The international human rights standards and HIV/AIDS together convey the idea of inextricable connection as both act in synergy. The modern concept of international human rights is a process and movement to identify and agree upon what governments should do and what they should not do to protect the dignity and worth of the individuals. Human rights are non-provable statements that derive their legitimacy from having been developed, noted upon and adopted by the nations of the world into the domain of international law; they do not achieve their status from divine inspiration or religion.

The concept of international human rights is based on the idea that all people are born free and equal in dignity and rights. The promotion of human rights was identified as the basic purpose of the United Nations in 1945. Then in 1948, the Universal Declaration on Human Rights¹ was adopted as a universal or common standard of achievement for all people and all nations. The UDHR along with the UN Charter, ICCPR and its optional protocol ICESCR constitute the "International Bill of Rights" which form the corpus of international human rights agencies. Although the UDHR is not a legally binding document, nations have endowed it with great legitimacy through their actions, including its legal and political invocation at the national and international levels. Principles of the UDHR are cited in numerous national constitutions and governments often refer while accusing other governments of violating the human rights². The human rights Covenants are legally binding, on the states that have become parties to them. Such states accept certain procedures and responsibilities including periodic submission of reports on their compliance with the substantive provisions of the texts.

¹. Herein after to be referred as UDHR
International Convention on Elimination of all forms of Racial Discrimination, 1969, the Convention on Elimination of all forms of Discrimination Against Women; 1981 and Convention on Rights of the Children, 1989 or issues (such as Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, 1987) etc. While there are few legal sanctions to compel states to meet their human rights obligations, states are increasingly monitored for their compliance by media and private individuals with regard to protection of basic human rights as well as basic measures to control the communicable diseases like HIV/AIDS. The HIV/AIDS epidemic has prompted renewed interest in human rights especially at international arena. But ironically the international human rights agencies have not paid sound attention to discriminatory policies, programmes and other societal determinants which operate as a barrier in preventing HIV/AIDS. There has for example, been wide support in the communities for unrestricted international travel by people with HIV/AIDS and discrimination on the basis of the disease has been denounced. But in practice, countries are becoming more concerned with immigration problems, it is likely that more draconian steps will be taken to restrict immigration worldwide. In USA, for example, the congress voted in 1993 to ban immigration by those infected with HIV/AIDS, and this bill was signed into law by President Clinton. The justification used was two fold: the cost of caring for these with HIV/AIDS infection and the is risk of spreading HIV to others. The discrimination based solely on disease status has not yet received sufficient attention as a violation of fundamental human rights. When governments sponsor such discrimination, the international human rights agencies can help by speaking clearly and strongly in support of fundamental human rights of PLHAs. Using military metaphors in areas of public health is ultimately destructive. Future oriented view of a flourishing international community provides, a much more constructive model and HIV/AIDS epidemic is helping the law and all of us to move, albeit painfully slowly, beyond the military metaphor and toward a sustainable international community based upon human rights approach.

In the past when restrictions on human rights in context of HIV/AIDS were recognized, they were often simply justified as necessary to protect public health. Indeed public health has a long tradition, anchored in the history
of infectious disease control, of limiting the 'rights of the few' for the 'good of
the many'. The coercive measures such as mandatory HIV testing, quarantine
and isolation are considered today as traditional measures of controlling
disease. Such measures are increasingly regarded as violative of international
human rights standards. Therefore more and more countries are opting for a
human rights approach such as voluntary testing, denouncing discrimination
against PLHAs. But human rights violations still exist in the design and
implementation of health policies, to the determinant of HIV/AIDS victims.
For instance, population policies have often failed to respect individual
choices in areas like confidentiality and free consent. Promotion and
protection of such human rights as education, employment, privacy and equal
rights in marriage and divorce are necessary if HIV/AIDS victim’s basic rights
are to be protected.

Such an approach would lead to better prevention and treatment,
respect for the dignity and privacy of individuals and facilitate more sensitive
and humane care. Stigmatization and discrimination thwart medical and public
health as well as legal efforts to help people with disease. The determinants,
scope and impact of the HIV/AIDS pandemic in epidemiological, social and
economic terms have been substantially documented. It is now recognized as
an immense challenge to international security, peace and development⁴. The
international human rights agencies have a major role in shaping appropriate
responses to the HIV epidemic and other global human rights challenges,
including public health responses and identifying deficiencies in public law
and health research agendas due to continued escalation of the epidemic
particularly in Asia⁴. States are obliged to avoid abuses of civil and political
rights by their own agents, and by private sector. Individually and collectively
through international assistance and co-operation states have to work for
progressive full realization of economic, social and cultural rights, including
the right to health⁵.

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Organization; 2002.
5. As provided under the International Covenant on Economic, Social and Cultural Rights, adopted by
General Assembly Resolution 2200A (XXI) of 16 December 1966: Article 2(1).
International Human Rights Facets and HIV/AIDS Victims

The international human rights framework is robust and authoritative as it stands for the proposition that rights cannot be given nor taken away by government, but exist innately for all human beings. Human rights are comprised of civil, cultural, economic, political and social rights. They are part of the customary international law as evidenced by the world embracing the principles of UDHR as well as of the two major international Covenants: the ICESCR and ICCPR. These documents contain a wide range of rights and fundamental freedoms like right to life, liberty, non discrimination, health, work, education etc and have been ratified by governments globally. Additional human rights conventions and guidelines govern the rights of women, children, religious and ethnic minorities, refugees, people living with HIV/AIDS etc. This synergistic relationship between international human rights framework and the well being of individuals form the bedrock of human dignity and worth.

RIGHT TO LIFE, LIBERTY AND SECURITY OF PERSON

The right to liberty and security of person should never be arbitrarily interfered with, based merely on HIV status by using measures such as quarantine, detention in special colonies, or isolation. There is no public health justification for such deprivation of liberty. Indeed, it has been known that public health interests are served by integrating people living with HIV within communities and benefiting from their participation in economic and public life. Article 9 of the ICCPR provides that “Everyone has the right to liberty and security of person. No one shall be subjected to arbitrary arrest or detention. No one shall be deprived of his liberty except on such grounds and in accordance with such procedures as are established by law”.

In exceptional cases involving objective judgments concerning deliberate and dangerous behaviour, restrictions on liberty may be imposed. Such exceptional cases should be handled under ordinary provisions of public health, or criminal laws, with appropriate due process protection. Compulsory HIV testing can constitute a deprivation of liberty and a violation of the right to security of person. This coercive measure is often utilized with regard to
groups least able to protect themselves because they are within the ambit of Government institutions or the criminal law, e.g. soldiers, prisoners, sex workers, injecting drug users and men who have sex with men. There is no public health justification for such compulsory HIV testing. Respect for the right to physical integrity requires that testing be voluntary and that no testing be carried out without informed consent.

NON-DISCRIMINATION AND EQUALITY BEFORE THE LAW

In context of HIV/AIDS international 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’. The Commission on Human Rights has confirmed that “other status” in non-discrimination provisions is to be interpreted to include health status, including HIV/AIDS. This means that States should not discriminate against people living with HIV or members of groups perceived to be at risk of infection on the basis of their actual or presumed HIV status. The Human Rights Committee has confirmed that a difference in treatment is not necessarily discriminatory if it is based on reasonable and objective criteria. The prohibition against discrimination thus requires States to review and, if necessary, repeal or amend their laws, policies and practices to proscribe differential treatment which is based on arbitrary HIV-related criteria.

RIGHT TO THE HIGHEST ATTAINABLE STANDARD OF PHYSICAL AND MENTAL HEALTH

The right to the highest attainable standard of physical and mental health comprises, inter alia, “the prevention, treatment and control of epidemic, diseases” and “the creation of conditions which would assure to all medical

7. Other groups singled out for discriminatory measures in the context of HIV, such as mandatory screening, are the military, the police, peacemaking forces, pregnant women, hospital patients, tourists, performers, people with haemophilia, tuberculosis or sexually transmitted diseases (STDs), truck drivers and scholarship-holders. Their partners, families, friends and care providers may also be subject to discrimination based on presumed HIV status
service and medical attention in the event of sickness”. In order to meet these obligations in the context of HIV, States should ensure the provision of appropriate HIV-related information, education and support, including access to services for sexually transmitted diseases, to the means of prevention (such as condoms and clean injection equipments) and to voluntary and confidential testing with pre-and post-test counselling, in order to enable individuals to protect themselves and others from infection. States should also ensure a safe blood supply and implementation of “universal precautions” to prevent transmission in settings such as hospitals, doctors’ offices, dental practices and acupuncture clinics, as well as informal settings, such as during home births. States should also ensure access to adequate treatment and drugs, within the overall context of their public health policies, so that people living with HIV can live as long and as successfully as possible. PLHAs should also have access to clinical trials and should be free to choose amongst all available drugs and therapies, including alternative therapies. International support is essential from both the public and private sectors, for developing countries for increased access to health care and treatment, drugs and equipment. In this context, 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 and no one is discriminated against in the health-care setting on the basis of their HIV status whether real or perceived.

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RIGHT TO PRIVACY: CONFIDENTIALITY

The right to privacy encompasses obligations to respect physical privacy, including the obligation to seek informed consent to HIV testing and privacy of information, including the need to respect confidentiality of all information relating to a person’s HIV status. Article 17 of the ICCPR provides that “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 such interference or attacks”.

The individual’s interest in his/her privacy is particularly compelling in the context of HIV, firstly, in view of the invasive character of a mandatory HIV test and, secondly, by reason of the stigma and discrimination attached to the loss of privacy and confidentiality, if HIV status is disclosed. The community has an interest in maintaining privacy that people will feel safe and comfortable in using public health measures, such as HIV prevention and care services. The interest in 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. All information on HIV sero-status obtained during the testing of donated blood organ or tissue must also be kept strictly confidential. The duty of States to protect the right to privacy, therefore, includes the obligation to guarantee that adequate safeguards are in place to ensure that no testing occurs without informed consent, 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. In this context, States must also ensure that HIV-related personal information is protected in the reporting and compilation of epidemiological data and that individuals are protected from arbitrary interference with their privacy in the context of media investigation and reporting.

The Human Rights Committee has found that the right to privacy is violated by laws which criminalize private homosexual acts between consenting adults. The Committee noted that “... the criminalization of homosexual practices cannot be considered a reasonable means or proportionate measure to achieve the aim of preventing the spread of HIV/AIDS...by driving underground many of the people at risk of infection...[it] would appear to run counter to the implementation of effective education programmes in respect of the HIV/AIDS prevention”. The Committee also noted that the term “sex” in article 26 of the Covenant which prohibits discrimination on various grounds includes “sexual orientation”. In many countries, there exist laws which render criminal, particular sexual relationships or acts between consenting adults, such as adultery, fornication, oral sex and sodomy. Such criminalization not only interferes with the right to privacy but it also impedes HIV/AIDS education and prevention work.

RIGHT TO LIBERTY OF MOVEMENT

The right to liberty of movement encompasses the right within a territory of a State of movement and the freedom to choose his/her residence, as well as the

rights of nationals to enter and leave their own country. Similarly, an alien lawfully within a State can only be expelled by a legal decision with due process protection. There is no public health rationale for restricting liberty of movement or choice of residence on the grounds of HIV status. Therefore, any restrictions on these rights based on suspected or real HIV status alone, including HIV screening of international travellers, are discriminatory and cannot be justified by public health concerns. Where States prohibit PLHAs from longer-term residency due to concerns about economic costs, States should not single out HIV/AIDS, as opposed to comparable conditions, for such treatment and should establish that such costs would indeed be incurred in the case of the individual alien seeking residency. In considering entry applications, humanitarian concerns, such as family reunification and the need for asylum, should outweigh economic considerations.

