



# **HIV/AIDS LEGAL ASSESSMENT TOOL**

## **ASSESSMENT METHODOLOGY MANUAL**

February 2011

The statements and analysis contained herein are the work of the American Bar Association's Rule of Law Initiative, which is solely responsible for its content. The statements and analysis expressed are solely those of the authors, and have not been approved by the House of Delegates or the Board of Governors of the American Bar Association and do not represent the position or policy of the American Bar Association. Furthermore, nothing in this publication is to be considered rendering legal advice for specific cases. Support for this project was provided by a grant from the U.S. Agency for International Development. The views expressed herein do not necessarily reflect those of the U.S. Agency for International Development or the U.S. Government.

# TABLE OF CONTENTS

## ACKNOWLEDGMENTS

|   |            |
|---|------------|
| <b>PART 1 - METHODOLOGY: OVERVIEW AND IMPLEMENTATION GUIDE .....</b>        | <b>1</b>   |
| <b>Methodology .....</b>  | <b>3</b>   |
| <b>Research and Data Collection .....</b>                                   | <b>7</b>   |
| <b>Country Report Template .....</b>  | <b>12</b>  |
| <b>Glossary of Terms .....</b>  | <b>14</b>  |
| <b>PART 2 – INTERNATIONAL LEGAL AND POLICY FRAMEWORK .....</b>              | <b>19</b>  |
| <b>Sources of International Law .....</b>                                   | <b>21</b>  |
| <b>Key Legal and Policy Concepts .....</b>                                  | <b>26</b>  |
| <b>PART 3 – ANALYTICAL FRAMEWORK.....</b>                                   | <b>33</b>  |
| <b>Structure and Factor Statements .....</b>                                | <b>35</b>  |
| <b>Country Background .....</b>   | <b>39</b>  |
| <b>Section I: Access to Essential Services .....</b>                        | <b>45</b>  |
| Factor 1: Public Education, Research, and Information Exchange .....        | 45         |
| Factor 2: HIV Prevention .....  | 48         |
| Factor 3: Testing, Counseling, and Referral.....                            | 52         |
| Factor 4: Treatment, Care, and Other Health Services.....                   | 55         |
| Factor 5: Social Protection and Material Assistance .....                   | 61         |
| Factor 6: Protection of Privacy and Confidentiality.....                    | 64         |
| <b>Section II: Equality of PLHIV in Public and Private Life.....</b>        | <b>67</b>  |
| Factor 7: Political, Social, and Cultural Life .....                        | 67         |
| Factor 8: Family, Sexual, and Reproductive Life.....                        | 71         |
| Factor 9: Education and Training .....                                      | 75         |
| Factor 10: Employment, Work, and Economic Life .....                        | 78         |
| Factor 11: Public and Private Housing .....                                 | 82         |
| Factor 12: Entry, Stay, and Residence.....                                  | 86         |
| Factor 13: Non-Criminalization of HIV Exposure and Transmission .....       | 91         |
| <b>Section III: Key Populations.....</b>                                    | <b>95</b>  |
| Factor 14: Women .....  | 95         |
| Factor 15: Children and Youth.....  | 101        |
| Factor 16: People who Use Drugs.....  | 106        |
| Factor 17: Adults Engaged in Commercial Sex.....                            | 111        |
| Factor 18: Men who Have Sex with Men, and Transgender People .....          | 115        |
| Factor 19: People under State Custody .....                                 | 119        |
| <b>Section IV: Access to Justice .....</b>                                  | <b>123</b> |
| Factor 20: Legal Protections.....   | 123        |
| Factor 21: Legal Awareness, Assistance, and Representation.....             | 126        |
| Factor 22: Access to a Forum, Fair Trial, and Enforcement of Remedies ..... | 128        |
| <b>PART 4 – ENDNOTES.....</b>   | <b>133</b> |



## ACKNOWLEDGMENTS

The American Bar Association Rule of Law Initiative (ABA ROLI) wishes to cordially thank the team who developed the conceptual framework and design of the HIV/AIDS Legal Assessment Tool, including Paulina Rudnicka, Senior Legal Analyst who served as the project coordinator, co-author, and editor; Leah Utyasheva, Independent Consultant, who served as a legal advisor and co-author; and Tessa Khan, Legal Analyst, who served as a co-author and greatly helped manage the project.

ABA ROLI could not have completed the HIV/AIDS Legal Assessment Tool without the assistance of a splendid team of colleagues, including Michael Maya and Simon Conté who conceived the idea of developing the Tool and oversaw the project; Brie Allen, who helped develop the concept of the Tool; participants of the HIV/AIDS Internal Working Group, including Simon Conté, Olga Ruda, Jennifer Tsai, Jessie Tannenbaum, Jim Wormington, Jeremy Biddle, and Brianne Stuart; as well as Anita Kocsis and Jeanette Matta who provided indispensable research and logistical support. Their invaluable contributions and constructive feedback are greatly appreciated.

ABA ROLI is also indebted to the extraordinary team of HIV/AIDS legal experts who reviewed and provided insightful comments on the draft methodology during an intensive two-day Expert Working Group Meeting. ABA ROLI greatly benefited from the counsel of Aziza Ahmed, Assistant Professor of Law at the Northeastern University School of Law and member of the Technical Advisory Group on HIV and the Law convened by the United Nations Development Programme; Kip Beardsley, Senior Technical Advisor at the Futures Group; Daniel Bruner, Director of Legal Services at the Whitman-Walker Clinic; Veronica Cenac, Director of the AIDS Action Foundation in Saint Lucia and Board Member of the Caribbean Vulnerable Communities Coalition; Anna Dolinsky, Associate at Akin, Gump, Strauss, Hauer & Feld, LLP; Catherine Hanssens, Executive Director of the Center for HIV Law and Policy; Lori Leibowitz, Ford Foundation Fellow; Rafael Mazin, Regional Advisor on HIV/AIDS at the Pan American Health Organization; Michael Pates, Director of the ABA AIDS Coordination Project; David Patterson, Program Manager of the HIV & Health Law Program at the International Development Law Organization; Wm. Lane Porter, International Public Health Law Consultant; Rebecca Schleifer, Advocacy Director in the Health and Human Rights Division of Human Rights Watch; Javier Vasquez, Regional Human Rights Law Advisor at the Pan American Health Organization; and Georgina Verdugo, Director of the Office for Civil Rights at the U.S. Department of Health and Human Services.

Last but not least, ABA ROLI wishes to thank the U.S. Agency for International Development for funding this project, and more generally, for its commitment to promoting human rights in the context of HIV/AIDS.



# Part 1

## Methodology: Overview and Implementation Guide





# METHODOLOGY

## Overview

As of 2008, there were approximately 33.4 million people living with HIV [hereinafter PLHIV] worldwide, with 2.7 million new infections per year and 7,400 new infections per day.<sup>1</sup> In 2009 alone, the HIV/AIDS epidemic claimed nearly 2 million lives. The Millennium Development Goal [hereinafter MDG] No. 6 – Combat HIV/AIDS, Malaria, and Other Diseases – and global commitments enshrined in the Declaration of Commitment on HIV/AIDS, Political Declaration on HIV/AIDS, and International Guidelines on HIV/AIDS and Human Rights have galvanized unprecedented efforts by the international community to halt the spread of HIV/AIDS, eliminate HIV-related discrimination, and achieve universal access to HIV treatment, prevention, care, and support for all those who need it.<sup>2</sup> However, although the spread of HIV appears to have stabilized in most regions and more people are surviving longer,<sup>3</sup> the core targets have not been met due to inadequate resources, lack of accountability, lack of political will, and insufficient dedication to HIV-related commitments.<sup>4</sup> The rate of new infections still surpasses the availability of treatment and for every two people put on HIV treatment each year, five more are newly infected.<sup>5</sup> The HIV/AIDS problem is further exacerbated by widespread discrimination against PLHIV and key populations. The international community has recognized that despite the progress, HIV/AIDS continues to be a global emergency which requires urgent, exceptional, comprehensive, and nationally-driven responses.<sup>6</sup>

**The elimination of discrimination and protection of human rights in the context of HIV/AIDS are the guiding principles of the HIV/AIDS Legal Assessment Tool.**

Prevention of HIV infection and elimination of HIV-related discrimination are some of the most critical aspects of the global AIDS response. When PLHIV enjoy full equality and inclusion in the political, economic, social, and cultural life, and when they are guaranteed fundamental human rights, they are more likely to seek testing, receive counseling, and maintain treatment regimens. Conversely, stigmatization and discrimination force people underground, increasing their vulnerability to HIV, and contributing to the spread of the epidemic. Because HIV-related discrimination constitutes a violation of human rights and seriously undermines HIV prevention efforts, eliminating such discrimination has become a top priority of the Joint United Nations Programme on HIV/AIDS [hereinafter UNAIDS], its ten cosponsors, other international organizations, donors, technical assistance providers, and HIV/AIDS advocates around the world.

## Components

Collection of country-specific information creates a necessary foundation for identifying important elements of the reform process in the field of HIV/AIDS and human rights. With this in mind, in 2011, the American Bar Association Rule of Law Initiative [hereinafter ABA ROLI] developed the HIV/AIDS Legal Assessment Tool [hereinafter the Tool], which is a mechanism for assessing countries' *de jure* and *de facto* compliance with international legal standards on the protection of human rights of people living with, perceived to be living with, and affected by HIV, and key populations.

**HIV/AIDS Legal Assessment Tool is designed to conduct assessments of the legal rights of PLHIV and key populations, providing a roadmap for addressing HIV-related discrimination and ensuring States' compliance with the applicable international legal standards.**

To enhance uniformity and detail in data collection, ABA ROLI developed the Assessment Methodology Manual, which is the Tool's core document. The Manual provides guidance to lawyers and civil society organizations [hereinafter CSOs] in how to implement an HIV/AIDS legal assessment: it describes the applicable *International Legal and Policy Framework*, offers an *Analytical Framework*, gives direction on how to write the *Country Background Chapter*, clarifies terminology, outlines a number of research techniques, presents a model format for assessment reports, and lists useful resources. The Tool foregoes any attempt to provide an overall numerical scoring of a country's reform progress. Experts agree that attempts at aggregate scoring based on this approach could be counterproductive.

## Analytical Framework

The Tool's *Analytical Framework* consists of 22 *Factor Statements* which serve as indicators or principles used to analyze domestic laws, policies, and practices in four key areas where HIV-related discrimination is likely to occur: 1) Access to Essential Services; 2) Equality of PLHIV in Public and Private Life; 3) Key Populations; and 4) Access to Justice. In addition to *Factor Statements*, the *Analytical Framework* provides a concise commentary on applicable international legal standards; presents illustrative *Examples of Compliance and Non-Compliance*; incorporates *Case Studies*; and offers flexible guidance on the *Areas of Inquiry*.

## Areas of Inquiry

The *Areas of Inquiry* incorporate a series of recommended questions that will direct the process of gathering and reporting information. The questions are organized into subsections corresponding to the various topics arising from the delineated international standards. The questions are not intended to solicit merely *yes* or *no* answers. Instead, the Assessor should use them to conduct thorough *de jure* and *de facto* analyses of each subject matter. Therefore, every question which starts with a phrase "does the State ensure," effectively reads "does the State ensure, in law and in practice." Each question which starts with a phrase "what measures are undertaken," effectively reads "what measures are undertaken by state and non-state actors, i.e., the national and local governments, CSOs, and other stakeholders." To the extent possible, the Assessor should address all the *Areas of Inquiry* presented in the *Analytical Framework*. The Assessor may also choose to address additional areas of inquiry to ensure that the analysis is accurate and comprehensive. In conducting the analysis, the Assessor should always take into account the country's political, economic, social, and cultural context, in particular the HIV risk environment. The Assessor should also consider local emerging trends which may affect the country's HIV response.

## Examples of Compliance and Non-Compliance, and Case Studies

The examples of compliance and non-compliance as well as case studies are intended to provide further guidance on how to interpret the applicable international legal standards. They are merely illustrative and should not be used as sole criteria for determining the country's conformity to the relevant international legal standards. The examples of compliance and case studies illustrate what a State can do to improve its adherence to international norms through legislative and policy reform, appropriate use of the justice system, and support for innovative HIV programs at the national and community levels. The examples of non-compliance illustrate what types of laws and practices contradict international standards.

## Objectives

The Tool is designed to provide a concrete picture of the challenges that need to be addressed in a particular country in order to eliminate HIV-related discrimination. More specifically, the Tool will be used to: 1) measure to what extent specific legal norms and conditions present in the country comply with international legal standards at a particular point in time; 2) highlight best practices and demonstrate the country's progress in reducing HIV-related discrimination; 3) uncover discriminatory norms entrenched in the country's regulatory framework; 4) identify policies and practices that perpetuate HIV-related discrimination; 5) discuss gaps in the country's efforts to protect the rights of PLHIV and key populations; and 6) illustrate the importance of law and policy reform in addressing HIV-related discrimination.

**The law and its application can have a profound impact on the lives of people, especially those who are marginalized and disempowered. The law is a powerful instrument to challenge stigma, promote public health, and protect human rights.**

*Helen Clark, UNDP Administrator (2011)*

The primary audience for the Tool will consist of host governments; CSOs; HIV/AIDS advocates and service workers; health care professionals; donors; technical assistance providers; and journalists. The assessments based on the Tool will accomplish multiple goals. They will: 1) generate a wealth of information on the status of PLHIV's human rights; 2) provide key stakeholders with detailed and hard-to-find information on the complex interplay between national laws, policies, and HIV-related services, including prevention, treatment, care, support, and protection from discrimination; 3) provide a roadmap for addressing HIV-related discrimination; 4) facilitate and enable prioritization of legislative reforms; 5) promote programming aimed at improving access to justice for PLHIV; 6) help spearhead local grassroots advocacy initiatives; 7) enhance

inter-agency collaboration and international cooperation; 8) facilitate more adequate coverage of the epidemic and related discrimination by the media; and 9) monitor progress in addressing HIV-related discrimination. In addition, both the Tool itself and the assessment reports will be used to train local CSOs on how international legal standards can be used to advance human rights in the context of HIV/AIDS through community-driven initiatives.

## Scope

The primary focus of the Tool is *HIV-related discrimination* against PLHIV in public and private life. Unless otherwise noted, the term *PLHIV* is understood to include people living with, perceived to be living with, and affected by HIV/AIDS. In addition, the Tool devotes a separate section of its analytical framework to *key populations* who experience unique HIV vulnerabilities and therefore require special attention in line with the *principle of equity*, i.e., women, children, youth, people who use drugs, people in state custody, adults engaged in commercial sex (sex workers), men who have sex with men [hereinafter MSM], and transgender people. Where appropriate, the Tool includes detailed analyses of HIV-related discrimination faced by *HIV advocates and service workers*.

**The Tool is uniquely equipped not only to uncover the incidence of HIV-related discrimination but also to address such questions as whether the country's legal system is sufficiently strong to protect PLHIV from discrimination, and whether the State has committed appropriate resources and taken concrete steps to reduce HIV-related discrimination and effectively ensure the rights of PLHIV in practice.**

The Tool adopts a broad definition of the term *discrimination*. In line with international guidance, *HIV-related discrimination* is understood as any measure entailing an arbitrary distinction that results in an unfair and unjust treatment of an individual based on his or her confirmed or perceived HIV status.

The Tool takes into account the fact that *HIV prevention* is one of the core pillars of the global AIDS response. Because the lack of access to HIV information and prevention measures, and resulting misconceptions about HIV transmission, perpetuate HIV-related discrimination, the Tool examines linkages and correlations between States' efforts to prevent the spread of HIV and the prevalence of discrimination.

The Tool is designed to measure States' compliance with *international legal standards*. Therefore, the analysis section focuses predominantly on laws, policies, strategies, programs, and other measures adopted and implemented by *national governments*. However, as mentioned above, assessors are also expected to take into full account the relevant measures undertaken by *local governments and non-state actors*, such as traditional and religious leaders, international organizations, donors, technical assistance providers, CSOs, the media, and prominent HIV advocates and experts.

## Assessment Team

Each assessment based on the Tool will draw upon a diverse pool of information and can be rapidly implemented by a relatively small team of legal specialists who are familiar with the country and the region, and have expertise in HIV-related legal issues. The team should be led by a legal expert with mastery of international legal standards on the protection of human rights in the context of HIV/AIDS. The lead assessor should be assisted by a local attorney with a thorough knowledge of the country's legal and policy framework. In most cases, the assessment team will also comprise of a translator and a logistics coordinator. The entire implementation process should be overseen by a project manager (Tool coordinator) who will also serve as an editor of the report and who will prepare the report for publication. The Tool coordinator should train other members of the assessment team on the methodology proposed by the Tool prior to the commencement of the research process.

To achieve optimum results, the implementation process should be community-driven and should – to the maximum extent possible – involve civil society and affected populations, i.e., PLHIV and key populations. To accomplish this goal, the assessment team should partner with an experienced CSO in the host country to assist it in conducting the assessment. Such an arrangement will achieve several goals. First, the involvement of the CSO will provide the assessment team with a better understanding of the priorities and challenges faced by the affected populations; it will also give the assessment team a better access to local

stakeholders, particularly hard-to-reach groups, thus enhancing the quality and accuracy of the assessment. Second, the CSO will develop a mastery of the methodology and will be able to independently conduct follow-on assessments. Third, the participation in the project will empower the CSO to implement adequate programming based on the results of the assessment. PLHIV, key populations, and civil society should be involved at all stages of the implementation process: from data collection, through interviews and focus groups, and in the peer review.

Lastly, the assessment team may consider involving law students in the implementation process, for example by partnering with a local university legal clinic. Such partnerships will be mutually beneficial: they will help speed up the process of gathering the *de jure* information and they will sensitize law students to the legal issues surrounding the national AIDS response.

# RESEARCH AND DATA COLLECTION

Social scientists might argue that some of the assessment criteria would best be ascertained through public opinion polls or very extensive interviews with local stakeholders. However, the Tool's in-depth analytical process is not intended to be a scientific, statistical survey. It is first and foremost a complex legal and factual inquiry into the country's infrastructure, regulatory framework, and its implementation. The assessment report which will result from this inquiry will consist of two components: the *de jure* analysis and the *de facto* analysis.

Sensitive to the potentially prohibitive cost and time involved, ABA ROLI structured the Tool implementation process in such a way that the inquiries derived from the Tool's methodology can be effectively addressed by desk and field research in the host country. The research will encompass a comprehensive review of the relevant legal provisions and secondary materials; discussions with informal focus groups; and 40-60 interviews with a cross-section of key informants.

## Fundamental Research Principles

The assessment team has the responsibility to ensure that both their research and reporting adhere to the highest ethical standards. Because of the special sensitivity of HIV/AIDS research, the assessment team should exercise particular care in observing the following core research principles:

- ▶ Maximize possible benefits of research and minimize possible harms
- ▶ Ensure safety of research participants
- ▶ Obtain informed consent, maintain privacy, and uphold confidentiality
- ▶ Honor all promises and agreements
- ▶ Safeguard list of interviewees and recorded data
- ▶ Do not disclose names of research participants
- ▶ Do not release information that either directly or indirectly links specific interviewees to specific responses
- ▶ Act with honesty and integrity
- ▶ Be objective, factual, and sensitive
- ▶ Maintain neutrality towards research participants
- ▶ Avoid bias, prejudice, and distortion of facts
- ▶ Ensure accurate language and terminology
- ▶ Avoid stigmatizing and discriminatory language
- ▶ Ensure responsible (accurate, objective, comprehensive, consistent, balanced, evidence-informed, gender-sensitive, clear, concise, and of good quality) reporting
- ▶ Build on but do not replicate work that has already been done
- ▶ Do not shy away from controversial issues but identify realistic reform opportunities
- ▶ Debunk misconceptions related to HIV transmission and prevention

## Ethics, Safety, and Neutrality

The assessment team must ensure a proper balance between the potential benefits of their research and the interests of the research participants, including their rights to privacy, dignity, security, and integrity of the person. Therefore, the assessment team should evaluate the risk environment in which the research will be conducted and give careful consideration to the circumstances under which research participants may be reluctant to share information. The assessment team should always avoid placing the research participants in

unsafe, embarrassing, unpleasant, or stressful situations. For example, in countries where same-sex conduct is criminalized and/or highly marginalized, inviting MSM to a focus group meeting may expose the participants – and potentially the researchers – to serious safety risks, including imprisonment. In circumstances like this, individual interviews in secure locations are a preferred method of gathering information.

In addition, the assessment team should take special precautions to preserve the research participants' rights to privacy and confidentiality. First, neither the names of interviewees nor any information that could identify them (e.g., position or role in the community) can be revealed to the public or others involved in the study. Second, the list of interviewees and interview notes must be adequately safeguarded. Third, information released in the assessment report cannot be either directly or indirectly attributed to specific interviewees, unless they give voluntary, informed, explicit, and written consent to have their names disclosed. The assessor should report information obtained through interviews and focus groups by using such phrases as: "according to interviewees," "many interviewees reported," "neither of the research participants claimed," etc.

To gather accurate and complete data, ensuring cooperation and developing trust of the research participants are also extremely important. Trust can be gained by preserving ethics in research, and ethics in research can be achieved through honesty, integrity, confidentiality, and objectivity. The assessment team should strive to establish a proper and collegial rapport with the research participants at the very beginning of each meeting. To do so, the assessors must introduce themselves and give the participants a fair and clear explanation of the purpose of the meeting and of how information obtained from them will be handled. The assessor should advise all participants that while the content of the interviews may be included in the assessment report, their names and affiliations as well as their involvement in the study will be kept strictly confidential. Based on this information, the interviewees should be asked to indicate their informed consent to participate in the study.

The assessment team should strive to maintain neutrality towards research participants and avoid any bias or prejudice. It is important not to give the participants an impression that certain types of answers are better or preferable. The assessors should also avoid sharing their opinions with research participants and should never suggest any answers to them.

### **Responsible Reporting**

Responsible reporting is reporting that is accurate, objective, evidence-informed, comprehensive, consistent, balanced, sensitive, clear, concise, of good quality, and properly cited. Responsible reporting is critical because important personal and policy decisions may be influenced by the study. For example, if the assessment report is viewed as a reliable source of quality information, it may be used as a persuasive tool to build public support and advocate for change. Conversely, if they report is subjective, biased, or inaccurate, it will be widely discredited and its value will be significantly diminished.

Responsible reporting means that the assessor must be very careful about the scientific, legal, and biomedical details as well as statistics. The assessor must ensure that statistics and other administrative data are obtained from reliable sources. The assessor must also analyze data critically and intelligently, bearing in mind that some official documents, including statistics, may be politically charged and may be aspirational rather than factual.

To reach the highest attainable level of objectivity and accuracy, the assessor should use triangulation in research, i.e. look at all the facts, phenomena, and events from multiple perspectives. Some of the most useful triangulation techniques include: collecting the same type of information from multiple observers disaggregated by various socio-demographic factors, and mixing quantitative methods (e.g., questionnaires) and qualitative methods (e.g., open-ended focus groups) of data collection.

Lastly, the use of standardized terminology is recommended. While drafting the assessment report, the Assessor should refer to the *Glossary of Terms* included in the Tool and take into account the most recent UNAIDS Terminology Guidelines.

### **Pre-Assessment**

Before embarking on the primary legal and factual research, the assessment team, in consultation with the donor and local partners, must determine the geographical scope of the assessment. For example, the assessment team may choose to focus the analysis on laws and practices at the national level. Alternatively,

the focus may be placed on particular regions or provinces. In any case, the field research should not be limited to the capital and other urban centers. The assessment team should travel to at least two locations outside of the main metropolitan area. These locations should be carefully selected taking into account the geographic and socio-demographic distribution of HIV infection, as well as the presence of innovative programming aimed promoting the human rights of PLHIV and key populations.

During the pre-assessment phase of the project, the assessment team should conduct basic background research to familiarize themselves with the key characteristics of the country and the HIV risk environment. Some information on the country’s social, political, and legal context will likely be readily available online or in libraries. However, the assessment team should also consult with the local partners to obtain additional materials (e.g., official statistics) that maybe less accessible or not yet translated. A detailed guidance on drafting the country background chapter is included in Part 3 of the Tool under *Analytical Framework*.

## De Jure Analysis

The *de jure* (textual) analysis seeks to determine if the country’s legal system is sufficiently strong to protect PLHIV and key populations from HIV-related discrimination and other violations of human rights based on real or perceived HIV status. The primary method of conducting the *de jure* analysis is a desk review of the country’s pertinent laws and policies, pending draft provisions, and secondary materials. Draft provisions are particularly important if they are: 1) close to passage; 2) likely to be enacted without being significantly changed; and 3) likely to substantially alter existing legislation or policy. The documents must be thoroughly analyzed and properly cited throughout the assessment report. It is recommended that the *de jure* research and analysis be completed prior to the *de facto* research. The coverage of domestic laws should not be limited to HIV-specific laws. The assessor is expected to include all laws, regulations, policies, strategies, action plans, and customary law that: 1) contain HIV-specific provisions; 2) cover human rights (including, but not limited to, the right to non-discrimination and the right to health); 3) regulate HIV risk behaviors. The suggested, but not exhaustive, list of resources includes:

| Laws and Policies   | Secondary Sources   |
|---|---|
| <ul style="list-style-type: none"> <li>• Constitution</li> <li>• Ratified international human rights treaties</li> <li>• State budget</li> <li>• Public health and disability legislation</li> <li>• Privacy and confidentiality legislation</li> <li>• All components of the national AIDS action framework, including HIV-specific laws, regulations, policies, and strategies</li> <li>• Statute of the national AIDS coordinating authority</li> <li>• Law on gender equality</li> <li>• Family law</li> <li>• Criminal law</li> <li>• Labor law, law on education</li> <li>• Laws governing state detention facilities</li> <li>• Prosecutorial guidelines</li> <li>• Professional codes of conduct, particularly for judges, prosecutors, law enforcement officers, health care workers, and journalists</li> </ul> | <ul style="list-style-type: none"> <li>• AIDSInfo Country Fact Sheet (UNAIDS)<sup>i</sup></li> <li>• Country and shadow reports submitted to international institutions in accordance with global AIDS reporting requirements</li> <li>• Country-specific reports, decisions, and judgments issued by international institutions</li> <li>• Statistics provided by reliable sources</li> <li>• Results of surveys and opinion polls</li> <li>• Records and materials obtained through the country’s system of access to public information</li> <li>• Books, reports, and other publications produced by state and non-state actors</li> <li>• Media coverage of HIV/AIDS and broadcasting standards</li> <li>• Documents outlining HIV-related programs, campaigns, and initiatives</li> <li>• Pertinent case law</li> </ul> |

The estimated time needed for desk research is 4-8 weeks, depending on the geographic scope of the assessment and translation needs.

<sup>i</sup> UNAIDS, AIDSInfo Country Fact Sheets, at: <http://www.unaids.org/en/dataanalysis/tools/aidsinfo/countryfactsheets/>.

## De Facto Analysis

The *de facto* (contextual) analysis seeks to determine if the State has committed appropriate resources and taken concrete steps to reduce HIV-related discrimination and effectively protect, promote, and fulfill the human rights of PLHIV and key populations in practice. In addition to State measures, initiatives undertaken by non-state actors should be examined to provide a comprehensive picture on the state of human rights in the context of HIV/AIDS in a given country.

The primary method of completing the *de facto* analysis is to conduct field research, i.e., detailed interviews and informal focus groups with a cross-section of key stakeholders. Whether or not this Tool produces valuable results will be determined largely by the assessment team’s ability to identify and interview an appropriate and diverse mix of individuals. Thus, a careful selection of key informants who possess the expertise and deep understanding of legal issues affecting PLHIV and key populations in the country is of paramount importance. Key informants should be selected in consultation with the CSO and local attorney involved in the implementation process. Assistance with identifying informants can be also obtained from other local partners, international organizations with presence in the country, government officials, non-governmental organizations, and the media. The research participants should be disaggregated not only by the positions or roles they play in their communities, but also by various socio-demographic factors, such as age, gender, education, sexual orientation, residence (urban vs. rural), and/or membership in a particular social group.

Both individual interviews and focus groups must be conducted in a proper setting, taking into full account all the above-stated ethical and safety considerations. The assessment team must be adequately trained and prepared to discuss issues that touch upon people’s intimate life, sexuality, and often marginalized and criminalized behaviors, such as drug use and sex work. Given the sensitivity of issues that are likely to be discussed during the interview process, the assessment team must make every effort to create an environment where participants of the study feel safe and fully comfortable to share pertinent information. The interviewers must avoid any bias and always use appropriate, non-stigmatizing language.

It is recommended that the assessment team meet with no fewer than 40-60 informants. The format of each meeting (individual interview vs. focus group) should be determined on a case-by-case basis. Focus groups should consist of at least 4-6 participants who share certain characteristics (e.g., HIV-positive women who face barriers in accessing mainstream health care services). On average, each meeting should last approximately 2 hours but the length of the meetings will depend on whether the assessment team needs an interpreter. In-person meetings are preferred but a few phone interviews may be conducted if it is the most reasonable method of gathering information (e.g., due to scheduling issues or cost of travel to remote areas). To obtain data from government officials, the assessment team may also contemplate using written questionnaires and /or the country’s system of access to public information.

Data obtained through interviews and focus group meetings should be recorded as verbatim as possible. Detailed notes can reduce the likelihood of bias and need for follow-up research. It is suggested that the interview notes are organized factor-by-factor, so that any missing elements of the emerging analysis can be promptly identified and addressed. Audio- or video-taping is not an acceptable form of recording data. In addition to being ethically objectionable due to confidentiality reasons, it may negatively affect the interviewees’ willingness to speak candidly. If an interviewee refers the assessment team to other potential informants, full contact informational should be obtained and advice should be sought as to whether the research participant feels comfortable being disclosed as a referral.

The suggested, but not exhaustive, list of institutional and individual informants includes:

| State Actors   | Non-State Actors   |
|--|--|
| <ul style="list-style-type: none"> <li>• National AIDS coordinating authority</li> <li>• HIV focal points in government agencies</li> <li>• Ministries of health, labor, education, and justice</li> <li>• National human and women’s rights bodies</li> <li>• Law- and policy-makers</li> <li>• Judges, prosecutors, and law enforcement</li> </ul> | <ul style="list-style-type: none"> <li>• PLHIV and members of key populations</li> <li>• Migrants and mobile populations</li> <li>• HIV/AIDS legal experts (academics and advocates)</li> <li>• Civil society and AIDS service organizations</li> <li>• Representatives of the private sector (including pharmaceutical industry)</li> <li>• Trade unions</li> </ul> |



|  |   |
|--|---|
| <p>officers</p> <ul style="list-style-type: none"> <li>• Staff of detention and correctional facilities</li> <li>• Representatives of intergovernmental organizations (e.g., UN, WHO, ILO, IOM)</li> </ul> | <ul style="list-style-type: none"> <li>• Health care and social workers</li> <li>• Traditional and religious leaders</li> <li>• Journalists</li> <li>• Donors and technical assistance providers</li> <li>• Lawyers, bar associations, and legal aid centers</li> </ul> |
|--|---|

The estimated time of field research is 2-3 weeks, depending on the size of the country and the scope of the assessment.

**Findings, Peer Review, and Publication**

After the pertinent *de jure* and *de facto* information is gathered and analyzed against the factor statements, the assessor should collect the results in a standardized format in a country report. Each report should begin with a country background chapter exploring the status of the HIV/AIDS epidemic, legal and infrastructural framework, and the role of civil society and private sector in the national HIV response. The country background chapter should be followed by a comprehensive factor-by-factor analysis section. Each factor narrative should be divided into subsections corresponding with the areas of inquiry, and should incorporate a concise conclusion statement. The country report template is provided below. The estimated time for producing the first draft of the report is 6-8 weeks.

Prior to publication, the assessment report must undergo both a rigorous internal review by the implementing entity and in-country peer review by key stakeholders, in order to ensure its accuracy, integrity, and a maximum degree of quality control. It is recommended that the advance copy of the report be examined by a cross-section of at least ten reviewers representing both state and non-state actors, including PLHIV. Each peer reviewer should have at least 2-3 weeks to evaluate the report and provide meaningful written comments. Alternately, a 2-day peer review workshop may be contemplated.

The assessment team may choose to ask peer reviewers not only to verify or clarify data already included in the assessment report, but also to submit additional information that may fill any potential gaps or omissions. It should be stipulated to all peer reviewers that their comments will be taken into consideration but that the formal editorial authority and control over the content of the report will remain with the assessment team and the implementing entity. The assessment team should thoroughly analyze all comments and suggestions submitted by peer reviewers and determine which of them should be reflected in the final report. The primary focus should be on any legal or factual errors that need to be corrected.

In normal circumstances, the final report should be captured in an electronic format, printed, and rolled-out at a public in-country event. The event should feature representatives of affected populations, the government, law- and policy-makers, CSOs, the private sector, donors, technical assistance providers, international organizations, and the media. A press release and a wide distribution of the assessment report are highly encouraged. A complete table of authorities, list of interviewees, interview notes, and list of peer reviewers should be kept on file by the implementing entity. The implementing entity must maintain strict confidentiality of the obtained data.

\*\*\*

The outlined implementation process draws heavily on the tested and well-respected approach of other assessment tools created by ABA ROLI, such as the Access to Justice Assessment Tool (AJAT), the Detention Procedure Assessment Tool (DPAT), the Judicial Reform Index (JRI), the Legal Education Reform Index (LERI), the Legal Profession Reform Index (LPRI), the Prosecutorial Reform Index (PRI), the CEDAW Assessment Tool, the ICCPR Assessment Tool, and the Human Trafficking Assessment Tool (HTAT).

# COUNTRY REPORT TEMPLATE

## Introduction

ABA ROLI will provide the assessor with a standard *Introduction* to the HIV/AIDS Legal Assessment Tool. In 4-6 pages, the *Introduction* will discuss the methodology and the scope of the assessment. It will also incorporate acknowledgments and information about the assessment team. No changes to the text of the *Introduction* should be made by the assessment team.

## Executive Summary

The *Executive Summary* should highlight the most important findings. It should be written after the country report is completed and, ideally, after it is revised based on internal and peer review comments. The *Executive Summary* should not exceed 5 pages, and should consist of the following sections:

### Brief Overview of the Results

#### Positive Developments Identified in the [Year] Report for [Country]

Access to Essential Services  
Equality of PLHIV in Private and Public Life  
Key Populations  
Access to Justice

#### Challenges Identified in the [Year] Report for [Country]

Access to Essential Services  
Equality of PLHIV in Private and Public Life  
Key Populations  
Access to Justice

## [Country] Background

The country background chapter should not exceed 6-8 pages and should consist of the following sections:

### Country Overview

Status of the HIV/AIDS Epidemic  
Legal and Infrastructural Framework  
Civil Society and Private Sector

# Country [Year] HIV/AIDS Legal Analysis

The *Implementation Analysis* should not exceed 80-100 pages, and should be written clearly and concisely. The report should be understandable to an external reader who does not have any knowledge of the country's legal system or government infrastructure.

## Section I: [Title]

### Factor 1: [Title]

[Text of the Factor Statement]

#### Conclusion

The *Conclusion* should consist of 3-4 sentences determining the State's compliance, or lack thereof, with the international legal standards embedded in the *Factor Statement*. To the extent possible, the language of the *Conclusion* should be parallel to the language of the *Factor Statement*. Each assertion included in the *Conclusion* should be elaborated in, and supported by, the subsequent *Implementation Analysis*. The *Conclusion* should not list recommendations for improving State's compliance with its international obligations and commitments. The *Conclusion* should be written after the *Implementation Analysis* for the particular *Factor* has been completed.

### Implementation Analysis:

The *Implementation Analysis* of each *Factor* should not exceed 3-4 pages. The text of the analysis should be divided into substantive subsections proposed by the *Analytical Framework*. Each substantive subsection should begin with the *de jure* assessment followed by the *de facto* assessment. To the extent possible, the analysis should address all the *Areas of Inquiry* listed in the *Analytical Framework*. Assessors may choose to address additional areas of inquiry to ensure that the analysis is accurate and comprehensive. Assessors are advised to cross-reference information that is or might be applicable to two or more *Factors* (e.g., see Factor 1 above). Replication of information should be avoided to the maximum extent possible. For example, assessors should analyze children's right to education in Factor 9 on Education and Training and cross-reference it in Factor 15 on Children.

## List of Acronyms

Each country report should conclude with a complete list of acronyms.

# GLOSSARY OF TERMS

|                                 |   |
|---------------------------------|---|
| <b>ABA ROLI</b>                 | American Bar Association Rule of Law Initiative   |
| <b>AIDS</b>                     | Acquired immunodeficiency syndrome – a disease caused by HIV  |
| <b>ART</b>                      | Antiretroviral therapy or antiretroviral treatment  |
| <b>Asylum-seekers</b>           | People who have made a claim to be recognized as refugees and are waiting for that claim to be accepted or rejected   |
| <b>Banjul Charter</b>           | African Charter on Human and Peoples' Rights  |
| <b>ACHR</b>                     | American Convention on Human Rights (Pact of San Jose)  |
| <b>CAT</b>                      | UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment   |
| <b>CEDAW</b>                    | UN Convention on the Elimination of All Forms of Discrimination against Women   |
| <b>Child, Adolescent, Youth</b> | A child is any person between 0 and 18 years of age; an adolescent is any person between 10 and 19 years of age; youth (young people) are people between 15 and 24 years of age.  |
| <b>CRC</b>                      | Convention on the Rights of the Child   |
| <b>CSO</b>                      | Civil society organization  |
| <b>Disability</b>               | Long-term physical, mental, intellectual or sensory impairment which, in interaction with various barriers, may hinder an individual's full and effective participation in society on an equal basis with others.   |
| <b>Discrimination</b>           | Any form of arbitrary distinction, exclusion, or restriction affecting a person, usually, but not only, by virtue of an inherent personal characteristic. HIV-related discrimination is therefore any measure entailing an arbitrary distinction that results in an unfair and unjust treatment of an individual based on his or her confirmed or perceived HIV status. |
| <b>ECHR</b>                     | European Convention on Human Rights   |
| <b>Educational Institution</b>  | Any private or public institution which provides primary, secondary, and higher education as well as technical and vocational training.   |
| <b>Episodic Disability</b>      | Fluctuating periods and degrees of wellness and disability associated with HIV infection. People with episodic disabilities face significant employment and income support issues because recurring periods of ill health make it difficult for them to work, especially full-time.   |
| <b>Gender Identity</b>          | A person's deeply felt individual experience of gender, which may or may not correspond with the sex assigned at birth.   |
| <b>GIPA</b>                     | Greater involvement of people living with HIV/AIDS  |

|                                      |   |
|--------------------------------------|---|
| <b>Hate Crime</b>                    | Traditional offence (e.g., violence, murder, arson, vandalism) with an added element of bias.   |
| <b>HIV</b>                           | Human immunodeficiency virus: a virus that weakens the immune system, ultimately leading to AIDS  |
| <b>HIV-Related Services</b>          | Measures undertaken to prevent, manage, and cope with HIV infection, including HIV information, prevention, testing, counseling, treatment, care, and support.  |
| <b>HIV Susceptibility</b>            | Individual's chance of becoming exposed to the virus (reflecting the risk environment and riskiness of behavior) and the chance of being infected with HIV once exposed.  |
| <b>HIV Vulnerability</b>             | Likelihood of significant HIV/AIDS-related impacts and damaging effects on individuals, households, and communities.  |
| <b>ICCPR</b>                         | International Covenant on Civil and Political Rights  |
| <b>ICESCR</b>                        | International Covenant on Economic, Social, and Cultural Rights   |
| <b>ILO</b>                           | International Labor Organization  |
| <b>ILO Recommendation</b>            | ILO Recommendation Concerning HIV and AIDS and the World of Work  |
| <b>International Labor Standards</b> | Legal instruments adopted by ILO which set out basic principles and rights at work, and aim at promoting opportunities to obtain decent and productive work in conditions of freedom, equity, security, and dignity.  |
| <b>IOM</b>                           | International Organization for Migration  |
| <b>Key Populations</b>               | Groups of people who are at higher risk of HIV exposure, infection, and transmission (most-at-risk populations) and vulnerable populations, i.e., groups people who are disproportionately affected by HIV and its impacts, including HIV-related discrimination. In most settings, key populations include: women, children, youth, people who use drugs, adults engaged in commercial sex, men who have sex with men, transgender people, and people under state custody. |
| <b>MDGs</b>                          | Millennium Development Goals – eight goals adopted by the international community at the UN Millennium Summit in September 2000. MDG no. 6 calls States to combat HIV/AIDS, Malaria, and Other Diseases.  |
| <b>Migrants</b>                      | Mobile people who take up residence or who remain for an extended stay in a foreign country.  |
| <b>Mobile Populations</b>            | People who move from one place to another temporarily, seasonally, or permanently for voluntary and non-voluntary reasons. Mobile populations include migrants, refugees, internally displaced people, and key employment groups involving mobility, such as truck drivers, seafarers, transport and agricultural workers, itinerant workers, and mobile employees of large industries.   |

|                                   |   |
|-----------------------------------|---|
| <b>MSM</b>                        | Males who have sex with other males, regardless of whether or not they have sex with women or have a personal or social identity associated with that behavior, such as being gay or bisexual.  |
| <b>Non-Refoulement</b>            | Prohibition on the return of a person to a State where there are substantial grounds for believing that the person would face a real risk of torture or other cruel, inhuman, or degrading treatment or punishment, or where his or her life or freedom would be threatened on account of race, religion, nationality, membership in a particular social group or political opinion.  |
| <b>NSP</b>                        | Needle and syringe exchange or distribution program – any program which makes sterile injecting equipment available to people who use drugs.  |
| <b>Opportunistic Infections</b>   | Illnesses caused by various organisms, some of which usually do not cause disease in persons with healthy immune systems. The leading HIV-associated opportunistic infection in developing countries is tuberculosis (TB).  |
| <b>OST</b>                        | Opioid substitution therapy – drug dependence treatment for people who are unwilling or unable to stop using drugs. The therapy gives people who use drugs access to medically prescribed oral substitution medicine (i.e. methadone or buprenorphine) in order to improve their quality of life and decrease or eliminate injection use of illegal drugs.  |
| <b>People under State Custody</b> | Males and females who are detained by state actors or under state authority, regardless of whether they have been formally arrested or convicted of a crime. This includes people placed in all types of state-controlled detention facilities, whether directly managed by state actors or managed by private actors under state contract (people in prisons, pretrial detention, and immigration detention).                    |
| <b>PLHIV</b>                      | People living with HIV (including people with asymptomatic HIV infection). Unless otherwise noted, the Tool understands the term PLHIV to include people perceived to be living with, suspected of, and affected by HIV. People affected by HIV are people who are directly affected by HIV but who are not living with HIV, e.g., family members and domestic partners of people living with HIV, and children orphaned by AIDS. |
| <b>Reasonable Accommodation</b>   | Necessary and appropriate modification or adjustment that is reasonably practicable and that enables a person living with HIV to enjoy or exercise human rights and fundamental freedoms on an equal basis with others.   |
| <b>Refugees</b>                   | People who have fled their homes and crossed an international border to escape persecution or conflict.   |
| <b>Residential Facilities</b>     | Public and private facilities which provide long-term shelter and care to people in need, including, but not limited to, nursing homes, orphanages, and shelters for refugees, the homeless, and victims of abuse or violence   |
| <b>Right to Health</b>            | Right to the highest attainable standard of health  |

|                               |   |
|-------------------------------|---|
| <b>Sex Workers</b>            | Adults engaged in commercial sex, i.e., female, male, and transgender adults who receive money or goods in exchange for sexual services, either regularly or occasionally, and who may or may not consciously define those activities as income-generating.   |
| <b>Sexual Orientation</b>     | A person's capacity for profound emotional and sexual attraction to, and intimate and sexual relations with, individuals of a different gender or the same gender.  |
| <b>Torture</b>                | Any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. |
| <b>Transgender People</b>     | Individuals whose gender identity and/or expression of their gender differs from social norms related to their gender of birth. Transgender people could identify as female-to-male or male-to-female, and may or may not have undergone surgery and/or hormonal therapy. Transgender does not imply any specific form of sexual orientation.   |
| <b>STI</b>                    | Sexually transmitted infection  |
| <b>Stigmatization</b>         | Dynamic process of devaluation that significantly discredits an individual in the eyes of others. HIV-related stigmatization refers to negative beliefs, feelings, and attitudes towards people living with or associated with HIV and AIDS.  |
| <b>TB</b>                     | Tuberculosis  |
| <b>UDHR</b>                   | Universal Declaration on Human Rights   |
| <b>UN</b>                     | United Nations  |
| <b>UNAIDS</b>                 | Joint United Nations Programme on HIV and AIDS  |
| <b>UNESCO</b>                 | United Nations Educational, Scientific and Cultural Organization  |
| <b>UNGASS</b>                 | United Nations General Assembly Special Session   |
| <b>UNODC</b>                  | UN Office on Drugs and Crime  |
| <b>Universal Access</b>       | Universal access to HIV prevention, treatment, care, and support  |
| <b>Vertical Transmission</b>  | Passage of HIV vertically from a mother to her child during the perinatal period (the period immediately before and after birth). Transmission may occur across the placenta or through breast milk. Vertical transmission of HIV is also referred to as perinatal or mother-to-child transmission (MTCT)   |
| <b>Violence against Women</b> | Any act that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private.  |
| <b>WHO</b>                    | World Health Organization   |





# Part 2

## International Legal and Policy Framework



# SOURCES OF INTERNATIONAL LAW

The HIV/AIDS Legal Assessment Tool directly ties all its factors to international legal standards on the protection of human rights of PLHIV and key populations. These principles are derived from a variety of international standard-setting documents and other sources of international law including: 1) multilateral human rights treaties; 2) international custom; and 3) non-binding human rights instruments. In addition, the Tool relies on international comparative law, decisions and judgments issued by international human rights bodies, and widely accepted norms and best practices articulated in reports and academic publications produced by highly qualified experts and publicists.

## Human Rights Treaties

Pursuant to the Vienna Convention on the Law of Treaties, a **treaty**<sup>ii</sup> is an international agreement concluded between States in written form and governed by international law. Every treaty in force is binding upon the parties, i.e., States who have expressed consent to be bound by it by signature, exchange of instruments constituting the treaty, ratification, acceptance, approval, accession, or by any other means if so agreed. Each State party must perform the treaty in good faith and may not invoke the provisions of internal law as justification for its failure to comply with the treaty.<sup>9</sup> Multilateral human rights treaties, concluded under the auspices of the United Nations [hereinafter UN], UN specialized agencies, and regional intergovernmental organizations, clearly and directly create legally binding obligations for State parties to respect, protect, promote, and fulfill human rights. The duty to respect means that States cannot commit any acts or omissions that interfere with or curtail the enjoyment of human rights. The duty to protect requires States to prevent violations of human rights by state and non-state actors and to provide individuals and groups with effective redress against human rights abuses. The duty to promote and fulfill entails States' positive action to facilitate the enjoyment of human rights through legislative reform; policy, budgetary, and administrative measures; enforcement mechanisms; and other appropriate means.<sup>10</sup>

There is no single international treaty devoted exclusively to HIV/AIDS or explicitly prohibiting discrimination on the basis of actual or perceived HIV status. Nevertheless, the cross-cutting principles of non-discrimination and equality – which are the cornerstones of international human rights law – are fully and unequivocally applicable in the context of HIV/AIDS. These principles were first promulgated in 1948 in the Universal Declaration of Human Rights [hereinafter UDHR] and subsequently reiterated in numerous international human rights treaties, including, but not limited to, the International Covenant on Civil and Political Rights [hereinafter ICCPR], the International Covenant on Economic, Social, and Cultural Rights [hereinafter ICESCR], the Convention on the Rights of the Child [hereinafter CRC], the Convention on the Elimination of All Forms of Discrimination against Women [hereinafter CEDAW], the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment [hereinafter CAT], the Convention on the Rights of Persons with Disabilities, the Convention on the Elimination of All Forms of Racial Discrimination, the European Convention for the Protection of Human Rights [hereinafter ECHR], the Charter of Fundamental Rights of the European Union, the European Social Charter, the American Convention on Human Rights [hereinafter ACHR], and the African Charter on Human and Peoples' Rights [hereinafter Banjul Charter].<sup>11</sup> In addition, several of the conventions of the International Labour Organization [hereinafter ILO] address work-related discrimination.

**International human rights principles provide a coherent, normative framework within which to analyze and redress AIDS-related discrimination. States are responsible and accountable, not only for the direct or indirect violation of rights, but also for ensuring that individuals can realize their rights as fully as possible.**<sup>7</sup>

*UNAIDS*

**States' obligations to promote and protect HIV/AIDS-related human rights are defined in existing international treaties. The UN human rights instruments and mechanisms provide the necessary tools for ensuring the implementation of HIV-related rights.**<sup>8</sup>

*UN High Commissioner for Human Rights*

<sup>ii</sup> **Treaty** is one of the four primary sources of international law enumerated in article 38 of the Statute of the International Court of Justice. In addition to treaties, article 38 lists: international custom; the general principles of law recognized by civilized nations; and judicial decisions and the teachings of the most highly qualified publicists of the various nations, as subsidiary means for the determination of rules of law.

Most human rights treaties, including ICCPR, impose an immediate obligation on State parties to respect and ensure the rights they proclaim. State parties are therefore required to adopt whatever legislative or other measures are necessary to give instant effect to these rights.<sup>12</sup> Some human rights treaties call for progressive implementation tied to available resources. For example, ICESCR obligates State parties to take steps to the maximum of available resources to achieve progressively the full realization of the rights it enumerates. It needs to be noted, however, that according to the UN Committee on Economic, Social, and Cultural Rights, ICESCR creates at least three obligations which have immediate effect: 1) obligation to guarantee that the rights set out in ICESCR are exercised without discrimination; 2) obligation to *take steps* toward the progressive realization of the rights within a reasonably short time; and 3) obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights.”<sup>13</sup>

## International Custom

The Statute of the International Court of Justice defines international custom as evidence of a general practice accepted as law. In order to establish the existence of a legally binding international custom, it is necessary to demonstrate a widespread practice by States conforming to the particular norm (objective element - *usus*), and evidence that States have followed this practice because they believe that they are legally obliged to comply with that norm (subjective element - *opinion juris*). Experts agree that, at the very minimum, international customary law prohibits States from practicing, encouraging, and condoning: genocide; apartheid, slavery and slave trade; extra-judicial killings; causing the disappearance of individuals; torture or other cruel, inhuman or degrading treatment or punishment; prolonged arbitrary detention; systematic discrimination; and consistent pattern of gross violations of internationally recognized human rights. Customary international law is binding upon all States.<sup>14</sup>

## Non-Binding Instruments

International treaties and customary law form the backbone of international human rights law.<sup>15</sup> There are, however, a great number of international human rights instruments which are not legally binding but which possess a moral and political force that can persuade States to observe human rights.<sup>16</sup> These include resolutions, declarations, guidelines, principles, recommendations, political commitments, calls for action, and policy pronouncements produced or endorsed by international organizations, conferences, and other forums. Some of these instruments, e.g., resolutions adopted by the UN General Assembly, rest on the consensus of States and thereby are referred to as “soft law.” While their breach does not constitute a violation of international law and does not entail State responsibility in the strict sense, they assume some authority that may be taken into account in legal proceedings.<sup>17</sup> Other instruments, such as guidelines written by renowned international experts or declarations produced by international non-governmental organizations, are not considered typical “soft law.” Nevertheless, they greatly contribute to the understanding, implementation, and development of the international human rights law.

Non-binding international standard-setting documents that have had the most profound impact on the global AIDS response include: the UN Millennium Declaration, Declaration of Commitment on HIV/AIDS [hereinafter Declaration of Commitment], Political Declaration on HIV/AIDS [hereinafter Political Declaration], and International Guidelines on HIV/AIDS and Human Rights [hereinafter International Guidelines].

### UN General Assembly Resolutions

- **UN Millennium Declaration (2000)** is a resolution of the UN General Assembly in which States committed themselves – with a deadline of 2015 – to halt and begin to reverse the spread of HIV/AIDS, malaria, and other major diseases, and to provide special assistance to children orphaned by HIV/AIDS.<sup>18</sup> “Combating HIV/AIDS, Malaria, and Other Diseases” has become known as the MDG No. 6. One of its three core time-bound targets called for achieving universal access to treatment for HIV/AIDS for all those who need it by 2010.<sup>19</sup>
- **Declaration of Commitment (2001)** is a resolution adopted at the UN General Assembly Special Session [hereinafter UNGASS] in which the international community set common targets for reducing the spread of HIV/AIDS and alleviating its impact. In adopting the Declaration of Commitment, States

obligated themselves to submit country progress reports to UNAIDS every two years. This is commonly referred to as UNGASS reporting process.

- **Political Declaration (2006)** is a resolution adopted unanimously in 2006 at the close of the UN General Assembly High Level Meeting on AIDS. The Political Declaration reaffirmed the UN Millennium Declaration and the Declaration of Commitment, and recognized the urgent need to scale up significantly towards the goal of universal access to comprehensive prevention programs, treatment, care and support by 2010.

### **International Guidelines (1996)**

International Guidelines is a UN-sponsored document which provides a framework for a rights-based response to HIV/AIDS. International Guidelines outline how human rights standards apply in the context of HIV/AIDS and translate them into practical measures that should be undertaken by States. These measures include: 1) improvement of States' capacity for multisectoral coordination and accountability; 2) reform of laws and legal support services with a focus on non-discrimination and protection of public health; and 3) support for increased private sector and community participation in the national AIDS responses.<sup>20</sup>

International Guidelines were developed and adopted by 35 experts in the field of HIV/AIDS and human rights at the Second International Consultation on HIV/AIDS and Human Rights convened in 1996 by UNAIDS and the UN Centre for Human Rights. They were published in 1998 by UNAIDS and the Office of the UN High Commissioner for Human Rights. In 2006, an updated and consolidated version of International Guidelines was launched, following their revision in 2002 by the Third International Consultation on HIV/AIDS and Human Rights.<sup>21</sup>

International Guidelines have been endorsed by the UN Commission on Human Rights and subsequently by the UN Human Rights Council in their biennial resolutions on the protection of human rights in the context of HIV/AIDS. These resolutions call upon all States, UN programs and specialized agencies, and international and non-governmental organizations to take all necessary steps to ensure the respect, protection, and fulfillment of human rights in the context of HIV/AIDS, as referred to in International Guidelines, as an essential part of efforts to achieve the goal of universal access.<sup>22</sup>

## **INTERNATIONAL GUIDELINES ON HIV/AIDS AND HUMAN RIGHTS**

**GUIDELINE 1 (National Framework):** States should establish an effective national framework for their response to HIV which ensures a coordinated, participatory, transparent and accountable approach, integrating HIV policy and program responsibilities across all branches of government.

**GUIDELINE 2 (Supporting Community Partnership):** States should ensure, through political and financial support, that community consultation occurs in all phases of HIV policy design, program implementation and evaluation and that community organizations are enabled to carry out their activities, including in the field of ethics, law and human rights, effectively.

**GUIDELINE 3 (Public Health Legislation):** States should review and reform public health laws to ensure that they adequately address public health issues raised by HIV, that their provisions applicable to casually transmitted diseases are not inappropriately applied to HIV and that they are consistent with international human rights obligations.

**GUIDELINE 4 (Criminal Laws and Correctional Systems):** States should review and reform criminal laws and correctional systems to ensure that they are consistent with international human rights obligations and are not misused in the context of HIV or targeted against vulnerable groups.

**GUIDELINE 5 (Anti-Discrimination and Protective Laws):** States should enact or strengthen anti-discrimination and other protective laws that protect vulnerable groups, people living with HIV and people with disabilities from discrimination in both the public and private sectors, ensure privacy and confidentiality and ethics in research involving human subjects, emphasize education and conciliation, and provide for speedy and effective administrative and civil remedies.

**GUIDELINE 6 (Access to Prevention, Treatment, Care, and Support):** States should enact legislation to provide for the regulation of HIV-related goods, services and information, so as to ensure widespread availability of quality prevention measures and services, adequate HIV prevention and care information, and safe and effective medication at an affordable price. States should also take measures necessary to ensure for all persons, on a sustained and equal basis, the availability and accessibility of quality goods, services and information for HIV prevention, treatment, care and support, including antiretroviral and other safe and effective medicines, diagnostics and related technologies for preventive, curative and palliative care of HIV and related opportunistic infections and conditions. States should take such measures at both the domestic and international levels, with particular attention to vulnerable individuals and populations.

**GUIDELINE 7 (Legal Support Services):** States should implement and support legal support services that will educate people affected by HIV about their rights, provide free legal services to enforce those rights, develop expertise on HIV-related legal issues and utilize means of protection in addition to the courts, such as offices of ministries of justice, ombudspersons, health complaint units and human rights commissions.

**GUIDELINE 8 (Women, Children, and Other Vulnerable Groups):** States, in collaboration with and through the community, should promote a supportive and enabling environment for women, children and other vulnerable groups by addressing underlying prejudices and inequalities through community dialogue, specially designed social and health services and support to community groups.

**GUIDELINE 9 (Changing Discriminatory Attitudes through Education, Training, and the Media):** States should promote the wide and ongoing distribution of creative education, training and media programmes explicitly designed to change attitudes of discrimination and stigmatization associated with HIV to understanding and acceptance.

**GUIDELINE 10 (Development of Public and Private Sector Standards and Mechanisms for Implementing these Standards):** States should ensure that Government and the private sector develop codes of conduct regarding HIV issues that translate human rights principles into codes of professional responsibility and practice, with accompanying mechanisms to implement and enforce these codes.

**GUIDELINE 11 (State Monitoring and Enforcement of Human Rights):** States should ensure monitoring and enforcement mechanisms to guarantee the protection of HIV-related human rights, including those of people living with HIV, their families and communities.

**GUIDELINE 12 (International Cooperation):** States should cooperate through all relevant programs and agencies of the United Nations system, including UNAIDS, to share knowledge and experience concerning HIV-related human rights issues and should ensure effective mechanisms to protect human rights in the context of HIV at international level.

## **Standards Developed by UNAIDS and its Cosponsors**

The international community's efforts to advance human rights in the context of HIV/AIDS are greatly supported by a wide range of guidelines, position papers, goal-setting documents, action and outcome frameworks, strategies, handbooks, toolkits, and policy briefs produced by UNAIDS, its Reference Group on HIV and Human Rights, and its ten cosponsors: the UN High Commissioner for Refugees [hereinafter UNHCR], UN Children's Fund [hereinafter UNICEF], the World Food Programme [hereinafter WFP], the UN Development Programme [hereinafter UNDP], the UN Population Fund [hereinafter UNFPA], the UN Office on

Drugs and Crime [hereinafter UNODC], ILO, the UN Educational, Scientific and Cultural Organization [hereinafter UNESCO], the World Health Organization [hereinafter WHO], and the World Bank. All these entities have established broadly recognized standards that are frequently invoked in the national law and policy reform processes.<sup>23</sup>

Some of the most prominent and overarching instruments include: 1) Joint Action for Results, UNAIDS Outcome Framework, 2009-2011; 2) UNAIDS Getting to Zero: 2011-2015 Strategy; 3) UNAIDS Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV 2010-2014; 4) UNAIDS, Protocol for the Identification of Discrimination against People Living with HIV/AIDS (2000); 5) UNAIDS, Reducing HIV Stigma and Discrimination: a Critical Part of National AIDS Programs (2007); 6) UNAIDS Guide to the United Nations Human Rights Machinery (1997); 7) UNAIDS/UNDP/IDLO Toolkit: Scaling Up HIV-related Legal Services (2009); and 8) World Bank, Legal Aspects of HIV/AIDS (2007).

- **Joint Action for Results, UNAIDS Outcome Framework 2009-2011** emphasizes that HIV prevention needs investment in structural interventions, including legal reforms to outlaw discrimination against PLHIV. The framework focuses on ten UNAIDS priority areas, each of which represents a pivotal element of the AIDS response.<sup>24</sup> See Key Legal and Policy Concepts below.
- **UNAIDS Getting to Zero: 2011-2015 Strategy** provides a roadmap for achieving UNAIDS' vision of "Zero new HIV infections. Zero discrimination. Zero AIDS-related deaths." The strategy is based on global commitments to achieve universal access to HIV-related services and to halt and reverse the spread of HIV by 2015. It proposes three strategic directions for a renewed global HIV response: 1) to revolutionize HIV prevention; 2) to catalyze the next phase of treatment, care and support; and 3) to advance human rights and gender equality.<sup>25</sup>

### **Standards Developed by Treaty-Based Bodies**

Additional guidance on HIV/AIDS and human rights has been provided to States by the UN human rights treaty-based bodies, particularly the Human Rights Committee, the Committee on Economic, Social, and Cultural Rights, the Committee on the Elimination of Discrimination against Women, and the Committee on the Rights of the Child. These committees of independent experts monitor the implementation of the core international human rights treaties (i.e., respectively, ICCPR, ICESCR, CEDAW, and CRC) and have the mandate to issue: 1) general comments or recommendations, which interpret the content of human rights provisions; 2) concluding observations in consideration of State parties' reports; and 3) decisions and views in cases alleging violations of human rights. Some of the most prominent general comments that are relevant to the HIV/AIDS and human rights discourse include: 1) General Comment No. 14 on the Right to the Highest Attainable Standard of Health, published in 2000 by the UN Committee on Economic, Social, and Cultural Rights; 2) General Comment No. 3 on HIV/AIDS and the Rights of the Child, published in 2003 by the UN Committee on the Rights of the Child; 3) General Recommendation No. 15 on the Avoidance of Discrimination against Women in National Strategies for the Prevention and Control of AIDS, published in 1990 by the UN Committee on the Elimination of Discrimination against Women; and 4) General Recommendation No. 24 on Women and Health, published by the UN Committee on the Elimination of Discrimination against Women in 1999.

### **Other Instruments**

HIV/AIDS and human rights agenda is further advanced by UN Special Envoys for HIV/AIDS appointed by the UN Secretary-General,<sup>26</sup> and by the UN Human Rights Council (previously the UN Commission on Human Rights) and its special procedures, including special representatives, working groups, and special rapporteurs, most notably the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health [hereinafter UN Special Rapporteur on the Right to Health].<sup>27</sup> The UN Human Rights Council regularly adopts two resolutions with focus on the epidemic: an annual resolution on access to medication in pandemics, and the above-mentioned biennial resolution on the protection of human rights in the context of HIV/AIDS.<sup>28</sup>

In addition to these global instruments, there are many international standard-setting documents produced on regional level in Africa, the Americas, Asia, and Europe. A more complete table of authorities is presented below.

