant about the outcomes and adjust our course of action as necessary.

By way of example, when the first needle and syringe programs were opened in the 1980s, often illegally or in a legal grey zone in many countries, we knew that rates of HIV were exploding among people who inject drugs. We also knew that they were often subject to abuse by law enforcement officers and even by health-care providers. At the time, we did not have extensive scientific evidence that the spread of HIV could be significantly slowed, without increasing drug use, by making sterile injecting equipment easily accessible to people who use drugs.

Nevertheless, it stood to reason that providing easy access to sterile equipment, combined with effective education about the need to avoid sharing used equipment, could

help people avoid a behaviour that carries a high risk of transmitting HIV and other blood-borne viruses, among other harms. We took action, acknowledging that people who use drugs can be agents of change and should be treated with dignity. We monitored the results and evaluated the programs thoroughly, and today it can no longer be disputed that harm reduction measures such as needle and syringe programs are essential health services and are key to realizing the human right of all persons to enjoy the highest attainable standard of health.

In Canada and elsewhere, the story has been the same with supervised injection sites, which science has shown, time and again, are important services protecting and promoting the health of some of those who are most marginalized and at risk of HIV and other harms.<sup>2</sup>

Similarly, despite the doubts expressed by many, we started making antiretroviral HIV treatment available in developing countries and then vastly scaled up treatment access, while continuing to monitor results. Today, even in the most fragile states and in the most difficult settings, people are benefiting from treatment. Adherence is good and there is no alarming evidence of widespread drug resistance. There is a substantial body of clinical evidence to show that the drugs work well, regardless of the setting. Lives are being saved on an unprecedented scale — not only in Toronto, but in Durban, Dushanbe, Port au Prince, Dar-es-Salaam and Vientiane.

The progress we have achieved represents not only a tremendous public health success, but also a major human rights victory. At the same time, advocates must be per-

sistent and reinvigorate efforts for human rights and treatment and prevention for all. Instead of building upon the results we have achieved and continuing to move forward resolutely, what I am hearing too often these days is the voices of the doubters and sceptics, as in the year 2000, when many people argued against providing treatment in developing countries.

### **A troubling backlash against HIV treatment**

Today, we have proven that we can provide treatment to everyone in need. Yet, some vocal people are saying that this is not sustainable, that perhaps “we should do less, but better,” that AIDS has received too much attention compared to other diseases, and that there is treatment just because AIDS activists have been louder than advocates for other health problems.

Some people are talking about a “treatment mortgage” that donors will have to pay in the long term — a very negative and inappropriate term when what we have done is saved lives and given new hope to millions of people and should be celebrating the treatment successes. This backlash against treatment is a backlash against human rights that we must resist. Instead of turning people away from treatment centres or putting them on waiting lists — something that is already happening in too many places, every day<sup>3</sup> — we should continue scaling up.

To be sure, many countries are facing difficult economic times. However, what some may not realize is that poor countries are among the hardest hit and that, in times of crisis, their needs are greatest. We should not allow this crisis to increase inequities again. Unless we act now, we

risk undoing the progress we have achieved since Cameron’s speech in Durban, and since the Global Fund was created eight years ago and become the world’s most powerful vehicle to reduce inequities in health — and hence a powerful vehicle for the realization of human rights.

A recent report by the World Bank and the International Monetary Fund examines the impact of the global economic recession on poverty and human development outcomes in developing countries.<sup>4</sup> It concludes that the progress in poverty reduction made before the economic crisis will likely slow, particularly in low-income countries in Africa.

No household in developing countries is immune. By the end of 2010, an additional 64 million people will fall into extreme poverty due to the crisis. Even households above the poverty line are coping by, among other things, buying cheaper food and reducing visits to doctors.

