

New Jersey, HIV, and the Law

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Abstract

HIV/AIDS has left a dark print on global history in the last four decades with no clear sign of disappearing despite profound medical advancements. The United Nation's Global Commission on HIV and the Law focused its attention on marginalized people (whom laws are supposed to protect) in 2012, and this paper continues that discussion with specific focus on New Jersey's marginalized groups. Specifically, it considers how the law isolates intravenous drug users, prisoners, and sex workers from accessing and utilizing HIV prevention care services. The law, which at times seems abstract and distant, can have profound effects on members of various stigmatized communities. Additionally, exposure laws (which are laws that restrict the sexual behavior of HIV positive people) and intellectual property laws (which are laws that protect creative design) also contribute to the high rates of new HIV transmission. Recommendations from the Global Commission publication are discussed throughout this paper in direct relation to the U.S. state of New Jersey.

On July 9, 2012, members of various media outlets and human rights-based non-governmental organizations (NGOs) from around the world gathered at the United Nations for a historic press conference. The UN's Global Commission on HIV and the Law was the first of its kind. In the four decades of the HIV virus's chilling history, this was the first time the United Nations set up a commission for the sole purpose of considering how the law affects the spread of HIV. The commission circulated their final report at the meeting, which contained several years' worth of research and interviews. The

findings were shocking: The publication stated that “laws create and punish vulnerability. They promote risky behavior, hinder people from accessing prevention tools and treatment, and exacerbate the stigma and social inequalities that make people more vulnerable to HIV infection and illness” (Global Commission on HIV and the Law, 2012, p. 7). Above all, the publication examined how the law affects marginalized groups within *all* societies and made several recommendations for states to incorporate into domestic laws.

In the United States, New Jersey was ranked the sixth highest state for new AIDS diagnoses in 2010 and, at the rate HIV is currently spreading, we can expect about 21,000 new infections within 15 years (State Health Facts). New Jersey can be viewed as a case study for considering how the United States addresses the spreading rates of HIV. As a society, Americans can either choose to ignore the research that recommends effective social policies for preventing HIV infection, or they can create a more targeted, effective legal system that can greatly lower HIV transmissions.

The Global Commission focused its attention on marginalized people (whom laws are supposed to protect), and this paper continues that discussion with specific focus on New Jersey’s marginalized groups. Specifically, it considers how the law isolates intravenous drug users, prisoners, and sex workers from accessing and utilizing HIV prevention care services. The law, which at times seems abstract and distant, can have profound effects on members of various stigmatized communities. Additionally, exposure laws (which are laws that restrict the sexual behavior of HIV positive people) and intellectual property laws (which are laws that protect creative design) also contribute to the high rates of new HIV transmission. Recommendations from the Global Commission publication are discussed throughout this paper in direct relation to the U.S. state of New Jersey. The recommendations are meant to save lives, time, and money.

Intravenous Drug Users (IDUs)

According to the New Jersey Department of Human Services' Division of Addiction Services, roughly 27 percent of all reported HIV cases in the state stem directly from intravenous drug users (IDUs), while another 5 percent of cases result from heterosexual sex with an HIV-positive (HIV+) IDU. Therefore, roughly 32 percent of all new HIV cases can be directly related to intravenous drug use (State of New Jersey, 2011). Addressing the HIV epidemic in New Jersey requires confronting the virus' association to IDUs.

Recommendation 3.1:

"Countries must reform their approach towards drug use. Rather than punishing people who use drugs who do no harm to others, they must offer them access to effective HIV and health services, including harm reduction and voluntary, evidence-based treatment for drug dependence" (Global Commission on HIV and the Law, 2012, p. 35)

Many drug users can lead productive lives if they are given the appropriate help, yet they are often instead thrown in jail – thereby furthering their addiction. Instead of criminalizing drug users, we need to consider effective and constructive ways of dealing with drug abuse. While jailing IDUs may be a simple way for society to deal with drug addiction, it diverts resources from other social problems (such as investigating violent crimes) and perpetuates problems such as the spread of HIV/AIDS. Studies show that in countries where drug use is decriminalized and harm reduction services are legalized (including clean-needle and syringe programs), HIV rates are dramatically reduced. In countries that outlaw harm reduction services, however, HIV rates remain the same or are growing (Global Commission on HIV and the Law, 2012).