# KEY LEGAL AND POLICY CONCEPTS

## Protection of Human Rights

HIV/AIDS is a disease of social exclusion. PLHIV and key populations face criminalization, stigmatization, ostracism, marginalization, vilification, and pervasive human rights abuses such as discrimination, harassment, violence, torture, and inhuman or degrading treatment and punishment. Some of these violations are entrenched in national laws and policies. The international community has recognized that the protection of human rights in national laws and policies is paramount to addressing the HIV epidemic and reducing HIV vulnerabilities. Consequently, States have explicitly committed themselves to respect, protect, and fulfill human rights in the context of HIV/AIDS, which is evidenced by a number of international instruments, including the Declaration of Commitment and Political Declaration. In the 2011-2015 Getting to Zero Strategy, UNAIDS unveiled its vision of **zero discrimination** and called States to make greater efforts to realize HIV-related human rights, particularly the rights of PLHIV and key populations, i.e., women, young people, MSM, people who use drugs, and sex workers and their clients.<sup>29</sup>

## HIV-Related Stigmatization and Discrimination

### Stigmatization

Stigmatization, as defined by UNAIDS, is a dynamic process of devaluation that significantly discredits an individual in the eyes of others. HIV-related stigma refers to negative beliefs, feelings, and attitudes towards people living with or associated with HIV and AIDS. It mostly affects people with actual and perceived HIV status; people who are related to someone living with HIV (including children of HIV-positive parents); and people who are most at risk of HIV infection.<sup>30</sup> Stigma is expressed in discrediting language and behaviour, which can take a form of verbal harassment, social exclusion, ostracism, abandonment, blaming, and gossip. Stigma can be also internalized in the form of feelings of shame, self-blame, and worthlessness. Ultimately, stigma can lead to social inequality, discrimination, and other violations of human rights, including physical or mental violence, torture, and inhuman or degrading treatment or punishment.<sup>31</sup> HIV-related stigma is underpinned by many factors. It often stems from prejudice and fear caused by misconceptions about how HIV is transmitted; the incurability of AIDS; and the association of HIV/AIDS with already stigmatized and marginalized populations, such as sex workers, people who use drugs, MSM, transgender people, and people under state custody. People who belong to these key populations experience multiple layers of stigmatization and often refrain from accessing HIV-related services out of a fear of being humiliated, rejected, treated differently, discriminated against, arrested, and imprisoned.<sup>32</sup>

**Realization of human rights and fundamental freedoms for all is essential to reduce vulnerability to HIV and the impact of AIDS.**

*UN Human Rights Council, Resolution on the Protection of Human Rights in the Context of HIV and AIDS preamble (2009)*

**The relationship between HIV and human rights is profound. Protection of human rights in the context of HIV reduces suffering, saves lives, protects the public health, and provides for an effective response to HIV.**

*International Guidelines, Foreword (1996)*

**Full realization of human rights and fundamental freedoms for all is an essential element in a global response to the HIV/AIDS pandemic. It reduces vulnerability to HIV/AIDS and prevents stigma and related discrimination against people living with or at risk of HIV/AIDS.**

*Declaration of Commitment para. 16 (2001)*

**Advancing human rights for the HIV response means ending the HIV-related stigma, discrimination, gender inequality and violence against women and girls that drive the risk of, and vulnerability to, HIV infection by keeping people from accessing prevention, treatment, care and support services.**

*UNAIDS, Getting to Zero Strategy 2011-2015 at 10 (2010)*



## Discrimination

Discrimination, as defined by UNAIDS, is any form of arbitrary distinction, exclusion, or restriction affecting a person, usually, but not only, by virtue of an inherent personal characteristic. HIV-related discrimination is therefore any measure entailing an arbitrary distinction that results in an unfair and unjust treatment of an individual based on his or her confirmed or perceived HIV status.<sup>33</sup>

HIV-related discrimination, which is often described as the enactment of stigma attached to PLHIV and key populations, is globally pervasive. It may be intentional or unintentional, direct or indirect, and may result from action or omission. It may occur in the family, community, and institutional settings, and may be institutionalized through existing laws, policies, and practices at the national and local levels of the government. Irrespective of its form, discrimination constitutes a violation of human rights proscribed by international human rights law and most national constitutions.<sup>34</sup>

The principle of non-discrimination, which requires that all persons in similar situations be treated in an equal manner,<sup>35</sup> is a cornerstone of international human rights law and a key feature of international standard-setting documents on HIV/AIDS and human rights:

- **International Guidelines** urge States to enact or strengthen anti-discrimination and other protective laws that protect vulnerable groups, PLHIV, and people with disabilities from discrimination in both the public and private sectors (Guideline no. 5).
- In adopting the **Declaration of Commitment** and **Political Declaration**, States made commitments to: 1) enforce legislation, regulations, and other measures aimed at eliminating all forms of discrimination and marginalization of PLHIV and vulnerable groups; 2) ensure their full enjoyment of all human rights and fundamental freedoms – in particular, their access to education, inheritance, employment, health care, social services, prevention, support, treatment, information, legal protection, privacy and confidentiality; 3) develop and implement financing plans and multisectoral strategies that confront stigma, social exclusion, and discrimination connected with the epidemic; and 4) address factors that make people vulnerable to infection, including underdevelopment, economic insecurity, poverty, lack of empowerment of women, lack of education, social exclusion, illiteracy, discrimination, lack of information, lack of HIV prevention commodities, and sexual exploitation.<sup>36</sup>

There is no one binding international instrument that expressly prohibits discrimination on the basis of HIV status. However, all major international human rights treaties have been interpreted to include HIV as a ground on which discrimination is prohibited:

- **ICESCR** and the **CRC** identify race, color, sex, language, religion, political or other opinion, national or social origin, property, disability, birth, and *other status* as non-exhaustible grounds of prohibited discrimination.<sup>37</sup> In its General Comment No. 20, the UN Committee on Economic, Social and Cultural Rights emphasized that *other status* includes health status and sexual orientation.<sup>38</sup> States must therefore ensure that a person's actual or perceived health status is not a barrier to realizing the rights under ICESCR. States must also adopt measures to address widespread stigmatization of

**Stigma, silence, discrimination and denial, as well as lack of confidentiality, undermine HIV prevention, care and treatment, and increase the impact of the epidemic on individuals, families, communities, and nations.**

*Declaration of Commitment para. 13 (2001)*

**Discrimination on the basis of HIV or AIDS status, actual or presumed, is prohibited by existing international human rights standards. The term "other status" in non-discrimination provisions in international human rights texts should be interpreted as covering health status, including HIV/AIDS.**

*UN Human Rights Council, Resolution on the Protection of Human Rights in the Context of HIV and AIDS preamble (2009)*

**The international human rights system explicitly recognized HIV status as a prohibited ground of discrimination.**

*International Guidelines, Foreword (1996)*

**There is now an international consensus on identifying and eliminating arbitrary discrimination on the grounds of HIV/AIDS status.**

*UNAIDS, Protocol for the Identification of Discrimination against People Living with HIV 5 (2000)*

people on the basis of their health status. Direct and indirect discrimination of any kind by both public and private entities must be eliminated both formally and substantially.<sup>39</sup>

- **UN Convention on the Rights of the Persons with Disabilities** prohibits all discrimination on the basis of disability,<sup>40</sup> but it does not explicitly mention HIV or AIDS or include a definition of *disability*.<sup>iii</sup> However, its preamble recognizes that disability is an evolving concept and that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinder their full, effective, and equal participation in the society. UNAIDS and experts recommend that States interpret the Disability Convention as including HIV/AIDS.<sup>41</sup>

The protection of public health is often cited by States to restrict human rights on the basis of health status, including HIV status. HIV-related discrimination is, however, ineffective as a public health measure: it fuels fear and intolerance and consequently, discourages people from disclosing their HIV status and/or accessing HIV-related services. In addition, discrimination may create complacency among individuals and groups who are not targeted and therefore may assume that they are not at risk of HIV. It also exacerbates vulnerabilities of marginalized groups. In its General Comment No. 20, the UN Committee on Economic, Social, and Cultural Rights warned States against instituting discriminatory restrictions in the interests of public health.

In line with the UNAIDS Protocol for the Identification of Discrimination against People Living with HIV [hereinafter UNAIDS Anti-Discrimination Protocol] and the Siracusa Principles on the Limitation and Derogation of Provisions in the International Covenant on Civil and Political Rights, the right to non-discrimination can be justifiably restricted only in certain narrowly defined circumstances, for example to ensure safe blood supply by restricting blood donations. More specifically, a discriminatory restriction can be justifiable only if the measure: 1) is in the interests of a legitimate objective; 2) is prescribed by the law; and 3) is compatible with the objectives and purposes of the Covenant. The means employed to achieve a legitimate objective must be proportionate to the aim pursued, and should consist of the least restrictive means possible. The restriction cannot jeopardize the essence of the right to non-discrimination. Further, individuals should be able to challenge every restriction of the right to non-discrimination and obtain a remedy against its abusive application. The burden of justifying the restriction lies with the State.<sup>42</sup>

## Right to Health

The right to the highest attainable standard of physical and mental health [hereinafter right to health] forms the basis of legal protections in the context of HIV/AIDS and should be placed in the center of the national HIV legal and policy framework. Internationally, the right to health was first articulated in 1946 Constitution of WHO which defined health as a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. The right to health was subsequently recognized in the UDHR and ICESCR, which is the central instrument of protection for the right to health. The right to health is also recognized in the International Convention on the Elimination of All Forms of Racial Discrimination, CEDAW, CRC, the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, the Convention on the Rights of Persons with Disabilities, and in the following regional human rights treaties: the Banjul Charter, the Additional Protocol to ACHR in the Area of Economic, Social and Cultural Rights (1988), and the European Social Charter.<sup>43</sup> The UN High Commissioner for Human Rights and WHO underline that the right to health is relevant to all States because every State has ratified at least one international human rights treaty recognizing the right to health. The right to health or the right to health care is also embedded in over 100 national constitutions.<sup>44</sup> It is important to note that under international law States are required to progressively realize the right to health to the maximum of available resources. Consequently, a difficult financial situation does not absolve States from the obligation to take action to fulfill the right to health.<sup>45</sup>

**Health is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity.**

*UN Committee on Economic, Social, and Cultural Rights, General Comment No. 14 on the Right to the Highest Attainable Standard of Health para. 1 (2000)*

<sup>iii</sup> **Persons with disabilities** are defined as people who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others. See CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES art. 1 (adopted December 13, 2006 by U.N. G.A. Res. 61/106, entered into force May 3, 2008, U.N. Doc. A/61/611).

Contrary to common misconceptions, the right to health is not the same as the right to be healthy. Rather, the right to health entails the right to enjoyment of a variety of goods, services, facilities, and conditions necessary for its fulfillment.<sup>46</sup> In its General Comment No. 14, the UN Committee on Economic, Social, and Cultural Rights underlined that the right to health embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment.<sup>47</sup> One of the most important components of the right to health for PLHIV and key populations is universal access to HIV-related services.

## Universal Access

In the 2006 Political Declaration, the global community made a historic commitment to provide universal access to HIV prevention, treatment, support, and care for all who need it by 2010.<sup>48</sup> The overall objective is to scale up an effective response to HIV/AIDS, i.e., increase access to the most effective HIV interventions, improve general health outcomes, and ultimately achieve UNAIDS' vision of zero discrimination, zero new HIV infections, and zero AIDS-related deaths.

The movement towards universal access is led by States with support from UNAIDS, its cosponsors, and other development partners, including civil society.<sup>49</sup> UNAIDS has identified ten priority intervention areas that States are urged to follow to achieve universal access.<sup>50</sup> In attempting to achieve universal access, States must set national targets in key areas such as HIV testing, treatment, and prevention.

## HIV Susceptibility, Vulnerability, and Key Populations

**HIV susceptibility** refers to an individual's chance of becoming exposed to the virus (reflecting the risk environment and riskiness of behavior) and the chance of being infected with HIV once exposed. **HIV vulnerability** is the likelihood of significant HIV/AIDS-related impacts and damaging effects on individuals, households, and communities. UNAIDS points out that HIV vulnerability results from a range of factors that reduce the ability of individuals and communities to avoid HIV infection. These may include: 1) personal factors such as the lack of knowledge and skills required to protect oneself and others; 2) factors pertaining to the quality and coverage of services, such as inaccessibility of services because of distance, cost and other factors; 3) societal factors such as social and cultural norms, practices, beliefs and laws that stigmatize and disempower certain populations and act as barriers to essential HIV-prevention messages. These factors, alone or in combination, may create or exacerbate individual vulnerability and, as a result, collective vulnerability to HIV. The vulnerability of individuals, households, communities and institutions vary with the stages of HIV/AIDS, from the risk of infection and the subsequent impacts of HIV/AIDS, to the vulnerabilities of survivors following the aftermath of an AIDS-related death.<sup>51</sup>

In this Tool, the term **key populations** is used to define groups of people who are at higher risk of HIV exposure, infection, and transmission (most-at-risk populations) and vulnerable populations, i.e., groups people who are disproportionately affected by HIV and its impacts, including HIV-related discrimination. In most settings, key populations include: women, children, youth, people who use drugs, adults engaged in commercial sex, MSM, transgender people, and people under state custody. The Tool recognizes that key populations are key to the epidemic and key to the response, and devotes a separate section to address their vulnerabilities, HIV-related discrimination against them, and their access to HIV-related services which should be guided by the principle of equity.

### UNAIDS 10 PRIORITY AREAS

(1) We can reduce sexual transmission of HIV; (2) We can prevent mothers from dying and babies from becoming infected with HIV; (3) We can ensure that people living with HIV receive treatment; (4) We can prevent people living with HIV from dying of tuberculosis; (5) We can protect drug users from becoming infected with HIV; (6) We can remove punitive laws, policies, practices, stigma and discrimination that block effective responses to AIDS; (7) We can meet the HIV needs of women and girls and can stop sexual and gender-based violence; (8) We can empower young people to protect themselves from HIV; (9) We can enhance social protection for people affected by HIV; and (10) We can empower men who have sex with men, sex workers and transgender people to protect themselves from HIV infection and to fully access antiretroviral therapy.

## Principle of Equity

The scale up towards universal access is guided by the cross-cutting principles of non-discrimination and equality. However, these principles are not always sufficient to ensure that PLHIV and key populations have sustainable access to comprehensive services that take into account their particular health challenges and needs. In many circumstances, special efforts are required to identify, prioritize, and give preference to the most vulnerable populations<sup>iv</sup> in order to overcome barriers to their access to services and ultimately bring them to a state of being equal to others. The Tool describes these special efforts as **reasonable accommodations**, i.e., necessary and appropriate modifications or adjustments that are reasonably practicable and that enable PLHIV to enjoy or exercise human rights and fundamental freedoms on an equal basis with others.

Positive measures of protection are particularly necessary when access to essential services is blocked by high prevalence of discrimination against a particular group of people. This principle of fairness or equity, which calls to treat like cases alike and different cases differently, is outlined in the 2004 Guidance on Ethics and Equitable Access to HIV Treatment and Care produced by UNAIDS and WHO. Both organizations underline that reaching the most vulnerable populations with effective services is vital for slowing down the spread of HIV.<sup>52</sup> The principle of equity is also supported by the International Guidelines. According to Guideline 6, States should take measures necessary to ensure the availability and accessibility of HIV-related services with a particular attention to vulnerable individuals and populations.<sup>53</sup> In line with Guideline 8, States should promote a supportive and enabling environment for women, children, and other vulnerable groups by addressing underlying prejudices and inequalities through, among others, specially designed social and health services.

In order to ensure equitable and sustainable access to comprehensive HIV-related services, States should identify economic, socio-cultural, political, and legal inequalities and other risk factors that disproportionately affect most vulnerable populations. States should subsequently disaggregate their health laws and policies and tailor them to those most in need of assistance. Otherwise, as OHCHR and WHO point out, seemingly neutral laws will benefit mainly the majority groups.<sup>54</sup>

## Risk Environment

HIV is a behaviorally-mediated infection. Its transmission is influenced not only by biological and physiological factors and individual risk practices, but also by a myriad of environmental conditions that shape individual HIV vulnerabilities. Risk factors exogenous to the individual form a risk environment which includes micro-level and macro-level physical, social, economic, and policy factors. These factors generate the context of HIV risk or protection.<sup>55</sup>

- **The micro-risk environment** focuses on personal decisions and the influence of community-level norms, practices, and conditions, including, but not limited to: homelessness; incarceration; exposure to violence or trauma; education; access to affordable housing; access to community health and social services; access to HIV testing and counseling; access to needle, syringe, and condom distribution programs; access to drug injecting sites and voluntary drug treatment; social and peer-group norms; relationship dynamics; sexuality; sexual orientation; local policing practices and crackdowns; and cost of living, health care, and prevention commodities.
- **The macro-risk environment** captures structural factors, such as national laws and policies and their enforcement; economic and political conditions; organized crime (e.g., drug trafficking and trafficking in persons); migration; gender, racial, and ethnic inequalities; prevalence of drug use; stigmatization, marginalization, and criminalization of key populations; weak civil society and community participation; political transition; exposure to war, conflict, or disaster; and wider cultural and religious beliefs. Some of the most important macro-determinants of HIV risk include laws and policies that govern: 1) access to

---

<sup>iv</sup> UNAIDS defines vulnerability as realities or characteristics over which a person or a group has little control and which make the person or group more likely to experience harm or not receive a benefit. Depending upon a local context, the most vulnerable groups may include: the poor, rural populations, women, children, migrants, sex workers, people who use drugs, MSM, transgender people, and people under state custody. See UNAIDS & WHO, GUIDANCE ON ETHICS AND EQUITABLE ACCESS TO HIV TREATMENT AND CARE 3-4, 29 (2004).

needles, syringes, and condoms; 2) drug treatment; 3) possession of drugs and drug paraphernalia; 4) sex work; 5) public health; 6) immigration; and 7) protection of human rights, including the right to health. Of equal importance is enforcement of these laws and policies.

The risk environment framework requires a comprehensive analysis of local HIV risk factors and provides a crucial insight into HIV prevention. It calls for evidence-informed, rights-based combination HIV interventions that are not only aimed at individual behavior but also at social structures in which individuals operate. These combination strategies should include structural interventions that address population-level determinants of HIV risk and that aim at creating local environments and social conditions supportive of risk reduction by individuals and communities. For example, a successful HIV strategy focusing on people who use drugs may require decriminalization of drug use, legalization of opioid substitution therapy [hereinafter OST], and increased coverage of health care with concomitant scale-up of HIV-related services.<sup>58</sup>

## Legal Environment

Laws, policies, and law enforcement practices that constitute determinants of HIV risk may be protective or punitive and repressive in nature. According to UNAIDS, in 2008, 67% of States reported having laws that prohibit discrimination against PLHIV and less than 40% of States reported having legal protections for MSM (39%), sex workers (33%), and people who use drugs (27%). 84 States reported having laws and policies that presented obstacles for key populations to access HIV-related services; 49 States had HIV-specific laws criminalizing HIV transmission and exposure; 86 States had laws prohibiting sexual intercourse between people of the same sex, with 7 providing the death penalty for it; 110 States criminalized some aspect of sex work; 51 States had HIV-related travel restrictions; and numerous countries criminalized harm reduction measures in the context of drug use.<sup>59</sup> In 2010, the percentage of States with laws prohibiting discrimination against PLHIV rose to 71 but 67% of States still reported laws and policies impeding access to HIV-related services.<sup>60</sup> In addition to punitive laws and policies, repressive law enforcement practices, including extrajudicial policing targeted at key populations (e.g., around pharmacies and harm reduction facilities), are commonplace in many States. They range from arrest without legal justification, planting of evidence, and extortion, to harassment, physical violence, torture, and rape.<sup>61</sup>

UNAIDS, its cosponsors, and experts stress that repressive social and legal environments produce fear, perpetuate stigma, institutionalize discrimination, limit HIV/AIDS funding, obstruct global prevention efforts, violate human rights, and block effective responses to HIV/AIDS by driving people underground and away from HIV-related services. They both reduce individuals' ability to avoid HIV infection and significantly impact the lives of PLHIV.<sup>62</sup> For example, in countries where sex work, male-to-male sex, or possession of drug paraphernalia are criminalized, sex workers, MSM, and people who

**Advancing human rights for the HIV responses means putting laws, policies, and programs in place to create legal environments that protect people from infection and support access to justice.**

*UNAIDS, Getting to Zero Strategy 2011-2015 at 22 (2010)*

**Legal protection against HIV-related discrimination is an essential prerequisite for an effective national HIV response. Discrimination can be reduced through the removal of punitive laws and enactment of protective legislation, robust enforcement of protective policies, training of service providers on non-discrimination in the context of HIV, educating people relevant rights and laws, promoting contact between those discriminated against and those discriminating, and providing access to legal services for affected populations.**

*UNAIDS, Non-Discrimination in HIV Responses 3, 10 (2010)*

**States are urged to consider taking the steps necessary towards the elimination of criminal and other laws that are counterproductive to HIV prevention, treatment, care and support efforts, or that violate the human rights of PLHIV and members of key populations. States are also urged to consider the enactment of laws protecting these persons from discrimination in HIV-related services.<sup>56</sup>**

*UN Human Rights Council, Resolution on the Protection of Human Rights in the Context of HIV and AIDS para. 13 (2009)*

**States should review and reform criminal laws and correctional systems to ensure that they are consistent with international human rights obligations and are not misused in the context of HIV or targeted at vulnerable groups. In any event, criminal law should not be allowed to impede provision of HIV prevention and care services.<sup>57</sup>**

*International Guidelines, Guideline 4 (1996)*

use drugs often fear prosecution and harassment by law enforcement authorities and avoid pharmacies, safe drug injecting sites, and health care centers where they can be spotted by the police. Conversely, supportive and protective legal environments enable States to better respond to HIV/AIDS. For example, access of key populations to HIV prevention programs is generally better in countries with non-discrimination laws in place.<sup>63</sup> Consequently, UNAIDS, its cosponsors, and experts have consistently underlined the importance of legal and policy reform in addressing stigma, challenging discrimination, and promoting and protecting human rights in the context of HIV/AIDS.<sup>64</sup>

International standards clearly call for removal of punitive laws and practices that impede the achievement of universal access. Elimination of these laws and practices is one of UNAIDS' ten priority areas outlined in the Outcome Framework 2009-2011. The priority areas reinforce the need to create enabling legal environments in which the law protects from discrimination, law enforcement practices are human rights-based, and individuals affected by HIV have access to justice.<sup>65</sup> In its Getting to Zero: 2011-2015 Strategy, UNAIDS urged States to make greater efforts to implement protective legal environments for PLHIV and key populations and set a goal to reduce by half the number of States with punitive laws and practices around HIV transmission, sex work, drug use, or homosexuality.

## **Global AIDS Reporting**

### **UNGASS Reporting**

The Declaration of Commitment requires the UN Secretary-General to submit regular progress reports on the HIV/AIDS epidemic to the UN General Assembly.<sup>66</sup> To discharge this obligation, the Secretary-General charged UNAIDS Secretariat with developing and implementing the country reporting process, commonly referred to as UNGASS Reporting. Member States are obliged to submit Country Progress Reports to UNAIDS Secretariat every two years and are encouraged to use a set of UNGASS Core Indicators. The first round of reporting took place in 2003, with subsequent rounds in 2004, 2006, 2008, and 2010.<sup>67</sup>

### **ICESCR Reporting**

State parties to ICESCR are required to incorporate information on HIV/AIDS interventions in their national reports to the UN Committee on Economic, Social, and Cultural Rights. The reports must include an account of measures undertaken to: 1) prevent HIV/AIDS; 2) educate high-risk groups, children, and adolescents as well as the general public on HIV transmission; 3) provide support to PLHIV and their families; and 4) reduce social stigma and discrimination.<sup>68</sup>

### **CEDAW Reporting**

State parties to CEDAW are required to incorporate information on the impacts of HIV/AIDS on women in their national reports to the CEDAW Committee. The reports must include an account of measures undertaken to: 1) address the magnitude of women's ill-health arising from HIV/AIDS; 2) cater to the needs of HIV-positive women; and 3) prevent discrimination against women in response to HIV/AIDS.<sup>69</sup>

### **CRC Reporting**

State parties to CRC are required to incorporate information on the extent to which national HIV/AIDS policies and programs explicitly recognize children and their rights in their national reports to the UN CRC Committee. The reports must pay special attention to discrimination against children on the basis of their (or their parents') HIV status.<sup>70</sup>

# Part 3

## Analytical Framework





# STRUCTURE AND FACTOR STATEMENTS

## Country Background Section

Country Overview  
Status of the HIV/AIDS Epidemic  
Legal and Infrastructural Framework  
Civil Society and Private Sector

## Analysis Section

### I. Access to Essential Services

#### **Factor 1: Public Education, Research, and Information Exchange**

Every person enjoys an equal right to seek, receive, and impart reliable and accurate information about bio-medical and socio-economic aspects of HIV/AIDS. The State implements and supports HIV-related awareness-raising, stigma-reduction, training, and information exchange programs, and ensures that HIV research adheres to the highest ethical standards.

#### **Factor 2: HIV Prevention**

Every person has equitable and sustainable access to a wide range of effective, human rights-based, and evidence-informed measures aimed at preventing HIV transmission.

#### **Factor 3: Testing, Counseling, and Referral**

Every person has unrestricted access to voluntary, confidential or anonymous HIV testing accompanied by quality counseling and referral to essential services. Arbitrary, mandatory, or compulsory HIV testing is prohibited.

#### **Factor 4: Treatment, Care, and Other Health Services**

PLHIV enjoy the right to the highest attainable standard of physical and mental health, including equitable and sustainable access to comprehensive health care. The State takes concrete steps to progressively realize universal access to HIV-related treatment and care.

#### **Factor 5: Social Protection and Material Assistance**

PLHIV enjoy the right to an adequate standard of living, including equitable access to social protection and other forms of material assistance, particularly in the event of unemployment, sickness, or disability.

#### **Factor 6: Protection of Privacy and Confidentiality**

PLHIV enjoy effective protection from arbitrary or unlawful interference with their privacy. Their medical and personal information is subject to strict rules of data protection and confidentiality.

### II. Equality of PLHIV in Public and Private Life

#### **Factor 7: Political, Social, and Cultural Life**

PLHIV enjoy full equality and inclusion in political, social, and cultural life. The State ensures the right of PLHIV, HIV/AIDS advocates, and service workers to peaceful assembly and association.

#### **Factor 8: Family, Sexual, and Reproductive Life**

PLHIV enjoy full equality in family life and the right to the highest attainable standard of sexual and reproductive health. The State facilitates prevention of vertical transmission.

**Factor 9: Education and Training**

PLHIV enjoy the right to equal educational opportunity. Where appropriate, special measures are employed to provide reasonable accommodations for PLHIV and increase their representation in educational institutions.

**Factor 10: Employment, Work, and Economic Life**

PLHIV enjoy equal rights to: work in public and private sectors, including just, favorable, safe, and healthy conditions of work; property and inheritance; and credit. Where appropriate, special measures are employed to provide PLHIV with income-generating opportunities and reasonable accommodations in the workplace.

**Factor 11: Private and Public Housing**

PLHIV enjoy equal access to adequate private and public housing, including residential facilities. Where appropriate, special measures are employed to provide reasonable accommodations for PLHIV and protect their rights in the place of residence. Segregation, exclusion, and coercive or punitive measures based on HIV status are prohibited.

**Factor 12: Entry, Stay, and Residence**

The State does not impose restrictions on the entry, stay, and residence of PLHIV based on HIV status. PLHIV are not returned to countries where they face persecution, torture, or other forms of cruel, inhuman, or degrading treatment. Migrants and mobile populations have equitable and sustainable access to comprehensive HIV-related services.

**Factor 13: Non-Criminalization of HIV Exposure and Transmission**

HIV exposure and non-intentional transmission are not criminalized. Deliberate and intentional transmission of HIV is prosecuted under general rather than HIV-specific criminal law.

### III. Key Populations

**Factor 14: Women**

The State takes all appropriate measures to reduce specific HIV vulnerabilities of women, eliminate HIV-related discrimination against them, and provide them with equitable and sustainable access to comprehensive HIV-related services.

**Factor 15: Children and Youth**

The State takes all appropriate measures to reduce specific HIV vulnerabilities of children and youth, eliminate HIV-related discrimination against them, and provide them with equitable and sustainable access to comprehensive HIV-related services.

**Factor 16: People who Use Drugs**

The State takes all appropriate measures to reduce specific HIV vulnerabilities of people who use drugs, eliminate HIV-related discrimination against them, and provide them with equitable and sustainable access to comprehensive HIV-related services.

**Factor 17: Adults Engaged in Commercial Sex**

The State takes all appropriate measures to reduce specific HIV vulnerabilities of adults engaged in commercial sex, eliminate HIV-related discrimination against them, and provide them with equitable and sustainable access to comprehensive HIV-related services.

**Factor 18: Men who Have Sex with Men, and Transgender People**

The State takes all appropriate measures to reduce specific HIV vulnerabilities of men who have sex with men, and transgender people, eliminate HIV-related discrimination against them, and provide them with equitable and sustainable access to comprehensive HIV-related services.

**Factor 19: People under State Custody**

The State takes all appropriate measures to reduce specific HIV vulnerabilities of people under state custody, eliminate HIV-related discrimination against them, and provide them with equitable and sustainable access to comprehensive HIV-related services. Terminally ill PLHIV are considered for early release and given proper treatment outside of prisons.

**IV. Access to Justice**

**Factor 20: Legal Protection**

Every person enjoys the right to an adequate and effective protection against violations of human rights based on HIV status, vulnerability, advocacy, or service work.

**Factor 21: Legal Awareness, Assistance, and Representation**

The State implements and supports educational programs aimed at raising legal literacy among PLHIV. PLHIV have equal access to adequate and affordable legal assistance and representation.

**Factor 22: Access to a Forum, Fair Trial, and Enforcement of Remedies**

PLHIV, HIV/AIDS advocates and service workers are guaranteed equal access to a forum administering justice, the right to a fair trial, and effective enforcement of remedies.



# COUNTRY BACKGROUND

## Guidance for Country Background Chapter

Country Background is intended to be a descriptive, non-analytical portion of a report based on the HIV/AIDS Legal Assessment Tool. Therefore, no *factor statement* is provided and assessors are not expected to produce a *de jure* or *de facto* analysis of the issues outlined below.

### Country Overview

The opening section of a country report should offer a concise overview of the host country's geographical location, population, history, political system, government, and economy.

### Status of the HIV/AIDS Epidemic

A country report should provide a synopsis of the status and nature of the HIV/AIDS epidemic in the host country at the time of the assessment, including:

- HIV prevalence (number of people living with HIV);
- HIV incidence (number of new infections during the past year) and trend data on HIV incidence;
- Number of AIDS-related deaths during the past year and trend data on AIDS-related mortality;
- Number of people eligible for HIV treatment under WHO guidelines;
- Number of people who receive HIV treatment;
- Core social and economic factors forming the local HIV risk environment;
- Main drivers and current patterns of the national HIV/AIDS epidemic, including geographic distribution of the epidemic and main modes of HIV transmission.

Where appropriate, data should be disaggregated by gender and age.

### Legal and Infrastructural Framework

The country's legal and infrastructural framework in the context of HIV/AIDS should be described taking into account the international guidance, which is summarized below. Drawing upon the risk environment framework, the narrative should cover both protective and repressive laws and policies which constitute determinants of HIV risk.

#### Laws and Policies

International standards urge States to develop and implement a comprehensive and multisectoral National AIDS Action Framework. The National AIDS Action Framework forms the basis for the national AIDS response and constitutes a fundamental component of the national legal and policy framework, which consists of the constitution, ratified international treaties, as well as national laws, regulations, and policy documents related to HIV/AIDS and human rights. According to International Guidelines, the legal and policy framework should include all policy areas, since only combination of well-integrated and coordinated approaches can address the complexities of the HIV epidemic.<sup>71</sup> The national legal and policy framework should be based on the principle of equality, and should:

- Guarantee human rights in the context of HIV/AIDS;
- Prohibit HIV-related discrimination;
- Confront HIV-related stigma and prejudice;
- Include measures aimed at reducing HIV vulnerabilities of key populations;
- Guarantee the right to the highest attainable standard of health;
- Address public health issues raised by HIV/AIDS;

- Outline steps towards achieving universal access;
- Fund and empower public health authorities to provide comprehensive HIV-related services;
- Regulate and ensure widespread availability of quality HIV-related goods and services;
- Ensure that criminal and administrative laws are not misused in the context of HIV/AIDS.

To meet the above-stated objectives, States are urged to review, enact, strengthen, reform, and enforce the relevant legislation, regulations, and policy measures and ensure that the national legal and policy framework is consistent with international human rights law. States are also urged to overcome the legal and regulatory barriers that block access to justice and HIV-related services. Further, States should adopt or revise disability laws to include HIV/AIDS in their legal definition of disability. HIV laws, policies, and strategies should be designed, developed, implemented, and monitored in a partnership with civil society, the private sector, PLHIV, and key populations.<sup>72</sup>

### Areas of Inquiry

- Briefly describe the national legal system, hierarchy of laws, legal status of international treaties under domestic law, and core constitutional and statutory principles on the protection of individual rights, including the right to non-discrimination and the right to health.
- List relevant international human rights treaties ratified by the State.
- List and briefly describe domestic laws and policies on HIV/AIDS, including, where applicable: 1) HIV-specific laws; 2) public health, human rights, criminal, and administrative laws covering issues raised by HIV; and 3) the National AIDS Action Framework and/or other HIV-related policies and strategies.
- Determine if the State's laws and policies contain provisions that: 1) guarantee human rights in the context of HIV/AIDS; 2) explicitly prohibit discrimination on the basis of health status, disability, and/or HIV/AIDS; 3) aim at reducing HIV-related stigmatization, discrimination, and HIV vulnerabilities of key populations; and 4) aim at achieving universal access.
- Determine if the State's laws and policies contain provisions that present obstacles to effective, evidence-informed HIV prevention, treatment, care, and support.

## Governmental Infrastructure

### Leadership and HIV Mainstreaming

The core international standard-setting documents on HIV/AIDS emphasize that strong, high-level leadership, sustained political will and commitment, as well as concerted efforts on the part of the government and other stakeholders at all levels of the society, are indispensable for an effective response to HIV/AIDS.<sup>73</sup> The leadership must demonstrate a dedication to HIV-related human rights and avoid unnecessary politicization of HIV. States should further ensure that HIV policies and programs are included in the mainstream of development planning and integrated across all branches of the government.<sup>74</sup> This can be accomplished through such methods as: 1) formation of inter-ministerial and parliamentary or legislative committees with representation from major and minor political parties; 2) securing a place for HIV and human rights issues in existing mainstream forums (e.g., regular meetings of Ministers); 3) formation of intergovernmental committees with provincial/state and national representation in federal systems; 4) formation of advisory bodies to governments on legal and ethical issues surrounding HIV/AIDS (with professional and community representation); and 5) sensitization and education of the judicial branch.<sup>75</sup>

### “Three Ones”

In 2003-2004, the international community reached a consensus on three principles guiding the design and implementation of national HIV/AIDS responses. Endorsed by UNAIDS, key international donors, and the Political Declaration, the “Three Ones” call for:

- **One National AIDS Action Framework** that provides the basis for coordinating the work of all partners.<sup>76</sup> A National AIDS Action Framework should be comprehensive, effective, transparent, highly-participatory, well-coordinated, and sustainable.<sup>77</sup> In addition, a National AIDS Action Framework requires: 1) clear priorities for resource allocation and accountability; 2) multisectoral cooperation; and 3) links with poverty-reduction and development frameworks.<sup>78</sup>

- **One National AIDS Coordinating Authority**, with a broad-based multisectoral mandate. Coordination of country-level HIV policies and programs can be best accomplished through the establishment and strengthening of national multisectoral AIDS coordinating authorities (e.g., committees or councils). Similar coordination is important within and between lower levels of the government.<sup>79</sup> A National AIDS Coordinating Authority requires, among others: 1) legal status and formal mandate with clearly defined roles and responsibilities; 2) democratic oversight by legislative authorities; and 3) acceptance and respect by all stakeholders.<sup>80</sup>
- **One National Monitoring and Evaluation (M&E) System**. Periodic monitoring of progress in realizing national HIV targets and commitments is essential to adequately assess States' national HIV/AIDS policies and investment priorities. A National M&E System should be operational, sound, and rigorous, and should be equipped to cover not only epidemiological data but also the promotion and protection of human rights of PLHIV through indicators measuring discrimination and stigma.<sup>81</sup> In addition, a functional National M&E System requires: 1) multisectoral costed work plan with standardized indicators and data collection procedures (preferably aligned around the core M&E elements stemming from the UNGASS reporting system, the MDGs, and universal access targets); 2) routine HIV program monitoring through surveys and surveillance; 3) national and sub-national HIV databases; and 4) dissemination of high-quality data for guiding policy formulation and program planning.<sup>82</sup>

These three pillars serve as the basis and overall focus for optimizing roles and coordinating partnerships and funding in the response to HIV/AIDS.<sup>83</sup>

### Financial Resources

Adequate resources are indispensable for mounting a comprehensive response to HIV/AIDS.<sup>84</sup> International standards urge States to: 1) increase and prioritize national budgetary allocations for HIV/AIDS programs; 2) develop and implement effective financing plans that are resourced, to the extent possible, from national budgets but without excluding external funding; and 3) ensure that international funding is aligned with national HIV/AIDS plans and strategies.<sup>85</sup> Resource allocations for addressing HIV/AIDS should be substantial, sustained, predictable, and geared towards achieving results.<sup>86</sup> It is important to note that States are required to track their HIV/AIDS funding and expenditures for the purposes of UNGASS Reporting using the National Funding Matrix. The matrix enables States to record AIDS spending within eight AIDS spending categories across three funding sources (public, international, and private). The eight AIDS spending categories include: 1) Prevention; 2) Care and Treatment; 3) Orphans and Vulnerable Children; 4) Program Management and Administration Strengthening; 5) Incentives for Human Resources; 6) Social Protection and Social Services; 7) Enabling Environment and Community Development; and 8) Research.<sup>87</sup>

### International Cooperation

The core international standard-setting documents on HIV/AIDS emphasize the importance of sharing HIV resources and expertise as well as building on countries' collective and diverse experiences through enhanced bilateral, regional, sub-regional, and international cooperation.<sup>88</sup> States are therefore urged to:

- Support and work in close partnership with the United Nations, particularly with UNAIDS and its ten cosponsoring organizations; the Global Fund to Fight AIDS, Tuberculosis and Malaria; as well as other international donors and intergovernmental organizations with HIV/AIDS programming;<sup>89</sup>
- Support regional, sub-regional, and inter-regional organizations and initiatives on HIV/AIDS;<sup>90</sup>
- Develop regional strategies, approaches, and plans to address HIV/AIDS and encourage local organizations to expand and strengthen regional partnerships, coalitions, and networks;<sup>91</sup>
- Convene and participate in regional and international conferences, seminars, workshops, training programs, and courses on HIV/AIDS and related issues.<sup>92</sup>
- Discharge their global AIDS reporting requirements.

### Areas of Inquiry

- |  |
|--|
| <input type="checkbox"/> Does the State provide high-level leadership to the national AIDS response?<br><input type="checkbox"/> Does the State integrate HIV policies and programs across all branches of the government?<br><input type="checkbox"/> How does the State coordinate HIV-related programs? |
|--|

- Does the State subscribe to the “Three Ones” principle? If yes, describe the national AIDS coordinating authority and the national AIDS M&E system.
- How are HIV-related programs coordinated at the regional and local levels of the government?
- Does the State have a national AIDS database or documentation center?
- Does the State have a transparent AIDS financing strategy?
- Does the State allocate adequate and sustainable resources to the national AIDS response?
- Does the State receive external funding for HIV-related programs?
- Does the State support international cooperation in the area HIV/AIDS?
- Does the State regularly report on its national AIDS response to the relevant international institutions?

## Health Care System

In order to ensure the right to health and form an adequate response to the HIV/AIDS epidemic, States must establish and maintain health care systems capable of providing equal, universal, and sustainable access to HIV-related services for all. National health care systems should also: 1) address concurrent epidemics (such as hepatitis C, TB, and sexually transmitted infections [hereinafter STIs]); 2) conduct epidemiological surveillance of HIV/AIDS and concurrent epidemics; and 3) engage in evidence-informed HIV prevention.<sup>93</sup>

## Health Services

A health system is the sum total of all organizations, people, and actions whose primary intent is to promote, restore or maintain health.<sup>94</sup> Good health services are those that deliver effective, safe, high quality health interventions to people who need them, when and where they need them, and with minimum waste of resources.<sup>95</sup> According to the UN Committee on Economic, Social, and Cultural Rights, health systems must provide goods and services that are:

- **Available** (they must be offered in sufficient quantity).
- **Accessible** (they must meet four accessibility dimensions: non-discrimination, physical accessibility, affordability, and information accessibility).
- **Acceptable** (they must be respectful of medical ethics and culturally appropriate);
- **Of good quality**, and scientifically and medically **appropriate**.<sup>96</sup>

In addition, health care systems should be capable of providing services that are continuous and integrated. Continuum of care means service provision embracing all levels and all elements of the health care system, including primary, secondary, and tertiary (specialist) care, as well as home- and community-based care.<sup>97</sup> Integration means delivering multiple health care services or interventions to the same patient by an individual health care worker or a team of providers, possibly from different fields.

Studies show that integrating HIV-related services with primary health care is necessary for more efficient treatment of HIV-related health conditions and concurrent epidemics. The crucial role of primary health care was first recognized by the global community in 1978 in the Declaration of Alma-Ata, which concluded the International Conference on Primary Health Care.<sup>98</sup> The primary health care approach was subsequently accepted by WHO as the key for achieving the goal of *health for all*. In 2009, WHO reaffirmed that the integration of primary health care and disease-specific programs contributes to achieving the health-related MDGs, which include combating HIV/AIDS.<sup>99</sup> Integration of HIV-related services into sexual and reproductive health care is also of great importance.

## Health System Strengthening

The international community has acknowledged that scaling up progress in the global AIDS response is not possible without substantial investment in national health systems, which, according to WHO, comprise of six building blocks: 1) service delivery; 2) health workforce; 3) health information systems; 4) access to essential medicines; 5) financing; and 6) leadership and governance.<sup>100</sup> Both the Declaration of Commitment and the Political Declaration declare that health system strengthening is necessary for the attainment of universal access. States are therefore urged to reinforce, adopt, and implement national strategies aimed at increasing the capacity of human resources for health.<sup>101</sup> According to WHO and UNAIDS, States can address the shortage of skilled health workers by various measures, including task-shifting, i.e., shifting tasks from more to less specialized health workers (e.g., from specialists to physicians, from physicians to nurses, and from



nurses to community health workers and lay providers, including PLHIV).<sup>102</sup> Regardless of their specialization, health care workers should be equipped with accurate and up-to-date information about HIV research, prevention, and treatment technologies. They should also receive sensitizing trainings that discuss HIV-related stigma and discrimination in the health sector. Finally, States should adopt, and ensure adherence to, ethical codes of conduct for health care providers.

In addition to the health workforce, States should improve other building blocks of their health systems and manage their interactions in ways that achieve more equitable and sustainable results across all health services and health outcomes.<sup>103</sup>

### Areas of Inquiry

- Briefly describe the institutional design of the national health care system (infrastructure, leadership and governance, financing mechanism, procurement system, and human resources for health).
- Briefly describe the health service delivery (availability, accessibility, acceptability, and quality). Disaggregate this information by gender and age of health service delivery recipients.
- Does the State provide free or low cost primary and secondary health care?
- Does the State integrate HIV-related services, including prevention, with primary health care, sexual and reproductive health care, and/or concurrent epidemics and drug dependence treatment services?
- Does the national health care system provide for continuity of care?
- Does the national health system have functioning procedures for the protection of privacy?
- Does the State monitor its HIV/AIDS and concurrent epidemics?
- Does the State undertake measures to strengthen the health system in the context of HIV/AIDS?
- Does the State provide health care workers with current information about HIV/AIDS?
- Has the State adopted ethical codes of conduct for health care workers? What institution is responsible for enforcing their provisions?

## Civil Society and Private Sector

### Multisectoral Cooperation

The international community has acknowledged that an effective response to HIV/AIDS must take into account the interests of a wide range of stakeholders. Therefore, the AIDS response requires broad multisectoral cooperation encompassing full and active participation of PLHIV, key populations, civil society, business community, the private sector (including pharmaceutical companies), and other stakeholders, such as medical, scientific, religious, and educational institutions, trade unions, and the media.<sup>104</sup> *Supporting Community Partnerships* constitutes Guideline No. 2 of the International Guidelines. The need for multisectoral cooperation is also emphasized in other international standard-setting documents on HIV/AIDS, including the UNAIDS Outcome Framework 2009-2011, which underlines that the response to HIV/AIDS should be about building bridges and working collectively to deliver results.<sup>105</sup>

In line with the international guidance, States are urged to foster stronger collaboration and the development of innovative partnerships between the public and private sectors in the national AIDS response.<sup>106</sup> The collaboration may, for example, take a form of medical-legal partnerships, networks involving PLHIV and the health sector, or coalitions involving health care providers and the business community. The private sector's involvement may include making charitable donations to AIDS service organizations or providing adequate HIV-related services to the employees. States should support the private sector's participation in the national AIDS response through, e.g., tax incentives.

States should further ensure, through political and financial support, that: 1) community consultation occurs in all stages of design, planning, implementation, and evaluation of HIV policies and programs; and that 2) community organizations can carry out their activities effectively.<sup>107</sup> To this end, States are encouraged to establish formal mechanisms tasked with facilitating community partnerships and ongoing community dialog, such as joint workshops of governmental and non-governmental stakeholders or formal review of written statements submitted by the community. States are also urged to provide financial and capacity-building support to community organizations specializing in HIV-related and human rights programming,<sup>108</sup> including AIDS service organizations, human rights CSOs, and CSOs representing PLHIV and key populations. Challenges to meaningful participation may include low skills and funding constraints of community groups

and individual HIV advocates. Consequently, technical and financial support provided by States and donors is essential for implementing the principle of greater involvement of PLHIV [hereinafter GIPA] and key populations.

### **Greater Involvement of PLHIV and Key Populations**

The idea that personal experience should shape the global and national AIDS responses was expressed in 1983 in the Denver Principles, which was the first manifesto issued by PLHIV.<sup>109</sup> The concept was further developed at the 1994 Paris AIDS Summit, where countries agreed to support GIPA at all levels in order to stimulate the creation of supportive political, legal, and social environments for PLHIV.<sup>110</sup> In the Declaration of Commitment, States endorsed the principle of greater involvement of both PLHIV and marginalized populations.

The full involvement and participation of PLHIV and key populations in the design, planning, implementation, and evaluation of HIV-related programs is crucial because people who have experienced HIV-related vulnerabilities are often in the best position to identify what works as an effective HIV/AIDS response.<sup>111</sup> The GIPA principle also benefits those involved personally: their participation in the AIDS response empowers them, improves their self-esteem, decreases isolation and depression, improves their health through better access to HIV-related information, and helps to reduce HIV-related stigmatization and discrimination.<sup>112</sup> States are therefore urged to include the principle of GIPA in their National AIDS Action Frameworks.

### **Areas of Inquiry**

- Does the State facilitate multisectoral cooperation in the context of HIV/AIDS?
- Does the State encourage and support the involvement of PLHIV and key populations in the national AIDS response? Is the principle of GIPA included in the National AIDS Action Framework?
- Does the State provide financial, political, and capacity building support to community partnerships and CSOs involved in HIV and human rights-related programming?
- Does the State ensure that community consultation and collaboration occur at all stages of design, planning, implementation, and evaluation of HIV-related policies and programs?
- List and briefly describe key CSOs and service organizations that implement HIV-related programs.
- Does the State encourage and support the private sector's involvement in the national AIDS response?
- List and briefly describe the private sector's contributions to the national AIDS response.

# Section I: Access to Essential Services

## Factor 1: Public Education, Research, and Information Exchange

Every person enjoys an equal right to seek, receive, and impart reliable and accurate information about bio-medical and socio-economic aspects of HIV/AIDS. The State implements and supports HIV-related awareness-raising, stigma-reduction, training, and information exchange programs, and ensures that HIV research adheres to the highest ethical standards.

### Introduction

Structural and social factors, such as stigma, discrimination, human rights violations, gender inequality, and ignorance about HIV/AIDS are some of the key drivers of the HIV/AIDS epidemic.<sup>113</sup> It is therefore imperative that States promote awareness about HIV/AIDS and actively seek to reduce HIV-related stigma and prejudice through education, training, and information exchange programs. This duty extends to ensuring that every person has the right to seek, receive and impart reliable and accurate information about medical and socio-economic aspects of HIV/AIDS, and that public stigma and discrimination-reduction strategies are actively pursued. Further, States should support HIV-related research and the broad dissemination of its benefits, and enforce the highest ethical standards whenever experimentation involves human subjects.

### International Standards and Commentary

#### Access to HIV-Related Information

##### *Right to Information*

Everyone has the right to freedom of expression, which includes freedom to seek, receive, and impart information and ideas of all kinds.

*ICCPR art. 19*

In order to realize the right to health and the right to freedom of expression, States must ensure that everyone has equal, timely, and sustained access to health-related information, including information about HIV/AIDS.<sup>114</sup> This requirement is supported by various international instruments. For example, in the Declaration of Commitment and the Political Declaration, States made a commitment to ensure the availability of information, education, and communication aimed at reducing risk-taking behaviors and encouraging responsible sexual behavior. This information should be provided in languages most understood by communities and respectful of cultures.<sup>115</sup> Also International Guidelines urge States to ensure for all persons, on a sustained and equal basis, the availability and accessibility of quality HIV information. International Guidelines emphasize that HIV-related information should be accessible in the workplace,<sup>116</sup> and that specific measures should be taken to facilitate the access of women, children, and vulnerable groups to HIV-related information.<sup>117</sup> Lastly, the UN Committee on Economic, Social, and Cultural Rights has interpreted States' obligation to realize the right to health as requiring the establishment of prevention and education programs for behavior-related health concerns, such as STDs and HIV/AIDS.<sup>118</sup>

##### Examples of Compliance

- State implements a widespread public awareness-raising campaign about HIV/AIDS.
- Life-skills based sex education and information about HIV is included in school curricula.
- Obligatory trainings for law enforcement officers and health care workers include sensitizing information about HIV/AIDS and related discrimination.

##### Examples of Non-Compliance

- State does not take any measures to reduce HIV-related stigma among the general population.
- State and civil society do not share information about medical and socio-economic aspects of HIV/AIDS.
- State fails to ensure that no one is forcefully subjected to HIV-related medical experimentation.

Public misconceptions about the nature, transmission, and treatment of HIV continue to hamper the global AIDS response. States are therefore urged to develop a multisectoral awareness-raising strategy that encompasses schools, workplaces and, through the use of mass media, the broader public.<sup>119</sup> International Guidelines encourage a widespread provision of information about HIV through the mass media, and warn States not to inappropriately censor or otherwise impede the dissemination of information about HIV/AIDS.<sup>120</sup> See Factor 7 below.

With respect to education within schools, States should take measures to foster responsible, informed decision-making about sexual behavior among young people. Unbiased, age-appropriate, life-skills based, and evidence-informed sex education, including information about HIV/AIDS, should be integrated into curricula, and should be presented in a way that is consistent with human rights. UNAIDS underlines that life-skills based education helps young people understand and assess the individual, social, and environmental factors that raise and lower the risk of transmission. It can have positive effect on behaviors, including delay in sexual initiation and reduction in number of sexual partners. School-based programs should promote respect of difference and reject discrimination.<sup>121</sup>

Further, States should encourage employers to implement HIV-related educational initiatives in the workplace with an aim of bringing about change in personal attitudes and behavior concerning HIV/AIDS. As recommended by ILO, such programs should provide accurate information about HIV transmission, dispel myths surrounding HIV, and consider the impact of HIV on the individual.<sup>122</sup> Ideally, they should be tailored according to such factors as age, gender, and behavioral risk factors.<sup>123</sup>

All HIV-related education and awareness-raising programs should be regularly monitored, rigorously evaluated, and periodically revised. States should also take concrete steps to facilitate inter-agency, multisectoral, and international exchange of information about medical, socio-economical, and legal aspects of the HIV/AIDS epidemic.

### **Areas of Inquiry**

- Does the State ensure that information about HIV/AIDS is available and accessible on equal and sustained basis to all, including general and key populations? Is the available information age-appropriate, evidence-based, and presented in an unbiased manner?
- Does the State ensure that gender and sexual identity stereotypes are not reinforced in sex education and HIV/AIDS information?
- What measures are undertaken to raise public awareness about HIV/AIDS and reduce misconceptions about HIV transmission?
- Does the State ensure that life-skills based sex education and information about HIV are incorporated into school curricula?
- Does the State facilitate access to HIV-related information in the workplace?
- Does the State ensure that HIV-related educational programs are regularly evaluated and updated?
- Does the State ensure appropriate coverage of HIV-related issues by the media?
- Does the State ensure that its broadcasting standards and practices do not impede the dissemination of HIV-related information?
- Does the State facilitate inter-agency, multisectoral, and international exchange of information about all aspects of HIV/AIDS epidemic?

### **Stigma Reduction**

The reduction of HIV-related stigma and discrimination is frequently overlooked by States, despite being critical to protecting the human rights of PLHIV and preventing the further spread of HIV/AIDS.<sup>124</sup> According to UNAIDS, HIV-related stigma is a process of devaluation of people either living with or associated with HIV and AIDS. Discrimination follows stigma and is defined as the unfair and unjust treatment of an individual based on his or her real or perceived HIV status.<sup>125</sup> The norms and prejudices that underlie stigma are often reinforced at the family, community, institutional, legal and policy levels.<sup>126</sup> Therefore, any efforts to address stigma must be comprehensive and widespread in their reach.

In order to challenge beliefs based on ignorance, prejudice, and punitive attitudes, International Guidelines urge States to implement training and media programs, including public information campaigns and

interactive educational workshops and seminars.<sup>127</sup> Numerous international and national bodies have strongly advocated for a stigma-reduction strategy that is multifaceted in its approach.<sup>128</sup> For example, UNAIDS urges States to: 1) identify the root causes of stigma and discrimination and the key concerns of affected populations; 2) measure levels of stigma and discrimination; and 3) use a combination of strategies, including participatory education and mass media campaigns, to raise awareness about HIV/AIDS and reduce fear of acquiring HIV through everyday contact.<sup>129</sup> According to UNAIDS, the most promising approaches feature a combination of empowerment of PLHIV, education, and activities that foster direct or indirect interaction between PLHIV and key target audiences.<sup>130</sup> Any stigma-reduction approach should also encompass trainings that aim to sensitize public officers, health care workers, as well as business, religious, and community leaders to HIV and human rights-related issues.<sup>131</sup>

### Areas of Inquiry

- Does the State have a visible and active policy of de-stigmatization in the context of HIV/AIDS?
- What measures are undertaken to reduce HIV-related stigma?
- Does the State ensure that health care workers and public servants (i.e., judges, government officials, law enforcement officers, social workers, and other individuals who are likely to come across PLHIV in their professional life) receive sensitizing trainings on HIV-related stigma and discrimination?

### HIV Research and Experimentation

The conduct of scientific research involving human subjects is governed by many international standards,<sup>132</sup> which emphasize the necessity of free and informed consent as a pre-condition to participation in medical experimentation.<sup>133</sup> UNAIDS has repeatedly called for independent and informed consent based on complete, accurate, and appropriately conveyed and understood information.<sup>134</sup> It is important that monitoring occurs over the course of the research to ensure that consent has not been retracted or modified.<sup>135</sup> Further, States should take into account the especially vulnerable position of women and children and implement additional ethical safeguards to ensure that they are not exploited or coerced into participating.<sup>136</sup> In line with international guidance, States should also ensure equitable access to the benefits emanating from HIV-related research.<sup>137</sup>

#### Rights Related to Scientific Research

Everyone has the right to enjoy the benefits of scientific progress and its applications.

*ICESCR art. 15*

No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his or her free consent to medical or scientific experimentation.

*ICCPR art. 7*

### Areas of Inquiry

- Does the State support HIV-related scientific research?
- Does the State ensure that HIV-related research adheres to the highest ethical standards?
- What is the protocol for obtaining consent from participants of HIV-related medical experimentation?
- Does that State ensure that PLHIV enjoy equitable access to the benefits of HIV-related research?

### Case Study

#### Champions for Change in the Caribbean

Since 2004, the Caribbean program Champions for Change – a joint initiative supported by the UK Department for International Development, the Caribbean Community and Common Market (CARICOM), and the Pan Caribbean Partnership against HIV/AIDS (PANCAP) – has implemented a broad range of initiatives designed to reduce the high levels of HIV-related stigma and discrimination in the region. It targeted different audiences through the engagement of an array of high-profile public figures – including political leaders, sports stars, and traditional and religious leaders – to model non-stigmatizing attitudes and behavior. It also included programming that addressed homophobia, sexual violence, and attitudes about drug users. The program utilized high-level conferences and various media outlets to distribute and broadcast the relevant programs.<sup>138</sup>

# Section I: Access to Essential Services

## Factor 2: HIV Prevention

**Every person has equitable and sustainable access to a wide range of effective, human rights-based, and evidence-informed measures aimed at preventing HIV transmission.**

### Introduction

Studies show that HIV prevention is 28 times more cost-effective than HIV treatment.<sup>139</sup> A comprehensive HIV prevention package could have averted 29 million (or 63%) of the 45 million new infections that, according to the estimates, occurred between 2002 and 2010.<sup>140</sup> However, over 25 years into the HIV epidemic, more than half of the countries submitting reports to UNAIDS acknowledge the existence of policies and practices that interfere with the accessibility and effectiveness of HIV prevention measures.<sup>141</sup> These gaps include, among others, policies that criminalize and marginalize key populations or impede access to affordable condoms and sterile drug injecting equipment. In many countries, prevention efforts do not reach persons who need them most, and general informational campaigns often do not translate into sustainable risk minimizing behavior. Furthermore, in many countries, a number of internationally-supported and highly effective HIV prevention measures, such as harm reduction and condom distribution, are considered to be controversial and, even if they are legally permitted, they lack political will and funding. For example, in Eastern Europe and Central Asia, where HIV is spread mainly through injecting drug use, repressive drug policies make harm reduction strategies unavailable to more than 95% of people who need them.<sup>142</sup>

In 2009, UNAIDS emphasized that prevention remains its first priority and called for a *prevention revolution* built upon equality and human rights. HIV prevention should be strategically tailored to local epidemics; should include biomedical, behavioral, and structural approaches; and should meaningfully involve beneficiaries. UNAIDS urges States to mount permanent prevention campaigns that are socially inclusive, that combat public hypocrisy on sexual matters, that build AIDS competencies, and that systematically promote sexual and reproductive health and rights.<sup>143</sup>

#### Examples of Compliance

- Universal infection control precautions are widely implemented in healthcare settings.
- Condoms, sterile injecting equipment, and bleach are affordable and easily accessible by the general public and key populations.

#### Examples of Non-Compliance

- State does not enforce universal precautions in the health care system.
- State condones abuses against people who carry HIV prevention commodities such as condoms and injection equipment.

### International Standards and Commentary

#### Access to HIV Prevention

Access to HIV prevention interventions is an integral part of the right to health and the right to life, discussed in detail in Factor 4 below. HIV prevention plays a pivotal role in implementing universal access commitments and the UN Millennium Declaration, in which States notably pledged to halt and begin to reverse the HIV epidemic by 2015.<sup>144</sup>

In the Declaration of Commitment and Political Declaration, States acknowledged that prevention of HIV infection must be the mainstay of the AIDS response and made commitments to intensify their HIV prevention efforts and to overcome legal, regulatory, and other barriers that block access to effective HIV prevention.<sup>145</sup> International Guidelines stress that States should ensure widespread availability of quality goods, services, and information for HIV prevention. In particular, States should provide access to: 1) HIV information, education, and communication (see Factor 1 above); 2) essential commodities, including male and female condoms, bleach, and sterile injecting equipment; 3) harm reduction efforts related to drug use (see Factor 16

below); 4) safe blood supplies; and 5) early and effective treatment of STIs (see Factor 8 below). States should consider providing preventative goods through various means, including vending machines in appropriate locations. Lastly, States should repeal all restrictions on the availability of preventative measures.<sup>146</sup>

Effective HIV prevention measures should be based on a number of overarching principles. They must be: 1) respectful of human rights, including gender equality; 2) differentiated and locally adapted to the relevant epidemiological, economic, social, and cultural contexts; and 3) evidence-informed, i.e., based on what is known to be effective. Lastly, HIV prevention should be accessible by all persons, on a sustained and equal basis.<sup>147</sup>

To ensure equitable access to HIV prevention, States must know their epidemics and direct interventions to those who need them most. In other words, States must address the social determinants of HIV risk, such as societal inequalities and criminalization or marginalization of certain key populations. International Guidelines underline that HIV prevention measures should be implemented with particular attention to vulnerable individuals and populations.<sup>149</sup> Further, States should implement a combination of preventative strategies to achieve the maximum impact. Lastly, States should build and maintain government leadership in HIV prevention as well as encourage community participation in the design and implementation of HIV prevention programs.<sup>150</sup>

### Areas of Inquiry

- Describe the national HIV prevention strategy. Does the strategy adhere to the overarching principles described above?
- Does the State allocate adequate funds for HIV prevention?
- Does the State ensure that CSOs, PLHIV, and representatives of key populations are involved in the development and implementation of the national HIV prevention policy?
- Does the State ensure sustainable availability and accessibility of evidence-informed and human rights-based HIV prevention measures for both the general population and all key populations?
- Does the State have laws and regulations that constitute barriers to effective HIV prevention? If yes, what actions are undertaken to repeal them?

### HIV Prevention Measures

HIV prevention programs must be comprehensive in scope and must use a full range of evidence-informed policy and programmatic interventions. According to UNAIDS, States should undertake the following essential programmatic actions:

- Prevent sexual transmission of HIV;
- Prevent mother-to-child transmission of HIV (see Factor 8 below);
- Prevent the transmission of HIV through injecting drug use (including harm reduction measures);
- Prevent HIV transmission in health care settings;
- Ensure the safety of the blood supply;
- Promote greater access to voluntary HIV counseling and testing (see Factor 3 below);
- Integrate HIV prevention into AIDS treatment services (see Factor 4 below);
- Focus on HIV prevention among young people (see Factor 15 below);
- Provide HIV-related information and education (see Factor 1 above);
- Confront and mitigate HIV-related stigma and discrimination;
- Provide access to vaccines and microbicides.<sup>151</sup>

#### Right to Health

In order to realize the right to health, States must take measures aimed at prevention and control of epidemics. Inherent in this obligation is a requirement to establish prevention and education programs for behavior-related health concerns such as STIs and HIV/AIDS.

*ICESCR art. 12;  
UN Committee on Economic, Social, and Cultural  
Rights, General Comment No. 14 para. 16*

#### Right to Life

The UN Human Rights Committee has interpreted the right to life, guaranteed under ICCPR, as including States' obligation to take measures aimed at reducing the spread of epidemics.<sup>148</sup>

*ICCPR art. 6*

More precisely, States should implement the following measures for the prevention of sexual and blood borne transmission of HIV:<sup>152</sup>

- **Promotion of condom use accompanied by lubricant use**, which is viewed as the most effective method of prevention of sexual transmission of HIV, both for same sex and heterosexual contacts.
- **Promotion of female-controlled methods of HIV prevention**, such as female condoms and microbicides, which can be used vaginally or rectally.
- **HIV counseling and testing**, which is viewed as an effective prevention method because people who know their HIV status, are aware of safe sexual behaviors, and receive treatment, tend to minimize their risk behavior.<sup>v</sup>
- **Prompt diagnosis and treatment of STIs**, which continues to be viewed by some health professionals as an effective prevention method because, according to a number of studies, certain untreated STIs may increase the risk of HIV transmission.<sup>153</sup>
- **Adult male circumcision**, which is recommended as a prevention strategy in countries with high HIV prevalence because, according to studies, it may reduce the transmission of HIV from women to circumcised men by 60%. Male circumcision must be: viewed only as an additional prevention strategy; delivered in a non-stigmatizing manner; safe; based on voluntary informed consent; and carried out with consideration of the right of the child.<sup>154</sup>
- **ART**, including post-exposure prophylaxis, provided in equitable manner (see Factor 4 below).
- **Harm reduction interventions**, including provision of clean injecting equipment and other materials to reduce harms associated with unsafe drug use.
- **OST<sup>vi</sup>** for drug dependence, which - by decreasing injection drug use - helps to significantly lower HIV spread among people who use drugs.
- **Blood supply safety**, which includes routine screening of all donated blood and avoidance of unnecessary blood transfusions.
- **Universal infection control precautions in health-care settings** [hereinafter universal precautions], which treat every patient as potentially infectious and require health workers to: wear protective gear; use syringes properly; and sterilize all equipment after use. This approach ensures injection safety, safe disposal of used injection paraphernalia, and administration of antiretroviral prophylaxis following potential HIV exposure.

#### Areas of Inquiry

- What measures are undertaken to prevent HIV transmission among the general and key populations?
- Does the State implement or support interventions aimed at behavioral change?
- Does the State ensure that universal precautions are implemented in health care and other settings involving exposure to blood and body fluids?
- Does the State ensure that post-exposure prophylaxis is available and accessible to all who need it?
- Does the State implement harm reduction strategies as an effective way of HIV prevention?
- Does the State ensure access to condoms and female-controlled prevention measures?
- Does the State implement HIV prevention in prisons as a health care measure?

<sup>v</sup> People with undiagnosed HIV infection are 3.5 times more likely to transmit HIV than individuals who have tested HIV-positive. It is estimated that currently 80% of PLHIV in low- and middle-income countries remain undiagnosed, and HIV counseling and testing services are not widely available in 70% of countries reporting data to UNAIDS. See GLOBAL HIV PREVENTION WORKING GROUP, FACT SHEET: PROVEN HIV PREVENTION STRATEGIES (2009).

<sup>vi</sup> **OST** is a drug dependence treatment for people who are unwilling or unable to stop using drugs. The therapy gives people who use drugs access to medically prescribed oral substitution medicine (i.e. methadone or buprenorphine) in order to improve their quality of life and decrease or eliminate injection use of illegal drugs.



## Case Study

### Provision of Condoms in New South Wales Prisons

In 1994, fifty inmates of prisons in New South Wales filed a lawsuit against the State of New South Wales seeking a mandatory injunction to force the government to reform its policies regarding condoms in prisons. Among other orders, the lawsuit sought to compel the government to supply condoms to the plaintiffs and other male prisoners, and to permit their possession and use. The court ruled that the claim could not be brought as a class action suit. However, the court also ruled that if some of the plaintiffs were able to establish that the failure of the government to permit their use of condoms constituted a breach of the duty of care owed to them as individuals, they could bring claims in the tort of negligence and be entitled to injunctive relief. Ultimately, the case helped bring about important policy changes to condom provisions for prisoners. Before the court action reached conclusion, the government introduced a successful pilot distribution of condoms in three New South Wales prisons. Subsequently, a State-wide distribution began. Its evaluation showed positive results and there were no indicators of negative consequences.<sup>155</sup>

## Section I: Access to Essential Services

### Factor 3: Testing, Counseling, and Referral

**Every person has unrestricted access to voluntary, confidential or anonymous HIV testing accompanied by quality counseling and referral to essential services. Arbitrary, mandatory, or compulsory HIV testing is prohibited.**

#### Introduction

A large percentage of people living with HIV are not aware of their serostatus. According to estimates, in the European Union around a third of those infected do not know it, while in some countries in Eastern Europe and Central Asia more than 60% of people with HIV remain undiagnosed.<sup>156</sup> HIV testing and counseling is important for both the individuals and the society: it intends to discourage high-risk behavior and empowers PLHIV both to protect others and to access treatment early, which lowers their risk of morbidity and mortality. In order to achieve the proclaimed goal of universal access to treatment for all who need it, scale up of HIV testing and counseling is necessary. However, HIV testing should not be a goal in itself: it should always be accompanied by referral to essential HIV-related services for every person tested. In addition, testing should be carried out in accordance with human rights principles and should be linked to interventions aimed at reducing stigma, discrimination, and risk of disclosure of testing results.