While international financial institutions and the international community have responded forcefully and quickly to the crisis with unprecedented millions to support the financial sector and other industries, efforts are now needed to regain momentum toward achieving all of the Millennium Development Goals (MDGs) in every region. One of those goals, to be achieved by 2015, is to have halted and begun reversing the spread of HIV. The year 2010 will be decisive. This is the year in which we decide if we will win the fight against AIDS and more broadly, meet the health-related MDGs.

The outcome of various important meetings in 2010 — such as the G8 and G20 meetings in Toronto, the International AIDS Conference in Vienna, the African Union Head

of State Summit in Kampala, the Millennium Development Goals Summit at the United Nations in New York and the Global Fund replenishment meeting — will determine whether we will be able to continue scaling up programs and ultimately win the fight or whether we will waver in our commitment and let the progress falter, allowing AIDS, tuberculosis and malaria to gain force again.

### **Action on maternal and child health**

There are four main priorities and challenges in the months and years ahead. The first is action for maternal and child health. Canada has been pushing the G8 for a wide focus on both child and maternal health. Several other meetings, including the “Women Deliver” Conference in Washington in June 2010, have focused on maternal and child health.

There has recently been some good news. Studies published in *The Lancet* have shown that significant progress has been achieved in the last decades, both on maternal<sup>5</sup> and on child health.<sup>6</sup> In many ways, the Global Fund has made key contributions to this progress, among other things by protecting millions of children and mothers against malaria infection, preventing mother-to-child transmission of HIV and providing treatment to women with HIV and tuberculosis.<sup>7</sup> The Global Fund has also adopted a progressive strategy on gender equality. Under this strategy, we support a range of structural interventions to enhance gender equity, increase women’s participation in decision-making and protect women against gender-based violence.

At the same time, nobody disputes that a lot more can and must be done.

However, it remains unclear whether bold action will follow all the talk. This would require significant additional resources for maternal and child health, and not a redistribution of resources from other under-funded areas of health and development to maternal and child health. It would also require a comprehensive approach, including funding for family planning and safe abortions, rather than an approach that fails to include these key aspects of sexual and reproductive health and rights.

**Action for maternal and child health needs to include championing of the rights of women.**

The HIV struggle has highlighted for the world the direct ways in which subordination of women and politicized denial of comprehensive reproductive services and information to women directly undermine health and rights of women. Action for maternal and child health needs to include a real championing of the rights of women, including their sexual and reproductive rights.

The Global Fund is ready and committed to continue playing an important role in maternal and child health. If indeed additional resources become available, we could take on added responsibilities, such as

hosting a new facility, focused on maternal and child health, at the Fund.

The second priority and challenge is to stop pitching HIV treatment against HIV prevention. We need to continue scaling up both. In remarks that I delivered at the International AIDS Conference in Mexico City in 2008, I celebrated the progress on access to treatment, and am pleased to report that we have made more progress since. At that time, three million people in developing countries were accessing treatment. Two years later, it is five million. With adequate resources, we can continue scaling up and ultimately provide access to everyone in need.

I also noted in Mexico City that, while the need to drastically scale up HIV prevention efforts had dominated the AIDS conference, we had finally “moved on from the fruitless debate between prevention and treatment that has plagued us in the past”.

### **An integrated approach to HIV prevention and treatment**

Sadly, it seems that assessment was premature. This is clearly an area in which we have gone backwards. Indeed, some have recently argued that the Global Fund and other funders are investing too much in HIV treatment, to the detriment of HIV prevention. They are wrong. At the Global Fund, we support programs developed at the country level that pursue an integrated and balanced approach covering both HIV prevention and treatment, and broader elements of comprehensive care.

Furthermore, there are strong public health arguments for investing in treatment. We cannot successfully prevent the further spread of HIV

unless we scale up both prevention and treatment. We know that people are less likely to come forward for HIV testing if they cannot access treatment. Now we have evidence that antiretroviral treatment plays a key role in decreasing HIV transmission.<sup>8</sup> We must move on from this fruitless debate and scale up both prevention and treatment. The supposed dichotomy between the two is a false one, and one that is too easily used as a justification for flat-lining or reducing funding commitments to the global AIDS response.

