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Legal, Structural, and Ethical Barriers to prevention and treatment of HIV/AIDS: A Review of Malaysia and Kazakhstan

SENIOR HONORS THESIS: PUBLIC HEALTH

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The Honors College Class of 2016

Abstract

The HIV/AIDS epidemic in nations that use Islamic scripture in law has faced several challenges. The conservative ethical and political approach to the epidemic has been ineffective in halting the spread of and treating the existence of HIV/AIDS. It is expected that there will be several structural barriers to obtaining care, treatment, and prevention services for HIV/AIDS in these nations particularly for vulnerable populations such as Men who have Sex with Men (MSM), People Who Inject Drugs (PWID), and sex workers. This research will investigate and analyze research, laws, politics, ethics, and structure in the nations of Malaysia and Kazakhstan and how the access of care and prevention of HIV/AIDS is affected and addressed. From this research barriers will be found and intervention mechanisms can be created to address this issue.

Introduction

The HIV epidemic has expanded rapidly in predominantly Muslim nations such as Kazakhstan and Malaysia and largely results from Injection Drug Use (IDU), professional sex work, and transmission among Men who have Sex with Men (MSM). These three priority populations are highly interconnected and are often investigated in tandem. Each of these nations has varying legal policies regarding these aforementioned transmission routes. The legal and ethical approaches to treating PLHIV (People Living with HIV/AIDS) has a tremendous impact the prognosis of the disease within a country. This approach is conservative in nature and is often based off of Sharia Law, either directly or indirectly, in many Muslim nations. The implications of this conservative ethical and legal approach to HIV/AIDS prevention and treatment are grave and often perpetuate the disease rather than minimize it. While the social obstacles faced by these three vulnerable populations differ, they all result from the same socio-political

Legal, Structural, and Ethical Barriers to prevention and treatment of HIV/AIDS in Malaysia and Kazakhstan

infrastructure. In addition to more apparent legal and ethical barriers, there can also be structural barriers that inhibit a PLHIV or PWID from accessing treatment or prevention services.

The state of HIV/AIDS in Malaysia and Kazakhstan needs further investigation. In 2011, both Malaysia and Kazakhstan were listed as nations who had insufficient or no epidemiological data on HIV and MSM.

Malaysia

Malaysia, a quasi-Constitutional Monarchy, elects government officials to office. However, the reach and control of their legal system reaches beyond a traditional constitutional monarchy.

The populations of Malaysia was 28,334,135 in 2010. Malaysian citizens are fractioned into ethnic groups¹. Of these ethnic groups 67.4% are bumiputera, a term used to describe the Malay race. The constitution defines all bumiputera as Muslims, but 61.3% of the population identifies as Muslim¹. The constitution claims to guarantee freedom of religion, but also names Islam as the state religion. In addition to the legal system based off of “English Common Law”, there is an entirely separate legal system called The Syariah Court. Judicial decisions and policies made by the Syariah Court are applied to all Muslims living in Malaysia. Malaysia is a devout Muslim country and its laws of the Syariah court are derived from Sharia Law.

The complexity of this system is amplified even more so for topics such as PLHIV, IDU, MSM, and sex work. The use of drugs, especially Injection Drug Use (IDU) is punishable by fines, imprisonment, or death.² As of the end of 2013, Malaysia had reported a cumulative number of 101,672 cases, 20,325 AIDS cases and 16,340 deaths related HIV/AIDS thus giving

the reported PLHIV at 85,332.³ The large majority of HIV cases (75%) were among people who inject drugs.⁴