RIGHT TO AN ADEQUATE STANDARD OF LIVING AND SOCIAL SECURITY SERVICES

Article 25 of the UDHR states that “Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control”. Enjoyment of the right to an adequate standard of living is essential to reduce vulnerability to the risk and consequences of HIV infection. It is particularly relevant to meeting the needs of PLHAs and/or their families, who have become impoverished by HIV/AIDS as a result of increased morbidity due to AIDS and/or discrimination which can result in unemployment, homelessness and poverty. If States introduce priority ranking for such services for resource allocation purposes, then PLHAs and persons with comparable conditions and disabilities should qualify for preferential treatment due to their dire circumstances. States should take steps to ensure that people living with HIV are not discriminatorily denied an adequate standard of living and/or social security and support services on the basis of their health status.
RIGHT TO MARRY AND TO FOUND A FAMILY : ISSUE OF MANDATORY TESTING

The right to marry and to found a family encompasses the right of “men and women of full age, without any limitation due to race, nationality or religion,…to marry and to found a family”, to be “entitled to equal rights as to marriage, during marriage and at its dissolution” and to protection by society and the State of the family as “the natural and fundamental group unit of society”. Therefore, it is clear that the right of people living with HIV is infringed by mandatory pre-marital testing and/or the requirement of “AIDS-free certificates” as a precondition for the grant of marriage licences under State laws. Secondly, forced abortions or sterilization of HIV-infected women violates the human right to found a family, as well as the right to liberty and integrity of the person. Women should be provided with accurate information about the risk of perinatal transmission to support them in making voluntary, informed choices about reproduction. Thirdly, measures to ensure the equal rights of women within the family are necessary to enable women to negotiate safe sex with their husbands/partners or be able to leave the relationship if they cannot assert their rights. Finally, recognition of the family as the fundamental unit of society is undermined by policies which have the effect of denying family unity. In the case of migrants, many States do not allow migrants to be accompanied by family members, and the resulting isolation can increase vulnerability to HIV infection. In the case of refugees, mandatory testing as a precondition of asylum can result in HIV-positive family members being denied asylum while the rest of the family is granted asylum. In the USA, 30 states contemplated adoption of mandatory premarital HIV testing strategy, but it was finally adopted by only two states, Illinois and Louisiana. In these states it was implemented only for a brief period before it was repealed. Further the cost of detecting a single HIV-positive was

12. See Article 16 of the Universal Declaration of Human Rights.

13. People living with HIV should be able to marry and engage in sexual relations whose nature does not impose a risk of infection on their partners. People living with HIV, like all people who know or suspect that they are HIV-positive, have a responsibility to practise abstinence or safer sex in order not to expose others to infection.

14. The chances of an HIV-infected woman giving birth to an HIV-positive baby is approximately 1 in 3. This rate may be significantly reduced if the woman is able to undergo pre-and post-natal treatment with antiretroviral. Since extremely difficult and complex ethical and personal decisions are involved, the choice to have a child should be left to the woman, with input from her partner, if possible.
huge and led to a jump in percentage of marriages that were solemnized in the surrounding states that did not have mandatory testing policy. In Thailand, particularly in Johor province, a similar policy was adopted, but its contribution in reducing HIV transmission at the community level is not established, given that other preventive measures are also being implemented on a large scale. In Ghana a number of churches implemented mandatory HIV testing for couples who were planning to marry, a decision that was condemned by the Ghana National Anti AIDS Commission. Consequently, these churches claimed that they have shifted to a policy of voluntary counseling and testing\textsuperscript{15}.

Advocates of mandatory HIV testing policies might back their argument with the “harm principle” which was put by 19\textsuperscript{th} century philosopher John Stuart Mill. It states, “The only purpose for which the power can rightfully be exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, both the physical and moral, is not sufficient warrant”\textsuperscript{16}. This principle, as it has also been used, might be very well applicable in control of epidemics of acute infectious diseases by testing and isolating, or quarantining individuals for brief periods of time, but may not be applicable to the epidemic of AIDS, that too in the present era of ever-increasing voices in support of human rights and respect for individual freedom and liberty. While it is not proven that mandatory premarital testing is really helpful in controlling the HIV epidemic, what is known for sure is the stigma and discrimination that an HIV-positive person faces throughout his or her lifetime. Would it be sufficient to harp on the “harm principle” for promoting mandatory premarital testing to prevent harm to others when maybe an equal or even greater harm may be caused to the infected person and even to his or her immediate family as a result. As long as the society at large does not accept a HIV-positive person in a positive manner, judge each HIV-positive person on a moral scale, and stigmatise and discriminate against them, maintenance of confidentiality of the HIV status of any person is of paramount importance.


\textsuperscript{16} See Mill JS. On liberty. Cambridge University Press; 1989

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FREEDOM OF EXPRESSION AND INFORMATION

Article 19 of the ICCPR states in part that “Everyone shall have the right to hold opinions without interference. ...Everyone shall have the right to freedom of expression; this right shall include the freedom to seek, receive and impart information and ideas of all kinds...”. This right, therefore, includes the right to seek, receive and impart HIV-related prevention and care information. Educational material which may necessarily involve detailed information about transmission risks and may target groups engaged in illegal behaviour, such as injecting drug use and sexual activity between the same sexes, where applicable, should not be wrongfully subject to censorship or obscenity laws or laws making those imparting the information liable for “aiding and abetting” criminal offences. States are obliged to ensure that appropriate and effective information on methods to prevent HIV transmission is developed and disseminated for use in different multicultural contexts and religious traditions. The media should be respectful of human rights and dignity, specifically the right to privacy, and use appropriate language when reporting on HIV. Media reporting on HIV should be accurate, factual, sensitive and avoid stereotyping and stigmatization.

FREEDOM OF ASSEMBLY AND ASSOCIATION

Article 20 of the Universal Declaration of Human Rights provides that “Everyone has the right to freedom of peaceful assembly and association”. This right has been frequently denied to non-governmental organizations working in the field of human rights, AIDS service organizations and community-based organizations with applications for registration being refused as a result of their perceived criticism of Governments or of the focus of some of their activities, e.g. sex work. In general, non-governmental organizations and their members involved in the field of human rights should enjoy the rights and freedoms recognized in human rights instruments and the protection of national law. In the context of HIV/AIDS, the freedom of assembly and association with others is essential to the formation of HIV related advocacy, lobby and self-help groups to represent interests and meet the needs of various groups affected by HIV/AIDS, including people living with HIV. Public health and an effective response to HIV/AIDS are
undermined by obstructing interaction and dialogue with such groups, other social actors, civil society and the Government. Furthermore, PLHAs should be protected against direct or indirect discrimination based on HIV status in their admission to organizations of employers or trade unions, continuation as members and participation in their activities, in conformity with ILO instruments on freedom of association and collective bargaining. At the same time, workers’ and employers’ organizations can be important factors in raising awareness on issues connected with HIV/AIDS and in dealing with its consequences in the workplace.

FREEDOM FROM CRUEL, INHUMAN OR DEGRADING TREATMENT OR PUNISHMENT

The right to freedom from cruel, inhuman or degrading treatment or punishment can arise in a variety of ways in the context of HIV, for example in the treatment of prisoners. In particular, the State, through prison authorities, owes a duty of care to prisoners, including the duty to protect the rights to life and to health of all persons in custody. Denial to prisoners of access to HIV-related information, education and means of prevention (bleach, condoms, clean injection equipment), voluntary testing and counselling, confidentiality and HIV-related health care and access to and voluntary participation in treatment trials, could constitute cruel, inhuman or degrading treatment or punishment. The duty of care also comprises a duty to combat prison rape and other forms of sexual victimization that may result, inter alia, in HIV transmission. Thus, all prisoners engaging in dangerous behaviour, including rape and sexual coercion, should be subjected to discipline based on their behaviour, without reference to their HIV status. There is no public health or security justification for mandatory HIV testing of prisoners, nor for denying inmates living with HIV access to all activities available to the rest of the prison population. Furthermore, the only justification for segregation of people living with HIV from the prison population would be for the health of themselves. Prisoners with terminal diseases, including AIDS, should be considered for early release and given proper treatment outside prison.
RIGHT TO WORK

“Everyone has the right to work...[and] to just and favourable conditions of work”. The right to work entails the right of every person to access to employment without any precondition except the necessary occupational qualifications. This right is violated when an applicant or employee is required to undergo mandatory testing for HIV and is refused employment or dismissed or refused access to employee benefits on the grounds of a positive result. States should ensure that PLHAs are allowed to work as long as they can carry out the functions of the job. Thereafter, as with any other illness, people living with HIV should be provided with reasonable accommodation to be able to continue working as long as possible and, when no longer able to work, be given equal access to existing sickness and disability schemes. The applicant or employee should not be required to disclose his or her HIV status to the employer nor in connection with his or her access to workers’ compensation, pension benefits and health insurance schemes. States’ obligations to prevent all forms of discrimination in the workplace, including on the grounds of HIV, should extend to the private sector also. As part of favourable conditions of work, all employees have the right to safe and healthy working conditions. “In the vast majority of occupations and occupational 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 possibility of transmission does exist in the workplace, such as in health-care settings, States should take measures to minimize the risk of transmission. In particular, workers in the health sector must be properly trained in universal precautions for the avoidance of transmission of infection and be supplied with the means to implement such procedures.

RIGHT TO ENJOY THE BENEFITS OF SCIENTIFIC PROGRESS AND ITS APPLICATIONS

The right to enjoy the benefits of scientific progress and its applications is important in the context of HIV in view of the rapid and continuing advances regarding testing, treatment therapies and the development of a vaccine. More

17. As stated under Article 23. of the Universal Declaration of Human Rights.

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basic scientific advances which are relevant to HIV concern are, the safety of the blood supply from HIV infection and the use of universal precautions which prevent the transmission of HIV in various settings, including that of health care. In this connection, however, developing countries experience severe resource constraints which limit not only the availability of such scientific benefits but also the availability of basic pain prophylaxis and antibiotics for the treatment of HIV related conditions. Furthermore, disadvantaged and marginalized groups within societies may have no or limited access to available HIV related treatments or to participate in clinical trials. Of deep concern is the need to share equitably among States and among all groups within States basic drugs and treatment, as well as the more expensive and complicated treatment therapies, where possible.

RIGHT TO SEEK AND ENJOY ASYLUM

Everyone has the right to seek and enjoy asylum from persecution in other countries. Under the 1951 Convention relating to the Status of Refugees and under customary international law, States cannot, in accordance with the principle of non-refoulement, (forcible return) return a refugee to a country where she or he faces persecution. Thus, States may not return a refugee to his country on the basis of his or her HIV status. Furthermore, where the treatment of people living with HIV can be said to amount to persecution, it can provide a basis for qualifying for refugee status. The United Nations High Commissioner for Refugees issued policy guidelines in March 1988 which state that refugees and asylum seekers should not be targeted for special measures regarding HIV infection and that there is no justification for screening being used to exclude HIV-positive individuals from being granted asylum.\(^{19}\)

The Human Rights Committee has confirmed that the right to equal protection of the law prohibits discrimination in law or in practice in any fields regulated and protected by public authorities.\(^{20}\) These would include travel regulations, entry requirements, immigration and asylum procedures. Therefore, although there is no right of aliens to enter a foreign country or to be granted asylum in any particular country, discrimination on the grounds of

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19. See UNHCR Health Policy on AIDS, 15 February 1988 (UNHCR/IDM)
20. See Human Rights Committee, General Comment No. 18 (37).
HIV status in the context of travel regulations, entry requirements, immigration and asylum procedures would violate the right to equality before the law.

RIGHT TO PARTICIPATION IN POLITICAL AND CULTURAL LIFE

Realization of the right to take part in the conduct of public affairs, as well as in cultural life, also guarantees the participation by those most affected by HIV in the development and implementation of HIV-related policies and programmes. These human rights are reinforced by the principles of participatory democracy; this assumes the involvement of people living with HIV and their families, women, children and groups vulnerable to HIV in designing and implementing programmes that will be most effective by being tailored to the specific needs of these groups. It is essential that PLHAs remain fully integrated in the political, economic, social and cultural aspects of community life. People living with HIV have the right to their cultural identity and to various forms of creativity, both as a means of artistic expression and as a therapeutic activity. Increasing recognition has been given to the expression of creativity as a popular medium for imparting HIV information, combating intolerance, and as a therapeutic form of solidarity.