#### Examples of Compliance

- State promotes and ensures access to voluntary and confidential HIV testing and counseling.
- State enforces precise rules and procedures for obtaining informed consent to HIV testing.

#### Examples of Non-Compliance

- State fails to ensure that HIV testing is accompanied by counseling and referral.
- State condones mandatory HIV testing for employment or marriage purposes.
- Members of armed forces and people employed in the hospitality sector undergo routine HIV testing.

#### International Standards and Commentary

Health care systems usually offer two modes of HIV testing: 1) client-initiated voluntary testing and counseling; and 2) provider-initiated testing where health care workers routinely offer opt-in testing (which is carried out only if a patient expressly agrees to it) or opt-out testing (which is carried out unless a patient expressly refuses). WHO and UNAIDS support the scale up of client-initiated HIV testing and counseling but recognize the need for provider-initiated testing because health facilities are a key point of contact with people who may need HIV-related services. They recommend the opt-out approach, including simplified pre-test information. Based on this approach, HIV testing should be recommended: 1) for all patients whose clinical presentation might result from HIV infection; 2) as a standard part of medical care for all patients attending health facilities in generalized HIV epidemics (e.g., in the context of prenatal care or STI treatment); and 3) more selectively in concentrated and low-level epidemics where the implementation of provider-initiated HIV testing should be guided by an assessment of the epidemiological and social context. WHO and UNAIDS stress that concerns about the potential coercion of patients can be alleviated by adequate training and supervision of health care providers and by close monitoring of provider-initiated HIV testing programs. In particular, health care workers should provide their patients with at least minimum information to obtain informed consent.<sup>157</sup>

UNAIDS, WHO, and other UN bodies urge States to ensure that HIV testing does not compromise the rights to privacy, bodily integrity, and self-determination. Therefore, HIV testing should be voluntary and accompanied by informed *consent*, *counseling*, and *confidentiality* (the ‘3 Cs’ approach).<sup>158</sup> International Guidelines stress that HIV testing should be carried out with the human rights-based approach, and that public health interests do not justify mandatory HIV testing, except in cases of blood/organ/tissue donations where human product, rather than the person, is tested.<sup>159</sup>

## Informed Consent and Confidentiality

Informed consent is an integral part of the right to health and should not be a mere acceptance of a medical intervention, but a voluntary and sufficiently informed decision.<sup>160</sup> This requirement protects the right of the patient to be involved in the medical decision-making, and assigns duties and obligations to healthcare providers. In the case of adults, the competence to consent to, refuse, or choose alternative medical intervention is based on the patient's legal capacity. With respect to obtaining consent for HIV testing in children, States should consider two issues: 1) consent on behalf of a child; and 2) involving the child in the HIV testing process. WHO and UNICEF urge States, among others, to: 1) develop a clear policy that articulates who may provide consent for a child and at what age children can consent for themselves; 2) amend consent laws to increase access to HIV testing by lowering the age at which a child may consent (e.g., from 18 to 14 or 12 years), making allowances for "mature" or "emancipated" children, or expanding the role of the informal caretaker or medical supervisor to provide consent for the child if no parent or legal guardian is available; 3) use child-friendly consent forms and protocols; and 4) develop policies addressing parental refusal to test where such testing in clinically indicated and in a child's best interest.<sup>161</sup> See also Factor 15 below.

### ***Freedom from Non-Voluntary Testing***

The right to freedom from non-voluntary HIV testing is based on such internationally guaranteed rights as: 1) the right to health, which includes the right to control one's health and body; 2) the right to liberty, security, and integrity of the person; and 3) the right to be free from non-consensual medical and scientific experimentation, which is derived from the right to be free from torture and inhuman or degrading treatment or punishment.

*ICCPR arts. 7, 9; ICESCR art. 12;  
UN Committee on Economic, Social, and Cultural  
Rights, General Comment No. 14. para. 8*

Informed consent is valid only when documented prior to a medical procedure and provided voluntarily, i.e., without coercion, undue influence, or misrepresentation.<sup>162</sup> Regulation of informed consent should specify: 1) the necessary form of recording; 2) whether consent should be written or oral; and 3) the minimum amount of information the patient requires to provide informed consent.

In order to provide informed consent, each patient must have equal access to high quality health information, which is easily understandable and presented in a manner culturally and otherwise acceptable. In providing health information, health care workers must take into account the patient's language skills, literacy, and comprehension levels. They must also ensure that the information is not too technical, complex, or hasty.<sup>163</sup> Requirement of informed consent to HIV testing promotes trust, cooperation, and transparency. Therefore, it reduces the likelihood of negative consequences for individuals who test HIV-positive.

HIV testing must be offered in a non-discriminatory manner and cannot be mandatory or compulsory. Non-voluntary testing for such purposes as, for example, obtaining travel documents (e.g., a visa), enrollment in educational institutions, pre-recruitment, and periodical medical assessment of certain personnel (e.g., military officers, health care workers, people in hospitality industry, truck drivers, and sailors) should be prohibited as it may lead to human rights violations. The UN Special Rapporteur on the Right to Health has criticized compulsory and routine HIV testing as disempowering and compromising human rights, with no public health justification. Compulsory HIV testing may: 1) result in inadequate provision of information and counseling; 2) deter individuals from accessing test results and appropriate health care services; 3) constitute deprivation of liberty and a violation of the right to security of person; and 4) result in increased stigma and discrimination.<sup>164</sup> This is particularly relevant when coercive HIV testing is utilized with regard to groups who, due to structural inequalities, are unable to effectively protect themselves because they are within the ambit of governmental institutions or the criminal law (e.g. soldiers, prisoners, injecting drug users, MSM, or refugees).

Voluntary testing with referral to essential HIV services is more likely to achieve public health goals of prevention through behavioral change, care, and health support. Efforts to increase access to and uptake of HIV testing and counseling must meet the needs of key populations and expand beyond clinical settings, for example by involving civil society and community-based organizations in providing the relevant services.<sup>165</sup>

Systems and individuals engaged in HIV testing and counseling should strive to prevent human rights violations associated with HIV testing. In particular, strict protection of confidentiality is of paramount importance because it gives people a strong incentive to use health care services and get tested. See Factor 6 below.

## Areas of Inquiry

- Describe the State's HIV testing regime.
- Does the State have a regulatory framework on HIV diagnostics, including Rapid Test Kits? Who has the authority to perform HIV tests?
- Does the State ensure that HIV testing and counseling is always carried out with informed consent?
- Does the State ensure that HIV testing providers offer adequate pre- and post- HIV testing information?
- What measures are undertaken to increase access to client-initiated voluntary HIV testing and counseling among the general and key populations?
- Does the State prohibit mandatory and compulsory HIV testing for all, including key populations?
- Does the State ensure that HIV testing providers comply with guidelines for the protection and respect of human rights (including protection of privacy and confidentiality)?
- Does the State ensure that HIV testing providers are subject to disciplinary measures if their services do not meet human rights standards?

## Counseling and Referral

HIV testing should be accompanied by pre-test information sessions and post-test counseling (preferably one-to-one and face-to-face), which pursue two general aims: 1) prevention of HIV transmission; and 2) support for those affected by HIV. HIV counseling is mandated by a person's right to make informed choices and to receive and impart information. HIV prevention counseling should focus on the client's own unique circumstances and risk and should help the client set and reach an explicit behavior-change goal to reduce the chance of acquiring or transmitting HIV. For example, persons with newly identified infections should be informed about transmission risks and should be advised to refrain from donating blood and organs. Persons who report a single, recent HIV exposure should be referred to services offering early postexposure prophylaxis.<sup>166</sup>

WHO and UNAIDS underline that HIV testing and counseling should be accompanied by a package of HIV-related prevention, treatment, care, and support services.<sup>167</sup> Those who test positive should be provided with a referral: their immediate needs should be assessed and prioritized, and they should receive assistance in accessing essential HIV-related services.<sup>168</sup> They should also receive protection from stigma, discrimination, and violence through a supportive social and legal environment.<sup>169</sup> Health-related information provided to PLHIV (through counseling, hotlines, and information sessions) should include advice on available HIV treatment and care options. Post-test counseling for PLHIV should focus on psychosocial support to cope with the emotional impact of the test result.<sup>170</sup>

## Areas of Inquiry

- Does the State ensure that HIV testing is only undertaken with counseling?
- Does the State ensure that referral, patient-tracking, and follow-up mechanisms are built into HIV testing and counseling programs?
- Does the State ensure that patients who test positive receive access to HIV-related services?

## Case Study

### Mandatory HIV Testing as a Violation of Zambian Constitution

On 27 May 2010, the Livingstone High Court in Zambia held that the Zambian Air Force's decision to subject two employees, Mr. K and Mr. C, to a mandatory HIV test violated their rights to privacy and to be free from inhuman and degrading treatment under the Zambian Constitution. Mr. K and Mr. C had been employed by the Zambian Air Force in non-combat positions for almost two decades. In 2001, they were tested for HIV without their consent and in 2002, they got dismissed from employment. They launched a lawsuit against the Zambian Air Force, arguing that the treatment violated their rights. In reaching its decision that mandatory HIV testing violated the Zambian Constitution, the court referenced Zambia's obligations under international and regional treaties, including the Banjul Charter.<sup>171</sup>

# Section I: Access to Essential Services

## Factor 4: Treatment, Care, and Other Health Services

**PLHIV enjoy the right to the highest attainable standard of physical and mental health, including equitable and sustainable access to comprehensive health care. The State takes concrete steps to progressively realize universal access to HIV-related treatment and care.**

### Introduction

HIV-related treatment and care, including ART, have proved to be effective, safe, and feasible, turning HIV/AIDS from a fatal disease to a manageable condition. Effective ART does not only save lives. It is also considered to be one of the most powerful instruments currently available to address discrimination, because awareness of the benefits of treatment helps to de-stigmatize HIV as an immediately fatal virus.<sup>172</sup> It also helps to prevent further HIV spread and enables PLHIV and their families to reenter the mainstream of social and economic relations. Between 2003 and 2010, the number of people receiving ART increased twelve-fold, reaching 5.2 million at the end of 2009. Despite these achievements, the global access to HIV treatment is far short of need: in 2008, the ART coverage in low- and middle-income countries remained around 42% of people in need.<sup>173</sup> Achievement of universal access to HIV treatment, care, and support remains a distant goal. Prices for second-line drugs are high and without access to generic medicines people in many parts of the world are unable to afford treatment, even with interventions of international and national donors. The dual epidemics of HIV, TB, and other diseases continue to endanger the survival of PLHIV. Lastly, discriminatory treatment of PLHIV by health care workers is a significant barrier to their access to adequate and timely health care services.

### International Standards and Commentary

International law guarantees the right to health for all, including PLHIV. According to the UN Committee on Economic, Social, and Cultural Rights, the right to health contains both freedoms and entitlements. The freedoms encompass the right to control one's health and body, including sexual and reproductive health, and the right to be free from interference, such as non-consensual medical treatment and experimentation. The entitlements include the right to a system of health protection which provides everyone with equal opportunity to enjoy the highest attainable standard of health.<sup>174</sup> It is important to note that the lack of resources does not absolve States from having to take action to realize the right to health.<sup>175</sup> The UN Committee on Economic, Social, and Cultural Rights underlines that States have a core obligation to ensure the satisfaction of, at the very least, the minimum essential level of the right to health. The core content of the right to health includes: 1) essential primary care; 2) essential drugs; 3) equitable distribution of all health facilities, goods, and services; and 4) non-discriminatory access to health facilities, goods, and services, especially for vulnerable or marginalized groups.<sup>176</sup> Some of the most important components of the right to health for PLHIV include: 1) non-discriminatory access to comprehensive physical and mental health care services; 2) universal and equitable access to HIV-related treatment, care, and support, including affordable medicines and palliative care; and 3) States' duty to address coexisting epidemics.

#### Examples of Compliance

- PLHIV enjoy equal access to comprehensive health care services, including primary, secondary, and dental care.
- PLHIV have equitable, reliable, and uninterrupted access to ART.
- State implements collaborative health care programs addressing concurrent epidemics.
- State recognizes palliative care and pain management as human rights.

#### Examples of Non-Compliance

- State condones unequal ART distribution which prioritizes some groups over others;
- State does not take sufficient measures to prevent stock-outs of anti-retroviral drugs;
- State condones discrimination of PLHIV by medical insurance companies;

## Access to Health Care

Discrimination on the ground of health, including actual or perceived HIV status, is prohibited in all spheres of life, including in access to health care services. According to the UN Committee on Economic, Social, and Cultural Rights, access to health for all means that health care services must be available, accessible, acceptable, of good quality, and scientifically and medically appropriate. The accessibility component has four dimensions: non-discrimination, physical accessibility, economic accessibility (affordability), and information accessibility. The non-discrimination dimension means that the system of health protection (facilities, goods, and services) must be accessible to all, including PLHIV, key populations, and other vulnerable or marginalized groups.<sup>177</sup> States are therefore obliged to ensure that PLHIV are not discriminated against in health care settings, i.e., that they have equal, timely, and sustainable access to comprehensive, good quality, and affordable physical and mental health services, including primary, secondary, and dental care. To guarantee that PLHIV are treated equally in health care settings, States must provide appropriate training for health personnel, including education on health and human rights and sensitivity training aimed at reducing stigma attached to HIV and eliminating conscious and unconscious bias against PLHIV.<sup>178</sup>

## Areas of Inquiry

- Does the State prohibit HIV-related discrimination in all health care settings?
- Does the State ensure that PLHIV: 1) have equal access to comprehensive health care (facilities, goods, and services); 2) are treated in a non-discriminatory manner by health care providers; and 3) are not segregated or isolated in health care facilities?
- What measures are undertaken to eliminate HIV-related discrimination in health care settings?
- Does the State ensure that health care workers undergo sensitivity training on HIV?

## Access to HIV-Related Treatment

In adopting the Declaration of Commitment and Political Declaration, the global community recognized that equitable access to the highest attainable standard of treatment for HIV/AIDS, including effective use of quality-controlled ART, is a fundamental component of the right to health for PLHIV and a key feature of a comprehensive AIDS response.<sup>181</sup> States have therefore committed themselves to: 1) significantly scale up access to the most effective HIV interventions; 2) move towards achieving universal access; and 3) overcome legal, regulatory, trade and other barriers that block access to effective HIV treatment, care, support, medicines, commodities, and services.<sup>182</sup> According to the most common definition, universal access to treatment is achieved when 80% of all people in urgent need of treatment are receiving it.<sup>183</sup>

WHO and UNAIDS emphasize that access to HIV-related treatment and care must be equitable. To promote equity in the distribution of HIV-related services, States should ensure,

### Right to Health

Every person has the right to a standard of living adequate for his or her health and well-being, including the right to medical care and necessary social services.

*UDHR art. 25*

**States recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.**

States are therefore required to undertake steps to the maximum of available resources and by all appropriate means, to progressively achieve the full realization of this right. Among others, States must take the necessary steps to: 1) prevent, treat, and control epidemics, endemic, and other diseases; and 2) create conditions which would assure everyone medical service and medical attention in the event of sickness.

*ICESCR arts. 2, 12*

### Right to Life

**Every human being has an inherent right to life. This right should be protected by law.**

*UDHR art. 3; ICCPR art. 6*

The UN Human Rights Committee has interpreted right to life as including the right to adequate health care, the right to health in general, and States' obligation to take measures aimed at reducing the spread of epidemics.<sup>179</sup> The Committee has pointed out that the high number of deaths from HIV, resulting from unequal access to treatment, raises issues under article 6 of ICCPR. The Committee has concluded that PLHIV have the right to ART as a part of the right to life.<sup>180</sup>

among others, that policies for scaling up HIV treatment are based on human rights and ethical principles, that opportunities exist for a relevant public dialogue, and that HIV-services are accessible by vulnerable and hard-to-reach populations.<sup>184</sup>

UNAIDS has made ensuring that PLHIV receive treatment one of its ten priority areas and in 2010 set a goal for 2015 of universal access to ART for PLHIV who are eligible for treatment.<sup>185</sup>

### Areas of Inquiry

- Does the State take concrete measures to scale up and achieve universal access to HIV treatment, care, and support for all? Is the scale up based on the principles of fairness and human rights?
- Does the State have laws or policies that block effective provision of HIV-related services? What measures are undertaken to repeal them?
- Does the State ensure that PLHIV have timely and uninterrupted access to all HIV-related health services, including diagnosis, screening for treatment eligibility, and ART?
- Does the State ensure that ART is provided on an equitable basis to key populations and other marginalized groups?

### Assess to Essential Medicines

Timely and uninterrupted access to affordable medication for HIV/AIDS is necessary to fully realize the right to health for PLHIV.<sup>188</sup> If drugs are not taken regularly, HIV can mutate, continue to multiply, and become resistant to treatment. If a person develops resistance, he or she must switch to another regimen, including more expensive second-line drugs. Conversely, early and regular ART reduces viral load, morbidity, mortality, and the risk of onward HIV transmission.

International Guidelines urge States to ensure, on a sustained and equal basis, the widespread availability and accessibility of safe, effective, and affordable medicines, diagnostics, and related technologies for HIV.<sup>189</sup> Also WHO underlines the importance of equitable, timely, and cost-effective access to essential HIV drugs and urges States to: 1) eliminate stock outs of anti-retroviral drugs; 2) ensure reliable manufacturing practices; 3) establish procurement, supply, storage, and distribution systems that minimize leakage and other waste; 4) implement treatment adherence interventions;<sup>190</sup> and 5) comply with the most current WHO guidelines on ART for HIV infection which provide specific, evidence-based treatment regimen recommendations.<sup>191</sup>

Brand name ART medicines are expensive and remain unaffordable to the majority of the worlds' population in need. Generic production, providing essential medicines at a fraction of the cost of brand-name medicines, is a preferred solution for addressing the global AIDS crisis, but it is often restricted by the rules of intellectual property protection established by the World Trade Organization [hereinafter WTO]. The WTO Agreement on Trade Related Aspects of Intellectual Property Rights [hereinafter TRIPS Agreement] requires States to establish basic criteria of patentability and a minimum patent term of 20 years. However, according to the WTO Declaration on the TRIPS Agreement and Public Health [hereinafter Doha Declaration], the TRIPS Agreement should be interpreted and implemented in a manner supportive of protection of public health and promotion of access to medicines for all. The Doha Declaration confirms the key flexibilities provided by TRIPS, such as compulsory licensing (use of patent-protected product without the consent of the patent holder) and parallel importation regimes, which allow countries to obtain patented medicines at the lowest price available on the

#### Right to Essential Medicines

**Access to medicine is a fundamental element in achieving progressively the full realization of the right to health. States are responsible to ensure access to all, without discrimination, of medicines, in particular essential medicines, that are affordable and of good quality.**<sup>186</sup>

*UN Human Rights Council (2009)*

In order to ensure access to medication in the context of pandemics such as HIV/AIDS, States should pursue policies that promote the availability in sufficient quantities of pharmaceuticals and medical technologies that are scientifically and medically appropriate and of good quality. Pharmaceuticals and medical technologies used to treat HIV/AIDS should be accessible to all without discrimination and affordable to all, including most vulnerable and socially disadvantaged sectors of the population.<sup>187</sup>

*UN Human Rights Commission (2002)*

global market. In addition, the Doha Declaration allows the least developed States not to provide any patent protection in the pharmaceutical sector until 2016.<sup>192</sup>

The Political Declaration reaffirms that the TRIPS Agreement should not prevent States from taking measures to protect public health and urges States to overcome barriers in pricing, tariffs, and trade agreements, and to make improvements to legislation, regulatory policy, health system's procurement protocols, and supply chain management in order to accelerate and intensify access to affordable and quality HIV/AIDS medicines and treatment commodities.<sup>193</sup> More precisely, States should: 1) incorporate TRIPS flexibilities into the national intellectual property laws and regulations; 2) reform national patent laws in line with the TRIPS Agreement and the Doha Declaration; 3) explore compulsory licensing approaches; 4) promote regional trade in generic medicines; 5) establish drug registration to ensure marketing of high quality drugs; 6) invest in regional and national productive capacity in the pharmaceutical sector; and 7) exempt HIV treatment and prevention commodities, including essential medicines, from all taxes and tariffs.<sup>194</sup> States should also encourage the private sector to balance corporate intellectual property rights with social responsibility toward public health and commitment to human rights, including the right to affordable medicines for PLHIV.

### Areas of Inquiry

- Does the State ensure that ART is affordable, e.g., by: 1) implementing TRIPS flexibilities; 2) exempting essential medicines from taxes and tariffs; and 3) ensuring that PLHIV are not discriminated against by medical insurance companies?
- Does the State ensure that HIV-related services and drugs are scientifically and medically appropriate?
- Does the State maintain drug registries ensuring high quality of medicines?
- Does the State have an adequate patient retention strategy to ensure treatment adherence?
- Does the State monitor patients who are on ART for 12 months after the initiation of treatment?

### Access to Care and Support

Provision of treatment is not sufficient to realize the right to health for PLHIV. According to the International Guidelines, States should ensure that everyone has access to curative and palliative care of HIV and related opportunistic infections and conditions; good nutrition; social, spiritual, and psychological support; as well as family-, community-, and home-based care.<sup>195</sup> Care and support include various interventions to prevent illness in PLHIV, such as: 1) provision of nutritional support, particularly for infants, children and pregnant women; 2) chemoprophylaxis against common opportunistic infections; 3) measures to reduce the incidence of pneumonia, diarrhea and other conditions that are more common or more serious in children or adults with HIV; 4) detection and treatment of common malignancies, other co-morbidities, and precancerous cervical lesions to prevent cervical cancer among HIV-positive women; 5) screening for active TB; 6) provision of mental health services to reduce risk behaviors that facilitate HIV infection and transmission (e.g., substance abuse); 7) provision of naloxone to reduce risks associated with opiate overdose among IDUs; and 8) immunization.

### Care and Support

Care for people with chronic illnesses, including HIV, presents an urgent challenge around the world. To reduce costs of hospitalization and to alleviate burden on the health care system, many developing countries promote provision of long- and short-term care by families and community-based organizations instead of institution-based care prevalent in developed countries. Most home- and community-based care is performed by older people, women, and girls and is often not recognized as an essential service; consequently, it is not compensated. This creates harsh economic and social consequences for caregivers, particularly if they are unable to pursue education, employment, and other opportunities.<sup>196</sup> To cope with the impacts of HIV/AIDS, community care should be recognized as a service and important component of access to HIV treatment. States should strive to create cadres of community health workers. Family and community caregivers should be provided with emotional and practical support, including technical assistance with nursing, infection control, and respite care; funding for purchasing ART and paying for operational costs; and compensation for their work.<sup>197</sup> The necessity to strengthen, provide additional resources to, and expand family and community-based care for PLHIV is emphasized in the Declaration of Commitment, Political Declaration, and in the International Guidelines.<sup>198</sup>



## Palliative Care

Palliative care is designed for symptomatic relief aimed at reducing pain and suffering of chronically ill or dying people. Provision of affordable palliative care, including clinical, psychological, spiritual, and social care, is an essential part of universal access and has its rationale in ensuring the inherent dignity of an individual. Pain relief gives ill people a chance to achieve the highest quality of life possible for as long as possible.<sup>199</sup> Pain should be controlled in a way that keeps the HIV patient as alert and active as possible; medication should not be withheld; and the dosage should be reviewed frequently and increased when necessary.<sup>200</sup> The right to pain relief applies to all conditions where pain occurs, including HIV/AIDS.

Both the Declaration of Commitment and International Guidelines urge States to ensure the availability and accessibility of palliative and psychosocial care, including pain prophylaxis.<sup>202</sup> In many countries, however, pain management is poorly addressed, largely due to the restrictive application of regulations covering controlled substances such as opioid which is the most common and effective pain medication included in the WHO Model List of Essential Medicines. Consequently, many patients with severe pain are denied access,<sup>203</sup> which impedes their right to adequate care and pain relief, and contradicts international guidance. The 1961 Single Convention on Narcotic Drugs explicitly states that the medical use of narcotic drugs is indispensable for the relief of pain and suffering and that States must ensure the availability of narcotic drugs for such purposes. Improving the treatment of pain, including by the use of opioid, is strongly advocated by WHO and the International Narcotics Control Board. Its importance is affirmed in the 2005 resolution of the UN Economic and Social Council on Treatment of Pain Using Opioid Analgesics.<sup>204</sup>

### *Right to Palliative Care*

The UN Committee on Economic, Social, and Cultural Rights has interpreted the right to health as including access to preventive, curative and palliative health services, and emphasized the importance of attention and care for chronically and terminally ill persons who should be spared avoidable pain and enabled to die with dignity.<sup>201</sup> The right to palliative care has been affirmed in the Declaration on the Promotion of Patients' Rights in Europe and in the Joint Declaration and Statement of Commitment on Palliative Care and Pain Treatment as Human Rights, which was signed in 2008 by representatives of several international and regional organizations from across the world, including the International Association for Hospice and Palliative Care and the Worldwide Palliative Care Alliance.

## Areas of Inquiry

- Describe institution- and community-based care and support services offered to PLHIV.
- Does the State recognize and support community and home-based care as an essential service? Is this work compensated?
- Does the State recognize palliative care and pain treatment as fundamental human rights?
- Does the State ensure that patients with HIV receive adequate support, palliative care, and pain relief?
- Does the State ensure that PLHIV receive appropriate end-of-life health care?
- Does the State have laws or policies that block rational use of controlled medicines for relieving severe pain among PLHIV? What measures are undertaken to repeal them?

## Addressing Co-Existing Epidemics

The dual epidemic of TB and HIV continues to be a major factor in morbidity and mortality among people living with HIV. The estimates suggest that the risk of acquiring TB is 20 to 37 times greater among people living with HIV than in the general population.<sup>205</sup> Multi-drug resistant TB, prevalent in Europe and Central Asia, is especially dangerous. In some parts of the world, TB accounts for about 12% of all HIV-related deaths. In countries with high HIV prevalence, up to 80% of people with TB test positive for HIV, and HIV-positive individuals are more likely to have reactivation and re-infection of TB. WHO strongly recommends that HIV/TB coinfection be addressed simultaneously. Studies show that ART can reduce TB rates by up to 90% at an individual level, by 60% at a population level and to reduce TB recurrence rates by 50%.<sup>206</sup> In addition, studies presented at the Conference on Retroviruses and Opportunistic Infections in 2010 demonstrated that initiation of ART during TB treatment reduced mortality among PLHIV by 55% when compared to ART initiation upon TB treatment completion.

Co-infection with viral hepatitis, especially hepatitis B and C, is also an increasing challenge, especially in countries where HIV mainly affects people who inject drugs. Viral hepatitis is, in fact, becoming a major cause of death among PLHIV.

In order to achieve equitable access to prevention, diagnosis, treatment, and care for dual epidemics, States should: 1) know their national epidemics; 2) direct targeted interventions at those who need them most; 3) establish collaborative health care programs; and 4) ensure that interventions for treatment and care include not only ART but also management of concomitant infections, co-morbidities, toxicities, cardiovascular diseases, malignancies, as well as palliative care and end-of-life care.<sup>207</sup>

### **Areas of Inquiry**

- Does the State adequately address co-existing epidemics?
- Does the State support and promote collaborative programs in the health care sector?
- Does the State integrate HIV-related services with treatment for TB and other co-existing epidemics?

### **Case Study**

#### **Community-Based Care in Thailand**

In 1990, a group of PLHIV in northern Thailand founded the New Life Friend Center focused on home- and community-based care for PLHIV. Since its formation, the Center has provided PLHIV with a wide range of services, from coping strategies and emotional support, through information sharing, to educating HIV-affected families on how to care and provide treatment to PLHIV. In addition, the Center has promoted broader acceptance of HIV/AIDS through community outreach programs, advocated for appropriate treatment and care of PLHIV within the health care system, and coordinated between PLHIV, relevant government agencies, and non-governmental organizations. As an organization run by PLHIV, the New Life Friend Center is highly responsive to the needs and challenges faced by people living with and affected by HIV/AIDS.<sup>208</sup>

# Section I: Access to Essential Services

## Factor 5: Social Protection and Material Assistance

**PLHIV enjoy the right to an adequate standard of living, including equitable access to social protection and other forms of material assistance, particularly in the event of unemployment, sickness, or disability.**

### Introduction

Poverty and HIV/AIDS are inextricably linked. On the one hand, poverty contributes to HIV vulnerability and exacerbates the impact of HIV because poor people are at higher risk of contracting HIV, progressing to AIDS, and dying from it. On the other hand, PLHIV may become impoverished either as a result of increased morbidity and lack of social support, or due to discrimination resulting in unemployment, loss of housing, or other negative consequences. Poverty is a significant obstacle to accessing HIV-related services. In order to break this cycle, PLHIV and their families should be provided with HIV-sensitive support and assistance and with equal access to general social protection, i.e., unemployment and welfare benefits, life insurance, pension, and other forms of material assistance and support.

#### Examples of Compliance

- PLHIV have equal access to general social protection.
- Social protection measures implemented by the State are HIV-sensitive.
- PLHIV have equal access to health insurance, life insurance, and pension.

### International Standards and Commentary

#### ***Right to an Adequate Standard of Living***

Everyone has the right to an adequate standard of living (including adequate food, clothing, and housing); to the continuous improvement of living conditions; and to social security and social insurance.<sup>209</sup>

*ICESCR arts. 9, 11*

Everyone has the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his [or her] control.<sup>210</sup>

*UDHR art. 25*

Enjoyment of the right to an adequate standard of living is essential in reducing the risk and consequences of HIV infection. Achieving an adequate standard of living for everyone, in particular eradicating poverty and hunger, was proclaimed by the global community as MDG no. 1, and is interconnected with achieving other MDGs, such as gender equality (MDG no. 3) and better health outcomes, including successful response to HIV/AIDS (MDGs no. 4, 5, and 6).

#### Examples of Non-Compliance

- Mandatory HIV testing is required to access health care insurance and social security benefits.

UNAIDS underlines that achieving social protection for PLHIV and their families is a critical step towards the realization of universal access. Consequently, enhancing social protection for people affected by HIV is one of the ten UNAIDS priority areas. According to UNAIDS, social

protection should go beyond social transfers, such as health care fee waivers or income support. Instead, it should consist of all public and private initiatives that provide income or consumption transfers to the poor, protect the vulnerable against livelihood risks, and enhance the social status and rights of the marginalized. The overall objective is to reduce the economic and social vulnerability of the underserved sectors of the society and enable poor households to better manage the economic impacts of HIV/AIDS.<sup>211</sup>

### HIV-Sensitive Social Protection

UNAIDS recommends social protection measures that are HIV-sensitive rather than HIV-exclusive. Consequently, PLHIV and households affected by HIV should be addressed in all existing national social

protection strategies rather than being singled out for targeted services. More specifically, social protection in the context of HIV should consist of three HIV-sensitive elements: 1) HIV-sensitive, inclusive, non-discriminatory, and equitable social protection laws and policies; 2) HIV-sensitive financial protection, including social transfers (e.g., cash, food and transportation vouchers, pro-poor health financing, fee exemptions, social and community-based health insurance, poverty-targeted grants, microcredit, and in-kind support), that are embedded into existing social protection programs; and 3) increased access to essential, affordable, quality, HIV-sensitive services. UNAIDS underlines that social transfers, including HIV-sensitive health insurance, can enhance adherence to ART and accelerate the global roll-out of ART.

## Access to Social Protection

International Guidelines urge States to ensure that PLHIV are not discriminatorily denied an adequate standard of living and social protection on the basis of their health status.<sup>212</sup> To accomplish this goal, States' anti-discrimination laws should cover PLHIV's access to social security and welfare benefits.<sup>213</sup> If States introduce priority ranking for social services for resource allocation purposes, PLHIV and persons with comparable conditions and disabilities should qualify for preferential treatment due to their dire circumstances.<sup>214</sup> According to International Guidelines and ILO, States should further ensure that there is no discrimination on the basis of HIV status against workers or their dependants in access to occupational insurance schemes and in relation to benefits under such schemes, including life, health, and disability insurance, and death and survivors' benefits. ILO underlines that HIV testing should not be required as a condition of eligibility for national social security schemes, general insurance policies, occupational schemes, and health insurance. Insurance companies should not require HIV testing before agreeing to provide coverage for a given workplace, although they may base their cost and revenue estimates on available epidemiological data for the general population. Employers should not facilitate any testing for insurance purposes and all information that they already have should remain confidential. To accomplish these goals, States should ensure collaboration and coordination among public authorities, employers, employers' and workers' organizations, and public and private programs that administer insurance and benefit programs.<sup>215</sup> Any exemptions for pension, retirement, and life insurance should only relate to reasonable actuarial data, so that HIV is not treated differently from analogous medical conditions.<sup>216</sup> International Guidelines emphasize that particular attention must be paid to ensuring access to health care for individuals outside the formal employment sector, who lack work-related health care benefits.<sup>217</sup>

States adopt different models of social support structure. Some countries cover access of PLHIV to social protection in their general anti-discrimination laws, some in their HIV laws, and some in legislation on social security benefits and material assistance. In addition, some countries have accorded protection to PLHIV under disability legislation, which is supported by UNAIDS. According to UNAIDS, OHCHR, and WHO, States are required to recognize that where persons living with HIV (asymptomatic or symptomatic) have impairments which, in interaction with the environment, result in stigma, discrimination or other barriers to their participation, they can fall under the protection of the Convention on the Rights of Persons with Disabilities.<sup>218</sup> In countries where HIV is considered a disability, PLHIV should be able to qualify for specific disability benefits. States should ensure, however, that legal definition of disability does not interfere with people's ability to receive services and does not negatively impact their status.

### Non-Discrimination of Persons with Disabilities

Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others. States must prohibit all discrimination on the basis of disability and guarantee to persons with disabilities equal and effective legal protection against discrimination. Among others, States must prohibit discrimination against persons with disabilities in the provision of health insurance and life insurance. In addition, States are required to take appropriate steps to safeguard and promote the realization of the right of persons with disabilities to social protection.

*Convention on the Rights of Persons with Disabilities arts. 1, 5, 25, 28*

## Areas of Inquiry

- Does the State ensure the right of PLHIV to an adequate standard of living and social protection in the event of unemployment, sickness, or disability?
- Does the State ensure that the system of social protection is HIV-sensitive?
- Does the State establish and implement HIV-sensitive financial protection, including social transfers?
- Does the State prohibit discrimination in the social protection sphere on the ground of health, disability, and/or HIV status?
- Does the State prohibit mandatory HIV testing as a precondition to accessing social security schemes, general insurance policies, occupational schemes, and health insurance?
- Does the State ensure that PLHIV have equal access to: 1) social protection and material assistance; 2) occupational insurance schemes (including health care, disability, and death and survivors' benefits); and 3) pension, retirement, and life insurance?
- What barriers in access to social protection and other benefits do PLHIV most commonly face? What measures are undertaken to eliminate these barriers?
- Does the State recognize HIV/AIDS as episodic disability and extend disability benefits to PLHIV?
- Does the State ensure that the confidentiality of HIV status is protected during application and receipt of social assistance and health benefits?

## Case Study

### Access to Illness Pension in Colombia

In the 1996 case *XX v. Gun Club Corporation et al.*, the Constitutional Court of Colombia issued a judgment which affirmed the HIV-positive plaintiff's right to equal access to an illness pension. In 1994, the Gun Club Corporation terminated the employment contract of plaintiff XX after he had tested HIV-positive. XX filed a lawsuit challenging the legality of his ex-employer's decision and seeking compensation for the benefits lost as a result of the dismissal. In addition, XX sought to preserve his entitlement to an illness pension from the Institute of Social Security. The case ended up in the Constitutional Court which held that the State could not permit discrimination against PLHIV for two reasons: 1) because discrimination is an unjust act *per se* and the rule of law is founded in justice; and 2) because the right to equality, in accordance with article 13 of the Constitution of Colombia, places an obligation on the State to especially protect those who are in a position of manifest weakness. The Constitutional Court found that an employee "may not be dismissed for being HIV-positive, as this motivation implies a serious social segregation, a form of medical apartheid, and ignorance of the equality of all citizens and the right to non-discrimination." The Court concluded that the most effective way to give effect to XX's rights was to compensate him financially and to restore his entitlement to social security, which was dependent upon contributions based on employment. The Court ordered the Gun Club Corporation to pay for damages. The Court also ordered that XX be reinstated with the Institute of Social Security and declared that he was entitled to an illness pension from the point at which progression of his illness qualified him for such benefit.<sup>219</sup>

# Section I: Access to Essential Services

## Factor 6: Protection of Privacy and Confidentiality

**PLHIV enjoy effective protection from arbitrary or unlawful interference with their privacy. Their medical and personal information is subject to strict rules of data protection and confidentiality.**

### Introduction

Stricter privacy protection is of paramount importance in the context of HIV/AIDS. Possible consequences of the loss of privacy and confidentiality if HIV status is disclosed may include stigmatization, discrimination, loss of employment, rejection by the community and family, retribution, harassment, and violence. Protection of privacy and confidentiality are important not only for individual human rights protection, but also for public health reasons, as it increases peoples' trust in the health care system and makes them more likely to utilize HIV-related services. Strictly defined rules should be followed for disclosure of health-related information without the patient's consent.

#### Examples of Compliance

- HIV reporting to public health agencies for epidemiological purposes is subject to strict rules of data protection.
- Health care workers follow strict and rights-based protocols for partner notification and contact tracing.

### International Standards and Commentary

#### *Right to Privacy*

Everyone has the right to respect for his or her private life. Arbitrary or unlawful interference with one's privacy is prohibited. Everyone has the right to the protection of law against such interference.

*ICCPR art. 17;  
ECHR art. 8; ACHR art. 11*

Privacy is the right of individuals to limit access by others to their person and personal life, including to information about their health status. The legal concept of privacy refers to the legal protection accorded to an individual to control access and

#### Examples of Non-Compliance

- State condones arbitrary or unwarranted disclosure of HIV status by testing agencies, doctors, pharmacists, school officials, police officers, other authority figures, employers, co-workers, or by the media.
- State requires mandatory nominal registration of PLHIV for public health reasons.

use of personal information. Confidentiality extends the protection of the right to privacy to some specific situations and relationships, e.g., between health care professionals and their patients. Confidentiality covers protection of data during storage, transfer, and use to prevent unauthorized disclosure of that information to third parties.<sup>220</sup> Protection of privacy in the context of HIV/AIDS can be accomplished through various means, including anonymous HIV testing and/or confidentiality of medical records where forms and records that include information about HIV test results do not include any data that directly or indirectly identifies the person to whom an HIV test relates.<sup>221</sup> States may choose to cover issues raised by HIV in the general privacy legislation or include protection of privacy and confidentiality in their HIV laws.

International Guidelines explicitly urge States to enact confidentiality and privacy laws and ensure protection of privacy and confidentiality in the context of HIV/AIDS. In particular, States should: 1) ensure that HIV-related information is included within the definitions of personal/medical data subject to privacy protections; 2) protect confidentiality of all information relating to a person's HIV status obtained during HIV testing of a person or HIV testing of donated blood or tissue; 3) prohibit unauthorized use and publication of HIV-related information on individuals; 4) guarantee that individuals have access to their own personal and medical records and the ability to request amendments to ensure that information is accurate, relevant, complete, and up-to-date; 5) ensure that health care workers undergo minimum ethics and/or human rights trainings, including confidentiality guidelines and the duty to provide treatment; 6) establish an independent agency to

redress breaches of confidentiality; and 7) ensure that professional bodies (e.g., of health care workers or journalists) develop codes of conduct and use them to discipline breaches of confidentiality and unreasonable invasion of privacy as professional misconduct. International Guidelines also underline that the right to privacy encompasses the obligation to respect one's physical privacy, including the obligation to seek informed consent to HIV testing.<sup>222</sup>

### Areas of Inquiry

- How does the State govern protection of privacy and confidentiality in the context of HIV/AIDS?
- Does the State ensure that HIV-related information is subject to privacy and confidentiality protections?
- Does the State protect PLHIV against arbitrary or unlawful interference with their privacy?
- Does the State prohibit unauthorized disclosure, use, and publication of HIV-related personal data?
- Does the State ensure that individuals have access to their own records?
- Does the State ensure that health care workers receive ethics training covering confidentiality?
- Does the State ensure redress in cases of breaches of confidentiality?
- Do PLHIV enjoy effective protection of their right to privacy and confidentiality in practice?

### Disclosure of HIV Information

According to International Guidelines, States have the duty to ensure that information on HIV status is not disclosed to third parties without informed consent of the individual.<sup>223</sup> Non-consensual disclosure can be permitted only under clear rules and in exceptional circumstances, which fall within two broad categories: discretionary disclosure and mandatory disclosure. Discretionary disclosure of HIV status by public authorities for health purposes should be possible only under specific circumstances, for example for the purposes of partner notification. Discretionary disclosure of HIV information for non-health purposes (e.g., to law enforcement agencies) is not supported by international standards because it may undermine confidence in the health system and deter people from seeking health care services. Mandatory disclosure may be possible due to a court order, in cases of rape or occupational exposure, or for public health surveillance purposes.<sup>224</sup>

### Epidemiological Surveillance and Media Reporting

International Guidelines underline that public health interests do not justify nominal registration of PLHIV and urge States to ensure that HIV-related personal information is protected in the reporting and compilation of epidemiological data and in the context of media investigation and reporting.<sup>225</sup> According to UNAIDS, using health data for public health goals must be based on human rights principles and must be balanced against the rights to privacy and confidentiality. Therefore, HIV/AIDS cases reported to public health authorities for epidemiological surveillance purposes should be subject to strict rules of data protection and confidentiality. When, in order to scale up HIV services, increased emphasis is placed on the collection of information to improve patient management and monitoring, the information systems must both ensure patient confidentiality and allow relatively easy access to the information at both the individual and aggregate level.<sup>226</sup>

#### PATIENTS' RIGHT TO PRIVACY

(1). All information about a patient's health status, medical condition, diagnosis, prognosis, and treatment and all other information of a personal kind must be kept confidential, even after death; (2) Confidential information can only be disclosed if the patient gives explicit consent or if the law expressly provides for this; (3) All identifiable patient data must be protected. (4) Patients have the right of access to their medical files and technical records and to any other files and records pertaining to their diagnosis, treatment and care; (5) Patients have the right to require the correction, completion, deletion, or updating of personal and medical data concerning them; (6) There can be no intrusion into a patient's private and family life unless and only if, in addition to the patient consenting to it, it can be justified as necessary to the patient's diagnosis, treatment and care; (7) Medical interventions may only be carried out when there is proper respect shown for the privacy of the individual; (8) Patients have the right to physical facilities which ensure privacy, particularly when health care providers are offering them personal care or carrying out examinations and treatment.

*WHO, Declaration on the Promotion of Patients' Rights in Europe sec. 4 (1994)*

## Mutual Disclosure and Partner Notification

It is estimated that up to 50% of PLHIV who are in relationships are part of discordant couples, that is their partner is HIV negative. There is no global policy that addresses the needs of such couples. However, WHO is currently developing Guidelines for Couples HIV Testing and Counseling. The draft Guidelines call States to: 1) offer couples and partners voluntary HIV testing and counseling with mutual disclosure; and 2) support couples in making informed decisions about prevention and conception. Partner notification is a form of disclosure that requires HIV-positive individuals to notify their sexual or drug injecting partners of their status for the purposes of public health. In cases when an HIV-positive individual is unwilling or unable to disclose his or her HIV status, a health care professional may be permitted to notify and counsel the patient's partners. In some instances, public health agencies are authorized to perform contact tracing to identify and inform potential partners of the fact that they may have been exposed to HIV.<sup>227</sup>

International Guidelines recommend voluntary notification and disclosure, and the provision of professional counseling for persons involved. Health care professionals should be authorized but not required to disclose HIV status to their patients' partners. Any disclosure should be made in accordance with clearly specified criteria: 1) the HIV-positive person has been thoroughly counseled; 2) counseling of the HIV-positive person has failed to achieve appropriate behavioral changes; 3) the HIV-positive person has refused to notify, or consent to the notification of his/her partner(s); 4) a real risk of HIV transmission to the partner(s) exists; 5) the HIV-positive person is given reasonable advance notice; 6) the identity of the HIV-positive person is concealed from the partner(s), if this is possible in practice; and 7) follow-up is provided to ensure support to those involved, as necessary.<sup>228</sup>

## Areas of Inquiry

- Does the State ensure that disclosure and use of personal and medical data related to one's HIV status is possible only with specific informed consent of the individual?
- Do State laws clearly define exemptions to consensual disclosure of HIV-related information?
- Does the State ensure that non-consensual disclosure of HIV status is performed in accordance with the law and human rights principles?
- Does the State ensure that reporting and compilation of HIV-related information for epidemiological purposes and media reporting follows strict rules of data protection and confidentiality?
- Does the State refrain from nominal registration of PLHIV?

## Case Study

### Protection of Confidentiality of HIV Status in South Africa

In the 2007 case of *NM and Others v Smith and Others*, the Constitutional Court of South Africa ruled in favor of three applicants who alleged that their rights to privacy, dignity, and psychological integrity were violated by publication of their HIV status without their consent. In March 2002, the names of three HIV-positive women were published in a biography of a politician Patricia de Lille. The information was previously made available in an inquiry report on the clinical trial that they participated in. The three women sued for damages in the Johannesburg High Court, naming de Lille, the author of the biography, and the publisher, New Africa Books, as respondents. The case ended up in the Constitutional Court, which ruled in favor of the applicants stating that an individual's HIV status deserves protection against indiscriminate disclosure due to the nature and negative social context of the disease as well as the potential intolerance and discrimination that result from its disclosure. The Court added that affirmation of secure privacy rights within the Constitution may encourage individuals to seek treatment and divulge information encouraging disclosure of HIV which has previously been hindered by fear of ostracism and stigmatization. Furthermore, the Court stated that the assumption that others are allowed access to private medical information once it has left the hands of authorized physicians and other personnel involved in the facilitation of medical care is fundamentally flawed. This assumption fails to take into account an individual's desire to control information about him or herself and to keep it confidential from others. In respect to the claim that the applicants' dignity was violated, the Court stated that there is nothing shameful about living with HIV/AIDS, but that it is nevertheless an affront to an infected person's dignity for another person to disclose details about the infected person's HIV status without his or her consent. The Court concluded that the respondents violated the dignity and psychological integrity of the applicants, and that no evidence was presented that the disclosure was in the public interest.<sup>229</sup>



## Section II: Equality of PLHIV in Public and Private Life

### Factor 7: Political, Social, and Cultural Life

**PLHIV enjoy full equality and inclusion in political, social, and cultural life. The State ensures the right of PLHIV, HIV/AIDS advocates, and service workers to peaceful assembly and association.**

#### Introduction

The right of all people to equality and inclusion in political, social, and cultural life is particularly significant for PLHIV, HIV/AIDS advocates, and service workers because of the high levels of stigma and discrimination they face in the public and private spheres. Ensuring that PLHIV enjoy freedom of expression, association, and free participation in public affairs is key to addressing misconceptions about HIV/AIDS and protecting the health and dignity of PLHIV and key populations.

The importance of these rights for PLHIV is reflected in the principle of greater involvement of people living with or affected by HIV/AIDS [hereinafter GIPA], which was endorsed at the 1994 Paris AIDS Summit and subsequently reiterated in numerous international standard-setting documents.<sup>230</sup> GIPA recognizes the critical role that PLHIV must play in any public response to the HIV/AIDS epidemic.<sup>231</sup> This, in turn, requires that PLHIV, HIV/AIDS advocates, and service-workers must not be deterred from freely communicating, organizing, or seeking public positions.

#### Examples of Compliance

- HIV/AIDS advocates can freely disseminate information and materials about HIV.
- State actively involves PLHIV in the design and implementation of HIV-related laws, policies, and programs.
- PLHIV can freely join trade unions and professional associations.
- State effectively protects HIV organizations from intimidation and harassment.

#### International Standards and Commentary

##### Freedom of Opinion and Expression

###### *Right to Hold Opinions and Freedom of Expression*

Everyone has the right to hold opinions without interference and the right to freedom of expression, which includes freedom to seek, receive, and impart information and ideas of all kinds, either orally, in writing, in print, in the form of art, or through any other media. Freedom of expression can be restricted only in circumstances prescribed by the law for the protection of the rights of others, national security, public order, or public health or morals.<sup>232</sup>

*ICCPR art. 19*

In the context of HIV/AIDS, an important component of the right to freedom of opinion and expression is the freedom to seek, receive, and impart information and ideas of all kinds, including information about HIV/AIDS.<sup>233</sup>

According to International Guidelines, this right should be applied to include equal access to HIV-related information, education, means of prevention, and health services.<sup>234</sup> Consequently, the dissemination of educational material pertaining to HIV/AIDS must not be prohibited or censored, whether it is intended for general distribution or

#### Examples of Non-Compliance

- PLHIV are prevented from holding public offices.
- State censors or prohibits evidence-informed public service announcements about HIV in the media.
- PLHIV are barred from entering sporting competitions, cultural events, public transportation, or public places, such as libraries.
- HIV advocacy organizations are subject to surveillance by State authorities.

targeted at key populations. States are urged to refrain from making those imparting HIV information to groups engaged in unlawful behavior liable for aiding or abetting criminal offences.<sup>235</sup>

The obligation to avoid censoring, withholding, or intentionally misrepresenting information related to HIV or sexual health is clearly articulated in the General Comments issued by the UN Committee on the Rights of the Child and the UN Committee on Economic, Social, and Cultural Rights.<sup>236</sup> The latter requires States to ensure that third parties do not limit access to health-related information.<sup>237</sup> International bodies, including UNAIDS and the UN Special Rapporteur on the Promotion and Protection of the Right to Freedom of Expression and Opinion, have emphasized the importance of the right to freedom of opinion and expression, and have reiterated the obligation of States not to restrict free expression in the context of HIV/AIDS-related advocacy and education.<sup>238</sup> UNAIDS has also stressed that journalists have the responsibility to report on HIV issues with accuracy and sensitivity.<sup>239</sup>

### Areas of Inquiry

- Does the State ensure that PLHIV, HIV/AIDS advocates, and service workers enjoy the rights to freedom of opinion and expression?
- Does the State ensure the right to seek, receive, and impart information about HIV/AIDS, particularly in the context of HIV education and advocacy?
- Does the State refrain from subjecting evidence-informed information about HIV to censorship and obscenity laws?
- Does the State refrain from making those imparting HIV information to groups engaged in unlawful behavior liable for aiding or abetting criminal offences?

### Political Participation

The right to political participation and the principle of participatory democracy are essential for empowering PLHIV to take on visible roles in the political sphere and for building public recognition and acceptance of PLHIV.<sup>241</sup> The importance of the full and active participation of PLHIV and key populations in a State's political life, particularly for the purpose of contributing to public policy concerning HIV/AIDS, is stressed in the Declaration of Commitment, the Political Declaration, and International Guidelines.<sup>242</sup> The principle of GIPA recognizes that PLHIV may be alienated from the political process as a result of the stigmatization and discrimination that often characterize social and political environments, and that the social or economic vulnerability of PLHIV – particularly those from key populations – may preclude them from involvement in public affairs. UNAIDS urges States to: 1) create an enabling environment for PLHIV to participate in political life; 2) make a concerted, large-scale effort to involve PLHIV in all aspects of the response to HIV; and 3) support measures that protect people who publicly disclose their HIV status. Political and community leaders, for example, can have a considerable impact on social attitudes to HIV/AIDS by endorsing information and awareness campaigns, and publicly supporting antidiscrimination laws.<sup>243</sup>

#### ***Right to Political Participation***

International law guarantees everyone the equal right to participate in public affairs and the political process, by voting or serving in public office.<sup>240</sup>

*UDHR art. 21; ICCPR art. 25*

### Areas of Inquiry

- Does the State ensure that PLHIV, HIV/AIDS advocates, and service workers enjoy the right to participate in the political process by voting or seeking public office?
- What measures are undertaken to involve PLHIV in all aspects of the public HIV response, particularly through participation in the political process and policy formulation?

### Social and Cultural Life

According to the UN Committee on Economic, Social, and Cultural Rights, the right of everyone to take part in cultural life encompasses equal access to any cultural goods, services, and events intended for the general public, including, but not limited to, libraries, museums, theatres, cinemas, and sports stadiums; the shared open spaces essential to cultural interaction, such as parks, squares, avenues, and streets; and nature's gifts, including nature reserves.<sup>244</sup> International Guidelines underline the importance of fully integrating PLHIV in the social and cultural aspects of community life, and urge States to extend anti-discrimination laws to areas

that are as broad as possible, including sport, clubs, trade unions, qualifying bodies, access to transport, and other services.<sup>245</sup> In addition, States should ensure that PLHIV are equally able to express their cultural identity and creativity. International Guidelines recognize that artistic expression can be both a therapeutic activity for PLHIV and an important medium for imparting HIV-related information, combating intolerance, and educating audiences about HIV/AIDS.<sup>246</sup>

### ***Right to Participate in Social & Cultural Life***

Everyone has the right to take part in cultural life. States are required to respect the freedom indispensable for creative activity.<sup>247</sup>

*ICESCR art. 15*

#### **Areas of Inquiry**

- Does the State ensure that PLHIV enjoy the right to participate in social and cultural life?
- Does the State ensure that PLHIV enjoy the right to equal access to any place or service intended for the general public?

#### **Freedom of Assembly and Association**

While PLHIV, HIV/AIDS activists, and service-workers have the same general right to assembly and association as other individuals, this protection is particularly pertinent to these groups given the many restrictions they may face on their activities and the ability to organize.<sup>249</sup> This can include: 1) prohibitive bureaucratic requirements for establishing or registering an HIV organization; 2) denial of membership to trade unions or professional associations on the basis of HIV status; 3) cancellation or interruption of peaceful demonstrations and public awareness events organized by HIV/AIDS activists; 4) harassment and intimidation of people employed by HIV service, harm reduction, and advocacy organizations by law enforcement officials (e.g., through unjustified interrogations, detention, and frequent government controls aimed at disrupting their work).<sup>250</sup> Curtailing HIV/AIDS activism poses a real threat to HIV prevention, treatment, and care.<sup>251</sup> Therefore, International Guidelines urge States to ensure that community organizations are enabled to carry out their activities, including in the fields of ethics, law and human rights, effectively,<sup>252</sup> and to decriminalize laws and regulations that restrict the movement or association of members of vulnerable groups in the context of HIV.<sup>253</sup>

### ***Right to Peaceful Assembly & Association***

Everyone has the right to peaceful assembly and association, including the right to join trade unions. These rights can be restricted only in circumstances prescribed by the law which are necessary in a democratic society for the protection of the rights of others; national security; or public safety, order, health, or morals.<sup>248</sup>

*UDHR art. 20; ICCPR arts. 21-22*

#### **Areas of Inquiry**

- Does the State ensure that PLHIV, HIV/AIDS advocates, and service workers enjoy the rights to peaceful assembly and association?
- Does the State ensure that people associated with HIV service and advocacy organizations are protected from harassment, intimidation, violence, and other human rights violations?

#### **Case Study**

##### **HIV/AIDS and the Media Guidelines in India**

Following a court case in India, where unbalanced reporting led to discrimination against an HIV-positive child, one of the key statutory bodies mandated to protect freedom of the press took steps to ensure that the discussion of HIV/AIDS in the media is uncensored, objective, sensitive, and factually accurate. In 2008, the Press Council of India, after intensive consultation with UNAIDS and representatives of local communities, released updated guidelines for the coverage of HIV-related news in the print and electronic media. In addition to urging journalists to avoid censorship and the promotion of *myths* regarding the prevention and transmission of HIV, the guidelines require, *inter alia*, that voices of PLHIV as well as vulnerable and marginalized people be heard more strongly in the media. The HIV/AIDS and the Media

Guidelines refer to the UNAIDS Terminology Guidelines and emphasize that the accuracy of HIV-related information in the media is critical. While reporting on HIV/AIDS journalists must ensure that HIV-related information is presented in a balanced manner. Distortion of facts is considered unacceptable and censorship is considered unethical.<sup>254</sup>

## Section II: Equality of PLHIV in Public and Private Life

### Factor 8: Family, Sexual, and Reproductive Life

**PLHIV enjoy full equality in family life and the right to the highest attainable standard of sexual and reproductive health. The State facilitates prevention of vertical transmission.**

#### Introduction

The family is the natural and fundamental group unit of society entitled to appropriate social, economic, and legal protection by the State.<sup>255</sup> The international community has recognized that both parents play an important role in the family and in the upbringing of children who – for their full and harmonious development – should grow up in a family environment, in an atmosphere of happiness, love, and understanding.<sup>256</sup> In the Declaration of Commitment, States expressed deep concern about the devastating impact of HIV/AIDS epidemic on the family, and affirmed the key role of the family in HIV prevention, care, support, and treatment.<sup>257</sup>

Despite their international obligations, many States fail to respect family-related rights, capabilities, and responsibilities of PLHIV by adopting laws and policies which restrict PLHIV's reproductive freedoms and infringe upon their right to respect for family life. Such laws and practices include:

- Mandatory pre-marital HIV testing and/or requirement of HIV-free certificates as a precondition for the grant of marriage licenses;
- Separation or isolation of HIV-positive family members;
- Arbitrary denial of child custody or visitation;
- Arbitrary exclusion of PLHIV from adoption and foster care programs;
- Mandatory HIV testing of pregnant women (i.e., testing without the possibility to opt-out);
- Performance of forced abortions on HIV-positive women;
- Involuntary sterilization of HIV-positive men and women;
- HIV-related discrimination in access to sexual and reproductive health care services, including family planning, pre- and post-natal care, child birth, as well as prevention and treatment of reproductive tract infections and STIs.<sup>258</sup>

Studies indicate that these practices perpetuate stigmatization of PLHIV and frequently fail to serve the purported public health objectives. Proponents of mandatory HIV testing argue that the practice serves public health objectives because it reduces HIV infection rates by containing HIV within the population of PLHIV. However, mandatory HIV testing related to family life has also negative public health consequences by creating a false sense of security among couples who test negative and disempowering women to negotiate or enforce safer sex practices with their partners. In addition, fear of stigma and discrimination may lead people to opt out of marriage or seek illegitimate marriage licenses.<sup>259</sup>

#### Examples of Compliance

- HIV-positive women have equitable access to affordable pre- and post-natal care.
- State supports alternative forms of conception for PLHIV.
- HIV/AIDS interventions are integrated into sexual and reproductive health care services.

#### Examples of Non-Compliance

- HIV-free certificate is a precondition for the grant of a marriage license.
- HIV status can be asserted as a sole ground for divorce.
- PLHIV are routinely forced to undergo sterilization or abortion.
- PLHIV are routinely denied child custody.
- PLHIV are routinely excluded from foster care and adoption programs.

## International Standards and Commentary

### Family Life

According to International Guidelines, laws and practices that restrict PLHIV's rights to marry and found a family, or have the effect of denying family unity, constitute examples of health-related discrimination and violate internationally recognized human rights.<sup>263</sup> International Guidelines underline, however, that PLHIV's rights to marry, found a family, and engage in sexual relations do not release them from a responsibility to practice abstinence or safer sex in order to protect their partners from exposure to HIV infection. International Guidelines further state that HIV status of a parent or child should not be treated differently from any other analogous medical condition in making decisions regarding custody, fostering, or adoption.<sup>264</sup> Experts recommend replacing these practices with efforts to expand couples' access to voluntary HIV testing and pre-marital counseling encompassing information on HIV prevention, treatment, and childbearing in the event of HIV infection.<sup>265</sup>

### Areas of Inquiry

- Does the State prohibit mandatory pre-marital HIV testing?
- Does the State place any restrictions on the PLHIV's right to marry and found a family? What measures are undertaken to eliminate these restrictions?
- Does the State ensure couples' access to voluntary pre-marital HIV testing and counseling?
- What impediments to the exercise of the right to found a family do PLHIV most commonly face? What measures are undertaken to eliminate these impediments?
- Does the State ensure family unity in the context of HIV/AIDS?
- Does the State prohibit asserting HIV status as the sole ground for divorce?
- Does the State prohibit mandatory HIV testing in child custody proceedings?
- Does the State ensure that HIV-positive parents are not arbitrarily denied child custody or visitation?
- Does the State ensure that HIV-positive prospective or foster parents are not arbitrarily excluded from adoption or foster care programs?

### Sexual and Reproductive Life

In line with international standards, sexual and reproductive rights of PLHIV include: 1) the right to decide freely and responsibly, free of coercion, discrimination, and violence, on matters related to one's sexuality (including the right to be free from sexual violence, forced abortion, and sterilization);<sup>266</sup> 2) the ability to have a satisfying and safe sex life (including the right to demand safer sex practices);<sup>267</sup> 3) freedom to decide if and when to reproduce (including the right to determine the number and spacing of children);<sup>268</sup> and 4) the right to appropriate health information and services (including access to safe, effective, affordable, and acceptable methods of family planning and STI treatment).<sup>269</sup>

The Declaration of Commitment, Political Declaration, and International Guidelines emphasize the need to strengthen and ensure access to confidential reproductive and sexual health care for women, men, children, and adolescents as means of reducing their vulnerability to HIV. States should also enhance policy and program coordination between

### *Rights to Marry & Found a Family*

International law guarantees everyone the right to respect for family life and the right to legal protection in the event of arbitrary or unlawful interference with one's family.<sup>260</sup> All men and women of marriageable age have the right to marry and found a family. Spouses are entitled to equal rights and responsibilities as to marriage, during marriage, and at its dissolution.<sup>261</sup> Because equality of spouses extends to all matters arising from their relationship, prohibition of discrimination should include all the grounds and procedures for separation, divorce, child custody, visiting rights, and the loss or recovery of parental authority.<sup>262</sup>

*UDHR arts. 12, 16; ICCPR arts. 17, 23*

### *Right to Sexual & Reproductive Freedom*

While there is no international treaty that explicitly guarantees the right to sexual and reproductive freedom, PLHIV's reproductive rights are derived from: 1) the right to found a family, which implies the possibility to procreate and live together; 2) the right to health, which includes the right to control one's health and body; and 3) the rights to liberty and integrity of the person.

*ICCPR art. 9; UN Human Rights Committee, General Comment No. 19 on the protection of Family, the Right to Marriage and Equality of the Souses para. 5 (1990); UN Committee on Economic, Social, and Cultural Rights, General Comment No. 14 para. 8; International Guidelines para. 118*

HIV/AIDS and sexual and reproductive health by integrating HIV/AIDS intervention into sexual and reproductive health care services.<sup>270</sup> According to the UN Human Rights Committee, any family planning policies must comply with the principle of non-discrimination and cannot be compulsory.<sup>271</sup>

### Areas of Inquiry

- Does the State prohibit mandatory HIV-testing of pregnant women?
- Does the State prohibit forced or coerced abortions and sterilizations?
- What impediments to the exercise of the right to sexual and reproductive freedom do PLHIV most commonly face? What measures are undertaken to eliminate these impediments?
- Does the State ensure that PLHIV have equal and sustainable access to temporary and permanent methods of contraception; prenatal, delivery and post-natal care; and STI treatment?

### Vertical Transmission<sup>vii</sup>

Pregnant women with HIV are at high risk of transmitting HIV to their infants during pregnancy, birth, or through breastfeeding. The estimated risk of 20-45% can be reduced to less than 2% by a package of evidence-based interventions, including pre- and post-natal anti-retroviral treatment.<sup>275</sup> Improving maternal health is one of the eight MDGs. Preventing mothers from dying and babies from becoming infected with HIV is also one of the ten UNAIDS priority areas.<sup>276</sup> Several multilateral and bilateral agencies have called for the virtual elimination of vertical transmission of HIV by 2015.<sup>277</sup> UNAIDS and other international bodies urge States to rapidly scale up their efforts to eliminate vertical transmission of HIV by implementing a comprehensive approach to prevention which includes: 1) primary prevention of HIV among women of childbearing age; 2) prevention of unintended pregnancies among women living with HIV; 3) prevention of HIV transmission from a woman living with HIV to her infant; and 4) provision of appropriate treatment, care, and support to women living with HIV and their children and families.<sup>278</sup>

Many HIV programs emphasize coercive measures aimed at preventing vertical transmission of HIV, such as mandatory HIV testing of pregnant women followed by forced abortions and sterilizations. International Guidelines stress that these practices violate women's rights and seldom empower them to prevent vertical transmission of HIV. International standards urge States to support PLHIV in making voluntary and informed choices about reproduction by ensuring that women have access to: 1) accurate information about the risks of vertical transmission of HIV; 2) voluntary and confidential prenatal HIV testing, counseling, and prevention education (including information on safe infant feeding and the future use of contraception); 3) effective pre- and post-natal treatment for mothers and their babies (including anti-retroviral therapy and, where appropriate, breast-milk substitutes); and 4) continuum of care after pregnancy, including support for the HIV-affected family.<sup>279</sup> States should strive to comply with the WHO guidelines on the prevention of vertical transmission of HIV and infant feeding in the context of HIV, which provide specific, evidence-based treatment regimen recommendations.<sup>280</sup>

#### *Right to Safe Pregnancy & Childbirth*

Women's right to safe pregnancy and childbirth is supported by several internationally recognized human rights, including the right to life, health, equality, and dignity.<sup>272</sup>

*UN Human Rights Council (2009)*

Expectant and new mothers have the right to special protection, including appropriate pre- and post-natal health care.<sup>273</sup>

*UDHR art. 25; ICESCR art. 10;  
CRC art. 24*

States are obliged to ensure that all women have access to appropriate, and, when necessary, free services related to pregnancy, confinement, and the post-natal period.