The third priority is to take serious action on HIV and human rights. In countries all over the world, people living with and communities affected by AIDS are still too often being denied their rights. This is despite evidence that the protection of human rights is central to an effective response to AIDS. Early on, people such as Jonathan Mann powerfully articulated that public health interventions can only be effective if affected people are empowered, informed and participate in decisions that concern their health.<sup>9</sup> He worked tirelessly to bring to the world's attention the basic notion that improved health cannot be achieved without basic human rights, and that these rights are meaningless without adequate health.

Human rights violations continue to happen despite the fact that governments — indeed, all UN Member States — have committed themselves, including in the General Assembly's 2006 *Political Declaration on HIV/AIDS*, to intensifying “efforts ... to ensure the full enjoyment of all human rights and fundamental freedoms by people living with HIV and members of vulnerable groups”.<sup>10</sup>

There has been progress in some areas in recent years. Most notably, the United States of America and, more recently, China have repealed, or are in the process of repealing, restrictions on entry of people living with HIV, which are unjustified. We should celebrate this.

In other areas of human rights, however, we have made little, if any, progress. This must change. There are many examples; let me highlight just a few. In May 2010, I was in Malawi, with UNAIDS Executive Director Michel Sidibé, just days after two men were sentenced to 14 years in prison with hard labour for “indecent practices between males” and “unnatural offences.” We discussed the case with President Bingu wa Mutharika, who said that case was opening the debate in Malawi around the health, societal, cultural and human rights ramifications of laws criminalizing homosexuality. The President since granted a presidential pardon to the jailed couple. This is, of course, great news and we applaud this decision.

**People living with and communities affected by AIDS are still too often being denied their rights.**

In many other countries in Africa, however, gay men and other men who have sex with men are increas-

ingly the target of a campaign of hate and have been arrested, detained and sentenced simply for having sex with another man or even for being suspected of having sex. This is not only unacceptable under international human rights law, but also counterproductive from the point of view of public health. It drives these men underground and away from the services they need. We cannot speak out enough about the worrisome trend we are seeing, and I call on legislators to change outdated penal codes that contain prohibitions against same-sex sexual activity.

### **Human rights abuses of illegal drug users**

People who use illegal drugs also continue to suffer widespread human rights abuses. They continue being denied harm reduction services, have poor and inequitable access to antiretroviral therapy, suffer abuse and sometimes torture at the hand of law enforcement officials, and are often incarcerated, for long periods of time, simply for using or possessing drugs.<sup>11</sup>

These abuses are reported from all regions of the world. They are abhorrent in themselves and we must fight them for this reason alone. They also increase people's vulnerability to HIV and negatively affect the delivery of HIV programs.

Much more needs to happen to fight these abuses. One of the priorities is to stop wasting resources on the failed so-called “war against drugs” that has turned into a war against people and communities — as has been highlighted time and again in report after report. Instead, these resources should be devoted to providing, to everyone who needs them, evidence-based and human rights-based interventions that prevent problematic drug

use, treat drug dependence and ensure harm reduction services for people who use drugs.

In the two years since the last International AIDS Conference, several reports have drawn attention to the fact that, in a number of countries, people who use drugs are detained, without due process, in compulsory drug detention centres. In these centres, they face what is called “treatment” and “rehabilitation.” In reality, these are coercion, forced labour and human rights abuses, including torture.<sup>12</sup> In many of these centres, the services provided are of poor quality and do not accord with either human rights or evidence. Not surprisingly, relapse rates are very high.<sup>13</sup>

Global Fund grants finance some services in a number of these centres. We have undertaken an initial analysis of our grant portfolio, which indicates that our grants support a range of HIV prevention and treatment services, as well as some training in providing such services, in some of these centres. Even providing such services in centres where serious human rights violations occur poses ethical dilemmas.

