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Women's Human Rights related to Health-Care Services in the Context of HIV/AIDS

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I. Introduction

Worldwide forty million people are living today with HIV, the virus that causes AIDS.¹ Demographic trends indicate that HIV/AIDS increasingly affects poor people and poor regions of the world.² Currently, 95% of people living with HIV/AIDS are in developing countries.³ Sub-Saharan Africa is the region most affected by the epidemic. About two-thirds of all people living with HIV/AIDS live in this region.⁴ Similarly, HIV/AIDS increasingly affects women. Although two decades ago, women and girls were at the periphery of the epidemic, they now account for 50% of the people living with HIV/AIDS globally and 58% of people living with HIV/AIDS in Sub-Saharan Africa.⁵ These trends are most pronounced among young people. In South Asia, the region with the second highest number of people living with HIV/AIDS, twice as many young women as young men – aged 15 to 24 – are living with HIV/AIDS.⁶ In Sub-Saharan Africa, adolescent girls are three to four times more likely to be HIV-positive than adolescent boys.⁷

Over the past three years, international commitment to addressing the epidemic has grown tremendously in all sectors.⁸ There is finally an international consensus that AIDS in the developing world is an international crisis that demands a global response.⁹ Perhaps the most significant recent development is the reduction in the price of antiretroviral treatment, which increases the length and quality of life for most people living with HIV/AIDS. Although the

¹ Joint United Nations Programme on HIV/AIDS (UNAIDS) & The World Health Organization (WHO), "AIDS Epidemic Update", at 4 (December 2003) at <http://www.who.int/hiv/pub/epidemiology/epi2003/en> cited January 13, 2004 (hereinafter AIDS Epidemic Update 2003).

² Cathi Albertyn & Mark Heywood, "Human Rights and HIV/AIDS in the Commonwealth", at 7 (April 30, 2001) at <http://www.alp.org.za/view.php?file=/resctr/rpaps/index.xml> cited January 13, 2004 (hereinafter HIV/AIDS in the Commonwealth).

³ UNAIDS/WHO, "Treating 3 Million by 2005 – Making It Happen – The WHO Strategy", at 3 (December 1, 2003) at <http://www.who.int/3by5/publications/documents/isbn9241591129/en/> cited December 13, 2003 (hereinafter WHO 3 by 5 Strategy).

⁴ AIDS Epidemic Update 2003, supra note 1, at 27.

⁵ General Assembly of the United Nations, Progress towards implementation of the Declaration of Commitment on HIV/AIDS, Report of the Secretary-General, A/58/184, at 6 (25 July 2003).

⁶ UNICEF, "Young People and HIV/AIDS: Opportunity in Crisis", at 5 (UNICEF, UNAIDS, WHO 2002) at <http://www.unicef.org/aids/index.html> cited September 27, 2003 (hereinafter Young People and HIV/AIDS).

⁷ UNAIDS, "Accelerating Action against AIDS in Africa", Executive Summary, 4 (Sept. 2003) at <http://www.unaids.org/en/events/thirteenth+international+conference+on+aids+and+stis.asp> cited September 28, 2003.

⁸ AIDS Epidemic Update 2003, supra note 1, at 4.

⁹ See Hon. Edwin Cameron, "India, South Africa and the AIDS Epidemic – Some Personal Reflections by a South African", at 4, delivered for the Judicial Colloquium on "HIV/AIDS: The Law & Ethics", (New Delhi, January 2002), at http://www.lawyerscollective.org/lc-hiv-aids/publication/other_articles.htm cited September 28, 2003.

price of such treatment was \$10,000 to \$12,000 per person per year in 2000,¹⁰ it has now dropped to just \$132 per person per year in low-income countries,¹¹ making widespread accessibility to this treatment politically feasible. The World Health Organization (WHO) – along with other organizations such as the World Bank, the Global Fund to Fight AIDS Tuberculosis and Malaria,¹² the Bill and Melinda Gates Foundation,¹³ the Clinton Foundation HIV/AIDS Initiative¹⁴ and the Bush Administration¹⁵ – has pledged to help make antiretroviral treatment available to all who need it.¹⁶

Currently, six million people in developing countries urgently need antiretroviral treatment, yet less than 30,000 people are receiving it.¹⁷ The WHO and its partners plan a rapid antiretroviral rollout with a goal of treating three million people by the end of 2005 as a target toward the ultimate goal of universal access.¹⁸ This global scale-up of antiretroviral treatment presents tremendous potential for extending the length and improving the quality of life for many people and their families. Assuming that hundreds of thousands of people will seek HIV testing, receive counseling and, if appropriate receive lifelong antiretroviral treatment, an enormous scale-up of health-care services will also be necessary. Moreover, thousands of individual medical and general public health records will be created to monitor the treatment and its impact on the HIV/AIDS epidemic. In the context of this scale-up, it is timely to explore the human rights issues that arise most frequently in HIV/AIDS-related health-care services.

The paper addresses the human rights issues that people, especially women and girls in developing countries, face in seeking HIV/AIDS-related health care. It begins by examining the impact of HIV/AIDS on women and girls, including their vulnerability to infection and to discrimination after infection as well as the increased burdens women and girls face in caring for

¹⁰ UNAIDS, Fact Sheet: Access to HIV Treatment and Care (September 2003) at http://www.unaids.org/html/pub/Publications/Fact-Sheets03/FS_Care_2003_en_doc.htm cited September 28, 2003.

¹¹ Lawrence K. Altman, "Clinton Group Gets Discount for AIDS Drugs", New York Times (October 24, 2003) at <http://www.aegis.com/channel/s/AD032203.html> cited October 27, 2003.

¹² UNAIDS Fact Sheet: Access to HIV Treatment and Care, supra note 10.

¹³ "Gates Foundation to add \$100M to India AIDS grant", USA Today (October 12, 2003) at http://www.businessfightsaids.org/news_read.asp?sct=1&ID=9134&PR=0&all=1 cited October 29, 2003.

¹⁴ Lawrence K. Altman, supra note 11.

¹⁵ Steven J. Reynolds, John G. Bartlett, Thomas C. Quinn, Chris Beyrer & Robert C. Bollinger, "Antiretroviral Therapy Where Resources Are Limited", 348 The New England Journal of Medicine 1806, 1806 (May 1, 2003) at <http://content.nejm.org/cgi/content/full/348/18/1806> cited November 3, 2003.

¹⁶ WHO 3 by 5 Strategy, supra note 3, at 5-6.

¹⁷ Id. at 4 ("Of the six million people who urgently need antiretroviral therapy in developing countries, fewer than 8% are receiving it"). See also A.D. Harries, D.S. Nyangulu, N.J. Hargreaves, O. Kaluwa, F.M. Salaniponi, "Preventing antiretroviral anarchy in sub-Saharan Africa", 358 Lancet 410 (4 August 2001) ("In countries with limited resources, it is not feasible to offer symptom-free HIV-infected individuals antiretroviral therapy.").

¹⁸ WHO 3 by 5 Strategy, supra note 3, at 6.

family members who fall ill. The paper then explains the international response to HIV/AIDS, presenting the history of the United Nations' political commitments on HIV/AIDS-related issues and an outline of international legal obligations arising from international human rights treaties. The final section of the paper discusses legal issues central to HIV/AIDS health-care services – voluntary HIV testing, medical confidentiality, HIV/AIDS-related discrimination in health-care services and the right to treatment – drawing on a sample of case law from English-speaking jurisdictions. The paper concludes that both education and litigation on these issues will be important to protecting the human rights of all people – but especially women and girls with HIV/AIDS in developing countries.

II. Women and Girls In the Context of the HIV/AIDS Epidemic

Over the past two decades, women and girls have increasingly become the victims of the HIV/AIDS epidemic.¹⁹ AIDS, and then HIV, were first detected in the United States and Europe in the early 1980s, where they were diagnosed predominantly in gay men.²⁰ Today, however, HIV is transmitted primarily heterosexually,²¹ and the economic, social, cultural and legal inequality of women and girls means that they are infected more frequently and at a younger age than men or boys.

Women and girls are at greater risk of being infected by HIV than men in part due to unequal access to information. In most societies, children are socialized along strong cultural gender norms. Generally, girls are expected to be sexually innocent and to preserve their virginity until marriage, whereas boys are expected to be more sexually knowledgeable and experienced.²² In many cultures, female ignorance of sexual matters is a sign of sexual purity, constraining women and girls from obtaining information about sex and reproduction.²³ Thus, women and girls believe that even seeking such information may call into question their virginity.²⁴ Consequently, women, and particularly young women and girls, are often poorly informed about sexual matters.²⁵ Studies from Brazil, India, Mauritius and Thailand all found that young women know little about their own bodies, pregnancy, contraception or sexually

¹⁹ Canadian HIV/AIDS Legal Network, "Using Rights and the Law to Reduce Women's Vulnerability to HIV/AIDS: A Discussion Paper", prepared by Cathi Albertyn, at 1 (2000) at <http://www.aidslaw.ca/Maincontent/reports.htm> cited September 23, 2003 (hereinafter Using Rights and the Law).

²⁰ HIV/AIDS in the Commonwealth, *supra* note 2, at 1.

²¹ *Id.*

²² UNAIDS, "Gender and HIV/AIDS: Taking stock of research and programmes", at 8-9 (March 1999) at <http://www.unaids.org/en/in+focus/topic+areas/gender+and+hiv-aids.asp?StartRow=60> cited October 11, 2003 (hereinafter Gender and HIV/AIDS).

²³ *Id.*

²⁴ *Id.* at 9.

²⁵ *Id.* at 9.

transmitted diseases.²⁶ This lack of knowledge limits their ability to protect themselves against HIV infection.²⁷

Even when informed about HIV transmission, however, women may not change their behavior because they are socialized to please men and to defer to their authority, especially in sexual matters.²⁸ Studies show that women engage in sexual behaviors that they know to be of high-risk for HIV infection because they want to please their male partners.²⁹ Similarly, in many cultures, it is understood that men make the decisions in sexual relations,³⁰ and that if a man initiates sex, the woman may not refuse him.³¹ Thus, many married women, although informed about HIV transmission, feel unable to negotiate safer sex with their partners.³² There is also widespread cultural acceptance of male infidelity in contrast to the expectation of female monogamy.³³

Violence against women and girls also makes them more vulnerable than men to HIV infection and plays a major role in the spread of HIV.³⁴ Fear of violence prevents women from trying to negotiate safer sexual behavior with their partners.³⁵ In interviews conducted in two cities in India, many married women reported their husbands forced them to have unsafe sexual intercourse when both knew of his HIV-positive status.³⁶ One report indicates that 41% of women in Uganda have been victims of domestic violence.³⁷ A study in South Africa found that

²⁶ Id.