RIGHT TO EDUCATION

Article 26 of the Universal Declaration of Human Rights states in part that “Everyone has the right to education. Education shall be directed to the full development of the human personality and to the strengthening of respect for human rights and fundamental freedoms. It shall promote understanding, tolerance and friendship...”. This right includes three broad components which apply in the context of HIV/AIDS. Firstly, both children and adults have the right to receive HIV-related education, particularly regarding prevention and care. Access to education concerning HIV is an essential life-saving component of effective prevention and care programmes. It is the State’s obligation to ensure, in every cultural and religious tradition, that appropriate means are found so that effective HIV information is included in educational programmes inside and outside schools. The provision of

education and information to children should not be considered as promoting early sexual experimentation; rather, as studies indicate, it delays sexual activity.23

Secondly, States should ensure that both children and adults living with HIV are not discriminatorily denied access to education, including access to schools, universities, scholarships and international education or subject to restrictions because of their HIV status. There is no public health rationale for such measures since there is no risk of transmitting HIV casually in educational settings. Thirdly, States should, through education, promote understanding, respect, tolerance and non-discrimination in relation to persons living with HIV/AIDS.

HUMAN RIGHTS OF WOMEN: GENDER EQUALITY

Discrimination against women, de facto and de jure, renders them disproportionately vulnerable to HIV/AIDS. Women’s subordination in the family and in public life is one of the root causes of the rapidly increasing rate of infection among women. Systematic discrimination based on gender also impairs women’s ability to deal with the consequences of their own infection and/or infection in the family, in social, economic and personal terms.24 With regard to prevention of infection, the rights of women and girls to the highest attainable standard of physical and mental health, to education, to freedom of expression, to freely receive and impart information, should be applied to include equal access to HIV/AIDS related information, education, means of prevention and health services. However, even when such information and services are available, women and girls are often unable to negotiate safer sex or to avoid HIV-related consequences of the sexual practices of their husbands or partners as a result of social and sexual subordination, economic dependence on a relationship and cultural attitudes. The protection of the sexual and reproductive rights of women and girls is, therefore, critical. This includes the rights of women to have control over and to decide freely and


responsibly, free of coercion, discrimination and violence, on matters related to their sexuality, including sexual and reproductive health. Measures for the elimination of sexual violence and coercion against women in the family and in public life not only protect women from human rights violations but also from HIV infection that may result from such violations. States have an obligation to protect women from sexual violence in both public and private life. The various UN standards like DEDAW, CEDAW and agencies like UNIFEM are primarily concerned with reducing women’s vulnerability to HIV/AIDS.

The DEDAW is a human rights proclamation issued by the United Nations General Assembly, outlining views on women’s rights. The Declaration was an important precursor to the legally binding CEDAW. The CEDAW is often described as an international Bill of Rights for women. The Convention defines discrimination against women as “any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.” The Committee on the Elimination of Discrimination against Women, which monitors the Convention has underscored the link between women’s reproductive role, their subordinate social position and their increased vulnerability to HIV infection. The Committee urges the state parties to strengthen attention to the gender dimensions in its efforts to combat the HIV/AIDS epidemic. It calls on the state party to increase its emphasis on men’s responsibilities in preventing the spread of the disease, including through awareness-raising and prevention campaigns, and the implementation of education programmes on sexual and reproductive health and rights directed at both women and men, including provision of condoms. It also urges the State parties to increase the minimum

26. The Declaration on Elimination of Discrimination against Women, Adopted on December 18, 1979 by the UN General Assembly through resolution no. 34/180.
27. The Convention on Elimination of all forms of Discrimination against Women.
age of sexual consent to protect girls effectively against sexual exploitation which explicitly helps in reversing the spread of HIV/AIDS.\footnote{Comments of the CEDAW, Combined third, fourth, fifth and sixth periodic report at its 689th and 690th meeting on 8th July 2005 (See CEDAW/C/SR/689 and 690).}

Furthermore, in order to empower women to leave relationships or employment which threaten them with HIV infection and to cope with it if they or their family members are infected with HIV, States should ensure women’s rights to, inter alia, legal capacity and equality within the family, in matters such as divorce, inheritance, child custody, property and employment rights, in particular equal remuneration of men and women for work of equal value, equal access to responsible positions, measures to reduce conflicts between professional and family responsibilities and protection against sexual harassment at the workplace. Women should also be enabled to enjoy equal access to economic resources, including credit, an adequate standard of living, participation in public and political life and to benefits of scientific and technological progress so as to minimize risk of HIV infection.

HIV prevention and care for women are often undermined by pervasive misconceptions about HIV transmission and epidemiology. There is a tendency to stigmatize women as “vectors of disease”, irrespective of the source of infection. As a consequence, women who are or are perceived to be HIV positive face violence and discrimination in both public and private life. Many HIV programmes targeting women are focused on pregnant women but these programmes often emphasize coercive measures directed towards the risk of transmitting HIV to the foetus, such as mandatory pre-natal and post-natal testing followed by coerced abortion or sterilization. Such programmes seldom empower women to prevent perinatal transmission by prenatal prevention education and an available choice of health services and overlook the care needs of women.

HUMAN RIGHTS OF CHILDREN
The rights of children are protected by all international human rights instruments and, in particular, under the Convention on the Rights of the Child, which establishes an international definition of the child as “every human being below the age of eighteen years unless under the law applicable
to the child, majority is attained earlier.” The Convention reaffirms that children are entitled to many of the rights that protect adults (e.g. the rights to life, non-discrimination, integrity of the person, liberty and security, privacy, asylum, expression, association and assembly, education and health), in addition to particular rights for children established by the Convention.

Many of these rights are relevant to HIV prevention, care and support for children, such as freedom from trafficking, prostitution, sexual exploitation and sexual abuse since sexual violence against children, among other things, increases their vulnerability to HIV/AIDS. The freedom to seek, receive and impart information and ideas of all kinds and the right to education provide children with the right to give and receive all HIV/AIDS related information needed to avoid infection and to cope with their status, if infected. The right to special protection and assistance of AIDS orphans, if deprived of his or her family environment, including alternative care and protection in adoption, in particular protects children if they are orphaned by HIV/AIDS. The right of disabled children to a full and decent life and to special care and the rights to abolition of traditional practices which are prejudicial to the health of children, such as early marriage, female genital mutilation, denial of equal sustenance and inheritance for girls are also highly relevant in the context of HIV. Under the Convention, the right to non-discrimination and privacy for children living with HIV and finally the rights of children to be actors in their own development and to express opinions and have them taken into account in making decisions about their lives should empower children to be involved in the design and implementation of HIV-related programmes for children.

The Role of International Human Rights Agencies in the context of HIV/AIDS

Various international agencies have identified the role of human rights jurisprudence as a comprehensive framework to address the underlying causes of HIV/AIDS related human rights abuses and issues. The agencies of UN family are engaged in helping the states to formulate laws and policies that integrate public health objectives and ethos of human rights standards.

32. See Article-1 of the Convention on the Rights of the Child.
The Joint United Nations Programme on HIV/AIDS or UNAIDS is the main advocate which anchors accelerated, comprehensive and coordinated global action on the HIV/AIDS. The mandate of the UNAIDS is to ensure universal enjoyment of all human rights, to remove obstacles to their effective implementation, and to enhance coordination and cooperation of human rights and HIV/AIDS related activities. It endeavours to contribute to an effective and sustainable response to the epidemic by raising awareness and understanding of the human rights dimensions of HIV/AIDS and by strengthening capacities to address HIV/AIDS related human rights issues at the national and international levels. For this together with OHCHR, UNAIDS works in close collaboration with its cosponsors-UNDP, UNICEF, WHO and ILO to streamline activities in the field of HIV/AIDS and human rights. It has also worked for strengthening the capacity and promoting the advocacy at the global and regional levels to address HIV/AIDS related human rights issues. Realizing that successes in responding to HIV/AIDS can reach the required scale only if the efforts in this field are underpinned by legal and social environments which advances human rights, gender equality and social justice goals, the UNAIDS in collaboration with UNDP launched the Global Commission on HIV and the Law, 2010. The objective of the Commission is to understand the role played by the law in facilitating universal access to HIV/AIDS prevention and treatment. The Commission is charged with developing “actionable and evidence-informed recommendations” to create national legal environments with effective and efficient HIV/AIDS responses.

The United Nations Commission on Human Rights was the principal mechanism and international forum concerned with the promotion and protection of human rights, until it was replaced by the UN Human Rights Council in 2006. The UNHRC examines, monitors and publicly report on human rights situations in various countries. It expertise in areas concerning the prevention of discrimination of any kind relating to human rights and

33. The UNAIDS was established in 1994 by a resolution of United Nations Economic and Social Council. It was launched in January, 1996. UNAIDS is guided by a Programme Coordinating Board with representatives of 22 Governments from all geographic regions, the UNAIDS co-sponsors and 5 representatives of NGO’s including associations of PLHAs. It is headquartered in Geneva.
34. The UNCHR was established on 10 December 1946. It was a body created under the United Nations Charter, specifically under Article 68. On 15 March 2006, the United Nations General Assembly voted overwhelmingly to replace UNCHR with UN Human Rights Council.
35. Hereinafter to be referred as UNHRC.
fundamental freedoms and the protection of racial, national, religious and linguistic minorities.

The mandate of the UNHRC is to ensure universal enjoyment of all human rights, to remove obstacles to their effective implementation, and to enhance coordination and cooperation of human rights related activities throughout the United Nation system. As human rights are intimately linked with the spread and impact of HIV/AIDS, UNHRC endeavours to contribute to an effective and sustainable response to the epidemic by raising awareness and understanding of the human rights dimensions of HIV/AIDS and by strengthening capacities to address HIV/AIDS related human rights issues at the national and international levels. In addition, UNHRC has, for several years, worked in close collaboration with UNAIDS and OHCHR towards the promotion and protection of human rights in the context of HIV/AIDS. The UNHRC, UNAIDS and OHCHR agreed to strengthen their cooperation in order to streamline activities in the field of HIV/AIDS and human rights. Key objectives of this ongoing collaboration includes the integration of HIV/AIDS issues into the work of the United Nations human rights machinery and ensuring the response of other UN agencies to programmes on the HIV/AIDS epidemic. Also to strengthen capacity at the national and regional level to address HIV/AIDS related human rights issues. OHCHR has made progress towards these objectives, in particular by supporting the work of the UNHRC and its special rapporteurs, the UN treaty bodies, national human rights institutions, as well as mainstreaming issues within the broader UN system.

The UNHRC (and before it the Commission on Human Rights) has long considered the impact of HIV/AIDS on human rights and, since 1996, has addressed the HIV/AIDS issue as part of its formal agenda. At present the Council regularly adopts two resolutions which focus on the epidemic: an annual resolution focusing on access to medication in pandemics, and a biennial resolution addressing the protection of human rights in the context of HIV/AIDS. As part of its continuing mandate, UNHRC prepares the Secretary-General’s reports on measures taken by member States and other bodies to implement both these resolutions. The UNHRC provides regular

briefings, together with UNAIDS, to the human rights treaty bodies with information on the background and status of the epidemic in priority countries; analysis of the links between HIV/AIDS and the core international human rights treaties; and identifications of particular issues of concern. OHCHR has provided support to the Committee on the Rights of the Child in developing a General Comment on HIV/AIDS and the Rights of the Child, as well as the General Comment on Adolescent Health and Development. Evidence of progress can be found in the increased attention paid by UN human rights treaty bodies to HIV/AIDS related issues, most notably in the increased references to HIV/AIDS in concluding observations and recommendations in States parties to the treaties.

The UNCHR together with OHCHR accords priority to the establishment and strengthening of national human rights institutions in accordance with the relevant international standards. The council has also drawn the attention of the broader UN System to the human rights dimensions of HIV/AIDS. It has contributed to the integration of a human rights perspective into the work of other UN agencies and programme. For example, it has recently developed a fact sheet on HIV/AIDS, gender and human rights for the Inter-Agency Task Team on Gender and HIV/AIDS. UNHRC is committed in its efforts to ensure a rights-based response to the HIV/AIDS epidemic. In addition to these activities, UNHRC, UNAIDS and OHCHR have identified key programming priorities like, promoting the further understanding and implementation of human rights in the context of HIV/AIDS, including by effective dissemination of the International Guidelines on HIV/AIDS and Human Rights, and Revised Guideline 6 on access to prevention, treatment, care and support, and strengthening capacity at the national level to address, HIV/AIDS related human rights issues. To achieve these priorities the Council, UNAIDS and OHCHR ensure that additional activities like producing a user-friendly version of the International Guidelines on HIV/AIDS and Human Rights and disseminating it widely to be undertaken.

The agencies have paid considerable attention on strengthening the focus on HIV/AIDS related human rights issues within mandates and activities of national human rights institutions, including development of a handbook as
referred to above. Also by gathering and publishing a compilation of practical case studies and fact sheets that highlight how HIV/AIDS related human rights can be addressed at the national level and operationalizing country level joint activities between UNCHR, UNAIDS and OHCHR.