Barriers to Treatment and Prevention for People Who Inject Drugs

For several decades since HIV/AIDS first appeared, IDU has largely been responsible for the spread of HIV in Malaysia. Throughout these decades substitution therapy and needle exchange programs were consistently rejected by the Malaysian government on the basis of its zero tolerance and drug-free policy. In 1983, there was an attempt to combat the growing drug problem, and Compulsory Drug Detention Centers (CDDCs) were legislatively mandated.⁵ These centers have been globally criticized for ethical concerns, human rights violations, and ineffectiveness in treating addiction. Some of these concerns include holding suspected drug users for two years without adjudication. Malaysia has one of the fastest growing needle and syringe programs in the world.⁵ In response, the Malaysian government began transitioning to voluntary drug treatment centers. These centers have seen more success, but their focus does not remain on IDU. Amid, escalating IDU related HIV cases and the release of the Millennium Development Goals, which showed that of the 8 goals, halting the spread of HIV/AIDS was the only goal that Malaysia had not yet achieved, along with advocacy from Non-Governmental Organizations (NGOs), the government consented to the implementation of methadone maintenance therapy and needle syringe exchange programs available in the Ministry of Health community clinics⁶. If there are positive outcomes, this will likely be scaled up in Ministry of Health facilities.

Unfortunately, due to the criminalized approach to People Who Inject Drugs (PWID), there is little access to and awareness of these treatment programs and transmission reduction services.⁷ Only 5% of PWID in Malaysia identified as having had access to Antiretroviral

Therapy (ART) ³. In addition, the Dangerous Drugs Act of 1952 (revised in 1980), which provides the legal basis for controlling the use and availability of illicit drugs, punishes anyone who has trafficked or attempted to traffic illicit drugs by death. ⁸ This makes it difficult to encourage PWID to seek treatment, as they believe they could be subject to accusation of drug trafficking, essentially forcing PWID to expose themselves to potential sentencing by death. The strict punishments on drug use in Malaysia have not been shown to deter people from using drugs. As seen in figure 1, drug arrests have steadily increased in Malaysia. This is likely due to an increased demand for drugs and because key performance indicators based on drug use continue to be ineffective in reducing future drug use. ⁹

Despite the aforementioned barriers faced by PWID, Malaysia's Ministry of Health continuously identifies decreasing new HIV infections, eliminating stigma, and reducing deaths related to AIDS as their priorities. This conflict of what the Ministry of Health identifies as priorities and the socio-cultural political norms and barriers, make progression in the field of HIV/AIDS prevention difficult in Malaysia.

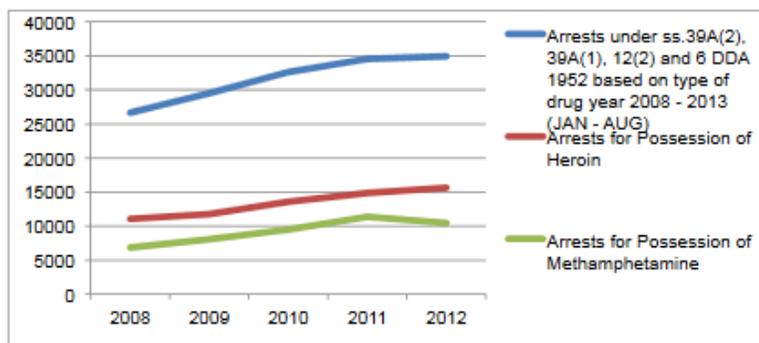


Figure 1: Annual Drug Arrests In Malaysia

Figure 1: This figure is from the Malaysian Aids Council June 2015 Technical Brief

The problem of IDU reaches far beyond the “typical” male user. IDU has largely been considered a problem among men, however, in Malaysia the women are increasingly becoming infected with HIV through IDU. In 2000 the male to female odds ratio for HIV infection was 9.6, in 2013 it was 3.7.¹⁰ 87% of infections among females occur via heterosexual intercourse. This contrasts the findings for men which indicate that only 47% acquire infection through sexual transmission of any form, both heterosexual and homosexual. The large portion of the remainder of men, 48% acquire infection through injection drug use. This data indicates that most women who contract HIV do so through their male partners who likely participate in IDU. There is an increased danger of sexual transmission when engaging in sexual intercourse with a male that injects drugs. Women also face increased obstacles attempting to access treatment or harm reduction services. There is a heightened stigma for women, as they are viewed by society as the care-taker. Women who acquire HIV either through IDU or an infected spouse often have their children taken away from them by child services as they are seen as unfit wives and mothers.¹¹