²⁷ Id.

²⁸ Id. at 10.

²⁹ Id.

³⁰ HIV/AIDS in the Commonwealth, *supra* note 2, at 13-14.

³¹ Using Rights and the Law, *supra* note 19, at 4.

³² UNAIDS, "Uganda: HIV and AIDS-related Discrimination, Stigmatization and Denial", at 9 (Aug. 2001), at http://www.unaids.org/en/in+focus/hiv_aids_human_rights/related+publications+.asp cited October 11, 2003 (hereinafter UNAIDS Uganda Report). A majority of married women in Uganda felt unable to control or negotiate the risk behavior of their male partners. Id. Women in Asia are even less likely than women in Africa to negotiate condom use in their private relationships. HIV/AIDS in the Commonwealth, *supra* note 2, at 10.

³³ HIV/AIDS in the Commonwealth, *supra* note 2, at 13-14.

³⁴ Using Rights and the Law, *supra* note 19, at 4.

³⁵ Gender and HIV/AIDS, *supra* note 22, at 16.

³⁶ UNAIDS, "India: HIV and AIDS-related Discrimination, Stigmatization and Denial", at 43 (August 2001) at http://www.unaids.org/en/in+focus/hiv_aids_human_rights/related+publications+.asp cited October 11, 2002 (hereinafter UNAIDS India Report).

³⁷ Lisa Karanja, "Just Die Quietly: Domestic Violence and Women's Vulnerability to HIV in Uganda", (Human Rights Watch 2003) at http://www.hrw.org/reports/2003/uganda0803/10.htm#_Toc47260371 cited January 14, 2004.

71% of female youth had experienced nonconsensual sex.³⁸ Another study in Zambia found that the high incidence of HIV among women under twenty years of age results from sexual abuse and coercion of girl orphans by their guardians, foster families and teachers.³⁹ Forced marriages, especially at an early age, and wife inheritance also put girls and women at increased risk of infection.⁴⁰ In sum, sexual abuse of young girls, domestic violence, forced marriage and rape are cultural norms of sexual coercion and violence against women that make safe sexual practices an unrealistic prevention method for many women and girls.

Women's economic and legal inequality also contributes to their vulnerability to HIV infection.⁴¹ Discriminatory laws and economic policies prevent women from gaining equal access to resources such as land, property, credit, employment and education, which in turn perpetuates economic dependence and vulnerability.⁴² Women who are more financially independent are more likely to be able to reduce their risk of HIV infection.⁴³ Patrilineal systems of inheritance in many countries, however, mean that women often lose their homes, lands and livelihoods when their husbands die.⁴⁴ Poor women may resort to bartering sex for food and maintenance for themselves and their families.⁴⁵ Women and girls also trade sex for jobs, promotions, permits and for school fees and marks.⁴⁶ Laws that deny women equal marital property rights or the equal right to initiate or oppose divorce similarly subordinate women to men, making them more vulnerable to violence and coercive sex.⁴⁷

Women and girls who are HIV-positive also face greater discrimination than men in their families and in health-care settings.⁴⁸ Within families, daughters, wives and daughters-in-law

³⁸ Gender and HIV/AIDS, supra note 22, at 11.

³⁹ Janet Fleishman, "Suffering in Silence: The Links between Human Rights Abuses and HIV Transmission in Zambia", (Human Rights Watch 2002) at www.hrw.org/reports/2003/zambia cited January 14, 2004.

⁴⁰ Using Rights and the Law, supra note 19, at 1.

⁴¹ Id. at 7.

⁴² See Gender and HIV/AIDS, supra note 22, at 15.

⁴³ Id. at 16.

⁴⁴ Using Rights and the Law, supra note 19, at 7.

⁴⁵ Id. at 7.

⁴⁶ Id. at 5. Reports from Uganda indicate that high school girls may have sex with older men in exchange for money or gifts to pay for school fees and books. Gender and HIV/AIDS, supra note 22, at 16.

⁴⁷ Using Rights and the Law, supra note 19, at 6. See generally, Mandeep Dhaliwal, "Creation of an Enabling and Gender Just Legal Environment as a Prevention Strategy for HIV/AIDS amongst Women in India", 4 Canadian HIV/AIDS Policy and Law Newsletter 86, 88 (Spring 1999).

⁴⁸ UNAIDS, "Comparative analysis: Research studies from India and Uganda, HIV and AIDS-related Discrimination, Stigmatization and Denial", at 14 (June 2000) at http://www.unaids.org/en/in+focus/hiv_aids_human_rights/related+publications+.asp cited October 11, 2003 (hereinafter Comparative Analysis: India and Uganda).

with HIV/AIDS experience greater discrimination than sons, husbands and sons-in-laws.⁴⁹ Married women indicate that they may not reveal their HIV-positive status to their husbands for fear of being victimized and deserted.⁵⁰ Women are blamed by their in-laws when husbands are infected with HIV. Even if the in-laws know the husband visited sex workers, they hold the wife at fault because she failed to control his desire to so.⁵¹ Although married women are stigmatized by their husbands' families, they are expected to provide for his care.⁵² After the husband's death, however, his family will often deny the wife a share of the husband's property or pension.⁵³ Discrimination is also evident in the quality of food and care provided to widows in both Uganda and India, and some have been required to leave the family home.⁵⁴

Many reports reveal the discrimination people living with HIV/AIDS experience in health-care systems, including denial of treatment, HIV testing without consent and breaches of confidentiality.⁵⁵ Women living with HIV/AIDS experience double discrimination in health-care settings. Reports indicate that pregnant women are routinely tested for HIV without their knowledge, much less informed consent to the procedure.⁵⁶ In India, spouses of all HIV-positive men are advised, and sometimes forced, to undergo HIV testing whether seeking medical care or not.⁵⁷ HIV testing is also administered as a rule to all patients prior to surgery and in cases where a suspicion of HIV arises based on their physical appearance or belonging to a high-risk group, such as sex workers.⁵⁸ Generally, such testing is mandatory, no consent is provided and there is no pre- or post-test counseling.⁵⁹

Confidentiality is also frequently breached by hospital staff who disclose HIV-test results to other staff not involved in the care and to family members or friends accompanying the patient.⁶⁰ In a recent survey, "29% of persons living with HIV/AIDS in India, 38% in Indonesia, and over 40% in Thailand said that their HIV-positive status had been revealed to someone else

⁴⁹ UNAIDS India Report, supra note 36, at 41.

⁵⁰ UNAIDS Uganda Report, supra note 32, at 13.

⁵¹ UNAIDS India Report, supra note 36, at 42.

⁵² Id. at 42.

⁵³ Id. at 44.

⁵⁴ Id.; UNAIDS Uganda Report, supra note 32, at 9.

⁵⁵ Comparative Analysis: India and Uganda, supra note 48, at 15.

⁵⁶ UNAIDS India Report, supra note 36, at 22.

⁵⁷ Id. at 23.

⁵⁸ Id. at 22.

⁵⁹ Id. at 23.

⁶⁰ Id. at 23-24.

without their consent".⁶¹ In the case of women, particularly pregnant women, "the principle of confidentiality is often disregarded altogether".⁶² Sometimes women are not told their own HIV-test results; rather results are reported only to the husband or mother-in-law.⁶³ Given the discrimination women face in their families, such disclosures put women at risk for serious ill-treatment, including homelessness and violence. Fear of breaches of confidentiality and the consequent discrimination prevents people from seeking testing and treatment for HIV/AIDS.⁶⁴

Women and girls also carry the burden of caring for those who are ill or orphaned as a result of HIV/AIDS.⁶⁵ In the context of the epidemic in Sub-Saharan Africa, where eleven million children have been orphaned,⁶⁶ and health care is often provided at home, these responsibilities can be staggering. Most of this work is done by women and girls. For example, a study in Zimbabwe, where adult HIV prevalence is about 25%,⁶⁷ found that 76% of children who left school to care for sick people were girls.⁶⁸ Thus, the care-giving burden has significant impact on the educational and economic equality of girls. Similarly, women and girls are disproportionately affected when a male head of household falls ill because they may be required to seek other sources of income as well as to provide care-giving.⁶⁹ Many of the women who carry out this double burden are infected with HIV themselves, and the added workload and stress contribute to worsening their own health.

All these forms of inequality are intertwined. Care-giving responsibilities prevent girls' access to education, limiting employment opportunities and creating economic dependence on men. Discrimination against widows and girl orphans makes them more vulnerable to sexual abuse and more likely to turn to sex work for survival. Violence against women and economic dependence on men prevent women from exercising control over their sexual relations, limiting their ability to protect themselves from HIV infection. Maltreatment of women with HIV by their families, communities and health-care providers inhibits women from seeking HIV testing and treatment. Multiple levels of inequality facilitate the spread of the HIV/AIDS epidemic, and thus control of the epidemic appears to be inextricably linked to addressing gender inequality.⁷⁰

⁶¹ AIDS Epidemic Update 2003, supra note 1, at 22.

⁶² UNAIDS India Report, supra note 36, at 24.

⁶³ Id. at 24.

⁶⁴ AIDS Epidemic Update 2003, supra note 1, at 21.

⁶⁵ Using Rights and the Law, supra note 19, at 5

⁶⁶ UNAIDS, "Agencies call for a quantum leap of efforts to address the spiraling orphan crisis", (September 25, 2003) at <http://www.unaids.org/en/media/press+releases.asp> cited September 29, 2003.

⁶⁷ AIDS Epidemic Update 2003, supra note 1, at 9.

⁶⁸ Using Rights and the Law, supra note 19, at 5.

⁶⁹ Gender and HIV/AIDS, supra note 22, at 17

⁷⁰ Using Rights and the Law, supra note 19, at 1.