*CEDAW art. 12*

States should give particular attention to maternal and emergency obstetric care which enables women to go safely through pregnancy and childbirth, and provides couples with the best chance of having a healthy infant.<sup>274</sup>

<sup>vii</sup> **Vertical transmission** is a passage of HIV vertically from a mother to her child during the perinatal period (the period immediately before and after birth). Transmission may occur across the placenta or through breast milk. Vertical transmission of HIV is also referred to as perinatal or mother-to-child transmission (MTCT).

## Areas of Inquiry

- What measures are undertaken to eliminate vertical transmission of HIV?
- Does the State ensure that women have access to voluntary and confidential pre-natal HIV testing, counseling, and prevention education?
- Does the State ensure that pregnant women and their babies have access to affordable pre- and post-natal ART?
- Does the State support alternative forms of conception for PLHIV (e.g., sperm purification and artificial insemination)?

## Case Study

### Prevention of Vertical Transmission in South Africa

In 2000, the South African government introduced an anti-retroviral treatment (ART) program aimed at preventing vertical transmission of HIV in 18 pilot sites.<sup>281</sup> Health care providers who did not participate in the study were prohibited from prescribing and administering ART to pregnant women living with HIV. In 2001, one physician and two CSOs (the Treatment Action Campaign and the Children's Rights Centre) filed a lawsuit seeking to compel the government to extend access to ART to all expecting mothers and their newborn children. The case ended up in the Constitutional Court which ruled that the government had an obligation to realize the constitutional right of pregnant women and their newborn children to access adequate health-care services. The government was ordered to make the ART available to pregnant women and newborns in all public hospitals and clinics, and to devise a comprehensive program to reduce the risk of vertical transmission of HIV. While the legal victory did not produce immediate results in all provinces, the case *TAC v. Minister of Health* has led to one of the world's leading judgments on the application of the right to health.<sup>282</sup> In 2003, the South African Department of Health issued its first national protocol for the prevention of mother-to-child transmission of HIV. The protocol was revised in 2008. Although it fails to fully comply with the WHO guidelines, it constitutes an important step forward towards reducing the number of preventable HIV infections among infants.<sup>283</sup>



## Section II: Equality of PLHIV in Public and Private Life

### Factor 9: Education and Training

**PLHIV enjoy the right to equal educational opportunity. Where appropriate, special measures are employed to provide reasonable accommodations for PLHIV and increase their representation in educational institutions.**

#### Introduction

Education is a human right with an immense power to transform.<sup>284</sup> It is indispensable for the development of individuals, societies, and for the realization of other human rights.

Education, human development, and an effective AIDS response interlink on many levels. On the one hand, education is negatively affected by the HIV/AIDS epidemic: it impacts the ability of children to go to school as many become orphaned by HIV, are forced to drop out of school to care for sick relatives, or cannot afford to attend school because of the economic burdens of the disease. HIV/AIDS also impacts the ability of teachers to teach. Additional barriers to access to educational and vocational institutions that PLHIV often face include: 1) mandatory HIV testing prior to enrolment or during annual health check-ups; 2) unequal access to scholarships and student loans; and 3) differential treatment in educational institutions,<sup>viii</sup> including isolation and segregation.

On the other hand, the positive results of education on the human rights-based response to HIV/AIDS are hard to overestimate. Education plays an important role in achieving the adequate standard of living, reducing poverty, decreasing vulnerability to HIV, and mitigating the consequences of the epidemic. Studies demonstrate that children and young people who attend school are less likely to acquire HIV and are less vulnerable to the impacts of HIV. Education is also vital in reducing HIV-related stigma and discrimination and supporting those affected by HIV and AIDS. A review of HIV/AIDS interventions in schools in Africa has confirmed the potential of education to bring about an improvement in attitudes towards PLHIV. The review found attitudinal changes in all programs under review, with school students showing greater acceptance of PLHIV regardless of the program's format, duration, content, or target population.<sup>285</sup> See also Factor 1 above.

Protection of PLHIV from HIV-related discrimination in educational sphere is of paramount importance. With increased access to ART and other medication, PLHIV have the prospect of long, healthy and productive lives, and can benefit from education as much as anybody else.

#### International Standards and Commentary

According to the UN Committee on Economic, Social, and Cultural Rights, education in all its forms and at all levels should be: 1) available; 2) accessible to everyone; 3) acceptable; and 4) adaptable. Apart from physical and economic *accessibility*, the accessibility requirement includes *non-discrimination*: education must

<sup>viii</sup> **Educational institution** is defined as any private or public institution which provides primary, secondary, and higher education as well as well as technical and vocational training.

#### Examples of Compliance

- State prohibits mandatory HIV testing for the purposes of enrollment in all types of educational institutions.
- State provides reasonable accommodations for people who are unable to afford or otherwise access education due to their HIV status.

#### Examples of Non-Compliance

- HIV-negative status is one of the criteria for enrollment in some or all educational institutions.
- State condones segregation of HIV-positive students.
- State runs special schools for HIV-positive children.
- Educational institutions require regular medical check-ups which include mandatory HIV testing.

be accessible to all, especially the most vulnerable groups, without discrimination on any of the prohibited grounds. Education must also be flexible so that it can adapt to the needs of changing societies and communities, and respond to the needs of students within their diverse social and cultural settings.<sup>286</sup>

The World Declaration on Education for All (1990), the Vienna Declaration and Program of Action (1993), and the MDGs (2000) all stress the significance of education for sustainable development, human rights, and democratization. International Guidelines explicitly emphasize the importance of education in countering stigma and discrimination, and promoting understanding, respect, and tolerance in relation to PLHIV.<sup>287</sup> International Guidelines further state that restrictions and limitations on the enrollment of PLHIV in educational institutions are not justified by the public health rationale because there is no risk of transmitting HIV casually in educational settings. Consequently, they constitute discrimination on the ground of health, and are prohibited by international law.<sup>288</sup>

In order to ensure equal access to education for PLHIV States should: 1) guarantee non-discrimination in primary, secondary and higher education, and in vocational trainings; 2) prohibit educational institutions from requiring HIV-free certificates for enrolment and access to scholarships and student loans; and 3) prohibit differential treatment in educational institutions, such as segregation or isolation. States should further ensure that educational institutions maintain strict protection of confidentiality of their students' personal data, including their HIV status. Finally, States should adopt an educational strategy which addresses HIV concerns in the sphere of education and, where necessary, guarantees special accommodations for PLHIV to increase their representation in educational institutions (e.g., in a form of scholarships).

### ***Right to Education***

Everyone has the right to education. Education should be directed to the full development of the human personality; should strengthen the respect for human rights; should enable all persons to participate effectively in a free society; and should promote understanding and tolerance. To fully realize the right to education, States should ensure that: 1) primary education is compulsory and available free to all; 2) secondary education (including technical and vocational training) is generally available and accessible to all; and 3) higher education is equally accessible to all.<sup>289</sup>

*UDHR art. 26; ICESCR art. 13; CRC art. 28*

States are required to eliminate discrimination in educational sphere, including: 1) depriving any person or group of persons of access to education of any type or at any level; 2) limiting any person or group of persons to education of an inferior standard; 3) establishing or maintaining separate educational systems or institutions for persons or groups of persons; or 4) inflicting on any person or group of persons conditions which are incompatible with the dignity of man.

*UNESCO Convention against Discrimination in Education arts. 1, 3*

### ***Education for All (EFA) Commitments with Respect to HIV and AIDS<sup>290</sup>***

In 2006, at the Sixth Meeting of the High-Level Group on EFA, ministers of education, heads of development agencies, and leaders of CSOs committed to: 1) linking education sector planning with commitments to achieving universal access; 2) reducing stigma and discrimination; 3) addressing the impact of HIV and AIDS on the education sector; 4) adopting anti-discriminatory workplace policies; 5) developing and strengthening life skills education to promote awareness of HIV and AIDS; 6) ensuring that orphans and vulnerable children have access to, and complete, quality basic education; 7) ensuring access to care and support and treatment for teachers and staff; and 8) fostering comprehensive education responses through cross-sectoral partnerships.

### **Areas of Inquiry**

- Does the State's education policy address HIV/AIDS, including HIV-related discrimination, drop out of school, as well as role of education in HIV prevention and stigma reduction?
- Does the State prohibit HIV-related discrimination in educational institutions?
- Does the State prohibit mandatory HIV testing in all educational institutions?
- Does the State ensure that PLHIV enjoy equal treatment and privacy protections in all educational institutions?

- Does the State provide reasonable accommodations for PLHIV to increase their representation in educational institutions?
- Does the State address the situation of HIV-affected children who drop out of school?
- What barriers in access to education do PLHIV most commonly face? What measures are undertaken to eliminate these barriers?

## **Case Study**

### **Prohibition of HIV-Related Discrimination in Education**

Some countries with specific HIV laws prohibit discrimination in education on the ground of HIV. For example, the Philippine's AIDS Prevention and Control Act of 1998, and Cambodia Law on the Prevention and Control of HIV/AIDS stipulate that no educational institution can refuse admission or expel, discipline, segregate, deny participation, benefits or services to a student or prospective student on the basis of his/her actual, perceived or suspected HIV status (or on the basis of HIV status of his/her family members). Macedonia's HIV/AIDS National Strategy states that children with HIV/AIDS must be fully integrated into normal educational and social activities. The Strategy mandates that these children have full access to public schools and that they are not subject to discrimination from their parents, teachers, and community members. The National HIV/AIDS Policy of Zimbabwe commands freedom from discrimination in all spheres of life and the right to full access to education for children with HIV.<sup>291</sup>

## Section II: Equality of PLHIV in Public and Private Life

### Factor 10: Employment, Work, and Economic Life

**PLHIV enjoy equal rights to: work in public and private sectors, including just, favorable, safe, and healthy conditions of work; property and inheritance; and credit. Where appropriate, special measures are employed to provide PLHIV with income-generating opportunities and reasonable accommodations in the workplace.**

#### Introduction

HIV/AIDS has a serious impact on the global and national economies; on the world of work both in formal and informal sectors; and on economic development of societies, communities, and individuals.<sup>292</sup> People infected with or affected by HIV often suffer from the lack of economic opportunities, inequality, and HIV-related discrimination in employment, property ownership, inheritance, and access to credit. Discrimination is often based on the assumption that HIV per se renders a person unable to work or hold certain positions. This is a misconception because PLHIV, especially those who undergo rigorous ART, are capable of long and productive employment. Protection from discrimination and provision of specific accommodations for PLHIV in the workplace and economic life are therefore of paramount importance.

#### Examples of Compliance

- State prohibits differential treatment of PLHIV in the workplace.
- PLHIV enjoy job security until they are no longer able to work.
- State supports flexible work policies in the context of HIV/AIDS.

#### International Standards and Commentary

##### Employment and Work

An equal right to work, including just and favorable conditions of work, is recognized in international human rights treaties and in numerous international labor standards and codes of practice developed and adopted by ILO.<sup>ix</sup> Two of them deal directly with issues raised by HIV/AIDS: the ILO Code of Practice on HIV/AIDS and the World of Work (2001) and the Recommendation Concerning HIV and AIDS and the World of Work [hereinafter ILO Recommendation], which is the first human rights instrument focusing specifically on HIV and the right to work.<sup>293</sup>

##### Access to Employment

HIV should be treated like any other illness or medical condition in the workplace. According to International Guidelines and ILO Recommendation, States should: 1) recognize HIV/AIDS as a workplace issue; 2) develop a national policy on HIV and the workplace; and 3) effectively prohibit discrimination and stigmatization of workers on the ground of actual or perceived HIV status by employers, clients, unions, and clients. The right to work entails the right of every person to access employment without any precondition, except the necessary occupational qualifications. States should therefore ensure that workers are not required to undergo HIV screening, undertake an HIV test, or disclose their HIV status for any purpose (e.g.,

#### Examples of Non-Compliance

- State condones HIV screening (including questioning and mandatory testing) for employment purposes.
- PLHIV are excluded from certain professions and face mandatory discharge from armed forces.
- PLHIV are routinely denied access to workplace benefits, for example sick or disability leave.

<sup>ix</sup> **International labor standards** are legal instruments adopted by ILO which set out basic principles and rights at work, and aim at promoting opportunities to obtain decent and productive work in conditions of freedom, equity, security, and dignity. They are either *conventions*, which are legally binding international treaties, or *recommendations*, which serve as non-binding guidelines. In addition, ILO develops Codes of Practice which set out practical guidelines for public authorities, employers, workers, enterprises, and specialized occupational safety and health protection bodies. Nearly half of all ILO instruments deal directly or indirectly with occupational safety and health issues. See ILO, at: [www.ilo.org](http://www.ilo.org).

to access workers' compensation, benefits, training, or promotion). All employment groups should be protected from targeted HIV testing and related discrimination, i.e., job applicants, job seekers, those in training (interns, apprentices), volunteers, persons in any employment or occupation (e.g., truck drivers, sailors, hospitality and tourist industry workers, armed forces, and uniformed services), and laid off or suspended workers. Prohibition of HIV-related discrimination should: 1) extend to all sectors of economic activity (private and public, formal and informal); and 2) cover recruitment of workers, maintenance of employment, and the pursuit of equal opportunities in the workplace. HIV status cannot be a cause for termination of employment. Temporary absence from work because of illness or caregiving duties related to HIV/AIDS should be treated in the same way as absences for other health reasons.<sup>294</sup>

### Reasonable Accommodations in the Workplace

PLHIV may face difficulties in achieving job and income security because of the episodic nature of HIV/AIDS<sup>x</sup> and possible side effects of treatment.<sup>296</sup> Therefore, International Guidelines and ILO Recommendation urge States to ensure employment security for PLHIV: they should be allowed to work as long as they are medically fit to carry out the functions of the job. In particular, States should support reasonable accommodations<sup>xi</sup> and retention policies for PLHIV in the workplace.<sup>297</sup> These may include: 1) modified duties; 2) flexible work-life balance policies (part-time work, job sharing, or telecommuting); 3) trial periods; 4) health benefits coverage; 5) automatic reinstatement of benefits; and 6) sick leave and disability support programs that take into account the specific needs of PLHIV who have episodic disabilities.<sup>298</sup> See also Factor 5 above.

### Conditions of Work

In line with international standards, all employees have the right to a safe and healthy working environment, including prevention of HIV transmission.<sup>299</sup> International Guidelines stress that in the vast majority of occupations and settings, work does not involve a risk of acquiring or transmitting HIV between workers, from worker to client, or from client to worker. However, where a direct link can be established between an occupation and the risk of infection, HIV should be recognized as an occupational disease or accident, and States should take measures to minimize the risk of transmission through well-defined safety and health measures (including access to post-exposure prophylaxis) and training. For example, health care workers must be properly trained in universal precautions and be supplied

**Right to Work**

States recognize the right to work, including the right of everyone to the opportunity to gain his or her living by work which he or she freely chooses or accepts. In order to achieve the full realization of the right to work, States are obliged to implement technical and vocational guidance and training programs, policies, and techniques to achieve steady economic, social and cultural development and full and productive employment.

*UDHR art. 23; ICESCR art. 6*

Discrimination includes any distinction, exclusion or preference which has the effect of nullifying or impairing equality of opportunity or treatment in employment or occupation

*ILO Discrimination (Employment and Occupation) Convention art. 1*

**Right to Just and Favorable Conditions of Work**

Everyone has the right to the enjoyment of just and favorable conditions of work, including: 1) fair wages and equal remuneration for work of equal pay without distinction of any kind; 2) safe and healthy working conditions; 3) equal opportunity for everyone to be promoted to an appropriate higher level, subject to no considerations other than those of seniority and competence; and 4) rest, leisure, and reasonable limitation of working hours.<sup>295</sup>

*UDHR art. 23; ICESCR art. 7*

Workers should be protected from sickness, disease and injury arising from their employment.

*ILO Constitution preamble*

<sup>x</sup> Episodic nature of HIV/AIDS or **episodic disability** refer to fluctuating periods and degrees of wellness and disability associated with HIV infection. People with episodic disabilities face significant employment and income support issues because recurring periods of ill health make it difficult for them to work, especially full-time.

<sup>xi</sup> ILO defines **reasonable accommodation** as any modification or adjustment to a job or to the workplace that is reasonably practicable and enables a person living with HIV or AIDS to have access to, or participate or advance in, employment.

hazard.<sup>300</sup> Occupational transmission of HIV (e.g., needle stick injuries) should be included in workers' compensation legislation.<sup>301</sup>

ILO Recommendation and International Guidelines emphasize that workplace has an important role to play in minimizing the effects of HIV and halting its spread. In particular, workplace should encourage and facilitate access of workers, their families, and their dependants to HIV-related services, including voluntary HIV testing, prevention programs and commodities, and free or affordable health care services.<sup>302</sup> Lastly, States should ensure effective: 1) prohibition of violence and harassment in the workplace; 2) protection of workers' privacy and confidentiality, including medical data related to HIV status; and 3) participation of workers in the design, implementation and evaluation of HIV-related workplace programs.<sup>303</sup>

### Areas of Inquiry

- Does the State have a national policy on HIV in the workplace? Does the policy emphasize the role of the workplace in responding to the HIV epidemic? Has the policy been developed in consultation with employers, employees, and their representatives?
- Does the State prohibit HIV-related discrimination in the workplace at all stages of employment? Does this prohibition cover all employment groups and all sectors of economic activity?
- Does the State prohibit mandatory HIV testing and screening by public and private employers?
- Does the State ensure that PLHIV enjoy: 1) equal access to employment; 2) equal treatment in the workplace; 3) just and favorable conditions of work; and 4) protection from arbitrary termination of employment?
- Does the State ensure employment security for PLHIV until they are no longer able to work, including reasonable accommodations and income-generating opportunities?
- Does the State ensure that PLHIV have access to sick or disability leave support?
- Does the State ensure that the confidentiality of HIV status is protected in the workplace?
- What barriers in access to employment do PLHIV most commonly face? What measures are undertaken to eliminate these barriers?
- Does the State ensure that employers provide their workers with access to HIV-related information for occupational health and safety reasons?
- Does the State ensure: 1) implementation of universal precaution and infection control measures, including safety training and provision of equipment in all work settings involving exposure to blood or body fluids; and 2) access to post-exposure prophylaxis for occupational transmission of HIV?
- Does workers' compensation legislation recognize occupational transmission of HIV?

### Property Ownership and Inheritance

In many countries, especially in Sub-Saharan Africa, property dispossession, i.e., disinheritance, illegal property seizure, or property grabbing, is a common consequence of testing HIV-positive. These practices have a devastating effect on the ability of PLHIV to survive and realize the right to adequate standard of living. Therefore, States should ensure that PLHIV's rights to property and inheritance are adequately protected. Because globally women and girls are disproportionately excluded from property ownership and inheritance laws, property dispossession is discussed in greater detail in Factor 14 below.

#### ***Right to Property***

Everyone has the right to own and peacefully enjoy property. Arbitrary deprivation of property is prohibited.

*UDHR art. 17;  
ECHR Protocol 1 art. 1;  
Banjul Charter art. 14; ACHR art. 21*

### Areas of Inquiry

- Does the State prohibit arbitrary deprivation of property based on actual or perceived HIV status?
- Does the State ensure that PLHIV enjoy equal rights to property and inheritance?
- What barriers in access to property and inheritance do PLHIV most commonly face? What measures are undertaken to eliminate these barriers?

## Financial Services

PLHIV face numerous barriers in access to credit, home loans, and other financial services. First, PLHIV may not qualify for a loan if, due to increased morbidity or discrimination, they have a poor credit score or no steady flow of income. Indeed, commercial banks rarely provide loans to poorer households and even less frequently to poor women. Second, PLHIV may not qualify for a loan if a lender requires a mandatory HIV test and/or an HIV-free certificate, which constitutes HIV-related discrimination. Without access to financial services, PLHIV are often stuck in the cycle of poverty with few opportunities to generate income. States should therefore ensure that commercial entities offering financial services, as well as community microcredit programs, provide PLHIV with equal access to their services. States should also encourage the establishment of special loan programs for PLHIV.

## Areas of Inquiry

- Does the State prohibit mandatory HIV testing by banks and other financial institutions?
- Does the State ensure that PLHIV have equal access to all forms of financial services, including credit?
- What barriers in access to financial services do PLHIV most commonly face? What measures are undertaken to eliminate these barriers?
- Does the State support the establishment of special loan programs for PLHIV?

## Case Study

### Prohibition of Mandatory HIV Testing by Employers in India

In the 1997 case *MX v. ZY*, the Bombay High Court of Judicature concluded that mandatory HIV testing of current and prospective employees as well as denial of employment to an HIV-positive person merely on the ground of HIV status, irrespective of the ability to perform the job requirements, is arbitrary, unreasonable, and illegal. Between 1986 and 1994, the petitioner MX was a casual laborer with ZY – a public sector corporation controlled by the national government of India. The ZY company required that casual laborers undergo medical test, and those determined to be medically fit were eventually employed on a permanent basis. In 1993, MX tested HIV-positive, but in all other respects was deemed healthy and fit for duty as a laborer. Despite this, the company removed MX from its waiting list of registered laborers. MX filed a lawsuit with the Bombay High Court of Judicature which found that ZY company infringed upon MX's constitutional right to equality. The judgment stressed the importance of non-discrimination in responding to HIV/AIDS in the following way: “[T]he State cannot be permitted to condemn the victims of HIV infection ... to certain economic death. It is not in the general public interest and is impermissible under the Constitution. The interests of the HIV-positive persons, the interests of the employer, and the interests of the society will have to be balanced in such a case. If it means putting certain economic burdens on the State or the public Corporations or the society, they must bear the same in the larger public interest.” The Court ordered that MX be immediately reinstated on the panel of casual laborers and be provided with work when available. It also ordered the company to pay MX back wages for the estimated amount of income lost since the date of his illegal dismissal.<sup>304</sup>

## Section II: Equality of PLHIV in Public and Private Life

### Factor 11: Public and Private Housing

**PLHIV enjoy equal access to adequate private and public housing, including residential facilities. Where appropriate, special measures are employed to provide reasonable accommodations for PLHIV and protect their rights in the place of residence. Segregation, exclusion, and coercive or punitive measures based on HIV status are prohibited.**

#### Introduction

Studies show many links between access to adequate housing and the enjoyment of the right to health, specifically in relation to HIV/AIDS. First, homelessness and unstable housing are associated with higher rates of HIV, poorer physical and mental health outcomes, more frequent violence, and decreased ability to reduce risk behaviors. Homeless and unstably housed persons are two to six times more likely to use hard drugs, share needles, or exchange sex than similar persons with secure housing. Furthermore, homeless or unstably housed PLHIV are more likely to have lower CD4 counts, higher viral loads, and higher mortality rates because they are less likely to initiate or adhere to ART regimens as well as access health care and social services. Conversely, appropriate housing promotes physical and mental health and improves health outcomes of PLHIV.<sup>305</sup>

PLHIV face many difficulties in obtaining public and private housing, including access to residential facilities, ability to rent apartments, and, due to potential community opposition and zoning out by restrictive bylaws, the ability to live in group homes. Additionally, low income, drug use, and recent incarceration act as barriers to housing.<sup>306</sup> Consequently, States should facilitate equal access of PLHIV to private and public housing and reduce various negative consequences of homelessness and inadequate housing. Elimination of barriers to housing, protection from eviction and segregation based on health status, as well as reasonable accommodations to those who need them, are indispensable.

#### International Standards and Commentary

##### Access to Adequate Housing

Adequate, i.e., safe, stable, and affordable housing, free from harassment and intimidation, is a basic human right of every person to acquire a secure place to live in peace and dignity.<sup>307</sup> The right to housing is a part of the right to an adequate standard of living, and is inextricably linked to the right to freedom from arbitrary or unlawful interference with one's home and privacy and other fundamental human rights, including rights to health, found a family, work, rest, food, and water.<sup>308</sup>

The UN Committee on Economic, Social, and Cultural Rights has noted that inadequate and deficient housing and living conditions are invariably associated with higher mortality and morbidity rates.<sup>309</sup> Consequently, it determined that housing is one of the underlying determinants of health and that States' core obligations relating to the right to health include ensuring access to basic shelter, housing, and sanitation.<sup>310</sup> In its General Comment No. 4, the UN Committee on Economic, Social, and Cultural Rights adopted a broad view

#### Examples of Compliance

- State provides low-income PLHIV with subsidized housing.
- State prohibits mandatory HIV testing as a precondition to access housing or residential facilities.
- Persons in residential facilities have equitable access to HIV-related services.

#### Examples of Non-Compliance

- HIV status is a fact requiring disclosure in real estate transactions.
- State condones forced evictions based on actual or perceived HIV status.
- PLHIV are routinely rejected by shelters and nursing homes.
- State refuses to grant building permits for the construction of special housing facilities for PLHIV.
- PLHIV are routinely segregated from the general population and/or placed in AIDS colonies.



of what constitutes adequate housing and stated that adequate housing must possess the following characteristics:

- **Legal security of tenure** which guarantees legal protection against forced eviction, harassment and other threats;
- **Availability** of services, materials, facilities and infrastructure;
- **Affordability**, which implies States' obligation to establish housing subsidies for those unable to obtain affordable housing, as well as forms and levels of housing finance which adequately reflect housing needs;
- **Habitability**;
- **Accessibility**, which includes States' obligations to: 1) accord full and sustainable access to adequate housing for disadvantaged groups, including PLHIV, who should be ensured some degree of priority consideration in the housing sphere; and 2) increase access to land by the landless and impoverished segments of the society.
- **Location**; and
- **Cultural adequacy**.<sup>311</sup>

The UN Committee on Economic, Social, and Cultural Rights stressed that the right to adequate housing applies to everyone. Therefore, enjoyment of this right must not be subject to any form of discrimination.<sup>312</sup>

The right to adequate housing is also embodied in International Guidelines which underline that the principle of non-discrimination is infringed when HIV status is used as the basis for differential treatment with regard to access to housing.<sup>314</sup> Examples of differential treatment include: 1) mandatory HIV testing and/or requirement of an HIV-free certificate as a precondition of access to housing; and 2) eviction and segregation on the basis of actual or perceived HIV status.

Finally, the principles of adequate shelter for all as well as equitable and sustainable human settlements are the cornerstones of the Habitat Agenda, which is a global plan of action drafted by the UN Human Settlements Programme (UN-HABITAT) and adopted in 1996 at the second UN Conference on Human Settlements.<sup>315</sup> The Habitat Agenda urges States not only to eliminate discrimination in housing, but also to provide equitable and sustainable access to adequate shelter and basic services, taking into account specific needs of vulnerable populations. Special accommodations for the underserved (including PLHIV) may include: targeted and transparent subsidies, various types of safety nets, and special living facilities and shelter solutions (residential facilities).<sup>316</sup>

The 2008 International Declaration on Poverty, Housing Instability and HIV/AIDS, presented by the National AIDS Housing Coalition and its partners at the 2008 International AIDS Conference, demands that policy makers address the lack of adequate housing as a barrier to effective HIV prevention, treatment and care, and that States fund and develop housing as a response to the HIV/AIDS epidemic.<sup>317</sup>

### Areas of Inquiry

- Do State policies address the links between poor health, HIV, and the lack of adequate housing?
- Does the State's housing policy address issues raised by HIV/AIDS?
- Does the State prohibit HIV-related discrimination in access to private and public housing?
- Does the State prohibit mandatory HIV testing as a precondition of access to housing?
- Does the State ensure that PLHIV enjoy security of housing tenure and equitable access to affordable, habitable, culturally appropriate, and safe housing, including emergency accommodation?
- Does the State provide public and/or subsidized housing to PLHIV with low income?

### ***Right to Adequate Housing***

The right of everyone to an adequate standard of living includes the right to adequate housing and to the continuous improvement of living conditions.

*UDHR art. 25; ICESCR art. 11; CEDAW art. 12; CRC art. 27*

States must devote utmost efforts to secure adequate housing for all sectors of the population.

*Charter of the Organization of American States art. 24*

States must prevent and reduce homelessness with a view to its gradual elimination, and to make the price of housing accessible to those without adequate resources.<sup>313</sup>

*European Social Charter*

No one should be subjected to arbitrary or unlawful interference with his home.

*UDHR art. 12; ICCPR art. 17; CRC art. 16; ECHR art. 8; ACHR art. 11*

- Does State ensure that PLHIV enjoy equal rights to land and home ownership, inheritance, and rental?
- Does the State protect PLHIV from harassment and other threats in the place of residence?
- Does the State protect PLHIV from forced evictions based on HIV status?
- What barriers in access to housing do PLHIV most commonly face? What measures are undertaken to eliminate these barriers?

## Access to Residential Facilities

The rights to life, health, adequate housing, privacy, and non-discrimination on the basis of HIV status require States to ensure that PLHIV have equitable access to public and private residential facilities that provide long-term shelter, treatment, and care for the elderly, the homeless, people with disabilities, orphans, victims of abuse or violence, and refugees. Actual or perceived HIV status should be irrelevant for the purposes of admission to residential facilities; thus, mandatory HIV testing as a precondition to access should be prohibited. Further, States should ensure that residential facilities provide PLHIV with access to HIV-related services and protection from HIV-related discrimination and all acts that increase the risk of HIV infection, such as rape and other forms of sexual violence or coercion. The importance of HIV prevention, free or affordable HIV testing, long- and short- term HIV and co-infections treatment, care, and support in public and private residential facilities should be recognized as a public health priority. Further, States should ensure that: 1) all residential facilities follow rigorous confidentiality protection protocols; and 2) persons employed in residential facilities receive training in the area of HIV in order to deal effectively with the special needs of PLHIV.

## Areas of Inquiry

- Does the State prohibit HIV-related discrimination in private and public residential facilities?
- Does the State prohibit mandatory HIV testing as a precondition to access to residential facilities?
- Does the State ensure that PLHIV enjoy equal treatment in all residential facilities?
- Does the State ensure that residential facilities protect the confidentiality of HIV status?
- Does the State ensure that residential facilities provide HIV-related services?
- Does the State ensure that PLHIV in residential facilities are protected against targeted violence, sexual abuse, discrimination, harassment, vilification, and other forms of victimization?
- Does the State ensure that staff of residential facilities receive education on tolerant and non-judgmental attitudes toward PLHIV as well as their special needs stemming from homelessness or social disadvantage?

## Coercive Measures

International Guidelines stress that coercive or punitive measures, such as segregation, quarantine, detention in special colonies, isolation, and other forms of deprivation of liberty based on HIV status are not justified by public health interests and constitute an arbitrary interference with PLHIV's right to liberty and security of person. Conversely, public health interests are served by integrating PLHIV within communities and benefiting from their participation in public and economic life. Where the liberty of PLHIV is restricted, States should guarantee them due process protection.<sup>318</sup>

### *Right to Liberty and Security of Person*

Everyone has the right to liberty and security of person. No one should be arbitrarily deprived of his or her liberty and/or subjected to arbitrary arrest or detention.

*UDHR art. 3; ICCPR art. 9; ECHR art. 5; Banjul Charter art. 6; ACHR art. 7*

## Areas of Inquiry

- Does the State prohibit arbitrary deprivation of liberty and other coercive or punitive measures, treatment, or interventions based solely on actual or perceived HIV status?

## Case Study

### Housing Opportunities for Persons with AIDS (HOPWA) in the US

In 1992, the U.S. Department of Housing and Urban Development instituted Housing Opportunities for Persons with AIDS in order to provide housing assistance and supportive services for low to moderate income persons with HIV/AIDS and their families. Funding is awarded to States or eligible metropolitan areas based upon the number of cumulative AIDS cases in that area, as determined by the Centers for Disease Control and Prevention. Currently, there are 29 states and 59 cities throughout the country that are qualified to receive funding. The funding goes to qualified residential facilities for PLHIV and to community-based organizations that provide supportive services to PLHIV. Money can be utilized for capital improvements, new construction, and facility renovations. There is no maximum length of stay for individuals at the facilities, and all provide staffing to assist residents. Another source of assistance available through HOPWA is short-term emergency housing assistance, which provides PLHIV with financial aid in paying their living expenses, such as rent, mortgages, and utilities, for a maximum period of five months.<sup>319</sup>

## Section II: Equality of PLHIV in Public and Private Life

### Factor 12: Entry, Stay, and Residence

**The State does not impose restrictions on the entry, stay, and residence of PLHIV based on HIV status. PLHIV are not returned to countries where they face persecution, torture, or other forms of cruel, inhuman, or degrading treatment. Migrants and mobile populations have equitable and sustainable access to comprehensive HIV-related services.**

#### Introduction

HIV-related restrictions on entry, stay and residence<sup>xii</sup> in a country remain common. In 2010, it was reported that 49 countries, territories and areas imposed some form of a travel restriction based on HIV status.<sup>320</sup> Five countries required declaration of HIV status for entry or stay, resulting for PLHIV in either a bar to entry or stay, or the need for a discretionary approval (e.g., through special visa waivers); five countries denied visas for even short-term stays; and 22 countries deported individuals once their HIV-positive status was discovered.<sup>321</sup> The deportation often took place without notice, leading to confinement in immigration detention, economic devastation, and separation from family and community. Some countries required mandatory HIV testing and/or for the purposes of entry, stay or residence; some countries recorded HIV-positive status in passports, visas, and other immigration documents; and some required periodic HIV tests for the renewal of visas or work permits.<sup>322</sup> In addition to being discriminatory, HIV-related travel restrictions can interfere with the rights to privacy, liberty, family life, freedom of association, health, the rights of migrant workers, and the principle of *non-refoulement*.<sup>323</sup> UNAIDS has called for the global freedom of movement for PLHIV and in 2010, set a goal of eliminating by 2015 HIV-related restrictions on entry, stay, and residence in half of the countries which have such restrictions.<sup>324</sup> UNAIDS, the International Organization for Migration [hereinafter IOM], and UNHCR have also called on States to scale up effective HIV responses for migrants and mobile populations,<sup>xiii</sup> nationals and non-nationals alike.

#### International Standards and Commentary

##### Entry, Stay, and Residence

States have the legal authority to control their borders and discretion to restrict entry into their country. However, States must apply due process protections and comply with international law which clearly prohibits discrimination on the basis of health status.<sup>325</sup> See Factor 4 above. In the context of economic migration, the right to non-discrimination is reiterated in the International Convention on the Protection of the Rights of All

#### Examples of Compliance

- State does not impose any HIV-related travel restrictions.
- State does not automatically deport PLHIV based on HIV status.
- States recognizes fear of persecution on account of HIV status as a ground for granting asylum.

#### Examples of Non-Compliance

- State returns PLHIV to countries where they face inhumane treatment based on HIV status.
- Migrants and refugees do not have access to ART.
- State does not address special HIV needs of mobile populations.

<sup>xii</sup> The term **HIV-related restrictions on entry, stay and residence** was adopted by the International Task Team on HIV-related Travel Restrictions convened in 2008 by UNAIDS to capture travel restrictions where: 1) HIV is a *formal and explicit* part of the law or regulation; 2) HIV is referred to *specifically*, apart from other comparable conditions; and 3) exclusion or deportation occurs because of *HIV-positive status only*. See UNAIDS, REPORT OF THE INTERNATIONAL TASK TEAM ON HIV-RELATED TRAVEL RESTRICTIONS: FINDINGS AND RECOMMENDATIONS 7 (2008).

<sup>xiii</sup> **Mobile populations** are people who move from one place to another temporarily, seasonally, or permanently for voluntary and non-voluntary reasons. Mobile populations include migrants, refugees, internally displaced people, and key employment groups involving mobility, such as truck drivers, seafarers, transport and agricultural workers, itinerant workers, and mobile employees of large industries. **Migrants** are mobile people who take up residence or who remain for an extended stay in a foreign country. See UNAIDS, POPULATION MOBILITY AND AIDS: TECHNICAL UPDATE 3 (2001).

Migrant Workers<sup>326</sup> and in the ILO Recommendation Concerning HIV/AIDS and the World of Work.<sup>327</sup> If a State invokes a public health exception to the obligation to treat all people equally, it must demonstrate a compelling reason for the limitation, and that it has chosen the least restrictive means necessary to achieve its public health goals.<sup>328</sup>

The principal justifications for HIV-related travel restrictions – the protection of public health and economic impact associated with HIV treatment and care – have been widely and thoroughly discredited by the global community.<sup>329</sup> As stated by the International Task Team on HIV-Related Travel Restrictions, convened in 2008 by UNAIDS [hereinafter International Task Team], HIV is transmissible, but not contagious in the sense of being spread by airborne particles or casual contact. Furthermore, there is no compelling evidence that either HIV-positive travelers can be assumed to engage in risky behavior or that their partners will not use protection.<sup>330</sup> Also International Guidelines clearly state that any restrictions based on HIV status on the rights to freedom of movement and to choose one's residence, including HIV screening of international travelers, immigrants, or asylum seekers, are discriminatory, violate the right to equal protection before the law, and cannot be justified by public health concerns.<sup>331</sup>

There are a number of reasons why restrictive measures may, in fact, be contrary to the public health interest. For example, there is evidence that, in order to avoid such restrictions, a number of PLHIV cease taking their medication when traveling.<sup>332</sup> This creates the risk of developing drug resistance and leads to a number of negative health outcomes.<sup>333</sup> Further, policies that target PLHIV exacerbate the stigmatization of HIV,<sup>334</sup> which may discourage nationals as well as non-nationals from availing themselves of prevention and treatment services.<sup>335</sup> This also gives rise to the misleading idea that HIV is a *foreign problem* that can be controlled through border control, rather than sound public health education and other prevention methods.<sup>336</sup>

Even if travel restrictions did serve to protect public interest, to be the least restrictive means to achieve that goal, the restrictions would have to be applied on the basis of individualized assessment, rather than as a blanket exclusion.<sup>337</sup> For example, if a State chooses to prohibit PLHIV from longer-term residency due to concerns about economic costs of HIV treatment and support, the exclusion or deportation should be based on an individual assessment of the actual costs that are likely to be incurred in the case of an individual alien. States cannot single out HIV/AIDS as opposed to other comparable conditions and economic considerations cannot override human rights considerations, such as family reunification, the right to seek asylum, or the right to humanitarian protection from *refoulement*.<sup>338</sup>

### **Mandatory HIV Screening**

In addition to the discriminatory premise of HIV-related travel restrictions, the manner in which individuals are screened for HIV frequently breaches international standards. In 2008, the International Task Team found that few migrants who are tested give informed consent to the test. Further, test results are often not kept confidential, nor is counseling nor referral to HIV-related services provided.<sup>339</sup> Testing under these conditions interferes with an individual's right to privacy and the highest attainable standard of health. See Factor 3 above. The ILO Recommendation Concerning HIV/AIDS and the World of Work expressly proscribes HIV testing of migrant workers and require that any results of such testing be kept confidential.<sup>340</sup> In line with their joint policy statement, UNHCR and IOM strictly oppose the use of mandatory HIV screening and any restrictions based on a refugee's HIV status by potential asylum or resettlement States.<sup>341</sup> Finally, UNAIDS and IOM recommend that HIV testing related to entry and stay in a country only be carried out with informed, voluntary consent; with pre- and post-test counseling; and with strict protection of confidentiality.<sup>342</sup>

**HIV-specific restrictions on entry, stay and residence based on HIV status are discriminatory, do not protect the public health and, if applied in a blanket manner, do not rationally identify those who may cause an undue burden on public funds.**

*UNAIDS, Report of the International Task Team on HIV-Related Travel Restrictions: Findings and Recommendations 5 (2008)*

**States are encouraged to eliminate HIV-specific restrictions on entry, stay and residence and ensure that people living with HIV are no longer excluded, detained or deported on the basis of their HIV status.**

*UN Human Rights Council, Resolution on the Protection of Human Rights in the Context of HIV/AIDS para. 4*

## Areas of Inquiry

- Does the State prohibit HIV-related discrimination of migrants and mobile populations?
- Does the State prohibit mandatory HIV screening and/or testing for the purposes of entry, stay, residence, or naturalization?
- Does the State ensure that HIV testing of migrants is undertaken only with informed consent, counseling, confidentiality, and referral?
- Does the State restrict PLHIV's entry, stay, or residence in the country based on HIV status? If yes, are these restrictions applied on the basis of an individualized assessment or as a blanket policy? Does the State take any measures to repeal HIV-related travel restrictions?
- Does the State refrain from using HIV status as a sole ground for deportation of PLHIV?

## Non-Refoulement and Asylum

The principle of *non-refoulement*<sup>xiv</sup> establishes a prohibition on the return of a person to a State where there are substantial grounds for believing that the person would face a real risk of torture or other cruel, inhuman, or degrading treatment or punishment. This principle has been clearly articulated in international and regional human rights treaties, including CAT and the UN Convention Relating to the Status of Refugees.<sup>xv</sup> Further, the UN Human Rights Committee has interpreted the prohibition of torture and cruel, inhuman or degrading treatment and punishment under ICCPR to include *non-refoulement*. Finally, the principle of *non-refoulement* is deemed to have risen to the level of international customary law.<sup>343</sup> See also Factor 22 below. Similarly, the right of to seek and enjoy asylum from persecution is enshrined in international and regional human rights instruments, including UDHR and the above-mentioned UN Convention Relating to the Status of Refugees.<sup>344</sup>

Some States require asylum seekers and people who apply for humanitarian protection to undergo mandatory HIV testing and, in the event of positive test results, automatically deport them to the countries of origin. These practices contradict the principle of *non-refoulement*, which has been explicitly reiterated in International Guidelines and a number of policy documents issued by the International Task Team and UNHCR. Accordingly, HIV status: 1) is not a ground for any exception to the principle of *non-refoulement*; 2) does not fall within the permitted grounds for expulsion to a third country; and 3) does not constitute a bar to accessing asylum procedures. Further, there is also no justification for HIV screening being used to exclude HIV-positive individuals from being granted asylum. Lastly, refugees and asylum seekers should not be targeted for special measures regarding HIV infection.<sup>345</sup>

### ***Principle of Non-Refoulement and the Right to Seek Asylum***

No State shall expel, return ("refouler") or extradite a person to another State where there are substantial grounds for believing that he would be in danger of being subjected to torture.

*CAT art. 3*

No State shall expel or return a refugee in any manner whatsoever to the frontiers of territories where his life or freedom would be threatened on account of his race, religion, nationality, membership in a particular social group or political opinion.

*UN Convention Relating to the Status of Refugees art. 33*

Everyone has the right to seek and to enjoy in other countries asylum from persecution.

*UDHR art. 14*

<sup>xiv</sup> The European Court of Human Rights (ECHR) and the Inter-American Commission on Human Rights have each issued a landmark decision where the principle of *non-refoulement* was used to protect PLHIV from deportation on the basis of human rights. In a landmark 1997 case *D v. United Kingdom*, ECHR found that a State may, in very exceptional cases, violate prohibition of inhumane treatment if it deports a severely ill person with HIV to a State where adequate treatment is unavailable and where there is no family to care for him or her. It needs to be noted, however, that the "exceptional" standard has since been narrowly interpreted by ECHR. For example, it excludes cases where HIV treatment is, in principle, available in the receiving country and where the disease has not reached a terminal stage. The Inter-American Commission on Human Rights has also used a three-prong threshold test to recommend that the United States refrain from deporting an HIV-positive individual to Jamaica. The test included: 1) extraordinary hardship; 2) availability of medical care in the receiving country; and 3) availability of social services and support, in particular the presence of close relatives. See HUMAN RIGHTS WATCH, RETURNED TO RISK: DEPORTATION OF HIV-POSITIVE MIGRANTS 7-9 (2009).

<sup>xv</sup> **Refugees** are people who have fled their homes and crossed an international border to escape persecution or conflict. **Asylum-seekers** are people who have made a claim to be recognized as refugees and are waiting for that claim to be accepted or rejected. See UNHCR, Asylum-Seeker Figures, at: <http://www.unhcr.org/pages/49c3646c20.html>.

Moreover, there is an increasing acceptance among States that a well-founded fear of persecution on account of HIV status can provide the basis for claiming refugee or asylum status, and that humanitarian medical grounds should be accepted as the basis for allowing residence.<sup>346</sup> For example, some States have held that HIV status can form the basis of membership in a particular social group for the purposes of a claim based on the UN Convention Relating to the Status of Refugees.<sup>347</sup> This approach is supported by International Guidelines.<sup>348</sup> It needs to be noted, however, that in many of these cases asylum seekers have had to demonstrate that they would endure *extreme harm* based on HIV if returned to the country of origin.<sup>349</sup>

### Areas of Inquiry

- Does the State adhere to the principle of *non-refoulement* without any exceptions?
- Does the State ensure that the rights to seek and enjoy asylum are not restricted based on HIV status?
- Does the State recognize that a well-founded fear of persecution on account of HIV status can provide the basis for claiming refugee or asylum status?

### Access to HIV-Related Services

In the Declaration of Commitment, States pledged to develop and implement strategies aimed at facilitating access to HIV-related services for migrants and mobile workers.<sup>350</sup> The importance of providing access to HIV programs for migrants and mobile populations – nationals and non-nationals alike – has been also emphasized in International Guidelines and other standard-setting documents produced by UNAIDS, UNHCR, and the IOM.<sup>351</sup> Further, the UN Committee on Economic, Social, and Cultural Rights has affirmed the right of migrants to the same health services as nationals of any State.<sup>352</sup> Even so, reports persist of PLHIV dying while being held in immigration detention where treatment was denied.<sup>353</sup> This underlines the vulnerability of populations who no longer have the protection of their country of origin and do not qualify for assistance in the country of destination.

UNAIDS emphasizes that HIV vulnerability of migrants and mobile populations is not created by being mobile in and of itself. Instead, it is formed by situations, behaviors, and structural barriers that these populations may encounter while in transit, at destination, or on their return home. These risk factors may include instability, illegal status, cultural and linguistic barriers, xenophobia, marginalization, exploitation, and unfamiliarity with the new community. Therefore, it is important that States address HIV needs of these populations at each stage of the mobility process: before they leave, as they travel, in communities and countries where they stay, and after they return home.<sup>354</sup>

UNAIDS has concluded that from a public health and programmatic perspective it is most effective and efficient to

**States may not return a refugee to persecution on the basis of his or her HIV status. Furthermore, where the treatment of PLHIV can be said to amount to persecution, it can provide a basis for qualifying for refugee status.**

*International Guidelines para. 129*

**HIV-related restrictions on entry, stay and residence should not result in the denial of the right to seek asylum, the right to be protected from refoulement or other rights applicable to refugees and asylum-seekers.**

*UNAIDS, Report of the International Task Team on HIV-Related Travel Restrictions: Findings and Recommendations 6 (2008)*

### ***Suggested HIV Actions for Migrants and Mobile Populations***

In 2001, UNAIDS recommended that States take the following action with respect to migrants and mobile people: (1) put migrants and mobile people into HIV strategic planning and into national and community HIV plans; (2) establish culturally and linguistically appropriate outreach and peer counseling; (3) support associations of migrants and help them integrate HIV/AIDS strategies into their work; (4) focus HIV prevention efforts in zones where there is increased likelihood of risk behaviors (e.g., truck stops, bus and train stations, harbors, and markets); (5) implement programs that cross national borders; (6) implement pre-departure briefings, and post-arrival and reintegration programs; (7) improve the legal status of, and legal support for, migrants and their families; (8) work with those who employ migrants to improve their living and health conditions; (9) make local health care facilities more accessible and user-friendly to migrants and mobile people; and (10) conduct operational research on the links between migration, mobility, and HIV/AIDS.

*UNAIDS, Population Mobility and AIDS: Technical Update 2 (2001)*

integrate HIV-related needs of mobile populations into existing health programs and HIV responses.<sup>355</sup> In relation to refugees, it is recommended that States develop and sustain regional initiatives that ensure continuity in HIV services across state borders.<sup>356</sup>

## Humanitarian Settings

People affected by humanitarian crises face acute HIV vulnerabilities. Conflict, displacement, instability, and food insecurity provide fertile ground for the spread of HIV. The risks are only intensified by violence and sexual abuse which are frequently used as weapons of war and which are common in camps for refugees and internally displaced people. Further, PLHIV in humanitarian settings often suffer from disruption of treatment, care, and support.<sup>357</sup>

In 2009, the Inter-Agency Standing Committee<sup>xvi</sup> issued revised Guidelines for Addressing HIV in Humanitarian Settings to help guide those involved in emergency response, and those responding to the epidemic, to plan the delivery of a minimum set of HIV interventions. The Guidelines propose a matrix of essential HIV interventions which include: 1) raising HIV awareness and empowering communities; 2) preventing HIV transmission in health-care settings; 3) providing access to good-quality condoms; 4) providing post-exposure prophylaxis for occupational and non-occupational exposure (e.g., in the clinical management of rape survivors); 4) managing STIs; 5) preventing vertical transmission; 6) providing ART to those in need; 7) providing basic health care and support to key populations at higher risk; 8) protecting against HIV-related human rights violations; 9) protecting orphans and unaccompanied, separated and other vulnerable children and youth; 10) protecting the population from gender-based violence; 11) ensuring food security, nutrition and livelihood support; 12) providing nutritional support to PLHIV; 13) promoting access to relevant and protective education for all children and young people; 14) integrating HIV in shelter activities, in camp coordination, and in camp management; and in water, sanitation and hygiene programs; and 16) implementing HIV in workplace programs.<sup>358</sup>

## Areas of Inquiry

- Does the State integrate HIV-related needs of migrants and mobile populations into existing health care programs and HIV responses?
- Does the State ensure that migrants and mobile populations have equitable and sustainable access to comprehensive HIV-related services?
- Does the State ensure that HIV-related programs are culturally and linguistically appropriate?
- Does the State ensure that migrants have access to the same HIV-related services as nationals?
- Does the State focus HIV prevention efforts in zones where mobile populations are at increased likelihood of HIV risk behaviors?
- If the State faces a humanitarian crisis, do those involved in emergency response implement at least a minimum set of HIV interventions?

## Case Study

### Integrated HIV-Related Services for Refugees in Guinea

In Guinea, the Government provided refugees with access to the local health care system on a fee-for-service basis and used UNHCR funding for refugee health care to set up new health centers and upgrade existing services in areas where refugees had settled. These integrated health care services relieved the Government and aid agencies from the expense of creating a parallel health care system in refugee camps, lowered the cost of providing treatment and care to the refugee population, and also benefited the local Guinean communities which gained better access to improved HIV-related services. By integrating refugee issues into the general public health system, the Government avoided adding to the misconception – and associated stigma – that HIV is a foreign problem or only an issue for refugees.<sup>359</sup>

---

<sup>xvi</sup> The Inter-Agency Standing Committee is the primary mechanism for facilitating interagency decision-making in response to complex emergencies and natural disasters. It comprises representatives of UN and non-UN humanitarian partners.



## Section II: Equality of PLHIV in Public and Private Life

### Factor 13: Non-Criminalization of HIV Exposure and Transmission

**HIV exposure and non-intentional transmission are not criminalized. Deliberate and intentional transmission of HIV is prosecuted under general rather than HIV-specific criminal law.**

#### Introduction

Criminalization of PLHIV by overly broad application of criminal law in cases of HIV exposure and transmission presents significant challenges to the AIDS response.<sup>360</sup> Many countries have chosen to prosecute HIV exposure (which did not lead to HIV transmission) and both intentional and non-intentional transmission, by specifically designed provisions, or by general laws governing assault causing bodily harm. Some countries have applied these provisions to criminalize mother-to-child transmission, failure to disclose HIV status to sexual partners, and even alleged exposure through spitting, scratching, and biting.<sup>361</sup> Many countries have initiated HIV-related prosecutions, and some 60 countries and judicial territories have recorded convictions. Nearly as many have recently enacted, or are considering enacting, HIV-specific criminal laws. In many instances, people have been convicted in cases where HIV has not been transmitted, or in cases which included little or no risk of transmission. In some countries the law criminalizes any acts "likely to cause danger;"<sup>362</sup> in others, it denies a right to consent to a risk which might result in HIV transmission.<sup>363</sup>

#### International Standards and Commentary

##### HIV Exposure and Transmission

**Criminal and/or public health legislation should not include specific offences against the deliberate and intentional transmission of HIV but rather should apply general criminal offences to these exceptional cases. Such application should ensure that the elements of foreseeability, intent, causality, and consent are clearly and legally established to support a guilty verdict and/or harsher penalties.**

*International Guidelines, Guideline 4*

HIV-specific criminal laws as well as: 1) prosecution for exposure without transmission; 2) prosecution for transmission without intent; and 3) prosecution for non-disclosure of HIV status have been rejected by experts and international organizations as counterproductive to HIV prevention efforts. According to experts, there is no data indicating that the broad application of criminal law to HIV exposure and transmission will achieve criminal justice or public health goals by preventing HIV transmission. There is no data demonstrating that the threat of criminal sanctions significantly changes or deters risky behaviors.<sup>364</sup> There is also no correlation between HIV prevalence and the willingness of States to use punitive measures to regulate HIV transmission.<sup>365</sup> Finally, there is no compelling evidence that incarceration positively modifies HIV risk behaviors. First, high-risk practices are common throughout prisons worldwide. Second, the rehabilitative effect of incarceration in cases of unintentional transmission is questionable because there is no criminal behavior amenable to rehabilitation.<sup>366</sup> Consequently, UNAIDS and the UN Special Rapporteur on the Right to Health have urged States to limit criminalization to cases of intentional transmission, and to immediately repeal laws criminalizing unintentional

#### Examples of Compliance

- State does not criminalize exposure to, or unintentional transmission of, HIV.
- State applies general criminal law to prosecute malicious transmission of HIV.

#### Examples of Non-Compliance

- State does not take steps to establish malicious intent while prosecuting cases of HIV transmission.
- State puts HIV-positive individuals in discordant couples at risk of prosecution, even when the partners know each other's HIV status.
- State prosecutes mothers for vertical transmission of HIV.
- State criminalizes HIV exposure regardless of actual transmission.

transmission of, or exposure to, HIV. States have also been urged to reconsider the use of specific laws criminalizing intentional transmission of HIV.<sup>367</sup>

UNAIDS and experts agree that broad application of criminal law to HIV exposure and unintentional transmission has numerous negative consequences. It:

- Infringes on the rights of PLHIV, contributes to HIV-related discrimination, disrupts lives, and seriously undermines public health goals;
- Exposes large numbers of people to possible prosecution without them being able to foresee their criminal liability;
- Discourages voluntary HIV testing, since ignorance about one's status might be seen as the best defense in case of prosecution;
- Places legal responsibility for HIV prevention exclusively on PLHIV, thus undermining the public health message of shared responsibility for safer behaviors;
- Creates a false sense of security because people may wrongly assume that their partners are HIV-negative if they did not disclose their status as required;
- Reinforces the stereotype that PLHIV are immoral and irresponsible;
- Deters PLHIV from using health care services;
- Increases the risk of violence directed towards affected individuals, particularly women.<sup>368</sup>

In addition, the relevant criminal provisions are likely to be disproportionately applied to people belonging to ethnic minorities, migrants, and key populations, because these groups are often blamed for transmitting HIV.

According to UNAIDS, instead of applying criminal law to HIV exposure and transmission, States should expand programs which have been proved to reduce the spread of HIV while protecting human rights of both PLHIV and people who are HIV-negative. Such measures should include addressing HIV-related discrimination, which is necessary in order to encourage people to disclose their HIV-positive status without the fear of prosecution or other negative consequences.

### **Intentional Transmission of HIV**

Cases where criminal law has a role to play in prosecuting HIV transmission have to be carefully defined. HIV-positive individuals should not bear all the responsibility in cases of negligent exposure or transmission. Therefore, prosecution is justified only in cases which meet all of the following criteria: 1) a person knows his or her positive HIV status; 2) the person acts with malicious intent to transmit HIV (i.e., intentionally engages in risky behavior to harm an unknowing partner); and 3) transmission of HIV does, in fact, occur.<sup>369</sup>

**UNAIDS urges governments to limit criminalization to cases of intentional transmission i.e. where a person knows his or her HIV positive status, acts with the intention to transmit HIV, and does in fact transmit it.**

*UNAIDS, Criminalization of HIV Transmission: Policy Brief 1 (2008)*

Criminal law should not be applied where: 1) there was no significant risk of transmission; 2) intent to transmit HIV cannot be proved; 3) the person attempted to transmit HIV but the transmission did not occur; 4) the person did not know that she or he was HIV positive or did not understand how HIV is transmitted; 5) the person disclosed his or her HIV-positive status to the person at risk (or honestly believed the other person was aware of his/her status through some other means); 6) the person did not disclose his or her HIV-positive status because of fear of violence or other serious negative consequences; 7) the person took reasonable measures to reduce risk of transmission, such as practicing safer sex through using a condom or other precautions to avoid higher risk acts; and/or 8) the person previously agreed on a level of mutually acceptable risk with the other person.<sup>370</sup>

Experts point out that each element of the crime of intentional transmission of HIV is difficult to prove legally and epidemiologically. Establishing who transmitted HIV is often difficult because both parties may have had more than one sexual or needle-sharing partner. Testing can only determine the degree of relatedness of two samples of HIV and cannot establish beyond a reasonable doubt the source, route, or timing of infection.

Therefore, an assessment of risk is always necessary, taking into account evidence-informed scientific data.<sup>xvii</sup>

In several countries prosecutions have been brought against women for vertical transmission of HIV. UNAIDS and the UN Special Rapporteur on the Right to Health stress that criminalizing vertical transmission is always inappropriate because: 1) everyone has the right to have children, including women living with HIV; 2) almost all pregnant women who are counseled about the benefits of ART agree to being tested and receiving treatment; 3) women who are reluctant to undergo HIV testing or treatment often fear HIV-related violence, discrimination or abandonment; 4) forcing women to undergo ART violates the legal requirement that medical procedures be performed only with informed consent; and 5) HIV-positive mothers often have no safer options than to breastfeed, because they lack milk substitutes or clean water to prepare formula.<sup>371</sup>

UNAIDS underlines that if a violent offence results in HIV transmission, or creates a significant risk of transmission, the HIV status of the offender may legitimately be considered an aggravating factor in sentencing only if the person knew that he or she was HIV positive.<sup>372</sup>

Furthermore, UNAIDS urges States to: 1) ensure that criminal law is not used inappropriately in the context of HIV (e.g., to target or punish people simply because of their HIV-positive status or membership in a particular social group); 2) limit police and prosecutorial discretion in application of criminal law by clearly and narrowly defining *intentional* transmission; by stipulating that an accused person's responsibility for HIV transmission be clearly established beyond a reasonable doubt; and by clearly indicating circumstances that should mitigate against criminal prosecution; and 3) ensure that any application of general criminal law to HIV transmission is consistent with international human rights law.<sup>373</sup>

Evidence shows that cases of intentional and malicious exposure or transmission of HIV are rare and most PLHIV who know their status take steps to prevent transmitting HIV to others.<sup>374</sup> Using general criminal laws in these infrequent cases is preferable to creating specific offences connected with HIV. Regardless of how intentional HIV transmission is governed in the legal framework, States must ensure that relevant penalties be proportionate to the crime committed.

### Areas of Inquiry

- Does the State have HIV-specific criminal law? If yes, what does it entail? Has the State taken any measures to repeal it?
- What types of HIV-related cases does the State prosecute and under what type of law?
- In how many and what types of HIV-related cases has the State achieved convictions?
- Does the State reject broad application of criminal law to prosecute HIV exposure and non-intentional transmission of HIV?
- Does the State reject broad application of criminal law to prosecute vertical transmission of HIV?
- Does the State restrict HIV-related prosecutions to exceptional cases of deliberate transmission of HIV?
- Does the State take all the necessary steps to establish malicious intent to transmit HIV in such cases?
- What defense to criminal liability in HIV-related cases does the State allow?
- Does the State ensure that penalties for HIV transmission are proportionate to the crime committed?

### Duty to Disclose HIV Status

In the Political Declaration, States pledged to promote a social and legal environment that is supportive of and safe for voluntary disclosure of HIV status.<sup>375</sup> People have an ethical obligation not to harm others. This does not mean, however, that States should impose a legal duty to disclose HIV status to health care workers, government officials, or sexual partners. Focusing on disclosure is not supported by international standards, because it fails to take into account the many reasons why people are unable or unwilling to

---

<sup>xvii</sup> HIV transmission during sex is not automatic. The risk varies according to many factors, such as type of sexual activity, infectiousness of a person (which decreases if a person undergoes ART), and presence of abrasions or STIs. Studies show that risk of HIV transmission from an insertive partner to a receptive partner during oral sex is estimated as ranging from zero to a risk of one in 2500. Risk for the insertive partner is so low that it is impossible to calculate. Risk of transmission from a man to a woman during single instance of vaginal intercourse is between 1 in 1250 to 1 in 333. Risk of transmission from a woman to a man is between 1 in 2500 to 1 in 263. Risk of transmission during unprotected anal intercourse is higher: between 1 in 122 and 1 in 70. See GLOBAL NETWORK OF PEOPLE LIVING WITH HIV (GNP+), THE GLOBAL CRIMINALIZATION SCAN REPORT 2010 at 21 (2010).

disclose their HIV status. Therefore, States should repeal laws directly mandating disclosure of HIV status and criminalizing the failure to disclose. Instead, States should empower PLHIV to practice safer sex and/or voluntarily disclose their status in safety.<sup>376</sup>

**UNAIDS does not support a legal obligation to disclose one's HIV-positive status. Everyone has the right to privacy about their health and should not be required by law to reveal such information, especially where it might lead to serious stigma, discrimination and possibly violence, as in the case of HIV status.**

*UNAIDS, Criminalization of HIV Transmission: Policy Brief 4 (2008)*

### **Areas of Inquiry**

- Does the State impose a legal duty to disclose HIV status?
- Does the State criminalize the failure to disclose HIV status?
- What measures are undertaken to repeal laws that create a legal duty to disclose HIV status?

### **Case Study**

#### **Use of Condom as a Defense to the Criminal Charge of HIV Exposure**

In the 2005 case *New Zealand Police v. Dalley*, the accused was charged with endangering his partner's health by exposing her to HIV. The accused had used a condom but had not informed his partner of his HIV-positive status. No HIV transmission occurred. The judge determined that the use of condom was sufficient to constitute reasonable precautions and care to avoid the transmission of HIV. The accused was found not guilty.<sup>377</sup>

## Section III: Key Populations

### Factor 14: Women

**The State takes all appropriate measures to reduce specific HIV vulnerabilities of women, eliminate HIV-related discrimination against them, and provide them with equitable and sustainable access to comprehensive HIV-related services.**

#### Introduction

Every day more than 3,000 women and girls become infected with HIV,<sup>378</sup> which constitutes the leading cause of death and disease among women of reproductive age (15-49 years).<sup>379</sup> It is estimated that worldwide women comprise 50% of PLHIV, while in Africa women account for nearly 60% HIV infections.<sup>380</sup> In many African countries, young women (aged 15-24) are three to six times more likely to be infected than young men.<sup>381</sup> HIV prevalence is significantly higher among women who are divorced or widowed, and among women who face multiple layers of vulnerability, such as migrants and women who use drugs and/or engage in commercial sex acts.<sup>382</sup>

Across the globe, women confront manifold violations of their human rights<sup>383</sup> which significantly impact their ability to protect themselves from and cope with HIV/AIDS. Women's vulnerability to HIV is multi-dimensional. Among the most prevalent factors that create, increase, or reinforce women's susceptibility and vulnerability to HIV/AIDS are:

- Biological, physiological, and health-related factors,<sup>xviii</sup> including poor sexual and reproductive health;<sup>384</sup>
- Inequality and stereotyped gender norms entrenched in the political, legal, economical, social, and cultural systems.

Discrimination against women in public and private life constitutes both the cause and the consequence of contracting HIV and manifests itself through: 1) a gender gap in education; 2) inequality in family and sexual life; 3) violence against women and harmful traditional practices; 4) barriers to health care; and 5) inequality in economic relations. Women are more likely than men to be stigmatized as "vectors of disease" or immoral and promiscuous for contracting HIV, irrespective of the source of infection.<sup>385</sup> They are also frequently blamed for causing the deaths of their husbands and spreading the epidemic. Lastly, women are more likely to care for their ill family members, which increases the need for resources and contributes to the feminization of poverty.

#### Examples of Compliance

- State implements a national strategy on women and HIV/AIDS.
- Portion of the national HIV budget is allocated to programs focused on women.
- State facilitates female-focused HIV prevention and stigma-reduction programs.

#### Examples of Non-Compliance

- Women need permission from male guardians to access HIV-related services.
- Women widowed by AIDS routinely lose their property and inheritance rights.
- Women lack access to life-skills based sex education and HIV information.