The priority populations PWID, MSM, and Sex workers are often overlapping populations. A country's approach to treating one of these priority populations is likely mirrored in the other populations. As previously mentioned, in Malaysia IDU is strictly prohibited and high stigmatized. This makes it difficult for PWID to access treatment. The same can be said for Men who have Sex with Men (MSM).

Barriers to HIV/AIDS Treatment and prevention for MSM in Malaysia

Homosexuals, in general, are not well treated in Malaysia. Malaysia Law Section 377 of Penal Code employs “carnal law” which is strict bans on sexual intercourse between men with legal punishments reaching as far as 20 years in prison and whipping¹². Homosexual acts between women carry a sentence of 3 years imprisonment and whipping¹². This is

Legal, Structural, and Ethical Barriers to prevention and treatment of HIV/AIDS in Malaysia and Kazakhstan predominantly the case in nations that utilize Sharia Law and is not unique to Malaysia. Incidents where MSM, transgender people, and HIV outreach workers were harassed by law enforcement agencies are well documented. There are reports of condoms and lubricant seized from MSM venues. Furthermore, condoms have been used as evidence of prostitution or otherwise 'deviant behavior.' In 2002, Human Rights Watch reported that the Government of Malaysia forced HIV groups to stop distributing condoms. ¹³¹⁴¹⁵

Evidence has also shown that criminalization and illegality of sex between men, which exacerbates the social stigma of homosexuality, can negatively affect HIV prevention and treatment programmes¹⁶¹⁷. Due to this stigmatized environment, the knowledge of transmission and the ability for MSM to access harm reduction services is greatly reduced. 20.1% believe that HIV cannot be transmitted through insertive or receptive anal sex and 83.2% of sampled Malay MSM reported having unprotected anal intercourse¹⁸. In addition, $\frac{2}{3}$ of this sample of MSM have never been tested for HIV. This is an improvement from the 29.7% of MSM that the Ministry of Health reported having been tested in 2008/2009¹⁸. As the trend of sexual (hetero or homosexual) transmission of HIV in Malaysia continues to be on the rise, pragmatic evidence-informed responses to reduce the risk of and vulnerabilities associated with HIV infection amongst MSM call for aggressive scale-up.¹⁹ There are some non-profit organizations that aim to treat and prevent HIV/AIDS in the MSM population of Malaysia, most notably the Purple Triangle Foundation. However, without the backing and support of the government and society of Malaysia their resources and potential progress are limited. As previously mentioned, the Purple Triangle Foundation reported Malaysia to be on a list of countries that have little or no epidemiological data on HIV as it relates to MSM.

More resources for the treating and prevention of HIV/AIDS must be allocated to the homosexual or MSM community.

Sex Workers

Sex work has had a large presence in parts of Asia for most of history. Sex work conducted in private is not illegal, however, the act of soliciting and operating a brothel are both illegal. The Penal Code (Act 574) and Minor Offences Act 1955 are laws that directly relate to sex work and sex workers. This act states that every prostitute behaving in a disorderly or indecent manner in or near any public resort shall be deemed to be an idle and disorderly person and shall be liable to a fine not exceeding one hundred ringgit or to imprisonment of a term not exceeding on month. While one hundred ringgit is only about 26 USD, most of these women are living in poverty. In addition, Sharia law is applied to Muslims who engage in sex work- the acts of ‘zina’ and ‘khalwat’²⁰. Zina is the unlawful sexual relations between two Muslim people who are not married and khalwat is infidelity to the person whom one is married to. The criminalization and harsh law enforcement practices targeting sex workers in Malaysia has raised multiple layers of issues. Although the Penal Code does not criminalize the act of sex work in private, the state-level sharia law operates to criminalize Muslim citizens who engage in sex work. The Malaysian government does little to protect sex workers. However, the Prevention and Control of Infectious Diseases Act of 1988 provides that it is an offense for a person who knows or has a reason to believe that they have HIV to do any act which they know or have reason to believe to be likely to spread the disease²¹