All compulsory drug treatment centres should be closed and replaced by drug treatment facilities that work and that conform to ethical standards and human rights norms. At the same time, as long as such centres exist, I strongly believe that detainees should at least be provided with access to effective HIV prevention and treatment, provided in an ethical manner and respectful of their rights and dignity.

### **The human rights of women and girls**

Another area in which progress lags far behind, with disastrous conse-

quences including fuelling the HIV epidemic, is the human rights of women and girls. In too many countries, women and girls continue to be subject to violence, denied sexual and reproductive health services, property and inheritance rights, and the basic means to protect themselves from HIV.

**The lack of support for programs that protect human rights is one of the failures in the response to AIDS.**

In Namibia, there have been many positive developments in recent years in the fight against AIDS. Nevertheless, recently advocacy groups have documented the stories of dozens of women living with HIV who were sterilized against their will in public maternity hospitals. One of the Global Fund’s grants included support for expansion of HIV testing and counselling and vertical transmission services in all of Namibia’s public maternity hospitals. I take the issue very seriously and we are examining its implications.

Cases such as these speak to what Joanne Csete, professor at the Mailman School of Public Health at Columbia University in New York, has called the “heart of the Global Fund’s human rights dilemma: espousing human rights principles while also being committed to allow-

ing HIV responses to be driven by countries.” Indeed, the Fund is firmly committed to both: to human rights-based programming and to the principle that responses must be driven and owned by countries, rather than imposed by donors. Countries must be in the driver seat and develop proposals. Independent technical experts then review all proposals and make decisions independently of the Global Fund.

Admittedly, our dual commitment to human rights and to country ownership sometimes poses challenges, particularly when countries fail to implement rights-based policies and programs or have policies that undermine human rights. One thing is clear, however: we do not support interventions that are not evidence-based or that infringe upon human rights.

The lack of support for programs that protect and promote human rights is one of the failures in the response to AIDS. Rights-based programming puts the needs of women and of the most marginalized populations at the centre, and addresses not only their most immediate health needs but recognizes, for example, that providing legal assistance may be as important to a person who injects drugs as a needle or a condom.

The Global Fund actively encourages rights-based programming, including through our gender equality and sexual orientation and gender identities strategies. Similarly, we have recently adopted an initiative to increase access to prevention and treatment for people who inject drugs, including in prisons and pre-trial detention settings, which we hope will contribute to vastly increased access to services for people who inject drugs.

Analysis of recent Global Fund applications shows that still relatively few countries include human rights programs in their proposals, such as long-term campaigns against stigma and discrimination, programs to combat violence against women, or legal services and law reform programs. This is slowly changing, and we look forward to working with partners in encouraging further advances on this front. We need a new, strong and united call for human rights and for continued, ambitious scale-up of treatment and prevention programs — now more than ever.

### **Need for an ambitious replenishment of the Global Fund**

Finally, the fourth priority and challenge: we need a robust, ambitious replenishment of the Global Fund. Without it, we will not be able to move resolutely forward, at the speed required, on any of the other three priorities I just mentioned. Since its inception, the Global Fund has become the main multilateral contributor to achievement of the health-related MDGs.

Today, the Global Fund provides approximately two thirds of international funding for malaria and TB and about one fifth of international funding for the response to HIV. Proposals totalling more than US\$19 billion have been approved for programs in over 140 countries. We fund antiretroviral therapy for 50 percent of the people living with HIV who currently access this lifesaving treatment in Africa, and for 75 percent in Asia. We are also the major multilateral source of external funding for harm reduction programs and other HIV prevention interventions,

such as prevention of mother-to-child transmission of HIV.

The results achieved by the Global Fund, together with its partners, are extraordinary. The programs we support have saved more than five million lives in the last six years. Every day, an additional 3600 lives are saved and thousands of new infections are prevented.

Canada could make a significant difference for maternal and child health.