The WHO\textsuperscript{37} takes the lead within the UNAIDS family on the global health sector response to HIV. To ensure a comprehensive and sustainable response to the epidemic, it provides evidence-based, technical support to states to help them scaling up HIV treatment, care and prevention services, as well as for maintaining and increasing access to drugs and diagnostics. For this the Programme staff works in collaboration with other UN agencies, Ministries of Health, development agencies, non-governmental organizations, health services providers, health-care institutions, PLHAs, and other partners. Working with six regional offices and 193 countries, the WHO HIV/AIDS programme focuses on five strategic directions to enable people to know their HIV status; maximize the health sector’s contribution to HIV prevention; accelerate the scale of HIV treatment and care; strengthen and expand health systems and invest in strategic information to better inform the HIV response. This programme is closely linked to the sexual and reproductive health; tuberculosis; blood safety; child and adolescent health; essential drugs and medicines; disease surveillance; mental health; vaccine and microbicide development; gender and women’s health; health education and substance dependence programmes. The World Health Organization has been advocating for bringing down barriers between people who were infected and those who were not infected and placing actual barriers (like condoms) between individuals and the virus. The World Health Assembly passed a resolution\textsuperscript{38} entitled “Avoidance of discrimination in relation to HIV infected people and people with AIDS”, which underlined that respect for human rights is vital for the success of national AIDS prevention and control programmes. It urge the member states to avoid discriminatory action in the provision of services, employment and travel. The first International Consultation on AIDS and

\textsuperscript{37} When diplomats first met to form the United Nations in 1945 one of the things they discussed was the setting up a global health organization, WHO’s contribution came into force on 7th April 1948- a date we now celebrate every year as World Health Day.

\textsuperscript{38} See Resolution WHA41.24 on 13 May 1988.
Human Rights recognized that there is no public health rationale for measures which arbitrarily limit individual rights, such as mandatory screening. In 1990, the WHO conducted regional workshops on the legal and ethical aspects of HIV/AIDS at Seoul, Brazil and New Delhi. These workshops developed guidelines to evaluate the current and elaborate the future legal measures for the control of HIV to be used as a check-list by countries considering legal policy issues. In August 2008, the WHO organized the International AIDS conference in Mexico city which brought together some 25,000 scientists, government representatives, health workers, activists, corporate leaders and PLHAs. It was an opportunity to share new scientific research and engage in dialogue concerning the global response to HIV/AIDS.

Beyond the suffering HIV/AIDS imposes on individuals and their families, the epidemic is profoundly affecting the social and economic fabric of societies. It is a major threat to the world of work as it affects the most productive segment of the labour force by reducing their earnings. It is imposing huge costs on enterprises through declining productivity, increasing labour costs and loss of skills and experience. In addition, HIV/AIDS is affecting fundamental rights at work, particularly in context of discrimination and stigmatization aimed at workers and people living with and affected by HIV/AIDS. The epidemic and its impact strike hardest at vulnerable groups including women and children, thereby increasing existing gender inequalities and exacerbating the problem of child labour. While there is no International Labour Convention that specifically addresses the issue of HIV/AIDS at the workplace, many instruments exist which cover both protection against discrimination and prevention of infection, and these can be and have been used. A group of eight ILO core Conventions define basic human rights at work.

39. It was organized by UNCHR in cooperation with the WHO in July 1989.
41. See WHO Document RS/90/GE/11(KOR).
42. The International AIDS Conference, 3-8 August, 2008. It is held very two years and WHO takes lead in coordinating it within the UN system.
43. Discrimination (Employment and Occupation) Convention 1958 (No.111). This is one of the eight fundamental conventions of the ILO. The others are: Occupational Safety and Health Convention 1981 (No.155), Occupational Health Services Convention 1985 (No.161), Termination of Employment Convention, 1982 (No.158), Vocational Rehabilitation and Employment (Disabled persons) Convention, 1983 (No.159), Social Security (Minimum Standards) Convention, 1952 (No.102),
Out of these, Discrimination (Employment and Occupation) Convention, No.111 is of particular importance in handling the issues of HIV/AIDS. It prohibits any “distinction, exclusion or preference which has the effect of impairing equality of opportunity or treatment in access to employment, training, promotion processes, security of tenure, remuneration, conditions of work, occupational safety and health measures and social security benefits.” It lists seven grounds of banned discrimination—race, color, sex, religion, political opinion, national extraction and social origin. The definition of discrimination contained in Convention does not refer to HIV status, since it was adopted well before the epidemic occurred. However as it is clear from Article 1(b), a government can choose to include other kinds of discrimination in its national policy to eliminate discrimination after consulting representative workers and employers organizations. So it could include the principle of non-discrimination on the grounds of HIV status in the policy. The UN Commission on Human Rights has affirmed in its Resolution 49/1999 that:

“Discrimination on the basis of HIV or AIDS status, actual or presumed, is prohibited by existing international human rights standards and … the term ‘or other status’ in non-discrimination provisions in international human rights texts should be interpreted to cover health status, including HIV/AIDS.” It should be noted that Convention No.111 does not mean that all workers always have to be treated equally, or in the same way. Sometimes treating workers differently is allowed—in a positive way. Special measures are permitted when they are designed to meet the particular requirements of someone who needs special assistance. Treating such workers differently is not deemed to be discrimination.45

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Labour Inspection Convention, 1947 (No.81) and Labour Inspection (Agriculture) Convention, 1969 (No.129).

44. The eight core Conventions are: The Forced labour Convention, 1930 (No.29); Freedom of Association and Protection of the Right to Organize, 1948 (No.87); Right to Organize and Collective Bargaining, 1949 (No. 98); Equal Remuneration Convention, 1951 (No.100); Abolition of Forced Labour Convention, 1957(No. 105); Discrimination (Employment and Occupation) Convention 1958 (No. 111); Minimum Age Convention, 1973 (No. 138) and the Worst forms of Child Labour Convention, 1999 (No.182).

45. This Convention, one of the eight which have been designated as core labour Convention, is a key text on the issue of discrimination at work. As well as defining discrimination, the Convention requires states which ratify to it, declare and pursue a national policy designed to promote, by methods appropriate to national conditions and practice. Equality of opportunity and treatment in respect of employment and occupation, with a view to eliminate any discrimination in respect thereof. The Convention has been ratified by 154 ILO member States.
In 1998, the International Labour Conference adopted the ILO Declaration of Fundamental Principles and Rights at Work and its Follow Up. The declaration recognizes that all states, by their membership in the ILO, have an obligation to respect, promote and put into practice in accordance with the Constitution, the principles concerning the fundamental rights which are the subject of the core Conventions. All these Conventions help to secure conditions of decent work in the face of a major humanitarian and development crisis. Already, valuable lessons have been learned in attempting to deal with the crisis globally. A few countries have achieved a degree of success in slowing down the spread of the infection and mitigating its impact on individuals and their communities in socio-economic and legal context. The code is a forward-looking and pioneering document which addresses present problems and anticipates future consequences of the epidemic and its impact on the world of work. Through this code, the ILO is increasing its support for international and national commitments to protect the rights and dignity of workers and all PLHAs.

The ILO estimates that over 20 million workers globally are living with HIV/AIDS. The size of the labour force in high-prevalence countries will be between 10 and 30 percent smaller by 2020 than it would have been without AIDS. Therefore the ILO is committed to making a strong statement through a Code of Practice on HIV/AIDS and the World of Work. It is instrumental in helping to prevent the spread of the epidemic, mitigate its impact on workers and their families and provide social protection to help cope with the disease. It covers key principles, such as the recognition of HIV/AIDS as a workplace issue, non-discrimination in employment, gender equality, screening and confidentiality, social dialogue, prevention and care and support, as the basis for addressing the epidemic in the workplace. It provides invaluable practical guidance to policy-makers, employers and workers organizations and other social partners for formulating and implementing appropriate workplace policy, prevention and care programmes, and for establishing strategies to address workers in the informal sector.

47. According to the ILO Director General’s report to the International Labour Conference in 1991, the term “informal sector” is understood to refer to very small scale units producing and distributing goods for sale in the market.
code is an important ILO contribution to the global effort to fight HIV/AIDS as it establishes the following ten fundamental principles for policies at all levels, and practical guidance for workplace programmes.

**Recognition of HIV/AIDS as a workplace issue:** HIV/AIDS is a workplace issue because it affects both workers and enterprises—cutting the workforce, increasing labour costs and reducing productivity. It should be treated like any other serious illness/condition in the workplace. This statement aims to counter discrimination and also the fears and myths that surround HIV/AIDS. The workplace has a role to play in the wider struggle to limit the spread and effects of the epidemic—especially those on prevention, training, and care.

**Non-discrimination:** Non-discrimination is a fundamental principle of the ILO and is at the heart of the ILO’s response to the epidemic. The principle of non-discrimination extends to employment status, recognized dependants, and access to health insurance, pension funds and other staff entitlements. Discrimination and stigmatization of people living with HIV/AIDS inhibits efforts aimed at promoting HIV/AIDS prevention: if people are frightened of the possibility of discrimination, they will probably conceal their status and are more likely to pass on the infection to others. Moreover they will not seek treatment and counselling.

**Gender Equality:** One of the main reasons for quick spread of HIV is gender inequality. The rate of new infections is increasing among women in most regions, and women tend to become infected at a younger age than men. A number of studies in Africa shows that girls aged 15-19 are five to six times more likely to be HIV-positive than boys of the same age group—for biological and cultural reasons. Women are also more likely than men to be involved in
caring for those who have the disease, or caring for orphans. It is therefore important that HIV/AIDS programmes respond to the circumstances and needs of men and women separately as well as together—both in terms of prevention and social protection to mitigate the impact of the epidemic.

**Healthy work environment:** In accordance with the provisions of the Occupational Safety and Health Convention 1981 the work environment should be healthy and safe, so far as is practicable, for all concerned parties. This includes the responsibility for employers to provide information and education on HIV transmission, and appropriate first aid provisions in the event of an accident. It does not however, give employers the right to test employees in the interest of public health, because casual contact at the workplace presents no risk of HIV transmission. A healthy work environment facilitates adaption of work to the capabilities of workers in the light of their physical and mental health—thereby mitigating the impact of HIV/AIDS on workers and enterprise alike.

**Social dialogue:** The successful implementation of an HIV/AIDS policy and programme requires co-operation and trust between employers, workers and their representatives and government where appropriate—this is not only fundamental to the way the ILO works, but is very practical also as any policy is more likely to be implemented effectively if it has been developed with the full participation of all concerned parties. Emphasis is also given to the leadership role of employers and workers organizations in breaking the silence around AIDS and promoting action.

**No screening for purpose of exclusion from employment or work process:** HIV/AIDS screening should not be required of job applicants or persons in employment. Compulsory HIV testing not only violates the right to confidentiality but is also impractical and unnecessary. At best, an HIV test result is a “snapshot” of someone’s infection status today. It’s no guarantee that he or she will not become infected tomorrow, or next month. It should also be remembered that people with HIV may remain perfectly fit and healthy for many years.

**Confidentiality:** There is no justification for asking job applicants or workers to disclose HIV-related personal information. Nor should co-workers be obliged to reveal such personal information about fellow workers. The right to
confidentiality doesn’t, of course, only apply to HIV/AIDS. Rules of confidentiality have been established in the ILO Code of Practice on the protection of workers’ personal data, 1997.

**Continuation of employment relationship:** HIV infection is not a cause for termination of employment. As with many other conditions, persons with HIV-related illness should be encouraged to work for as long as medically fit in available, appropriate work. This principle is based on the fact that being HIV-positive is not the same as having AIDS and related infections. Workers infected by HIV can, in most cases, carry on at their jobs for a number of years. It benefits the enterprise as well as the worker if she or he can be helped to work as for long as medically fit. Reasonable accommodation to help workers continue in employment can include rearrangement of working time, special equipment, opportunities for rest breaks, time off for medical appointments, flexible sick leave, part-time work and return-to-work arrangements.