III. The Role of Human Rights Law in Responding to the HIV/AIDS Epidemic

A. The Human Rights Approach

Historically, public health officials have used aggressive strategies to fight communicable diseases.⁷¹ These measures have included identifying infected individuals; tracking, notifying and testing people who may have been exposed; and isolating and quarantining individuals who may pose a risk of infecting others.⁷² Similarly, customary public health methods to combat sexually-transmitted diseases have required infected individuals to disclose the names of their sexual partners, who were then traced, contacted, tested and treated.⁷³

The central components of aggressive public health strategies – name reporting of infected individuals, partner notifications, mandatory testing and treatment, and quarantine or isolation – implicate human rights such as the rights to privacy and personal autonomy, the right against discriminatory treatment, and the freedom of movement and association.⁷⁴ Nonetheless, control of epidemics has traditionally been accepted as justification for such infringements on individual rights.⁷⁵ Recognizing the state's vital public health role, courts have generally granted great deference to other branches of government, upholding these public health programs against human rights challenges.⁷⁶

Some governments have adopted traditional public health measures to address the HIV/AIDS epidemic, including compulsory testing to work, marry or travel; mandatory notification of families or employers of HIV status; prohibitions against people with HIV from marrying, working or traveling; and isolation of people with HIV/AIDS. Studies have shown, however, that these repressive measures deter people from getting tested, seriously calling into question their effectiveness in combating HIV/AIDS.⁷⁷

Early in the epidemic, however, advocates recognized that HIV/AIDS required a different public health approach, and they were able to convince officials in some countries to adopt a strategy that respects the human rights of individuals with HIV/AIDS and of those belonging to

⁷¹ Roger Doughty, "The Confidentiality of HIV-related Information: Responding to the Resurgence of Aggressive Public Health Interventions in the AIDS Epidemic", 82 *California Law Review* 111, 118-19 (1994).

⁷² *Id.* at 118.

⁷³ *Id.* at 119.

⁷⁴ See HIV/AIDS in the Commonwealth, *supra* note 2, at 21 (interests of public health traditionally outweigh individual rights to privacy, bodily autonomy and freedom of movement).

⁷⁵ *Id.*

⁷⁶ Roger Doughty, *supra* note 71, at 120-22 and cases cited therein.

⁷⁷ *Id.* at 129-30. See also Richard Parker & Peter Aggleton, "HIV/AIDS-related Stigma and Discrimination: A Conceptual Framework and an Agenda for Action", Population Council, at 5 (2002) at <http://www.popcouncil.org/horizons/horizonsreports.html> cited September 8, 2004.

groups at high risk for infection.⁷⁸ These advocates recognized that, to combat the disease, they needed the cooperation of groups at high risk for infection because it was crucial for high-risk individuals to come forward for testing, to modify their high-risk behavior and to notify partners.⁷⁹ Yet, HIV/AIDS spread first among socially stigmatized groups⁸⁰ – gay men, injection drug users and sex workers – who had good reasons not to come forward for HIV testing. Their conduct or status was often stigmatized or even criminalized.⁸¹ High-risk individuals understood that testing could lead to disclosure, which would expose them to discrimination, ostracism and even violence.⁸² Without testing and counseling the disease thus spread rapidly in these populations, and people even suspected of being infected by HIV lost jobs, housing, health care, friends and family.⁸³

Frequent disclosure of HIV-related information and the severe consequences made it difficult for affected populations to trust the health-care system enough to come forward for testing and to cooperate with public health programs.⁸⁴ A strong guarantee of confidentiality of HIV/AIDS-related information thus became the central component of successful HIV/AIDS programs.⁸⁵ For the same rationale, it was essential that testing and partner notification be voluntary. The human rights-respecting public health policy came about primarily because it was the most effective strategy to convince people at risk to come forward for HIV/AIDS services, which was necessary to stop the spread of HIV/AIDS.⁸⁶ Indeed, the rights-respecting strategies have proven effective in combating the disease.⁸⁷

Justice Michael Kirby of Australia has described this concurrence of public health policy and human rights protection as the AIDS paradox: respect for the human rights of people infected or at high risk for infection is necessary to reduce the vulnerability of uninfected people to infection.⁸⁸ A rights-respecting climate encourages voluntary testing, counseling, education,

⁷⁸ Id. at 125.

⁷⁹ Id. at 125-26.

⁸⁰ Roger Doughty, *supra* note 74, at 123.

⁸¹ See, e.g., United Nations Human Rights Committee, Communication. No. 488/1991, Nicholas Toonan v. Australia (4 April 1991), CCPR/C/50/D/488/1992 at [http://www.unhcr.ch/tbs/doc.nsf/\(Symbol\)/d22a00bcd1320c9c80256724005e60d5?Opendocument](http://www.unhcr.ch/tbs/doc.nsf/(Symbol)/d22a00bcd1320c9c80256724005e60d5?Opendocument) cited January 16, 2004 (criminalizing homosexual practices is not reasonable measure to prevent spread of HIV/AIDS; by driving underground people at risk for infection, it runs counter to effective HIV/AIDS programmes).

⁸² Id. at 125.

⁸³ Id. at 124.

⁸⁴ Id. at 126.

⁸⁵ Id.

⁸⁶ Id.

⁸⁷ Hon. Edwin Cameron, *supra* note 9, at 2.

⁸⁸ HIV/AIDS in the Commonwealth, *supra* note 2, at 21.

treatment and disclosure about HIV, all measures necessary to stop the epidemic.⁸⁹ Repressive measures, on the other hand, stigmatize people with HIV and populations at high risk and perpetuate discrimination against them.⁹⁰ The failure to protect the human rights of people infected with HIV encourages secrecy about HIV, driving high-risk populations underground, away from education, testing and counseling services, where HIV will be unknowingly spread.⁹¹ Although the human rights approach is the most effective method to protect both HIV-infected and uninfected people, repressive measures are still widely imposed and consequently, discrimination, ostracism and violence against people with HIV/AIDS continues and the HIV/AIDS epidemic thrives.

B. International Political Commitments

After twenty years of experience with the HIV/AIDS epidemic, there is consensus at the international level that it is necessary to protect the human rights of people infected with HIV and people most at risk for infection to prevent the spread of the epidemic.⁹² Over the past decade, the human rights paradigm has generally been accepted by international bodies, evidenced by their generation of standards and programs to combat HIV/AIDS based on respect for human rights.⁹³ UNAIDS, for example, declares that it "has adopted a rights-based approach in its policies, programmes and activities" and "works to mainstream HIV/AIDS into human rights and vice versa".⁹⁴ Similarly, UNICEF, according to its mission, "is guided by the Convention on the Rights of the Child and strives to establish children's rights as enduring ethical principles and international standards of behaviour towards children".⁹⁵ WHO has also committed to strengthen its "capacity to integrate a human rights-based approach in its work," to support governments in integrating "a human rights-based approach in health development," and to advancing "the right to health in international law and international development processes".⁹⁶

In 1996, UNAIDS and the Office of the High Commissioner for Human Rights (OHCHR) convened an international consultation on HIV/AIDS in response to a request by the United Nations Commission on Human Rights to elaborate guidelines on promoting and

⁸⁹ Id.

⁹⁰ Comparative Analysis: India and Uganda, *supra* note 48, at 11-12.

⁹¹ HIV/AIDS in the Commonwealth, *supra* note 2, at 21.

⁹² Id.

⁹³ See generally, UNAIDS, "HIV/AIDS, Human Rights and the Law", at http://www.unaids.org/en/in+focus/hiv_aids_human_rights.asp cited September 28, 2003.

⁹⁴ "UNAIDS activities in HIV/AIDS, Human Rights and Law", at http://www.unaids.org/en/in+focus/hiv_aids_human_rights/unaids+activities+hr.asp cited October 1, 2003.

⁹⁵ UNICEF's Mission Statement, at http://www.unicef.org/about/who/index_mission.html cited January 15, 2004.

⁹⁶ WHO Health and Human Rights, at <http://www.who.int/hhr/en/> cited January 15, 2004.

protecting respect for human rights in the context of HIV/AIDS.⁹⁷ This consultation of HIV/AIDS and human rights experts adopted the International Guidelines on HIV/AIDS and Human Rights, which were published by UNAIDS and OHCHR in 1998 for States to use in implementing effective, rights-based responses to HIV/AIDS.⁹⁸ The twelve Guidelines translate international human rights principles into practical steps for action in the context of HIV/AIDS.⁹⁹ In 2002, following another international consultation on HIV/AIDS, Guideline 6 on "Access to prevention, treatment, care and support" was revised to reflect recent developments in the medical treatment of HIV/AIDS and the international law on HIV/AIDS. A central tenet of Guideline 6 is that "[u]niversal access to HIV/AIDS prevention, treatment, care and support is necessary to respect, protect and fulfill human rights related to health, including the right to enjoy the highest attainable standard of health".¹⁰⁰

Significantly, in June 2001, the 189 member states of the United Nations General Assembly adopted the Declaration of Commitment on HIV/AIDS, which endorsed an international commitment to human rights as an essential element of the global response to HIV/AIDS.¹⁰¹ This landmark in the struggle against HIV/AIDS specifically recognizes "that stigma, silence, discrimination and denial, as well as lack of confidentiality, undermine prevention, care and treatment efforts and increase the impact on individuals, families, communities and nations".¹⁰² The Declaration establishes time-bound targets to respond to the epidemic, such as (1) ensuring by 2005 that 90% of people aged 15 to 24 have access to HIV education to reduce their vulnerability to infection,¹⁰³ and (2) reaching by 2005 an annual expenditure on the epidemic of seven to ten billion US dollars in low and middle income countries.¹⁰⁴

⁹⁷ United Nations Commission on Human Rights, Resolution 1996/43, "The protection of human rights in the context of human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS)", E/CN.4/RES/1996/43.

⁹⁸ United Nations HIV/AIDS and Human Rights: International Guidelines, HR/PUB/98/1, at http://www.unaids.org/en/in+focus/hiv_aids_human_rights.asp cited September 28, 2003 (hereinafter International Guidelines).

⁹⁹ International Guidelines, supra note 98, at 9 ¶ 10.

¹⁰⁰ United Nations HIV/AIDS and Human Rights: International Guidelines – Revised Guideline 6, HR/PUB/2002/1, at 15 ¶ b.

¹⁰¹ United Nations General Assembly, Declaration of Commitment on HIV/AIDS, A/RES/S-26/2 (8 August 2001). It is also notable that the United Nations Security Council has acknowledged the importance of the human rights approach to HIV/AIDS in adopting resolution 1308, which requests the Secretary-General to take further steps to train peacekeeping personnel in HIV prevention and encourages states to execute policies for HIV/AIDS prevention, voluntary and confidential testing and counseling, and treatment for peacekeeping personnel. United Nations Security Council Resolution 1308, S/RES/1308 (2000).

¹⁰² Id. at ¶ 13.

¹⁰³ Id. at ¶ 53.