As an alternative approach to American drug policy, Portugal has managed to alter their system in a way that has produced positive results. In 2001, Portugal decriminalized the possession of all drugs small enough to suggest personal use; prosecution of drug traffickers has remained. There are still penalties for using drugs, but now they only serve as an administrative offense along the same lines as receiving a parking ticket. Instead of being sentenced to jail, those found to be in possession of small amounts of drugs go before a panel consisting of a psychologist, a social worker and a legal adviser. The panel may impose a range of sanctions, including fines, community service, and suspension of professional licenses. The panel may also recommend educational programs or treatment for those dependent on drugs (Global Commission on HIV and the Law, 2012, p. 34).

Changed drug laws in Portugal altered the drug habits of citizens in a significant way. The number of people prescribed methadone and buprenorphine, common drugs to ease addiction urges, has more than doubled after decriminalization. Treatment is being funded with the money Portugal saves on police and prisons. Portugal also reports the lowest rates of lifetime marijuana use in the European Union, a drop in teen drug use, and a decrease in lifetime heroin use in 16- to 18-year olds. There has also been a decrease in deaths related to drug use. Moreover, new HIV infections among people who use drugs fell about 17 percent from 1999 to 2003 (Global Commission on HIV and the Law, 2012, p. 34).

Portugal's legal move does not have to be isolated; it provides lessons for the United States, including the state of New Jersey. On July 19, 2012, New Jersey Governor Chris Christie signed a jail reform bill that moved New Jersey's policies in a direction similar to Portugal. Under the new bill, pilot New Jersey drug courts, which have already existed for twelve years, will expand to three new counties and will broaden criteria that bring people before a drug court as opposed to a criminal court. If eligible for the drug court, appearance will no longer be voluntary (a choice was previously given between the

two types of courts) and becomes mandatory if one falls into that category. Participants must have a drug addiction, be receptive to treatment, and be deemed able to benefit from treatment to qualify for this option (Spoto, 2012). A full 25 percent of current inmates are non-violent drug users; the process will begin to phase them out of prison systems in eligible counties and make them inpatient or outpatients in a rigorous rehab program designed by the drug courts (John's Addiction, 2012). Cost-wise, housing estimates for inmates in New Jersey prisons costs about \$42,000 per year per inmate, while drug courts and rehabilitation programs cost about \$11,300 per year per patient (Spoto, 2012). Furthermore, these legal changes “remove the fear of arrest and stigma and encourage people who use drugs to get tested for HIV or access treatment” (Global Commission on HIV and the Law, 2012, p. 34).

New Jersey must also push for syringe exchange programs through the pending A-3122 Bill, known as the Blood-Borne Disease Harm Reduction Act. Syringe exchange programs (SEPs) are places where IDUs can exchange dirty syringes for clean ones and prevent IDUs from sharing needles. The World Health Organization recommended SEPs in 2004 after finding “overwhelming” evidence that they are a way of dramatically reducing HIV. Their experimental research concluded there was no evidence of any major unintended consequences or increased drug use, while there were some indications of positive externalities such as recruitment into rehabilitation and primary health care as needed (World Health Organization, 2004, p. 28). A comparative analysis of two Scottish cities shows the dramatic effects of SEPs: In 1981, Edinburgh banned the sale and possession of syringes without a prescription, but HIV rates among IDUs remained over 50 percent by 1984. In Glasgow, however, no such ban was in place and HIV rates among IDUs remained between 1% and 2% (Global Commission on HIV and the Law, 2012, p. 30).

Drug policies such as the outlawing of syringe sales are usually passed with good intentions; however, it must be realized that the net impact of these policies are causing more harm than good.

Evidence shows that it's important to implement astute public policy for the benefit of all. Support for the A-3122 bill, introduced on June 14, 2012, is crucial. Still, SEPs are not enough to fully address HIV among IDUs; according to the World Health Organization, the UN Commission on Narcotic Drugs, and other UN human rights bodies, there must be a mix of different harm reduction services. The following are considered the most effective mix of harm reduction services: clean-needle and syringe programs, opioid substitution therapy and other evidence-based drug dependence treatment, HIV testing and counseling, antiretroviral therapy, prevention and treatment of STIs, condom distribution, targeted information and education, vaccination, diagnosis and treatment of viral hepatitis, prevention, and the diagnosis and treatment of tuberculosis (Global Commission on HIV and the Law, 2012, p. 30).

Prisoners

Laws often foster an environment in which prisoners cannot access the necessary health services for preventing HIV transmission. With people of color composing 93 percent of those incarcerated in New Jersey (The Sentencing Project) and accounting for roughly 74 percent of all new HIV cases in New Jersey (State of New Jersey, 2011), recommendations in this section are vital for success in tackling the virus.