<sup>xviii</sup> Biologically women are up to eight times more likely to acquire HIV during an unprotected heterosexual intercourse than men. Biological factors that increase women's vulnerability to HIV/AIDS include: 1) larger mucosal surface area in the female genital organs, 2) higher concentration of HIV in semen than in vaginal fluids, and 3) greater exchange of semen than vaginal fluids during sex. HIV transmission risk is higher in presence of untreated vaginal trauma and STIs which give the HIV easy access into the bloodstream. Vaginal trauma can be incurred during childbirth, sexual intercourse, and female genital mutilation rituals. Vulnerability is also increased among girls and young women who have immature reproductive tracts.

## International Standards and Commentary

### Strategy on Women and HIV/AIDS

The international community has recognized that: 1) the global HIV/AIDS epidemic disproportionately affects women and girls and reinforces gender inequalities; that 2) gender equality and empowerment of women are fundamental not only to reducing women's susceptibility to HIV but also to reversing the epidemic in its totality;<sup>386</sup> and 3) a human rights-based approach is indispensable to effectively address the intersection of gender and HIV.<sup>387</sup> The international community has further agreed that the overall expansion and feminization of the HIV epidemic necessitates urgent and holistic action across all international development goals. Consequently, a comprehensive, gender-transformative response to HIV/AIDS must encompass an accelerated development and implementation of multisectoral and coordinated national strategies that address gender dimensions of HIV/AIDS. The overarching goal is to alleviate women's complex HIV vulnerabilities by increasing their ability both to protect themselves from HIV infection and to mitigate the impacts of HIV/AIDS, including HIV-related discrimination.<sup>388</sup>

UNAIDS has made meeting the needs of women and girls and stopping gender-based violence one of its ten priority areas and in 2010, set a goal for 2015 of having HIV-specific needs of this population addressed in at least half of national HIV responses. UNAIDS has also proclaimed a policy of zero tolerance for gender-based violence.<sup>389</sup>

In line with gender-specific recommendations formulated in the Declaration of Commitment, Political Declaration, International Guidelines, Beijing Declaration and Platform of Action, Resolution on Women, the Girl Child and HIV/AIDS, and the UNAIDS Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV (2010-2014),<sup>xx</sup> States should:

- Promote equality, women's rights, and an enabling environment for women's empowerment;
- Eliminate all forms of discrimination against women, including violence and harmful practices;
- Implement a gender-sensitive response to HIV/AIDS;
- Reflect the gender dimension of the epidemic in all national HIV policies, strategies, and budgets;
- Ensure women's leadership and full involvement in the decision-making related to the design, implementation, and evaluation of HIV programs;
- Provide women with effective protection from HIV-related discrimination;
- Ensure women's equal access to HIV-related services;
- Facilitate community dialogue on women, equality, and HIV/AIDS;
- Provide support to women's organizations and networks of women living with HIV;
- Support research on safe, affordable, and effective HIV prevention methods controlled by women.

#### ***Right to Non-Discrimination***

Women have the right to be free from discrimination, i.e., any distinction, exclusion, or restriction made on the basis of sex. States are obliged to pursue a policy of eliminating discrimination against women by any person, organization, or enterprise (including public institutions), through all appropriate measures. States must also ensure the full development and advancement of women as well as effective protection of women against any acts of discrimination. In particular, States must modify or abolish laws, regulations, customs, practices, as well as the social and cultural patterns of conduct that are based on the idea of the inferiority of either of the sexes or on stereotyped roles for men and women.<sup>xix</sup>

*CEDAW arts. 1-5*

<sup>xix</sup> The principle of non-discrimination on the basis of sex is also enshrined in other human treaties and declarations, including UDHR, ICCPR, ICESCR, ECHR, ACHR, the Banjul Charter and its Protocol on the Rights of Women in Africa.

<sup>xx</sup> UNAIDS, AGENDA FOR ACCELERATED COUNTRY ACTION FOR WOMEN, GIRLS, GENDER EQUALITY AND HIV (2010-2014) was drafted by the Global Task Force on Women, Girls, Gender Equality and HIV comprised of high-level leaders and experts from 51 countries and diverse constituencies representing civil society, women's organizations, networks of women with HIV, government, academia, and the UN system. The document was launched in 2010 as an operational plan supporting the UNAIDS, ACTION FRAMEWORK: ADDRESSING WOMEN, GIRLS, GENDER EQUALITY AND HIV issued in 2009. The Action Framework focuses on action in three areas: 1) Know your epidemic and response in gender terms; 2) Addressing women and girls in plans and budgets; and 3) Strengthen advocacy, capacity, and mobilization of resources.

To accomplish these objectives, States must know their national epidemic in gender terms. Therefore, they should: 1) collect and analyze epidemiological and qualitative data disaggregated by sex; and 2) examine the social, developmental, economic, and health impact of HIV/AIDS on gender equality with an aim to design a well-tailored response addressing the unique needs of women and men.<sup>390</sup>

### Areas of Inquiry

- Does the State have a strategy aimed at empowering women and eliminating all forms of discrimination against them? Is the strategy sufficiently strong to advance women's rights in the context of HIV/AIDS?
- Does the State recognize women as a key population in the context of HIV/AIDS?
- Does the State allocate a specific budget for HIV programs focusing on women?
- Does the State implement and support gender-sensitive HIV programs and policies? Does the State involve women in their design and implementation?
- Does the State implement and support gender-sensitive HIV trainings for judicial and law enforcement officers as well as social workers and health care providers?
- Does civil society play an active role in addressing HIV vulnerabilities of women?
- Does the State provide support for CSOs that implement programs on HIV-related women's rights?
- Does the State conduct or facilitate gender analyses of the HIV/AIDS epidemic?
- Does the State promote international and multisectoral cooperation in the area of women and HIV?

### Reduction of Vulnerability and Elimination of Discrimination

#### Education

HIV infection rates are at least twice as high among women who do not finish primary school as among those who do.<sup>392</sup> Yet, in indigent families boys often have priority in accessing education; additionally, in areas significantly affected by HIV/AIDS, many girls either do not attend school at all or leave school early to care for their ill parents or relatives. Furthermore, women tend to have very limited access to sex education and HIV information, which is associated with socio-cultural norms dictating women to remain ignorant about sexual matters. Given the profound correlation between gender gap in education and women's vulnerability to HIV, international standards urge States to: 1) remove all barriers to women's and girls' access to education; 2) provide women and girls with life-skills based sex education; 3) intensify efforts in raising women's awareness about HIV/AIDS; and 4) address the situation of women and girls who drop out from school due to HIV/AIDS.<sup>393</sup>

#### ***Right to Equality in Education***

Women have equal rights with men in the field of education. This includes: 1) the right to equal educational opportunity; 2) elimination of any stereotyped concept of the roles of men and women at all levels and in all forms of education; 3) reduction of female student drop-out rates; and 4) access to specific information that helps women protect the health and well-being of their families.<sup>391</sup>

*CEDAW art. 10*

#### Family and Sexual Life

Women's inequality in family and sexual life significantly limits their ability to protect themselves from HIV infection and cope with socio-economic impacts of HIV/AIDS. States should therefore eliminate discriminatory social and cultural norms leading to women's subordination and inferiority within family structures.<sup>xxi</sup> In particular, States should: 1) promote shared responsibility of men and women to ensure safe sex; 2) protect women's right to have control over, and decide freely on, matters related to their sexuality (including the right to decline sex; negotiate terms of sexual relationship or safer sexual practices; and use female-

#### ***Right to Equality in Family Life***

States must eliminate discrimination against women in all matters relating to marriage and family relations.

*CEDAW art. 16*

<sup>xxi</sup> Discriminatory social and cultural norms include those that: 1) condone male promiscuity while demanding women's passivity and compliance in sexual relations; 2) lead to women's financial and emotional dependence on male partners; and 3) endorse patriarchal decision-making and ownership of family resources.

controlled HIV prevention methods); 3) prohibit forced marriage and remarriage; and 4) remove legal impediments to obtaining separation or divorce.<sup>394</sup>

### **Violence and Harmful Traditional Practices**

Violence against women<sup>xxii</sup> and harmful traditional practices seriously inhibit women's ability to enjoy human rights, are harmful to women's health, and place them at high risk of HIV infection,<sup>397</sup> particularly if they lead to, or increase the likelihood of, trauma to the vagina or anus. These practices include sexual violence (particularly if it involves forced or coerced sexual penetration); early marriage, sexual initiation, and pregnancy; use of drying agents in the vagina; and female genital mutilation. The risk of infection is even greater if unsterile equipment is used in the cutting rituals. Other practices, customs, and rituals which carry enhanced risk of HIV infection include: 1) trafficking in persons; 2) polygamy, which creates concurrent sexual networks between a husband and his multiple wives;<sup>398</sup> 3) wife inheritance by male relatives of the diseased husbands; and 4) widow cleansing involving sexual contacts with designated cleansers or the late husbands' relatives.<sup>xxiii</sup> Experts underline that violence or fear of violence may intimidate women from: 1) disclosing HIV status and seeking HIV-related services; 2) declining sex or negotiating safer sexual practices; and 3) leaving risky relationships. Accordingly, violence may both augment women's vulnerability to HIV infection and constitute one of the psychosocial consequences of disclosure of HIV-positive status. International law requires States to eliminate all forms of violence against women. States should address violence against women and harmful traditional practices as an integral part of the national AIDS response.<sup>399</sup> Among others, States should ensure that government officials as well as community and religious leaders are well-educated about the links between violence against women and the spread of HIV.

### **Economic Life**

Across the globe, women endure profound disrespect for their economic rights, which promotes women's economic vulnerability to HIV by limiting their access to HIV-related services.<sup>400</sup> This is particularly true in situations where HIV stigma and ostracism prevent women from obtaining assistance from their families and communities. Women's economic vulnerability to HIV results primarily from: 1) inability to obtain or sustain employment; 2) employment in low-paying and insecure occupations; 3) greater domestic responsibilities; 4) inability to conclude contracts and own,

### ***Right to be Free from Violence and Harmful Traditional Practices***

States are required to suppress trafficking in persons and all other forms of violence against women. The betrothal and the marriage of a child are prohibited. States are required to specify a minimum age for marriage and to make the registration of marriages in an official registry compulsory. States are further compelled to eliminate the practices of female genital mutilation, polygamy, and forced marriage or remarriage.<sup>395</sup>

*CEDAW arts. 5-6, 10, 12, 16*

States should refrain from invoking any custom, tradition, or religious consideration to avoid actions aimed at the elimination of violence against women.<sup>396</sup>

*UN Declaration on the Elimination of Violence against Women art. 4*

### ***Women's Economic Rights***

States are required to eliminate discrimination against women in employment and economic life, and ensure their equal rights to family benefits; bank loans, mortgages, and other forms of financial credit; and the same rights for both spouses regarding the ownership and disposition of property. States are also required to repeal all laws and practices which violate widows' inheritance rights. In case of division of marital property, States should accord the same weight to financial and non-financial contributions.

*CEDAW arts. 11, 13, 16, 32; UN Committee on the Elimination of Discrimination against Women, General Recommendation No. 21 paras. 34-35*

<sup>xxii</sup> **Violence against women** is defined as any act that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private. The term encompasses violence in the family, within the general community, and violence perpetrated or condoned by the State. See UN DECLARATION ON THE ELIMINATION OF VIOLENCE AGAINST WOMEN arts. 1-2. It needs to be noted that CEDAW does not contain a provision explicitly prohibiting violence against women. However, the UN Committee on the Elimination of Discrimination against Women took a position that violence against women is prohibited as a form of discrimination against women within the meaning of art. 1 of CEDAW. See UN COMMITTEE ON THE ELIMINATION OF DISCRIMINATION AGAINST WOMEN, GENERAL RECOMMENDATION NO. 12: VIOLENCE AGAINST WOMEN (adopted 1989, U.N. Doc. A/44/38) and GENERAL RECOMMENDATION NO. 19: VIOLENCE AGAINST WOMEN (adopted 1992, U.N. Doc. A/47/38).

<sup>xxiii</sup> **Widows' cleansing** is practiced in some communities in Africa and Asia in an attempt to part with the past, exorcise dead spirits, and establish a family's ownership over the husband's property.



control, or administer property; and 5) patrilineal system of inheritance leading to spousal disinheritance (e.g., after a wife's disclosure of her HIV-positive status), forced evictions, and "property grabbing" by in-laws (e.g., in case of HIV-positive widows). Poverty often forces women to resort to transactional sex, which furthers their susceptibility to infection. Given that economic empowerment of women and girls is essential to reversing the HIV epidemic, international standards urge States to: 1) strengthen and enforce women's rights to employment, property, and inheritance; and 2) adjust economic, social, and development policies to address the special needs of women affected by HIV/AIDS (including women who are HIV-positive and women who provide care to PLHIV).<sup>401</sup>

## Areas of Inquiry

- What are the most prevalent factors that create HIV vulnerability among women?
- What measures are undertaken to mitigate HIV vulnerability among women?
- Does the State prohibit mandatory HIV testing and HIV-related discrimination against women?
- What measures are undertaken to ensure that women enjoy effective protection from HIV-related discrimination in practice?

### Education

- Does the State ensure women's equal right to education?
- What is the level of HIV/AIDS literacy among women? What percentage of women can correctly identify ways of preventing transmission of HIV and reject common misconceptions about HIV?
- Does the State ensure women's access to comprehensive sex, health, and HIV education?
- Do women and girls tend to be removed from school to support their HIV-affected families? Is this practice legally sanctioned? What measures are undertaken to address the situation of women and girls who drop out of school due to HIV/AIDS?

### Family and Sexual Life

- Does the State ensure women's equality in marriage and family relations?
- Does the State ensure women's right to freely: enter into marriage; seek and obtain divorce or legal separation; and leave risky relationships?
- If the law requires HIV-free certificate for entering marriage or allows using HIV-positive status as a legal reason for divorce, do these practices affect women more than men?
- Does the State prohibit forced marriage and remarriage?
- Does the State promote women's right to have control over the matters related to their sexuality?
- Does the State implement or support programs aimed at promoting shared responsibility of men and women to adopt safe, non-coercive, and responsible sexual and reproductive behavior?

### Violence against Women and Harmful Traditional Practices

- Does the State prohibit all forms of violence against women and harmful traditional practices?
- What measures are undertaken to ensure that women enjoy effective protection from violence and harmful practices in reality? Are any of these measures undertaken in the context of HIV/AIDS?
- Do women suffer increased incidence of violence based on their HIV status?
- Is violence or fear of violence a major obstacle to women seeking HIV-related services?
- Does the State address violence against women as an integral part of the national AIDS response?
- Does the State specifically address violence against women with HIV?

### Economic Life

- Does the State ensure women's equality in economic life?
- If not, does the State address women's economic inferiority and HIV/AIDS in an integrated manner?
- Does the State address economic impact of HIV/AIDS on women (e.g., in their role as caregivers)?
- Does the State ensure that HIV-affected women have equitable access to employment, economic opportunities, and social assistance?

## Access to HIV-Related Services

Women and girls tend to have different and unequal access to health resources for the prevention of HIV infection and for treatment and care of HIV/AIDS.<sup>402</sup> Although in low- and middle-income countries adult women have slightly better access to ART,<sup>403</sup> they encounter significant barriers to health care created, among others, by: 1) fear of seeking HIV testing and/or disclosing HIV status; 2) requirement of permission from a male guardian or family to obtain health care; 3) lack of resources; 4) physical inability to access medical services (e.g., in communities which surround women's mobility or practice sex segregation such as purdah);<sup>404</sup> 5) lack of time due to greater domestic responsibilities; 6) inability to stay in in-patient health care

facilities in the absence of affordable child care; and 7) lack of respect for privacy and confidentiality of female patients. It is important to note that in many patriarchal cultures families customarily allocate resources for health care to boys and men before girls and women. Consequently, women and girls may be last to receive HIV treatment even if it is otherwise available in their communities.<sup>405</sup> In line with international guidance, States should expand and equalize women's access to adequate, integrated, multisectoral, and specially designed health care services for HIV/AIDS, TB, sexual and reproductive health, nutrition, and harm reduction.<sup>406</sup>

### ***Women's Right to Health***

States are required to eliminate discrimination against women in their access to health care services, including those related to family planning.<sup>xxiv</sup>

*CEDAW art. 12*

### **Areas of Inquiry**

- What is the HIV prevalence rate among women?
- What measures are undertaken to reduce the incidence of HIV among women and increase their access to HIV-related services?
- Does the State address the magnitude of women's ill-health arising from HIV/AIDS?
- Does the State ensure that women have equitable and sustainable access to: 1) voluntary and confidential HIV testing; and 2) comprehensive HIV-related services? Are these services integrated with primary care, sexual and reproductive health care, or offered in women's clinics?
- Does the State ensure women's access to evidence-informed HIV prevention measures, including those controlled by women, such as female condoms and microbicides?
- Does the State ensure that health care services are gender-sensitive?
- Does the State ensure that health care providers receive specialized and sensitizing training in the prevention, detection of, and treatment of HIV in women?
- Does the State ensure women's right to privacy, confidentiality, and dignity in health care settings?

### **Case Study**

#### **Protecting Widows in Zambia**

Widow cleansing through unprotected sexual intercourse is one of the most deep-rooted and widespread customs in Zambia.<sup>407</sup> When the practice became implicated in the spread of HIV/AIDS, the international community and civil society intensified their advocacy efforts to either eradicate the ritual or substitute it with alternative cleansing methods, such as a symbolic gesture of wearing white beads on the widow's right hand or covering her body with corn mash.<sup>408</sup> For example, in early 1990s, the AIDS Care and Prevention Department at Chikankata Hospital, located in Southern Zambia, conducted a series of consultations with the area's traditional leaders who subsequently enacted a law abolishing widow cleansing by sexual intercourse.<sup>409</sup> In 2003, the Zambia Integrated Health Program (ZIHP), funded by USAID and led by Abt Associates, organized a countrywide campaign to educate Zambia's traditional rulers – the chiefs and their indunas (senior officials) - about the correlation between harmful traditional practices, including sexual cleansing, and HIV/AIDS. The campaign was endorsed by the Zambian Ministry of Health and President Mwanawasa who urged the chiefs to induce behavioral change with respect to practices that promote HIV/AIDS transmission.<sup>410</sup> During the same year many local leaders resolved to ban widow sexual cleansing.<sup>411</sup> In 2005, the Government of Zambia amended the country's penal code to make it illegal for any person to engage in the ritual.<sup>412</sup> Although many Zambians still defy the health-related risks associated with sexual cleansing and the practice continues in many communities under customary law, the groundwork has been laid to eliminate or replace it entirely.<sup>413</sup>

<sup>xxiv</sup> The PROTOCOL TO THE AFRICAN CHARTER ON HUMAN AND PEOPLES' RIGHTS ON THE RIGHTS OF WOMEN IN AFRICA art. 14 (*adopted* July 11, 2003 by the African Union Assembly, *entered into force* Nov. 25, 2005, AU Doc. CAB/LEG/66.6), requires States to respect and protect women's right to health, encompassing sexual and reproductive health, protection against HIV/AIDS, and the right to be informed about one's health status and about the health status of one's partner, particularly if affected by STIs and HIV/AIDS.

## Section III: Key Populations

### Factor 15: Children and Youth

**The State takes all appropriate measures to reduce specific HIV vulnerabilities of children and youth, eliminate HIV-related discrimination against them, and provide them with equitable and sustainable access to comprehensive HIV-related services.**

#### Introduction<sup>xxv</sup>

In 2008, approximately 2.1 million children under 15 were living with HIV and 430,000 were newly infected, mainly through vertical transmission. Children accounted for 16% of new infections and 14% of all HIV-related mortality. Young people, aged 15-24, accounted for an estimated 40% of new infections, while the infection rate among young women in the same age group exceeded 65%. Of the 2 million people who died of AIDS-related illnesses, 280,000 were children under 15.<sup>414</sup> It is estimated that more than 17.5 million children have lost one or both parents to AIDS. Millions more have been gravely affected as the HIV epidemic has spread through their families and communities, contributing to the increased risk of stigma, discrimination, and economic hardship which undermines children's right to adequate standard of living.<sup>415</sup> In its General Comment No. 3, CRC has identified four groups of children who face acute vulnerability to HIV infection and HIV-related discrimination:

- Children who are HIV-positive;
- Children who have lost a parental caregiver due to HIV/AIDS (orphans; children who are arbitrarily removed from their HIV-positive parents; and children whose parents voluntarily give up their parental rights because of the inability to cope with the impacts of HIV/AIDS);
- Children whose families or communities are severely strained by the impacts of HIV/AIDS; and
- Children who are most prone to HIV.<sup>416</sup>

While all children can be rendered vulnerable to HIV by various political, economic, social, and cultural factors, their susceptibility to HIV infection is elevated by: 1) lack of access to education, including sex education; 2) lack of access to HIV prevention measures; 3) early marriage and other harmful traditional practices; 4) early sexual initiation and inability to negotiate safe sex practices; 5) sexual abuse, exploitation, and trafficking in persons; 6) use of drugs; 9) migration and displacement; 10) detention; 11) poverty; 12) conflict; and 13) disability.<sup>417</sup> Young people are also at enhanced risk of HIV, especially those who are sexually active at an early age and those who experiment with multiple sexual partners, unprotected sex, alcohol, and drugs. Research shows that youth's vulnerability to HIV is compounded by widespread ignorance about how HIV is spread and how to avoid infection.<sup>418</sup> In 2010, WHO estimated that only 30% of young men and 19% of young women had the comprehensive and correct knowledge to protect themselves from acquiring the virus.<sup>419</sup>

#### Examples of Compliance

- State implements a national strategy for the protection of children and youth affected by HIV.
- State ensures early detection and treatment of HIV in children.
- State ensures children's access to HIV information and prevention commodities.
- State supports programs promoting extended family and community care for children who have lost their parents due to AIDS.

#### Examples of Non-Compliance

- State fails to protect children from practices that increase their susceptibility to HIV infection (e.g., sexual abuse and trafficking in persons).
- Children are arbitrarily removed from their HIV-positive parents.
- Children orphaned by AIDS routinely lose their right to property and inheritance.
- Orphanages, foster care and adoption agencies require mandatory HIV testing of children.

<sup>xxv</sup> The Tool adopts the following definitions of the terms child, adolescent, and youth: a child is any person between 0 and 18 years of age; an adolescent is any person between 10 and 19 years of age; youth (young people) are people between 15 and 24 years of age.

Due to their status as minors, children suffer from increased risk of mandatory HIV-testing.<sup>420</sup> They are also in greater danger of privacy infringements, poverty, deprivation of property, disinheritance, eviction, homelessness, food insecurity, reduced parental care, arbitrary separation from parents, abandonment by spouses and caregivers, rejection by educational institutions and social service providers (including child care, foster care, and adoption agencies), school dropout, loss of life opportunities, exploitation, violence, illness, anxiety, depression, and death.<sup>421</sup>

## International Standards and Commentary

### Strategy on Children, Youth, and HIV/AIDS

The global community has recognized that HIV/AIDS seriously threatens children's survival, well-being, and development, and that children require special protection against infection as well as the socio-economic impacts of the epidemic.<sup>425</sup> UNAIDS has made empowering young people to protect themselves from HIV one of its ten priority areas and in 2010 set a goal for 2015 of reducing by half sexual transmission of HIV among young people.<sup>426</sup> In an array of international instruments States have been called upon to:

- Adopt, as a matter of priority, a holistic, child rights-based approach to HIV/AIDS and place children at the center of the response to the epidemic;
- Integrate a multisectoral response for children affected by HIV/AIDS into the national development instruments;
- Ensure non-discrimination and full realization of human rights of children;
- Implement child-oriented HIV programs, laws, and policies, including an active policy of de-stigmatization;
- Involve children in the design and implementation of HIV-related programs;
- Build the capacity of social welfare and justice systems to better protect children from HIV vulnerabilities;
- Ensure that government officials, judges, and social service providers receive training about the special needs and problems of HIV-affected children and families;
- Strengthen coordination of actions and services provided to children affected by HIV/AIDS; and
- Ensure appropriate balance between the right of the child to be involved in the decision-making according to his/her evolving capabilities and the rights and duties of parents and legal guardians.<sup>427</sup>

#### ***Core Children's Rights in the Context of HIV/AIDS***

International law guarantees all children the rights to life, health, survival, development, information, special care, assistance, and protection from discrimination on any ground, including their own or their parents' HIV status.<sup>422</sup> In all actions concerning children, whether taken by public authorities or private institutions, the best interest of the child must be a primary consideration.<sup>423</sup> According to the UN Committee on the Rights of the Child, these rights should constitute the guiding themes in the consideration of HIV/AIDS at all levels of prevention, treatment, and care.<sup>424</sup>

To ensure that children are included in HIV-related programs and services, the international community has launched a child-focused global campaign, Unite for Children, Unite Against AIDS Initiative. The campaign's concerted effort focuses on four main areas, known as the *four Ps*: 1) prevention of vertical transmission of HIV (see Factor 8 above); 2) provision of pediatric treatment; 3) prevention of infection among adolescents and young people; and 4) protection and support for children affected by AIDS.<sup>428</sup> Global response to AIDS in the context of young people is led by the Inter-Agency Task Team on HIV and Young People convened by the UN Population Fund (UNFPA) [hereinafter IATT]. IATT has identified *four core areas* of action that target HIV risk and vulnerability reduction among young people: 1) information to acquire knowledge; 2) opportunities to develop life skills necessary to change attitudes and risk behaviors; 3) appropriate health services; and 4) creation of safe and supportive environment. States are strongly encouraged to address the *four Ps* and the *four core areas* in their national strategies on children, youth, and HIV/AIDS.<sup>429</sup>

### Areas of Inquiry

- Does the State recognize children and youth as key populations in the context of HIV/AIDS?
- Does the State allocate specific budget for HIV programs focusing on children and youth?
- Does the State implement and support child- and youth-oriented HIV programs and policies?

- Does the State ensure that all HIV laws, programs, and policies take into account the best interest of the child? Does the State involve children and youth in their design and implementation?
- Does the State implement and support age-sensitive HIV trainings for judicial and law enforcement officers as well as social workers and health care providers?
- Does the civil society play an active role in addressing HIV vulnerabilities of children and youth?
- Does the State provide support for CSOs that implement programs on HIV-related children's rights?

## Reduction of Vulnerability and Elimination of Discrimination

In line with international guidance, all children and youth affected by HIV/AIDS must be provided with a supportive environment and effective protection from mandatory HIV testing, HIV-related discrimination, and arbitrary separation from their HIV-positive parents. States must protect their privacy and ensure that they have equal and adequate access to education, social services, property, and inheritance.<sup>431</sup> Children affected by HIV/AIDS, particularly if they are infected and/or deprived of their family environment, require special protection, assistance, and care.<sup>432</sup> A child's best interest is served if they can stay with their siblings in the care of their extended family. If HIV-affected children are unable to remain within existing family or community structures, States should provide them with family-type alternative care (e.g., foster care or adoption). Any forms of institutionalized care should serve as a measure of last resort. States must ensure that institutions, services, and facilities responsible for the care and protection of children comply with strict legal safeguards so that HIV-affected children are protected against all forms of HIV-related discrimination, including rejection, isolation, abuse, and exploitation. Programs must be developed to support these children's successful reintegration into their communities.<sup>433</sup> Furthermore, States must effectively prohibit segregation of HIV-positive children in educational institutions, child care centers, and orphanages. This prohibition should extend to the establishment of special institutions or facilities intended for HIV-positive children. See Factor 11 above. Finally, States should take steps to reduce child abandonment due to HIV/AIDS, for example by providing special education to HIV-affected parents and families.

### Areas of Inquiry

- What are the most prevalent factors that create HIV vulnerability among children and youth?
- What measures are undertaken to mitigate HIV vulnerability among children and youth?
- Does the State ensure mandatory registration of children after birth?
- Does the State prohibit mandatory HIV testing and HIV-related discrimination of children and youth?
- What measures are undertaken to ensure that children and youth enjoy effective protection from HIV-related discrimination in practice?
- Does the State provide special protection to children and youth affected by HIV?
- Does the State protect children and youth from maltreatment in the context of HIV/AIDS?
- Does the State facilitate recovery and social reintegration of children who fall victims to maltreatment?
- Does the State prohibit arbitrary separation of children from their HIV-positive parents?
- Does the State provide protection to children who have lost their parents due to HIV/AIDS?
- Does the State support placement of orphaned children in non-institutional settings?
- Does the State protect children from HIV-related discrimination and abuse by social service institutions? Does the State ensure that these institutions comply with strict legal safeguards?

### *Right to Special Protection*

CRC guarantees each child the right to be registered immediately after birth, and, as far as possible, the right to be cared for by his or her parents. Each child has the right to be protected from: 1) separation from his or her parents against their will unless such separation is necessary for the best interest of the child; 2) arbitrary or unlawful interference with his or her privacy and family; 3) all forms of social, economic, and sexual exploitation (including child prostitution and pornography); 4) trafficking; 5) neglect; 6) physical or mental violence and abuse (including sexual abuse); and 7) use of narcotic drugs. States are required to: 1) promote recovery and social reintegration of any child who is a victim of maltreatment; and 2) ensure children's right to the adequate standard of living, including the right to benefit from social security. States are further obliged to provide special protection and assistance to children who are deprived of their family environment. Alternative care may include foster care, Islamic kafalah, adoption, or placement in suitable institutions.<sup>430</sup>

*CRC arts. 3, 7-9, 16, 19-20, 26-27, 32-37, 39*

## Access to HIV-Related Services

HIV progresses rapidly in children. Without treatment, one third of HIV-infected infants die in their first year of life, rising to almost half of the infected children by age two. Evidence demonstrates that early diagnosis of HIV and immediate initiation of pediatric ART formulas is crucial to their survival.<sup>436</sup> Consequently, many international standards urge States to ensure that children have adequate and equal access to: 1) voluntary and confidential HIV testing with consent either by the child (in line with his/her evolving capacities), or by the parent or legal guardian; and 2) age-appropriate and integrated health care services, including pediatric HIV treatment and counseling, as well as sexual and reproductive health care.<sup>437</sup> In addition, international guidance emphasizes the importance of HIV prevention among children and young people. In particular, children and youth should be provided with services necessary to develop the life skills required to reduce their vulnerability to HIV infection. This includes access to: 1) primary and secondary education; 2) youth-friendly information about sexual and reproductive life; 3) HIV education; 4) HIV prevention, including condoms and harm reduction measures; and 5) social services (particularly for children who live on the streets or use drugs). HIV education (including peer education and community dialog) should be offered inside and outside of schools; should be tailored to the child's age level and mental capacity; and should acknowledge the realities of the lives of children and adolescents, particularly when addressing their sexual life or drug use.<sup>438</sup> See also Factor 9 above. Per UNAIDS, States should also take concrete steps to empower young people not only to protect themselves and their partners, but also to actively contribute to the national AIDS response through peer education, volunteerism, and participation in the global "HIV prevention revolution."<sup>439</sup>

## Consent to Health Care

The UN Committee on the Rights of the Child has noted that children are more likely to use health care services that are friendly, supportive, and non-discriminatory; that give them the opportunity to participate in decisions affecting their health; that are confidential and non-judgmental; and that do not require parental consent.<sup>440</sup> International law recognizes the right of the child to be heard in health care, which must be, however, balanced against the rights and duties of parents and other persons legally responsible for the child. The UN Committee on the Rights of the Child underlines that children have the right to express their views and be involved in practices and decisions relating to their own health care in a manner consistent with their evolving capacities. The child's views must be given due weight when a professional case-by-case analysis indicates that the child is capable of forming her or his own views in a reasonable and independent manner. States should develop a good practice for assessing the evolving capacity of the child and ensure that children have access to confidential medical counselling and advice without parental consent where this is needed for their safety or well-being. Children may need such access, for example, where they are in need of reproductive health education or services. The right to counselling and advice is distinct from the right to give medical consent and should not be subject to any age limit. Establishing a fixed age at which the right to consent to medical intervention transfers to the child is encouraged. States should, however, ensure that due weight is given to the views of younger children who can demonstrate capacity to express informed opinions on their treatment.<sup>441</sup>

### ***Rights to Health and Information***

Each child has the right to the highest attainable standard of health and the right to seek, receive, and impart information of all kinds, including information about HIV/AIDS. States must take measures to: 1) diminish infant and child mortality; 2) ensure the provision of and children's access to the necessary medical assistance and health care; and 3) develop preventative health care and family planning services.<sup>434</sup> Furthermore, States must ensure that children have access to information from a diversity of sources, especially those aimed at promotion of their well-being and health.<sup>435</sup>

*CRC arts. 13, 17, 24*

### ***Right to Be Heard***

The child who is capable of forming his or her own views has the right to express those views freely in all matters affecting the child. The views of the child must be given due weight in accordance with the age and maturity of the child. States must, however, respect the responsibilities, rights and duties of parents or other persons legally responsible for the child, to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of his or her rights.

*CRC arts. 5, 12*

## Areas of Inquiry

- What is the HIV prevalence rate among children and young people?
- What measures are undertaken to reduce the incidence of HIV among children and young people and increase their access to HIV-related services?
- What is the level of HIV/AIDS literacy among children and youth? What percentage of children and young people can correctly identify ways of preventing transmission of HIV and reject common misconceptions about how HIV is spread?
- Does the State ensure children's and youth's access to evidence-informed HIV prevention measures, including life skills-based sex education, condoms, and harm reduction measures?
- Does the State ensure that children and youth have equitable and sustainable access to: 1) voluntary and confidential HIV testing; and 2) comprehensive health care services encompassing sexual and reproductive health, pediatric HIV treatment, and other HIV-related services?
- Does the State ensure children's and youth's right to privacy, confidentiality, and dignity in health care?

### **Consent to Health Care**

- How does the State's regulatory framework govern medical consent in the context of children?
- Does the State ensure children's right to be heard in health care?
- Does the State ensure that children have access to confidential medical counselling and advice without parental consent where this is needed for their safety or well-being?

## Case Study

### **Community-Based Care for HIV-Affected Children in Papua New Guinea**

Papua New Guinea (PNG), where approximately 30% of children are considered to be at risk of HIV, has faced a critical child protection situation. To mitigate the impact of HIV/AIDS on the growing population of orphans and vulnerable children, the Government of PNG has adopted the Lukautim Pikinini Act (a Child Welfare Act which extends human rights protections to children affected by HIV/AIDS); developed a community-driven National Strategy for the Protection, Care and Support of Children Vulnerable to Violence, Abuse, Exploitation and Neglect in the Context of the HIV Epidemic (MVC Strategic Plan); and proceeded to establish a Child Fund aimed at providing financial support to community-based, church, and NGO child-protection models. The PNG Government's policy is to improve the well-being of children and their access to essential services by mainstreaming HIV interventions into family, community, civil society, and Government child protection systems. The PNG Government discourages institutional-type care for children; instead, it seeks to strengthen the capacity of the extended family and community to care for children affected by HIV/AIDS. Among others, the PNG Government supports and promotes the extended community-care model developed by the Catholic Diocese of Kundiawa in Simbu Province. Through a network of trained child protection volunteers, the program identifies children affected by HIV/AIDS and delivers integrated protection, care, and outreach services with strong participatory focus. The program's care centers, which function as service access points and not as orphanages, are built by the community. The program's key successes have been cost-effectiveness, sustainability, adaptability, the sense of ownership by the community, and the cultural attitude that children belong to the extended family.<sup>442</sup>

## Section III: Key Populations

### Factor 16: People who Use Drugs

**The State takes all appropriate measures to reduce specific HIV vulnerabilities of people who use drugs, eliminate HIV-related discrimination against them, and provide them with equitable and sustainable access to comprehensive HIV-related services.**

#### Introduction

People who use drugs, particularly those who inject drugs and share injecting equipment, are among the most heavily affected by HIV.<sup>xxvi</sup> Eastern Europe and parts of Asia are the only regions in the world where the HIV epidemic continues to grow, fuelled by injection drug use. Five countries (China, Vietnam, Russia, Ukraine, and Malaysia) have the most significant injection drug-driven HIV epidemics. Taken together these countries account for 2.4 million cases of HIV infection and nearly half of all people who inject drugs living with HIV worldwide. People who inject drugs account for more than 60% of all HIV infections in Belarus, Georgia, Kazakhstan, Kyrgyzstan, Moldova, Russia, Ukraine, Tajikistan, Uzbekistan, Iran, and Indonesia.<sup>443</sup> Approximately 30–50% of HIV-positive injection drug users in Europe are unaware of being infected. Notwithstanding this alarming public health situation, there is a worldwide resource-allocation imbalance of 3:1 in favour of spending on security and law enforcement rather than on public health.<sup>444</sup>

#### Examples of Compliance

- State implements non-coercive harm reduction measures aimed at HIV prevention among people who use drugs.
- People who use drugs have equitable access to HIV-related services.
- State does not criminalize possession of drug paraphernalia.

#### International Standards and Commentary

##### Reduction of HIV Vulnerability and Elimination of Discrimination

People who use drugs face increased vulnerability to HIV due to many legal, social, and individual factors, including hard-line drug policy measures that inadvertently exacerbate their marginalization and stigmatization. These measures include criminalization of simple drug use (consumption); possession of drug paraphernalia; and possession of miniscule amounts of drugs (such as trace amounts in a syringe). In addition, people who use drugs are often perceived as dangerous and unable to make decisions for themselves. Consequently, they are subjected to various coercive health measures, including mandatory HIV and drug testing, and compulsory drug dependence treatment.

#### Examples of Non-Compliance

- State prohibits NSPs and OST.
- State implements policing practices that hinder access of people who use drugs to pharmacies and health care services.
- People who use drugs are routinely subjected to compulsory HIV testing and drug dependence treatment.

According to WHO and other organizations, drug dependence is an illness.<sup>445</sup> It is a chronic, relapsing medical condition with a physiological and genetic basis that could affect any human being.<sup>446</sup> Therefore, differential treatment of people who use drugs constitutes discrimination on the ground of health and is prohibited by international law.

UNAIDS has made protecting drug users from becoming infected with HIV one of its ten priority areas and in 2010 set a goal for 2015 of reducing by half the number of countries with punitive laws and practices around drug use that bloc effective HIV responses. UNAIDS has also underlined the importance of making comprehensive, evidence-informed, and human rights-based interventions accessible to drug users (i.e., harm reduction and demand reduction) and ensuring that legal and policy frameworks serve HIV prevention

<sup>xxvi</sup> Non-injection drug use also enhances susceptibility to HIV because it leads to impaired judgment and may increase risky sexual behavior.



efforts.<sup>447</sup> States should ensure that people who use drugs are involved in the design, implementation and monitoring of health care and social protection measures intended for them, including HIV prevention and other HIV-related services.<sup>448</sup>

## HIV Interventions

Harm reduction is a set of practical strategies that reduce the overall consumption and negative consequences of drug use, incorporating a spectrum of strategies from safer use, to managed use, to abstinence.<sup>450</sup> Harm reduction programs include voluntary drug dependence treatment, safe drug consumption programs, broad availability and accessibility of sterile injecting equipment in pharmacies, and outreach to hard-to-reach populations. Implementation of these measures is consistent with international human rights law and permissible under the international drug control treaties, which encourage the adoption of a health-oriented approach to illicit drug use and drug dependence rather than relying solely upon a sanction-oriented approach.<sup>451</sup>

Effective and comprehensive national harm reduction strategies are essential in the context of the right to health and HIV/AIDS.<sup>452</sup> UNAIDS underlines that harm reduction programs and HIV prevention information are among the most efficient and cost-effective measures to prevent the HIV epidemic among people who use drugs.<sup>453</sup> The Declaration of Commitment recognizes the importance of the increased availability of, and non-discriminatory access to, sterile injecting equipment,<sup>454</sup> and International Guidelines urge States to repeal any restrictions on the availability of preventive measures, such as condoms, bleach, and clean needles and syringes.<sup>455</sup>

### *Comprehensive Package of HIV Interventions for People who Use Drugs*

In 2009, WHO, UNODC, and UNAIDS developed a comprehensive package of HIV interventions for people who use drugs, which include: (1) NSPs; (2) OST and other drug dependence treatment; (3) HIV testing and counselling; (4) ART; (5) prevention and treatment of STIs; (6) condom programs for people who use drugs and their sexual partners; (7) targeted information, education and communication for people who use drugs and their sexual partners; (8) vaccination, diagnosis and treatment of viral hepatitis; and (9) prevention, diagnosis and treatment of TB.<sup>449</sup>

- **Drug dependence treatment** plays a key role in reducing the risk of HIV transmission because of its capacity to diminish drug use, to reduce the frequency of injecting, to decrease the incidence of associated risk-taking behaviour, and to stabilize people's health.<sup>456</sup> Drug dependence treatment is an urgent public health priority, with OST being one of the most effective known interventions.
- **Safe drug consumption programs**, including safe drug consumption facilities as well as needle and syringe exchange or distribution programs [hereinafter NSPs], are among the most practical HIV prevention strategies for people who use drugs, with needle distribution being more effective in reducing risk behaviors than needle exchange.<sup>457</sup> Provision of these measures reduces the likelihood of transmission of infections via unclean injecting equipment.

## Punitive Laws and Practices

In many countries, criminal liability for simple drug use and/or possession of drug paraphernalia creates a legal barrier to the effective functioning of NSPs and impedes access of people who use drugs to HIV-related services. Criminalization of possession of trace amounts of illegal drugs is also a concern for NSPs' clients, who may be reluctant to return or safely dispose of syringes that contain residue from injection. In addition, the operation of NSPs can be at odds with legal provisions that criminalize facilitation or incitement to drug use. In the lack of appropriate interpretation, these provisions can cause confusion between law enforcement and health care providers who may choose to refrain from reaching out to people who use drugs and providing them with essential education or materials for safer drug use. Furthermore, strict and repressive law enforcement practices may deter people who use drugs from accessing essential services owing to the fear of arrest, incarceration, criminal punishment, harassment, and violence.<sup>xxvii</sup> They may also foster

---

<sup>xxvii</sup> In many countries repressive law enforcement practices associated with the "war on drugs" include, among others: excessive street-level policing at or near safe drug injection sites, pharmacies, and health care centers; arrests for carrying unused syringes (even in countries where possession of syringes is legal); police crackdowns leading to extrajudicial searches, arrests, detention, and executions; use of drugs to coerce confessions; and coercive interrogation and torture. Studies show that people who use drugs are commonly viewed as easy targets to fill arrest quotas or to supplement police salaries through

prejudicial attitudes towards people who use drugs, directing action toward punishment of the *offender*, rather than fostering understanding and assistance.<sup>458</sup>

Treating persons who use drugs as criminal offenders is counterproductive from a right to health perspective. WHO has recognized that legislation that penalizes people who inject drugs for possession of sterile injecting equipment, as well as legislation that penalizes health workers who make such equipment available, can be an important barrier to HIV control among people who use drugs.<sup>459</sup> According to International Guidelines, criminal law should not impede access of people who use drugs to HIV-related services. States are therefore urged to review their criminal laws and consider: 1) authorization or legalization and promotion of NSPs; and 2) repeal of laws criminalizing the possession, distribution, and dispensing of needles and syringes.<sup>460</sup> The UN Special Rapporteur on the Right to Health and many other human rights experts have taken it one step further and have advocated for decriminalization or de-penalization of drug use and possession.<sup>xxviii</sup>

**Criminal law should not be an impediment to measures taken by States to reduce the risk of HIV transmission among injecting drug users and to provide HIV-related care and treatment for injecting drug users.**

*International Guidelines, Guideline 4*

Investigation and adjudication of drug offences require sensitive decision-making by actors of the criminal justice system, especially prosecutors who are vested with the discretion to decide whether or not to pursue a particular case. Prosecutors should be encouraged to waive prosecution of drug consumption and possession of drug paraphernalia in the interest of preventing the spread of HIV, particularly if the amounts of drugs involved are small and if the evidence is obtained through police surveillance at or near pharmacies and safe drug consumption sites. The principles of non-coercive and non-punitive drug policies should be reflected in official prosecutorial guidelines and should be included in the professional training of prosecutors and law enforcement officers. In line with the UN Guidelines on the Role of Prosecutors, prosecutors should perform their professional functions without engaging in intimidation, hindrance, harassment, or improper interference.<sup>461</sup>

People who use drugs may face additional HIV-related risks when incarcerated. Thus, alternatives to incarceration for small-scale, non-violent offences committed by people who use drugs to fund their drug habit are also recommended as more effective in reducing social, health, and economic harms of illegal drug use.<sup>462</sup> The alternatives may include fines, referral to voluntary drug dependence treatment, and other forms of non-custodial sentences.

### **Coercive Health Measures**

In line with international guidance, States should refrain from imposing targeted coercive and compulsory health measures on people who use drugs, such as forced HIV or drug testing or treatment. These measures constitute an arbitrary interference with the right to liberty and security of person, the right not to be subjected without free consent to medical or scientific experimentation, and the right to health whose cornerstone is informed consent to treatment. Together with discrimination by health care workers, coercive health measures contribute to the HIV vulnerability of people who use drugs by pushing them away from health care services.<sup>463</sup> See Factors 1 and 11 above.

UNODC and WHO stress that drug treatment must be evidence-informed and respect human rights.<sup>464</sup> International standards call for the closure of detention centers for drug treatment which impose arbitrary confinement and other human rights abuses (e.g., forced labor) on drug users. These approaches should be substituted with programs that encourage voluntary testing and provide information on how to decrease HIV risk behaviors. UNODC emphasizes that involuntary drug dependence treatment may be justifiable only in

---

extortion. In fact, police in some settings arrest people simply because their arms show the marks of past injection. See Ralf Jürgens et al., *People who Use Drugs, HIV, and Human Rights* 475-486, *THE LANCET* (2010).

<sup>xxviii</sup> Decriminalization of drug use is not equated with *legalization* of drug use. When decriminalized, drug use and possession can remain legally prohibited, but criminal penalties for such offences either are not applied at all or only minor penalties are given. Decriminalization generally entails complete removal of criminal punishment for the conduct in question (administrative penalties may be applied instead), whereas de-penalization requires removal of custodial sentences, although the conduct remains a criminal offence. Legalization, by contrast, involves no prohibitions on the relevant conduct. See REPORT OF THE SPECIAL RAPPORTEUR ON THE RIGHT OF EVERYONE TO THE ENJOYMENT OF THE HIGHEST ATTAINABLE STANDARD OF PHYSICAL AND MENTAL HEALTH TO THE GENERAL ASSEMBLY 20-22 (August 6, 2010, U.N. Doc. A/65/255).

emergency short-term situations when the person poses an imminent threat to him- or herself or to others. Even in these circumstances, however, the ethics of treatment without consent and its legality under international human rights law is debatable.<sup>465</sup>

### Areas of Inquiry

- What is the HIV prevalence rate among people who use drugs?
- Does the State recognize people who use drugs as a key population in the context of HIV/AIDS?
- Does the State allocate specific budget for HIV programs focusing on people who use drugs?
- Does the State involve people who use drugs in the design and implementation of HIV programs?
- What measures are undertaken to mitigate HIV vulnerability among people who use drugs?
- Does the State support civil society initiatives that address HIV vulnerability of people who use drugs?
- Does the State prohibit mandatory HIV testing and HIV-related discrimination of people who use drugs?
- What measures are undertaken to ensure that people who use drugs enjoy effective protection from HIV-related discrimination in practice?

#### HIV Interventions

- Does the State implement and support HIV interventions for people who use drugs?
- Does the State ensure that HIV interventions for people who use drugs are evidence-informed and human rights-based?

#### Punitive Laws and Practices

- How does the State's regulatory framework govern simple drug use, possession of drug paraphernalia, and possession of miniscule amounts of drugs? Does the State take any measures to decriminalize these conducts? To what extent are these conducts prosecuted?
- Does the State recognize the link between criminalization, marginalization, and discrimination of people who use drugs and their vulnerability to HIV?
- Does the State ensure that criminal and other laws are not an impediment to measures undertaken to mitigate HIV vulnerability among people who use drugs and provide them with HIV-related services?
- Does the State protect people who use drugs from repressive law enforcement practices and human rights violations by state and non-state actors in the context of HIV/AIDS and harm reduction?
- Does the State employ alternatives to incarceration for minor drug-related offences?

#### Coercive Health Measures

- How does the State's regulatory framework govern medical consent in the context of drug use?
- Does the State ensure that people who use drugs are not subjected to coercive health measures?

### Access to HIV-Related Services

People who use drugs suffer from discrimination in health care setting and significantly inadequate access to HIV prevention interventions and treatment. Evidence-informed measures, such as NSPs and OST are prohibited in the parts of the world most heavily affected. Coverage of essential HIV-related services for people who use drugs is alarming with a global average of fewer than two needles per one person injecting drugs per month, with only 8% of opioid users in opioid treatment, and with only 4% of people injecting drugs with HIV infection receiving ART.<sup>466</sup> Also hepatitis C treatment and overdose management receive inadequate attention from States, despite being significant health risks for people who use drugs.<sup>467</sup>

The global community has acknowledged that in order to decrease HIV prevalence among people who use drugs there is a need for a massive scale-up of HIV prevention, treatment, and care. In their respective resolutions, the UN Human Rights Council and the UN Economic and Social Council endorsed the comprehensive package of HIV interventions for people who use drugs and urged States to: 1) increase the capacity and resources for the implementation of the package; 2) address the gap in access to HIV-related services for people who use drugs in all settings, including prisons; and 3) develop comprehensive models of appropriate service delivery.<sup>468</sup>

International Guidelines underline that people who use drugs have the right to equitable access to HIV-related services, including ART.<sup>469</sup> According to WHO, UNAIDS, and UNODC, interventions included in the comprehensive package of HIV-related services for people who use drugs should be: 1) physically accessible (geographically distributed and available in hard-to-reach locations, including prisons); 2) affordable; 3) equitable and non-discriminatory; 4) non-rationed; and 5) not restricted by socio-demographic and other criteria (e.g., age, gender, sexual orientation, sexual behavior, citizenship, nationality, religion, confinement,

employment status, profession, health insurance status, and substance use status). All interventions should be offered voluntarily in an enabling environment created by supportive legislation, policies and strategies.<sup>470</sup>

## Training

States' obligation to protect the human rights of people who use drugs implies the duty of States to ensure that government officials, prosecutors, law enforcement officers, judges, health care providers, social workers, and community and religious leaders are sensitized to the multiple layers of HIV vulnerability affecting people who use drugs. They should also be trained to protect and respect their human rights, including the right to non-discrimination in the provision of HIV-related services.<sup>471</sup>

## Areas of Inquiry

- Does the State ensure that people who use drugs have equitable and sustainable access to: 1) voluntary and confidential HIV testing; and 2) comprehensive HIV-related services?
- What barriers to HIV prevention, treatment and care do people who use drugs most commonly face? What measures are undertaken to eliminate these barriers?
- Does the State ensure that people who use drugs enjoy the rights to privacy, confidentiality, and dignity?
- Does the State ensure that state and non-state actors who are likely to come in contact with people who use drugs in their professional life receive sensitizing training and education on health-oriented and human rights-based approach to drug use and drug dependence?

## Case Study

### Harm Reduction Strategies in Western Europe

In 2000, Portugal decriminalized personal consumption and possession for consumption of drugs. While it is a crime to possess more than an average of 10 days' consumption, possession of drugs below that limit is considered an administrative offence. Ten years after the law went into force, general population surveys showed three positive trends: a decrease in the prevalence of any drug use among young people; a consistent increase in the number of addicted people in treatment; and a dramatic decrease of HIV incidence in people who use drugs (from 54% in 2001 to 30% in 2007).<sup>472</sup> In Germany, the supply of sterile disposable syringes to people who use drugs is specifically excluded from the offence of providing an opportunity for drug use.<sup>473</sup> In England and Wales, the Legal Guidance for the Crown Prosecution Office acknowledges that public interest criteria may be prominent in drug cases and that the need to prevent the spread of serious infections outweighs the normal requirement for prosecution. Its section on AIDS and Needle Exchange Schemes states that normally it is not in the public interest to prosecute a drug user retaining used needles, a drug user possessing sterile needles, *bona fide* operators of NSPs, and simple possession cases based on police surveillance at or near needle exchange centers.<sup>474</sup>

## Section III: Key Populations

### Factor 17: Adults Engaged in Commercial Sex

**The State takes all appropriate measures to reduce specific HIV vulnerabilities of adults engaged in commercial sex, eliminate HIV-related discrimination against them, and provide them with equitable and sustainable access to comprehensive HIV-related services.**

#### Introduction

Adults engaged in commercial sex (sex workers)<sup>xxix</sup> are at high risk of acquiring HIV. They are also disproportionately affected by the impact of HIV/AIDS. In many regions, significantly higher rates of HIV infection have been documented among sex workers and their clients as compared to other population groups.<sup>475</sup> It is estimated that almost one third (32%) of new HIV infections in Ghana, 14% in Kenya, and 10% in Uganda are linked to commercial sex. In Myanmar, almost one in five (18%) surveyed women engaged in commercial sex tested HIV-positive in the mid-2000s. In southern India, up to 15% of women engaged in commercial sex were living with HIV. In Ukraine, 14-31% of sex workers are living with HIV, which is almost certainly attributed to the overlap of paid sex with injecting drug use. Approximately 4% of women engaged in commercial sex in the Dominican Republic, 9% in Jamaica, and 27% in Guyana are found to be HIV-positive.<sup>476</sup> Transactional sex is widespread in both developing and developed countries. People engaged in commercial sex can be of all ages, but many are young and lack information about HIV. The majority are female, but many men and transgender people also engage in paid sex, and their clients are mostly male. In some countries, a high percentage of sex workers are migrants.

#### Examples of Compliance

- State implements or supports harm reduction programs and HIV-related outreach activities aimed at AECS;
- State includes AECS in the design and implementation of HIV-related programs and policies;
- State ensures that AECS and their clients have access to HIV education and preventative commodities;

#### Examples of Non-Compliance

- AECS lack access to health care services due to their illegal status and inability to obtain health insurance.
- State fails to protect AECS from exploitation, harassment, violence, and other forms of victimization by state and non-state actors.

#### International Standards and Commentary

##### Reduction of HIV Vulnerability and Elimination of Discrimination

**Criminal law should not impede provision of HIV prevention and care services to sex workers and their clients.**

*International Guidelines, Guideline 4*

The increased vulnerability of sex workers to HIV is explained by their stigmatization, marginalization, and the criminalization of their status, which – according to many human rights experts – diminishes their “bargaining power” to choose clients and negotiate safer sex practices

(particularly condom use); exposes them to human rights abuses; and limits their access to essential services.<sup>477</sup> Most States do not recognize transactional sex as a legitimate form of employment. Consequently, the vast majority of adults engaged in commercial sex do not have access to state benefits, health insurance, and are not protected by occupational health and safety regulations. The prohibition of commercial sex also renders any sex transaction agreement illegal on the grounds of being contrary to the public policy, resulting in no legal recourse.<sup>478</sup> Sex workers who use drugs are at further risk: the combination

<sup>xxix</sup> Throughout this document the terms “adults engaged in commercial sex” and “sex workers” are used interchangeably. **Sex workers** are female, male and transgender adults who receive money or goods in exchange for sexual services, either regularly or occasionally, and who may or may not consciously define those activities as income-generating. See UNAIDS, GETTING TO ZERO: 2011-2015 STRATEGY 60 (2010).

of commercial sex and drug-taking puts them beyond the protection of the law and makes them particularly vulnerable to exploitation and abuse, often by those in positions of authority.<sup>479</sup>

## HIV Interventions

Empowering sex workers to protect themselves from HIV infection and fully access ART is one of UNAIDS' ten priority areas. UNAIDS urges States to deliver a comprehensive package of HIV interventions to sex workers and ensure that law enforcement agencies and the judicial system protect their rights. Furthermore, UNAIDS has set a goal for 2015 of reducing by half the number of countries with punitive laws and practices around sex work that block effective HIV responses.<sup>481</sup>

UNAIDS suggests that protection of sex workers in the context of HIV/AIDS should rest on three pillars: 1) assuring universal access to comprehensive HIV-related services for all sex workers and their clients; 2) building supportive environments, strengthening partnerships, and expanding choices (including alternatives to the sex industry for those who want to leave it); and 3) addressing structural factors that disempower sex workers, contribute to their HIV vulnerability, and exacerbate the HIV epidemic. These factors include: social exclusion, discrimination, lack of meaningful protection, limited economic opportunities, poverty, gender inequality, mobility, displacement, harmful policies, and exposure to risks associated with the sex industry, such as violence, harassment, and sexual exploitation.

UNAIDS emphasizes that full and equal participation of sex workers in the design and implementation of HIV interventions is indispensable for their success.<sup>482</sup>

## Punitive Laws and Practices

Many States adopt a punitive approach to sex work through the criminalization of: 1) the selling of sexual services (which entails criminal penalties for sex workers); 2) the purchase of sexual services (which entails criminal penalties for clients); and 3) various practices around sex work, such as solicitation, pimping, keeping a brothel, recruiting or arranging sex work of others, living off the proceeds of sex work, or facilitating sex work through the provision of information or assistance. In addition, some States apply other laws to curb transactional sex (e.g., vagrancy or public nuisance laws to detain or arrest street sex workers or laws prohibiting homosexual acts to criminalize male and transgender sex workers). Regardless of the form of criminalization, adults engaged in commercial sex face widespread harassment, intimidation, exploitation, and violence, frequently perpetrated or condoned by those in the position of authority, including law enforcement officers.<sup>xxx</sup> The fear of police, pimps, and clients often deters sex workers from reporting crimes committed against them and seriously impedes their access to health care, including HIV-

### ***Comprehensive Package of HIV Interventions for Sex Workers***

In 2002, UNAIDS developed a comprehensive package of HIV interventions for sex workers which includes: (1) promotion of safer sexual behavior among sex workers, their partners, and clients (condom promotion, availability, accessibility, distribution, and correct use; sex education; negotiation skills; and supportive policies); (2) promotion, availability, accessibility, and affordability of STI and other sexual and reproductive health services; (3) care and support for sex workers living with HIV; (4) outreach programs for hard-to-reach sex worker groups (including health, social and legal services); (5) promoting self-esteem and solidarity among sex workers; (6) peer education among sex workers, clients, and associated groups; and (7) advocacy for policy and law reform at national and local levels, including respect for human rights.<sup>480</sup>

### ***Right to Freedom from Sexual Exploitation***

International law prohibits the use of children in prostitution and other sexual activities and practices and all forms of trafficking in persons, but does not require States to suppress consensual transactional sex among adults.<sup>483</sup>

### ***Right to Work***

Many human rights experts and selected States interpret the internationally-recognized right to work and to freely choose one's profession to include "sex work" as a legitimate occupation subject to standard labor laws and occupational health and safety regulations.

<sup>xxx</sup> In many countries repressive law enforcement practices associated with curbing sex work include, among others: sex by deception and coercion, extortion, public humiliation, harassment, and extreme violence.

related services.<sup>484</sup>

The UN Special Rapporteur on the Right to Health has stressed that criminalization of sex work and repressive policing lead to poorer health outcomes for sex workers and has recommended a right-to-health approach to sex work. This approach entails the decriminalization or legalization of sex work along with the institution of appropriate occupational health and safety regulations.<sup>485</sup> Also UNAIDS has urged States to move towards decriminalization of sex work in order to create supportive environments for adults engaged in commercial sex and ensure that they work and live in safe and healthy conditions.<sup>486</sup> According to International Guidelines, criminal law should not impede access of sex workers to HIV-related services. States are therefore urged to review their criminal laws and consider: 1) de-criminalization of adult sex that involves no victimization; and 2) legal regulation of occupational health and safety conditions to protect sex workers and their clients.<sup>487</sup>

It is of paramount importance that States make a clear distinction between sex work and trafficking in persons. Trafficking in persons, sexual slavery, and sexual exploitation always merit criminalization.<sup>488</sup> In its Guidance Note on HIV and Sex Work, UNAIDS highlighted the human right to liberty and security of person as well the right not to be trafficked or held in slave-like conditions. UNAIDS has also affirmed that all forms of the involvement of children in commercial sex, and all forms of sexual exploitation or abuse, contravene international human rights law.<sup>489</sup> According to International Guidelines, States should ensure that those who have been trafficked or otherwise coerced into transactional sex are: 1) removed and protected from participation in the sex industry; 2) not prosecuted for participation in the sex industry; and 3) provided with medical and psychosocial support services.<sup>490</sup>

### **Coercive Health Measures**

States should refrain from imposing targeted coercive health care measures on sex workers, such as compulsory STI or drug testing and treatment, and mandatory HIV testing which, in some countries, constitutes an entry point to accessing any health services. As mentioned in Factors 1 and 11 above, these measures constitute an arbitrary interference with the right to liberty and security of person, the right not to be subjected without free consent to medical or scientific experimentation, and the right to health whose cornerstone is informed consent to treatment. Furthermore, these practices stigmatize people engaged in commercial sex as being almost solely responsible for the spread of STIs, including HIV, even though they have limited ability to negotiate safe sex and access health services. These approaches should be substituted with programs that encourage voluntary testing and provide information on how to decrease risk behaviors.

### **Areas of Inquiry**

- What is the HIV prevalence rate among adults engaged in commercial sex?
- Does the State recognize sex workers as a key population in the context of HIV/AIDS?
- Does the State allocate specific budget for HIV programs focusing on sex workers?
- Does the State involve sex workers in the design and implementation of HIV programs?
- What measures are undertaken to mitigate HIV vulnerability among sex workers?
- Does the State support civil society initiatives that address HIV vulnerability of sex workers?
- Does the State prohibit mandatory HIV testing and HIV-related discrimination of sex workers?
- What measures are undertaken to ensure that people who engage in commercial sex enjoy effective protection from HIV-related discrimination in practice?

#### **HIV Interventions**

- Does the State implement and support HIV interventions for sex workers?
- Does the State ensure that HIV interventions for sex workers are evidence- and human rights-based?

#### **Punitive Laws and Practices**

- How does the State's regulatory framework govern sex work? Does the State take any measures to decriminalize or legalize consensual adult sex work? To what extent are sex workers prosecuted?
- Does the State recognize the link between criminalization, marginalization, and discrimination of people engaged in commercial sex and their vulnerability to HIV?
- Does the State ensure that criminal and other laws do not impede measures undertaken to mitigate HIV vulnerability among sex workers and provide them with HIV-related services?
- Does the State protect sex workers from repressive law enforcement practices and human rights violations by state and non-state actors in the context of HIV/AIDS and harm reduction?

Does the State employ alternatives to incarceration of sex workers if selling of sex services is illegal?

### **Coercive Health Measures**

Does the State ensure that sex workers are not subjected to coercive health measures?

## **Access to HIV-Related Services**

Because of their illegal status, mobility, and exploitation associated with the sex industry, adults engaged in commercial sex frequently lack access to health care, including treatment for STIs, which can increase physiological vulnerability to HIV.<sup>491</sup> They also have inadequate access to HIV-related services. UNAIDS notes that to date the global HIV response has devoted insufficient attention and resources to address HIV and transactional sex, with less than 1% of global funding for HIV prevention spent on this purpose.<sup>492</sup>

Both UNAIDS and International Guidelines urge States to: 1) ensure universal access to comprehensive, evidence-informed HIV-related services taking into account specific vulnerabilities of sex workers; and 2) implement specially designed and targeted HIV programs for those sex workers who do not have access to mainstream interventions. HIV information and prevention programs, including behavioral interventions, should be directed not only at sex workers but also their clients and others involved in the sex industry. HIV prevention services should include harm reduction measures, condom and lubricant distribution programs, and outreach activities for hard-to reach and street-based groups.<sup>493</sup>

## **Training**

States' obligation to protect the human rights of sex workers implies the duty of States to ensure that government officials, prosecutors, law enforcement officers, judges, health care providers, social workers, and community and religious leaders are sensitized to the multiple layers of HIV vulnerability affecting people engaged in commercial sex work. They should also be trained to protect and respect their human rights, including the right to non-discrimination in the provision of HIV-related services.<sup>494</sup>

## **Areas of Inquiry**

- Does the State ensure that sex workers have equitable and sustainable access to: 1) voluntary and confidential HIV testing; and 2) comprehensive HIV-related services?
- What barriers to HIV prevention, treatment and care do sex workers most commonly face? What measures are undertaken to eliminate these barriers?
- Does the State ensure that sex workers enjoy the rights to privacy, confidentiality, and dignity?
- Does the State ensure that state and non-state actors who are likely to come in contact with sex workers in their professional life receive sensitizing training and education on health-oriented and human rights-based approach to sex work?