¹⁰⁴ Id. at ¶ 80.

Unfortunately, the Declaration does not mention the International Guidelines on HIV/AIDS and Human Rights, nor does it acknowledge a human rights based approach as central to international and national strategies on HIV/AIDS. Rather, it addresses human rights primarily in four paragraphs that focus on eliminating discrimination against (1) women and girls to reduce their the vulnerability of to HIV infection,¹⁰⁵ and (2) people living with HIV/AIDS and members of vulnerable groups.¹⁰⁶ Equating human rights with discrimination fails to acknowledge the broad range of human rights implicated by the HIV/AIDS epidemic. Nonetheless, the Declaration does recognize that privacy and confidentiality are important in ensuring access to health care and other basic services.¹⁰⁷

In 2003, UNAIDS delivered its first report on the progress that has been made towards the targets set in the Declaration, the first comprehensive assessment to date of the national responses to HIV/AIDS.¹⁰⁸ Among the key findings are: (1) 38% of countries have yet to adopt legislation prohibiting discrimination against people living with HIV/AIDS, (2) 64% of countries have not adopted legislation to prohibit discrimination against populations that are vulnerable to HIV/AIDS, and (3) the disproportionate impact of HIV/AIDS on women and girls continues to grow.¹⁰⁹ These statistics are disappointing. Moreover, they are based on responses of member states, which may overstate official commitment to human rights responses to HIV/AIDS.¹¹⁰ For example, several countries responded positively, yet had no specific HIV/AIDS-related legislation; they relied on general legislation against discrimination.¹¹¹ In effect, there is general international consensus on the necessity of respecting and protecting human rights in efforts to combat HIV/AIDS, which has been translated into resolutions, declarations and guidelines at the international level, but this understanding has proven difficult to put into law or action at the national level.

C. The International Human Rights Legal Framework

In contrast to the declarations of the political bodies of the United Nations, international human rights treaties impose legal obligations on the states that are parties to them. Moreover,

¹⁰⁵ Id. at ¶s 59-61.

¹⁰⁶ Id. at ¶ 58.

¹⁰⁷ Id. at ¶ 58.

¹⁰⁸ UNAIDS, "Follow-up to the 2001 United Nations General Assembly Special Session on HIV/AIDS: Progress Report on the Global Response to the HIV/AIDS Epidemic, 2003", at 9 (September 2003) at http://www.unaids.org/en/events/un+general+assembly+special+session+on+hiv_aids/follow+up+to+the+2001+un+general+assembly+special+session+on+hiv_aids+-+september+2003.asp cited October 11, 2003 (hereinafter Progress Report 2003). See also United Nations General Assembly, Progress toward implementation of the Declaration of Commitment on HIV/AIDS: Report of the Secretary-General, A/58/184 (25 July 2003). The UNAIDS Progress Report is a detailed companion to the Secretary-General's Report to the General Assembly.

¹⁰⁹ Progress Report 2003, *supra* note 108, at 10-11.

¹¹⁰ Id. at 50.

¹¹¹ Id. at 50.

almost every state is party to at least one of the five international human rights treaties which recognize some general rights that are relevant to protecting human rights in the context of HIV/AIDS.¹¹² The international human rights treaties, thus, provide a legal framework for defining State obligations in protecting HIV/AIDS-related human rights and a resource for implementing human rights protections through legal proceedings in the national arena.

Both the International Covenant on Civil and Political Rights (ICCPR)¹¹³ and the International Covenant on Economic, Social and Cultural Rights (ICESCR)¹¹⁴ – the two core treaties of the International Bill of Human Rights – recognize numerous rights that are relevant in the context of responding to the HIV/AIDS epidemic. The ICCPR, for example, recognizes, the "right to life",¹¹⁵ "the right to liberty and security of person",¹¹⁶ the "right to liberty of movement" within a State.¹¹⁷ It also recognizes the right to be free from "arbitrary or unlawful interference" with "privacy, family, home or correspondence", and from "unlawful attacks" on "honor and reputation".¹¹⁸ The ICCPR contains the right "to seek, receive and impart information and ideas of all kinds",¹¹⁹ the "freedom of association"¹²⁰ and "the right and opportunity . . . to take part in the conduct of public affairs".¹²¹ It also recognizes the principles of nondiscrimination, equal protection and equality before the law and further states that "the law shall prohibit any discrimination and guarantee to all persons equal and effective protection against discrimination on any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status".¹²²

The Human Rights Committee, charged with monitoring compliance with the ICCPR, has considered the applicability of some ICCPR rights to HIV/AIDS-related issues in deciding

¹¹² The Convention on the Rights of the Child, in particular, recognizes the right to health for children and has 192 state parties as of November 2003.

¹¹³ International Covenant on Civil and Political Rights, General Assembly Resolution 2200A (XXI) (16 December 1966) at http://www.unhchr.ch/html/menu3/b/a_ccpr.htm cited January 16, 2004 (hereinafter ICCPR). There are 151 state parties to the ICCPR as of November 2003.

¹¹⁴ International Covenant on Economic, Social and Cultural Rights, General Assembly Resolution 2200A (XXI) (16 December 1966) http://www.unhchr.ch/html/menu3/b/a_ceschr.htm cited January 16, 2004 (hereinafter ICESCR). There are 148 state parties to the ICESCR as of November 2003.

¹¹⁵ ICCPR, article 6(1).

¹¹⁶ ICCPR, article 9(1).

¹¹⁷ ICCPR, article 12(1).

¹¹⁸ ICCPR, article 17(1).

¹¹⁹ ICCPR, article 19(2).

¹²⁰ ICCPR, article 22(1).

¹²¹ ICCPR, article 25(a).

¹²² ICCPR, article 26.

upon an individual complaint in *Toonan v. Australia*.¹²³ In that case, the complainant challenged a law criminalizing consensual sex between adult men, which was in effect in one of six states in Australia. The Committee decided that the statute violated the article 17 right to privacy and therefore should be repealed. In response to the government's rationale for maintaining the criminal statute, the Committee stated that "the criminalization of homosexual practices cannot be considered a reasonable means or proportionate measure to achieve the aim of preventing the spread of AIDS/HIV" because this "would appear to run counter to the implementation of effective education programmes in respect of the HIV/AIDS prevention" in that they drive underground people at risk for infection.¹²⁴ Moreover, no link was shown between criminalization of homosexual activity and effective control of the spread of HIV/AIDS.¹²⁵

The ICESCR also has several relevant provisions. Among these are the "right to work", the "right to a decent living", the right to "equal opportunity for everyone to be promoted", and the right to a "reasonable limitation of working hours".¹²⁶ Further, marriages may only be with "the free consent" of both spouses,¹²⁷ "[c]hildren and young persons should be protected from economic and social exploitation",¹²⁸ and everyone has the right "to an adequate standard of living for himself and his family, including adequate food, clothing and housing".¹²⁹ The ICESCR also recognizes that everyone has the right "to enjoy the benefits of scientific progress and its applications"¹³⁰ – which should include advancements in medical treatments – and that states must guarantee rights enunciated in the Covenant "without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status".¹³¹ Perhaps most pertinent here, the ICESCR grants the "right of everyone to the enjoyment of the highest attainable standard of physical and mental health", which requires states to take steps for, among other things, "the prevention, treatment and control of epidemic[s]", and for "the creation of conditions which would assure to all medical service and medical attention in the event of sickness".¹³²

¹²³ See UN HRC, Comm. No. 488/1991, *Toonan v. Australia* (4 April 1991), CCPR/C/50/D/488/1992, *supra* note 81.

¹²⁴ *Id.* at ¶ 8.5.

¹²⁵ *Id.* at ¶ 8.5.

¹²⁶ ICESCR, article 7.

¹²⁷ ICESCR, article 10(1).

¹²⁸ ICESCR, article 10(3).

¹²⁹ ICESCR, article 11(1).

¹³⁰ ICESCR, article 15(1)(b).

¹³¹ ICESCR, article 2(1).

¹³² ICESCR, article 12.

The Committee on Economic, Social and Cultural Rights, which monitors compliance with the ICESCR, has issued a general comment on the right to health enunciated in article 12 to provide guidance to state parties on the content and implementation of the right.¹³³ General Comment No. 14 on the right to the highest attainable standard of health details various state obligations related to HIV/AIDS. Specifically, the comment provides that the right to health includes "the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health"¹³⁴ and "proscribes any discrimination in access to health care and underlying determinants of health, as well as to the means and entitlements for their procurement, on the grounds of . . . health status (including HIV/AIDS)".¹³⁵ It also states that the right to health includes the right to be free from "non-consensual medical treatment",¹³⁶ the right to "essential drugs, as defined by the WHO",¹³⁷ the right "to seek, receive and impart information and ideas concerning health issues",¹³⁸ and to health facilities, goods and services "designed to respect confidentiality".¹³⁹ The comment indicates that article 12 requires the State parties to establish prevention and education programmes for behaviour-related health concerns such as HIV/AIDS,¹⁴⁰ to ensure provision of a "health insurance system which is affordable for all", and to promote medical research, education and information campaigns with respect to HIV/AIDS.¹⁴¹

Finally, the Committee emphasizes in its comment that any limitations on rights that the state parties impose with respect to health or on the grounds of protecting public health, such as restricting the movement of or incarcerating people with transmissible diseases such as HIV/AIDS, are subject to the limitations clause in article 4 of the Covenant.¹⁴² Therefore, they "must be in accordance with the law, including international human rights standards, compatible with the nature of the rights protected by the Covenant, in the interest of legitimate aims pursued, and strictly necessary for the promotion of the general welfare in a democratic society".¹⁴³

¹³³ Committee on Economic, Social and Cultural Rights, General Comment No. 14 (2000), The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights), E/C.12/2004/4 (General Comments) (11 August 2000) at [http://www.unhcr.ch/tbs/doc.nsf/\(Symbol\)/40d009901358b0e2c1256915005090be?Opendocument](http://www.unhcr.ch/tbs/doc.nsf/(Symbol)/40d009901358b0e2c1256915005090be?Opendocument) cited January 16, 2004.

¹³⁴ Id. at ¶ 8.

¹³⁵ Id. at ¶ 18.

¹³⁶ Id. at ¶ 8.

¹³⁷ Id. at ¶ 12(a).

¹³⁸ Id. at ¶ 13(b).

¹³⁹ Id. at ¶ 13(c).

¹⁴⁰ Id. at ¶ 16.

¹⁴¹ Id. at ¶ 36.