Recommendation 3.5.1:

“Countries must ensure that in places of detention, necessary health care is available, including HIV prevention and care services...[including] provision of condoms, comprehensive harm reduction services, voluntary and evidence-based treatment for drug dependence and ART” (Global Commission on HIV and the Law, 2012, p. 58)

Despite laws prohibiting sex between inmates, sex behind bars is common knowledge. Yet in New Jersey (like in most U.S. states), condoms are prohibited from being distributed in prisons (M. Hill, Buddies of New Jersey, personal communication, 11 February 2013). Prisoners sometimes resort to using plastic bags, gloves, or anything they can get their hands on as a form of safety from STDs (Global Commission on HIV and the Law, 2012, p. 55). Condoms must be made readily available to prisoners who want to voluntarily use them. Although some suggest this is condoning sex within prisons, accepting the reality of the situation is vital. A joint study by the World Health Organization, UNAIDS, and UNODC found that no prison system that has implemented a condom distribution policy has sought to reverse it, and that there have not been any major unintended consequences from providing condoms (World Health Organization, UNAIDS, United Nations Office on Drugs and Crime, 2007, p. 19). Furthermore, policies should be enforced to prevent rape in prisons, and mechanisms must remain in place to prosecute rapists. Allowing rape to occur within a facility is a serious human rights violation and is not acceptable.

Some prisoners also illegally use drugs while incarcerated, and the short supply of clean needles results in the sharing of dirty ones. This has caused a rapid spread of HIV within the prison system, especially in New Jersey where about 25 percent of inmates are non-violent drug users. The New Jersey General Assembly must ensure syringe exchange programs under the A-3122 Bill will also be extended to prisons. This approach has worked elsewhere; when Switzerland implemented a syringe exchange program in 50 of its prisons, all but one completely eliminated needle sharing among inmates. Evaluations of syringe exchange programs in European prisons overall indicate that drug use decrease or remain stable over time, with no new cases of HIV, hepatitis B or hepatitis C (Global Commission on HIV and the Law, 2012, p. 57). These findings drove 12 countries from Europe, the Middle East, North Africa, and Central Asia to integrate these policies within their prisons (Global Commission on HIV and the Law,

2012, p. 56) – a policy that New Jersey should also implement. Additionally, any harm reduction programs made available to IDUs outside of prison must also be made available to those inside prison.

Laws Outlawing Prostitution

Those who engage in sex work, or prostitution, are considered a high-risk group for contracting HIV. Re-evaluating the laws governing sex workers in New Jersey can bring these elevated HIV rates down through effective public policy.

Recommendation 3.2:

“...countries must ensure safe working conditions and offer sex workers and their clients access to effective HIV and health services and commodities” (Global Commission on HIV and the Law, 2012, p. 43)

Since sex work is illegal in 49 U.S. states (Nevada counties are allowed to legalize sex work at their own discretion), sex workers earn their living in an underground system that is unregulated and without the societal protections that other workers take for granted. As a result, these men and women are at risk of daily violence, including rape and beatings. While people who remain “on the grid” are guaranteed protection from police, those protections are not available to sex workers; it is unrealistic to expect a sex worker to report any acts of violence to the police if it will lead to his or her arrest for prostitution. Putting aside normative judgments about sex work, we need to realize that most sex workers are not forced to sell sex but rather regard it as their legitimate profession. “Sex work is not always a desperate or irrational act,” noted the Global Commission on HIV and the Law (2012). “It is a realistic choice to sell sex...” (p. 39).

Some countries have begun to include sex workers in broader discussions of workers' rights. In 2010, the South African Labour Appeal Court found that despite prostitution's illegality, sex workers were entitled to protection from unfair working conditions. Sex workers can more easily protect themselves and report illegal and dangerous actions if they feel safe reporting crimes to the police. Sex worker independence would increase with decriminalization, since the worker would no longer have to rely on someone else's illegal behavior for protection and the profession would be much less of an "underground" system. Similar to other at-risk groups mentioned in this paper, living without fear of prosecution decreases risky behavior that may result in the spread of HIV (Global Commission on HIV and the Law, 2012, p. 36-7). As citizens, we are all entitled to equal protection under the law, regardless of profession. To single out or eliminate a group of people from these fundamental rights is a human rights violation that must be curbed.

Furthermore, governments must allow sex workers access to effective HIV preventive measures – including condoms. According to a Human Rights Watch study, police in major U.S. cities use the mere possession of "large amounts of condoms" to arrest sex workers (Boseley, 2012). Police spot women in urban areas buying or holding a large stack of condoms and, on that basis alone, will interrogate them and sometime detain them. A sex worker from Los Angeles said: "After the arrest, I was always scared ... there were times when I didn't have a condom when I needed one, and I used a plastic bag" (Boseley, 2012). The overall impact of these profiling practices by police proves to be a major public health concern. If police are instilling fear in sex workers that prevent them from buying condoms, then it is less likely that sex workers will use condoms for disease prevention. These policies perpetuate the spread of HIV and prevent safer-sex practices.