## **Case Study**

### **Regulation of Sex Work in New Zealand**

In 2003, New Zealand adopted the Prostitution Reform Act which decriminalized consensual transactional sex among adults with direct aim of safeguarding the human rights of adults engaged in commercial sex. Since decriminalization, sex workers have reported feeling that they have enforceable rights, including the rights to health and security of person. Reportedly, sex workers in New Zealand enjoy increased ability to refuse particular clients and practices, and negotiate safer sex.<sup>495</sup>



## Section III: Key Populations

### Factor 18: Men who Have Sex with Men, and Transgender People

**The State takes all appropriate measures to reduce specific HIV vulnerabilities of men who have sex with men, and transgender people, eliminate HIV-related discrimination against them, and provide them with equitable and sustainable access to comprehensive HIV-related services.**

#### Introduction<sup>xxx1</sup>

HIV prevalence among MSM is high in all regions of the world, with rates as high as 25% in Africa, 11% in the Caribbean, 28% in Southeast Asia, and 51% in some parts of Latin America. Among transgender persons, HIV prevalence is likely to be even higher: over 25% in three Latin American countries and ranging from 10-42% in five Asian countries.<sup>496</sup> Moreover, there is evidence suggesting the resurgence of the HIV epidemic among MSM in North America and in Western Europe, where it was considered stabilized. Data from 23 European countries show that the annual number of HIV diagnoses among MSM rose by 86% between 2000 and 2006. In the US, new HIV infections attributed to unprotected sex between men increased by more than 50% from 1991–1993 to 2003–2006.<sup>497</sup> Many MSM and transgender people report discrimination in access to health care and in other areas of public life, including education, employment, and access to justice. In its extreme form, discrimination includes harassment and violence perpetrated by the police and health care workers.<sup>498</sup> The negative association of HIV/AIDS with homosexuality often leads MSM to avoid HIV testing and treatment

**Criminal law prohibiting sexual acts (including adultery, sodomy, fornication and commercial sexual encounters) between consenting adults in private should be reviewed with the aim of repeal. In any event, they should not be allowed to impede provision of HIV prevention and care services.**

*International Guidelines, Guideline 4*

because of the fear of being subject to criminal sanctions, violence, or discrimination. Specific HIV services for MSM and transgender people tend to be limited. For example, in the Asia-Pacific region, almost 90% of MSM have no access to HIV prevention or care.<sup>499</sup>

#### Examples of Compliance

- State prohibits all forms of discrimination on the grounds of sexual orientation and gender identity.
- State implements stigma-reduction strategies to eliminate the portrayal of HIV as a “gay disease.”
- State ensures that MSM and transgender people have equitable access to HIV-related services.

#### Examples of Non-Compliance

- Criminalization of same-sex conduct hinders HIV prevention efforts among MSM and transgender people.
- MSM refrain from accessing HIV-related services due to well-founded fear of prosecution for sodomy.

<sup>xxx1</sup> The Tool recognizes the differences between sexual orientation and gender identity. Nevertheless, Factor 19 addresses MSM and transgender people together due to their similar HIV risks. Specific emphasis is placed on MSM and trans-women (male-to-female transgender people). The Tool also recognizes that lesbian women face discrimination and specific HIV vulnerabilities because of structural factors, including sexual violence. However, HIV risks are significantly higher among MSM and trans-women due to physiological factors associated with the mode of HIV transmission. The term **MSM** describes males who have sex with other males, regardless of whether or not they have sex with women or have a personal or social identity associated with that behavior, such as being gay or bisexual. See UNAIDS, UNAIDS ACTION FRAMEWORK: UNIVERSAL ACCESS FOR MEN WHO HAVE SEX WITH MEN AND TRANSGENDER PEOPLE 2 (2009). The term **transgender** comprises individuals whose gender identity and/or expression of their gender differs from social norms related to their gender of birth. The term **transgender people** describes a wide range of identities, roles and experiences, which can vary considerably from one culture to another. See UNAIDS, GETTING TO ZERO STRATEGY 2011-2015 at 61 (2010). **Sexual orientation** is defined as a person’s capacity for profound emotional and sexual attraction to, and intimate relations with, individuals of a different gender or the same gender. **Gender identity** refers to a person’s deeply felt individual experience of gender, which may or may not correspond with the sex assigned at birth. See THE YOGYAKARTA PRINCIPLES ON THE APPLICATION OF INTERNATIONAL HUMAN RIGHTS LAW IN RELATION TO SEXUAL ORIENTATION AND GENDER IDENTITY (2007).

## International Standards and Commentary

### Reduction of HIV Vulnerabilities and Elimination of Discrimination

MSM and transgender people are made more vulnerable to HIV by the specifics of HIV transmission,<sup>xxxii</sup> but even more significantly by stigma, discrimination, criminalization of their status, and other human rights violations. Consensual same-sex conduct is a criminal offence in approximately 86 countries in seven of which it is punishable by death penalty.<sup>502</sup> Other laws may also indirectly prohibit or suppress same-sex conduct, such as anti-debauchery statutes.<sup>503</sup> The UN Special Rapporteur on the Right to Health points out that the criminalization of same-sex conduct between consenting adults infringes not only upon the right to health but also upon other human rights, including the rights to privacy and equality. In jurisdictions where same-sex conduct is criminalized, affected individuals are much less likely to gain access to effective health services, and HIV prevention measures that are tailored to their needs are often suppressed. In addition, criminalization perpetuates discriminatory beliefs of some health care providers who consider homosexuality and transgender behavior as diseases or disorders. This can result in the application of inhumane and unethical treatments, such as aversion therapy to treat homosexuality. These attitudes and practices disempower affected individuals to fully realize their right to health by accessing health care settings.<sup>504</sup>

Empowering MSM and transgender people to protect themselves from HIV infection and fully access ART is one of UNAIDS' ten priority areas. UNAIDS urges States to deliver a comprehensive package of HIV interventions to these key populations and ensure that that law enforcement agencies and the judicial system protect their rights. Furthermore, UNAIDS has set a goal for 2015 of reducing by half the number of countries with punitive laws and practices around homosexuality that block effective HIV responses.<sup>506</sup>

International Guidelines urge States to reduce HIV vulnerability among MSM and transgender people by eliminating discrimination against them and by protecting their human rights. In particular, States are urged to: 1) review, with the aim of repeal, criminal laws prohibiting same-sex conduct between consenting adults in private; 2) provide penalties for vilification of people who engage in same-sex relationships; 3) give legal recognition to gender identity as well as same-sex marriages and/or relationships; 4) govern such relationships with consistent property, divorce and inheritance provisions; 5) establish the same age of consent to sex and marriage for heterosexual and homosexual relationships; and 6) ensure adequate legal protection in cases of assault against MSM and transgender people.

Under no circumstances should criminal law be allowed to impede the provision of HIV prevention, treatment, and care services to MSM or transgender people.<sup>507</sup>

#### Right to Non-Discrimination

UDHR and UN human rights treaties do not explicitly mention sexual orientation or gender identity. However, the term "other status" in non-discrimination provisions embedded in ICCPR and ICESCR has been interpreted by the UN human rights treaty-based bodies to include sexual orientation.<sup>500</sup> The view that discrimination on the ground of sexual orientation or gender identity is prohibited by international human rights law as been endorsed by OHCHR and the UN Secretary-General.<sup>501</sup>

#### Package of HIV Interventions for MSM and Transgender People

In 2009, UNAIDS noted that a package of HIV interventions for MSM and transgender people requires, among others: (1) conducive legal and social environment; (2) improvement of the human rights situation; (3) removal of laws that criminalize sex between males; (2) strengthening and promoting the evidence base on MSM, transgender people, and HIV; (3) empowerment of MSM and transgender people; (4) public campaigns to address homophobia and transgender discrimination; (5) safe access to HIV information, condoms, water-based lubricants, HIV- and STI-related services, and harm reduction measures; and (6) addressing the HIV-related risks and needs of the female sexual partners of MSM and transgender people.<sup>505</sup>

<sup>xxxii</sup> The unadjusted probability per coital act of transmitting HIV is calculated to be 80 times higher for receptive anal intercourse than for vaginal intercourse, whether that anal sex is homosexual or heterosexual. See GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA, THE GLOBAL FUND STRATEGY IN RELATION TO SEXUAL ORIENTATION AND GENDER IDENTITIES 3 (2009); UNAIDS, UNAIDS ACTION FRAMEWORK: UNIVERSAL ACCESS FOR MEN WHO HAVE SEX WITH MEN AND TRANSGENDER PEOPLE 2 (2009).

In addition, States should prohibit compulsory, coercive and abusive health measures targeting MSM, such as compulsory HIV and STI testing, *treatment* of sexual orientation, or coercive gender reassignment.<sup>508</sup> See Factors 1, 11, and 17 above. States should also ensure the participation of MSM and transgender people in the planning, implementation and review of HIV-related responses.<sup>509</sup>

### Areas of Inquiry

- What is the HIV prevalence rate among MSM and transgender people?
- Does the State recognize MSM and transgender people as key populations in the context of HIV/AIDS?
- Does the State allocate specific budget for HIV programs focusing on MSM and transgender people?
- Does the State involve MSM and transgender people in the design and implementation of HIV programs?
- What measures are undertaken to mitigate HIV vulnerability among MSM and transgender people?
- Does the State support civil society initiatives that address HIV vulnerability of MSM and transgender people?
- Does the State prohibit discrimination on the basis of sexual orientation and gender identity?
- Does the State prohibit mandatory HIV testing and HIV-related discrimination of MSM and transgender people?
- What measures are undertaken to ensure that MSM and transgender people enjoy effective protection from HIV-related discrimination in practice?

#### HIV Interventions

- Does the State implement and support HIV interventions for MSM and transgender people?
- Does the State ensure that HIV interventions for MSM and transgender people are evidence- and human rights-based?

#### Punitive Laws and Practices

- How does the State's regulatory framework govern same-sex conduct between consenting adults? To what extent is sex between men prosecuted? Does the State take any measures to decriminalize sexual acts between consenting adults?
- Does the State recognize the link between criminalization, marginalization, and discrimination of MSM and transgender people and their vulnerability to HIV?
- Does the State ensure that criminal and other laws do not impede measures undertaken to to mitigate HIV vulnerability among MSM and transgender people and to provide them with HIV-related services?
- Does the State protect MSM and transgender people from repressive law enforcement practices and human rights violations by state and non-state actors in the context of HIV/AIDS?

#### Coercive Health Measures

- Does the State ensure that MSM and transgender people are not subjected to coercive health measures?

### Access to HIV-Related Services

The right to health for MSM and transgender people includes the entitlement to an equitable and sustainable system of health protection, including access to comprehensive HIV-related services. States should therefore: 1) ensure that all sexual and reproductive health services respect the diversity of sexual orientations and gender identities; and 2) facilitate educational campaigns that promote tolerance and address discrimination among the general population, law enforcement personnel, and health care providers. These and other obligations of States with regards to the provision of health care without discrimination on the basis of sexual orientation or gender identity are listed in the Yogyakarta Principles – a document adopted in 2006 by the world's renowned human rights experts, which outlines the application of international human rights law in relation to sexual orientation and gender identity.

### Areas of Inquiry

- Does the State ensure that MSM and transgender people have equitable and sustainable access to: 1) voluntary and confidential HIV testing; and 2) comprehensive HIV-related services?
- What barriers to HIV prevention, treatment and care do MSM and transgender people most commonly face? What measures are undertaken to eliminate these barriers?

- Does the State ensure that MSM and transgender people enjoy the rights to privacy, confidentiality, and dignity?
- Does the State ensure that state and non-state actors who are likely to come in contact with MSM and transgender people in their professional life receive sensitizing training and education on human rights-based approach to sexual orientation and gender identity?

## **Case Study**

### **Litigation to Decriminalize Same-Sex Conduct in India**

In the 1992 case *Toonen v. Australia*, the UN Human Rights Committee ruled that prohibition of sex discrimination under the ICCPR includes prohibition of discrimination based upon sexual orientation, and that criminalization is not a reasonable measure to prevent the spread of HIV. In 2009, the High Court of Delhi cited the case *Toonen v. Australia* in its judgment issued in the matter of *Naz Foundation v. Government of NCT of Delhi and Others*. The Naz Foundation claimed that by criminalizing private, consensual same-sex conduct, section 377 of the Indian Penal Code perpetuated negative and discriminatory beliefs towards same-sex conduct, driving MSM's activities underground, and crippling HIV prevention efforts. The High Court of Delhi found section 377 of the Indian Penal Code to be unconstitutional.

## Section III: Key Populations

### Factor 19: People under State Custody

**The State takes all appropriate measures to reduce specific HIV vulnerabilities of people under state custody, eliminate HIV-related discrimination against them, and provide them with equitable and sustainable access to comprehensive HIV-related services. Terminally ill PLHIV are considered for early release and given proper treatment outside of prisons.**

#### Introduction

Many of the same cultural, social, and economic conditions that increase one's vulnerability to HIV also increase vulnerability to imprisonment.<sup>510</sup> At the same time, the HIV/AIDS epidemic represents a serious health threat for people under state custody<sup>xxxiii</sup> worldwide. In many countries, HIV rates and associated TB and STI rates in prison populations are substantially higher than in the general population.<sup>511</sup> While most PLHIV under state custody acquired HIV before imprisonment, the risk of being infected in prisons is significant. Although evidence shows that HIV risk behaviors are common in detention facilities, prevention and harm reduction measures are not easily available.<sup>512</sup> In fact, possession of preventative commodities is often prohibited by internal prison rules. In Canadian prisons, HIV rates are 22 times greater than in the general population.<sup>513</sup> In Kyrgyzstan, it is reported that approximately 60% of prisoners use drugs while incarcerated and the cumulative number of HIV cases in prisons in 2007 was almost 120 times the national average.<sup>514</sup> The prevalence of HIV infection in South African prisons is reported to be about 40%, which is double the level in the general population.<sup>515</sup> PLHIV under state custody are often stigmatized and lack necessary health care services. Fear of HIV and lack of information about how it is spread places PLHIV at increased risk of isolation, violence, breach of confidentiality, and other human rights abuses from inmates and prison staff.

#### International Standards and Commentary

##### Reduction of HIV Vulnerability and Elimination of Discrimination

According to the UN Basic Principles for the Treatment of Prisoners, the rights of people in prisons cannot be limited beyond what is necessitated by the condition of detention or incarceration.<sup>516</sup> The loss of liberty is the punishment, not the deprivation of fundamental human rights or dignity.

International law prohibits torture and all forms of discrimination against prisoners, including children, and guarantees persons deprived of liberty, the right to dignity and humane treatment.<sup>517</sup> According to CRC and UN standards on juvenile justice, the arrest, detention or imprisonment of a child should be used only as a measure of last resort and for the shortest appropriate period of time. Juveniles deprived of liberty should be

#### Examples of Compliance

- People in custody have access to a comprehensive set of HIV prevention measures.
- State regulations on correctional institutions include provisions on prison health care and HIV.
- State considers HIV-positive prisoners for early release on compassionate grounds.

#### Examples of Non-Compliance

- Prisoners living with HIV are segregated from the general prison population.
- People in custody do not have access to OST and ART, although these interventions are available to the general population.

<sup>xxxiii</sup> The term **people under state custody** refers to males and females who are detained by state actors or under state authority, regardless of whether they have been formally arrested or convicted of a crime. This includes people placed in all types of state-controlled detention facilities, whether directly managed by state actors or managed by private actors under state contract (people in prisons, pretrial detention, and immigration detention). *Note:* While implementing the Tool, the Assessor should take into account specific conditions in various types of detention facilities. For example, people in pretrial detention may face increased health challenges caused by less adequate health services or rapid turnover of detainees.

separated from adults, and should receive care that takes into account their special needs determined by age, personality, sex, and health. They should also receive protection from harmful influences and risk situations.<sup>518</sup>

### **HIV Interventions**

International Guidelines note that the State, through prison authorities, owes a duty of care to all people in custody, including the duty to protect the rights to life and health. Therefore, prison administrations have the responsibility to: 1) safeguard the confidentiality of prisoners' HIV status; 2) establish effective protection from HIV-related discrimination; and 3) define and put in place policies and practices that will create a safer environment and diminish the risk of HIV transmission, which also includes a duty to combat prison rape and other forms of sexual abuse. These measures should include adequate staffing and effective surveillance. Prisoners who engage in dangerous behavior should be subject to appropriate discipline but with no reference to their HIV status.<sup>519</sup>

WHO, UNODC, and UNAIDS have called on States to urgently scale up comprehensive and targeted HIV programs in prisons.<sup>521</sup> HIV interventions should take into account specific vulnerabilities faced by people in custody and accept that drug use and sex happen in detention facilities, and that both conducts may lead to increased HIV risks.<sup>522</sup>

For the prevention of STIs and sexual transmission of HIV, prison systems should make condoms available to all people in custody. Condoms should be easily and discreetly accessible in and outside of rooms for conjugal visits, together with water-based lubricants.<sup>523</sup> For the protection from blood-borne HIV transmission, prison NSPs, safer tattooing programs, and – as a second line strategy to NSPs - provision of bleach for disinfecting used injecting equipment are recommended.<sup>524</sup> Evidence shows that NSPs lead to no negative consequences such as violence or increased drug use.<sup>525</sup> States are also urged to establish effective voluntary drug dependence treatment programs. Studies show these programs are effective in reducing the frequency of injecting drug use and sharing of injecting equipment. They also lead to stabilized health, prison safety, and reduced chances of re-incarceration. Aftercare and rehabilitation after release are also extremely important.<sup>526</sup>

### **Coercive Health Measures**

International Guidelines stress that mandatory HIV testing of people in prisons is unethical, ineffective, has no public health justification, and should be prohibited.<sup>527</sup> There is also no public health or security justification for denying PLHIV under state custody access to activities, facilities, privileges, or release programs available to the rest of the prison population. Furthermore, the only justification for isolation of PLHIV from the prison population is for their own health.<sup>528</sup> PLHIV should not be excluded from placement in semi-liberty hostels or centers, or any other type of open or low-security prison, nor should such placement be contingent upon disclosure of HIV status.<sup>529</sup> See Factor 16 above.

### **Right to Be Free from Torture**

No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.

*UDHR art. 5; ICCPR art. 7; CRC art. 37; ECHR art. 3; Banjul Charter art. 5; ACHR art. 5*

### **Right to Humane Treatment**

All persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person.

*ICCPR art. 10, CRC art. 37*

**States should review and reform criminal laws and correctional systems to ensure that they are consistent with international human rights obligations and are not misused in the context of HIV or targeted at vulnerable groups.**

*International Guidelines, Guideline 4*

### **Management of HIV Infection in Prisons**

According to WHO, UNODC, and UNAIDS, an effective management of HIV infection in prisons must be based, among others, on the following principles: 1) good prison health is good public health; 2) good prisoner health is good custodial management; 3) adherence to international law; 4) respect for human rights; 5) equivalence in prison health care; 6) holistic approach to health; 7) evidence-based interventions; 8) addressing vulnerability, stigma, and discrimination; 9) collaborative, inclusive, and intersectional cooperation and action; and 10) reducing prison population.<sup>520</sup>

## Areas of Inquiry

- What is the HIV prevalence rate among people under state custody?
- Does the State recognize people in custody as a key population in the context of HIV/AIDS?
- Do State regulations on correctional institutions include human rights-based provisions on HIV/AIDS?
- Does the State allocate specific budget for HIV programs focusing on people in custody?
- What measures are undertaken to mitigate HIV vulnerability among people in custody?
- Does the State support civil society initiatives that address HIV vulnerability of people in custody?
- Does the State prohibit mandatory HIV testing and HIV-related discrimination of people in custody?
- What measures are undertaken to ensure that people in custody enjoy effective protection from HIV-related discrimination in practice?
- Does the State ensure that people in custody enjoy the rights to privacy, confidentiality, and dignity?
- Does the State protect people in custody from torture, inhumane treatment, rape, sexual abuse, harassment, vilification, and other violations of human rights?

### HIV Interventions

- Does the State implement and support HIV interventions for people in custody?
- Does the State ensure that HIV interventions for people in custody are evidence- and human rights-based?

### Coercive Health Measures

- Does the State ensure that people in custody are not subjected to coercive health measures, such as mandatory HIV testing and segregation?

## Access to HIV-Related Services

In line with the **principle of equivalence** articulated, among others, in the UN Basic Principles for the Treatment of Prisoners, people under state custody are entitled, without discrimination, to a standard of health care at least equivalent to that available in the outside community.<sup>530</sup> Therefore, States should make all HIV-related services available to people in custody at least to the level available to the general population.<sup>531</sup> According to International Guidelines and the UN Committee against Torture, denial to prisoners of access to adequate medical care, including HIV-related services, could constitute cruel, inhuman or degrading treatment or punishment.<sup>532</sup>

First, prison authorities should ensure easy and voluntary access to HIV testing and counseling at any time during imprisonment, and inform people about the availability of the service, both at the time of admission and regularly thereafter.<sup>533</sup> Furthermore, people under state custody should receive HIV education on entry, during their prison term, and in pre-release programs. States should encourage participation of inmates and staff in peer education programs as well as in the development and dissemination of relevant educational materials. As mentioned above, access to HIV prevention measures (condoms, bleach, and clean injection equipment) should also be secured.<sup>534</sup>

Second, prison medical services should provide people in custody with sexual and reproductive health care, sex education, HIV post-exposure prophylaxis, and treatment for HIV and related illnesses, including TB.<sup>535</sup> TB is increasingly associated with HIV/AIDS, and is easily spread in the prison environment due to overcrowding, insufficient ventilation, and inadequate nutrition. Therefore, States must take steps to: 1) reduce the risks of TB related to the prison environment; 2) screen for TB on entry, at regular intervals during imprisonment, and through contact tracing; and 3) provide effective treatment for TB.<sup>536</sup>

International standards encourage the participation of community organizations, people in prisons, and staff in prison health.<sup>537</sup> Finally, prison staff should receive HIV-related human rights and ethics training.<sup>538</sup>

## Areas of Inquiry

- Does the State adhere to the principle of equivalence of health care in prisons?
- Does the State ensure that people in custody have equitable and sustainable access to: 1) voluntary and confidential HIV testing; and 2) comprehensive HIV-related services?

- Does the State ensure continuity of care when detained PLHIV are transferred between facilities?
- What barriers to HIV prevention, treatment and care do people in custody most commonly face? What measures are undertaken to eliminate these barriers?
- Does the State ensure that prison staff receive sensitizing training on human rights and HIV/AIDS?

## Early Release

According to International Guidelines, people with terminal diseases, including AIDS, should be considered for early release on compassionate grounds and given proper treatment outside prison.<sup>539</sup> Prison medical services should provide full information on such people, on their request, to the authorities competent to decide upon early release. Health status of an offender should also be taken into account in the imposition of pre-trial detention and during sentencing, especially to incarceration.<sup>540</sup>

## Areas of Inquiry

- Does the State consider PLHIV with terminal illnesses for early release on compassionate grounds?
- Does the State provide PLHIV with a continuum of health care after release from prisons?
- Does the State take PLHIV's health status into consideration in the imposition of detention?

## Case Study

### PW v. South Africa Department of Correctional Services (1997–2003)

PW was incarcerated from November 1993 to December 1994 and repeatedly tested HIV-negative. He had a sexual relationship with an HIV-positive man while in prison, and in 1994 tested positive for HIV. PW filed a lawsuit against the South Africa Department of Correctional Services claiming that he was unaware of his partner's HIV status at the time of their relationship, and that the prison authorities ignored and tolerated the practice of sexual relationships in prisons while denying all prisoners access to condoms. PW argued that the policy prohibiting condoms was not necessary for the achievement of any public purpose and asserted that the conduct of the prison authorities amounted to negligence and breached the *Correctional Services Act of 1959*. He further argued that the Department of Correctional Services had violated his rights under the Constitution, in particular: 1) the right to be detained under conditions consistent with human dignity, and to be provided with adequate medical treatment at State expense; 2) the right to freedom and security of the person; 3) the right not to be subjected to torture and cruel, inhuman, or degrading treatment or punishment; 4) the right to life; and 5) the right to respect for and protection of dignity. PW sued for future medical expenses, loss of earnings, and general damages for pain and suffering. The lawsuit was settled out of court and the terms of the agreement were confidential. Despite the fact that the case was settled, it illustrates the use of litigation to hold a government accountable for the impact of its policies and its actions on people's health. In 1996, the Department of Correctional Services developed a new policy on managing HIV and AIDS in prisons. In 2000, this policy was supplemented by a Management Strategy on HIV/AIDS in Prisons.<sup>541</sup>



## Section IV: Access to Justice

### Factor 20: Legal Protections

Every person enjoys the right to an adequate and effective protection against violations of human rights based on HIV status, vulnerability, advocacy, or service work.

#### Introduction

The obligation of States to enact legislation and policies aimed at eliminating all forms of HIV-related discrimination is clearly articulated in a number of international instruments, including the Declaration of Commitment and the Political Declaration.<sup>542</sup> According to International Guidelines, law reform in this area should encompass not only norms embodied in the formal legal system, but also those stemming from traditional and customary laws.<sup>543</sup> The rights contained in legal instruments, however, have little practical value without legal protections through which they can be enforced by national justice institutions. Per UNDP, legal protection or legal standing is a state where the rights of disadvantaged people are recognized within the scope of the criminal and civil justice systems, thus giving entitlement to remedies.<sup>544</sup> For groups who are unable or unwilling to access the formal legal system, informal justice systems can be a key source of protection.<sup>545</sup> Further, the efficacy of any legal framework protecting human rights in the context of HIV/AIDS relies heavily on such mechanisms as human rights commissions or ombudspersons, which have a mandate to monitor and document instances of HIV-related mistreatment and discrimination.

#### International Standards and Commentary

##### Legal Remedies

###### *Right to Effective Remedy*

States are required to adopt laws and other measures (including sanctions) that are necessary to establish legal protection of, and give effect to, human rights and freedoms guaranteed under international law. Any person whose rights or freedoms are violated has the right to an effective remedy and judicial protection, notwithstanding that the violation has been committed by persons acting in an official capacity.<sup>546</sup>

*UDHR art. 8; ICCPR art. 2;  
CEDAW art. 2; CRC art. 4*

International standards affirm that the existence of an effective remedy for the violation of a right is integral to the full realization of that right. International Guidelines not only urge States to enact anti-discrimination and other protective laws – including laws prohibiting HIV vilification – but to also provide for speedy and effective administrative and civil remedies.<sup>547</sup> The availability of compensation for damages suffered by PLHIV as a result of discrimination or other human rights violations is an important element of this obligation. According to UNAIDS, UNDP, and IDLO, States should also support alternative remedies provided for by traditional and customary justice systems if they are consistent with international human rights standards.<sup>548</sup>

###### Examples of Compliance

- State's legal system provides for legal remedies against HIV-related discrimination.
- State's human rights bodies record cases of HIV-related discrimination and provide recommendations for systematic redress.
- State vigorously prosecutes human rights abuses against PLHIV.

###### Examples of Non-Compliance

- State's legal system does not allow plaintiffs to seek compensatory damages in cases alleging HIV-related discrimination.
- State's human rights bodies refuse to address systematic discrimination against PLHIV in public and private life.
- Law enforcement officials routinely discriminate against PLHIV while investigating crimes committed against them.

## Areas of Inquiry

- Does the State's formal and/or customary legal system: 1) contain anti-discrimination provisions that cover HIV-related discrimination; and 2) provide for remedies for acts of discrimination and other human rights violations against individuals based on their HIV status, vulnerability, advocacy, or service work?
- Does the State ensure that available remedies include financial compensation for damages suffered as a result of mistreatment?

## Monitoring and Enforcement of Human Rights

International Guidelines underline that laws that prohibit and provide redress for HIV-related discrimination, harassment, and other human rights violations are not sufficient to ensure effective protection of the rights of PLHIV. Mechanisms for monitoring whether these laws are appropriately administered and enforced by the formal and informal justice systems must also be established, preferably at the community and national levels. States are therefore urged to: 1) support and strengthen HIV/AIDS-related expertise in relevant government agencies (e.g., by establishing HIV focal points in ministries of justice and health); and 2) ensure that human rights commissions, ombudspersons, and/or health complaint units document individual and systemic cases of HIV-related discrimination or mistreatment.<sup>549</sup> National institutions with a mandate to investigate and adjudicate complaints of discrimination or other human rights abuses, issue public pronouncements and reports with a focus on the legal protection of PLHIV, and make recommendations for systematic redress, add an important dimension to the legal protection of PLHIV.<sup>550</sup> Ensuring that professional bodies (e.g., of health care workers or journalists) assert and protect the human rights of PLHIV – including the right to privacy – through their codes of professional conduct is also encouraged.<sup>551</sup> International Guidelines specifically urge States to establish an independent agency to redress breaches of confidentiality.<sup>552</sup> Lastly, States are encouraged to recognize the competence of international human rights bodies to receive complaints or communications from individuals who claim that their rights have been violated.<sup>553</sup> Access to these additional oversight mechanisms is especially important when the national legal system fails to adequately protect the rights of PLHIV.

## Areas of Inquiry

- Do national human rights monitoring and enforcement mechanisms consider HIV-related issues? Do they make recommendations for systematic redress?
- What measures are undertaken to ensure that cases of HIV-related discrimination are systematically recorded, documented, and addressed?
- Does the State maintain HIV focal points within the government to monitor HIV-related discrimination and other human rights abuses?
- Does the State have a body responsible for researching trends among HIV-related legal cases and identifying systemic patterns of discrimination?
- Does the State have an independent agency that provides redress for breaches of confidentiality?
- Is the State party to the following treaties and protocols that provide individuals with access to international human rights enforcement mechanisms: 1) ICCPR and its First Optional Protocol; 2) CEDAW and its First Optional Protocol; 3) Convention on the Rights of Persons with Disabilities and its Optional Protocol; and 4) Declaration under article 22 of CAT?
- Have any of the international human rights bodies heard HIV-related cases against the State? If yes, what was their outcome?

## Case Study

### Kenyan National Commission on Human Rights

The Kenyan National Commission on Human Rights has taken a number of steps to ensure that the legal rights of PLHIV are protected, including property rights of Kenyan widows. After the onset of the HIV epidemic in Kenya, many widows were disinherited, which is in violation of their right to inherit their husband's property under formal Kenyan law. Because the formal legal system is not accessible or affordable for many Kenyan women, a Kenyan NGO, KELIN, and the Kenyan National Commission on Human Rights, have been working with Luo councils of elders to ensure that the resolution of inheritance disputes is guided by human rights norms.<sup>554</sup> The Kenyan National Commission has also published a policy concerning HIV/AIDS in the workplace, which covers the responsibilities of employers towards PLHIV in the areas of job security, confidentiality, occupational benefits, non-discrimination and protection against victimization and stigmatization.<sup>555</sup> Further, the Commission has committed to monitoring and evaluating the impact of the policy.<sup>556</sup>

## Section IV: Access to Justice

### Factor 21: Legal Awareness, Assistance, and Representation

**The State implements and supports educational programs aimed at raising legal literacy among PLHIV. PLHIV have equal access to adequate and affordable legal assistance and representation.**

#### Introduction

Without access to legal services, the rights of PLHIV to numerous opportunities and commodities, such as health care, housing, education, employment, and social services, can be seriously compromised.<sup>557</sup> Among the core legal services identified by UNAIDS, UNDP, and IDLO as essential to securing the rights of PLHIV are access to legal information, advice, and representation.<sup>558</sup> These services play a critical role in the realization of human rights of PLHIV. Consequently, they require adequate State funding and support.<sup>559</sup>

#### International Standards and Commentary

##### Legal Awareness

Legal education provides a key source of protection and empowerment that can be utilized by PLHIV to challenge HIV-related stigma and discrimination.<sup>560</sup> The duty of States to develop, implement, and support services that educate PLHIV and key populations about their legal rights is emphasized in a number of international instruments, including International Guidelines and Political Declaration.<sup>561</sup> Legal literacy programs should raise the awareness of PLHIV about laws pertaining to, but not limited to, discrimination, healthcare services, privacy, social services, property, inheritance, education, and reproductive rights.<sup>562</sup> The nature of the service – whether over the phone, internet, or in person – and the format of the information must be appropriate to the mobility, resources, and literacy of target groups.<sup>563</sup> States are also urged to support production and dissemination of legal materials focusing on HIV/AIDS and legal rights (e.g., brochures, directories of legal services, practice and training manuals, bench books for judges, and student texts) and integrate HIV/AIDS into standard legal education curricula, both within law schools and in the context of continuing legal education for legal professionals.<sup>564</sup> International Guidelines suggest that such materials should cover relevant case law, law reform, national enforcement of relevant laws, and the prevalence of human rights abuses.<sup>565</sup>

##### Areas of Inquiry

- What measures are undertaken to educate PLHIV and key populations about their legal rights?
- Does the State support legal awareness raising programs implemented by CSOs and international organizations?
- Does the State ensure production and dissemination of materials covering HIV/AIDS and legal rights?
- Does the State ensure that legal literacy material is presented in a format and style that is readily accessible by PLHIV and key populations?

#### Examples of Compliance

- State implements and supports programs aimed at raising legal awareness among PLHIV.
- HIV-related issues are included in public and private law school curricula.
- State provides financial assistance to CSOs offering free legal services to PLHIV.
- State supports medical-legal partnership and integration of legal services in healthcare settings.

#### Examples of Non-Compliance

- Legal materials focusing on HIV-related human rights are largely unavailable.
- PLHIV face discrimination in accessing legal services offered by law firms and State-run legal aid agencies.
- Legal services that specialize in HIV-related cases are precluded from receiving State funding.

- Does the State ensure that issues related to HIV/AIDS are covered in law school curricula and in the continuing legal education programs for lawyers and judges?

## Legal Assistance and Representation

In order to effectively assert their rights and, when necessary, initiate legal action, PLHIV must have access to professional legal advice and representation. Any legal aid should be provided by a duly accredited lawyer or, where that is impractical, by an appropriately trained and accredited paralegal.<sup>566</sup> Because poverty, social stigma, and marginalization preclude many PLHIV from accessing legal services, States are called upon to facilitate their access to free legal advice and representation.<sup>567</sup> International Guidelines specifically urge States to support legal aid systems specializing in HIV case work, and to encourage private sector law firms to offer pro bono services to PLHIV, for example through formal inducements such as tax reduction.<sup>568</sup> In addition to law firms and State-run legal aid agencies, HIV-related legal services can be provided by traveling lawyers, CSOs, community legal aid centers, and university-based legal clinics. Irrespective of the model, it is recommended that all legal services accessed by PLHIV operate in a manner that is consistent with such principles as confidentiality, non-discrimination in the provision of services, and meaningful participation of PLHIV in the planning and delivery of the services.<sup>569</sup> In addition, all legal services should be based on a comprehensive needs assessment and situation analysis to ensure that they are adapted to the needs of the local community.<sup>570</sup> This evaluation should include existing traditional or community-based justice systems that provide an alternative recourse for PLHIV.<sup>571</sup> Finally, States are urged to support and facilitate cooperation between lawyers and other providers of HIV-related services, particularly healthcare practitioners. Such cooperation can be accomplished, for example, through medical-legal partnerships which are well-equipped to address the social determinants of health that create hardships for affected populations: they can train healthcare providers to identify legal issues that affect their patients' health and they can integrate free legal services in healthcare settings.<sup>572</sup> Developing referral networks and general outreach initiatives is also key to creating awareness among PLHIV of the existence of relevant legal services.<sup>573</sup>

## Areas of Inquiry

- Does the State ensure that PLHIV have equal access to adequate legal services provided by duly accredited lawyers or paralegals?
- Does the State facilitate the provision of free legal services to PLHIV who are unable to access or afford services of paid lawyers?
- Does the State support legal services that specialize in HIV-related casework? To what extent are they available and accessible?
- What types of legal services do PLHIV most commonly access? Are they adequate?
- Does the State facilitate partnerships between lawyers and HIV-related service providers, such as health care workers? Are these partnerships effective in creating a holistic approach to HIV/AIDS?
- Does the State ensure that: 1) legal services are integrated in healthcare settings; and that 2) health care providers are trained in identifying potential legal issues that may affect their HIV patients' health?

## Case Study

### Legal Awareness-Raising in Vietnam

The Health Policy Initiative in Vietnam coordinates a program that brings together a number of NGOs, including the Vietnam Lawyers Association, to provide legal education, outreach, advice and representation to PLHIV in several provinces. The organizations have collaborated to run a national HIV hotline, which advises PLHIV about their rights and performs outreach to the broader community. In addition, the legal offices in each province employ HIV-positive staffers who work as peer outreach counselors. The services offered by the program have been widely utilized: between 2007 and September 2008, the five clinics have conducted about 1,100 consultations and the hotline has offered advice to over 2,700 callers from all 64 provinces.<sup>574</sup>

## Section IV: Access to Justice

### Factor 22: Access to a Forum, Fair Trial, and Enforcement of Remedies

**PLHIV, HIV/AIDS advocates and service workers are guaranteed equal access to a forum administering justice, the right to a fair trial, and effective enforcement of remedies.**

#### Introduction

The extent to which a justice system provides effective protection to PLHIV, including protection of their human rights, heavily depends on the existence of accessible, competent, and independent justice institutions; on the guarantee of fairness during legal proceedings; on the timely resolution of disputes; and on the timely and effective enforcement of remedies. PLHIV, HIV advocates, and service-workers face a range of impediments to their access to a forum administering justice. Even if a forum is affordable and physically accessible, they may be deterred from using it if they fear loss of privacy, unauthorized disclosure of HIV status, intimidation, harassment, or stigmatization during legal proceedings.<sup>575</sup> It is imperative that States take measures to address all of these aspects of the dispute-resolution process so that PLHIV, HIV advocates and service-workers are empowered to invoke their legal rights through formal or informal justice systems.

#### International Standards and Commentary

##### Access to a Forum

###### *Right to a Hearing*

Everyone claiming a remedy for a violation of human rights should have these rights determined by competent judicial, administrative, or legislative authorities.

*UDHR art. 8; ICCPR art. 2;  
Banjul Charter art. 7; ACHR art. 8*

Improving and facilitating access to formal and informal forums administering justice as well as alternative forms of dispute resolution, should constitute a fundamental component of States' efforts aimed at ensuring the protection

of human rights of PLHIV. Whether or not a forum administering justice is accessible by PLHIV, HIV advocates and service workers will depend on a number of factors, including: 1) number of courts and their geographical distribution; 2) public transport infrastructure; 3) existence of any risks associated with traveling to or using the forum; 4) economic accessibility; 5) level of protection of privacy and confidentiality; 6) availability of legal aid; and 7) disability.

Without physical and economic access to justice institutions and a minimum level of financial security, it is unlikely that PLHIV will have the motivation or capacity to avail themselves of the legal system's protections. States should therefore create an enabling environment for PLHIV who seek remedies for violation of their human rights by: 1) providing economic support necessary to overcome the basic costs associated with the legal system (e.g., transportation costs and filing fees); 2) implementing appropriate economic empowerment initiatives, such as micro-financing or micro-lending projects,<sup>576</sup> and 3) providing legal aid or subsidized legal services to the indigent. See Factor 21 above. Because the informal justice system is often less costly and more accessible to marginalized groups,<sup>577</sup> where appropriate, States should encourage the judiciary to consider diversion of cases to informal forums administering justice, and empower informal justice sector to

###### Examples of Compliance

- Forums administering justice are easily accessible by PLHIV in urban and rural areas.
- State effectively protects PLHIV's privacy during legal proceedings.
- HIV-related issues are incorporated into training curricula for judges and law enforcement officers.
- Terminally ill PLHIV have access to expedited dispute resolution and enforcement of remedies.

###### Examples of Non-Compliance

- HIV-related prejudice among judges, law enforcement officers, and/or court personnel impede PLHIV's access to justice institutions and their right to a fair trial.
- States fails to protect PLHIV from harassment and intimidation during legal proceedings.

consider a wider range of cases, for example, through intensive training programs.<sup>578</sup> States should ensure, however, that informal institutions administer justice in a way that is consistent with human rights principles and that they do not reinforce harmful traditional norms or practices.<sup>579</sup>

### Areas of Inquiry

- Does the State ensure that PLHIV, HIV advocates and service workers have equal access to forums administering justice?
- Does the State's justice system infrastructure create an enabling environment for access to justice?
- Does the State ensure that forums administering justice are easily accessible in both urban and rural communities?
- Are the costs associated with dispute resolution in the formal justice system reasonable?
- Does the State provide economic support to parties, including PLHIV, who are unable to overcome the basic costs associated with filing a lawsuit and participating in legal proceedings?
- Does the State support alternative dispute resolution and, where appropriate, diversion of cases to the informal justice sector?

### Fair Trial

States must ensure that all forums administering justice treat all persons, including PLHIV, HIV advocates and service workers, equally. This obligation includes protection of privacy and protection from HIV-related discrimination, harassment, and intimidation during legal proceedings.

Protection of privacy of parties to legal proceedings concerning HIV-related issues is critical to ensuring due process rights; minimizing the risk of discrimination; and encouraging parties to talk openly about sensitive issues.<sup>581</sup> International Guidelines urge States to authorize PLHIV to demand that their identity and privacy be protected in legal proceedings in which HIV-related information will be raised. This can be accomplished by bringing cases under pseudonym and representative complaints, including the possibility of CSOs lodging cases on behalf of PLHIV.<sup>582</sup> Where appropriate, States should support other privacy and confidentiality measures, such as videoconferencing or closed hearings.

#### *Right to a Fair Trial*

Everyone has the right to a fair and public hearing by a competent, independent, and impartial tribunal. The press and the public may be excluded from all or part of a trial for reasons of morals, public order, or national security in a democratic society, or to protect the interest of the private lives of the parties. Everyone charged with a criminal offence has the right to be presumed innocent until proved guilty according to the law. States are required to ensure that all persons are equal before the courts and tribunals.<sup>580</sup>

*ICCPR art. 14; Banjul Charter art. 7;  
ACHR art. 8; ECHR art. 6*

International Guidelines and other international instruments stress the importance of providing HIV education and sensitivity trainings to court and law enforcement officers in order to eliminate bias and prejudice based on HIV status and ensure that PLHIV are protected from stigma, harassment, and intimidation during legal proceedings.<sup>583</sup> These trainings should address the importance of non-stigmatizing personal conduct and use of non-judgmental language.<sup>584</sup> The Statement of Principles on HIV, the Law and the Judiciary in sub-Saharan Africa specifically notes that judicial education should include the use of internationally accepted non-stigmatizing language to eliminate myths, misconceptions, and prejudices related to HIV/AIDS.

To accomplish the above-stated objectives, States are urged to disseminate International Guidelines throughout their judicial systems and use them in the development of jurisprudence, conduct of court cases involving HIV-related matters, and HIV-related training of judicial officers.<sup>585</sup> States should also ensure that prohibition of discrimination on any ground, including HIV status, be entrenched in the relevant professional codes of conduct, with accompanying mechanisms to implement and enforce these codes.<sup>586</sup>

### Areas of Inquiry

- Does the State prohibit stigmatization, discrimination, intimidation, and harassment of PLHIV, HIV advocates and service workers during legal proceedings?
- Does the State ensure that all forums administering justice treat all persons, including PLHIV, equally?

- Does the State ensure the right of PLHIV, HIV advocates and service workers to a fair trial?
- What measures are undertaken to protect the privacy of parties in legal proceedings which concern HIV-related issues?
- Does the State ensure that judges, court personnel, prosecutors, and law enforcement officers receive sensitizing trainings about HIV/AIDS?
- Do codes of professional conduct for judges, prosecutors, and law enforcement officers include provisions prohibiting discrimination on the basis of health and/or HIV status? Are these provisions enforced, e.g., through disciplinary measures?

### Timely Dispute Resolution and Enforcement of Remedies

In the context of HIV/AIDS, timely resolution of legal disputes<sup>587</sup> is of critical importance, particularly if they involve terminally ill parties or plaintiffs seeking access to life-saving treatment. International Guidelines urge States to provide for speedy and effective procedures for seeking redress, including, where appropriate, fast tracking of cases.<sup>588</sup> Alternative dispute resolution processes, which may offer reduced costs, stress, and time, are also an option that should be presented to PLHIV.<sup>589</sup>

These considerations also apply to the enforcement of remedies, which should be accelerated, for example, when the relevant remedy is intended to improve the health of the complainant.<sup>590</sup> States are also urged to ensure that other impediments to the enforcement of remedies are eliminated, such as the payment of fees on which enforcement is conditional and power imbalances within the community that permit the dominant party – such as the State – to resist compliance with a forum’s ruling.<sup>591</sup>

### Areas of Inquiry

- Does the State ensure that legal disputes concerning HIV-related issues are resolved in a timely and, where appropriate, expedited manner?
- Does the State ensure timely and effective enforcement of remedies in cases concerning HIV-related issues?

### Investigation and Prosecution of Human Rights Abuses

It is essential that human rights abuses, including hate crimes,<sup>xxxiv</sup> committed against PLHIV and HIV service workers and advocates be vigorously investigated and prosecuted. As part of their obligation to protect individuals from torture<sup>xxxv</sup> and cruel, inhuman or degrading treatment,<sup>592</sup> States must ensure that such acts are not perpetrated with impunity and that victims have access to adequate services. International standards require that, in protecting and serving all persons in the community, prosecutors and law enforcement officers do not act in a discriminatory manner.<sup>593</sup> Moreover, State officers are obliged to know, and apply, international standards for human rights. In particular, they should perform official functions without intimidation, hindrance, interference or unjustified exposure to civil, penal or other liability.<sup>594</sup> Where abuses are alleged to be committed by State agents, any investigation should be carried out by a body independent of those alleged to be responsible.<sup>595</sup>

<sup>xxxiv</sup> **Hate crime** is understood as a traditional offence (e.g., violence, murder, arson, vandalism) with an added element of bias.  
<sup>xxxv</sup> **Torture** is understood as any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. See CONVENTION AGAINST TORTURE AND OTHER CRUEL, INHUMAN OR DEGRADING TREATMENT OR PUNISHMENT art. 1 (adopted December 10, 1984 by U.N. G.A. Res. 39/46, entered into force June 26, 1987, U.N. Doc. A/39/51).



### ***Right to Freedom from Torture and Cruel, Inhuman or Degrading Treatment or Punishment***

No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.

*UDHR art. 5; ICCPR art. 7; CRC art. 37;  
ECHR art. 3; Banjul Charter art. 5; ACHR art. 5*

States must take effective legislative, administrative, judicial or other measures to: 1) prevent acts of torture; 2) ensure that all acts of torture are offences under criminal law; 3) make acts of torture punishable by appropriate penalties which take into account their grave nature; 4) ensure that any individual subjected to torture has the right to complain to, and to have his case promptly and impartially examined by, competent authorities; 5) protect complainant and witnesses against ill-treatment or intimidation; and 6) ensure that the victim obtains redress and has an enforceable right to fair and adequate compensation, including the means for as full rehabilitation as possible.

*CAT arts. 1- 4, 13-14*

### **Areas of Inquiry**

- Does the State prohibit and provide adequate penalties for acts of torture, cruel, inhuman or degrading treatment or punishment, hate crimes, and other human rights abuses against PLHIV?
- Does the State promptly and effectively investigate and prosecute human rights abuses against PLHIV?
- Does the State ensure that law enforcement officers do not act in a discriminatory manner when investigating or prosecuting HIV-related crimes?
- Does the State ensure that victims of HIV-related crimes have access to adequate victim services (including medical care, psychological counseling, and protection from re-victimization)?

### **Case Study**

#### **Accelerated Dispute Resolution in Argentina**

Courts in Argentina have, on a number of occasions, promptly facilitated the access of PLHIV to ART when the government was unable or unwilling to do so. In its 2002 decision, the Federal Civil and Commercial Court granted an order against the Ministry of Health for the uninterrupted supply of ART on the same day the complaint was filed.<sup>596</sup> The court ordered the Ministry of Health to take the necessary steps within two days to ensure a regular and uninterrupted supply of medicine for the treatment of HIV. This was consistent with an earlier decision by the Supreme Court that required the government to ensure an uninterrupted supply of antiretroviral drugs.<sup>597</sup>



# Part 4

## Endnotes



- <sup>1</sup> UNAIDS, OUTLOOK REPORT 2010 at 7 (2009).
- <sup>2</sup> UN, We Can End Poverty 2015: Millennium Development Goals Background, at <http://www.un.org/millenniumgoals/bkgd.shtml>.
- <sup>3</sup> UN, MILLENNIUM DEVELOPMENT GOALS REPORT 2010 at 40 (2010) [hereinafter 2010 MDGs REPORT].
- <sup>4</sup> *Id.* at 4; POLITICAL DECLARATION ON HIV/AIDS para. 4 (adopted June 2, 2006 by U.N. G.A. Res. 60/262) [hereinafter POLITICAL DECLARATION].
- <sup>5</sup> 2010 MDGs REPORT, *supra* note 3, at 45.
- <sup>6</sup> OHCHR & UNAIDS, INTERNATIONAL GUIDELINES ON HIV/AIDS AND HUMAN RIGHTS para. 12 (2006) [hereinafter INTERNATIONAL GUIDELINES]; DECLARATION OF COMMITMENT ON HIV/AIDS para. 7 (adopted June 27, 2001 by U.N. G.A. Res. S-26/2) [hereinafter DECLARATION OF COMMITMENT]; POLITICAL DECLARATION paras. 3, 14.
- <sup>7</sup> UNAIDS, HIV-RELATED STIGMA, DISCRIMINATION AND HUMAN RIGHTS VIOLATIONS: CASE STUDIES OF SUCCESSFUL PROGRAMS 2 (2005) [hereinafter UNAIDS, HIV-RELATED STIGMA, DISCRIMINATION AND HUMAN RIGHTS VIOLATIONS].
- <sup>8</sup> OHCHR, Introduction to HIV/AIDS and Human Rights, at: <http://www2.ohchr.org/english/issues/hiv/introhiv.htm>.
- <sup>9</sup> VIENNA CONVENTION ON THE LAW OF TREATIES arts. 1 (a), 11, 26-27 (adopted May 23, 1969 by UN Conference on the Law of Treaties, Treaty Series, vol. 1155, p. 331, entered into force January 27, 1980).
- <sup>10</sup> OHCHR, International Human Rights Law, at: <http://www.ohchr.org/EN/ProfessionalInterest/Pages/InternationalLaw.aspx>; FRANÇOIS-XAVIER BAGNOUD CENTER FOR HEALTH AND HUMAN RIGHTS, HARVARD SCHOOL OF PUBLIC HEALTH & ICASO, HIV & HUMAN RIGHTS IN A NUTSHELL 5 (2004) [hereinafter HIV & HUMAN RIGHTS IN A NUTSHELL].
- <sup>11</sup> OHCHR, What are Human Rights, at: <http://www.ohchr.org/en/issues/Pages/WhatareHumanRights.aspx>.
- <sup>12</sup> THOMAS BUERGENTHAL, DINAH SHELTON & DAVID STEWART, INTERNATIONAL HUMAN RIGHTS IN A NUTSHELL 48 (3rd ed., West Group 2002) [hereinafter INTERNATIONAL HUMAN RIGHTS IN A NUTSHELL]; HURST HANNUM, GUIDE TO INTERNATIONAL HUMAN RIGHTS PRACTICE 6 (3rd ed., Transnational Publishers, Inc. 1999) [hereinafter GUIDE TO INTERNATIONAL HUMAN RIGHTS PRACTICE]; INTERNATIONAL COVENANT ON CIVIL AND POLITICAL RIGHTS art. 2 (adopted December 16, 1966 by U.N. G.A. Res. 2200A/XXI, entered into force March 23, 1976, U.N. Doc. A/6316) [hereinafter ICCPR].
- <sup>13</sup> UN COMMITTEE ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS, GENERAL COMMENT NO. 3: THE NATURE OF STATES PARTIES OBLIGATIONS paras. 1-2, 10 (adopted December 14, 1990, U.N. Doc. E/1991/23); INTERNATIONAL HUMAN RIGHTS IN A NUTSHELL, *supra* note 12, at 68.
- <sup>14</sup> GUIDE TO INTERNATIONAL HUMAN RIGHTS PRACTICE, *supra* note 12, at 9-10.
- <sup>15</sup> OHCHR, International Human Rights Law, at: <http://www.ohchr.org/EN/ProfessionalInterest/Pages/InternationalLaw.aspx>.
- <sup>16</sup> GUIDE TO INTERNATIONAL HUMAN RIGHTS PRACTICE, *supra* note 12, at 7-10.
- <sup>17</sup> Walter Kälin, How Hard is Soft Law?, Presentation at the Roundtable Meeting, Ralph Bunche Institute for International Studies, CUNY Graduate Center (December 19, 2001).
- <sup>18</sup> UN MILLENNIUM DECLARATION para. 19 (adopted September 8, 2000 by U.N. G.A. Res. 55/2, U.N. Doc. A/55/49) [hereinafter UN MILLENNIUM DECLARATION].
- <sup>19</sup> UN, We Can End Poverty 2015: Millennium Development Goals Background, at <http://www.un.org/millenniumgoals/bkgd.shtml>.
- <sup>20</sup> See generally INTERNATIONAL GUIDELINES.
- <sup>21</sup> INTERNATIONAL GUIDELINES paras. 9-12.
- <sup>22</sup> PROTECTION OF HUMAN RIGHTS IN THE CONTEXT OF HUMAN IMMUNODEFICIENCY VIRUS (HIV) AND ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) preamble, para. 1 (adopted October 22, 2009 by UN Human Rights Council Res. 12/27) [hereinafter PROTECTION OF HUMAN RIGHTS IN THE CONTEXT OF HIV/AIDS 2009]. The International Guidelines were annexed to the UN Commission on Human Rights resolution no. 1997/33, and subsequently referred to in the UN Commission on Human Rights resolutions no. 1999/49, 2001/51, 2003/29, 2003/47, 2004/26, 2005/23, and 2005/84. See also PROTECTION OF HUMAN RIGHTS IN THE CONTEXT OF HUMAN IMMUNODEFICIENCY VIRUS (HIV) AND ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) (adopted April 11, 1997 by the Commission on Human Rights Res. 1997/33).
- <sup>23</sup> UNAIDS, Policies, at: <http://www.unaids.org/en/resources/policies/>; WHO, Guidelines on HIV/AIDS, at: [http://www.who.int/rpc/guidelines/hiv\\_aids/en/index.html](http://www.who.int/rpc/guidelines/hiv_aids/en/index.html).
- <sup>24</sup> UNAIDS, JOINT ACTION FOR RESULTS: UNAIDS OUTCOME FRAMEWORK 2009–2011 at 6-8 (2010) [hereinafter UNAIDS, OUTCOME FRAMEWORK 2009–2011].
- <sup>25</sup> UNAIDS, GETTING TO ZERO: 2011-2015 STRATEGY 7 (2010) [hereinafter UNAIDS, GETTING TO ZERO STRATEGY]; see also UNAIDS, Strategy Goals by 2015, at: <http://www.unaids.org/en/strategygoalsby2015>.
- <sup>26</sup> UNAIDS, UN Special Envoys for HIV/AIDS, at: <http://www.unaids.org/en/aboutunaids/unspecialenvoysforhivaids/>.
- <sup>27</sup> OHCHR, Introduction to HIV/AIDS and Human Rights, at: <http://www2.ohchr.org/english/issues/hiv/introhiv.htm>.
- <sup>28</sup> OHCHR, The Role of OHCHR, at: <http://www2.ohchr.org/english/issues/hiv/roleohchr.htm>.
- <sup>29</sup> UNAIDS, GETTING TO ZERO STRATEGY, *supra* note 25, at 7-11.
- <sup>30</sup> UNAIDS, HIV-RELATED STIGMA, DISCRIMINATION AND HUMAN RIGHTS VIOLATIONS, *supra* note 7, at 7-8; UNAIDS, REDUCING HIV STIGMA AND DISCRIMINATION: A CRITICAL PART OF NATIONAL AIDS PROGRAMS 9 (2007) [hereinafter UNAIDS, REDUCING HIV STIGMA AND DISCRIMINATION]; UNAIDS, NON-DISCRIMINATION IN HIV RESPONSES 2 (2010) [hereinafter UNAIDS, NON-DISCRIMINATION IN HIV RESPONSES]; UNAIDS, STIGMA AND DISCRIMINATION FACT SHEET (2003) [hereinafter UNAIDS, STIGMA AND DISCRIMINATION FACT SHEET].
- <sup>31</sup> UNAIDS, NON-DISCRIMINATION IN HIV RESPONSES, *supra* note 30, at 2, 5; UNAIDS, STIGMA AND DISCRIMINATION FACT SHEET, *supra* note 30.
- <sup>32</sup> UNAIDS, HIV-RELATED STIGMA, DISCRIMINATION AND HUMAN RIGHTS VIOLATIONS, *supra* note 7, at 4, 7; UNAIDS, REDUCING HIV STIGMA AND DISCRIMINATION, *supra* note 30, at 10.
- <sup>33</sup> UNAIDS, PROTOCOL FOR THE IDENTIFICATION OF DISCRIMINATION AGAINST PEOPLE LIVING WITH HIV 7 (2000) [hereinafter UNAIDS, PROTOCOL FOR THE IDENTIFICATION OF DISCRIMINATION AGAINST PLHIV]; UNAIDS, HIV-RELATED STIGMA, DISCRIMINATION AND HUMAN RIGHTS VIOLATIONS, *supra* note 7, at 9; UNAIDS, REDUCING HIV STIGMA AND DISCRIMINATION, *supra* note 30, at 9; UNAIDS, STIGMA AND DISCRIMINATION FACT SHEET, *supra* note 30.
- <sup>34</sup> UNAIDS, HIV-RELATED STIGMA, DISCRIMINATION AND HUMAN RIGHTS VIOLATIONS, *supra* note 7, at 9-11; UNAIDS, NON-DISCRIMINATION IN HIV RESPONSES, *supra* note 30, at 2-3; UNAIDS, PROTOCOL FOR THE IDENTIFICATION OF DISCRIMINATION AGAINST PLHIV, *supra* note 33, at 7-8; UNAIDS, REDUCING HIV STIGMA AND DISCRIMINATION, *supra* note 30, at 7.
- <sup>35</sup> UNAIDS, PROTOCOL FOR THE IDENTIFICATION OF DISCRIMINATION AGAINST PLHIV, *supra* note 33, at 7.
- <sup>36</sup> DECLARATION OF COMMITMENT paras. 13, 16, 37, 58, 62; UNAIDS, KEEPING THE PROMISE: SUMMARY OF THE DECLARATION OF COMMITMENT ON HIV/AIDS 12-15 (2001); POLITICAL DECLARATION paras. 11, 29.
- <sup>37</sup> INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS art. 2 (2) (adopted December 16, 1966 by U.N. G.A. Res. 2200A/XXI, entered into force January 3, 1976, U.N. Doc. A/6316) [hereinafter ICESCR]; CONVENTION ON THE RIGHTS OF THE CHILD art. 2 (1) (adopted November 20, 1989 by U.N. G.A. Res. 44/25, entered into force September 2, 1990, U.N. Doc. A/44/49) [hereinafter CRC].

- <sup>38</sup> UN COMMITTEE ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS, GENERAL COMMENT No. 20: NON-DISCRIMINATION IN ECONOMIC, SOCIAL AND CULTURAL RIGHTS para. 33 (*adopted* July 2, 2009, U.N. Doc. E/C.12/GC/20) [hereinafter CESCR, GENERAL COMMENT No. 20 ON NON-DISCRIMINATION].
- <sup>39</sup> CESCR, GENERAL COMMENT No. 20 ON NON-DISCRIMINATION para. 8.
- <sup>40</sup> CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES art. 5 (2) (*adopted* December 13, 2006 by U.N. G.A. Res. 61/106, *entered into force* May 3, 2008, U.N. Doc. A/61/611).
- <sup>41</sup> OHCHR, WHO & UNAIDS, DISABILITY AND HIV POLICY BRIEF (2009) [hereinafter DISABILITY AND HIV POLICY BRIEF]; UN COMMISSION ON HUMAN RIGHTS, SUB-COMMISSION ON PREVENTION OF DISCRIMINATION AND PROTECTION OF MINORITIES, REPORT OF THE SUB-COMMISSION ON PREVENTION OF DISCRIMINATION AND PROTECTION OF MINORITIES (*adopted* August 23, 1996, U.N. Doc. E/CN.4/Sub.2/1996/41).
- <sup>42</sup> UNAIDS, PROTOCOL FOR THE IDENTIFICATION OF DISCRIMINATION AGAINST PLHIV, *supra* note 33, at 9; *see also* SIRACUSA PRINCIPLES ON THE LIMITATION AND DEROGATION PROVISIONS IN THE INTERNATIONAL COVENANT ON CIVIL AND POLITICAL RIGHTS (*adopted* September 28, 1984 by the UN Economic and Social Council, U.N. Doc. E/CN.4/1984/4) [hereinafter SIRACUSA PRINCIPLES].
- <sup>43</sup> OHCHR & WHO, THE RIGHT TO HEALTH: FACT SHEET No. 31 at 1, 9-10 (2008) [hereinafter RIGHT TO HEALTH FACT SHEET].
- <sup>44</sup> *Id.* at 1, 10.
- <sup>45</sup> *Id.* at 5; ICESCR arts. 2, 12.
- <sup>46</sup> RIGHT TO HEALTH FACT SHEET, *supra* note 43, at 5.
- <sup>47</sup> CESCR, GENERAL COMMENT No. 14: THE RIGHT TO THE HIGHEST ATTAINABLE STANDARD OF HEALTH para. 4 (*adopted* August 11, 2000, U.N. Doc. E/C.12/2000/4) [hereinafter CESCR, GENERAL COMMENT No. 14 ON THE RIGHT TO HEALTH].
- <sup>48</sup> UNAIDS, UNIVERSAL ACCESS TO HIV PREVENTION, TREATMENT, CARE AND SUPPORT: ROAD MAP AND NEXT STEPS FOR 2010 AND BEYOND 1 (2010).
- <sup>49</sup> UNAIDS, Universal Access to HIV Prevention, Treatment, Care and Support, at: <http://www.unaids.org/en/aboutunaids/universalaccesstohivtreatmentpreventioncareandsupport/>.
- <sup>50</sup> UNAIDS, OUTCOME FRAMEWORK 2009–2011, *supra* note 24, at 6-8.
- <sup>51</sup> UNAIDS, UNAIDS EXPANDED BUSINESS CASE: ENHANCING SOCIAL PROTECTION 5 (2010) [hereinafter UNAIDS, EXPANDED BUSINESS CASE]; CLARE BISHOP-SAMBROOK, HIV/AIDS SUSCEPTIBILITY AND VULNERABILITY PATHWAY: A TOOL FOR IDENTIFYING INDICATORS, ROLE MODELS, AND INNOVATIONS 1-2 (2003); UNAIDS INTER-AGENCY TASK TEAM ON HIV AND YOUNG PEOPLE, GUIDANCE BRIEF: OVERVIEW OF HIV INTERVENTIONS FOR YOUNG PEOPLE 3 (2008) [hereinafter IATT, OVERVIEW OF HIV INTERVENTIONS FOR YOUNG PEOPLE].
- <sup>52</sup> UNAIDS AND WHO, GUIDANCE ON ETHICS AND EQUITABLE ACCESS TO HIV TREATMENT AND CARE 3-4, 13, 29, 32, 36, 43 (2004) [hereinafter UNAIDS & WHO, GUIDANCE ON ETHICS]; RIGHT TO HEALTH FACT SHEET, *supra* note 43, at 7-8.
- <sup>53</sup> INTERNATIONAL GUIDELINES Guideline 6, paras. 24-25.
- <sup>54</sup> RIGHT TO HEALTH FACT SHEET, *supra* note 43, at 11.
- <sup>55</sup> Tim Rhodes & Milena Simic, *Transition and the HIV Risk Environment*, BRITISH MEDICAL JOURNAL (2005) [hereinafter *Transition and the HIV Risk Environment*]; Steffanie Strathdee et al., *HIV and Risk Environment for Injecting Drug Users: the Past, Present and Future*, THE LANCET (2010) [hereinafter *HIV and Risk Environment*]; Chris Beyrer et al., *Time to Act: a Call for Comprehensive Responses to HIV in People who Use Drugs*, THE LANCET (2010) [hereinafter *Time to Act*].
- <sup>56</sup> *See also* UNAIDS, GETTING TO ZERO STRATEGY, *supra* note 25, at 7, 10-11.
- <sup>57</sup> INTERNATIONAL GUIDELINES para. 21.
- <sup>58</sup> *Transition and the HIV Risk Environment*, *supra* note 55; *HIV and Risk Environment*, *supra* note 55; *Time to Act*, *supra* note 55.
- <sup>59</sup> UNAIDS, NON-DISCRIMINATION IN HIV RESPONSES, *supra* note 30, at 10.
- <sup>60</sup> UNAIDS, Punitive Laws, at: <http://www.unaids.org/en/strategygoalsby2015/punitivelaws/>.
- <sup>61</sup> UNAIDS, NON-DISCRIMINATION IN HIV RESPONSES, *supra* note 30, at 10; Anya Sarang et al., *Policing Drug Users in Russia: Risk, Fear, and Structural Violence*, SUBSTANCE USE AND MISUSE (2010) [hereinafter *Policing Drug Users in Russia*].
- <sup>62</sup> UNAIDS, GETTING TO ZERO STRATEGY, *supra* note 25, at 7; UNAIDS, NON-DISCRIMINATION IN HIV RESPONSES, *supra* note 30, at 10; UNAIDS, Punitive Laws, at: <http://www.unaids.org/en/strategygoalsby2015/punitivelaws/>; UNDP, Human Rights Violations Limit Access to HIV Prevention and Care Services, at: <http://content.undp.org/go/newsroom/updates/hiv-www-news/-human-rights-violations-limit-access-to-hiv-prevention-and-care-services.en>; *Policing Drug Users in Russia*, *supra* note 61.
- <sup>63</sup> UNAIDS, NON-DISCRIMINATION IN HIV RESPONSES, *supra* note 30, at 10.
- <sup>64</sup> UNAIDS, HIV-RELATED STIGMA, DISCRIMINATION AND HUMAN RIGHTS VIOLATIONS, *supra* note 7, at 13-16.
- <sup>65</sup> UNAIDS, NON-DISCRIMINATION IN HIV RESPONSES, *supra* note 30, at 3.
- <sup>66</sup> DECLARATION OF COMMITMENT para. 100.
- <sup>67</sup> UNAIDS, Monitoring Country Progress, at: <http://www.unaids.org/en/KnowledgeCentre/HIVData/CountryProgress/Default.asp>; *see also* UNGASS, GUIDELINES ON CONSTRUCTION OF CORE INDICATORS FOR 2010 REPORTING (2009) [hereinafter UNGASS, GUIDELINES ON CORE INDICATORS].
- <sup>68</sup> ICESCR art. 12; UN COMMITTEE ON ECONOMIC, SOCIAL, AND CULTURAL RIGHTS, GUIDELINES ON TREATY-SPECIFIC DOCUMENTS TO BE SUBMITTED BY STATE PARTIES UNDER ARTICLES 16 AND 17 OF THE INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS para. 57 (e) (*adopted* March 24, 2009, U.N. Doc. E/C.12/2008/2).
- <sup>69</sup> CONVENTION ON THE ELIMINATION OF ALL FORMS OF DISCRIMINATION AGAINST WOMEN arts. 12, 18 (*adopted* December 18, 1979 by U.N. G.A. Res. 34/180, *entered into force* September 3, 1981, U.N. Doc. A/34/46) [hereinafter CEDAW]; UN COMMITTEE ON THE ELIMINATION OF DISCRIMINATION AGAINST WOMEN, GENERAL RECOMMENDATION No. 15: AVOIDANCE OF DISCRIMINATION AGAINST WOMEN IN NATIONAL STRATEGIES FOR THE PREVENTION AND CONTROL OF ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) (*adopted* February 3, 1990, U.N. Doc. A/45/38) [hereinafter CEDAW, GENERAL RECOMMENDATION No. 15 ON WOMEN AND HIV/AIDS]; UN COMMITTEE ON THE ELIMINATION OF DISCRIMINATION AGAINST WOMEN, GENERAL RECOMMENDATION No. 24: ARTICLE 12 OF THE CONVENTION (WOMEN AND HEALTH) para. 17 (*adopted* May 2, 1999, U.N. Doc. A/54/38/Rev.1) [hereinafter CEDAW, GENERAL RECOMMENDATION No. 24 ON WOMEN AND HEALTH].
- <sup>70</sup> UN COMMITTEE ON THE RIGHTS OF THE CHILD, GENERAL COMMENT No. 3: HIV/AIDS AND THE RIGHTS OF THE CHILD para. 40 (f) (*adopted* March 17, 2003, U.N. Doc. CRC/GC/2003/3) [hereinafter CRC, GENERAL COMMENT No. 3 ON CHILDREN AND HIV/AIDS].
- <sup>71</sup> INTERNATIONAL GUIDELINES para. 3, 16.
- <sup>72</sup> *See, e.g.*, POLITICAL DECLARATION paras. 15-16; INTERNATIONAL GUIDELINES para. 22; DUBLIN DECLARATION ON PARTNERSHIP TO FIGHT HIV/AIDS IN EUROPE AND CENTRAL ASIA (*adopted* February 24, 2004 by EU Ministerial Conference "Breaking the Barriers - Partnership to Fight HIV/AIDS in Europe and Central Asia").
- <sup>73</sup> INTERNATIONAL GUIDELINES para. 14; DECLARATION OF COMMITMENT paras. 37-46; POLITICAL DECLARATION para. 16.
- <sup>74</sup> INTERNATIONAL GUIDELINES para. 12; DECLARATION OF COMMITMENT para. 38.
- <sup>75</sup> INTERNATIONAL GUIDELINES paras. 12-13, 15.
- <sup>76</sup> INTERNATIONAL GUIDELINES Guideline 1. The need for an adequate national AIDS framework is also emphasized in the DECLARATION OF COMMITMENT and POLITICAL DECLARATION.