¹⁴² Id. at ¶ 28.

¹⁴³ Id.

Further, the comment states that any "such limitations must be proportional"; therefore "the least restrictive alternative must be adopted", "of limited duration and subject to review".¹⁴⁴

In addition to HIV/AIDS-related provisions of the ICCPR and the ICESCR, the other three core international human rights treaties also contain relevant provisions. In particular, the International Convention on the Elimination of Racial Discrimination (CERD),¹⁴⁵ the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)¹⁴⁶ and the United Nations Convention on the Rights of the Child (CRC)¹⁴⁷ all enumerate rights related to health. The Committee on the Elimination of Discrimination Against Women has issued general comments that address HIV/AIDS, including General Recommendation No. 24 on Women and Health.¹⁴⁸ This comment states that "issues of HIV/AIDS and other sexually transmitted diseases are central to the rights of women and adolescent girls to sexual health".¹⁴⁹ It notes that women and girls lack adequate information and services, have insufficient power to refuse sex or insist on safe sexual practices and are subject to marital rape and polygamy, which expose them to HIV infection.¹⁵⁰ The comment indicates that states should ensure the right to sexual health information for all women and girls, especially sex workers and trafficked women and girls, in programmes designed to respect their rights to privacy and confidentiality.¹⁵¹

¹⁴⁴ Id. at ¶ 29.

¹⁴⁵ Convention on the Elimination of Racial Discrimination, article 5(e)(iv), General Assembly Resolution 2106 (XX) (21 December 1965) at http://www.unhchr.ch/html/menu3/b/d_icerd.htm cited January 16, 2004 (right to public health, medical care, social security and social services). There are 169 state parties to CERD as of November 2003.

¹⁴⁶ Convention on the Elimination of All Forms of Discrimination Against Women, articles 11.1(f) and 12, General Assembly Resolution 34/180 (18 December 1979) at <http://www.unhchr.ch/html/menu3/b/e1cedaw.htm> cited January 16, 2004 (right to equality with men concerning the "right to protection of health and to safety in working conditions" and to equal access to health care services). There are 174 state parties to CEDAW as of November 2003.

¹⁴⁷ United Nations Convention on the Rights of the Child, article 24, General Assembly Resolution 44/25 (20 November 1989) at <http://www.unhchr.ch/html/menu2/6/crc/treaties/crc.htm> cited January 16, 2004 ("right of the child to the enjoyment of the highest attainable standard of health"). There are 192 state parties to the CRC as of November 2003.

¹⁴⁸ Committee on the Elimination of Discrimination against Women, General Recommendation No. 24, Women and Health (Article 12) (2 February 1999) at [http://www.unhchr.ch/tbs/doc.nsf/\(Symbol\)/77bae3190a903f8d80256785005599ff?Opendocument](http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/77bae3190a903f8d80256785005599ff?Opendocument) cited January 16, 2004.

¹⁴⁹ Id. at ¶ 18.

¹⁵⁰ Id.

¹⁵¹ Id.

The Committee on the Rights of the Child has issued General Comment No. 3 on HIV/AIDS and the rights of the child.¹⁵² The Committee notes in this comment that "the majority of new infections are among young people" and that "women and girls are increasingly becoming infected".¹⁵³ It emphasizes that "effective HIV/AIDS prevention requires States to refrain from censoring, withholding or intentionally misrepresenting health-related information" and that states must ensure that children "acquire the knowledge and skills to protect themselves".¹⁵⁴ Further, it maintains that "States parties should ensure access to voluntary, confidential HIV counseling and testing for all children".¹⁵⁵ The comment also addresses issues concerning children who are more susceptible to HIV infection and to discrimination on the basis of HIV status, including children orphaned by HIV/AIDS, child victims of sexual and economic exploitation and child victims of violence and sexual abuse.¹⁵⁶

Regional instruments contain similar human rights guarantees. Among the human rights guarantees contained in regional instruments is the "right to protection of health" in the European Social Charter.¹⁵⁷ The African Charter on Human and Peoples' Rights states that "every individual shall have the right to enjoy the best attainable state of physical and mental health", and states parties shall ensure that their people "receive medical attention when they are sick".¹⁵⁸ The Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights contains a detailed provision on the right to health, which begins by establishing that "[e]veryone shall have the right to health, understood to mean the enjoyment of the highest level of physical, mental and social well-being".¹⁵⁹ The Inter-American Commission on Human Rights, which monitors compliance with the American Convention on Human Rights and the Protocol, has considered a case brought by a group of people with HIV against El Salvador, requesting that the Commission find a violation by the State for failure to provide them

¹⁵² Committee on the Rights of the Child, General Comment No. 3 (2003), CRC/GC/2003/3 (17 March 2003) at [http://www.unhcr.ch/tbs/doc.nsf/\(Symbol\)/309e8c3807aa8cb7c1256d2d0038caaa?Opendocument](http://www.unhcr.ch/tbs/doc.nsf/(Symbol)/309e8c3807aa8cb7c1256d2d0038caaa?Opendocument) cited January 16, 2004.

¹⁵³ Id. at ¶ 2.

¹⁵⁴ Id. at ¶ 16.

¹⁵⁵ Id. at ¶ 22.

¹⁵⁶ See generally, id. at ¶s 30 –39.

¹⁵⁷ European Social Charter (1961), article 11, at <http://conventions.coe.int/treaty/en/Treaties/Html/035.htm> cited January 16, 2004.

¹⁵⁸ African Charter on Human and People's Rights (1981), article 16, at <http://www.achpr.org/html/basicinstruments.html> cited January 16, 2004. In addition, the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa recognizes "the right to health of women, including sexual and reproductive health". Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, article 14, at <http://www.africa-union.org/home/welcome.htm> cited September 8, 2004. The Protocol was adopted by the African Union Assembly on July 11, 2003 but has not come into force.

¹⁵⁹ Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (Protocol of San Salvador) (1988), article 10(1) at <http://www.oas.org/juridico/english/Treaties/a-52.html> cited January 16, 2004.

with antiretroviral treatment.¹⁶⁰ The Commission issued precautionary measures, requesting that El Salvador provide antiretroviral treatment to prevent the claimants from dying and El Salvador has since provided the claimants with treatment.¹⁶¹

In sum, numerous international and regional human rights instruments enunciate rights relevant in the context of HIV/AIDS. All international instruments and forums, however, rely upon the states as the primary parties responsible for promoting and protecting human rights. The international laws are designed to encourage states to establish national laws and systems for human rights protection. In some countries, international law is directly applicable to provide the basis for a legal action in a domestic forum. In most countries, international laws must be adopted through legislation or constitutional reform processes before they can be the basis for legal action in domestic forums. Nonetheless, most countries already recognize many of rights enunciated in the international instruments in national constitutions or legislation. Even where international law has not been carried over into domestic law, however, the international norms and standards that a country has agreed to accept by international treaty are persuasive authority on interpreting and giving substantive content to domestic laws already in place. Thus, for example, where domestic laws include general equal-protection or nondiscrimination provisions, these may be construed in domestic forums to prohibit discrimination on the basis of HIV/AIDS status. International human rights standards and norms related to HIV/AIDS, thus, serve as useful tools to educate and encourage domestic lawmakers – judicial, legislative and administrative – to adopt a human rights approach to respond to the HIV/AIDS epidemic.

IV. Domestic Case Law Arising in Health-care Settings

At the domestic level, progress towards a human rights based approach to the HIV/AIDS epidemic is uneven. In the United Nations Declaration of Commitment on HIV/AIDS, the heads of state committed to "enact, strengthen or enforce, as appropriate, legislation, regulations and other measures to eliminate all forms of discrimination against and to ensure the full enjoyment of all human rights and fundamental freedoms by people living with HIV/AIDS and members of vulnerable groups".¹⁶² The target date for achieving a comprehensive legal framework for responding to the HIV/AIDS epidemic was 2003.¹⁶³

The first report to the General Assembly on progress toward the commitments finds that almost half the countries in sub-Saharan Africa, where thirty million people are living with HIV/AIDS, have not adopted legislation to protect people with HIV/AIDS from discrimination.¹⁶⁴ Even fewer countries have adopted legislation to protect populations at high

¹⁶⁰ See Jorge Odir Miranda Cortéz, No. 12.249, Inter-American Commission on Human Rights, at 5 & n.2 (February 29, 2000) at <http://www.cidh.org/annualrep/2000sp/CapituloIII/Admisible/ElSalvador12.249.htm> cited January 16, 2004.

¹⁶¹ Id.

¹⁶² UN Declaration of Commitment on HIV/AIDS, supra note 101, ¶ 58.

¹⁶³ Id.

¹⁶⁴ Progress Report 2003, supra note 108, at 50.

risk of HIV infection from discrimination, although such laws are necessary to ensure access to HIV prevention, care and treatment services.¹⁶⁵ Indeed, many countries officially discriminate against such groups by, for example, maintaining laws that criminalize homosexual conduct and sex work.¹⁶⁶ Similarly, many countries maintain laws, such as inheritance and divorce laws, that discriminate against women thus making women and girls more vulnerable to HIV infection.¹⁶⁷

There is no doubt that many countries have not met their commitments to enact the legislation necessary to address the HIV/AIDS epidemic. The current effort to scale up availability and access to antiretroviral treatment throughout the developing world makes this an important time to re-examine the legal framework for human rights protections related to HIV/AIDS in health-care settings. Central to an effective HIV/AIDS strategy are the human rights requirements of informed consent for HIV testing, confidentiality of HIV/AIDS-related information, prohibitions on discrimination against people with HIV/AIDS – especially in health-care settings, and access to antiretroviral and other treatment for HIV/AIDS and related infections. For women in particular there continue to be widespread violations of these rights, contributing to the continued spread of the epidemic. The international commitments and human rights instruments provide a helpful framework in identifying the shortcomings in domestic legal protections on these issues.

A. HIV Testing

The International Guidelines indicate that "[c]ompulsory HIV testing can constitute a deprivation of liberty and a violation of the right to security of person".¹⁶⁸ Moreover, the Guidelines state that "public health does not justify mandatory HIV testing or registration, except in cases of blood/organ/tissue donations where the human product, rather than the person, is tested before use on another person".¹⁶⁹ Mandatory HIV testing is, however, permitted or required in many countries to screen people with regard to access to education, employment, health care, travel, social security, housing, insurance and asylum.¹⁷⁰ This coercive measure is often used by governments in institutions, such as the military or prisons, or in relation to criminal proceedings against "sex workers, injecting drug users and men who have sex with

¹⁶⁵ *Id.*

¹⁶⁶ *Id.* at 51. The International Guidelines recommend decriminalizing "sex work that involves no victimization" and "then legally regulating occupational health and safety conditions to protect sex workers and their clients". International Guidelines, *supra* note 98, Guideline 4¶ 29(c).