Recommendation 3.2.1:

“Countries must repeal laws that prohibit consenting adults to buy or sell sex, as well as laws that otherwise prohibit...brothel-keeping. Complementary legal measures must be taken to ensure safe working conditions to sex workers” (Global Commission on HIV and the Law, 2012, p. 43)

Sex work is alive and well in New Jersey; a sex worker can make up to \$10,000 a month in affluent areas like Bergen County, where 27 arrests for prostitution were made in March 2012. About 1,500 arrests were made for prostitution throughout the entire state of New Jersey in 2010; that statistic does not fully represent the scope of sex work occurring in the state, since many cases of sex work do not result in arrest (Quirk & Harris, 2012).

Although the decriminalization of sex work is sometimes viewed as an immoral task, it is necessary for preventing HIV transmission. This perspective is slowly having an impact on court decisions and government policies. In 2010, a Canadian judge found that provisions against prostitution were unconstitutional since the law “force[d] prostitutes to choose between their liberty interest and their right to security of person” (Global Commission on HIV and the Law, 2012, p. 41). In 1998, the International Labour Organization took an unprecedented and controversial stance calling for the legal recognition of sex work and the protection of both the sex seller and buyer (Lim, 1998).

This global call to end work discrimination against sex workers must happen in New Jersey, as well. Provision 2C:34-1 of the New Jersey Penal Code, which outlaws prostitution, must be repealed. Current prosecution of sex workers must be stopped, all sex workers detained must be given amnesty, and all sex workers must be free from legal harassment on the grounds of a public health crisis. In the words of one sex worker: “When I can work in safe and fair conditions. When I am free of discrimination. When I am free of labels like ‘immoral’ or ‘victim’...when I am free to do my job without harassment, violence or breaking the law. When sex work is recognized as work. When we have safety,

unity, respect, and our rights. When I am free to choose my own way. *Then* I am free to protect myself and others from HIV (Global Commission on HIV and the Law, 2012, p. 27).

Exposure Laws

Governments around the world, out of fear, have enacted what be called “exposure laws.” These laws, meant to prevent HIV+ people from maliciously spreading the virus to others, were created when an HIV-positive diagnosis equaled a death sentence. However, medical advancements mean that living long, healthy lives with HIV is now possible.

Recommendation 2.1:

“Countries must not enact laws that explicitly criminalize HIV transmission, HIV exposure or failure to disclose HIV status. Where such laws exist, they are counterproductive and must be repealed...” (Global Commission on HIV and the Law, 2012, p. 25)

Fear is a common obstacle to repealing exposure laws. The argument goes that these laws protect the public from becoming infected with the virus, and getting rid of the laws would leave uninfected individuals vulnerable. Despite such fears, the Global Commission on HIV and the Law (2012) has found no evidence to suggest that exposure laws change the sexual conduct of people living with HIV by the purposes intended (p. 20).

In New Jersey, Penal Code 2C:34-5 (b) reads: “A person is guilty of a crime of the third degree who, knowing that he or she is infected with [HIV]...commits an act of sexual penetration without the informed consent of the other person” (New Jersey Code, 2009). Simply put, the law has been broken if

an HIV-positive person has any sexual contact with another person and does not inform him or her of the infection. This discriminates against HIV+ people in one of two ways: First, it puts the sole responsibility on the HIV-positive person to be honest about their sexual history when it requires nothing of the other person. Provided that someone is willing to have sex with another person – yet they are not willing to ask if they have any sexually transmitted infections/diseases – then there is shared blame. Exposure laws take responsibility off sexual partners when we should be teaching sexual responsibility. Second, receiving an HIV-positive diagnosis does not mean a person must take an oath of celibacy. Revealing one’s HIV status is an inherently intimate action, but forcing it during a natural act elicits emotional scrutiny others would not have to face. With condoms being easily accessible and antiretroviral therapy dramatically reducing the possibility of transmission, the law serves no other purpose than to give those who are HIV negative peace of mind. Fear of prosecution under exposure laws may prevent people from getting tested or participating in prevention programs, and these laws discriminate against HIV-positive people.