- <sup>77</sup> DECLARATION OF COMMITMENT para. 7; POLITICAL DECLARATION para. 20.
- <sup>78</sup> UNAIDS, "THREE ONES" KEY PRINCIPLES: COORDINATION OF NATIONAL RESPONSES TO HIV/AIDS – GUIDING PRINCIPLES FOR NATIONAL AUTHORITIES AND THEIR PARTNERS 2 (2004) [hereinafter UNAIDS, "THREE ONES" KEY PRINCIPLES]; UNAIDS, "THREE ONES" KEY PRINCIPLES PAMPHLET (2004), at: [http://data.unaids.org/pub/BrochurePamphlet/2004/threeones\\_keyprinciples\\_flyer\\_en.pdf](http://data.unaids.org/pub/BrochurePamphlet/2004/threeones_keyprinciples_flyer_en.pdf) [hereinafter "THREE ONES" PAMPHLET]
- <sup>79</sup> INTERNATIONAL GUIDELINES para. 15.
- <sup>80</sup> UNAIDS, "THREE ONES" KEY PRINCIPLES, *supra* note 78, at 2; "THREE ONES" PAMPHLET, *supra* note 78, at 2-3.
- <sup>81</sup> DECLARATION OF COMMITMENT paras. 94-96; POLITICAL DECLARATION para. 49.
- <sup>82</sup> POLITICAL DECLARATION para. 49; UNAIDS, "THREE ONES" KEY PRINCIPLES, *supra* note 78, at 2; "THREE ONES" PAMPHLET, *supra* note 78, at 4; *see also* UNAIDS, ORGANIZING FRAMEWORK FOR A FUNCTIONAL NATIONAL HIV MONITORING AND EVALUATION SYSTEM (2008).
- <sup>83</sup> UNAIDS, "THREE ONES" KEY PRINCIPLES, *supra* note 78, at 1; "THREE ONES" PAMPHLET, *supra* note 78, at 1; *see also* WHO, "Three Ones" Agreed by Donors and Developing Countries, at: <http://www.who.int/3by5/newsitem9/en/index.html>; UNAIDS, THE "THREE ONES" IN ACTION: WHERE WE ARE AND WHERE WE GO FROM HERE (2005).
- <sup>84</sup> POLITICAL DECLARATION para. 15.
- <sup>85</sup> DECLARATION OF COMMITMENT paras. 37-38; 82; POLITICAL DECLARATION paras. 16, 39.
- <sup>86</sup> DECLARATION OF COMMITMENT para. 79; POLITICAL DECLARATION para. 39.
- <sup>87</sup> UNGASS, GUIDELINES ON CORE INDICATORS, *supra* note 67, at 24-25, 83.
- <sup>88</sup> DECLARATION OF COMMITMENT paras. 27, 29, 99.
- <sup>89</sup> POLITICAL DECLARATION paras. 6, 14, 50-51; DECLARATION OF COMMITMENT paras. 44-45.
- <sup>90</sup> DECLARATION OF COMMITMENT paras. 39-40.
- <sup>91</sup> DECLARATION OF COMMITMENT paras. 39, 41-42.
- <sup>92</sup> DECLARATION OF COMMITMENT para. 102.
- <sup>93</sup> WHO, UNAIDS & UNICEF, TOWARDS UNIVERSAL ACCESS: SCALING UP PRIORITY HIV/AIDS INTERVENTIONS IN THE HEALTH SECTOR – PROGRESS REPORT 106 (2010) [hereinafter TOWARDS UNIVERSAL ACCESS: 2010 PROGRESS REPORT].
- <sup>94</sup> WHO, What is a Health System, at: <http://www.who.int/features/qa/28/en/>.
- <sup>95</sup> WHO, Health Systems, at: <http://www.who.int/healthsystems/topics/en/>.
- <sup>96</sup> CESCR, GENERAL COMMENT NO. 14 ON THE RIGHT TO HEALTH para. 12.
- <sup>97</sup> INTERNATIONAL GUIDELINES Guideline 6, para. 55.
- <sup>98</sup> DECLARATION OF ALMA-ATA (*adopted* September 12, 1978 by the International Conference on Primary Health Care).
- <sup>99</sup> WHO, UNAIDS & UNICEF, TOWARDS UNIVERSAL ACCESS: SCALING UP PRIORITY HIV/AIDS INTERVENTIONS IN THE HEALTH SECTOR – PROGRESS REPORT 118-119 (2009) [hereinafter TOWARDS UNIVERSAL ACCESS: 2009 PROGRESS REPORT].
- <sup>100</sup> WHO, MONITORING THE BUILDING BLOCKS OF HEALTH SYSTEMS: A HANDBOOK OF INDICATORS AND THEIR MEASUREMENT STRATEGIES vi (2010).
- <sup>101</sup> DECLARATION OF COMMITMENT para. 25; POLITICAL DECLARATION paras. 15, 35-36.
- <sup>102</sup> INTER-PARLIAMENTARY UNION, UNAIDS & UNDP, TAKING ACTION AGAINST HIV AND AIDS: A HANDBOOK FOR PARLIAMENTARIANS 117 (2007) [hereinafter IPU, UNAIDS & UNDP, A HANDBOOK FOR PARLIAMENTARIANS].
- <sup>103</sup> *See, e.g.*, TOWARDS UNIVERSAL ACCESS: 2010 PROGRESS REPORT, *supra* note 93, at 8, 105-106.
- <sup>104</sup> DECLARATION OF COMMITMENT para. 33; POLITICAL DECLARATION paras. 14, 16, 20, 51; INTERNATIONAL GUIDELINES paras. 16-18.
- <sup>105</sup> UNAIDS, OUTCOME FRAMEWORK 2009–2011, *supra* note 24, at 5.
- <sup>106</sup> DECLARATION OF COMMITMENT para. 46.
- <sup>107</sup> INTERNATIONAL GUIDELINES paras. 16-18; DECLARATION OF COMMITMENT para. 33.
- <sup>108</sup> INTERNATIONAL GUIDELINES paras. 16, 18.
- <sup>109</sup> *See, e.g.*, UNAIDS, POLICY BRIEF ON THE GREATER INVOLVEMENT OF PEOPLE LIVING WITH HIV (2007) [hereinafter UNAIDS, POLICY BRIEF ON GIPA]; WALT SENTERFIT, THE DENVER PRINCIPLES: THE ORIGINAL MANIFESTO OF THE PWA SELF-EMPOWERMENT MOVEMENT (1998).
- <sup>110</sup> UNAIDS, FROM PRINCIPLE TO PRACTICE: GREATER INVOLVEMENT OF PEOPLE LIVING WITH OR AFFECTED BY HIV/AIDS (GIPA) (1999) [hereinafter UNAIDS, FROM PRINCIPLE TO PRACTICE: GIPA].
- <sup>111</sup> DECLARATION OF COMMITMENT para. 33.
- <sup>112</sup> UNAIDS, POLICY BRIEF ON GIPA, *supra* note 109, at 1.
- <sup>113</sup> UNAIDS, REDUCING HIV STIGMA AND DISCRIMINATION, *supra* note 30, at 5; UNAIDS, HIV-RELATED STIGMA, DISCRIMINATION AND HUMAN RIGHTS VIOLATIONS, *supra* note 7, at 4; HUMAN RIGHTS WATCH, THE LESS THEY KNOW, THE BETTER: ABSTINENCE-ONLY HIV/AIDS PROGRAMS IN UGANDA 16 (2005) [hereinafter HRW, THE LESS THEY KNOW, THE BETTER]; *see also* UNAIDS, Prevention, Vulnerability and Rights Division, at: <http://www.unaids.org/en/AboutUNAIDS/PolicyAndPractice/DriversOfTheEpidemic/default.asp>; Open Society Institute, Health and Human Rights – A Resource Guide: HIV/AIDS and Human Rights, at: [http://equalpartners.info/Chapter2/ch2\\_TOC.html](http://equalpartners.info/Chapter2/ch2_TOC.html) [hereinafter OSI, Health and Human Rights Guide].
- <sup>114</sup> INTERNATIONAL GUIDELINES Guideline 6, para. 144; CESCR, GENERAL COMMENT NO. 14 ON THE RIGHT TO HEALTH para. 17.
- <sup>115</sup> DECLARATION OF COMMITMENT para. 52; POLITICAL DECLARATION para. 22.
- <sup>116</sup> INTERNATIONAL GUIDELINES Guideline 6, paras. 22 (d), (x), 23-24.
- <sup>117</sup> *Id.* paras. 22 (f)-(g), 40.
- <sup>118</sup> CESCR, GENERAL COMMENT NO. 4: THE RIGHT TO ADEQUATE HOUSING para. 16 (*adopted* December 13, 1991, U.N. Doc. E/1992/23) [hereinafter CESCR, GENERAL COMMENT NO. 4 ON THE RIGHT TO ADEQUATE HOUSING].
- <sup>119</sup> *See, e.g.*, DECLARATION OF COMMITMENT para. 63; UNAIDS, INTENSIFYING HIV PREVENTION: UNAIDS POLICY POSITION PAPER 49 (2005) [hereinafter UNAIDS, INTENSIFYING HIV PREVENTION]; INTERNATIONAL LABOR ORGANIZATION, AN ILO CODE OF PRACTICE ON HIV/AIDS AND THE WORLD OF WORK (2001) paras. 5 (1)(d), 5 (3)(e), 6 (1) [hereinafter ILO CODE OF PRACTICE ON HIV/AIDS AND WORK]; CRC, GENERAL COMMENT NO. 3 ON CHILDREN AND HIV/AIDS paras 14-15.
- <sup>120</sup> INTERNATIONAL GUIDELINES para. 40.
- <sup>121</sup> CRC, GENERAL COMMENT NO. 3 ON CHILDREN AND HIV/AIDS para. 16; UNGASS, GUIDELINES ON CORE INDICATORS, *supra* note 67, at 46; HRW, THE LESS THEY KNOW, THE BETTER, *supra* note 113, at 7.
- <sup>122</sup> ILO CODE OF PRACTICE ON HIV/AIDS AND WORK para 6; INTERNATIONAL GUIDELINES para. 22.
- <sup>123</sup> ILO CODE OF PRACTICE ON HIV/AIDS AND WORK para. 6.
- <sup>124</sup> UNAIDS, REDUCING HIV STIGMA AND DISCRIMINATION, *supra* note 30, at 5.
- <sup>125</sup> *Id.* at 9.
- <sup>126</sup> *Id.* at 13.
- <sup>127</sup> INTERNATIONAL GUIDELINES para. 63.

<sup>128</sup> DARA CARR & LAURA NYBLADE, TAKING ACTION AGAINST HIV STIGMA AND DISCRIMINATION: GUIDANCE DOCUMENT AND SUPPORTING RESOURCES 7 (United Kingdom Department for International Development 2007) [hereinafter DARA CARR & LAURA NYBLADE, TAKING ACTION AGAINST HIV STIGMA AND DISCRIMINATION]; UNAIDS, REDUCING HIV STIGMA AND DISCRIMINATION, *supra* note 30, at 11; UNAIDS, UNAIDS ACTION FRAMEWORK: ADDRESSING WOMEN, GIRLS, GENDER EQUALITY AND HIV 8 (2009) [hereinafter UNAIDS ACTION FRAMEWORK ON WOMEN AND HIV]; DECLARATION OF COMMITMENT para. 37.

<sup>129</sup> UNAIDS, REDUCING HIV STIGMA AND DISCRIMINATION, *supra* note 30, at 11-12; DARA CARR & LAURA NYBLADE, TAKING ACTION AGAINST HIV STIGMA AND DISCRIMINATION, *supra* note 128, at 7.

<sup>130</sup> UNAIDS, REDUCING HIV STIGMA AND DISCRIMINATION, *supra* note 30, at 15.

<sup>131</sup> INTERNATIONAL GUIDELINES Guideline 9, para. 62 (c).

<sup>132</sup> ICCPR art. 7; INTERNATIONAL GUIDELINES Guideline 5; DECLARATION OF HELSINKI – ETHICAL PRINCIPLES FOR MEDICAL RESEARCH INVOLVING HUMAN SUBJECTS (*adopted* June 1964 by World Medical Association General Assembly, *as amended*) [hereinafter WMA DECLARATION OF HELSINKI]; UNAIDS, ETHICAL CONSIDERATIONS IN BIOMEDICAL HIV PREVENTION TRIALS Guidance Point 17 (2007) [hereinafter UNAIDS, ETHICAL CONSIDERATIONS IN HIV PREVENTION TRIALS]; UNAIDS, ETHICAL CONSIDERATIONS IN HIV PREVENTIVE VACCINE RESEARCH Guidance Point 15 (2000) [hereinafter UNAIDS, ETHICAL CONSIDERATIONS IN HIV VACCINE RESEARCH].

<sup>133</sup> INTERNATIONAL GUIDELINES Guideline 5; WMA DECLARATION OF HELSINKI paras. 22, 24; UNAIDS, ETHICAL CONSIDERATIONS IN HIV VACCINE RESEARCH, *supra* note 132, Guidance Point 12; UNAIDS, ETHICAL CONSIDERATIONS IN HIV PREVENTION TRIALS, *supra* note 132, Guidance Point 16.

<sup>134</sup> UNAIDS, ETHICAL CONSIDERATIONS IN HIV VACCINE RESEARCH, *supra* note 132, Guidance Point 12; UNAIDS, ETHICAL CONSIDERATIONS IN HIV PREVENTION TRIALS, *supra* note 132, Guidance Point 16.

<sup>135</sup> UNAIDS, ETHICAL CONSIDERATIONS IN HIV PREVENTION TRIALS, *supra* note 132, Guidance Point 17; UNAIDS, ETHICAL CONSIDERATIONS IN HIV VACCINE RESEARCH, *supra* note 132, Guidance Point 15.

<sup>136</sup> INTERNATIONAL GUIDELINES para. 22 (e); WMA DECLARATION OF HELSINKI para. 9; UNAIDS & WHO, GUIDANCE ON ETHICS *supra* note 52, at 44; UNAIDS, ETHICAL CONSIDERATIONS IN HIV PREVENTION TRIALS, *supra* note 132, Guidance Point 8; UNAIDS, ETHICAL CONSIDERATIONS IN HIV VACCINE RESEARCH, *supra* note 132, Guidance Point 7.

<sup>137</sup> INTERNATIONAL GUIDELINES para. 22 (e) (iv); UNAIDS, ETHICAL CONSIDERATIONS IN HIV PREVENTION TRIALS, *supra* note 132, Guidance Point 19; UNAIDS, ETHICAL CONSIDERATIONS IN HIV VACCINE RESEARCH, *supra* note 132, Guidance Point 2.

<sup>138</sup> CARIBBEAN COMMUNITY AND PAN CARIBBEAN PARTNERSHIP AGAINST HIV AND AIDS, CHAMPIONS FOR CHANGE: REDUCING HIV/AIDS STIGMA AND DISCRIMINATION IN THE CARIBBEAN (2005).

<sup>139</sup> Prevention could be classified as primary, secondary, and tertiary. In terms of HIV, primary prevention is focused on preventing uninfected people from becoming infected. Secondary HIV prevention is aimed at preventing transmission from HIV-positive people and preserving their health; tertiary prevention aims to minimize the effects of ill health.

<sup>140</sup> UN, MILLENNIUM DEVELOPMENT GOALS: GOAL 6 – COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES FACT SHEET (2008), at <http://www.un.org/millenniumgoals/2008highlevel/pdf/newsroom/Goal%206%20FINAL.pdf>.

<sup>141</sup> IPU, UNAIDS & UNDP, A HANDBOOK FOR PARLIAMENTARIANS, *supra* note 102, at 70.

<sup>142</sup> UNAIDS, UNAIDS REPORT ON THE GLOBAL AIDS EPIDEMIC Annex 1 (2008) [hereinafter UNAIDS, 2008 REPORT ON GLOBAL AIDS EPIDEMIC]; COMMISSION ON NARCOTIC DRUGS, UN ECONOMIC AND SOCIAL COUNCIL, RESPONDING TO THE PREVALENCE OF HIV/AIDS AND OTHER BLOOD-BORNE DISEASES AMONG DRUG USERS: REPORT OF THE EXECUTIVE DIRECTOR paras. 9-19 (2009) (U.N. Doc. E/CN.7/2010/11).

<sup>143</sup> Michel Sidibe, Mobilizing Prevention as a Movement for Universal Access, Speech to the Program Coordinating Board of UNAIDS (December 8, 2009).

<sup>144</sup> UN MILLENNIUM DECLARATION para. 19.

<sup>145</sup> POLITICAL DECLARATION paras. 22, 42.

<sup>146</sup> INTERNATIONAL GUIDELINES paras. 20-26, 39, 144; *see also* GLOBAL HIV PREVENTION WORKING GROUP, FACT SHEET: PROVEN HIV PREVENTION STRATEGIES (2009) [hereinafter FACT SHEET: PROVEN HIV PREVENTION STRATEGIES].

<sup>147</sup> DECLARATION OF COMMITMENT para. 52; INTERNATIONAL GUIDELINES Guideline 6.

<sup>148</sup> *See also* UN HUMAN RIGHTS COMMITTEE, GENERAL COMMENT No. 6: THE RIGHT TO LIFE (*adopted* April 30, 1982) [hereinafter CCPR, GENERAL COMMENT No. 6 ON THE RIGHT TO LIFE].

<sup>149</sup> INTERNATIONAL GUIDELINES Guideline 6.

<sup>150</sup> IPU, UNAIDS & UNDP, A HANDBOOK FOR PARLIAMENTARIANS, *supra* note 102, at 79-80.

<sup>151</sup> UNAIDS, INTENSIFYING HIV PREVENTION, *supra* note 119, at 32.

<sup>152</sup> Prevention of vertical transmission of HIV is discussed in *Factor 8* on Family, Sexual, and Reproductive Life.

<sup>153</sup> *See* FACT SHEET: PROVEN HIV PREVENTION STRATEGIES, *supra* note 146. It is important to note that a growing body of medical evidence indicates that treatment of STIs does not necessarily protect against HIV acquisition. Assessors are strongly encouraged to review the current medical data on this subject at the time of the assessment.

<sup>154</sup> It is important to emphasize that male circumcision does not provide complete protection against HIV. HIV-infected circumcised men can still transmit HIV to female and male sexual partners. There is no strong evidence that male circumcision reduces the risk of HIV transmission to a female partner, or that it reduces the risk of HIV transmission during anal sex to a male or female receptive partner. *See* UNAIDS, SAFE, VOLUNTARY, INFORMED MALE CIRCUMCISION AND COMPREHENSIVE HIV PREVENTION PROGRAMMING: GUIDANCE FOR DECISION-MAKERS ON HUMAN RIGHTS, ETHICAL AND LEGAL CONSIDERATIONS 2 (2007).

<sup>155</sup> UNAIDS & CANADIAN HIV/AIDS LEGAL NETWORK, COURTING RIGHTS: CASE STUDIES IN LITIGATING THE HUMAN RIGHTS OF PEOPLE LIVING WITH HIV 109-112 (2006) [hereinafter UNAIDS, COURTING RIGHTS]; UNAIDS & WHO, HIV AND AIDS IN PLACES OF DETENTION 21, 67 (2008).

<sup>156</sup> WHO, SCALING UP HIV TESTING AND COUNSELING IN THE WHO EUROPEAN REGION: POLICY FRAMEWORK (2010) [hereinafter WHO, SCALING UP HIV TESTING AND COUNSELING].

<sup>157</sup> WHO AND UNAIDS, GUIDANCE ON PROVIDER-INITIATED HIV TESTING AND COUNSELING IN HEALTH FACILITIES 5-8, 36-39 (2007); *see also* UNAIDS & WHO, POLICY STATEMENT ON HIV TESTING (2004).

<sup>158</sup> UNAIDS & WHO, POLICY STATEMENT ON HIV TESTING 1 (2004).

<sup>159</sup> INTERNATIONAL GUIDELINES para. 120.

<sup>160</sup> UN, REPORT OF THE SPECIAL RAPPORTEUR ON THE RIGHT OF EVERYONE TO THE ENJOYMENT OF THE HIGHEST ATTAINABLE STANDARD OF PHYSICAL AND MENTAL HEALTH paras. 5-6 (August 10, 2009, U.N. Doc. A/64/272) [hereinafter 2009 REPORT OF THE SPECIAL RAPPORTEUR ON THE RIGHT TO HEALTH TO THE GA].

<sup>161</sup> *See* CONVENTION FOR THE PROTECTION OF HUMAN RIGHTS AND DIGNITY OF THE HUMAN BEING WITH REGARD TO THE APPLICATION OF BIOLOGY AND MEDICINE: CONVENTION ON HUMAN RIGHTS AND BIOMEDICINE (OVIEDO CONVENTION) (*adopted* April 4, 1997 by the Council of Europe); ADDITIONAL PROTOCOL TO THE CONVENTION ON HUMAN RIGHTS AND BIOMEDICINE CONCERNING BIOMEDICAL RESEARCH (*adopted*



January 25, 2005 by the Council of Europe); CHARTER OF FUNDAMENTAL RIGHTS OF THE EUROPEAN UNION art. 3 (*adopted* December 7, 2000 by the European Parliament, the European Council and the European Commission Act. No. 2000/C 364/01, *entered into force* December 1, 2009) [hereinafter CHARTER OF FUNDAMENTAL RIGHTS OF THE EU]; 2009 REPORT OF THE SPECIAL RAPPORTEUR ON THE RIGHT TO HEALTH to the GA, *supra* note 160; WHO & UNICEF, POLICY REQUIREMENTS FOR HIV TESTING AND COUNSELING OF INFANTS AND YOUNG CHILDREN IN HEALTH FACILITIES 7-8 (2010).

<sup>162</sup> 2009 REPORT OF THE SPECIAL RAPPORTEUR ON THE RIGHT TO HEALTH TO THE GA, *supra* note 160, para.14.

<sup>163</sup> *Id.* para. 23.

<sup>164</sup> *Id.* para. 27.

<sup>165</sup> WHO, SCALING UP HIV TESTING AND COUNSELING, *supra* note 156, at 1.

<sup>166</sup> U.S. CENTERS FOR DISEASE CONTROL AND PREVENTION, REVISED GUIDELINES FOR HIV COUNSELING, TESTING, AND REFERRAL (2001) [hereinafter CDC, REVISED GUIDELINES FOR HIV COUNSELING, TESTING, AND REFERRAL].

<sup>167</sup> WHO & UNAIDS, GUIDANCE ON PROVIDER-INITIATED HIV TESTING AND COUNSELING IN HEALTH FACILITIES 5 (2007).

<sup>168</sup> CDC, REVISED GUIDELINES FOR HIV COUNSELING, TESTING, AND REFERRAL, *supra* note 166.

<sup>169</sup> IPU, UNAIDS & UNDP, A HANDBOOK FOR PARLIAMENTARIANS, *supra* note 102, at 73.

<sup>170</sup> INTERNATIONAL GUIDELINES Guideline 6; WHO & UNAIDS, GUIDANCE ON PROVIDER-INITIATED HIV TESTING AND COUNSELING IN HEALTH FACILITIES 40 (2007).

<sup>171</sup> Priti Patel, *Zambian Court Issues Groundbreaking Decision Concerning HIV Testing without Informed Consent*, in HIV/AIDS POLICY AND LAW REVIEW 15/1 at 31 (Canadian HIV/AIDS Legal Network 2010).

<sup>172</sup> USAID, STIGMA, SCALE-UP, AND TREATMENT GOVERNANCE: STUMBLING BLOCK OR WINDOW OF OPPORTUNITY? 1 (2006).

<sup>173</sup> WHO, NEW PROGRESS AND GUIDELINES ON HIV TREATMENT: FACT SHEET (2010) [hereinafter WHO, NEW PROGRESS AND GUIDELINES ON HIV TREATMENT].

<sup>174</sup> CESCR, GENERAL COMMENT NO. 14 ON THE RIGHT TO HEALTH para. 8.

<sup>175</sup> RIGHT TO HEALTH FACT SHEET, *supra* note 43, at 5.

<sup>176</sup> CESCR, GENERAL COMMENT NO. 14 ON THE RIGHT TO HEALTH para. 43.

<sup>177</sup> *Id.* para. 12 (b).

<sup>178</sup> *Id.* para. 44.

<sup>179</sup> ICCPR art. 6; CCPR, GENERAL COMMENT NO. 6 ON THE RIGHT TO LIFE para. 5.

<sup>180</sup> ICCPR art. 6; UN HUMAN RIGHTS COMMITTEE, CONCLUDING OBSERVATIONS REGARDING KENYA para. 15 (*adopted* April 29, 2005, U.N. Doc. CCPR/CO/83/KEN); UN HUMAN RIGHTS COMMITTEE, CONCLUDING OBSERVATIONS REGARDING NAMIBIA para. 10 (*adopted* August 12, 2004, U.N. Doc. CCPR/CO/81/NAM).

<sup>181</sup> RIGHT TO HEALTH FACT SHEET, *supra* note 43, at 21; DECLARATION OF COMMITMENT paras. 15, 55.

<sup>182</sup> POLITICAL DECLARATION paras. 15, 20, 24, 49.

<sup>183</sup> IPU, UNAIDS & UNDP, A HANDBOOK FOR PARLIAMENTARIANS, *supra* note 102, at 114.

<sup>184</sup> *Id.* at 114-115.

<sup>185</sup> UNAIDS, OUTCOME FRAMEWORK 2009–2011, *supra* note 24, at 7-8; UNAIDS, GETTING TO ZERO STRATEGY, *supra* note 25, at 10.

<sup>186</sup> ACCESS TO MEDICINE IN THE CONTEXT OF THE RIGHT OF EVERYONE TO THE ENJOYMENT OF THE HIGHEST ATTAINABLE STANDARD OF PHYSICAL AND MENTAL HEALTH paras. 1-2 (*adopted* October 12, 2009 by the UN Human Rights Council Res. 12/24, U.N. Doc. A/63/263).

<sup>187</sup> ACCESS TO MEDICATION IN THE CONTEXT OF PANDEMICS SUCH AS HIV/AIDS paras. 1-2 (*adopted* April 22, 2002 by UN Commission on Human Rights Res. 2002/32); *see also* REPORT ON THE FIFTY-EIGHTH SESSION OF THE COMMISSION ON HUMAN RIGHTS (*adopted* April 26, 2002, U.N. Doc. E/2002/23 - E/CN.4/2002/200).

<sup>188</sup> POLITICAL DECLARATION para. 12.

<sup>189</sup> INTERNATIONAL GUIDELINES Guideline 6.

<sup>190</sup> TOWARDS UNIVERSAL ACCESS: 2009 PROGRESS REPORT, *supra* note 99, at 35-36; TOWARDS UNIVERSAL ACCESS: 2010 PROGRESS REPORT, *supra* note 93, at 104.

<sup>191</sup> WHO, NEW PROGRESS AND GUIDELINES ON HIV TREATMENT, *supra* note 173.

<sup>192</sup> IPU, UNAIDS & UNDP, A HANDBOOK FOR PARLIAMENTARIANS, *supra* note 102, at 126.

<sup>193</sup> POLITICAL DECLARATION paras. 42-44.

<sup>194</sup> IPU, UNAIDS & UNDP, A HANDBOOK FOR PARLIAMENTARIANS, *supra* note 102, at 123.

<sup>195</sup> INTERNATIONAL GUIDELINES Guideline 6.

<sup>196</sup> UNAIDS, PALLIATIVE CARE: TECHNICAL UPDATE 4 (2000) [hereinafter UNAIDS, PALLIATIVE CARE].

<sup>197</sup> SIDACTION, UNAIDS & WHO, EXPANDING ACCESS TO HIV TREATMENT THROUGH COMMUNITY-BASED ORGANIZATIONS 37-39 (2005); UNAIDS, EXPANDED BUSINESS CASE, *supra* note 51, at 14.

<sup>198</sup> DECLARATION OF COMMITMENT para. 56; POLITICAL DECLARATION para. 36; INTERNATIONAL GUIDELINES paras. 26, 46.

<sup>199</sup> HELP THE HOSPICES FOR THE WORLDWIDE PALLIATIVE CARE ALLIANCE, ACCESS TO PAIN RELIEF – AN ESSENTIAL HUMAN RIGHT 1 (2007).

<sup>200</sup> UNAIDS, PALLIATIVE CARE, *supra* note 196, at 4.

<sup>201</sup> CESCR, GENERAL COMMENT NO. 14 ON THE RIGHT TO HEALTH para. 25; CESCR, GENERAL COMMENT NO. 12: THE RIGHT TO ADEQUATE FOOD para. 12 (*adopted* May 12, 1999, U.N. Doc. E/C.12/1999/5).

<sup>202</sup> DECLARATION OF COMMITMENT para. 56; INTERNATIONAL GUIDELINES paras. 20, 24, 47.

<sup>203</sup> *See generally* HRW, "PLEASE DO NOT MAKE US SUFFER ANY MORE..." ACCESS TO PAIN TREATMENT AS A HUMAN RIGHT (2009).

<sup>204</sup> TREATMENT OF PAIN USING OPIOID ANALGESICS para. 1 (*adopted* July 22, 2005 by the Economic and Social Council Res. No. 2005/25, U.N. Doc. E/2005/INF/2/Add.1); UN SINGLE CONVENTION ON NARCOTIC DRUGS preamble (*adopted* 1961 by UN Conference for the Adoption of a Single Convention on Narcotic Drugs, *as amended* by the 1972 Protocol); WHO, ACCESS TO CONTROLLED MEDICATIONS PROGRAMME 5-8 (2007).

<sup>205</sup> WHO, UNAIDS & UNICEF, Towards Universal Access: Scaling up Priority HIV/AIDS Interventions in the Health Sector – Progress Report 76 (2008).

<sup>206</sup> *Id.* at 47-49; WHO, RAPID ADVICE: ANTIRETROVIRAL THERAPY FOR HIV INFECTION IN ADULTS AND ADOLESCENTS 11 (2009).

<sup>207</sup> *See, e.g.*, TOWARDS UNIVERSAL ACCESS: 2009 PROGRESS REPORT, *supra* note 99, at 76-77.

<sup>208</sup> WHO, COMMUNITY HOME-BASED CARE IN RESOURCE-LIMITED SETTINGS: A FRAMEWORK FOR ACTION 93 (2002).

<sup>209</sup> *See also* UNIVERSAL DECLARATION OF HUMAN RIGHTS art. 25 (*adopted* December 10, 1948 by U.N. G.A. Res. 217A(III), U.N. Doc. A/810) [hereinafter UDHR]; EUROPEAN SOCIAL CHARTER Part I: arts. 12-14 (*adopted* October 18, 1961 by the Council of Europe, *as amended* May 3, 1996, *entered into force* July 1, 1999) [hereinafter EUROPEAN SOCIAL CHARTER].

<sup>210</sup> UDHR art. 25.

<sup>211</sup> UNAIDS, EXPANDED BUSINESS CASE, *supra* note 51, at 3-4.

<sup>212</sup> INTERNATIONAL GUIDELINES para. 148.

- <sup>213</sup> *Id.* para. 22.
- <sup>214</sup> *Id.* para. 147.
- <sup>215</sup> INTERNATIONAL LABOR ORGANIZATION, RECOMMENDATION CONCERNING HIV AND AIDS AND THE WORLD OF WORK (No. 200) paras. 20, 37 (adopted June 17, 2010 by International Labor Conference) [hereinafter ILO RECOMMENDATION]; ILO CODE OF PRACTICE ON HIV/AIDS AND WORK para. 8 (2); INTERNATIONAL GUIDELINES paras. 22, 34.
- <sup>216</sup> INTERNATIONAL GUIDELINES para. 22 (iv).
- <sup>217</sup> *Id.* para. 34.
- <sup>218</sup> DISABILITY AND HIV POLICY BRIEF, *supra* note 41, at 1, 6.
- <sup>219</sup> XX v. Gun Club Corporation et al., Judgment No. SU-256/96 (Constitutional Court of Colombia, May 30, 1996), in UNAIDS, COURTING RIGHTS, *supra* note 155, at 13-17.
- <sup>220</sup> THE WORLD BANK, LEGAL ASPECTS OF HIV/AIDS: A GUIDE FOR POLICY AND LAW REFORM 10-12 (2007) [hereinafter WORLD BANK, LEGAL ASPECTS OF HIV/AIDS]; UNAIDS, Confidentiality and Security of Information, at: [http://www.unaids.org/en/media/unaids/contentassets/documents/dataanalysis/Epi\\_ConfidentialitySecurityHIV%20Information\\_en.pdf](http://www.unaids.org/en/media/unaids/contentassets/documents/dataanalysis/Epi_ConfidentialitySecurityHIV%20Information_en.pdf).
- <sup>221</sup> AUSTRALIAN FEDERATION OF AIDS ORGANIZATIONS, AUSTRALIAN HIV/AIDS LEGAL GUIDE 82 (1993).
- <sup>222</sup> INTERNATIONAL GUIDELINES Guidelines 5, 10, paras. 20, 22, 64, 119-121.
- <sup>223</sup> *Id.* para. 121.
- <sup>224</sup> WORLD BANK, LEGAL ASPECTS OF HIV/AIDS, *supra* note 220, at 33.
- <sup>225</sup> INTERNATIONAL GUIDELINES paras. 120-121.
- <sup>226</sup> UNAIDS, INTERIM GUIDELINES ON PROTECTING THE CONFIDENTIALITY AND SECURITY OF HIV INFORMATION 6 (2007).
- <sup>227</sup> WORLD BANK, LEGAL ASPECTS OF HIV/AIDS, *supra* note 220, at 17; WHO, Experts to Discuss HIV Testing and Counselling for Discordant Couples, at: [http://www.who.int/hiv/events/testing\\_counselling/en/index.html](http://www.who.int/hiv/events/testing_counselling/en/index.html); WHO, DRAFT GUIDELINES ON COUPLES HIV TESTING AND COUNSELLING 6-7 (2011).
- <sup>228</sup> INTERNATIONAL GUIDELINES para. 19.
- <sup>229</sup> NM and Others v. Smith and Others, Judgment No. CCT 69/05 ZACC 6 (Constitutional Court of South Africa, April 4, 2007), at: <http://www.saflii.org/za/cases/ZACC/2007/6.html>; see also Leah Utyasheva, *South Africa: Constitutional Court protects privacy rights of people living with HIV*, in HIV/AIDS POLICY AND LAW REVIEW Vol. 12, No. 2/3 at 55-56 (Canadian HIV/AIDS Legal Network 2007).
- <sup>230</sup> See, e.g., INTERNATIONAL GUIDELINES Guideline 2, paras. 17-18; HIV & HUMAN RIGHTS IN A NUTSHELL, *supra* note 10; DARA CARR & LAURA NYBLADE, TAKING ACTION AGAINST HIV STIGMA AND DISCRIMINATION, *supra* note 128, at 10-11; ILO CODE OF PRACTICE ON HIV/AIDS AND WORK para. 5 (1); DECLARATION OF THE SECOND ASIA-PACIFIC MINISTERIAL MEETING ON HIV/AIDS art. 26 (2004); BRAZZAVILLE COMMITMENT ON SCALING UP TOWARDS UNIVERSAL ACCESS TO HIV AND AIDS PREVENTION, TREATMENT, CARE AND SUPPORT IN AFRICA BY 2010 art. 4 (2006); RESOLUTION ON A RIGHTS-BASED APPROACH TO THE EU'S RESPONSE TO HIV/AIDS (adopted July 8, 2010 by the European Parliament, RSP/2010/2771).
- <sup>231</sup> UNAIDS, FROM PRINCIPLE TO PRACTICE: GIPA, *supra* note 110.
- <sup>232</sup> See also AFRICAN (BANJUL) CHARTER ON HUMAN AND PEOPLES' RIGHTS art. 9 (1) (adopted June 27, 1981 by the Organization of African Unity, entered into force October 21, 1986, OAU Doc. CAB/LEG/67/3 rev. 5) [hereinafter BANJUL CHARTER]; EUROPEAN CONVENTION FOR THE PROTECTION OF HUMAN RIGHTS AND FUNDAMENTAL FREEDOMS art. 10 (adopted November 4, 1950 by the Council of Europe, as amended by Protocols No. 3, 5, 8, and 11, entered into force September 3, 1953, 213 U.N.T.S. 222) [hereinafter ECHR]; ARAB CHARTER ON HUMAN RIGHTS art. 26 (adopted September 15, 1994 by the League of Arab States, entered into force March 15, 2008) [hereinafter ARAB CHARTER ON HUMAN RIGHTS].
- <sup>233</sup> ICCPR art. 19.
- <sup>234</sup> INTERNATIONAL GUIDELINES para. 111.
- <sup>235</sup> *Id.* para. 138; UNAIDS & OHCHR, HANDBOOK ON HIV AND HUMAN RIGHTS FOR NATIONAL HUMAN RIGHTS INSTITUTIONS 8 (2007) [hereinafter UNAIDS & OHCHR, HANDBOOK FOR NATIONAL HUMAN RIGHTS INSTITUTIONS]; see also OSI, Health and Human Rights Guide, *supra* note 113.
- <sup>236</sup> CESCR, GENERAL COMMENT NO. 14 ON THE RIGHT TO HEALTH para. 34; CRC, GENERAL COMMENT NO. 3 ON CHILDREN AND HIV/AIDS para. 16.
- <sup>237</sup> CESCR, GENERAL COMMENT NO. 14 ON THE RIGHT TO HEALTH para. 35.
- <sup>238</sup> See, e.g., UN, REPORT OF THE SPECIAL RAPPOREUR ON THE PROMOTION AND PROTECTION OF THE RIGHT TO FREEDOM OF OPINION AND EXPRESSION (January 9, 2003, U.N. Doc. E/CN.4/2003/67); UN, REPORT OF THE SPECIAL RAPPOREUR ON THE PROMOTION AND PROTECTION OF THE RIGHT TO FREEDOM OF OPINION AND EXPRESSION (March 8, 2004, U.N. Doc. E/CN.4/2004/62 Add.3); REPORT OF THE SPECIAL RAPPOREUR ON THE PROMOTION AND PROTECTION OF THE RIGHT TO FREEDOM OF OPINION AND EXPRESSION (February 25, 2008, U.N. Doc. A/HRC/7/14).
- <sup>239</sup> Press Release, UNAIDS, New Guidelines for Media Reporting in India (November 18, 2008) [hereinafter New Guidelines for Media Reporting in India].
- <sup>240</sup> See also ARAB CHARTER ON HUMAN RIGHTS art. 19; AMERICAN CONVENTION ON HUMAN RIGHTS (PACT OF SAN JOSE, COSTA RICA) art. 23 (adopted Nov. 22, 1969 by the Organization of American States, entered into force July 18, 1978, O.A.S. Treaty Series No. 36) [hereinafter ACHR].
- <sup>241</sup> See generally UNAIDS, REDUCING HIV STIGMA AND DISCRIMINATION, *supra* note 30; REPORT OF THE UN SECRETARY GENERAL ON THE PROGRESS MADE IN THE IMPLEMENTATION OF THE DECLARATION OF COMMITMENT ON HIV/AIDS AND THE POLITICAL DECLARATION ON HIV/AIDS (April 1, 2010, U.N. G.A. A/64/735 2010).
- <sup>242</sup> POLITICAL DECLARATION para. 20; DECLARATION OF COMMITMENT para. 37; INTERNATIONAL GUIDELINES para. 141.
- <sup>243</sup> UNAIDS, FROM PRINCIPLE TO PRACTICE: GIPA, *supra* note 110.
- <sup>244</sup> CESCR, GENERAL COMMENT NO. 21: RIGHT OF EVERYONE TO TAKE PART IN CULTURAL LIFE paras. 16 (a), 21 (adopted December 21, 2009, U.N. Doc. E/C.12/GC/21).
- <sup>245</sup> INTERNATIONAL GUIDELINES Guideline 5; paras. 22 (a) (i), 141.
- <sup>246</sup> *Id.* paras. 141-142.
- <sup>247</sup> See also Banjul Charter art. 17 (2); Arab Charter on Human Rights art. 36; Protocol of Amendment to the Charter of the Organization of American States, "Protocol of Buenos Aires" art. IX (f) (adopted February 27, 1967).
- <sup>248</sup> See also BANJUL CHARTER art. 10-11; ECHR art. 11; ARAB CHARTER ON HUMAN RIGHTS art. 28; ACHR arts. 15-16; ILO, FREEDOM OF ASSOCIATION AND PROTECTION OF THE RIGHT TO ORGANIZE CONVENTION (No. 87) (adopted July 9, 1948, entered into force July 4, 1950).
- <sup>249</sup> See, e.g., OSI, NOW MORE THAN EVER: TEN REASONS WHY HUMAN RIGHTS SHOULD OCCUPY THE CENTER OF THE GLOBAL AIDS STRUGGLE (2007); INTERNATIONAL GUIDELINES paras. 139-140; OSI, Health and Human Rights Guide, *supra* note 113.
- <sup>250</sup> INTERNATIONAL GUIDELINES paras. 139-140; see also OSI, Health and Human Rights Guide, *supra* note 113.
- <sup>251</sup> See, e.g., Press Release, Amnesty International, China Must Halt Harassment and Censorship of HIV/AIDS Activists (July 9, 2010).

<sup>252</sup> INTERNATIONAL GUIDELINES Guideline 2.  
<sup>253</sup> *Id.* Guideline 5.  
<sup>254</sup> Press Council of India, HIV/AIDS and the Media, at: [http://www.nbanewdelhi.com/pdf/final/NBA\\_Guidelines\\_HIV-AIDS-2.pdf](http://www.nbanewdelhi.com/pdf/final/NBA_Guidelines_HIV-AIDS-2.pdf); New Guidelines for Media Reporting in India, *supra* note 239.  
<sup>255</sup> UDHR art. 16 (3); ICCPR art. 23 (1); ICESCR art. 10 (1); CRC preamble; EUROPEAN SOCIAL CHARTER Part I: art. 1; AMERICAN DECLARATION OF THE RIGHTS AND DUTIES OF MAN art. VI (*adopted* May 2, 1948 by the Organization of American States G.A. Res. XXX) [hereinafter ADRDM]; ACHR art. 17; BANJUL CHARTER art. 18; BEIJING DECLARATION AND PLATFORM FOR ACTION para. 29 (*adopted* September 15, 1995 by the U.N. Fourth World Conference on Women, U.N. Docs. A/CONF.177/20 and A/CONF.177/20/Add.1) [hereinafter BEIJING PLATFORM FOR ACTION].  
<sup>256</sup> CEDAW preamble; CRC preamble.  
<sup>257</sup> DECLARATION OF COMMITMENT paras. 2, 31.  
<sup>258</sup> INTERNATIONAL GUIDELINES para. 118; UNAIDS, UNAIDS GUIDE TO THE UNITED NATIONS HUMAN RIGHTS MACHINERY 73-74, 80, 85 (1997) [hereinafter UNAIDS GUIDE TO UN HUMAN RIGHTS MACHINERY]; WORLD BANK, LEGAL ASPECTS OF HIV/AIDS, *supra* note 220, at 141-142.  
<sup>259</sup> OSI, MANDATORY PREMARITAL HIV TESTING: AN OVERVIEW 3-4 (2010) [hereinafter OSI, MANDATORY PREMARITAL HIV TESTING].  
<sup>260</sup> See also ECHR art. 8; CHARTER OF FUNDAMENTAL RIGHTS OF THE EU art. 7; ADRDM art. V; ACHR art. 11.  
<sup>261</sup> See also ECHR art. 12; PROTOCOL No. 7 TO THE ECHR art. 5 (*adopted* September 22, 1984 by the Council of Europe, *as amended* by Protocol No. 11, *entered into force* November 1, 1998) [hereinafter ECHR PROTOCOL No. 7]; CHARTER OF FUNDAMENTAL RIGHTS OF THE EU art. 9; ACHR art. 17; ADRDM art. VI.  
<sup>262</sup> See also CCPR, GENERAL COMMENT NO. 19: PROTECTION OF THE FAMILY, THE RIGHT TO MARRIAGE AND EQUALITY OF THE SPOUSES paras. 8-9 (*adopted* July 27, 1990) [hereinafter CCPR, GENERAL COMMENT NO. 19 ON THE PROTECTION OF THE FAMILY]; ECHR arts. 8, 12; ECHR PROTOCOL No. 7 art. 5; ACHR arts. 11, 17.  
<sup>263</sup> INTERNATIONAL GUIDELINES para. 118.  
<sup>264</sup> *Id.* para. 22 (f).  
<sup>265</sup> UNAIDS GUIDE TO UN HUMAN RIGHTS MACHINERY, *supra* note 258, at 73-74; OSI, MANDATORY PREMARITAL HIV TESTING, *supra* note 259, at 4.  
<sup>266</sup> INTERNATIONAL GUIDELINES paras. 22 (f), 111, 118; BEIJING PLATFORM FOR ACTION paras. 94-96; PROGRAM OF ACTION OF THE UNITED NATIONS INTERNATIONAL CONFERENCE ON POPULATION AND DEVELOPMENT para. 7 (3) (*adopted* October 18, 1994, U.N. Doc. A/CONF.171/13) [hereinafter ICPD PROGRAM OF ACTION]; PROTECTION OF HUMAN RIGHTS IN THE CONTEXT OF HIV/AIDS 2009 para. 6.  
<sup>267</sup> ICPD PROGRAM OF ACTION para. 7 (2); INTERNATIONAL GUIDELINES para. 22 (f); BEIJING PLATFORM FOR ACTION para. 94.  
<sup>268</sup> ICPD PROGRAM OF ACTION para. 7 (2-3); INTERNATIONAL GUIDELINES para. 22 (f); CESCR, GENERAL COMMENT NO. 14 ON THE RIGHT TO HEALTH para 14, footnote 12; CEDAW art. 16 (1) (e); WORLD BANK, LEGAL ASPECTS OF HIV/AIDS, *supra* note 220, at 141; BEIJING PLATFORM FOR ACTION paras. 94-95.  
<sup>269</sup> ICPD PROGRAM OF ACTION para. 7 (2); INTERNATIONAL GUIDELINES para. 22 (f); CESCR, GENERAL COMMENT NO. 14 ON THE RIGHT TO HEALTH para. 12; BEIJING PLATFORM FOR ACTION paras. 94, 97; PROTECTION OF HUMAN RIGHTS IN THE CONTEXT OF HIV/AIDS 2009 paras. 5-6.  
<sup>270</sup> DECLARATION OF COMMITMENT paras. 60, 63; POLITICAL DECLARATION paras. 21, 30, 34; INTERNATIONAL GUIDELINES paras. 20 (a), 60 (h).  
<sup>271</sup> CCPR, GENERAL COMMENT NO. 19 ON THE PROTECTION OF THE FAMILY para. 5.  
<sup>272</sup> PREVENTABLE MATERNAL MORTALITY AND MORBIDITY AND HUMAN RIGHTS para. 2 (*adopted* June 17, 2009 by UN Human Rights Council Res. 11/8).  
<sup>273</sup> See also ADRDM art. VII.  
<sup>274</sup> CESCR, GENERAL COMMENT NO. 14 ON THE RIGHT TO HEALTH para 12; BEIJING PLATFORM FOR ACTION paras. 94, 106 (e); ICPD PROGRAM OF ACTION para. 7 (2).  
<sup>275</sup> WHO, UNICEF & INTERAGENCY TASK TEAM ON PREVENTION OF HIV TRANSMISSION IN PREGNANT WOMEN, MOTHERS AND THEIR CHILDREN, GUIDANCE ON GLOBAL SCALE-UP OF THE PREVENTION OF MOTHER-TO-CHILD TRANSMISSION OF HIV: TOWARDS UNIVERSAL ACCESS FOR WOMEN, INFANTS AND YOUNG CHILDREN AND ELIMINATING HIV AND AIDS AMONG CHILDREN 7 (2007).  
<sup>276</sup> UNAIDS, OUTCOME FRAMEWORK 2009–2011, *supra* note 24, at 6; INTERNATIONAL GUIDELINES para. 118.  
<sup>277</sup> UNICEF, Childinfo, Prevent Mother-to-Child Transmission of HIV, at: [http://www.childinfo.org/hiv\\_aids\\_mother\\_to\\_child.html](http://www.childinfo.org/hiv_aids_mother_to_child.html).  
<sup>278</sup> UNAIDS, Vertical Transmission and Maternal Mortality, at: <http://www.unaids.org/en/strategygoalsby2015/verticaltransmissionandmaternalmortality/>; WOMEN, THE GIRL CHILD AND HIV AND AIDS para. 29 (*adopted* March 10, 2010 by UN Commission on the Status of Women Res. E/CN.6/2010/L.2/Rev.1) [hereinafter WOMEN, THE GIRL CHILD AND HIV/AIDS].  
<sup>279</sup> INTERNATIONAL GUIDELINES paras. 114, 118; DECLARATION OF COMMITMENT para. 54; POLITICAL DECLARATION para. 27; WOMEN, THE GIRL CHILD AND HIV/AIDS para. 29; UNAIDS, OUTCOME FRAMEWORK 2009–2011, *supra* note 24, at 12.  
<sup>280</sup> The most recent guidelines: “Antiretroviral drugs for treating pregnant women and preventing HIV infections in infants” were published in 2010. It needs to be noted, however, that WHO revises its recommendations when new medical evidence on the use of HIV treatment regimens emerges. Assessors are therefore strongly advised to analyze the country’s efforts to eliminate vertical transmission of HIV vis-à-vis WHO guidelines which are in force at the time of the assessment. For more information please visit WHO website at: <http://www.who.int/hiv/pub/mtct/en>.  
<sup>281</sup> JILLAN NICHOLSON ET AL., INTERIM FINDINGS ON THE NATIONAL PMTCT PILOT SITES: SUMMARY OF LESSONS AND RECOMMENDATIONS 1 (Health Systems Trust 2002).  
<sup>282</sup> UNAIDS, COURTING RIGHTS, *supra* note 155, at 82-85.  
<sup>283</sup> Press Release, Treatment Action Campaign, Department of Health Announces New PMTCT Guidelines (January 30, 2008).  
<sup>284</sup> Kofi A. Annan, *Foreword*, in UNICEF, THE STATE OF THE WORLD’S CHILDREN 4 (1999).  
<sup>285</sup> Melanie Gallant & Eleanor Maticka-Tyndale, *School-based HIV Prevention Programmes for African Youth*, SOCIAL SCIENCE AND MEDICINE (2004).  
<sup>286</sup> CESCR, GENERAL COMMENT NO. 13: THE RIGHT TO EDUCATION para. 6 (*adopted* December 3, 1999, U.N. Doc. E/C.12/1999/10).  
<sup>287</sup> INTERNATIONAL GUIDELINES para. 137.  
<sup>288</sup> *Id.* para. 137.  
<sup>289</sup> See also BANJUL CHARTER art. 17; PROTOCOL TO THE CONVENTION FOR THE PROTECTION OF HUMAN RIGHTS AND FUNDAMENTAL FREEDOMS art. 2 (*adopted* March 20, 1952 by the Council of Europe, *entered into force* May 18, 1954).  
<sup>290</sup> The Education for All movement is a global commitment to provide quality basic education for all children, youth and adults. The movement was launched at the World Conference on Education for All in 1990 by UNESCO, UNDP, UNFPA, UNICEF and the World

Bank. Participants endorsed an “expanded vision of learning” and pledged to universalize primary education and massively reduce illiteracy. See UNESCO, About Education for All, at [http://www.unesco.org/education/efa/ed\\_for\\_all/](http://www.unesco.org/education/efa/ed_for_all/).

<sup>291</sup> WORLD BANK, LEGAL ASPECTS OF HIV/AIDS, *supra* note 220, at 158.

<sup>292</sup> ILO RECOMMENDATION preamble.

<sup>293</sup> ILO, HIV/AIDS, at: <http://www.ilo.org/global/topics/hiv-aids/lang--en/index.htm>.

<sup>294</sup> ILO RECOMMENDATION paras. 3, 10-11; INTERNATIONAL GUIDELINES paras. 22, 149.

<sup>295</sup> See also EUROPEAN SOCIAL CHARTER; BANJUL CHARTER art. 15.

<sup>296</sup> ILO RECOMMENDATION para. 21; CANADIAN WORKING GROUP ON HIV AND REHABILITATION [hereinafter CWGHR], Episodic Disabilities, at: [http://www.hivandrehab.ca/EN/episodic\\_disabilities/index.php](http://www.hivandrehab.ca/EN/episodic_disabilities/index.php).

<sup>297</sup> ILO RECOMMENDATION paras. 1, 13, 21; INTERNATIONAL GUIDELINES paras. 22, 149.

<sup>298</sup> ILO RECOMMENDATION para. 21; see also CWGHR, POLICY ISSUES ON REHABILITATION IN THE CONTEXT OF HIV DISEASE: A BACKGROUND AND POSITION PAPER (2000); CWGHR, POLICIES AND PROGRAMS TO FACILITATE LABOR FORCE PARTICIPATION FOR PEOPLE WITH EPISODIC DISABILITIES: RECOMMENDATIONS FOR A CANADIAN CONTEXT BASED ON AN INTERNATIONAL ANALYSIS (2006).

<sup>299</sup> ILO RECOMMENDATION para. 30; INTERNATIONAL GUIDELINES para. 150; CDESCR, GENERAL COMMENT NO. 14 ON THE RIGHT TO HEALTH para. 36.

<sup>300</sup> ILO RECOMMENDATION paras. 16, 31-33; INTERNATIONAL GUIDELINES para. 150.

<sup>301</sup> INTERNATIONAL GUIDELINES para. 22.

<sup>302</sup> *Id.* para. 22; ILO RECOMMENDATION paras. 3, 16, 18.

<sup>303</sup> ILO RECOMMENDATION para. 14; INTERNATIONAL GUIDELINES para. 22.

<sup>304</sup> MX v. ZY, AIR 1997 Bom 406 (India High Court of Judicature, 1997), in UNAIDS, COURTING RIGHTS, *supra* note 155, at 18-20.

<sup>305</sup> WHO, HEALTH PRINCIPLES OF HOUSING preface (1989); *Unstable Housing Status Increases The Risk Of HIV Transmission*, SCIENCE DAILY, November 20, 2007; National AIDS Housing Coalition, HIV/AIDS Housing: Preventing HIV Transmission, at: <http://www.nationalaidshousing.org/PDF/preventinghiv.pdf>; CANADIAN AIDS SOCIETY, BRING ME HOME: POSITION STATEMENT ON HOUSING AND HIV/AIDS (2009).

<sup>306</sup> THE CENTER FOR HIV LAW AND POLICY, HOUSING RIGHTS OF PEOPLE WITH HIV/AIDS: A PRIMER 3 (2010) [hereinafter HOUSING RIGHTS OF PEOPLE WITH HIV/AIDS].

<sup>307</sup> *Id.* at 3, 11; CDESCR, GENERAL COMMENT NO. 4 ON THE RIGHT TO ADEQUATE HOUSING para. 8.

<sup>308</sup> CDESCR, GENERAL COMMENT NO. 4 ON THE RIGHT TO ADEQUATE HOUSING paras 1, 8; see also CDESCR, GENERAL COMMENT NO. 7: THE RIGHT TO ADEQUATE HOUSING: FORCED EVICTIONS (*adopted* May 20, 1997, U.N. Doc. E/1998/22).

<sup>309</sup> CDESCR, GENERAL COMMENT NO. 4 ON THE RIGHT TO ADEQUATE HOUSING para. 8.

<sup>310</sup> ICESCR art. 12; CDESCR, GENERAL COMMENT NO. 14 ON THE RIGHT TO HEALTH paras. 4, 11, 36, 43.

<sup>311</sup> CDESCR, GENERAL COMMENT NO. 4 ON THE RIGHT TO ADEQUATE HOUSING para. 8; HOUSING RIGHTS OF PEOPLE WITH HIV/AIDS, *supra* note 306, at 12.

<sup>312</sup> CDESCR, GENERAL COMMENT NO. 4 ON THE RIGHT TO ADEQUATE HOUSING para. 6.

<sup>313</sup> EUROPEAN SOCIAL CHARTER Part I: art. 31, Part II: arts. 15 (3), 16, 19 (4) (b), 23, 30-31.

<sup>314</sup> INTERNATIONAL GUIDELINES paras. 105, 147.

<sup>315</sup> HOUSING RIGHTS OF PEOPLE WITH HIV/AIDS, *supra* note 306, at 13; UN AGENCY FOR HUMAN SETTLEMENTS, THE HABITAT AGENDA GOALS AND PRINCIPLES, COMMITMENTS AND THE GLOBAL PLAN OF ACTION (*adopted* June 1996 by the Second UN Conference for Human Settlements) [hereinafter HABITAT AGENDA].

<sup>316</sup> HABITAT AGENDA paras. 27, 39-40, 97.

<sup>317</sup> NATIONAL AIDS HOUSING COALITION, INTERNATIONAL DECLARATION ON POVERTY, HOUSING INSTABILITY AND HIV/AIDS (2008).

<sup>318</sup> INTERNATIONAL GUIDELINES Guideline 3, paras. 20, 133.

<sup>319</sup> SOUTHERN AIDS COALITION, HOUSING PERSONS WITH HIV DISEASE 2 (2009).

<sup>320</sup> UNAIDS, HIV-related Travel Restrictions, at: <http://www.unaids.org/en/strategygoalsby2015/hiv-relatedtravelrestrictions/#1>.

<sup>321</sup> UNAIDS, MAPPING OF RESTRICTIONS ON THE ENTRY, STAY AND RESIDENCE OF PEOPLE LIVING WITH HIV 2 (2009).

<sup>322</sup> UNAIDS, REPORT OF THE INTERNATIONAL TASK TEAM ON HIV-RELATED TRAVEL RESTRICTIONS: FINDINGS AND RECOMMENDATIONS 3, 5 (2008) [hereinafter UNAIDS, REPORT ON HIV-RELATED TRAVEL RESTRICTIONS].

<sup>323</sup> *Id.* at 6.

<sup>324</sup> UNAIDS, GETTING TO ZERO STRATEGY, *supra* note 25, at 7; see also UNAIDS, REPORT ON HIV-RELATED TRAVEL RESTRICTIONS, *supra* note 322.

<sup>325</sup> WORLD BANK, LEGAL ASPECTS OF HIV/AIDS, *supra* note 220, at 69; HRW, RETURNED TO RISK: DEPORTATION OF HIV-POSITIVE MIGRANTS 6 (2009) [hereinafter HRW, RETURNED TO RISK].

<sup>326</sup> CONVENTION ON THE PROTECTION OF THE RIGHTS OF ALL MIGRANT WORKERS AND MEMBERS OF THEIR FAMILIES art. 7 (*adopted* December 18, 1990 by U.N. G.A. Res. 45/158, *entered into force* July 1, 2003, U.N. Doc. A/45/49) [hereinafter CONVENTION ON THE PROTECTION OF THE RIGHTS OF MIGRANT WORKERS].

<sup>327</sup> ILO RECOMMENDATION para. 3 (c).

<sup>328</sup> See SIRACUSA PRINCIPLES.

<sup>329</sup> UNAIDS & IOM, STATEMENT ON HIV/AIDS-RELATED TRAVEL RESTRICTIONS 2-8 (2004) [hereinafter UNAIDS & IOM, STATEMENT ON HIV/AIDS-RELATED TRAVEL RESTRICTIONS]; see also WHO, REPORT OF THE CONSULTATION ON INTERNATIONAL TRAVEL AND HIV INFECTION (1987); WHO, STATEMENT ON SCREENING OF INTERNATIONAL TRAVELERS FOR INFECTION WITH HIV (1988); WHO, POLICY OF NON-SPONSORSHIP OF INTERNATIONAL CONFERENCES ON AIDS IN COUNTRIES WITH HIV/AIDS-SPECIFIC SHORT-TERM TRAVEL RESTRICTIONS (1993); WHO, REPORT OF THE PREPARATORY MEETING FOR A CONSULTATION ON LONG-TERM TRAVEL RESTRICTIONS AND HIV/AIDS (1994); CANADIAN HIV/AIDS LEGAL NETWORK, HIV/AIDS AND IMMIGRATION: FINAL REPORT 50 (2001).

<sup>330</sup> UNAIDS, REPORT ON HIV-RELATED TRAVEL RESTRICTIONS, *supra* note 322, at 17-18.

<sup>331</sup> INTERNATIONAL GUIDELINES paras. 127, 131. In March 2011 this was reiterated by the European Court of Human Rights which, in holding that the refusal of residency on the basis of HIV status was a breach of the ECHR, stressed that travel and residence restrictions on PLHIV were not only ineffectual but also potentially harmful to the public health of the host country. See *Kiyutin v. Russia*, Judgment No. 2700/10 (European Court of Human Rights, March 10, 2011).

<sup>332</sup> UNAIDS, REPORT ON HIV-RELATED TRAVEL RESTRICTIONS, *supra* note 322, at 19.

<sup>333</sup> *Id.*

<sup>334</sup> *Id.* at 20; UNAIDS & IOM, STATEMENT ON HIV/AIDS-RELATED TRAVEL RESTRICTIONS, *supra* note 329, at 2, 18; ALL-PARTY PARLIAMENTARY GROUP ON AIDS, MIGRATION AND HIV: IMPROVING LIVES IN BRITAIN. AN INQUIRY INTO THE IMPACT OF THE UK NATIONALITY AND IMMIGRATION SYSTEM ON PEOPLE LIVING WITH HIV para. 30 (2003).

<sup>335</sup> UNAIDS & IOM, STATEMENT ON HIV/AIDS-RELATED TRAVEL RESTRICTIONS, *supra* note 329, at 2, 18; UNAIDS, REPORT ON HIV-RELATED TRAVEL RESTRICTIONS, *supra* note 322, at 20.