¹⁶⁷ See, e.g., Mandeep Dhaliwal, *supra* note 47, at 2 ("In India, the legal status of women in practically all spheres of law – ie., consent to sex, marriage, divorce, maintenance and inheritance – is subordinate to men on the basis of profound gender discrimination."); Lisa Karanja, *supra* note 35, at 19 (documenting customary and statutory laws that discriminate against women in Uganda in areas of marriage, divorce and inheritance and inadequate legal protections against discrimination and domestic violence).

¹⁶⁸ International Guidelines, *supra* note 98, at ¶ 113.

¹⁶⁹ *Id.* at ¶ 98.

¹⁷⁰ *Id.* at ¶ 83.

men".¹⁷¹ Courts in some countries have held against governments imposing such mandatory testing of arrestees and prisoners where the infringement on the arrestees' or prisoners' rights was not justified by any evidence of a legitimate objective.¹⁷²

The Guidelines state that "[r]espect for the right to physical integrity requires that testing be voluntary".¹⁷³ Moreover, it is the duty of states "to ensure that no HIV testing occurs without informed consent".¹⁷⁴ Nonetheless, in some countries, tests are routinely carried out on patients prior to surgery and on pregnant women and their newborns without consent.¹⁷⁵ HIV tests performed without informed consent give rise to a variety of legal claims that may be asserted in courts, including violations of (1) statutory provisions specifically prohibiting HIV testing without informed consent, (2) constitutional or statutory rights to privacy, and (3) common-law torts, such as assault and battery, intrusion upon seclusion, and intentional infliction of emotional distress.¹⁷⁶ Plaintiffs generally asserted multiple causes of action on the same facts.

In the health-care setting, HIV testing without informed consent often occurs where a blood sample is taken from an individual with consent for another diagnostic test but then an HIV test is also performed on the sample without any knowledge or authorization by the person from whom the blood was taken. These were the circumstances in *Doe v. High-Tech Institute, Inc.*, a case from the United States.¹⁷⁷ In that case, the plaintiff was a student, who was required by the school to provide a blood sample for a rubella test and to sign a consent form for this test. Without plaintiff's knowledge, the teacher requested that the laboratory test plaintiff's blood sample for HIV. The test yielded a positive result, and thus, the laboratory was required under state law to report the plaintiff's name, address and HIV-positive status to the school and to the department of health.¹⁷⁸

¹⁷¹ Id. at ¶ 113.

¹⁷² See Annotation, "Damage Action for HIV Testing Without Consent of Person Tested", 77 A.L.R.5th 541 § 4 (2000) (collecting cases against the United States federal government under the fourth amendment to the United States Constitution for mandatory HIV testing of arrestees and prisoners).

¹⁷³ International Guidelines, *supra* note 98, at ¶ 113.

¹⁷⁴ Id. at ¶ 99.

¹⁷⁵ See, e.g., Canadian HIV/AIDS Legal Network, "News from Venezuela", 5 Canadian HIV/AIDS Policy and Law Review No. 4, International News (2000) at <http://www.aidslaw.ca/Maincontent/otherdocs/Newsletter/vol5no42000/intnews.htm#IN4> cited January 16, 2004 (stating that Venezuela Ministry of Health and Social Development had authorized mandatory HIV testing for all pregnant women as part of prenatal care); Gina A. Angelletta, "New York Public Health Law § 2500-F: The Hand that Robbed the Cradle of Privacy", 18 St. John's Journal of Legal Commentary 175, 176 (2003) (arguing that state statute requiring all newborns to be tested for HIV violated mothers' right to privacy and autonomy).

¹⁷⁶ See Annotation, *supra* note 177, §§ 5, 8-10 (collecting cases).

¹⁷⁷ *Doe v. High-Tech Institute, Inc.*, 972 P.2d 1060 (Colorado Court of Appeal 1999).

¹⁷⁸ Id. at 1064.

Plaintiff sued the school, asserting a claim for invasion of privacy based on the unreasonable disclosure of private facts and a claim of intrusion upon seclusion based on conducting the HIV test without his consent.¹⁷⁹ The court of appeals noted that the facts supporting the two claims were distinct. Thus, the court concluded that the plaintiff could recover for both claims.¹⁸⁰ Noting that the diagnosis of HIV carries a strong social stigma, the court held that the unauthorized test was serious enough to be considered offensive by a reasonable person; thus, in the circumstances set forth, the test was sufficient to establish an unreasonable intrusion upon seclusion.¹⁸¹ Other common-law jurisdictions should similarly recognize a privacy claim for intrusion upon seclusion for an unauthorized HIV test.

A similar allegation – that HIV testing was conducted without consent – was made by the plaintiff in a case that came before the High Court of South Africa, *VRM v. Health Professions Council of South Africa*.¹⁸² In that case, the plaintiff alleged that she had visited the defendant doctor when she was six months pregnant, and at this appointment, the doctor took a blood sample.¹⁸³ Plaintiff subsequently returned with her husband, who asked the doctor about a bill he had received for an "HIV Elisa", and whether the test had anything to do with AIDS.¹⁸⁴ The doctor replied that it did not.¹⁸⁵ Plaintiff's child was later stillborn, and the doctor wrote on the death certificate "stillborn/HIV-positive".¹⁸⁶ Plaintiff was not informed that an HIV test had been performed and that she was HIV-positive until after she learned of the stillbirth.¹⁸⁷

Plaintiff brought a complaint to the Committee of Preliminary Enquiry of the Health Professions Council of South Africa, alleging, among other things, that the doctor had conducted an HIV test without her consent and without providing pre- or post-test counseling.¹⁸⁸ The Committee found that "there had been no improper or disgraceful conduct on the part of the [doctor]".¹⁸⁹ On appeal, the High Court of South Africa ruled that there was a factual dispute

¹⁷⁹ Id.

¹⁸⁰ Id. at 1066.

¹⁸¹ Id. at 1071.

¹⁸² *VRM v. Health Professions Council of South Africa*, A 1679/2002, High Court of South Africa (Transvaal Provincial Division) (10 October 2003) at http://www.alp.org.za/view.php?file=/resctr/jdgmnts/20020527_jvrmvshpc.xml cited January 16, 2004.

¹⁸³ Id. at ¶ 3.

¹⁸⁴ Id. at ¶ 3 (8)-(9).

¹⁸⁵ Id. at ¶ 3 (10).

¹⁸⁶ Id. at ¶ 3 (17), (23).

¹⁸⁷ Id. at ¶ 3 (18).

¹⁸⁸ Id. at ¶ 1, 3 (24).

¹⁸⁹ Id. at ¶ 6.

about whether the doctor had informed the plaintiff that her blood sample had been taken for an HIV test and that the Committee was not empowered to decide factual disputes without conducting an inquiry.¹⁹⁰ Thus, the court set aside the Committee's decision.¹⁹¹ Because health-care providers and women have reported widespread HIV testing of pregnant women without their knowledge or consent, the VRM case, although not yet concluded, is an important case to establish the impropriety and illegality of such testing.

B. Confidentiality

Confidentiality of HIV-related information is the central component of an effective HIV/AIDS strategy. It is also closely related to the issues of informed consent for testing, voluntary pre- and post-test counseling and voluntary partner notification. On these issues, the International Guidelines refer to article 17 of the International Covenant on Civil and Political Rights. Article 17 states: "No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence, nor to unlawful attacks on his honour and reputation. Everyone has the right to the protection of the law against interference or attacks."¹⁹² The Guidelines indicate that the right to privacy covers both (1) physical privacy, requiring informed consent to HIV testing, and (2) information privacy, requiring consent to disclose any information relating to a person's HIV status.¹⁹³

In the context of HIV/AIDS, an individual's privacy interest is particularly compelling because of the stigma attached to an HIV-positive diagnosis and the discrimination that may result from its disclosure.¹⁹⁴ Moreover, the Guidelines point out that "[t]he community has an interest in maintaining privacy so that people will feel safe and comfortable in using public health measures, such as HIV/AIDS prevention and care services".¹⁹⁵ Thus, states have a duty to protect the right to privacy by creating adequate safeguards to ensure "that confidentiality is protected, particularly in health and social welfare settings, and that information on HIV status is not disclosed to third parties without the consent of the individual".¹⁹⁶ Further, "States must also ensure that HIV-related personal information is protected in the reporting and compilation of epidemiological data". In the context of the massive scale-up of anti-retroviral treatment currently underway by WHO and its partners,¹⁹⁷ the States' obligation to create systems for protecting the confidentiality of the documentation is particularly important.

¹⁹⁰ Id. at ¶ 25.

¹⁹¹ Id.

¹⁹² ICCPR, article 17.

¹⁹³ International Guidelines, *supra* note 98, at ¶ 97.

¹⁹⁴ Id. at ¶ 98.

¹⁹⁵ Id.

¹⁹⁶ Id. at ¶ 99.

¹⁹⁷ See WHO 3 by 5 Strategy, *supra* note 3.

Violations of the right to confidentiality may give rise to several causes of action, including claims brought under (1) statutes specifically prohibiting unauthorized disclosure of HIV-related information, (2) statutes generally prohibiting disclosure of medical information, (3) constitutional and statutory provisions protecting the right to privacy, (4) common-law privacy doctrines, and (5) theories of intentional or negligent infliction of emotional distress.¹⁹⁸ Plaintiffs may assert several theories in a single case. For example, the plaintiff in *Urbaniak v. Newton*, a California case, alleged violations of an HIV-confidentiality statute, a constitutional right to privacy and intentional and negligent infliction of emotional distress, where a physician who conducted an examination for an unrelated worker's compensation claim revealed to the plaintiff's employer that the plaintiff was HIV-positive.¹⁹⁹ The court found that the facts, as alleged, supported the right to privacy claim, but not the other claims because (1) the HIV statute applied only to an HIV-test result, not the plaintiff's voluntary disclosure to the nurse of his HIV status, and (2) the physician's conduct was not "outrageous" and "beyond all bounds of decency" as required for the emotional distress claims.²⁰⁰

In another case, *Jansen van Vuuren v. Kruger*, the appellate court in South Africa ruled in favor of a patient's right to medical confidentiality of his HIV status.²⁰¹ In that case, the patient's health-care provider had disclosed the patient's HIV status to two other health-care providers during a golf game. The court held that a physician had a duty to maintain confidentiality, which could be limited under certain circumstances in the public interest. The court declared that, in this case however, the public interest did not warrant the disclosure of the patient's HIV status.