We had a first replenishment meeting in March 2010, where we outlined the health impacts that could be achieved with resources of US\$13 billion, US\$17 billion and US\$20 billion, respectively, over the three years from 2011–2013. With US\$13 billion, we would be able to continue funding the successful programs countries are implementing, but we would not be able to continue scaling up programs at the same level as in recent years. Efforts to fight AIDS, TB and malaria would slow down.

In contrast, if we had sufficient resources to enable countries to continue scaling up programs rapidly, we could come close to, reach or even exceed the health-related MDGs. By 2015, we could

- eliminate malaria as a public health problem in most countries where it is endemic;
- prevent millions of new HIV infections;
- dramatically reduce deaths from AIDS;
- virtually eliminate transmission of HIV from mother to child;
- substantially reduce child mortality and improve maternal health;
- achieve significant declines in TB prevalence and mortality; and
- continue strengthening health systems.

The final decisions about how much each country, including Canada, will contribute to the Global Fund for 2011–2013 are to be announced at our replenishment conference in New York in October 2010.

Canada has a big role to play, in each of the priorities and challenges I have set out. As an example, I very much welcome the initiative for maternal and child health Canada has been promoting. As the host of the 2010 G8 and G20, Canada could make a significant difference for maternal and child health if its initiative leads to bold, coordinated, well-funded and comprehensive action, necessarily including women's sexual and reproductive health and rights.

On access to treatment, Canada can complement a major contribution to the Global Fund by also making Canada's Access to Medicines Regime (CAMR) — which was supposed to enable licensing of pharmaceuticals under patent in Canada for the limited purpose of exporting lower-cost, generic versions of those medicines to eligible importing countries — workable. This would facilitate access by developing countries

to medicines, including fixed-dose combinations and paediatric formulations. As recognized by the World Health Organization and the Global Fund, fixed-dose combinations of antiretrovirals — that is, multiple medicines in one tablet — are critical to achieving universal access to HIV treatment, as is the more efficient use of funds by procuring needed medicines at the lowest price possible.

In 2004, Canada provided international leadership by enacting CAMR. Yet, this regime has delivered only one medicine once, under one licence, to one country: Rwanda — surely not what Canada sought to achieve with its much-lauded initiative. In the face of the ongoing need for sustainable sources of affordable medicines, CAMR can and should be reformed so that it can deliver on the promise.

As Jonathan Mann taught us, the fight against AIDS is a fight for human rights, and the fight for human rights is an essential component of the fight against AIDS. The efforts that advocates undertake for health and human rights is changing history and bringing hope to people around the world. Together, we must continue and keep up the fight.

— Michel Kazatchkine

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<sup>1</sup> E. Cameron, "The deafening silence of AIDS," *HIV/AIDS Policy & Law Review* 5(4) (2000): pp. 79–86, on-line: [www.aidslaw.ca/publications/publicationsdocEN.php?ref=238](http://www.aidslaw.ca/publications/publicationsdocEN.php?ref=238).

<sup>2</sup> See, e.g.: E. Wood et al., "Summary of findings from the evaluation of a pilot medically supervised safer injecting facility," *Canadian Medical Association Journal* 175(11) (2006): pp. 1399–1404; A. M. Bayoumi and G. S. Zaric, "The cost-effectiveness of Vancouver's supervised injection facility," *Canadian Medical Association Journal*, 179(11) (2008): pp. 1143–1151.

<sup>3</sup> Médecins sans Frontières, *No time to quit: HIV/AIDS treatment gap widening in Africa*, May 2010, on-line: [www.msf.org/source/countries/africa/southafrica/2010/no\\_time\\_to\\_quit/HIV\\_Report\\_No\\_Time\\_To\\_Quit.pdf](http://www.msf.org/source/countries/africa/southafrica/2010/no_time_to_quit/HIV_Report_No_Time_To_Quit.pdf).