Recommendation 2.4:

“Countries may legitimately prosecute HIV transmission that was both actual and intentional, using general criminal law, but such prosecutions should be pursued with care and required a high standard of evidence and proof” (Global Commission on HIV and the Law, 2012, p. 25)

With exposure laws being repealed, general New Jersey criminal code would still allow for prosecution of actual and intentional HIV transmissions under the premises of bioterrorism. Under New Jersey law, bioterrorism is defined as “the intentional use or threat of use of any biological agent, to cause death, disease, or other biological malfunction in a human” (State of New Jersey, 2005). Using bioterrorism-related laws – rather than intrusive court battles that are often fueled by fear – would treat

this issue in a more humane way. Only in cases where there is proof of causing harm, and the actual spread of HIV, will there be a trial. While New Jersey's exposure law currently incites fear in HIV-positive people simply for having sex, lifting this marginalizing legislation will allow them more equal treatment under the law.

Recommendation 2.5:

"The convictions of those who have been successfully prosecuted for HIV exposure, non-disclosure and transmission must be reviewed...[they must be] released from prison with pardons or similar actions to ensure that these charges do not remain on criminal or sex offender records" (Global Commission on HIV and the Law, 2012, p. 25)

The case of Gregory Dean Smith highlights the importance of reviewing and overturning convictions based on exposure, non-disclosure, and transmission. Smith was sentenced to 25 years for allegedly spitting and biting guards in New Jersey's Camden County Jail in 1989 – his charge was attempted murder, assault, and terroristic threats. Even though Smith testified that he fully understood that HIV could not be transmitted by spitting or biting, he was sentenced to 25 years in prison, sparking outrage by AIDS activists across the country (Sullivan, 1993). Information regarding HIV was limited in 1989, and AIDS phobia ran rampant among most members of society (including the judge and jury in Smith's trial). Even today, his conviction for "attempted murder, assault, and terroristic threats" has yet to receive proper justice. In his honor, the New Jersey's Attorney General should review those who were similarly charged and ensure there was both actual and intentional attempt to spread HIV.

Intellectual Property

First brought to North America during the time of English rule, laws monopolizing intellectual property have been a part of American business for more than two centuries. Similar to patents, someone gets intellectual property (IP) rights to an invention or design when it was the result of one's creativity. IP laws are meant to spark research and development in all professions as a way to create an incentive that otherwise would not exist. Now, as transnational corporations have dramatically expanded, there has evolved a need to protect intellectual property abroad. In 1996, members of the World Trade Organization (WTO) agreed to the Trade Related Aspects of Intellectual Property Rights (TRIPS), setting up an international IP law system and protecting people's creative designs around the world.

Recommendation 6.2:

"High-income countries...must immediately stop pressuring low- & middle-income countries to adopt or implement TRIPS-plus measures in trade agreements that impede access to lifesaving treatment" (Global Commission on HIV and the Law, 2012, p. 86)

Unfortunately when it comes to medicine, IP laws mean dramatically higher prices for medicine that can otherwise be produced very cheaply – something that is devastating to countries with limited resources. In 2001, the WTO affirmed that TRIPS "can and should be interpreted and implemented in a manner supportive of WTO member's right to protect public health and, in particular, to promote access to medicines for all" (World Trade Organization, 2001, Article 4). Thailand, for example, is estimated to save about \$358 million on medical expenditures because of this interpretation (Global Commission on HIV and the Law, 2012, p. 80). Under international law, the United States and other highly developed

countries are not supposed to enforce international IP laws towards healthcare; nonetheless, this is simply not the case. Thailand was placed on the United States' Special 301 Priority Watch list for three years as punishment partly because they followed the World Trade Organization's TRIPS recommendations (Global Commission on HIV and the Law, 2012, p. 81).

The United States has become increasingly isolated in its acceptance of this view. Brazil, for example, declared in 1970 that "pharmaceutical products and processes [are] non-patentable" (Global Commission on HIV and the Law, 2012, p. 79) and this stance has played a key role in Brazil's low HIV rates. Recently, a Kenyan Lady Justice ruled that "intellectual property should not override the right to life, right to health and right to human dignity outlined in [the Kenyan] Constitution" (Global Commission on HIV and the Law, 2012, p. 82). Given U.S. President Barack Obama's position on providing access to healthcare to all, U.S. citizens should be aware that the United States has not been advancing this right within the international community.

Conclusion

If we want to lower HIV transmission rates, we must not let any group fall from our radar. Fact and reason should guide us – not ideology. "We cannot continue to let people suffer and die because of inequality, ignorance, intolerance and indifference," noted the Global Commission on HIV and the Law (2012). "[The] cost of inaction is simply too high" (p. 4). For key marginalized populations and those living with HIV, the law is neither abstract nor distant. Even when changing the law might seem too complicated or challenging, the government must work to protect the rights of all people within its borders. New Jersey, or any other U.S. state, does not need to wait for a cure. Measurable changes in HIV transmission rates can happen today – just by changing the law.

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