Many of the cases involving breaches of confidentiality also involve issues related to notification of the partner of the person testing positive for HIV. On partner notification, the guidelines provide that "[p]ublic health legislation should authorize, but not require, that health-care professionals decide, on the basis of each individual case and ethical considerations, whether to inform their patients' sexual partners of the HIV status of their patient".²⁰² The decision to inform a partner should only be made where (1) the HIV-positive person "has been thoroughly counseled", (2) counseling "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) there is a real risk of transmission to the partner(s), (5) "[t]he HIV-positive person is given reasonable advance notice", (6) if possible, the identity of the HIV-positive

¹⁹⁸ Roger Doughty, *supra* note 71, at 140-41 (1994) (listing interrelated levels of legal protection to guard confidentiality of HIV-related information).

¹⁹⁹ *Urbaniak v. Newton*, 226 Cal.App.3d 1128 (1991).

²⁰⁰ *Id.* at 1112-13.

²⁰¹ *Jansen van Vuuren v. Kruger*, 1993(4) SA 842(A), cited in Marlise Richter, "Review of HIV/AIDS Legislation in Six Southern African Countries" (September 25, 2003) at http://www.alp.org.za/view.php?file=/resctr/rpapr/20030331_hsrc_leg.xml cited January 13, 2004.

²⁰² International Guidelines, *supra* note 98, Guideline 3 ¶ 28(g).

person is concealed from the person(s) notified, and (7) follow-up support is provided as necessary.²⁰³ These conditions are helpful in reviewing cases raising partner notification issues.

In *Mr. X v. Hospital Z*, for example, the Supreme Court of India considered a case in which a hospital had revealed the HIV status of a doctor to his fiancé and her family.²⁰⁴ As a result, the marriage was cancelled, and the doctor was ostracized by his community. In court, the doctor asserted two claims against the hospital: (1) violation of a duty to maintain confidentiality under medical ethics, and (2) violation of the right to privacy under the Indian Constitution. The court held that there was no violation of medical confidentiality because the case fell under an exception to the confidentiality rule, which allowed for disclosure in the public interest where there is an immediate or future health risk to an identifiable person. The court concluded that, in this case, the plaintiff's proposed marriage presented such a risk to the plaintiff's fiancé. For the same reason, the court held that there was no violation of the constitutional right to privacy.²⁰⁵

The decision in *Mr. X* does not detail the facts sufficiently to evaluate whether any of the preconditions for partner notification were satisfied, and, apparently, does not take any such factors into consideration. Further, the court goes on to hold that people with sexually transmitted diseases do not have a right to marry that is enforceable in court, an issue that was not raised in the case. Indeed, the court's decision is hostile towards people living with HIV, stating that "AIDS is the product of indisciplined sexual impulse", and that although people suffering from "the dreadful disease" deserve sympathy, "'sex' with them or possibility thereof has to be avoided as otherwise they would infect and communicate the dreadful disease to others".²⁰⁶ The decision has received considerable criticism, and the court has withdrawn its comments concerning the right to marry but not its conclusions undermining the rights to medical confidentiality and privacy.²⁰⁷

Several other cases have considered whether a health-care provider has a duty to warn the partner of a person infected with HIV. In *P.D. v. Harvey*, an Australian case, P.D. and her fiancé had visited the doctor together to be tested for HIV prior to getting married, but they received their test results separately.²⁰⁸ During the joint consultation, the doctor did not raise the issue of

²⁰³ Id.

²⁰⁴ *Mr. X v. Hospital Z*, (1998) 8 SCC 296 (unpaginated electronic version) at <http://www.lawyerscollective.org/lc-hiv-aids/index.htm> cited October 14, 2003.

²⁰⁵ Id.

²⁰⁶ Id.

²⁰⁷ *Mr. X v. Hospital Z*, 2002 SCCL.COM 701 (2002) (apparently withdrawing observations regarding the right to marry) (unpaginated electronic version) at <http://www.lawyerscollective.org/lc-hiv-aids/index.htm> cited October 14, 2003; Jaynath K. Krishnan, "The Rights of the New Untouchables: A Constitutional Analysis of HIV Jurisprudence in India", 25 Human Rights Quarterly 791, 809-811 (2003) (criticizing the court's decision).

²⁰⁸ *P.D. v. Harvey*, (2003) NSWSC 487 (Supreme Court of New South Wales, Australia) (unpaginated electronic version) at <http://www.austlii.edu.au/cgi-bin/disp.pl/au/cases/nsw/supreme%5fct/2003/487.html?query=title+%28+%22pd%22+%29> cited October 15, 2003.

confidentiality with P.D. or the fiancé and did not explain that to them that they would not have access to each other's test results. The tests showed that P.D. was HIV-negative, whereas her fiancé was HIV-positive. The doctor provided no post-test counseling, but simply referred the fiancé to a specialist. Thereafter, P.D. and the fiancé were married, and P.D. was infected with HIV. P.D. sued, and the court found that the doctor had breached a duty of care owed to P.D. and that, as a result, P.D. became infected with HIV. Consequently, the court awarded her substantial damages.²⁰⁹

In another Australian case, *B.T. v. Oei*, the court found that the defendant doctor had negligently failed to diagnose that A.T. was HIV-positive, and thereby breached a duty to A.T.'s sexual partner who was infected by A.T. after the doctor should have made such a diagnosis.²¹⁰ In a Canadian case, *Pittman Estate v. Bain*, the Ontario Court of Justice held a doctor, a hospital and the Canadian Red Cross liable to the wife of a patient who was infected with HIV after the defendants knew, but failed to inform the patient, that he had received a transfusion with HIV-infected blood.²¹¹

Partner notification issues are particularly relevant to heterosexual women.²¹² First, they may not see themselves at risk for infection when they believe that their partners are monogamous and HIV-negative.²¹³ In such circumstances, they are unlikely to seek testing, counseling and treatment unless notified by the partner or another person legally responsible where the partner has refused to do so. Second, a woman who receives an HIV-positive test result may face difficulties notifying her partner, or insisting on safe sexual practices, due to fear of a violent response from the partner.²¹⁴ In either scenario, the right to confidentiality and the role of careful pre- and post-test counseling become evident and crucial to proper consideration of the options available to each individual.

C. Discrimination

Fear of discrimination prevents people from seeking testing and treatment for HIV/AIDS.²¹⁵ The fear is well-founded. Even in health-care settings, where people with HIV/AIDS should be encouraged to seek care and counseling, discrimination is widespread.²¹⁶ One study revealed that one in ten doctors and nurses in Nigeria had refused to care for a person

²⁰⁹ *Id.*

²¹⁰ *B.T. v. Oei*, (1999) NSWSC 1082, 1999 NSW LEXIS 63, 91 (Supreme Court of New South Wales, Australia).

²¹¹ *Pittman Estate v. Bain*, 19 C.C.L.T. (2d 1, 112 D.L.R. (4th) 257 (1994).

²¹² Roger Doughty, *supra* note 71, at 173.

²¹³ *Id.* at 171.

²¹⁴ See *id.* at 173.

²¹⁵ AIDS Epidemic Update 2003, *supra* note 1, at 21.

²¹⁶ *Id.*

with HIV/AIDS or had denied a person with HIV/AIDS admission to a hospital.²¹⁷ In the same study, 20% of doctors and nurses surveyed believed that people with HIV/AIDS "had behaved immorally and deserved their fate".²¹⁸ In the Philippines, a survey found that 50% of people living with HIV/AIDS had experienced discrimination by health-care workers.²¹⁹ Similarly, research in India found that 70% of people living with HIV/AIDS had faced discrimination, usually within their families and in health-care settings.²²⁰ Addressing discrimination in health-care settings is essential in breaking the cycle of stigma and discrimination experienced by people living with HIV/AIDS in other settings.

The International Guidelines note that "[i]nternational human rights law guarantees the right to equal protection before the law and freedom from discrimination on any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status".²²¹ Although the ICCPR and the ICESCR do not specifically enumerate disability or HIV/AIDS as illegal grounds for discrimination, the Commission on Human Rights, among others, has declared that the terms "other status" in the nondiscrimination provisions should be construed to include health status, including HIV/AIDS.²²² Similar anti-discrimination legislation, defining disability broadly enough to include HIV/AIDS, exists in the United States, the United Kingdom, Canada, Australia, New Zealand and Hong Kong.²²³ Some countries, such as South Africa, have enacted legislation that prohibits discrimination on the basis of HIV/AIDS explicitly.²²⁴ Most commonwealth countries, however, have no legislation against HIV/AIDS discrimination.²²⁵ The Guidelines further note that nondiscrimination provisions should also apply to prohibit discrimination against "members of groups perceived to be at risk of infection on the basis of their actual or presumed HIV status".²²⁶ Most countries do not have such nondiscrimination legislation either.

Cases alleging discrimination in the health-care setting may be asserted under (1) statutory provisions prohibiting discrimination on the basis of HIV/AIDS status, (2) statutory provisions prohibiting discrimination on the basis of disability, and (3) constitutional provisions

²¹⁷ Id.

²¹⁸ Id.

²¹⁹ Id. at 42.

²²⁰ Id.

²²¹ International Guidelines, *supra* note 98, at ¶ 85.

²²² Id. at ¶ 86; United Nations Commission on Human Rights, Resolution 1996/43 ¶ 1, E/CN.4/RES/1996/43 (April 19, 1996).

²²³ International Guidelines, *supra* note 98, Annex 1 ¶ 3; HIV/AIDS in the Commonwealth, *supra* note 2, at 19.

²²⁴ HIV/AIDS in the Commonwealth, *supra* note 2, at 21.

²²⁵ Id.