**Prevention:** HIV infection is preventable. Prevention of all means of transmission can be achieved through a variety of strategies. Prevention is not simply a matter of providing a few posters, leaflets, or talks. A climate for prevention needs to be created, including an open discussion of relevant issues and respect for human rights. Measures for prevention include a combination of information, participatory education, practical support for behaviour change such as condom distribution, treatment for sexually transmitted infections, and the promotion of voluntary counseling and testing where available.

**Care and support:** Solidarity, care and support should guide the response to HIV/AIDS in the world of work. Prevention, care and treatment should be seen as a continuum rather than separate elements of a workplace programme. The availability of treatment encourages confidential voluntary testing, making it easier to provide care and encouraging prevention. Care and support includes the provision of voluntary testing and counseling, treatment for opportunistic infections—especially TB—and antiretroviral therapy where affordable, workplace accommodation, employee and family assistance programmes, and access to benefits from health insurance and occupational schemes.
Across the world, HIV/AIDS threatens the lives and rights of women, severely restricting their hope for development. This sets the stage for both individual suffering and social and economic decline. The picture is made more complex by gender inequality, poverty and blatant violations of human rights without tackling these issues, overall efforts to address the epidemic will be futile. Therefore the United Nation family, has shown great fortitude through its co-sponsor UNIFEM which brings gender equality and human rights perspectives to its work on women and HIV/AIDS. It focuses on enhancing HIV/AIDS policies and translating them into effective strategies on the ground. In a number of countries, HIV-positive women have taken a leading role in HIV/AIDS advocacy by forming networks that provide a strong platform for their voices to be heard. UNIFEM has purposefully sought out and supported these groups, which pool the collective experiences of women who know firsthand the issues they face and the support they need. The positive women create a network that sends representatives to attend government policy sessions on HIV/AIDS, advise public health providers on how to make services accessible and friendly to women, and participate in the national programming deliberations for grants from the Global Fund on AIDS, tuberculosis and malaria.

In partnership with UNAIDS, UNIFEM has launched the Gender and HIV/AIDS Web Portal. The portal features current research, multimedia materials and toolkits, and is designed for community activities, government officials, development practitioners and journalists. For nearly three decades, HIV/AIDS have been devastating individuals and families with the tragedy of untimely death and medical, financial and social burdens. Although children's concerns have always been present within the great spectrum of need associated with HIV, they have to some extent been overshadowed by the very scale of the epidemic in the adult population. Thanks to UNICEF’s evidence and accelerated action, the story of how the HIV/AIDS epidemic is affecting children is being rewritten. No longer a sidebar, children are now central to strategies and actions to avert and address the consequences of the epidemic.

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48. UNIFEM is a women’s fund at the UN. It provides financial and technical assistance to innovative programmes, strategies to foster women's empowerment and gender equality.

49. UNICEF was created by the UN General Assembly on December 11, 1946 to provide emergency food and health care to children in countries devastated by World War-II. Headquartered in New York, UNICEF became a permanent number of United Nations System in 1953.
is estimated that more than 1,000 babies continue to be born with HIV every day, many of them destined to die before age two if they do not receive medication.

Unite For Children, United Against AIDS is a global campaign launched by UNICEF in 2005 to raise awareness of the plight of children globally in relation to HIV/AIDS and to spur action. The priority areas of the campaign is preventing mother-to-child transmission, providing paediatric and young people, and protecting and supporting children affected by HIV/AIDS and integrating interventions into existing system without losing the capacity to address the specific needs of children affected by HIV/AIDS is a challenge.

Due to UNICEF’s remarkable progress in providing HIV prevention services, virtual elimination of mother-to-child, or vertical transmission of HIV by 2015 has now become a reachable goal. For many countries in Eastern and Southern Africa, Latin America, East Asia, and Central and Eastern Europe. Global initiatives to improve maternal and child health outcomes related to Millennium Development Goals 4, 5 and 6 such as the Secretary-General’s Global Strategy for Women’s and Children’s Health, launched in September, 2010 and the ’H4+’ Commitment by WHO, UNICEF, and UNAIDS to reduce maternal and newborn mortality in the most affected countries highlight prevention of MTCT as a priority, particularly in countries with a high HIV burden.

One innovation expected to expand the use of more efficacious regimens for MTCT is the mother baby pack. Developed by UNICEF, WHO and other partners, the pack contains ARVs for women, nevirapine syrup for infants for six weeks and the antibiotic contrimoxazole for mothers and infants; it is intended for use in communities where delivery is frequently at home or outside of health facilities. UNICEF is leading a review of vulnerability indicators for orphans and vulnerable children, to identify robust measures that can be tracked over time in different contexts. UNICEF led research50 into the factors contributing to child vulnerability has found that social protection can contribute to more equitable development outcomes by reducing the poverty and social exclusion of households and children affected

by the epidemic. It can also contribute to more equitable health outcomes by reducing structural inequalities that drive the epidemic, such as gender inequalities, and helping overcome barriers to access to treatment.

Financial protection, including cash transfers, is one pillar of an effective social protection approach; initiatives to promote access to services and policies and legislation that promote more equitable outcomes and reduce social exclusion are others. These components of an AIDS sensitive social protection approach are taken from the UNAIDS business case for social protection developed by UNICEF and other UNAIDS co-sponsors.

Improving links between state and non-state actors involved in the response to orphans and vulnerable children, and between social welfare and health-sector responses, can improve vulnerable children's access to prevention, treatment and care services and ensure more equitable outcomes. In many African and Asian Countries, UNICEF is working to strengthen the capacity of district and local government and civil society organizations to plan, implement and manage a quality, comprehensive decentralized response to the needs of orphans and other vulnerable children. For instance the Government of Guyana, with support from UNICEF and PEPFAR, launched its first child protection agency in 2009, accompanied by new legislation and policies to protect children.

The UNICEF urges that the child protection systems also need to be strengthened to ensure the application of the United Nations Guidelines for the Alternative Care of Children, adopted by the General Assembly in December 2009. Building on the Convention on the Rights of the Child, the guidelines provide governments and other implementing and policy partners with a common reference point for establishing alternative care. Where alternative care is necessary, they reiterate the importance of providing the appropriate type of care in the best interests of the child. As a response to the global recognition that many child protection systems are not equipped to support the needs of vulnerable children and those affected by HIV/AIDS, UNICEF has recently developed a toolkit to map child protection systems.

In Eastern Europe and Central Asia, a culture of 'blame and banishment' is fuelling an underground HIV epidemic among children and young people at society's margins: children living with HIV, adolescents
engaged in risky behaviours, pregnant women using drugs and the more than 1 million children and young people who live or work on the streets. The UNICEF Report: Blame and Banishment, 2010 has set out the issues faced by these marginalized populations and found that in a regions where health structures and law enforcement are following a legacy of authoritarianism and control, meeting the needs and respecting the rights of these children and young people is challenging.

With a view to prevent HIV infection among adolescents and young people, the UNICEF, UNESCO, UNAIDS and WHO developed the International Technical guidance on Sexuality Education. It is an important resource for schools, teachers and health educators working with young people to provide them with comprehensive knowledge of HIV/AIDS. The guidance was released in 2009 as two volumes, one provides evidence of positive impact of quality sexuality education and key sexual behaviours and the other focuses on content.\textsuperscript{51}

Significant developments have taken place with regard to the right to health and access to HIV related prevention, treatment, care and support, including advances in the availability of diagnostic tests and HIV related treatments, including antiretroviral therapies. There have been increased commitments at the international, regional and domestic levels towards the full realization of all human rights related to HIV, including improved access to health services for people living with HIV/AIDS. Key among these are: the Declaration of Commitment on HIV/AIDS,\textsuperscript{52} the Millennium Development Goals,\textsuperscript{53} General Comment 14 of the Committee on Economic, Social and Cultural Rights,\textsuperscript{54} and the Commission on Human Rights resolutions on the right to the highest attainable standard of health and access to medication.\textsuperscript{55}

In June 2001, a historic U.N. General Assembly Special on HIV/AIDS for the first time generated global acknowledgement of the pandemic as not only a public health crisis but also a threat to societies and international

\textsuperscript{52} Declaration of Commitment on HIV/AIDS (‘Global Crisis—Global Action’), General Assembly Resolution S-26/2 of 27 June 2001
\textsuperscript{53} See United Nations Millennium Declaration, General Assembly Resolution 55/2 of 8 September 2000
\textsuperscript{54} See General Comment 14 on the right to the highest attainable standard of health, adopted on 11 May 2000 (E/C.12/2000/4).
security. The special session put virtually all of the world’s leaders on record as endorsing a set of specific global targets in combating HIV/AIDS, while its formal declaration explicitly underscored the links between poverty, underdevelopment, and illiteracy to the spread and impact of HIV/AIDS. It also recognized that stigma, silence, discrimination, and lack of confidentiality undermined prevention and care efforts, and that gender equality and the empowerment of women and girls were fundamental to reducing vulnerability.

The Declaration affirmed that access to medication in the context of pandemics such as HIV/AIDS was fundamental to the right to health. Specifically, states pledged 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 of people living with HIV/AIDS and members of vulnerable groups, in particular to ensure their access to inter alia, education, inheritance, employment, health care, social and health services, prevention, support and treatment, information and legal protection, while respecting their privacy and confidentiality; and develop strategies to combat stigma and social exclusion connected with the epidemic.

These efforts arguably increased the political will to address HIV/AIDS, and increased the allocation of resources committed to fighting the epidemic. In 2001, the Global Fund to fight HIV/AIDS, TB and Malaria was created. The same year, a revitalized WHO announced an ambitious plan to get three million people on anti-retroviral treatment by the end of 2005. But these declarations and commitments of new resources, while seeming to recognize the central importance of combating the human rights violations had a very limited practical impact. Scientific-based prevention programmes are increasingly being replaced by conservative, moralistic sexual abstinence campaigns that stigmatize those living with HIV/AIDS and still do not recognize critical obstacles that rights-based approaches would help overcome.

The available evidence underscores the extraordinary diversity between countries and regions in implementing the response envisioned in the Declaration of Commitment. While select countries have reached key targets and milestones for 2005, set out in the Declaration of Commitment, many countries have failed to fulfill the pledges specified in the Declaration. The report of the UN General Assembly provides an update on progress in the global AIDS response since the 2001 special session, identifies critical challenges that must be addressed and makes urgent recommendations to strengthen AIDS efforts at the global, regional and country levels. In more than 70 countries surveyed, utilization of testing, prevention programmes and counseling services quadrupled in the past five years from roughly 4 million in 2001 to 16.5 million in 2005. However stigma and discrimination against people infected as well as affected by HIV/AIDS still remains a serious obstacle to the success of HIV prevention programmes, including services for vulnerable populations and for preventing MTCT. The report states that according to over 30 civil society reports, stigma and discrimination against PLHAs is pervasive. Women typically experience the most severe forms of stigma and discrimination. Half of the countries submitting reports to UNAIDS noted the existence of policies that interfere with the accessibility and effectiveness of HIV related measures of stigmatized population. Legal systems in many countries also fail to provide adequate protection to children affected by HIV/AIDS and elderly caregivers. Several reports indicate, however, that many such national laws have not been implemented or rigorously enforced, often because of a lack of adequate budget allocations for human rights monitoring.

A new and forward-looking Political Declaration of HIV/AIDS was adopted unanimously by UN member States at the close of the United Nations General Assembly 2006. This High Level Meeting on AIDS provided a strong mandate to move the AIDS response forward, particularly with regard to scaling up towards universal access to HIV prevention, treatment, care and support. It reaffirms the 2001 Declaration of Commitment on HIV/AIDS and the Millennium Development Goals, in particular the goal to halt and begin to

58. See Resolution 60/224 of 2001
reverse the spread of AIDS by 2015. Key actions towards helping ensure an invigorated response to HIV/AIDS agreed by Member States include the calling for ambitious national targets, to be developed by countries as the world moves toward universal access to comprehensive prevention programmes, treatment, care and support and emphasizing the need to strengthen policy and programme linkages and coordination between AIDS, sexual and reproductive health, national development plans and strategies, including poverty eradication strategies, and to address, where appropriate, the impact of HIV/AIDS on national development plans and strategies; committing to an intensification of efforts to eliminate all forms of stigma and discrimination against people living with HIV and members of vulnerable groups, and to ensure their full enjoyment of all human rights and fundamental freedoms, in particular their access to comprehensive AIDS programmes; and finally pledging to promote access to HIV/AIDS education, information, voluntary counselling and testing and related services, with full protection of confidentiality and informed consent, and to promote social and legal environments that are safe for voluntary disclosure of HIV status.

