

## UNAIDS

### Welcome

Dear Delegates,

Welcome to the UNAIDS committee at BUSUN 2010! I hope you are all ready for a weekend that is challenging and exciting.

I am Ruth Shefner, your chair. I am a sophomore this year at Brown and am concentrating in Community Health. While this is my first time chairing a committee at BUSUN, this conference and I go way back. BUSUN 2006, during my freshman year of high school, was my first exposure to Model UN conferences, and was my first time on the Brown campus. Obviously, both the school and the conference had an impact. Afterwards, at my high school conference, I chaired a variety of committees and was Co-Secretary General. Last year [after coming to Brown] I was also on the operations staff for BUSUN.

I hope you find these background guides useful as an overview of the topics and a guide for further research. Obviously there is much more to these topics than I have included, so please keep looking! In addition to researching the topics in particular, it would be incredibly useful if each delegate had a working knowledge of the virus and its history. This doesn't mean you need to understand the science of the disease, but you should be aware of the patterns of transmission and general social trends that it has followed. The more you put into this conference, the more you will get out of it, and the better our committee will be! Please feel free to email me with any questions that you have, and I look forward to meeting you in November!

Sincerely,  
Ruth Shefner  
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## Committee History

UNAIDS, also known as the Joint United Nations Programme on HIV/AIDS, was established in 1994 to strengthen, enhance, and unite the United Nations' response to AIDS. Since going into effect in 1996, UNAIDS has shared facilities with the World Health Organization and has brought together efforts of UNHCR, UNICEF, WFP, UNDP, UNFPA, UNODC, ILO, UNESCO, WHO, and the World Bank to work towards prevention, treatment, and awareness of HIV/AIDS. UNAIDS is guided by a Programme Coordinating Board with representatives of 22 governments from all geographic regions, the UNAIDS Cosponsors, and five representatives of nongovernmental organizations (NGOs), including associations of people living with HIV/AIDS. As the world's largest advocate for global action on HIV/AIDS, UNAIDS has established partnerships and has received donations from governments, NGOs, foundations, corporations, private groups, and individuals. (UNAIDS.org)

### Topic 1: Homosexual Rights and the Spreading of AIDS in Sub-Saharan and East Africa

Homophobia, which is sometimes referred to as "the last accepted prejudice," exists everywhere. Even in nations with outright bans on legal discrimination on the basis of sexual orientation, homophobic attitudes persist. In much of Latin America, Europe, and North America, homophobia is a large part of the socialization process, with boys expected to act certain ways in order to avoid the stigma of "being gay." In nations where no laws criminalize homophobic prejudice, the abuse is more direct. LGBT people may be victims of bullying, excluded from housing or employment, or even raped or killed. Nowhere is this seen more explicitly than in Sub-Saharan Africa, where there "continues to be rampant denial,

stigmatization and condemnation of homosexuality” (Foreman 199). Often referred to as “un-African,” as for example by Kenyan archbishop Zacchaeus Okoth there is a widespread denial, repression, or lack of recognition for homosexual attraction across the region, and many governments, including Uganda and other African nations, still classify any homosexual relationships as illegal. This stigmatization and discrimination against homosexuality is having devastating effects, exacerbating the AIDS epidemic that has already ravaged the continent. Faced with possible arrest or abuse, homosexuals are afraid to ‘out’ themselves, making it impossible for those who are HIV positive to be reached for treatment and others to be reached by prevention and awareness efforts. In addition, in places with more severe anti-gay environments, homosexual individuals may pretend to be heterosexual, having multiple partners of both sexes. This multiplies the risk of transmission and infection.

#### *Case Study:*

Uganda may be examined as a case study of the negative effects of discrimination against homosexuals. Like 38 of 53 African nations, homosexuality in Uganda is a crime punishable by up to 14 years in prison. In October 2009, however, MP David Bahati proposed a law which would broaden the criminalization of homosexuality, introducing the death penalty for those with previous convictions, who are HIV positive, or engage in relations with members of the same sex under the age of 18. The bill also includes provisions to extradite citizens living outside of the nation back to Uganda for punishment and penalties for companies and organizations that support gay rights.