²²⁶ International Guidelines, *supra* note 98, at ¶ 86.

guaranteeing nondiscrimination or equal protection before the laws. Many countries, however, have neither the legislation nor the constitutional provisions that could apply to prohibit HIV/AIDS-related discrimination. Most nondiscrimination provisions do not explicitly refer to HIV/AIDS. Where provisions prohibit discrimination on the basis of disability or contain an open category, such as the "other status" category contained in the international human rights treaties, the language may be interpreted by the courts to cover HIV/AIDS-related discrimination. Where none of these options is available, denial of medical treatment on the basis of HIV/AIDS status may be challenged under constitutional provisions that guarantee the right to life or that prohibit inhuman and degrading treatment. For example, a woman in Nigeria living with HIV has filed a case for denial of treatment on the basis of her HIV status, alleging both denial of the right to life and inhuman and degrading treatment.²²⁷

In *Bragdon v. Abbott*, the United States Supreme Court considered whether HIV infection that has not progressed to the symptomatic phase is a disability under the Americans with Disabilities Act of 1990.²²⁸ This legislation prohibits discrimination against people with disabilities in, among other settings, the "professional office of a health care provider".²²⁹ The Court held that HIV is an impairment from the moment of infection.²³⁰ Thus, it concluded that HIV infection is a disability under the nondiscrimination law. Similar determinations – that HIV infection is a disability for purposes of nondiscrimination laws – have been recognized in Canada²³¹ and Australia.²³²

Discrimination in health-care settings remains an important area to enact legislation in the countries where there are no prohibitions on either disability discrimination or HIV/AIDS discrimination. Not surprisingly, many of the same countries have no laws prohibiting discrimination on the basis of sex and continue to have various sex discriminatory laws in effect on a wide range of issues. Both discrimination on the basis of HIV/AIDS status and on the basis of sex are widely recognized as factors perpetuating the HIV/AIDS epidemic. In the context of the antiretroviral scale-up, it is particularly important to establish the legal framework to protect the human rights of patients and to respond effectively to the HIV/AIDS epidemic. Perhaps greater access to HIV/AIDS treatment in the near future will provide the impetus necessary to enact the nondiscrimination legislation to which all countries committed themselves in 2001.

²²⁷ See, e.g., "Nigeria: HIV-Positive Woman Sues Over Treatment Denial", Pambazuka News (January 30, 2003) at <http://www.pambazuka.org/newsletter.php?id=12869> cited October 10, 2003.

²²⁸ *Bragdon v. Abbott*, 524 U.S. 624 (1998).

²²⁹ *Id.* at 629 (citing 42 U.S.C. §§ 12181(7)(F) & 12182(a)).

²³⁰ *Id.* at 637, 647.

²³¹ *Hamel v. Malaxos*, 20 C.C.L.T. (2d) 272 (Cour du Quebec, Chambre Civile 1993) (holding that HIV-positive status is handicap under the Quebec Charter of Human Rights and Freedom).

²³² *Heystraten v. Naidu*, 2000 WESTLAW 1241521 (New South Wales Administrative Decisions Tribunal 2000) (recognizing that HIV-positive status was a disability but finding that plaintiff had failed to establish facts of discrimination on this basis).

D. Access to Treatment

Access to treatment is at the forefront of the HIV/AIDS and human rights issues now facing developing countries.²³³ The recent reduction in the price of antiretroviral treatment, together with new international funding commitments, make universal access a realistic goal for the near future. The scale-up will raise many human rights issues, not least of which will be equality in access to the medications that are being made available in developing countries that frequently do not have the infrastructure to deliver them. Aside from claims for equal access to treatment, the International Guidelines indicate two explicit international rights upon which the right to access to treatment may be asserted: (1) the right to health,²³⁴ and (2) the right to enjoy the benefits of scientific progress.²³⁵

The Guidelines state that, to guarantee the right to health, states should "ensure access to adequate treatment and drugs, within the overall context of their public health policies, so that people living with HIV/AIDS can live as long and as successfully as possible".²³⁶ The Guidelines further note that "[i]nternational support is essential from both the public and private sectors for developing countries for increased access to health care and treatment, drugs and equipment".²³⁷ In addition, "States may have to take special measures to ensure that all groups in society, particularly marginalized groups, have equal access to HIV-related prevention, care and treatment services".²³⁸ In view of the rapid and continuing advances in treatments, the right to enjoy the benefits of scientific progress and its applications is also important in the context of HIV/AIDS.²³⁹ The Guidelines note that severe resource constraints of developing countries and marginalized groups limit their access to these scientific benefits as well as to "basic pain prophylaxis and antibiotic treatment for HIV-related conditions".²⁴⁰ Thus, issues of equity among states and among groups within states are important issues to consider in delivering basic drugs and other treatments.²⁴¹

Numerous claims have been filed against governments in developing countries to obtain access to antiretroviral treatment. In February 2003, five women with HIV/AIDS filed a petition against Jamaica in the Inter-American Commission on Human Rights, alleging violations of both

²³³ HIV/AIDS in the Commonwealth, *supra* note 2, at 21.

²³⁴ International Guidelines, *supra* note 98, at ¶¶ 121, 123.

²³⁵ *Id.* at ¶ 103.

²³⁶ *Id.* at ¶ 123.

²³⁷ *Id.*

²³⁸ *Id.* ¶ 124.

²³⁹ *Id.* at ¶ 103.

²⁴⁰ *Id.* ¶ 103.

²⁴¹ *Id.*

the right to health and the right to enjoy the benefits of scientific progress under the American Convention on Human Rights. They have requested that the Commission order the government to provide them with antiretroviral drugs.²⁴² In earlier cases in the Inter-American Commission, the Commission has granted precautionary measures, requesting that people with HIV/AIDS be treated with antiretroviral therapy in El Salvador, Ecuador, the Dominican Republic, Peru, Bolivia, Nicaragua, Guatemala, Chile and Honduras.²⁴³ People living with HIV/AIDS have also been successful in seeking orders for antiretroviral treatment in domestic courts in several Latin American countries.²⁴⁴

In South Africa, the Constitutional Court considered a case challenging the government's policy to deny pregnant women access to the antiretroviral Nevirapine, which is used to prevent HIV transmission from mother to child at birth.²⁴⁵ The government had decided to limit the use of Nevirapine in public sector health services to eighteen pilot sites. Under this programme, doctors in the private sector could prescribe Nevirapine, but doctors in the public sector, who did not work at one of the pilot sites, were unable to prescribe Nevirapine for their patients.²⁴⁶ As a result, most pregnant women were denied access to Nevirapine, although it was simple to administer, effective in reducing HIV transmission to the children and had been offered to the government free of charge. In support of the restrictive programme, the government contended that it was not effective to provide Nevirapine absent a comprehensive package of services that it was unable to provide on a wide scale due to inadequate resources and infrastructure. This package included HIV testing, pre- and post-test counseling and breast-milk substitutes to prevent transmission from mother to child through breastfeeding.²⁴⁷

Plaintiffs brought suit, alleging that the government's programme breached the constitutional right to health care and the child's right to access to basic health-care services.²⁴⁸ The Constitutional Court of South Africa found that, even if the full package was desirable, its

²⁴² "Jamaica: Petition for Antiretroviral Drugs Filed", 8 Canadian HIV/AIDS Law and Policy Review No. 12003 (April 2003) at <http://www.aidslaw.ca/Maincontent/otherdocs/Newsletter/vol8no12003/treatment.htm#t7> cited October 10, 2003.

²⁴³ "Inter-American Commission on Human Rights Holds Hearing on Access to Treatment in Latin America and the Caribbean", 7 Canadian HIV/AIDS Law and Policy Review No. 2-32003 (December 2002) at <http://www.aidslaw.ca/Maincontent/otherdocs/Newsletter/vol7no2-32003/treatment.htm#t13> cited October 15, 2003.

²⁴⁴ See Jaume Vidal Casanovas, "Ruling for Access. A noted inventory of Court cases related to access to essential medicines as a human right" (June 2003) (collecting cases from Argentina, Columbia, Costa Rica and Venezuela).

²⁴⁵ *Minister of Health v. Treatment Action Campaign*, 2002 (5) SA 703 (Constitutional Court of South Africa 2002).

²⁴⁶ *Id.* at ¶ 11.

²⁴⁷ *Id.* at ¶ 51.

²⁴⁸ Plaintiffs challenged the government's restrictive programme under two provisions of the South African Constitution. The first provision provides that "[e]veryone has the right to have access to health care services, including reproductive health care". The second provision provides that "[e]very child has the right to basic nutrition, shelter, basic health care and social services". *Id.* at ¶ 4.

absence did not reasonably justify denying Nevirapine to mothers and children outside the pilot sites.²⁴⁹ Thus, the Court held that the government's programme violated the constitutional right to health care.²⁵⁰ It ordered the government to make Nevirapine available to all pregnant women who give birth at public facilities where Nevirapine was medically indicated by appropriate testing and counseling.²⁵¹ Further, the Court ordered the government to take reasonable measures to extend testing and counseling services throughout the public sector to expedite the use of Nevirapine for the purpose of reducing risk of mother-to-child transmission of HIV.²⁵²

Where treatment is not available, there is little incentive for people to learn their HIV status, particularly when stigma and discrimination are the likely outcomes if the test reveals an HIV-positive result.²⁵³ Greater access to antiretroviral treatment is a powerful incentive for individuals to seek testing and counseling, and the prospect of longer and more productive lives for people living with HIV will reduce the anxiety and sense of hopelessness in communities that can often trigger discrimination.²⁵⁴ Thus, the litigation challenging denial of access to these essential medicines is vital to breaking the cycle of discrimination against people living with HIV/AIDS, to reducing the caretaking burden on women and girls, and ultimately, to effectively reducing the spread of the epidemic.

V. Conclusion

Research indicates that human rights violations related to HIV/AIDS are frequent in health-care settings. Violations of rights by health-care providers – including discrimination against people with HIV/AIDS, breaches of confidentiality concerning HIV/AIDS-related information and HIV testing without informed consent – are routine in some countries. Moreover, women are increasingly affected by HIV/AIDS and thus increasingly the victims of these violations. Despite the Declaration of Commitment by the governments of all countries to enact appropriate legislation by 2003 to combat these violations, many countries do not have the necessary legislation in place. Nonetheless, even where legislation is absent, it is possible to challenge human rights abuses under common-law doctrines, constitutional provisions and international human rights treaties. The current worldwide scale-up of access to antiretroviral treatment is bringing these health care-related human rights issues to the forefront in developing countries. Litigation has played an important role in the past in promoting and protecting the human rights of people living with HIV/AIDS, and no doubt will continue to do so in the future.

²⁴⁹ Id. at ¶¶ 66-67.

²⁵⁰ Id. at ¶ 80.

²⁵¹ Id. at ¶ 135.

²⁵² Id.

²⁵³ AIDS Epidemic Update 2003, *supra* note 1, at 22.

²⁵⁴ Id.