Again to strengthen political will, engagement with the community, respect for human rights and mobilization of resources, the first Global Parliamentary meeting on AIDS was held in 2007 at Manila. The main aim of the event was to enhance the commitment and collaboration of parliaments worldwide as crucial stakeholders in the AIDS response. A High-level meeting on AIDS took place at the UN Headquarters in New York in 2008 which reviewed progress made in implementing the 2001 Declaration of Committee on HIV/AIDS and adopted the 2008 Political Declaration on HIV/AIDS.

The International Guidelines on HIV/AIDS and Human Rights

In 1996 an international expert consultation group convened by UNAIDS and the OHCHR prepared the “International Guidelines on HIV/AIDS and Human

59. Opened on Wednesday 28 November in Manila by Mr. Manny Villar, President of the Senate of the Philippines. Around 200 participants from around the world attended the three-day meeting which was been organized by the Inter-Parliamentary Union in cooperation with the Senate of the Philippines and in close collaboration with the United Nations Development Programme and the Secretariat of the UNAIDS.
Rights. These Guidelines developed out of the need to guide the states and other stakeholders on how to best promote, protect and fulfill human rights in the context of the HIV/AIDS epidemic. The Guidelines provide a comprehensive understanding of the complex relationship between the public health and the human rights rationale of HIV/AIDS. In particular, states could benefit from guidelines that outline clearly how human rights standards apply in the area of HIV/AIDS and indicate concrete and specific measures, both in terms of legislation and practice, that should be undertaken.

Due to persistent global disparity in access to treatment, as well as political and legal developments in 2002, OHCHR and the Executive Director of UNAIDS convened a Third International Consultation on HIV/AIDS and Human Rights to update guidelines. This document consolidates the original Guidelines with revised Guideline-6, together with its related commentary and recommendations for implementation. OHCHR has asked States to take all necessary steps to ensure the respect, protection and fulfillment of HIV/AIDS related human rights as contained in the Guidelines, and has urged States to ensure that their laws, policies and practices comply with the Guidelines. The content and philosophy of these guidelines are summarized below.

These Guidelines could be divided into three parts. The first part contains the Guidelines for State action comprising action-oriented measures to be employed by the Governments in the areas of law, administrative policy and practice that will protect human rights and achieve HIV-related public health goals; the second part provides the recommendations for dissemination and implementation of the Guidelines; and third part focuses on the international human rights obligations and HIV, as it describes the human rights principles underlying a positive response to HIV. The Guidelines recognize that States bring to the HIV epidemic different economic, social and cultural values, traditions and practices— a diversity which should be celebrated as a rich source for an effective response to HIV/AIDS. In order to benefit from this diversity, a process of participatory consultation and cooperation was undertaken in the drafting of the Guidelines, so that the

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61. It was held on 25-26 July 2002 in Geneva.
Guidelines reflect the experience of people affected by the epidemic, address relevant needs and incorporate regional perspectives. Furthermore the Guidelines reaffirm that diverse responses can and should be designed within the context of universal human rights standards.

The principal users of the Guidelines will be the States, legislators and Government policy-makers, including officials involved in national AIDS programmes and relevant departments and ministeries, such as health, foreign affairs, justice, employment, welfare and education. Other users who will benefit from the Guidelines include inter-governmental organizations, NGOs, CBOs, networks of PLHAs, ASOs and networks on ethics, law and human rights. The Guidelines address many difficult and complex issues, some of which may or may not be relevant to the situation in a particular country. For these reasons, it is essential that the Guidelines be taken by critical actors at the national and community level and considered in a process of dialogue involving a broad spectrum of those most directly affected by the issues addressed in the Guidelines.

Guideline one states that to be effective, the response to HIV must mobilize key actors throughout all branches of government and include all policy areas, since only a combination of well-integrated and coordinated approaches can address the complexities of the epidemic. In all sectors, leadership must be developed and must demonstrate a dedication to HIV related human rights. Governments should avoid unnecessary politicization of HIV which diverts Government energy and divides the community rather than engendering a sense of solidarity and consensus in dealing with epidemic. Political commitment to dedicate adequate resources to respond to the epidemic within States is essential. It is equally important that these resources be channelled into productive and coordinated strategies. Roles and lines of responsibility within Government, including human rights issues, should be clarified.

Most countries already have national AIDS committees and some countries have established subnational committees too. However, the

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63. 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 programme responsibilities across all branches of government.
persistent lack of coordination in the working of these committees indicates a
need to consider possible additional structures or to strengthen and reorient
existing institutions. Similar coordination is essential between coordinating
committees and multidisciplinary advisory groups within the lower levels of
government. Such coordination is necessary not only in creating specialized
HIV bodies, but also in securing a place for HIV/AIDS human rights issues in
existing mainstream forums, such as regular gatherings of Ministries of, e.g.
health, justice and social welfare etc. A multidisciplinary body with
professional and community representation should exist to advise Government
on legal and ethical issues. These bodies at the national level should also
ensure coordination with UNAIDS, its cosponsors and other international
agencies to reinforce cooperation and assistance to areas relating to HIV and
human rights. Guideline 2\(^64\) represents that Community partners like CBOs,
NGOs and ASOs should have knowledge and experience that States need in
order to fashion effective States responses. This is the case particularly with
regard to human rights issues, as community representatives are either directly
affected by human rights problems or work directly with those who are
affected. States should, therefore, ensure that this knowledge and experience is
used in the development of HIV policies, programmes and creating structural
means to obtain them. As community representatives do not necessarily
possess organizational ability or skills for advocacy, lobbying and human
rights work, this contribution should be enhanced by State funding for
administrative support, capacity-building, human resource development and
implementation of activities.

Laws regulate conduct between the State and the individual and
between individuals, they provide an essential framework for the observance
of human rights, including HIV-related human rights. The guidelines
encourage the enactment of meaningful and positive legislation, to describe
the basic legal components necessary to provide support for the protection of
HIV/AIDS related human rights and effective HIV/AIDS prevention and care

\(^{64}\) GUIDELINE 2 : Supporting Community Partnership : States should ensure, through political and
financial support, that community consultation occurs in all phases of HIV policy design, programme
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.
programmes. Guidelines 3 to 6 encourage law and law reform which would bring national HIV-related laws into conformity with international and regional human rights standards. Although the content of the strategies primarily addresses formal law, law reform should also encompass traditional and customary laws. The process of HIV law review and reform should be incorporated into the State’s general activities regarding the observance of human rights norms and be integrated into the national AIDS response. It is recognized that some of the recommendations for law and law reform, particularly those concerning the status of women, drug use, sex work and the status of men having sex with men, might be controversial in particular national, cultural and religious contexts. It is the obligation of States to establish how they can best meet their international human rights obligations and protect the public health within their political, cultural and religious contexts. The OHCHR, UNAIDS and agencies like ILO can offer Governments technical assistance in the process of law review and reform.

Guideline 7 urges that States (and the private sector) should encourage and support specialist and generalist legal services to enable people living with HIV and affected communities to enforce their human and legal

65. 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 (as revised in 2002): Assess 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.

66. 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.
rights through the use of such services. Information and research resources on legal and human rights issues should also be made available. Such services should also address the issue of reducing the vulnerability to infection within and the impact of HIV on vulnerable groups. The location and format of the information (e.g. plain and understandable language) provided via such services should render it accessible to members of these groups. Models exist in many countries.

The 8th guideline provides that states should take measures to reduce the vulnerability, stigmatization and discrimination that surround HIV and promote a supportive and enabling environment by addressing underlying prejudices and inequalities within societies and a social environment conducive to positive behaviour change. An essential part of this enabling environment involves the empowerment of women, youth and other vulnerable groups to deal with HIV by taking measures to improve the social and legal status, involving them in the design and implementation of programmes and assisting them to mobilize their communities. The vulnerability of some groups is due to their limited access to resources, information, education and lack of autonomy. Special programmes and measures should be designed to increase access. In many countries, community based organizations and NGOs have already begun the process of creating a supportive and enabling environment in their response to the HIV

67. Models include the Group for Life (Group Pela Vidda) in Rio de Janeiro, Brazil, which offers free legal services, brochures, bulletins, telephone hotline and media campaigns. Legal rights brochures have been produced in the United Kingdom by the Terrence Higgins Trust and Immunity's Legal Centre (D. Taylor (ed.), HIV, You and the Law). Resource directories have been produced in the United States by the American Bar Association (Directory of Legal Resources for People with AIDS & HIV, AIDS Coordination Project, Washington, D.C., 1991) and the Gay Men's Health Crisis (M. Holtzman (ed.), Legal Services Referral Directory for People with AIDS, New York, 1991). Several other organizations in the United States have produced practitioner's or volunteer's training manuals, such as the Whitman-Walker Clinic (Washington, D.C.) the AIDS Project (Los Angeles), the National Lawyers Guild, State AIDS Legal Services Organization (San Francisco) and the American Civil Liberties Union (William Rubenstein, Ruth Eisenberg and Lawrence Gostin, The Rights of Persons Living with HIV/AIDS (Southern Illinois Press, Carbondale, Illinois, 1996). A manual for paralegals is being prepared in South Africa by the Pietermaritzburg branch of Lawyers for Human Rights with the assistance of the AIDS Law Project and with training coordination being provided by the AIDS Legal Network. Other resources include bench books for judges (A.R. Rubenfield (ed.), AIDS Benchbook, National Judicial College, American Bar Association, Neno, Nevada, January 1991), the Southern Africa AIDS Information Dissemination Service and newsletters such as the Canadian HIV/AIDS Policy and Law Newsletter and Australia's Legal Link (see also AIDS/STD Health Promotion Exchange, Royal Tropical Institute, the Netherlands).

68. 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.
epidemic. Governments must recognize these efforts and lend moral, legal, financial and political support to strengthen them.

The use of formal standards and their implementation through Government process and law alone cannot change the negative attitudes and prejudices surrounding HIV into respect for human rights. Public programming explicitly designed to reduce the existing stigma has been shown to help create a supportive, tolerant and understanding environment. The reach of such programming should be a mixture of general and focused programmes using media, including creative and dramatic presentations, compelling ongoing information campaigns for tolerance and inclusion and interactive educational workshops and seminars. Thus the goal of the 9th guideline69 is to challenge beliefs based on ignorance, prejudices and punitive attitudes by appealing to human compassion. Guideline 1070 talks about the development of standards by the public and private sectors. First, these translate human rights principles into practice from an insider’s perspective and reflect more closely the community’s concerns. Second, they are likely to be more pragmatic and acceptable to the sector involved. Third, they are more likely to be “owned” and implemented if developed by the sector itself. Firstly, they might have a more immediate impact than legislation.

Standard-setting and promotion of HIV related human rights standards alone are insufficient to address human rights abuses in the context of HIV. Effective mechanisms must be established at the national and community levels to monitor and enforce HIV related human rights. Guideline 1171 emphasizes that the states should see as part of its national responsibility to address HIV. The existence of monitoring mechanisms should be publicized, particularly among networks of people living with HIV, in order to maximize

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69. GUIDELINE 9: Changing discriminatory attitude 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.

70. 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.

71. 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.
their use and impact. Monitoring is necessary to collect information, formulate and revise policy, and establish priorities for change and benchmarks for performance measurement. Monitoring should be both positive and negative, i.e. reporting on good practice to provide models for others to emulate, as well as identifying abuses. The non-governmental sector can provide an important means to monitor human rights abuses, as it has closer contact with the affected communities generally. Formal grievance bodies may be too bureaucratic and their procedures too time-consuming and stressful to attract a representative sample of complaints. Training is necessary for community participants to develop skills so as to be able to analyze and report findings at a level of quality which is credible for States and international human rights bodies.

Guideline 12 urges for international co-operation and support for HIV/AIDS related human rights. The United Nations bodies, agencies and programmes comprise some of the most effective and powerful forums through which States can exchange information and expertise on HIV-related human rights issues and build support among themselves to implement a rights-based response to HIV. States in their work with and governance of these bodies can use these bodies as tools for promoting the Guidelines. States must however both encourage and enable these bodies through political and financial support to take effective and sustained action in terms of promoting the Guidelines and must respond positively to the work done by these bodies.