Gay and human rights activists, as well as governments around the world, have spoken out against the proposed bill, calling it a form

of state-sponsored genocide. In particular, there is a concern that the bill will exacerbate the AIDS epidemic, which has already infected 5.4% of the adult population. During the 1990s, Uganda worked hard to combat the rise in AIDS and managed to create a rare turnaround in the spread of the disease. This new legislation, however, threatens to undo that progress. Elizabeth Mataka, the U.N. Special Envoy on AIDS in Africa has expressed alarm at the bill, noting that the threat of subsequent execution would serve as a strong deterrent to getting tested for HIV. South Africa, the only nation in Sub-Saharan Africa to legalize homosexuality, has objected to the bill as well, with the HIV Clinicians Society of South Africa sending a letter to the Ugandan president, warning him that the bill threatens to have a “profoundly negative impact on Uganda’s efforts to combat HIV”(http://blogs.timeslive.co.za/hiv/2010/01/08/hiv-clinicians-condemn-ugandas-anti-homosexuality-bill/).

#### Questions to Consider:

1. One fear of the global community is that Uganda will serve as a model for other African nations, where antipathy to homosexuality is also high. What measures can this committee take to ensure that other countries, especially neighbors such as Rwanda and Burundi, do not follow suit?
2. Laws such as the one in Uganda may have the effect of causing homosexuals to flee into other countries, burdening the healthcare systems and causing increased hostilities and discrimination in their new host countries. What can this committee do to address this issue and prevent the spreading of discrimination, as well as increased HIV transmission across borders?
3. How can this committee work with the cultural institutions that are precluding a comprehensive response to AIDS in order to reach the homosexual populations that are currently being underserved/ignored?

## Resources:

<http://blogs.timeslive.co.za/hiv/2010/01/08/hiv-clinicians-condemn-ugandas-anti-homosexuality-bill/>

<http://www.isn.ethz.ch/isn/Current-Affairs/Special-Reports/LGBT-and-Human-Rights/Analysis>

<http://www.eldis.org/vfile/upload/1/document/0708/DOC21154.pdf>

<http://www.afrol.com/articles/24587>

## Topic 2: Treatment of Prisoners and the Proliferation of AIDS

UNAIDS has listed prisoners as one of the four "major at-risk and neglected populations" in the HIV/AIDS pandemic (2006 Report on the Global AIDS Epidemic). A variety of factors make prisons especially fertile grounds for the transmission of AIDS. Despite strict regulations, intravenous drug use is rampant in prisons, and clean needles are virtually non-existent. Also used for tattooing, one needle may be used by a large number of inmates. In addition, sex is a major form of disease transmission in prisons. Sexual assault and rape are common forms of intimidation among inmates, and prisoners are also known to engage in sex with other men out of boredom while in prison. Even should they desire to use condoms, they are unavailable in virtually all penal institutions.

Not only is transmission itself a major issue in prisons, but problems with testing and treatment also compound the situation. Concerned about the confidentiality of test results, and afraid of the stigmatization that may result from a positive HIV test by fellow inmates afraid of infection and hostile towards homosexuals, many inmates are deterred from being tested, even when tests are made available. The same fears of social isolation and violence from other inmates and prison guards may also keep inmates who are already HIV

positive from seeking treatment. Untreated and undercover, these inmates are prime sources for the further transmission of disease. For those prisoners who do seek treatment, conditions in the facilities and the frequent movement of prisoners in and between institutions may also undermine the dosing schedules of antiretroviral (ARV) treatment and compromise the effectiveness of treatment.

### *Case Study:*

Russia's rate of HIV infection is one of the fastest in the world, and according to Alexander Kononets, head of the health department of the country's Federal Prison Service, there are 42,000 inmates living with HIV/AIDS in Russian prisons and jails. This is approximately 4.1 percent of Russia's inmates - a rate nearly 30 times higher than registered for Russia's non-incarcerated population. Most of whom lack access to proper antiretroviral treatment and medical care. As well, there is limited education provided to inmates about the disease and a shortage of doctors providing care.

Not only do many prisoners enter prisons already HIV positive and receive inadequate care, but the prisons themselves are a breeding ground for transmission. 20% of Russian prisoners admit using intravenous drugs in prison, up to a third of whom began using the drugs while in jail. A study of prison inmates also reports that as many as 85% of prisoners with a 1.5-10 year sentence had sexual encounters in prison—the vast majority of which were without the use of protection. When released back into the general population, they carry the disease, as well as tuberculosis—which has become increasingly common in the Russian prison system—back into the general population. Thus, the Russian prison system "serves as both an incubator for the spread of HIV ...and also as a vehicle for spreading HIV into the general population when inmates are released" (Rense.com).