Foremost, harassment by personnel from the many law enforcement (police vice squad, immigration department, anti-drugs agency and the religious police) and the allegations of extensive corruption. Secondly, the threat of detention for engaging in sex work by law

Legal, Structural, and Ethical Barriers to prevention and treatment of HIV/AIDS in Malaysia and Kazakhstan

enforcement officers if sex workers are found to possess condoms (exceeding three); used condoms taken and used as evidence of sex work activity, thus, countering HIV prevention interventions such as condom promotion and safe sex behavior. There have also been reports of pervasive abuse against sex workers by pimps, clients, partners and law enforcement personnel. In addition, disempowerment of sex workers as there are impediments to complaints and recourse against violations by law enforcement personnel (both civil and religious) are documented.²²²³²⁴

Kazakhstan

The Republic of Kazakhstan has a population of 17,693,000 and accounts for 60% of central Asia's GDP. This is predominately due to the vast oil/gas and mineral resources. This population and economic size makes Kazakhstan a pivotal member of Central Asia. Kazakhstan was the last of the Soviet republics to declare independence following the dissolution of the Soviet Union in 1991. Today, the political system is a unitary republic. This is a complex system that encapsulates a president, prime ministers, a cabinet, and a bicameral house.

Kazakhstan has 131 ethnicities with 63% of that being Kazakhs.²⁵ About 70% of the populations identifies as Islamic. Officially, Kazakhstan allows freedom of religion but this has been questioned by a number of religious leaders and human rights organizations. Human Rights Watch has described Kazakhstan as heavily restricting freedom of assembly, speech, and religion.²⁶

The criminal code (article 118) on the approach to HIV/AIDS in Kazakhstan has three major points.

1. Knowingly placing prisoner person in danger of HIV/AIDS shall be punished with a fine of up to two hundred monthly calculation indices or corrective labor in the same. This includes involvement in public work for up to one hundred and eight hours or imprisonment of up to 180 hours, or imprisonment for up to 60 days.
2. Infection of another person with HIV/AIDS from a person who knew he/her had this disease shall be punished by imprisonment for a term not exceeding 5 years.
3. Acts specified in paragraph two of this article, transmission or engaging in acts that may lead to transmission to any person known as a minor shall be punished by imprisonment of four to eight years whether the party was aware or unaware.

As of 2013, the rate of HIV in Kazakhstan was 86.5/100,000²⁷. It has been estimated that between 1987 and 2013, 60.9% of people who tested positive for HIV were infected intravenously and 34% sexually²⁷. In Kazakhstan, the law on HIV/AIDS prevention stipulates that the government is responsible for providing treatment free of charge to people living with HIV/AIDS and for their social protection, this includes providing information HIV/AIDS, prevention activities and guaranteeing the human rights of people with HIV/AIDS. Voluntary testing is available in Kazakhstan. Although the aim of this law was to make a provision for free treatment for people living with HIV/AIDS, this is not what occurs in practice. Budgets do not usually allow such costly medicines to be procured and as a result, most people do not have access to antiretroviral medication. However, in 2002 more progressive legislation regarding HIV was passed and it included the abolishment of compulsory testing of the populations specified in previous legislation such as prisoners and the introduction of anonymous and voluntary testing. The government of Kazakhstan is increasing its actions against HIV under a National Programme. The goal of this program are that 80% of HIV-infected people have access

to health care and social programs that are covered. In 2004, the WHO regional Office for Europe guidelines on antiretroviral therapy protocols were adopted²⁸.