Approach of the Various National Courts on HIV/AIDS Related Issues

HIV/AIDS have raised a multiplicity of legal questions, and prompted a "juridical outburst" of laws, policies and programmes. In some cases, legislation has been helpful and proactive in addressing some of the factors, be they structural or individual, which sustain or fuel the epidemic. In other cases, sadly, legislation has perpetuated or even compounded the problem. The UDHR has also recognized that everyone has the right to an effective

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72. GUIDELINE 12 : International Cooperation : States should cooperate through all relevant programmes 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.
remedy by the competent national tribunals for acts violating the human rights and fundamental freedoms granted to him by the constitution or by law. The exercise of this right is an important mechanism for defending or promoting the human rights of people living with HIV and those for whom marginalization and the denial of human rights heightens vulnerability to HIV/AIDS.

Judiciary can be part of a broader effort to ensure that government action is consistent with states' obligations under national laws that guarantee rights and freedoms, as well as states' obligations under international law to respect, protect and fulfil human rights. Where government policies or practices are challenged, judiciary attempts to hold governments accountable for their action or inaction. Ideally, judiciary can ensure the necessary tempering of laws through impartial and principled review and can encourage or compel state action where political will has been lacking. On occasion, judiciary can empower the socially disadvantaged, including groups most vulnerable to HIV/AIDS and even where such actions fail, the courts can shine a spotlight on areas for legal and policy reform, contributing to a larger process of social change.

Although laws and legal systems vary from country to country, the legal issues for people living with and affected by HIV/AIDS are in many cases strikingly similar. Like non-legal barriers in approaching the judiciary, such as stigma; the creative use of legal mechanisms to protect the vulnerable, and thereby the importance of judiciary in broader social mobilization and other forms of human rights activism. In different regions of the globe considerable litigation has occurred, aimed at protecting and promoting the human rights of HIV/AIDS victims and the judiciary in most of the cases has emerged as champion of the rights of HIV/AIDS victims.

The Canadian Human Rights Tribunal in case of Canada (Attorney General) v/s Thwaites ruled that discrimination against an HIV-positive soldier is unconstitutional. Thwaites was one of the first decisions in the world to address the issue of discrimination within the military against PLHAs. The courts though in numerous other jurisdictions have not followed this human

73. 1994, 3 FC 38, Federal Court of Canada-Trial Division.
rights focused approach in cases of discrimination against members of armed forces. For instance, in JRB et al v/s Ministry of Defence. The Supreme Court of Venezuela delivered a mixed ruling from a human rights perspective. The Court found the State liable for failing to protect the privacy of its employee's personal health information, ordered it to ensure adequate medical treatment for personnel with HIV/AIDS, and take proactive measures aimed at challenging discriminatory attitudes and improving HIV prevention, care and treatment within the armed forces. Instead of calling on the State and society generally to act in a spirit of solidarity, it squarely described and rejected the stigma surrounding HIV/AIDS. However, the Court did not support the petitioner's claim to a right to continue to serve in the armed forces. The Ministry of Defence put before the Court various publications in which concern was expressed about the overall challenge that high rates of HIV infection among personnel presents for armed forces. From this, the Court drew the blanket conclusion that HIV infection is incompatible with a military career. Similarly, it failed to give serious consideration to whether the individual petitioners in this case had been discriminated against when removed from their positions, even though there was no evidence that they were unable to fulfil their duties. In this respect, the decision falls short in protecting the human rights of individual people living with HIV.

This ruling is at odds with recent and encouraging developments from other jurisdictions. For example in a Colombian case of XX v/s Ministry of National Defence the court made use of constitutional rights, such as the right to life, equality, work, privacy, health and the freedom to choose one's profession or occupation. The court held that the expulsion of a student due to HIV positive status was discriminatory and violated his right to education. Similarly in H.N. Nanditume v/s Minister of Defence, the Namibian court held that exclusion of person from military services solely because of his HIV-positive status is discriminatory. In Hoffmann v/s South African Airways,77 the South African court’s ruling affirms that the blanket exclusion of HIV-positive people from employment infringes the constitutional guarantee of

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77. Case CCT 17/00, 2000 (11) BCLR 1235, Constitutional Court of South Africa, Johannesburg.
equality. Individual job applicants should be evaluated in terms of their individual circumstances, including their ability to perform the essential duties of a job, rather than on the fact they are HIV-positive. The Court pointed out that PLHAs cannot be "condemned to economic death" by the denial of equal opportunity in employment. This judgment is of considerable importance both domestically and internationally, particularly to the extent that it may influence the judiciary in other countries to extend legal protection against discrimination to PLHAs in employment sector.

However in Karen Perreira v/s The Buccleuch Montessori Pre-School and Primary Ltd. et. al, the same dismissed the case against the school for deferring the enrolment of child living with HIV. The judgment was disappointing in its approach as it allows a school to effectively exclude a child with HIV as long it "defers" the application, rather than to reject the child outright. The judgment failed to provide guidance as to the basis on which such deferral may take place and what steps the education sector should take to accommodate children with HIV.

In the area of employment, the judgment of Diau v/s Bostswana Building Society (BSS) highlights the vital role of judiciary. The court held that an employee cannot be dismissed for refusing compulsory HIV antibody test. From a human rights perspective, there are positive and negative aspects of this decision. On the positive side, the decision affirms the "horizontal" application of the Botswana Constitution to entities other than state. According to the court, private actors who wield significant economic and social power, are not beyond the reach of the Constitution. In any legal system where there are no specific human rights laws applicable to private actors, the application of the constitutional provisions may offer PLHAs a measure of protection for their fundamental human rights. Another positive element of the decision was the willingness of the court to view Botswana's National HIV/AIDS Policy, to the extent that its provisions are consistent with the values espoused by the Constitution. The final positive element was the court's willingness to examine international human rights instruments, the constitutions of other countries, HIV/AIDS related decisions from other

78. Case No. 4377/02, High Court of South Africa, Johannesburg, 22 October 2003.
countries and other international sources of guidance on human rights of
HIV/AIDS victims.

A significant negative aspect of the decision was the court's
classification of the HIV test as "compulsory post-employment test", rather
than compulsory testing as a condition of employment. The respondent made a
specific, written demand for a certified document of HIV status more than six
months after the applicant joined the job. However, it was clear from the
evidence that the plaintiff's employment was conditional on successful
completion of a medical examination which included an HIV test or certified
document of HIV status. As a result, the decision does not address whether
HIV testing as a condition of employment is legal under Botswana law. In a
country such as Botswana, with an exceedingly high rate of HIV infection in
the working-age population, the law must strive to protect individual human
rights by preventing infringements, not merely by providing remedies where
infringements have already occurred. A second, related limitation of the
decision was the court's narrow analysis of the question of HIV/AIDS related
discrimination. It is encouraging that the court recognized that discrimination
based on a person's real or perceived HIV positive status is constitutionally
prohibited. But its approach to the question of demanding HIV testing as a
condition of employment fell short of fully protecting against such
discrimination. It has been recognized in many jurisdictions that it amounts to
discrimination in employment to require information such as a job candidate's
marital status, religion, sexual orientation, race or ethnicity etc. Similarly,
inquiring into an employee's HIV status is also recognized in many
jurisdictions as constituting, in itself, a discriminatory practice. This case
presented a good opportunity for the court to establish proactively that it is
discriminatory per se under the Constitution of Botswana to impose HIV
testing as a condition of employment. This would have been consistent with
the court's declaration that the language of the constitution must be given a
broad and purposeful interpretation, so as to give effect to its spirit, and this is
particularly true of those provisions that are concerned with the protection of
fundamental human rights.

The courts have dealt comprehensively with these issues regarding
access to HIV/AIDS related treatment, keeping in mind the importance of
fundamental right to health. In case of Alonso M Ceballos v/s Instituto de Seguros Sociales, the Columbian court held that the state is under constitutional obligation to ensure HIV/AIDS treatment. The court cited Article-12 of ICESCR which expressly recognizes positive obligations on the part of the State to protect and promote access to health services. The right to equality was also mentioned by the court. The court emphasized the particular obligation on the part of the State towards those who are 'debilitated' by poverty or 'physical or mental condition. This was one of the first cases in Latin America to consider enforceability of the right to health of PLHA, challenging the discriminatory denial of health care services. The claim specifically to the issue of antiretroviral drugs came up in cases of L.G. Murillo Rodriguez et al v/s Caja Costarricense de Seguro and William Garcia Aluarey v/s Caja Costarricense de Seguro. The court held that social security must cover ARV drug costs for PLHAs.

Within one week of this decision, dozens of PLHAs indicated their intention to file petitions to obtain access to medicines. Facing the possibility of hundreds of such applications, the Court ordered the ‘Social Security Fund’ to develop a plan to provide coverage to all PLHAs in need of antiretrovirals, which it did within a few weeks. Costa Rica thereby became the first American country to include coverage of antiretroviral drugs within its national health insurance plan. These cases have also helped to stimulate activism beyond Costa Rica’s borders. For example, in April 1998, an organization advocating for the rights of PLHAs in Panama filed an application with the Supreme Court in Panama seeking an order compelling coverage for antiretroviral drugs by the ‘Social Security Fund’, similar to what had been achieved in Costa Rica. In December 1998, the Court rejected the application on technical grounds, with no consideration of its substantive merits. However, the Court did signal that the ‘Social Security Fund’ was responsible for ensuring appropriate health care.

In D v/s United Kingdom the European Court of Human Rights ruled that deportation of man with AIDS to a country without adequate treatment

81. Decision No.6096-97, Constitutional Chamber of Supreme Court of Justice, Costa Rica, 1997.
82. Decision No.5934-97, Constitutional Chamber of Supreme Court of Justice, Costa Rica, 1997.
constitutes degrading treatment and is violative of Article 3 of the European Convention of Human Rights. While taking this significant stand, the Court appeared hesitant as it may be afraid that it could open the floodgates to an influx of “medical refugees” to wealthier countries with a publicly funded health system capable of delivering access to life-saving or life-extending care. It was, therefore, at great pains to point out that its ruling was heavily dependent on the compassionate circumstances of this particular case. As such, it did not establish a precedent that is likely to be widely applicable beyond the small number of people whose situation might be as dire as that of the applicant.

Subsequent experience bears out the limits of this judgment. There have been some further cases seeking to build on the ruling. Those cases have been unsuccessful on their facts, demonstrating the Court’s unwillingness to expand any further the applicability of Article 3 of the Convention to protect people with serious health conditions. For example, in 1998, the court rejected the application of a HIV positive person challenging his deportation from France to the Democratic Republic of Congo as violative of Article 3, where the infection had already reached an advanced stage and where the care facilities in the receiving country were precarious. However, the Court subsequently struck out the application. Two years later, in the case of a Zambian woman living with HIV facing deportation from Sweden, the European Court affirmed its judgment in D. v. United Kingdom but went on to reject her complaint on the facts. It pointed out that: she was only HIV-positive (and had not progressed to a likely terminal stage of AIDS); she had only just recently begun antiretroviral therapy; according to the Swedish Embassy, AIDS treatment is available in Zambia; and her children and other family members live in Zambia. Given these circumstances, the Court did not find that removing her from Sweden to Zambia would amount to inhuman treatment contrary to Article 3 of the Convention.

More recently, in May 2005 the UK House of Lords issued a ruling setting out a very restrictive interpretation of the European Court’s judgment.

In D v/s. United Kingdom. In N (FC) v/s. Secretary of State for the Home Department the House of Lords rejected an appeal against a deportation order filed by a 30 year old woman living with HIV, who argued that expelling her to Uganda, a country where access to HIV medication and medical care was uncertain, was in breach of the European Convention. She had travelled to the United Kingdom in 1998 and claimed asylum based on her experience of being kidnapped and raped by members of both the Lord’s Resistance Army and a faction of the Ugandan security forces. She was diagnosed as HIV-positive upon her arrival in the UK; as a result of medication and medical care, her condition stabilized over the years she remained in the UK. Her asylum application was eventually refused by the Secretary of State, but an adjudicator allowed her appeal, finding that her expulsion would amount to torture or to inhuman or degrading treatment, contrary to Article 3 of the European Convention. Eventually, the House of Lords overturned this decision and reinstated the deportation order.