<sup>336</sup> UNAIDS & IOM, STATEMENT ON HIV/AIDS-RELATED TRAVEL RESTRICTIONS, *supra* note 329, at 2; UNAIDS, REPORT ON HIV-RELATED TRAVEL RESTRICTIONS, *supra* note 322, at 24.

<sup>337</sup> UNAIDS & IOM, STATEMENT ON HIV/AIDS-RELATED TRAVEL RESTRICTIONS, *supra* note 329, at 9; UNAIDS, REPORT ON HIV-RELATED TRAVEL RESTRICTIONS, *supra* note 322, at 24.

<sup>338</sup> INTERNATIONAL GUIDELINES para. 126; UNAIDS, REPORT ON HIV-RELATED TRAVEL RESTRICTIONS, *supra* note 322, at 6, 23.

<sup>339</sup> UNAIDS, REPORT ON HIV-RELATED TRAVEL RESTRICTIONS, *supra* note 322, at 26-27; *see also* COORDINATION OF ACTION RESEARCH ON AIDS AND MOBILITY (CARAM) ASIA, POLICY BRIEF: REMOVAL OF MANDATORY HIV TESTING FOR MIGRANT WORKERS (2007).

<sup>340</sup> ILO RECOMMENDATION paras. 25-28, 47; CONVENTION ON THE PROTECTION OF THE RIGHTS OF MIGRANT WORKERS arts. 14, 28.

<sup>341</sup> INTER-PARLIAMENTARY UNION & UNHCR, REFUGEE PROTECTION: A GUIDE TO INTERNATIONAL REFUGEE LAW 53 (2001) [hereinafter A GUIDE TO INTERNATIONAL REFUGEE LAW].

<sup>342</sup> UNAIDS & IOM, STATEMENT ON HIV/AIDS-RELATED TRAVEL RESTRICTIONS, *supra* note 329, at 2.

<sup>343</sup> HRW, RETURNED TO RISK, *supra* note 325, at 6-10; A GUIDE TO INTERNATIONAL REFUGEE LAW, *supra* note 341, at 14.

<sup>344</sup> UN CONVENTION RELATING TO THE STATUS OF REFUGEES (*adopted* July 28, 1951, *entered into force* April 22, 1954, 189 U.N.T.S. 150).

<sup>345</sup> INTERNATIONAL GUIDELINES paras. 129-130; UNAIDS, REPORT ON HIV-RELATED TRAVEL RESTRICTIONS, *supra* note 322, at 28-29; UNHCR, HEALTH POLICY ON AIDS (1988); UNAIDS, STRATEGIES TO SUPPORT THE HIV-RELATED NEEDS OF REFUGEES AND HOST POPULATIONS 11 (2005) [hereinafter UNAIDS, STRATEGIES TO SUPPORT THE HIV-RELATED NEEDS OF REFUGEES AND HOST POPULATIONS]; UNHCR, 10 Key Points on the Protection of Refugees, IDPs, and Other Persons of Concern, *at*: <http://www.unhcr.org/458938362.pdf>.

<sup>346</sup> UNAIDS, REPORT ON HIV-RELATED TRAVEL RESTRICTIONS, *supra* note 322, at 28.

<sup>347</sup> HRW, RETURNED TO RISK, *supra* note 325, at 10.

<sup>348</sup> INTERNATIONAL GUIDELINES para. 129.

<sup>349</sup> WORLD BANK, LEGAL ASPECTS OF HIV/AIDS, *supra* note 220, at 73.

<sup>350</sup> DECLARATION OF COMMITMENT para. 50.

<sup>351</sup> *Id.* para. 50; INTERNATIONAL GUIDELINES para. 60; UNAIDS, PRACTICAL GUIDELINES FOR INTENSIFYING HIV PREVENTION: TOWARDS UNIVERSAL ACCESS 24 (2007) [hereinafter UNAIDS, PRACTICAL GUIDELINES FOR INTENSIFYING HIV PREVENTION]; Press Release, UNAIDS & IOM, UNAIDS and IOM Sign Agreement to Improve Access to HIV Services for Migrants (January 21, 2011); UNAIDS, HIV AND REFUGEES POLICY BRIEF 1-2 (2007) [hereinafter UNAIDS, HIV AND REFUGEES POLICY BRIEF]; *see also* UNAIDS, STRATEGIES TO SUPPORT THE HIV-RELATED NEEDS OF REFUGEES AND HOST POPULATIONS, *supra* note 345; UNHCR, NOTE ON HIV/AIDS AND PROTECTION OF REFUGEES, INTERNALLY DISPLACED PERSONS AND OTHER PERSONS OF CONCERN (2006).

<sup>352</sup> CESCR, GENERAL COMMENT No. 14 ON THE RIGHT TO HEALTH para. 18.

<sup>353</sup> *See, e.g.*, HRW, CHRONIC INDIFFERENCE – HIV/AIDS SERVICES FOR IMMIGRANTS DENIED BY THE US (2007).

<sup>354</sup> UNAIDS, POPULATION MOBILITY AND AIDS: TECHNICAL UPDATE 2-5 (2001).

<sup>355</sup> UNAIDS, STRATEGIES TO SUPPORT THE HIV-RELATED NEEDS OF REFUGEES AND HOST POPULATIONS, *supra* note 345, at 7; UNAIDS, HIV AND REFUGEES POLICY BRIEF, *supra* note 351, at 3; *see also* UNAIDS, PRACTICAL GUIDELINES FOR INTENSIFYING HIV PREVENTION, *supra* note 351.

<sup>356</sup> UNAIDS, HIV AND REFUGEES POLICY BRIEF, *supra* note 351, at 3.

<sup>357</sup> A GUIDE TO INTERNATIONAL REFUGEE LAW, *supra* note 341, at 52-53.

<sup>358</sup> INTER-AGENCY STANDING COMMITTEE, GUIDELINES FOR ADDRESSING HIV IN HUMANITARIAN SETTINGS 2-5 (2009).

<sup>359</sup> UNAIDS, STRATEGIES TO SUPPORT THE HIV-RELATED NEEDS OF REFUGEES AND HOST POPULATIONS, *supra* note 345, at 18.

<sup>360</sup> UNAIDS, UNAIDS REPORT ON THE GLOBAL AIDS EPIDEMIC 10 (2010) [hereinafter UNAIDS, 2010 GLOBAL AIDS REPORT].

<sup>361</sup> According to U.S. Centers for Disease Control and Prevention, saliva has never been proved to result in transmission of HIV. Centers for Disease Control and Prevention, Can HIV be Transmitted by Being Spit on by an HIV-Infected Person?, *at*: <http://www.cdc.gov/hiv/resources/qa/transmission.htm>.

<sup>362</sup> For example, Zimbabwe's Criminal Law (Codification and Reform) Act, adopted in 2005, made it a crime for anyone who realizes "that there is a real risk or possibility that he or she is infected with HIV" to do "anything" that he or she "realizes involves a real risk or possibility of infecting another person with HIV". *See* CRIMINAL LAW (CODIFICATION AND REFORM) ACT OF ZIMBABWE sec. 78-80 (Law No. 23/2004, *adopted* June 3, 2005).

<sup>363</sup> GLOBAL NETWORK OF PEOPLE LIVING WITH HIV, THE GLOBAL CRIMINALIZATION SCAN REPORT 2010 at 17 (2010) [hereinafter GNP+, 2010 GLOBAL CRIMINALIZATION SCAN REPORT].

<sup>364</sup> UNAIDS & UNDP, POLICY BRIEF: CRIMINALIZATION OF HIV TRANSMISSION (2008) [UNAIDS & UNDP, CRIMINALIZATION OF HIV TRANSMISSION];

<sup>365</sup> GNP+, 2010 GLOBAL CRIMINALIZATION SCAN REPORT, *supra* note 363, at 3.

<sup>366</sup> UN, REPORT OF THE SPECIAL RAPPOREUR ON THE RIGHT OF EVERYONE TO THE ENJOYMENT OF THE HIGHEST ATTAINABLE STANDARD OF PHYSICAL AND MENTAL HEALTH TO THE UN HUMAN RIGHTS COUNCIL paras. 56-57 (April 27, 2010, U.N. Doc. A/HRC/14/20) [hereinafter 2010 REPORT OF THE SPECIAL RAPPOREUR ON THE RIGHT TO HEALTH TO THE HRC].

<sup>367</sup> *See, e.g.*, UNAIDS & UNDP, CRIMINALIZATION OF HIV TRANSMISSION, *supra* note 364; 2010 REPORT OF THE SPECIAL RAPPOREUR ON THE RIGHT TO HEALTH TO THE HRC, *supra* note 366, paras 51-75.

<sup>368</sup> *Id.*

<sup>369</sup> WORLD BANK, LEGAL ASPECTS OF HIV/AIDS, *supra* note 220, at 85; OSI, TEN REASONS TO OPPOSE THE CRIMINALIZATION OF HIV EXPOSURE OR TRANSMISSION (2008).

<sup>370</sup> UNAIDS & UNDP, CRIMINALIZATION OF HIV TRANSMISSION, *supra* note 364.

<sup>371</sup> 2010 REPORT OF THE SPECIAL RAPPOREUR ON THE RIGHT TO HEALTH TO THE HRC, *supra* note 366, paras 66-67; UN WOMEN, UNAIDS & UNFPA, SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS OF WOMEN AND GIRLS LIVING WITH HIV: SUMMARY OF KEY ISSUES 7 (2011).

<sup>372</sup> UNAIDS & UNDP, CRIMINALIZATION OF HIV TRANSMISSION, *supra* note 364.

<sup>373</sup> *Id.*

<sup>374</sup> *Id.* at 2.

<sup>375</sup> POLITICAL DECLARATION para. 25.

<sup>376</sup> UNAIDS & UNDP, CRIMINALIZATION OF HIV TRANSMISSION, *supra* note 364, at 4.

<sup>377</sup> Canadian HIV/AIDS Legal Network, Summary: New Zealand Police v. J. W. Dalley, *at*: <http://www.aidslaw.ca/EN/lawyers-kit/documents/4.Dalley2005summary.pdf>.

<sup>378</sup> UNAIDS & WHO, 2009 AIDS Epidemic Update: Epidemiology Core Slides, *at*: [http://data.unaids.org/pub/EPISlides/2009/2009\\_epiupdate\\_core\\_en.ppt](http://data.unaids.org/pub/EPISlides/2009/2009_epiupdate_core_en.ppt).

<sup>379</sup> UNAIDS, FACT SHEET: WOMEN, GIRLS, AND HIV (2010).

- <sup>380</sup> WHO, Gender Inequalities and HIV, at: [http://www.who.int/gender/hiv\\_aids/en/](http://www.who.int/gender/hiv_aids/en/); UNAIDS & WHO, 2009 AIDS EPIDEMIC UPDATE 22 (2009) [hereinafter 2009 AIDS EPIDEMIC UPDATE]; POLITICAL DECLARATION para. 7. It is important to note that men and boys also face unique vulnerabilities to HIV, such as social encouragement to have multiple sexual partners or use alcohol or drugs.
- <sup>381</sup> Global Coalition on Women and AIDS, Background: Preventing HIV Infection in Girls and Women, at: [http://data.unaids.org/GCWA/gcwa\\_bg\\_prevention\\_en.pdf](http://data.unaids.org/GCWA/gcwa_bg_prevention_en.pdf); 2009 AIDS EPIDEMIC UPDATE, *supra* note 380, at 22.
- <sup>382</sup> In Guinea, for example, widowed women are seven times more likely to be living with HIV than single women. See 2009 AIDS EPIDEMIC UPDATE, *supra* note 380, at 22-23.
- <sup>383</sup> UN Women, Human Rights, at: [http://www.unifem.org/gender\\_issues/human\\_rights/](http://www.unifem.org/gender_issues/human_rights/).
- <sup>384</sup> James E. Cummins, Jr. & Charlene S. Dezzutti, *Sexual HIV-1 Transmission and Mucosal Defense Mechanisms*, AIDS REVIEWS 144 (Vol. 2. No. 3/2000).
- <sup>385</sup> INTERNATIONAL GUIDELINES para. 114.
- <sup>386</sup> DECLARATION OF COMMITMENT paras. 14, 59; POLITICAL DECLARATION para. 7; WOMEN, THE GIRL CHILD AND HIV/AIDS preamble; ICPD PROGRAM OF ACTION para. 7 (28).
- <sup>387</sup> UNAIDS ACTION FRAMEWORK ON WOMEN AND HIV, *supra* note 128, at 3.
- <sup>388</sup> DECLARATION OF COMMITMENT para. 59; POLITICAL DECLARATION paras. 7, 15; WOMEN, THE GIRL CHILD AND HIV/AIDS preamble, para. 25; UNAIDS, AGENDA FOR ACCELERATED COUNTRY ACTION FOR WOMEN, GIRLS, GENDER EQUALITY AND HIV 2010-2014 at 10-15 (2010) [hereinafter UNAIDS, AGENDA FOR COUNTRY ACTION FOR WOMEN AND HIV].
- <sup>389</sup> UNAIDS, OUTCOME FRAMEWORK 2009-2011, *supra* note 24, at 7-8; UNAIDS, GETTING TO ZERO STRATEGY, *supra* note 25, at 10.
- <sup>390</sup> DECLARATION OF COMMITMENT paras. 59, 61; POLITICAL DECLARATION paras. 15, 30; WOMEN, THE GIRL CHILD AND HIV/AIDS paras. 4-5, 18, 32-33, 35-37; INTERNATIONAL GUIDELINES Guidelines 8, 9, paras. 22 (f), 60; BEIJING PLATFORM FOR ACTION paras. 99, 109; UNAIDS ACTION FRAMEWORK ON WOMEN AND HIV, *supra* note 128, at 1; UNAIDS, AGENDA FOR COUNTRY ACTION FOR WOMEN AND HIV, *supra* note 388, at 7, 16.
- <sup>391</sup> See also UNESCO CONVENTION AGAINST DISCRIMINATION IN EDUCATION art. 1 (*adopted* December 14, 1960 by the UNESCO General Conference, *entered into force* May 22, 1962).
- <sup>392</sup> WOMEN, THE GIRL CHILD AND HIV/AIDS preamble.
- <sup>393</sup> DECLARATION OF COMMITMENT para. 60; WOMEN, THE GIRL CHILD AND HIV/AIDS paras. 9-10, 31; INTERNATIONAL GUIDELINES Guideline 8, para. 60 (f); BEIJING PLATFORM FOR ACTION para. 85 (l); CEDAW, GENERAL RECOMMENDATION NO. 15 ON WOMEN AND HIV/AIDS; CEDAW, GENERAL RECOMMENDATION NO. 24 ON WOMEN AND HEALTH para. 21.
- <sup>394</sup> DECLARATION OF COMMITMENT para. 59; POLITICAL DECLARATION para. 30; WOMEN, THE GIRL CHILD AND HIV/AIDS para. 19; INTERNATIONAL GUIDELINES Guideline 9, para. 22 (f); BEIJING PLATFORM FOR ACTION paras. 98-99, 269; UNAIDS, AGENDA FOR COUNTRY ACTION FOR WOMEN AND HIV, *supra* note 388, at 17.
- <sup>395</sup> See also CEDAW, GENERAL RECOMMENDATION NO. 24 ON WOMEN AND HEALTH paras. 15, 18; CEDAW, GENERAL RECOMMENDATION NO. 14 ON FEMALE CIRCUMCISION (*adopted* 1990, U.N. Doc. A/45/38); CEDAW, GENERAL RECOMMENDATION NO. 21 ON EQUALITY IN MARRIAGE AND FAMILY LIFE paras. 14, 16 (*adopted* 1994, U.N. Doc. A/49/38); PROTOCOL TO PREVENT, SUPPRESS AND PUNISH TRAFFICKING IN PERSONS, ESPECIALLY WOMEN AND CHILDREN, SUPPLEMENTING THE UN CONVENTION AGAINST TRANSNATIONAL ORGANIZED CRIME (*adopted* November 15, 2000 by U.N. G.A. Res. 55/25, *entered into force* December 25, 2003) [hereinafter UN TRAFFICKING PROTOCOL]; UN CONVENTION ON CONSENT TO MARRIAGE, MINIMUM AGE FOR MARRIAGE AND REGISTRATION OF MARRIAGES (*adopted* November 7, 1962 by U.N. G.A. Res. 1763 A (XVII), *entered into force* December 9, 1964).
- <sup>396</sup> DECLARATION ON THE ELIMINATION OF VIOLENCE AGAINST WOMEN art. 4 (*adopted* December 20, 1993 by U.N. G.A. Res. 48/104, U.N. Doc. A/48/49) [hereinafter DECLARATION ON THE ELIMINATION OF VIOLENCE AGAINST WOMEN].
- <sup>397</sup> BEIJING PLATFORM FOR ACTION paras. 99, 122-123, 269; UN COMMITTEE ON THE ELIMINATION OF DISCRIMINATION AGAINST WOMEN, GENERAL RECOMMENDATION NO. 19: VIOLENCE AGAINST WOMEN paras. 1, 7, 11, 20 (*adopted* 1992, U.N. Doc. A/47/38); DECLARATION ON THE ELIMINATION OF VIOLENCE AGAINST WOMEN preamble.
- <sup>398</sup> INTERNATIONAL COUNCIL OF AIDS SERVICE ORGANIZATIONS (ICASO), GENDER, SEXUALITY, RIGHTS, AND HIV: AN OVERVIEW FOR COMMUNITY SECTOR ORGANIZATIONS 9-10 (2007).
- <sup>399</sup> DECLARATION OF COMMITMENT para. 61; POLITICAL DECLARATION paras. 30-31; WOMEN, THE GIRL CHILD AND HIV/AIDS paras. 13-14.
- <sup>400</sup> WOMEN, THE GIRL CHILD AND HIV/AIDS preamble.
- <sup>401</sup> DECLARATION OF COMMITMENT paras. 58, 68; POLITICAL DECLARATION paras. 30, 32; WOMEN, THE GIRL CHILD AND HIV/AIDS preamble, paras. 5, 20, 34; INTERNATIONAL GUIDELINES Guideline 9, para. 22 (f).
- <sup>402</sup> WOMEN, THE GIRL CHILD AND HIV/AIDS preamble.
- <sup>403</sup> Data shows that in 2008 about 45% of women in need and 37% of men in need received ART in low- and mid-income countries. See UNAIDS, PRACTICAL GUIDELINES FOR INTENSIFYING HIV PREVENTION, *supra* note 351, at 59.
- <sup>404</sup> Purdah is a practice of secluding women from public observation and from contact with men. Sex segregation is common in many Muslim and some Hindu communities.
- <sup>405</sup> INTERNATIONAL GUIDELINES Guideline 6, para. 31.
- <sup>406</sup> DECLARATION OF COMMITMENT para. 60; POLITICAL DECLARATION para. 30; WOMEN, THE GIRL CHILD AND HIV/AIDS paras. 9, 21; BEIJING PLATFORM FOR ACTION para. 109 (m); INTERNATIONAL GUIDELINES Guideline 8; UNAIDS, AGENDA FOR COUNTRY ACTION FOR WOMEN AND HIV, *supra* note 388, at 13.
- <sup>407</sup> Parkie Mbozi, *The Impact of Negative Cultural Practices on the Spread of HIV/AIDS in Zambia*, in UNESCO, MEDIA & HIV/AIDS IN EAST AND SOUTHERN AFRICA: A RESOURCE BOOK 76 (2000).
- <sup>408</sup> Abt Associates, *Traditional Leaders in Zambia: A Weapon Against AIDS* (2004), at: <http://www.abtassociates.com/Page.cfm?PagelD=12626> [hereinafter Abt Associates, *Traditional Leaders in Zambia*].
- <sup>409</sup> WORLD BANK, LEGAL ASPECTS OF HIV/AIDS, *supra* note 220, at 147.
- <sup>410</sup> Abt Associates, *Traditional Leaders in Zambia*, *supra* note 408.
- <sup>411</sup> BUREAU OF DEMOCRACY, HUMAN RIGHTS, AND LABOR, U.S. DEPARTMENT OF STATE, 2003 COUNTRY REPORTS ON HUMAN RIGHTS PRACTICES: ZAMBIA (2004).
- <sup>412</sup> FREEDOM HOUSE, FREEDOM IN THE WORLD 2009: COUNTRY REPORT ZAMBIA (2009).
- <sup>413</sup> Sharon LaFraniere, *AIDS Now Compels Africa to Challenge Widows' "Cleansing"*, NEW YORK TIMES, May 11, 2005; BUREAU OF DEMOCRACY, HUMAN RIGHTS, AND LABOR, U.S. DEPARTMENT OF STATE, 2009 COUNTRY REPORTS ON HUMAN RIGHTS PRACTICES: ZAMBIA (2010).
- <sup>414</sup> 2009 AIDS EPIDEMIC UPDATE, *supra* note 380, at 8; UNICEF, ChildInfo, at: [http://www.childinfo.org/hiv\\_aids.html](http://www.childinfo.org/hiv_aids.html) [hereinafter UNICEF, ChildInfo].
- <sup>415</sup> UNICEF, ChildInfo, *supra* note 414; UNAIDS GUIDE TO UN HUMAN RIGHTS MACHINERY, *supra* note 258, at 89.
- <sup>416</sup> CRC, GENERAL COMMENT NO. 3 ON CHILDREN AND HIV/AIDS para. 3.

- <sup>417</sup> CRC, GENERAL COMMENT NO. 3 ON CHILDREN AND HIV/AIDS paras. 2-3, 30; UNAIDS GUIDE TO UN HUMAN RIGHTS MACHINERY, *supra* note 258, at 80; INTERNATIONAL GUIDELINES para. 117.
- <sup>418</sup> See generally UNAIDS, HIV/AIDS AND YOUNG PEOPLE: HOPE FOR TOMORROW (2003).
- <sup>419</sup> WHO, Young People: Health Risks and Solutions (2010), at: <http://www.who.int/mediacentre/factsheets/fs345/en/index.html>.
- <sup>420</sup> UNAIDS GUIDE TO UN HUMAN RIGHTS MACHINERY, *supra* note 258, at 73-74, 80.
- <sup>421</sup> CRC, GENERAL COMMENT NO. 3 ON CHILDREN AND HIV/AIDS para. 1; UNAIDS GUIDE TO UN HUMAN RIGHTS MACHINERY, *supra* note 258, at 73-74, 80, 88-89; WORLD BANK, LEGAL ASPECTS OF HIV/AIDS, *supra* note 220, at 153.
- <sup>422</sup> UDHR art. 25 (2); ICCPR art. 24; ICESCR art. 10 (3); CRC preamble, arts. 2, 6, 13, 24; CRC, GENERAL COMMENT NO. 3 ON CHILDREN AND HIV/AIDS paras. 7-9; CHARTER OF FUNDAMENTAL RIGHTS OF THE EU art. 24 (1); EUROPEAN SOCIAL CHARTER Part I: art. 17; ADRDM art. VII; ACHR art. 19; BANJUL CHARTER art. 18; INTERNATIONAL GUIDELINES para. 116.
- <sup>423</sup> CRC art. 3 (1); CHARTER OF FUNDAMENTAL RIGHTS OF THE EU art. 24 (2).
- <sup>424</sup> CRC, GENERAL COMMENT NO. 3 ON CHILDREN AND HIV/AIDS para. 5.
- <sup>425</sup> UNAIDS GUIDE TO UN HUMAN RIGHTS MACHINERY, *supra* note 258, at 73-74.
- <sup>426</sup> UNAIDS, OUTCOME FRAMEWORK 2009–2011, *supra* note 24, at 7-8; UNAIDS, GETTING TO ZERO STRATEGY, *supra* note 25, at 10.
- <sup>427</sup> UNICEF, ChildInfo, *supra* note 414; CRC, GENERAL COMMENT NO. 3 ON CHILDREN AND HIV/AIDS paras. 4, 10; PROTECTION OF HUMAN RIGHTS IN THE CONTEXT OF HIV/AIDS 2009 para. 8; DECLARATION OF COMMITMENT paras. 63, 65-67; POLITICAL DECLARATION para. 32; INTERNATIONAL GUIDELINES paras. 22 (g)-(h), 60 (i), 117; UNAIDS GUIDE TO UN HUMAN RIGHTS MACHINERY, *supra* note 258, at 87; INTER-AGENCY TASK TEAM ON CHILDREN AND HIV AND AIDS, NATIONAL RESPONSES FOR CHILDREN AFFECTED BY AIDS: REVIEW OF PROGRESS AND LESSONS LEARNED 2, 4 (2008) [hereinafter NATIONAL RESPONSES FOR CHILDREN AFFECTED BY AIDS].
- <sup>428</sup> UNICEF, ChildInfo, *supra* note 414.
- <sup>429</sup> IATT, OVERVIEW OF HIV INTERVENTIONS FOR YOUNG PEOPLE *supra* note 51, at 5-6.
- <sup>430</sup> See also OPTIONAL PROTOCOL TO THE CONVENTION ON THE RIGHTS OF THE CHILD ON THE SALE OF CHILDREN, CHILD PROSTITUTION, AND CHILD PORNOGRAPHY art. 1 (adopted May 25, 2000 by U.N. G.A. Res. 54/263, entered into force January 18, 2002); ICCPR art. 17; ICESCR art. 10 (3); UN TRAFFICKING PROTOCOL; CHARTER OF FUNDAMENTAL RIGHTS OF THE EU art. 24 (3); EUROPEAN SOCIAL CHARTER Part I: art. 17; INTERNATIONAL GUIDELINES para. 116.
- <sup>431</sup> DECLARATION OF COMMITMENT para. 65; INTERNATIONAL GUIDELINES paras. 22 (g), 117; CRC, GENERAL COMMENT NO. 3 ON CHILDREN AND HIV/AIDS paras. 31-33; WORLD BANK, LEGAL ASPECTS OF HIV/AIDS, *supra* note 220, at 154.
- <sup>432</sup> UNAIDS GUIDE TO UN HUMAN RIGHTS MACHINERY, *supra* note 258, at 88; INTERNATIONAL GUIDELINES para. 117; CRC, GENERAL COMMENT NO. 3 ON CHILDREN AND HIV/AIDS paras. 36-39.
- <sup>433</sup> INTERNATIONAL GUIDELINES para. 117; CRC, GENERAL COMMENT NO. 3 ON CHILDREN AND HIV/AIDS paras. 34-35; WORLD BANK, LEGAL ASPECTS OF HIV/AIDS, *supra* note 220, at 154; CRC art. 3 (3).
- <sup>434</sup> CRC art. 24; CRC, GENERAL COMMENT NO. 3 ON CHILDREN AND HIV/AIDS paras. 5-6.
- <sup>435</sup> See also CRC, GENERAL COMMENT NO. 3 ON CHILDREN AND HIV/AIDS paras. 5-6, 16.
- <sup>436</sup> UNICEF, ChildInfo, *supra* note 414.
- <sup>437</sup> DECLARATION OF COMMITMENT paras. 56, 63; POLITICAL DECLARATION paras. 9, 34; INTERNATIONAL GUIDELINES para 22 (g); UNAIDS GUIDE TO UN HUMAN RIGHTS MACHINERY, *supra* note 258, at 88-89; CRC, GENERAL COMMENT NO. 3 ON CHILDREN AND HIV/AIDS paras. 22-24, 28.
- <sup>438</sup> DECLARATION OF COMMITMENT paras. 53, 63; POLITICAL DECLARATION para. 34; INTERNATIONAL GUIDELINES paras. 22 (g), 60 (g)-(h), 117; UNAIDS GUIDE TO UN HUMAN RIGHTS MACHINERY, *supra* note 258, at 88-89; CRC, GENERAL COMMENT NO. 3 ON CHILDREN AND HIV/AIDS paras. 11, 16-17; IATT, OVERVIEW OF HIV INTERVENTIONS FOR YOUNG PEOPLE *supra* note 51, at 3-4.
- <sup>439</sup> Press Release, UNAIDS, Young People Key to Reversing the Global AIDS Epidemic and Leading the Response (July 27, 2011); UNAIDS, OUTLOOK: YOUNG PEOPLE ARE LEADING THE PREVENTION EVOLUTION (2010).
- <sup>440</sup> CRC, GENERAL COMMENT NO. 3 ON CHILDREN AND HIV/AIDS para. 20.
- <sup>441</sup> UN COMMITTEE ON THE RIGHTS OF THE CHILD, GENERAL COMMENT NO. 12: THE RIGHT OF THE CHILD TO BE HEARD paras. 44, 98-102 (adopted July 20, 2009, U.N. Doc. CRC/C/GC/12).
- <sup>442</sup> Carol Kidu, Community Based Care for Children Affected by HIV and AIDS in Papua New Guinea, PowerPoint Presentation at the 9th International Congress on AIDS in Asia and the Pacific (ICAAP) (2009), available at: [www.unicef.org/eapro/6\\_Minister\\_Kidu\\_MVC\\_presentation\\_for\\_Bali.ppt](http://www.unicef.org/eapro/6_Minister_Kidu_MVC_presentation_for_Bali.ppt); UNICEF, SCALING UP THE RESPONSE FOR CHILDREN: COUNTRY BACKGROUND REPORT: PAPUA NEW GUINEA 12 (2006); NATIONAL RESPONSES FOR CHILDREN AFFECTED BY AIDS, *supra* note 427, at 45-46, 90; UNGASS, 2010 COUNTRY PROGRESS REPORT: PAPUA NEW GUINEA 124 (2010).
- <sup>443</sup> Time to Act, *supra* note 55.
- <sup>444</sup> EURASIAN HARM REDUCTION FRAMEWORK, DRUG POLICY POSITION PAPER 2 (2010).
- <sup>445</sup> WHO, CLINICAL GUIDELINES FOR CLINICAL WITHDRAWAL AND TREATMENT OF DRUG DEPENDANCE IN CLOSED SETTINGS 4-5 (2009); Press Release, UNODC, UNODC Launches "Pro-health" Drug Campaign on World Health Day (April 7, 2009); see also WHO, NEUROSCIENCE OF PSYCHOACTIVE SUBSTANCE USE AND DEPENDENCE: SUMMARY (2004).
- <sup>446</sup> HRW, SKIN ON THE CABLE: THE ILLEGAL ARREST, ARBITRARY DETENTION AND TORTURE OF PEOPLE WHO USE DRUGS IN CAMBODIA 4 (2010).
- <sup>447</sup> UNAIDS, OUTCOME FRAMEWORK 2009–2011, *supra* note 24, at 7-8; UNAIDS, GETTING TO ZERO STRATEGY, *supra* note 25, at 10.
- <sup>448</sup> CANADIAN HIV/AIDS LEGAL NETWORK, LEGISLATING FOR HEALTH AND HUMAN RIGHTS: MODEL LAW ON DRUG USE AND HIV/AIDS, Module 8: Outreach and Information (2006) [hereinafter MODEL LAW ON DRUG USE AND HIV/AIDS].
- <sup>449</sup> WHO, UNODC & UNAIDS, TECHNICAL GUIDE FOR COUNTRIES TO SET TARGETS FOR UNIVERSAL ACCESS TO HIV PREVENTION, TREATMENT AND CARE FOR INJECTING DRUG USERS 6 (2009) [hereinafter TECHNICAL GUIDE ON UNIVERSAL ACCESS FOR INJECTING DRUG USERS].
- <sup>450</sup> Harm Reduction Coalition, Principles of Harm Reduction, at: <http://www.harmreduction.org/section.php?id=62>.
- <sup>451</sup> FLEXIBILITY OF TREATY PROVISIONS AS REGARDS HARM REDUCTION APPROACHES (Decision No. 74/10, adopted September 30, 2002 by the UN International Narcotics Control Board, UN Doc. E/INCB/2002/W.13/SS.5); see also International Harm Reduction Association, at: [www.ihra.org](http://www.ihra.org); UNODC, FROM COERCION TO COHESION: TREATING DRUG DEPENDENCE THROUGH HEALTH CARE, NOT PUNISHMENT 1 (2010) [hereinafter UNODC, FROM COERCION TO COHESION].
- <sup>452</sup> Time to Act, *supra* note 55.
- <sup>453</sup> UNAIDS, PRACTICAL GUIDELINES FOR INTENSIFYING HIV PREVENTION, *supra* note 351, at 46.
- <sup>454</sup> DECLARATION OF COMMITMENT paras. 23, 52.
- <sup>455</sup> INTERNATIONAL GUIDELINES Guideline 6, para. 39.
- <sup>456</sup> See WHO, UNAIDS & UNODC, POLICY BRIEF: REDUCTION OF HIV TRANSMISSION THROUGH DRUG-DEPENDENCE TREATMENT (2004).
- <sup>457</sup> Alex H. Kral et al., Injection Risk Behaviors Among Clients of Syringe Exchange Programs with Different Syringe Dispensation Policies, JOURNAL OF ACQUIRED IMMUNE DEFICIENCY SYNDROMES 1307-1312 (Vol. 37, Issue 2, 2004).

- <sup>458</sup> UN, REPORT OF THE SPECIAL RAPPORTEUR ON THE RIGHT OF EVERYONE TO THE ENJOYMENT OF THE HIGHEST ATTAINABLE STANDARD OF PHYSICAL AND MENTAL HEALTH TO THE GENERAL ASSEMBLY Part II (August 6, 2010, U.N. Doc. A/65/255) [hereinafter 2010 REPORT OF THE SPECIAL RAPPORTEUR ON THE RIGHT TO HEALTH TO THE GA]; see also MODEL LAW ON DRUG USE AND HIV/AIDS, *supra* note 448, Module 1: Criminal Law and Module 2: Treatment of Drug Dependence.
- <sup>459</sup> WHO, UNAIDS & UNODC, POLICY BRIEF: PROVISION OF STERILE INJECTING EQUIPMENT TO REDUCE HIV TRANSMISSION, EVIDENCE FOR ACTION ON HIV/AIDS AND INJECTION DRUG USE 2 (2004); MODEL LAW ON DRUG USE AND HIV/AIDS, *supra* note 448, Module 3: Sterile Syringe Programs.
- <sup>460</sup> INTERNATIONAL GUIDELINES Guideline 4, para. 21 (d).
- <sup>461</sup> GUIDELINES ON THE ROLE OF PROSECUTORS paras. 1, 4 (*adopted* September 7, 1990 by the Eighth UN Congress on the Prevention of Crime and the Treatment of Offenders, U.N. Doc. A/CONF.144/28/Rev.1) [hereinafter GUIDELINES ON THE ROLE OF PROSECUTORS].
- <sup>462</sup> See WHO, UNODC & UNAIDS, INTERVENTIONS TO ADDRESS HIV IN PRISONS: DRUG DEPENDENCE TREATMENT (2007) [hereinafter INTERVENTIONS TO ADDRESS HIV IN PRISONS].
- <sup>463</sup> 2010 REPORT OF THE SPECIAL RAPPORTEUR ON THE RIGHT TO HEALTH TO THE GA, *supra* note 458, part IV; Roxanne Saucier et al., *The Limits of Equivalence: Ethical Dilemmas in Providing Care in Drug Detention Centers*, INTERNATIONAL JOURNAL OF PRISONER HEALTH 37-43 (2010).
- <sup>464</sup> TECHNICAL GUIDE ON UNIVERSAL ACCESS FOR INJECTING DRUG USERS, *supra* note 449, at 12.
- <sup>465</sup> UNODC, FROM COERCION TO COHESION, *supra* note 451, at 7-10.
- <sup>466</sup> Bradley M. Mathers et al., *HIV Prevention, Treatment, and Care Services for People who Inject Drugs: a Systematic Review of Global, Regional, and National Coverage*, THE LANCET (2010).
- <sup>467</sup> EURASIAN HARM REDUCTION FRAMEWORK, DRUG POLICY POSITION PAPER 2 (2010).
- <sup>468</sup> Joint United Nations Programme on HIV/AIDS (UNAIDS) para. 19 (*adopted* July 24, 2009 by the Economic and Social Council Res. 2009/6, U.N. Doc. E/2009/L.23); see also PROTECTION OF HUMAN RIGHTS IN THE CONTEXT OF HIV/AIDS 2009 preamble, para. 5.
- <sup>469</sup> INTERNATIONAL GUIDELINES para 31.
- <sup>470</sup> TECHNICAL GUIDE ON UNIVERSAL ACCESS FOR INJECTING DRUG USERS, *supra* note 449, at 9.
- <sup>471</sup> INTERNATIONAL GUIDELINES Guideline 9, para. 62.
- <sup>472</sup> *Time to Act*, *supra* note 55.
- <sup>473</sup> MODEL LAW ON DRUG USE AND HIV/AIDS, *supra* note 448, Module 3: Sterile Syringe Programs, p. 7.
- <sup>474</sup> The Crown Prosecution Service, Legal Guidance: Drug Offences (2010), at: [http://www.cps.gov.uk/legal/d\\_to\\_g/drug\\_offences/index.html#a10](http://www.cps.gov.uk/legal/d_to_g/drug_offences/index.html#a10).
- <sup>475</sup> UNAIDS, SEX WORK AND HIV/AIDS: TECHNICAL UPDATE 2 (2002) [hereinafter UNAIDS, SEX WORK AND HIV/AIDS].
- <sup>476</sup> UNAIDS, 2010 GLOBAL AIDS REPORT, *supra* note 360, at 42.
- <sup>477</sup> 2010 REPORT OF THE SPECIAL RAPPORTEUR ON THE RIGHT TO HEALTH TO THE HRC, *supra* note 366, para. 29.
- <sup>478</sup> *Id.* para. 43.
- <sup>479</sup> In many parts of the world, sex work and injecting drug use are intricately linked: people who are dependent on drugs resort to commercial sex in order to purchase drugs and avoid the pain of physical withdrawal from drugs, while sex workers turn to drugs to escape the pressures of their lifestyle.
- <sup>480</sup> UNAIDS, SEX WORK AND HIV/AIDS, *supra* note 475.
- <sup>481</sup> UNAIDS, OUTCOME FRAMEWORK 2009–2011, *supra* note 24, at 7-8; UNAIDS, GETTING TO ZERO STRATEGY, *supra* note 25, at 10.
- <sup>482</sup> UNAIDS, GUIDANCE NOTE ON HIV AND SEX WORK 9-11 (2009) [hereinafter UNAIDS, GUIDANCE NOTE ON HIV AND SEX WORK].
- <sup>483</sup> CRC arts. 34-35; CEDAW art. 6; UN TRAFFICKING PROTOCOL art. 3.
- <sup>484</sup> 2010 REPORT OF THE SPECIAL RAPPORTEUR ON THE RIGHT TO HEALTH TO THE HRC, *supra* note 366, Part III.
- <sup>485</sup> *Id.*
- <sup>486</sup> UNAIDS, SEX WORK AND HIV/AIDS, *supra* note 475, at 10.
- <sup>487</sup> INTERNATIONAL GUIDELINES Guideline 4, para. 21.
- <sup>488</sup> 2010 REPORT OF THE SPECIAL RAPPORTEUR ON THE RIGHT TO HEALTH TO THE HRC, *supra* note 366, Part III.
- <sup>489</sup> UNAIDS, GUIDANCE NOTE ON HIV AND SEX WORK, *supra* note 482, at 3.
- <sup>490</sup> INTERNATIONAL GUIDELINES Guideline 4, para. 21.
- <sup>491</sup> IPU, UNAIDS & UNDP, A HANDBOOK FOR PARLIAMENTARIANS, *supra* note 102, at 167, 186.
- <sup>492</sup> UNAIDS, GUIDANCE NOTE ON HIV AND SEX WORK, *supra* note 482, at 2.
- <sup>493</sup> INTERNATIONAL GUIDELINES paras. 21 (c), 60 (j); UNAIDS, GUIDANCE NOTE ON HIV AND SEX WORK, *supra* note 482, at 8-9.
- <sup>494</sup> INTERNATIONAL GUIDELINES Guideline 9, para. 62.
- <sup>495</sup> Ministry of Justice of New Zealand, Prostitution Law Reform, at: <http://www.justice.govt.nz/policy/commercial-property-and-regulatory/prostitution/prostitution-law-reform>; Ministry of Justice of New Zealand, The PRA and Human Rights, at: <http://www.justice.govt.nz/policy/commercial-property-and-regulatory/prostitution/prostitution-law-review-committee/publications/plrc-report/3-the-pra-and-human-rights>.
- <sup>496</sup> UNAIDS, UNAIDS ACTION FRAMEWORK: UNIVERSAL ACCESS FOR MEN WHO HAVE SEX WITH MEN AND TRANSGENDER PEOPLE 2 (2009) [hereinafter UNAIDS ACTION FRAMEWORK ON MSM AND TRANSGENDER PEOPLE]; see also GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA, THE GLOBAL FUND STRATEGY IN RELATION TO SEXUAL ORIENTATION AND GENDER IDENTITIES 5 (2009).
- <sup>497</sup> UNAIDS, 2010 GLOBAL AIDS REPORT, *supra* note 360, at 50.
- <sup>498</sup> UNDP & ASIA PACIFIC COALITION ON MALE SEXUAL HEALTH, HUMAN RIGHTS AND HIV RESPONSE AMONG MEN WHO HAVE SEX WITH MEN AND TRANSGENDER PEOPLE IN ASIA AND THE PACIFIC: AN AGENDA FOR ACTION 6 (2010).
- <sup>499</sup> Press Release, UNDP, 90% of MSM in Asia Pacific Have No Access to HIV Prevention and Care (August 11, 2009).
- <sup>500</sup> See, e.g., CESCR, GENERAL COMMENT No. 14 ON THE RIGHT TO HEALTH para. 18; CESCR, GENERAL COMMENT No. 15: THE RIGHT TO WATER (*adopted* November 29, 2002, U.N. Doc. E/C.12/2002/11); CESCR, GENERAL COMMENT No. 18: THE RIGHT TO WORK (*adopted* November 24, 2005, U.N. Doc. E/C.12/GC/18); CRC, GENERAL COMMENT No. 4: ADOLESCENT HEALTH AND DEVELOPMENT IN THE CONTEXT OF THE CONVENTION ON THE RIGHTS OF THE CHILD (*adopted* July 1, 2003, U.N. Doc. CRC/GC/2003/4); UN COMMITTEE AGAINST TORTURE, GENERAL COMMENT No. 2: IMPLEMENTATION OF ARTICLE 2 BY STATES PARTIES (*adopted* January 24, 2008, U.N. Doc. CAT/C/GC/2); UN COMMITTEE ON THE ELIMINATION OF DISCRIMINATION AGAINST WOMEN, GENERAL RECOMMENDATION No. 28: THE CORE OBLIGATIONS OF STATES PARTIES UNDER ARTICLE 2 OF CEDAW (*adopted* October 19, 2010, U.N. Doc. CEDAW/C/2010/47/GC.2).
- <sup>501</sup> OHCHR, Combating Discrimination Based on Sexual Orientation and Gender Identity, at: <http://www.ohchr.org/en/issues/discrimination/pages/lgbt.aspx>.
- <sup>502</sup> UNAIDS ACTION FRAMEWORK ON MSM AND TRANSGENDER PEOPLE, *supra* note 496, at 5.
- <sup>503</sup> 2010 REPORT OF THE SPECIAL RAPPORTEUR ON THE RIGHT TO HEALTH TO THE HRC, *supra* note 366, para. 8.
- <sup>504</sup> *Id.* paras 6-26.



- <sup>505</sup> UNAIDS ACTION FRAMEWORK ON MSM AND TRANSGENDER PEOPLE, *supra* note 496, at 10-11.
- <sup>506</sup> UNAIDS, OUTCOME FRAMEWORK 2009–2011, *supra* note 24, at 7-8; UNAIDS, GETTING TO ZERO STRATEGY, *supra* note 25, at 10; *see also* UNAIDS ACTION FRAMEWORK ON MSM AND TRANSGENDER PEOPLE, *supra* note 496.
- <sup>507</sup> INTERNATIONAL GUIDELINES Guidelines 4, 5, paras. 21 (b), 22 (h); UNAIDS ACTION FRAMEWORK ON MSM AND TRANSGENDER PEOPLE, *supra* note 496, at 10.
- <sup>508</sup> THE YOGYAKARTA PRINCIPLES ON THE APPLICATION OF INTERNATIONAL HUMAN RIGHTS LAW IN RELATION TO SEXUAL ORIENTATION AND GENDER IDENTITY Principle 17 (2007).
- <sup>509</sup> UNAIDS ACTION FRAMEWORK ON MSM AND TRANSGENDER PEOPLE, *supra* note 496, at 10.
- <sup>510</sup> UNODC, WHO & UNAIDS, HIV PREVENTION, CARE, TREATMENT AND SUPPORT IN PRISON SETTINGS: A FRAMEWORK FOR AN EFFECTIVE NATIONAL RESPONSE 12 (2006) [hereinafter HIV PREVENTION, CARE, TREATMENT AND SUPPORT IN PRISON SETTINGS].
- <sup>511</sup> Ralf Jürgens et al., *Interventions to Reduce HIV Transmission Related to Injecting Drug Use in Prison*, THE LANCET (2009).
- <sup>512</sup> *Id.*
- <sup>513</sup> Press Release, AIDS Action Now, Harper is Creating an AIDS Crisis: HIV in Canada Goes Up, Promised AIDS Funding Not Delivered (November 30, 2010).
- <sup>514</sup> UNODC & CANADIAN HIV/AIDS LEGAL NETWORK, ACCESSIBILITY OF HIV PREVENTION, TREATMENT AND CARE SERVICES FOR PEOPLE WHO USE DRUGS AND INCARCERATED PEOPLE IN AZERBAIJAN, KAZAKHSTAN, KYRGYZSTAN, TAJIKISTAN, TURKMENISTAN AND UZBEKISTAN: LEGISLATIVE AND POLICY ANALYSIS AND RECOMMENDATIONS FOR REFORM 18 (2010).
- <sup>515</sup> Abiola C. Senok & G. A. Botta, *Human Immunodeficiency Virus and Hepatitis Virus Infection in Correctional Institutions in Africa: Is This the Neglected Source of an Epidemic?* at 481-482, JOURNAL OF MEDICAL MICROBIOLOGY (Vol. 55 No. 5, 2006).
- <sup>516</sup> UN BASIC PRINCIPLES FOR THE TREATMENT OF PRISONERS para. 5 (*adopted* December 14, 1990 by U.N. G.A. Res. 45/111 annex) [hereinafter UN BASIC PRINCIPLES FOR THE TREATMENT OF PRISONERS]; 2009 REPORT OF THE SPECIAL RAPPORTEUR ON THE RIGHT TO HEALTH TO THE GA, *supra* note 160, para. 80.
- <sup>517</sup> UN BASIC PRINCIPLES FOR THE TREATMENT OF PRISONERS para. 2; UN STANDARD MINIMUM RULES FOR THE TREATMENT OF PRISONERS para. 6 (*adopted* August 30, 1955 by the First UN Congress on the Prevention of Crime and the Treatment of Offenders, U.N. Doc. A/CONF/611, annex I, *as amended*) [hereinafter UN STANDARD MINIMUM RULES FOR THE TREATMENT OF PRISONERS].
- <sup>518</sup> CRC art. 37; UN STANDARD MINIMUM RULES FOR THE ADMINISTRATION OF JUVENILE JUSTICE ("THE BEIJING RULES") paras. 19, 26 (*adopted* 1985 by U.N. G.A. Res. 40/33); UN RULES FOR THE PROTECTION OF JUVENILES DEPRIVED OF THEIR LIBERTY paras. 1, 28 (*adopted* December 14, 1990 by U.N. G.A. Res. 45/113).
- <sup>519</sup> INTERNATIONAL GUIDELINES paras. 21, 152-153.
- <sup>520</sup> HIV PREVENTION, CARE, TREATMENT AND SUPPORT IN PRISON SETTINGS, *supra* note 510, at 8-15.
- <sup>521</sup> INTERVENTIONS TO ADDRESS HIV IN PRISONS, *supra* note 462; INTERNATIONAL GUIDELINES para. 60.
- <sup>522</sup> *See* UNAIDS, WHO GUIDELINES ON HIV INFECTION AND AIDS IN PRISONS (1999) [hereinafter WHO GUIDELINES ON HIV/AIDS IN PRISONS].
- <sup>523</sup> INTERVENTIONS TO ADDRESS HIV IN PRISONS, *supra* note 462; INTERNATIONAL GUIDELINES Guideline 4, para. 21 (e).
- <sup>524</sup> *Id.*
- <sup>525</sup> INTERVENTIONS TO ADDRESS HIV IN PRISONS, *supra* note 462.
- <sup>526</sup> *Id.*
- <sup>527</sup> INTERNATIONAL GUIDELINES Guideline 4.
- <sup>528</sup> *Id.* Guideline 4, paras. 21 (e), 153.
- <sup>529</sup> 2009 REPORT OF THE SPECIAL RAPPORTEUR ON THE RIGHT TO HEALTH TO THE GA, *supra* note 160, paras. 79-82.
- <sup>530</sup> *See, e.g.*, UN BASIC PRINCIPLES FOR THE TREATMENT OF PRISONERS para. 9; UN STANDARD MINIMUM RULES FOR THE TREATMENT OF PRISONERS para 22; WHO GUIDELINES ON HIV/AIDS IN PRISONS, *supra* note 522, at 4; BODY OF PRINCIPLES FOR THE PROTECTION OF ALL PERSONS UNDER ANY FORM OF DETENTION OR IMPRISONMENT principle 24 (*adopted* December 9, 1988 by U.N. G.A. Res. 43/173); *see also* RECOMMENDATION No. R (98) 7 CONCERNING THE ETHICAL AND ORGANIZATIONAL ASPECTS OF HEALTH CARE IN PRISON (*adopted* April 8, 1998 by the Council of Europe); DUBLIN DECLARATION ON HIV/AIDS IN PRISONS IN EUROPE AND CENTRAL ASIA (*adopted* February 23, 2004 by the EU Ministerial Conference "Breaking the Barriers - Partnership to Fight HIV/AIDS in Europe and Central Asia").
- <sup>531</sup> WHO GUIDELINES ON HIV/AIDS IN PRISONS, *supra* note 522, at 4.
- <sup>532</sup> INTERNATIONAL GUIDELINES para. 152; UN COMMITTEE AGAINST TORTURE, CONCLUDING OBSERVATIONS: NEW ZEALAND para. 175 (*adopted* August 5, 1998, U.N. Doc. A/53/44); HRW, UNJUST AND UNHEALTHY: HIV, TB, AND ABUSE IN ZAMBIAN PRISONS 23-27 (2010); *see also* EUROPEAN COMMITTEE FOR THE PREVENTION OF TORTURE AND INHUMAN OR DEGRADING TREATMENT OR PUNISHMENT, THIRD GENERAL REPORT ON THE CPT'S ACTIVITIES COVERING THE PERIOD 1 JANUARY TO 31 DECEMBER 1992 para. 31 (1993); CCPR, GENERAL COMMENT 21: REPLACES GENERAL COMMENT 9 CONCERNING HUMANE TREATMENT OF PERSONS DEPRIVED OF LIBERTY (*adopted* April 10, 1992); 2009 REPORT OF THE SPECIAL RAPPORTEUR ON THE RIGHT TO HEALTH TO THE GA, *supra* note 160, paras. 79-82.
- <sup>533</sup> UNODC & WHO, HIV TESTING AND COUNSELING IN PRISONS AND OTHER CLOSED SETTINGS: TECHNICAL PAPER 31-44 (2009); 2009 REPORT OF THE SPECIAL RAPPORTEUR ON THE RIGHT TO HEALTH TO THE GA, *supra* note 160, paras. 79-82; INTERNATIONAL GUIDELINES Guideline 4, para. 21 (e).
- <sup>534</sup> INTERNATIONAL GUIDELINES para. 21.
- <sup>535</sup> *Id.*
- <sup>536</sup> 2009 REPORT OF THE SPECIAL RAPPORTEUR ON THE RIGHT TO HEALTH TO THE GA, *supra* note 160, paras. 79-82.
- <sup>537</sup> WHO GUIDELINES ON HIV/AIDS IN PRISONS, *supra* note 522, at 4-5.
- <sup>538</sup> INTERNATIONAL GUIDELINES para. 62.
- <sup>539</sup> *Id.* paras. 21, 153.
- <sup>540</sup> AMERICAN BAR ASSOCIATION RULE OF LAW INITIATIVE, HANDBOOK OF INTERNATIONAL STANDARDS ON SENTENCING PROCEDURE 23-25 (2010).
- <sup>541</sup> PW v. South Africa Department of Correctional Services (1997–2003), *in* UNAIDS, COURTING RIGHTS, *supra* note 155, at 120-122.
- <sup>542</sup> DECLARATION OF COMMITMENT para. 58; POLITICAL DECLARATION para. 29.
- <sup>543</sup> INTERNATIONAL GUIDELINES para. 57.
- <sup>544</sup> UNDP, ACCESS TO JUSTICE: PRACTICE NOTE 7 (2004).
- <sup>545</sup> *See, e.g.*, OSI, ENSURING JUSTICE FOR VULNERABLE COMMUNITIES IN KENYA (2007) [hereinafter OSI, ENSURING JUSTICE FOR VULNERABLE COMMUNITIES IN KENYA].
- <sup>546</sup> *See also* ECHR arts. 1, 13; ACHR art. 25; Banjul Charter arts. 1, 7; AFRICAN COMMISSION ON HUMAN AND PEOPLE'S RIGHTS, PRINCIPLES AND GUIDELINES ON THE RIGHT TO A FAIR TRIAL AND LEGAL ASSISTANCE IN AFRICA para. C (a) (DOC/OS(XXX)247, 2005) [hereinafter AFRICAN COMMISSION, PRINCIPLES AND GUIDELINES ON THE RIGHT TO A FAIR TRIAL].
- <sup>547</sup> INTERNATIONAL GUIDELINES Guideline 5.

<sup>548</sup> UNAIDS & IDLO, TOOLKIT ON HIV-RELATED LEGAL SERVICES 31 (2009) [hereinafter TOOLKIT ON HIV-RELATED LEGAL SERVICES].

<sup>549</sup> INTERNATIONAL GUIDELINES Guideline 7, 11.

<sup>550</sup> UNAIDS & OHCHR, HANDBOOK FOR NATIONAL HUMAN RIGHTS INSTITUTIONS, *supra* note 235, at 5; *see also* SOUTH AFRICAN HUMAN RIGHTS COMMISSION, ANNUAL REPORT sec. 2.15.6 (2007-2008).

<sup>551</sup> INTERNATIONAL GUIDELINES Guideline 10.

<sup>552</sup> *Id.* Guideline 5.

<sup>553</sup> In the context of HIV-related discrimination, States should ratify the OPTIONAL PROTOCOL TO ICCPR (adopted December 16, 1966 by U.N. G.A. Res. 2200A (XXI), U.N. Doc. A/6316, *entered into force* March 23, 1976), the OPTIONAL PROTOCOL TO CEDAW (adopted October 6, 1999, *entered into force* December 22, 2000), and the OPTIONAL PROTOCOL TO THE CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES (adopted December 13, 2006, *entered into force* May 3, 2008). States should also make the necessary declaration under art. 22 of the CONVENTION AGAINST TORTURE AND OTHER CRUEL, INHUMAN OR DEGRADING TREATMENT OR PUNISHMENT (adopted December 10, 1984 by U.N. G.A. Res. 39/46, *entered into force* June 26, 1987, U.N. Doc. A/39/51) [hereinafter CAT].

<sup>554</sup> TOOLKIT ON HIV-RELATED LEGAL SERVICES, *supra* note 548, at 20; UNAIDS & OHCHR, HANDBOOK FOR NATIONAL HUMAN RIGHTS INSTITUTIONS, *supra* note 235, at 18.

<sup>555</sup> KENYA NATIONAL COMMISSION ON HUMAN RIGHTS, HIV AND AIDS WORKPLACE POLICY 3 (2008).

<sup>556</sup> *Id.* at 8.

<sup>557</sup> AIDS COORDINATING COMMITTEE, AMERICAN BAR ASSOCIATION, NATIONAL AIDS STRATEGY: A LEGAL PERSPECTIVE 2-5 (2009) [hereinafter ABA, NATIONAL AIDS STRATEGY].

<sup>558</sup> TOOLKIT ON HIV-RELATED LEGAL SERVICES, *supra* note 548, at 13.

<sup>559</sup> *Id.* at 11.

<sup>560</sup> UNAIDS, REDUCING HIV STIGMA AND DISCRIMINATION, *supra* note 30, at 12.

<sup>561</sup> INTERNATIONAL GUIDELINES Guideline 7; DECLARATION OF COMMITMENT para. 58; POLITICAL DECLARATION para. 29; UNAIDS, ADDRESSING HIV-RELATED LAW AT NATIONAL LEVEL para. 2 (2008) [hereinafter UNAIDS, ADDRESSING HIV-RELATED LAW AT NATIONAL LEVEL]; UNAIDS, POSITIVE HEALTH, DIGNITY AND PREVENTION 16 (2009); PROTECTION OF HUMAN RIGHTS IN THE CONTEXT OF HIV/AIDS 2009; UNAIDS, REDUCING HIV STIGMA AND DISCRIMINATION, *supra* note 30, at 12; *see also* STATEMENT OF PRINCIPLES ON HIV, THE LAW AND THE JUDICIARY IN SUB-SAHARAN AFRICA para. 22 (adopted December 12, 2009 by the Meeting of Eminent African Jurists on HIV and the Law in the 21st Century) [hereinafter STATEMENT OF PRINCIPLES ON HIV, THE LAW AND THE JUDICIARY IN SUB-SAHARAN AFRICA]; PENAL REFORM INTERNATIONAL, LILONGWE DECLARATION ON ACCESSING LEGAL AID IN THE CRIMINAL JUSTICE SYSTEM IN AFRICA paras 3, 10 (adopted November 24, 2004 by the Conference on Legal Aid in Criminal Justice: the Role of Lawyers, Non-Lawyers and Other Service Providers in Africa) [hereinafter LILONGWE DECLARATION].

<sup>562</sup> TOOLKIT ON HIV-RELATED LEGAL SERVICES, *supra* note 548, at 56-57.

<sup>563</sup> INTERNATIONAL GUIDELINES para. 59.

<sup>564</sup> *Id.* Guideline 7; *see also* PENAL REFORM INTERNATIONAL, LILONGWE PLAN OF ACTION FOR ACCESSING LEGAL AID IN THE CRIMINAL JUSTICE SYSTEM IN AFRICA 5-6 (2004) [hereinafter LILONGWE PLAN OF ACTION].

<sup>565</sup> INTERNATIONAL GUIDELINES Guideline 7.

<sup>566</sup> LILONGWE PLAN OF ACTION, *supra* note 564, at 6; *see also* AFRICAN COMMISSION, PRINCIPLES AND GUIDELINES ON THE RIGHT TO A FAIR TRIAL.

<sup>567</sup> INTERNATIONAL GUIDELINES Guideline 7; ABA, NATIONAL AIDS STRATEGY, *supra* note 557, at 2; *see also* ICCPR art. 14 (3) (d); BANJUL CHARTER art. 7 (1); AFRICAN COMMISSION, PRINCIPLES AND GUIDELINES ON THE RIGHT TO A FAIR TRIAL part H; ACHR art. 8 (2); ARAB CHARTER ON HUMAN RIGHTS art. 13 (1); ECHR art. 6 (3); LILONGWE DECLARATION para. 3.

<sup>568</sup> INTERNATIONAL GUIDELINES Guideline 7; *see also* LILONGWE DECLARATION paras. 3, 8.

<sup>569</sup> TOOLKIT ON HIV-RELATED LEGAL SERVICES, *supra* note 548, at 18-20.

<sup>570</sup> *Id.* at 27-31.

<sup>571</sup> LILONGWE DECLARATION paras. 1, 3; *see also* LILONGWE PLAN OF ACTION, *supra* note 564.

<sup>572</sup> *See, e.g.,* American Bar Association, Medical-Legal Partnerships Pro Bono Support Project, at <http://www.abanet.org/legalservices/probono/medlegal/home.shtml>.

<sup>573</sup> IDLO, HIV AND HEALTH LAW PROGRAM 2009-2012 at 15 (2010).

<sup>574</sup> USAID, MAKING POLICIES WORK FOR PEOPLE: HIV LEGAL CLINICS AND HOTLINE IN VIETNAM ENSURE THAT PLHIV KNOW AND EXERCISE THEIR RIGHTS (2009).

<sup>575</sup> For a discussion of the challenges faced by women and PLHIV in courts *see*: THE WORLD BANK, THE GENDER AND LEGAL DIMENSIONS OF HIV/AIDS: WOMEN'S ACCESS TO JUSTICE AND THE ROLE OF THE JUDICIARY (2005) [hereinafter THE WORLD BANK, THE GENDER AND LEGAL DIMENSIONS OF HIV/AIDS].

<sup>576</sup> OSI, ENSURING JUSTICE FOR VULNERABLE COMMUNITIES IN KENYA, *supra* note 545, at 9.

<sup>577</sup> *See, e.g.,* OSI, ENSURING JUSTICE FOR VULNERABLE COMMUNITIES IN KENYA, *supra* note 545, at 8.

<sup>578</sup> LILONGWE PLAN OF ACTION, *supra* note 564, at 8.

<sup>579</sup> LILONGWE DECLARATION para. 5; LILONGWE PLAN OF ACTION, *supra* note 564, at 10.

<sup>580</sup> *See also* AFRICAN COMMISSION, PRINCIPLES AND GUIDELINES ON THE RIGHT TO A FAIR TRIAL paras.1-2, 6 (e).

<sup>581</sup> TOOLKIT ON HIV-RELATED LEGAL SERVICES, *supra* note 548, at 34; THE WORLD BANK, THE GENDER AND LEGAL DIMENSIONS OF HIV/AIDS, *supra* note 575, at 12-16.

<sup>582</sup> INTERNATIONAL GUIDELINES Guideline 5, para. 22 (a), (c).

<sup>583</sup> *Id.* Guideline 9, para. 62; TOOLKIT ON HIV-RELATED LEGAL SERVICES, *supra* note 548, at 32-35; UNAIDS, ADDRESSING HIV-RELATED LAW AT NATIONAL LEVEL, *supra* note 561, para. 2; *see also* PROTECTION OF HUMAN RIGHTS IN THE CONTEXT OF HIV/AIDS 2009; THE WORLD BANK, THE GENDER AND LEGAL DIMENSIONS OF HIV/AIDS, *supra* note 575; STATEMENT OF PRINCIPLES ON HIV, THE LAW AND THE JUDICIARY IN SUB-SAHARAN AFRICA.

<sup>584</sup> TOOLKIT ON HIV-RELATED LEGAL SERVICES, *supra* note 548, at 34.

<sup>585</sup> INTERNATIONAL GUIDELINES para. 80.

<sup>586</sup> *Id.* Guideline 10.

<sup>587</sup> The importance of timely resolution of criminal trials is highlighted in a number of international human rights treaties. *See, e.g.,* ICCPR art. 14 (3); ACHR art. 8 (1). The ECHR requires States to ensure that both criminal trials and trials involving the determination of civil rights and obligations are resolved "within a reasonable time." *See* ECHR art. 6 (1).

<sup>588</sup> INTERNATIONAL GUIDELINES Guideline 5, para. 22 (a).

<sup>589</sup> TOOLKIT ON HIV-RELATED LEGAL SERVICES, *supra* note 548, at 34.

<sup>590</sup> *See, e.g.,* INTERNATIONAL GUIDELINES Guideline 11.

---

<sup>591</sup> See generally INDONESIA NATIONAL DEVELOPMENT PLANNING AGENCY, GADJAH MADA UNIVERSITY CENTRE FOR RURAL AND REGIONAL DEVELOPMENT STUDIES & UNDP INDONESIA, JUSTICE FOR ALL, AN ASSESSMENT OF ACCESS TO JUSTICE IN FIVE PROVINCES IN INDONESIA (2006).

<sup>592</sup> ICCPR arts. 6-7; CAT art. 3.

<sup>593</sup> UDHR art. 2; ICCPR arts. 2-3; UN CODE OF CONDUCT FOR LAW ENFORCEMENT OFFICIALS paras. 1-2 (*adopted* December 17, 1979 by U.N. G.A. Res. 34/169) [hereinafter UN CODE OF CONDUCT FOR LAW ENFORCEMENT OFFICIALS]; GUIDELINES ON THE ROLE OF PROSECUTORS para. 13.

<sup>594</sup> ICCPR art. 2 (3); UN CODE OF CONDUCT FOR LAW ENFORCEMENT OFFICIALS para. 2; GUIDELINES ON THE ROLE OF PROSECUTORS paras. 2, 4, 12.

<sup>595</sup> See, e.g., HRW, HATED TO DEATH: HOMOPHOBIA, VIOLENCE AND JAMAICA'S HIV/AIDS EPIDEMIC 5 (2004).

<sup>596</sup> AV & CM v. Ministerio de Salud de la Nacion (Federal Civil and Commercial Court of Argentina, April 26, 2002) *in* UNAIDS, COURTING RIGHTS, *supra* note 155, at 79-81.

<sup>597</sup> Asociación Benghalensis y otros v. Ministerio de Salud y Acción Social, Judgment No. 323:1339 (Supreme Court of Justice of Argentina, June 1, 2000), *in* UNAIDS, COURTING RIGHTS, *supra* note 219, at 80.