Barriers to Care for People who Inject Drugs in Kazakhstan

The main legislative article in this regard is Law 279 (1998) ‘On narcotic drugs, psychotropic substances, and precursors and measures to counter their trafficking and abuse’ of the Republic of Kazakhstan. This law stipulates that storage, distribution, and use of drugs is the basis for prosecution. A series of interviews conducted by Human Rights Watch in 2007 reported that police often arrest clients of harm reduction services by confiscating clean syringes and also extract bribes for the possession of them²⁹. The prevalence of HIV among PWID in Kazakhstan reached 19% in 2006 and has steadily increased since then.³⁰ Despite this, the government of Kazakhstan itself has taken no position and provides no funding for harm reduction programs. Drug use and HIV initiatives depend upon the international donor community (primarily UNAIDS and the Open Society Institute)³¹. In 2009, nearly 60% of PWID were reached by HIV prevention programs provided by the international donor community, but these were not harm reduction services. Harm reduction programs in the region reach about 5% of drug users. Despite the negativity of this data, knowledge of HIV status is relatively high in Kazakhstan. 61% of people who inject drugs have had an HIV test in the last year and know the results of it³². While this may not sound significant, it is high considering the lack of government support in harm reduction services.

Kazakhstan has made efforts towards a harm reduction approach to HIV in PWID. Kazakhstan has introduced alternative forms of punishment for drug addicts in the form of compulsory treatment. In 2011, ‘Salamatty Kazakhstan’ program, was directly aimed at the development and improvement of the prevention of drug abuse and its consequences as well as

the development of treatment for addicts. 42% of these activities are intended to develop and improve the monitoring, coordination, and development of human resources, 33% to prevent drug use among the population and 4% to develop and improve the treatment and rehabilitation of people who use drugs (this only includes the expansion of opioid substitution treatment)³³.

Despite being noted as one of the strategic direction within the overall national healthcare development program 'Salmatty Kazakhstan', Kazakhstan does not have a specified HIV program²⁸. Currently, the Ministry of Health coordinates the response to the epidemic through providing a legal-political framework and strengthening partnerships among all stakeholders.

UNAIDS provides support to the government on policy issues and in 2004 UNESCO implemented a regional project supported by UNAIDS Programme Acceleration Funds aimed at establishing regional corps of trainers for expanding voluntary counselling and testing among vulnerable population groups and helping eligible people living with HIV/AIDS in adhering to antiretroviral therapy.³⁴ There were attempts at needle exchange programs in prisons in the early 2000. A project covering 18 prisons includes needle exchange and along with the distribution of condoms³⁵. Many of these projects were abandoned.

The government's unwillingness to involve itself in needle exchange programs has slowed the reduction of HIV/AIDS transmission in Kazakhstan. The move towards this harm reduction service that decreases transmission would likely have a significant positive impact on the IDU community. There is much more that could be done in attempting to decrease the spread of HIV, along with harm reduction services for those with HIV in Kazakhstan.

Barriers to HIV/AIDS treatment for MSM in Kazakhstan

Prior to 1998, anal intercourse between men was specifically criminalized. The draconian Soviet Laws prohibiting sex between men were overturned in Kazakhstan in 1998³⁶. While

same-sex sexual activity is legal, same-sex households do not have access to the same legal protection as opposite-sex couples. There are no anti-discrimination for employment laws, no anti-discrimination laws in the provision of goods and services or hate crime and hate speech. Gay marriage is also illegal in Kazakhstan. As a result, relationship status and family rights go completely unrecognized by the government. In 2008, a statement supporting LGBT (Lesbian, Gay, Bisexual, and Transgender) rights was presented at the General Assembly of the United Nations. This statement was backed by the European Union and the large majority of the developed world. The Arab-league, including Kazakhstan, developed a counter statement opposing this support of LGBT rights. This is an open opposition to the rights of MSM by the Kazakhstan government. It has also been found that LGBT acceptance has either slowed or reversed in Russian or other former USSR republics, this is in opposition to the trend around the rest of the world³⁷.