In their judgment, the Lords were at pains to construe the judgment in D v. United Kingdom as narrowly as possible. They started from the principle that states have the right to control the entry, residence and expulsion of “aliens.” Yet, in exercising this right, the State must not violate the European Convention’s prohibition on torture or cruel, inhuman or degrading treatment. However, aliens facing deportation cannot claim an entitlement to remain in the State in order to benefit from continuing medical or other assistance. The scope of Article 3 in the European Convention could be extended to address medical or humanitarian concerns only in “exceptional circumstances”- such as the imminent death that was facing D in the European Court’s 1997 decision. In the case of N, the court found she was healthy and her death was not imminent; therefore, her situation could not be considered “exceptional". The House of Lords allowed the deportation order to stand, but also noted that the Home Secretary could exercise his discretion not to deport her to Uganda. As a result, under UK law the availability of treatment and health care in an applicant’s country of origin are virtually irrelevant to a claim under Article 3 or the European Convention; only those who are gravely ill will likely be

protected from deportation. The House of Lords was clearly afraid of establishing a precedent that would open the floodgates to “other foreign AIDS sufferers aspiring to these benefits of treatment and associated welfare” in the United Kingdom.

With regard to the government's obligation to fulfil constitutional right to medicines and treatment of HIV/AIDS and other opportunistic infections, the Supreme Court of Venezuela in case of Cruz Bermudez v/s Ministry of Health and Social Action and Lopey et al v/s Instituto Venezolano de Seguros Sociales ruled that the failure of the government to provide uninterrupted supply of the necessary medications needed for ARV therapy and the treatment of opportunistic infections is in violation of right to health and threatened PLHAs right to life, to the benefits of science and technology and to social security.

The decision of the Inter-American Commission on Human Rights in case of Odír Miranda was the first case on the issue of access to medications for treating PLHAs to proceed before any regional human rights mechanism. The decision affirmed the right of every PLHA to health care, medical, surgical and psychological treatment as well as counselling and preventive measures to impede the progress of the HIV infection. As such it contributed to treatment activism throughout the region, complementing high profile cases before a number of courts by setting a significant and positive precedent.

The case of AV & CM v/s Ministerio de Salud de la Nación and EM Caprio Castro et al v/s Progmma Natinala del & Ministerio de Salud Publica are few in a string of decisions in which PLHAs have been successful in obtaining court orders directing the government to take positive steps to provide antiretroviral drugs. But these judicial or legal victories are not sufficient to protect and fulfil the right to enjoy the highest attainable standard of health, unless governments are willing to provide resources to address the problems faced by PLHAs.

87. Decision No.916, Court File No. 15.789, Supreme Court of Venezuela (Political-Administrative Chamber) 1999.
In case of Minister of Health and others v/s Treatment Action Campaign (TAC) and others\textsuperscript{92} the court held that government had constitutional obligation to implement plan for antiretroviral drugs to reduce mother-to-child transmission of HIV. The judgment concentrated in particular on two basic human rights: the right to access health care services, including reproductive health care and the right of the child to basis health care services. The Constitutional Court's eagerly anticipated judgment was handed down in early July 2002, on the eve of the XIVth International Conference on AIDS in Barcelona, and drew considerable attention from media and civil society worldwide. Unusually, the judgment was delivered unanimously by the eleven judges rather than ascribed to any particular justice, a mark of the seriousness with which the highest court in South Africa viewed this case. Indeed, TAC v. Minister of Health has become one of the world's leading cases on the justiciability of the right to health of women including reproduction rights.

Again, the case of AIDS Access Foundation et al v/s Bristol Myers-Squible Company and Department of Intellectual Property, Central Intellectual Property and International Trade Court was the first such proceeding of its kind in Thai legal history and was driven entirely by civil society activists who saw an opportunity to use the law to challenge excessive patent protection that was blocking access to a needed medicine for most PLHAs in Thailand. It was significant that court directly cited the WTO's Doha Declaration and explicitly interpreted it as support for the conclusion that the rights to life and to health can take precedence on mere property rights. Some states and commentators have suggested that the Doha Declaration is of no legal significance and is merely political, but this is arguably incorrect as a matter of law and this case provides a useful example of how the declaration has influenced judicial decision making at various national levels as well.

At the same time judiciary in a number of cases worldwide came forward in protecting the human rights of prisoners as well. In case of Pedro Orlando Ubaque v/s Director, National Model Prison\textsuperscript{93} the court upheld the rights of the HIV-positive inmates by applying international standards like the UN standard Minimum Rules for the treatment of prisoners, 1955, the 1993

\textsuperscript{92} Case No. CT 8/02, Constitutional Court of South Africa, 2002.

\textsuperscript{93} Decision No. T/502/94, Constitutional Court of Columbia, 1994.
WHO Guidelines on HIV infection and AIDS in prisons and the International Guidelines on HIV/AIDS and Human Rights. (specifically guideline-4). Similarly in case of Leatherwood et al v/s Campbell94, the court compelled the prison administration to take steps to improve the living conditions in prisons. However, this litigation did not end Alabama's policy of segregation of HIV-positive prisoners from the general prison population. This policy is counter not only to the International Guidelines on HIV/AIDS and Human Rights, but also to the WHO Guidelines on HIV infection and AIDS in prison. The relevant part of that policy states:

“Since segregation, isolation and restrictions on occupational activities, sports and recreation are not considered useful or relevant in the case of HIV-infected prisoners. Decisions on isolation for health condition should be taken by medical staff only, and on the same grounds as for the general public, in accordance with public health standards and regulations. Prisoners' rights should not be restricted further than is absolutely necessary on medical grounds”.

At odds with this common approach from expert bodies in the fields of both health and human rights, the policy of segregation of HIV-positive inmates has been upheld by US courts. A federal court upheld mandatory testing and segregation in the state prison in 1990 and stated that prisoners who requested AZT treatment were not entitled to "state of the art" treatment, but only reasonable care according to the community standard. Given subsequent developments in the widely accepted standard of care for treatment of people living with HIV, theoretically this position denying antiretroviral treatment would no longer withstand challenge.

The policy of segregation has continued to attract support from higher courts in recent times. In 1999, in Davis v/s. Hopper, the US Court of Appeals (11th Circuit) ruled that the State policy of total segregation of inmates with HIV did not violate the Americans with Disabilities Act or the 1973 Rehabilitation Act. The court concurred with the prison officials' argument that, because of prisoners' unpredictable behaviour and the fatal nature of AIDS, all inmates with HIV pose a "direct threat" to other inmates and

corrections officers and thus may be categorically excluded from prison programmes. In January 2000, the US Supreme Court refused to consider an appeal by inmates who challenged their segregation in that state's prisons, and let stand the decision in Davis v. Hopper. These decisions are at odds with international standards.

In a number of cases the courts have denied compassionate bail, release, sentence reduction as well as parole to prisoners living with HIV/AIDS. The court in the above cases observed that unfortunate medical condition provoke human sympathy but such condition is generally not a matter for mitigation of a perfectly proper sentence, particularly for crimes of gravity. The court agreed that in appropriate and extreme cases, the court is entitled to take such matters into account, properly balancing public interest and exceptional hardship suffered by an accused. In contrast to this judicial approach, South African Court in case of Stanfield v/s Minister of correctional services and others the court relied on language in international human rights law with respect to protection from "cruel, inhuman and degrading treatment," echoing Article 7 of the ICCPR -language which was also repeated in the South African Constitution. The decision also relied on language very similar to Article 10 of the Covenant, which guarantees that all "persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person."

The court's attempt to distinguish the illness of the applicant in this case from HIV rests on the assumption that persons living with HIV and in need of treatment for their illness would receive it in South African prisons. Insofar as South African prisoners living with HIV continue to be unable to realize their right to be treated for their illness, many of the arguments made in favour of this applicant should also be pertinent to their rights and entitlements. At the time of publication of this document, treatment for HIV unfortunately also remained beyond the reach of many persons in South Africa who are not in prison; some judicial authorities might find this to be an argument for not supporting the right of prisoners living with HIV to treatment for their illness. Such arguments must be weighted against the eventuality,

95. See R v/s Jo Chi Keung, 3 HKCA, 155 Hongkong 1996. Also see, HKSAR v/s UT Jesus Juan, 941 HKCA, Hongkong, 2001, HKSAR v/s Isang Wai Kei, HKCA, 1056, 2003.
96. 12 BCLR 1384, High Court-Cape of Good Hope Provincial Division, 2003.
noted so graphically by the court, of "untold numbers of prisoners dying in prisons in the most inhuman and undignified way."

With respect to the question of capacity of the courts, many a times the governments had argued vehemently that the court had no power to make an order that would have the effect of requiring it to pursue a particular policy. To do so would effectively undermine the doctrine of separation of powers, a fundamental concern of a constitutional democracy. In dealing with such arguments, the judiciary found that "although there are no bright lines that separate the roles of legislature, executive and the judiciary from one another, there are certain matters that are pre-eminently within the domain of one or other of the arms of government and not others. However this did not precluded the courts from making a decision that would have an impact on policy for promotion of human rights of PLHAs. But experiences in several countries, underlines the point that legal victories, while necessary, were not sufficient to protect and fulfil the rights of PLHAs. As long as the governments were unable or unwilling to dedicate the necessary resources or to address systemic problems in the administration of programmes, judicial pronouncements endorsing the human rights of PLHAs would not produce needed action. Court proceeding can provide a focus for broader advocacy efforts. However without complementary human rights activism and culture for respect for rights and rule of law, judgements will simply remain theoretical victories.

**Limitations of International Human Rights Standards in Reversing HIV/AIDS Epidemic**

It has been almost 15 years since the International Guidelines were adopted by the Second International Consultation on HIV/AIDS and Human Rights in 1996. In terms of the fast and ever-evolving epidemic, much has happened in this decade both good and bad. Evidence of the effectiveness of a treatment for HIV was first announced in 1996, which for many changed HIV from a situation of hopelessness to a manageable health condition. But still, widespread access to antiretroviral, as much as to HIV prevention, care and support, remains a major global health and human rights emergency for millions in need. Nonetheless, the number of those having such access is
rising. In this regard, governments and the international community has made various commitments from time to time to pursue all necessary efforts towards achieving the goal of universal access to comprehensive HIV prevention programmes, treatment, care and support by 2010. Some relevant time-bound commitments (including human rights relating to HIV/AIDS), have been made during the decade in Millennium Declaration and in the Declaration of Commitment adopted by the UN special session on HIV/AIDS in 2001 and confirmed and expanded by the Political Declaration of the 2006 and 2008 High Level Meeting on AIDS at the General Assembly Session. These commitments reflect what works in the response to HIV/AIDS, as well as much greater political commitments to the response. Global funding for HIV programmes has risen almost 30-fold in the course of the decade.

Nevertheless, the situation remains grave, with a doubling of people living with HIV, with young people, particularly young women, having the fastest rates of infection, and with some 16 million children having been orphaned by AIDS. The International Human Rights Standards, as reflected in the International Guidelines on HIV/AIDS and Human Rights, does not provide, or claim to provide, a moral code for living with HIV/AIDS. It says nothing, for example, about our personal moral responsibility to care for affected people, although it addresses State’s obligations in these areas. It does not provide particular guidelines on injecting drug use, other than the general principles of non-discrimination and the obligations to control diseases, which can arguably be used to require the introduction of proven public health measures such as needle and syringe programmes. Although international standards on HIV/AIDS include monitoring individual complaints about State’s behaviour, the provisions for enforcement are generally weak, unlike, for example, trade agreements.97 In contrast with World Trade Organization infringements, no mechanism exists to impose monetary fines on violators of human rights of PLHAs.98

98. The International Development aid can be tailored to support democratic freedoms and good governance as a precondition to further assistance of PLHA’s.
Historically, human rights approaches in the western countries have tended to privilege civil and political rights over socio-economic and development rights. In the early year of the epidemic, this prompted a focus on discrimination against people living with HIV/AIDS and on vulnerable groups such as men and the injecting during users, which reflected the preoccupations with individual rights and protection of citizens from state interference. For many developing countries especially the African and Asian countries, such a narrow concept of rights fails to engage with the full range of social, political and cultural factors that underline vulnerability to HIV and response to AIDS. It is not surprising, therefore, the practitioners in developing countries may be skeptical of approaches that focus solely on libertarian notions of rights.\(^9^9\) This reinforces the need for international human rights approaches to policy development which are able to integrate attention to socio-economic rights in response to HIV/AIDS.\(^1^0^0\)

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