### Questions to Consider:

1. Despite evidence that HIV prevention measures effectively reduce HIV related risk-behaviors both within the general community and within prison populations, governments have failed to respond to the AIDS crisis in prison systems or implement recommended testing programs. What steps can this committee take to address government reluctance and/or ambivalence to addressing AIDS prevention tactics within penal institutions?
2. For those who are HIV positive, prisons are a dangerous place, with inmates facing stigmatization, physical abuse, and even murder. What can be done to create a less hostile environment for HIV positive prisoners, thus encouraging them to be tested and make known their HIV positive status?
3. Poor conditions in prisons currently make it impossible for prisoners to receive the treatment that they need. In what ways can this committee improve the ability of prisons to serve their HIV positive inmates more comprehensively? To what extent is this solely the responsibility of the government, and what role should the international community take?

### Resources:

<http://www.avert.org/prisons-hiv-aids.htm>  
<http://www.medicalnewstoday.com/articles/95207.php>  
<http://www.rense.com/general41/10p.htm>

### Topic 3: Licensing and Patenting of Intellectual Property

Since the emergence of the AIDS virus in the 1980s, much controversy has surrounded the issue of how drugs should be provided to patients and the balance that should exist between profit and public good. This debate has taken the form of a conflict over HIV drug costs. The cost of brand name drugs is

typically very high, with AIDS drugs costing up to 15,000 dollars per person per year. Pharmaceutical companies claim that their prices are necessary in order to cover the costs for the research and development of new and better treatments. However, the high costs are prohibitive for the majority of infected people in developing nations, leaving many of the most AIDS-stricken nations without access to care. Generic drugs, which are identical copies of brand name drugs sold at much lower prices, have emerged as viable alternatives for providing care to poor populations. Nations such as Brazil, India, and South Africa have begun manufacturing their own generic forms of antiretroviral treatments in the 1990s, revolutionizing access to treatment in the developing world and cutting down death rates by monumental levels. Their provision of cheap replacements also drove down the cost of brand name first line AZT treatments (a type of ARV drug), stirring discontent among big pharmaceutical companies, who complain that the generic drugs cut down on their profits, and thus their ability to produce new AIDS treatments.

In 1995, a piece of international legislation called TRIPS --The Agreement on Trade Related Aspects of Intellectual Property Rights--was introduced to support big pharmaceutical companies' right to patent drugs. Applying to all WTO members, TRIPS mandates member governments to give copyright and patent protection to all new products for a 20-year period, during which time no one may use, make, or sell the product without authorization. Because of the wide reaching effects of this legislation, member nations were given a tiered grace period for implementation, with developed nations granted a year, developing nations granted 5 years, and least developed nations 10 years to make themselves compliant with the standards.

Understanding the negative effects that the legislation would have on the ability of

developing nations to supply drugs to their populations, TRIPS included a number of provisions for avoiding the patent laws in dire situations. Through voluntary licensing, governments, individuals, or organizations can request permission from pharmaceutical companies to reproduce patented products. Governments can also grant compulsory licenses, which allow generic companies to reproduce patented products without fear of prosecution.

Despite these provisions, however, TRIPS has had negative consequences on the ability of nations to provide treatments to their people. Compulsory licenses are only viable for limited production of generic drugs, and manufacturers are often only allowed to supply the drugs domestically. Most developing nations, therefore, who lack the ability to manufacture their own drugs, are left without options. Nations who have taken advantage of the compulsory licensing provision have also faced negative repercussions from pharmaceutical companies and other governments. Brazil, which has been an international leader in fighting TRIPS and supplying free drugs to its people, has faced hostilities from the United States, which has threatened suits against the nation. Thailand has also faced conflicts.

#### Questions to Consider:

1. How do you balance the legitimate concerns of companies who develop drugs with the needs of victims without funds to buy drugs at market prices? What is the relationship between private interest and public good, and who should be the arbitrator?
2. Currently most people in the developing world have a non drug resistant form of AIDS, making first line treatments, which do not fall under the 20 year patent period, effective. However, as resistance to treatment increases in conjunction with expanded access, second line treatments will become increasingly

necessary, making access to these drugs, which are still protected under TRIPS, a significant issue. What can be done to maximize access to these drugs for nations lacking the political influence or financial capital necessary to secure these drugs on a mass scale?

3. Should nations such as Brazil and South Africa be penalized for ignoring patent laws and manufacturing their own drugs?

4. Should TRIPS be abolished for medicines? If so, what form of regulatory structure should replace it?

#### Resources:

<http://www.avert.org/generic.htm>

<http://www.un.org/ecosocdev/geninfo/afrec/vol15no1/151aids8.htm>

<http://pubs.acs.org/subscribe/journals/mdd/v04/i06/html/06rules.html>

<http://www1.american.edu/ted/aidstrips.htm>