This hyper-stigmatized environment has drastically slowed the movement towards coverage of treatment for MSM infected with HIV and even more drastically slowed the development of harm reduction services, prevention resources, and testing resources. Due to the negative environment surrounding them, MSM of Kazakhstan do not feel safe utilizing testing sites. The association of HIV and MSM leads many MSM in fear of publicizing their sexuality. The implication of these conservative ideals are seen in the lack of treatment, harm reduction, and prevention services available to this marginalized population of Kazakhstan³⁷.

WHO/UNAIDS estimated Kazakhstan's total antiretroviral therapy needs increased from about 460 people to about 1500 people between 2003 and 2005³⁸. Despite this, the government did not declare a national treatment target for 2005. As a rule, antiretroviral therapy is not provided at public expense to people living with HIV/AIDS. Only children younger than 15

years and pregnant women with HIV have access to antiretroviral therapy under the publically financed health system³⁶. However, pregnant woman did not have access to antiretroviral therapy until 2001. Antiretroviral therapy has been so difficult to access that in the first half of 2003, only 17 people were reported to be receiving antiretroviral therapy³⁸. This increased to 240 by December 2005, still not nearly reaching the majority of people in need of antiretroviral therapy³⁸.

It has been suggested, based on past research, that the stigma of homosexuality, pushes MSM towards bisexual behavior. MSM often have wives and also engage in homosexual intercourse regularly³⁹. This increases the risk of spreading HIV to women. In Kazakhstan, it is highly unusual for married couple to utilize contraceptive methods and woman are often uneducated about health and disease. In a 2007 study that investigated HIV awareness of women in Semey, Kazakhstan, it was found that only 28% knew that there were methods of protecting oneself from HIV such as condom use⁴⁰. Furthermore, only 46% of HIV positive pregnant women were aware that HIV could be spread through breast feeding⁴⁰.

The maltreatment of MSM in Kazakhstan has proven to be detrimental to stopping the spread of HIV/AIDS in the nation, but rather increased spread to women and reducing the amount of accessed treatment. The first step that would have to be taken to progress the treatment and prevention of HIV/AIDS in Kazakhstan is a more open and progressive policy towards homosexuality itself.

Barriers to Care for Sex Workers in Kazakhstan

Prostitution in Kazakhstan is legal in private settings, similarly to Malaysia. However, brothels and pimping are illegal. The treatment of those who exchange sexual activities for

Legal, Structural, and Ethical Barriers to prevention and treatment of HIV/AIDS in Malaysia and Kazakhstan

money in Kazakhstan is poor. This begins with law enforcement. Frequent police indifference has been documented. Examples include threats or further abuse in response to sex workers reports of violence⁴¹. This makes it extremely difficult and risky for sex workers to report to authorities incidences of actual attempted rapes, beatings, and sexual assaults. Often, police entities responsible for taking complaints of rape and violence against women are ineffective. Policemen have been found distorting the information and blaming the victims rather than the perpetrator⁴¹. The highly repressive environment and the regular raids against sex workers in Kazakhstan makes it difficult to conduct studies about violence faced by sex workers. Therefore, there is little data regarding HIV and sex workers.

Agencies and researches have been unsuccessful determining the percentage of sex workers living with HIV that are receiving antiretroviral therapy⁴¹. Further investigation and research must be done to establish a status report of HIV/AIDS incidence of sex workers in Kazakhstan and their access to treatment.

Discussion

The structural, political, and ethical barriers to HIV/AIDS prevention and care are an immense contributory factor to the spread of HIV/AIDS in the countries of Kazakhstan and Malaysia. It was found that in these two nations hyper-criminalization with punishments such as death for drug use, the illegality of homosexuality or lack of rights and protection, harassment by law enforcement for all vulnerable populations, and associated stigmas are the structures preventing the development of prevention mechanisms and resources along with treatments and harm reduction for HIV/AIDS.