<sup>4</sup> The International Bank for Reconstruction and Development/The World Bank, *Global Monitoring Report 2010: The MDGs after the Crisis*, 2010, on-line: <http://web.worldbank.org/WBSITE/EXTERNAL/EXTDEC/EXTGLOBALMONITOR/EXTGLOMONREP2010/0,,contentMDK:22519784~pagePK:64168427~piPK:64168435~theSitePK:6911226,00.html>.

<sup>5</sup> M. Hogan et al., "Maternal mortality for 181 countries, 1980–2008: a systematic analysis of progress towards Millennium Development Goal 5," *The Lancet* 355(9726): 1609–1623, on-line: [www.thelancet.com/journals/lancet/article/PIIS0140-6736\(10\)60518-1/abstract](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(10)60518-1/abstract).

<sup>6</sup> J. Knoll Rajaratnam, "Neonatal, postneonatal, childhood, and under-5 mortality for 187 countries, 1970–2010: a systematic analysis of progress towards Millennium Development Goal 4," *The Lancet*, early publication online, 24 May 2010: [www.thelancet.com/journals/lancet/article/PIIS0140-6736\(10\)60703-9/fulltext#](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(10)60703-9/fulltext#).

<sup>7</sup> The Global Fund to Fight AIDS, Tuberculosis and Malaria, *Investments in the health of women and children: Global Fund support of millennium development goals 4 and 5*, 2010, on-line: [www.theglobalfund.org/documents/replenishment/2010/Investment%20in%20Health%20of%20Women%20and%20Children\\_GF%20Support%20to%20MDG%204%20and%205.pdf](http://www.theglobalfund.org/documents/replenishment/2010/Investment%20in%20Health%20of%20Women%20and%20Children_GF%20Support%20to%20MDG%204%20and%205.pdf).

<sup>8</sup> D. Donnell et al., "Heterosexual HIV-1 transmission after initiation of antiretroviral therapy: a prospective cohort analysis," *The Lancet*, early publication, on-line: [www.thelancet.com/journals/lancet/article/PIIS0140-6736\(10\)60705-2/abstract](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(10)60705-2/abstract).

<sup>9</sup> See, e.g., J. Mann et al. (eds.), *Health and human rights: a reader* (London: Routledge, 1999).

<sup>10</sup> United Nations General Assembly, *Political declaration on HIV/AIDS*, 60<sup>th</sup> session, 2 June 2006.

<sup>11</sup> R. Jürgens et al., "People who use drugs, HIV, and human rights," *The Lancet*, in press.

<sup>12</sup> See, e.g., R. Pearshouse, "Patients, not criminals? An assessment of Thailand's compulsory drug dependence treatment system," *HIV/AIDS Policy & Law Review* 14(1) (2000): pp. 11–17; World Health Organization Western Pacific Region, *Assessment of compulsory treatment of people who use drugs in Cambodia, China, Malaysia and Viet Nam: An application of selected human rights principles*, 2009; Open Society Institute, *At What Cost? HIV and Human Rights Consequences of the Global "War on Drugs"*, 2009; D. Wolfe, "Paradoxes in antiretroviral treatment for injecting drug users: Access, adherence and structural barriers in Asia and the former Soviet Union," *International Journal of Drug Policy* 18(4) (2007): pp. 246–54; Su J., "Analysis of 272 cases swallowing foreign body in compulsory detoxification," *Chinese Journal of Drug Dependence* 13(3) (2004): pp. 221–3; Human Rights Watch, "Skin on the Cable": *The Illegal Arrest, Arbitrary Detention and Torture of People Who Use Drugs in Cambodia*, 2010; Human Rights Watch, *An Unbreakable Cycle: Drug Dependency Treatment, Mandatory Confinement, and HIV/AIDS in China's Guangxi Province*, 2008; Human Rights Watch, *Where Darkness Knows No Limits: Incarceration, Ill-Treatment and Forced Labor as Drug Rehabilitation in China*, 2010.

<sup>13</sup> *Ibid.*