While organizations that attempt, successfully or not, to provide resources to this country are absolutely essential to halting the spread of HIV/AIDS, to make the greatest contributions changes must be made in political and ethical policies. Further progress can be made by lobbying for more progressive approaches to HIV/AIDS. These suggestions could be made to Ministries of Health or Departments of Justice. In these nations, it is also important that any policies would not violate Islamic Scripture. Cultural and religious competency is an essential aspect of any proposed interventions or policies towards HIV/AIDS and/or vulnerable population (IDU, MSM, and sex workers). An intervention that would be most likely to see success in countries such as Malaysia or Kazakhstan would have the following components:

1. Multi-level approach (Interpersonal, intrapersonal, community, institutional, and government).
2. Involvement of religious leaders both locally and nationally when possible.
3. Confidentiality in order to encourage the participation of those at risk for HIV/AIDS and those infected with HIV/AIDS.
4. Incorporate practices of the Muslim culture such as time for prayer.

By appealing to all levels of the social-ecological model (Figure 2), an intervention would be able to combat potential barriers ranging from unsupportive family members to barriers that result from public policy. In order to appropriately incorporate the ideals and beliefs of Islam a project director would need to find religious leaders willing to participate at the start and expand the network of religious leaders in support of the intervention over time. Lastly, without confidentiality it will be difficult to encourage people to participate in such an intervention in Kazakhstan and Malaysia.

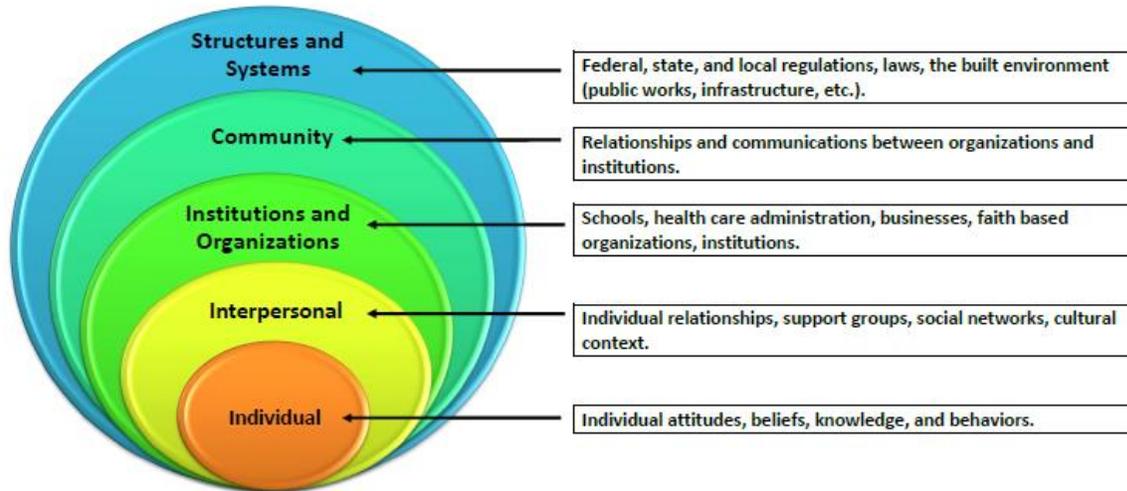


Figure 2: The socioecological model is a framework that any proposed intervention should utilize. The goal is to incorporate as many levels as possible into the intervention chosen. Retrieved from: <http://www.cdc.gov>

It is essential that resources and advocacy are allocated towards nations such as Malaysia and Kazakhstan. These nations are populous countries with relatively large influence in foreign relations and the trade market. More progressive policies aimed at reducing the transmission of HIV/AIDS along with treating those already infected with HIV/AIDS have the potential to lead other predominately Islamic nations.

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